A STUDY OF AMERICAN TEACHERS' PROFESSIONAL EXPERIENCES AND

PERSPECTIVES RELATED TO HIV/AIDS IN THE CLASSROOOM, IN COMPARATIVE

PERSPECTIVE

by

MARY MICHAELSELLERS PONTZER

(Under the Direction of Dr. Diane L. Brook Napier)

ABSTRACT

The purpose of this qualitative study was to explore selected Georgian teachers'

professional experiences and perspectives related to HIV/AIDS and the classroom and to

highlight similarities between the experiences and perspectives of participants and teachers in

other countries, as reported by other researchers in scholarly literature. These professional

experiences and perspectives included teaching about HIV/AIDS; instructing students living with

or affected by HIV/AIDS; managing safety and confidentiality concerns; dealing with stigma and

stereotypes associated with HIV/AIDS; grappling with personal feelings about death, dying,

homosexuality; and teacher training issues related to HIV/AIDS. In addition to describing

selected teachers' professional experiences and perspectives on issues related to HIV/AIDS and

the classroom, the study also highlighted broader challenges and struggles associated with the

impact of the HIV/AIDS pandemic for teachers. The study revealed that participants had a range

of professional experiences and perspectives related to HIV/AIDS and the classroom, and that

many of their experiences and perspectives were similar to those of teachers in other countries,

as reported by other researchers in scholarly literature.

INDEX WORDS: HIV/AIDS, Teacher training, Teacher issues, Teacher isolation, Pre-service teacher training, Professional development, Student health issues, Comparative and international education, South Africa

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DEDICATION

This dissertation is dedicated to the memory of my father, Michael Sellers, who shared his love of learning with me from an early age and steadfastly supported me in all of my endeavors with abundant love.

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First, I would like to thank my participants who shared their stories with me and touched me with their courage and grace in the classroom, despite difficult odds and seemingly impossible situations.   Without their participation and insights on the questions and issues, this study would not have been possible. I am grateful for my major professor, Dr. Diane L. Brook Napier, who stood by me and supported me in even the most challenging times. She has become a confidant, a mentor, and a friend throughout my studies in the Social Foundations of Education program, and I simply cannot express how meaningful that support has been. My committee members, Drs. John M. Mativo, John D. Napier, and Jay W. Rojewski were extremely helpful and generous with their time and constructive criticism, and I am thankful for their commitment to excellence, valuable insights and suggestions. I would also like to thank my colleagues and friends, Lesley Graybeal and Kelly McFaden, for their support, friendship, and humor.

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good hands gave me the peace of mind to focus on my work. Finally, I have to thank my "junior

researcher," my daughter, Alexandra. I wrote the first three chapters of this dissertation in the

weeks after she was born when she was swaddled and secured to my chest with a Moby Wrap.

She has continued to be by my side throughout the process. She is my constant motivation and

my constant companion, and I am proud to share this degree with her.

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CHAPTER 1

THE RESEARCH PROBLEM

The purpose of this qualitative study was to explore selected Georgian teachers'

professional experiences and perspectives related to HIV/AIDS and the classroom and to

highlight similarities between the experiences and perspectives of participants and teachers in

other countries, as reported by other researchers in scholarly literature. I highlighted broader

challenges and struggles associated with the impact of the HIV/AIDS pandemic for teachers. In

this chapter, I provide an introduction to the dissertation: a statement of the research problem; a

statement of purpose; a discussion of the background to the problem in the context of the history

and current status of the HIV/AIDS pandemic; a statement of goals and objectives; a list of

research questions that guided the study; and a discussion of the significance and limitations of

the study.

Statement of the Problem

HIV/AIDS is a global health, educational, political, cultural, social, and economic crisis.

Global infection rates—including those in America—remained quite high nearly thirty years

after the advent of the pandemic. Since there was no vaccine to prevent HIV infection or cure

for AIDS, education was the best prevention strategy against the disease (Maylath & Gray, 1993;

White & Ballard, 1993). Public schools had the potential to be integral sites for disseminating

life-saving HIV/AIDS education, and since the early 1900s, schools and educators played a

crucial role in delivering sexuality education messages to American youth (Campos, 2002).

Since the onset of the American HIV/AIDS pandemic, organizations such as the Centers for

Disease Control and Prevention (CDC) argued that public schools should play a role in combating HIV/AIDS by providing appropriate, effective HIV/AIDS education. Subsequently, many teachers became important actors in the overall fight against HIV/AIDS by delivering HIV/AIDS prevention messages to their students. The professional impact of the HIV/AIDS pandemic on teachers, within the larger landscape of the HIV/AIDS pandemic, is the specific area of focus for my research.

In addition to providing HIV/AIDS education to students, there were many other ways in which some teachers dealt with the HIV/AIDS pandemic in the context of the classroom. For instance, many teachers taught students in their classrooms that were living with HIV/AIDS. With the advent of new, more effective treatments, HIV/AIDS positive youth were increasingly present in schools (Foulk, Gessner, & Koorland, 2001; Spears, 2006). Further, some students were affected by a family member's or friend's seropositive status. As infection rates remained steady in the United States, the chance of teaching a student affected by HIV/AIDS in some way increased. Some of these infected or affected students needed special considerations or had special needs in the classroom. Subsequently, teachers needed at least a minimal understanding of the students' health, psychological, and emotional needs.

Other issues such as safety and confidentiality concern were important to consider in terms of the impact of the pandemic for educators. Teachers needed to address stigma and stereotypes surrounding HIV/AIDS, as well as their own feelings about death, dying, homosexuality, and other potentially difficult topics associated with HIV/AIDS. A final issue related to teachers and HIV/AIDS was the specialized pre-service or in-service HIV/AIDS training designed to help educators better negotiate realities associated with HIV/AIDS in the classroom.

Given the various ways in which some classroom teachers dealt with HIV/AIDS, I explored selected teachers' professional experiences and perspectives on issues related to HIV/AIDS in the classroom. I examined aspects of these experiences and perspectives that were also found in international scholarly literature about teachers and HIV/AIDS. Although this study was grounded in the American context, and specifically in the State of Georgia, I used comparative insights to emphasize shared experiences and perspectives for teachers in the face of the HIV/AIDS pandemic. I obtained comparative insights from research in South Africa, Namibia, Botswana, Uganda, Malawi, Mali, Lesotho, Nigeria, Mexico, Belize, Haiti, Great Britain, Tanzania, Vietnam, and Thailand. Including international insights was particularly important for this study because of the fact that HIV/AIDS is an international medical, educational, political, social, and cultural phenomenon. Given the nature of globalization and the vast amount of borrowing (Wiseman & Baker, 2005) that occurs between countries' educational, health, and government policies, comparative insights on teachers' professional experiences and perspectives related to HIV/AIDS in other countries were useful for better understanding the implications of the HIV/AIDS crisis for education in the context of my study and in general.

I also found it pertinent to include international insights because of my own interest into the nature of the South African HIV/AIDS pandemic from my 2008 professional study abroad program to South Africa with George Mason University. During my visit to South Africa, I visited several key sites in Johannesburg, Pretoria, and Cape Town, where I was able to witness firsthand the magnitude of the impact of the HIV/AIDS pandemic in that nation. I spent time at two sites: the Kliptown Youth Program (http://sites.google.com/a/meadowbrook-ma.org/kyp/) located within a Johannesburg township and the Acres of Love orphanage

(http://www.acresoflove.org/), also in Johannesburg. I attended lectures at the University of Pretoria, visited an HIV/AIDS clinic in Hammanskraal, and toured the headquarters of an HIV/AIDS legal task force called the Center for the Study of AIDS in Pretoria (http://www.csa.za.org). These experiences combined to provide me with some understanding of the challenges facing South Africa and the world at large in the fight against HIV/AIDS. In the spirit of recognizing the important impact this experience had on me personally and professionally, I drew on and from subsequent reading and examination of research from South Africa and other countries.

Statement of Purpose

Using the guidelines set forth by Creswell (1998), the statement of purpose for my study is as follows: The purpose of this qualitative study was to explore selected Georgian teachers' professional experiences and perspectives related to HIV/AIDS and the classroom and to highlight similarities between the experiences and perspectives of participants and teachers in other countries, as reported by other researchers in scholarly literature. These experiences and perspectives included teaching about HIV/AIDS; instructing students living with or affected HIV/AIDS; managing safety and confidentiality concerns; dealing with stigma and stereotypes associated with HIV/AIDS; grappling with personal feelings about death, dying, homosexuality; and teacher training issues related to HIV/AIDS. Although the United States and specifically the State of Georgia were the primary contexts for this study, I included comparative insights from international scholarly literature that revealed shared experiences and perspectives between participants in this study and teachers in other countries.

Background to the Problem

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) were first identified in the 1980s, although there was evidence of both the virus and the syndrome dating back to the 1930s (Shilts, 2007). Although HIV/AIDS appeared to be isolated among gay men during the infancy of the pandemic, the virus became alarmingly widespread and there were an estimated 33 million individuals living with HIV/AIDS worldwide in 2008 (Boler & Archer, 2008). In certain sub-Saharan African countries such as South Africa, recent estimates indicated that one in five adults were infected with HIV/AIDS (UNAIDS, 2009). In 2010, an American was newly infected with HIV/AIDS every nine and a half minutes (Centers for Disease Control and Prevention [CDC], 2010). The vast numbers of individuals infected with the virus meant that entire communities, regions, and nations were severely impacted by HIV/AIDS. Consequently, HIV/AIDS was one of the greatest health crises in human history and posed threats to social, cultural, political, and economic structures worldwide.

Since there was no vaccine to cure or prevent HIV/AIDS to date, education was heralded as one of the most powerful tools to combat the virus (Maylath & Gray, 1993; White & Ballard, 1993). In some cases, issues such as community resistance, implementation hurdles, and teacher discomfort with the subject matter prevented students from receiving effective HIV/AIDS education. The barriers to effective HIV/AIDS education coupled with the sheer magnitude of the HIV/AIDS crisis make the overall field of HIV/AIDS education a critical area of inquiry. There are multiple dimensions to the field of HIV/AIDS education, including curriculum concerns, teaching training issues, and teacher experiences and perspectives. The history of HIV/AIDS, current HIV/AIDS statistics, and a thorough exploration of issues pertaining to HIV/AIDS education are dealt with in more detail in Chapter Two.

Rationale

The rationale for this study had personal and scholarly dimensions. On a personal level, I had an acute interest in the HIV/AIDS pandemic because my cousin, Andrew, died from AIDS in the 1990s. Although I was in junior high when he passed away, his death had a profound impact on me. Throughout high school and my undergraduate studies, I followed developments concerning the HIV/AIDS pandemic quite closely. When I lived in Atlanta, I volunteered for a meal delivery service for homebound individuals living with HIV/AIDS, which provided me with an opportunity to see the daily impact of the pandemic for several individuals.

Beginning as a Master's student in English Education, I developed an interest in HIV/AIDS as an area of scholarly research. While there were a considerable number of studies that examined HIV/AIDS education curriculums, I felt it was also important to better understand teachers' unique professional experiences and perspectives related to HIV/AIDS and the classroom. In my study, I included comparative insights in order to gain a more holistic view of the range of teachers' professional experiences and perspectives related to HIV/AIDS and the classroom and to reflect my academic interest in the international HIV/AIDS pandemic. Better understanding of teacher's professional experiences and perspectives on issues associated with HIV/AIDS could improve the overall nature of HIV/AIDS education and contribute to the growing field of comparative research on HIV/AIDS.

Goals and Objectives

The primary goal for this qualitative study was to explore selected teachers' professional experiences and perspectives related to HIV/AIDS and the classroom. I had an additional goal to highlight similarities between the experiences and perspectives of participants and teachers in other countries, as reported by other researchers in scholarly literature.

My specific objectives for this study were:

- To understand and describe selected teachers' professional experiences and perspectives on issues related to HIV/AIDS in the classroom;

- To understand these selected teachers' professional experiences and perspectives in terms of the broader challenges and struggles teachers face in the classroom in terms of HIV/AIDS;

- To draw on international HIV/AIDS education research in order to compare the experiences and perspectives of participants in this study with teachers in other countries and reveal universal issues related to HIV/AIDS and the classroom.

See Appendix A for a chart demonstrating how the study objectives were aligned with the research questions.

Research Questions

The goals and objectives of the study were instrumental in shaping my research questions. The research questions guiding my study were as follows:

1. What are selected teachers' experiences and perspectives on issues related to HIV/AIDS in the classroom?

    a. What are their experiences and perspectives about teaching about HIV/AIDS?

    b. What are their experiences and perspectives about teaching students living with HIV/AIDS?

    c. What are their experiences and perspectives about teaching students affected by a family member or friend's seropositive status?

    d. What are their experiences and views about managing safety and confidentiality concerns related to HIV/AIDS in the classroom context?

e. What are their experiences and perspectives about dealing with stigma and stereotypes surrounding HIV/AIDS in the classroom context?

f. What, if any, are their experiences and perspectives about negotiating personal feelings related to issues such as death, dying, homosexuality, and illness related to HIV/AIDS?

g. What are their experiences and perspectives about HIV/AIDS related pre-service or in-service teacher training programs?

2. How do selected teachers' professional experiences and perspectives illuminate broader challenges and struggles associated with the impact of the HIV/AIDS pandemic for teachers?

3. How do these selected teachers' professional experiences and perspectives compare to the experiences and perspectives of teachers in other countries, as reported by other researchers in scholarly literature, and reveal universal issues related to HIV/AIDS and the classroom?

These research questions, as well as the methods that I employed to answer them, were included in the following research matrix.

Research Question	Rationale	Data Sources	Analysis Methods
1. What are selected teachers' experiences and perspectives on issues related to HIV/AIDS in the classroom? a. What are their experiences and perspectives about teaching about HIV/AIDS? b. What are their experiences and perspectives about teaching students living with HIV/AIDS? c. What are their experiences and perspectives about teaching students affected by a family member or friend's seropositive status? d. What are their experiences and views about managing safety and confidentiality concerns related to HIV/AIDS in the classroom context? e. What are their experiences and perspectives about dealing with stigma and stereotypes surrounding HIV/AIDS in the classroom context? f. What, if any, are their experiences and perspectives about negotiating personal	Elicit emic perspective for thorough understanding of the ways in which teachers encounter and deal with HIV/AIDS in the classroom	Scholarly literature In-depth interviews Field Notes	Transcription, coding, and analysis of interviews and field notes for context/themes/categories

feelings related to issues such as death, dying, homosexuality, and illness related to HIV/AIDS? g. What are their experiences and perspectives about HIV/AIDS related pre-service or in-service teacher training programs?			
2. How do selected teachers' professional experiences and perspectives illuminate broader challenges and struggles associated with the impact of the HIV/AIDS pandemic for teachers?	Links individual participants' professional experiences and perspectives to broader landscape of challenges and struggles teachers encounter	Scholarly literature In-depth interviews Field notes	Transcription, coding, and analysis of interviews and field notes for context/themes/categories
3. How do these selected teachers' professional experiences and perspectives compare to the experiences and perspectives of teachers in other countries, as reported by other researchers in scholarly literature, and reveal universal issues related to HIV/AIDS and the classroom?	Widens scope of dissertation, makes connections from local to global (and vice versa), provides international and comparative context. Highlights the big picture and answers the "so what" question of the dissertation	Scholarly literature In-depth interviews Field notes	Transcription, coding, and analysis of interviews and field notes for context/themes/categories

Figure 1: Research matrix

Significance of the Study and Limitations

This study focused on selected teachers' professional experiences and perspectives on issues related to HIV/AIDS in the classroom. Through future publications, conference presentations, or other forms of dissemination, the findings from this study could provide insights for other educators, school personnel, or other interested parties about the impact of the HIV/AIDS pandemic for educators. It may be useful to understand selected teachers' professional experiences and perspectives on issues related to HIV/AIDS in order to call attention to what is actually happening in classrooms in terms of the intersection of HIV/AIDS and education. The study also revealed issues such as communication gaps in schools and teacher isolation, and these findings may contribute to the more general scholarly field of teacher studies.

The study included comparative insights from multiple nations in order to explore shared experiences and perspectives among teachers in any country in terms of HIV/AIDS. Drawing upon the notion that there is strength in numbers, emphasizing shared experiences and perspectives on the issues may increase overall support for teachers given the similar realities they face in terms of HIV/AIDS in the classroom. Study participants, in particular, may appreciate the fact that their experiences and perspectives are, in some cases, similar to other teachers around the world.

Some of the limitations to this study were the result of the fact that the study was "bounded," (Merriam, 1998, p. 28) and that I focused only on a selection of participants in the State of Georgia. Among those participants, there were further limitations based on the similar demographics and backgrounds of the participant pool. Overall, these limitations led to a lack of

generalizability of the findings of the study (Mertens, 2005). These and other limitations are outlined in more detail in Chapter Five of the dissertation.

In the following chapter, Chapter Two, I explore relevant scholarly research that informed my study. In Chapter Three, I provide details about the general study design, the theoretical framework underlying the study, the methodology of the study, and specific methods that I employed during data collection and analysis. Chapter Four of the dissertation features the findings of the study. In the final chapter, Chapter Five, I discuss implications of the findings and universal issues that emerged from the study, as well as reflections on the role of researcher and directions for future research.

CHAPTER 2

REVIEW OF THE LITERATURE

In this chapter of the dissertation, I review scholarly literature related to the study. First, I explore the general history of HIV/AIDS as represented in research and current HIV/AIDS statistics. Second, I include an overview of both the history of sexuality education and contemporary sexuality education in the United States. Next, I examine HIV/AIDS education in the United States and specifically in the State of Georgia, and I discuss HIV/AIDS related classroom realities for teachers. I conclude the chapter with a brief overview of selected scholarly literature that provides an international context for the study.

History of HIV/AIDS

AIDS was first detected in the United States in 1981, although its history dated back to the 1930s in Western Africa (Shilts, 2007; Kanabus, Allen, & de Boer, 2010). It was commonly believed that HIV jumped species from simian to human sometime between 1930 and 1950 when a hunter in West Africa was infected with HIV from the blood of a monkey through a bite or improper cleaning of a carcass (Kanabus et al., 2010). Factors such as increased international travel, increased injection drug use, and a growing blood product industry led to the accelerated spread of the virus during the late twentieth century (Kanabus et al., 2010). The virus likely moved from Africa to Haiti during the late 1960s, after which point the virus took root in the United States (Kanabus et al., 2010).

Early cases of HIV/AIDS appeared to be confined to gay men living in the United States (Shilts, 2007). However, AIDS was soon reported among other groups, namely hemophiliacs

and other individuals who received tainted blood products, a large group of Haitian immigrants, and intravenous drug users (IDUs). By 1985, merely four years after the syndrome was first identified, over 20,000 cases were reported by the World Health Organization (WHO) (Kanabus & Fredriksson, 2010a). Nearly 16,000 of those infected lived in the United States (Kanabus & Fredriksson, 2010a), which made the United States a ground zero for the pandemic. Morens, Folkers and Fauci (2009) suggested that pandemics shared many characteristics, such as wide geographic distribution, traceable transmission from place to place, high attack rates, explosive spread, and minimal population immunity. Pandemics were also infectious, contagious, and severe (Morens, Folkers & Fauci, 2009).

Scientists worked throughout the early 1980s to better understand HIV/AIDS. The first major development came in 1986 when researchers determined that HIV caused AIDS (Shilts, 2007). While this discovery had several implications for the understanding of the origin and treatment of AIDS, the most important realization was that HIV could lie relatively dormant in the body for many years before developing into AIDS. In some cases, people were HIV positive for nearly ten years before developing full-blown AIDS (Shilts, 2007). Ultimately, the discovery of HIV meant that early AIDS statistics were actually inaccurate because they did not take into account the countless persons who lived, possibly asymptomatically, with HIV worldwide. By the time scientists began to more fully understand the nature of HIV and AIDS, the pandemic spread worldwide. By the end of 1986, over 38,000 cases of HIV/AIDS in 85 different countries were reported to the WHO (Kanabus & Fredriksson, 2010a). Of those cases, nearly 32,000 were among Americans (Kanabus & Fredriksson, 2010a).

There were other significant developments in the late 1980s concerning HIV and AIDS. Although Dutch scientists suspected an African connection to HIV/AIDS since the first cases

appeared in the early 1980s (Shilts, 2007), it was not until 1986 that scientists looked in earnest

for African cases of HIV/AIDS. They found extensive evidence of HIV/AIDS on the African

continent, namely in Zaire and Uganda (Kanabus & Fredriksson, 2010a). Just as with the

discovery of HIV, the unearthing of widespread evidence of HIV/AIDS in Africa meant that

previous prevalence estimates did not accurately express the full extent of the global AIDS

pandemic. By 1987, the WHO reported close to 48,000 cases of AIDS globally, more than

double the number reported in 1985 (Kanabus & Fredriksson, 2010b).

Throughout the remainder of the 1980s and the 1990s, there was a great deal of

awareness-building surrounding the HIV/AIDS pandemic. There were public service

announcements, education campaigns, and media coverage of the pandemic. Public education

campaigns in the United States and abroad were direct and aggressive. A billboard created by

the European Union featured a couple seated on a giant condom fashioned into a rocket ship, and

television advertisements in the United States featured condoms in the forefront of a couple in

bed together (Kanabus & Fredriksson, 2010c). In addition to this direct style of public education

campaigns, celebrities living with HIV/AIDS, such as Arthur Ashe, Earvin "Magic" Johnson,

Freddie Mercury, Rock Hudson, Rudolf Nureyev, and Pedro Zamora brought attention to the

pandemic. International figures such as Diana Princess of Wales, Elton John, Bill Gates, and

Nelson Mandela used their celebrity status to increase attention, funding, and compassion for the

HIV/AIDS cause. Despite these efforts, HIV/AIDS continued to spread globally. By 1990,

experts estimated nearly 10 million worldwide with HIV, and an additional 300,000 persons

lived with full-blown AIDS (Kanabus & Fredriksson, 2010b). The 1990s were also notable in the

history of HIV/AIDS because the United States was no longer the epicenter of the pandemic. Of

the 14 million HIV cases at the end of 1993, over 9 million were among individuals living in

Sub-Saharan Africa, while less than one million were among Americans (Kanabus &

Fredriksson, 2010b). In the context of this study, I found it useful to explore the history of

HIV/AIDS in order to better understand the current status of the pandemic in the United States

and abroad.

Current HIV/AIDS Statistics

HIV/AIDS has been a global health and humanitarian crisis for nearly three decades. A

2003 report indicated that more than three times the number of people who died in the September

11, 2001 terrorist attacks died of HIV/AIDS each day worldwide (Hunter, 2003). In 2007, over

33 million people were living with HIV worldwide, and nearly 7,000 new infections occurred

daily across the globe (Boler & Archer, 2008). Most frightening was the notion that many

scientists believe that HIV/AIDS was still "in its infancy" (Hunter, 2003, p. 7), which signaled

that estimates of infections and deaths were inadequate. The HIV/AIDS pandemic continued to

be devastating because the majority of new infections occurred among individuals younger than

25 years of age, which meant individuals in their economic, social, and reproductive primes were

infected (The Henry J. Kaiser Family Foundation, 2009a).

Although the primary mode of transmission varied from country to country, globally

speaking, heterosexual sexual activity was the primary means through which HIV/AIDS was

spread (The Henry J. Kaiser Family Foundation, 2009a). Globally, women were particularly at

risk for infection because of the increased likelihood that they lived in poverty and experienced

gender inequity, sexual violence, endemic rape, and lack of access to education and health

services, which were all linked to increased incidence of HIV/AIDS (The Henry J. Kaiser Family

Foundation, 2009a). In Sub-Saharan Africa, women accounted for nearly 60% of all HIV/AIDS

infections (The Henry J. Kaiser Family Foundation, 2009a). Children were also widely affected

by the pandemic. There were over 2.1 million children living with HIV/AIDS in 2008, and during that year alone, approximately 430,000 new infections were reported among youth (The Henry J. Kaiser Family Foundation, 2009a). A 2009 report indicated that an additional 17.5 million children were affected by HIV/AIDS, as they became orphans due to the loss of one or both parents to the virus (The Henry J. Kaiser Family Foundation, 2009a).

Global statistics.

Sub-Saharan Africa was hardest hit by the HIV/AIDS pandemic. Although home to only 12% of the global population, 67% of HIV/AIDS infections occurred in Sub-Saharan Africa (The Henry J. Kaiser Family Foundation, 2009a). Further, 86% of pediatric HIV/AIDS cases were among children living in Sub-Saharan Africa (The Henry J. Kaiser Family Foundation, 2009a). Southern Africa, in particular, was devastated by the pandemic. In South Africa, for instance, in 2009 one in five adults was infected with the virus (UNAIDS, 2009). After Sub-Saharan Africa, the Caribbean was the second most affected region where 1% of the total adult population lived with the virus (The Henry J. Kaiser Family Foundation, 2009a). Other nations such as Brazil, Estonia, Russia, Ukraine, Cambodia, Myanmar, Thailand, Vietnam, Pakistan, and Indonesia had high numbers of infected individuals, although these numbers paled in comparison to those reported in Sub-Saharan Africa (The Henry J. Kaiser Family Foundation, 2009a).

Although the pandemic remained a serious threat to humanity, there were positive steps towards weakening the impact of the virus worldwide. While the number of daily new infections remained high, there was an overall decline in new infections between 2001 and 2008 when annual new infections decreased from 3.2 million to 2.7 million (The Henry J. Kaiser Family Foundation, 2009a). This decline was in part due to the natural course of the pandemic, but there were also signs that prevention, treatment, and testing programs had a positive impact on

infection rates (Boler & Archer, 2008). Although the numbers of individuals who received antiretroviral treatment (ART) rose dramatically since these therapies were first introduced in 1996, recent reports indicated that more than half of the individuals who might have benefited from ART did not receive such treatments, signaling that there was still tremendous work to be done (The Henry J. Kaiser Family Foundation, 2009a).

American statistics.

While the majority of new infections occurred in sub-Saharan Africa, the United States remained in the throes of an HIV/AIDS crisis. As of 2007, nearly 600,000 Americans died from HIV/AIDS since the virus was first identified (The Henry J. Kaiser Family Foundation, 2009b). The CDC (2008a) estimated that there were over 56,000 new American infections in 2006, which represented an increase in annual infections from previous years. Of the 56,000 estimated new infections, the CDC noted that only approximately 35,314 new cases were reported (CDC, 2008b). This statistic was important because it meant that approximately 21,000 Americans were unknowingly infected with HIV/AIDS and could have spread the virus to others. Similarly, a 2001 survey indicated that only 45.6% of Americans had ever been tested for HIV/AIDS in their lifetimes, which signaled that many Americans were unknowingly infected with the virus (The Henry J. Kaiser Family Foundation, 2009b). Reportedly, over one million people in the United States were living with HIV/AIDS in 2009 (The Henry J. Kaiser Family Foundation, 2009b).

Of those Americans infected with HIV/AIDS, nearly 80% were male (CDC, 2008b). The disparity in infections on the basis of gender was due in large part to the fact that male-to-male sexual contact was the most prevalent form of transmission of the virus in the United States. Approximately 44% of persons living with HIV/AIDS contracted the virus through homosexual

intercourse (The Henry J. Kaiser Family Foundation, 2009b). Transmission by injecting drugs and needle sharing accounted for 23% of infections and heterosexual intercourse represented 14% of infections (The Henry J. Kaiser Family Foundation, 2009b). In addition to a gender disparity among individuals infected with HIV/AIDS, there was also evidence of a growing racial and ethnic disparity as racial and ethnic minorities represented 71% of new infections (The Henry J. Kaiser Family Foundation, 2009b). Further, of the one million Americans living with HIV/AIDS, survey data indicated that over half of those individuals were Black (The Henry J. Kaiser Family Foundation, 2009b). Finally, recent studies indicated that HIV/AIDS was the number one cause of death among Black women ages 25-34 (CDC, 2008c). Although there were many contributing factors for risk of HIV/AIDS infection, Cuccinelli and De Groot (1997) argued that "individuals who are underprivileged, discriminated against, or marginalized" (p. 225) were at the greatest risk of HIV/AIDS infection. In the United States, gays and racial and ethnic minorities have frequently fallen into these categories.

Georgia statistics.

In 2007, 33,847 Georgians, approximately 3% of the state's total population, were living with HIV/AIDS, (The Henry J. Kaiser Family Foundation, 2010) making Georgia the state with the fifth highest number of HIV/AIDS infections after California, New York, Florida and Texas (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2009). Two hundred and forty of those infected in Georgia were under the age of 18 (The Henry J. Kaiser Family Foundation, 2010). These figures solely represented reported cases—many individuals living with HIV/AIDS were unaware of their seropositive status. In fact, in 2001, only 54% of Georgians reported ever having been tested for HIV (The Henry J. Kaiser Family Foundation, 2010). As was the case nationally, male-to-male sexual contact was the most common form of

transmission in Georgia, and 80% of HIV/AIDS cases in the state were among men (The Henry J. Kaiser Family Foundation, 2010). Another national trend evident in Georgia was the increasingly racialized nature of the pandemic. In 2007, two-thirds of persons living with HIV/AIDS in Georgia were Black, 30% were White, and approximately 3% were Latino (The Henry J. Kaiser Family Foundation, 2010). In terms of my study, these figures were significant because they illustrated that many groups in Georgia were particularly at-risk for HIV/AIDS infection and Georgian youth may need HIV/AIDS education to help prevent the spread of HIV/AIDS in the state.

HIV/AIDS and American Youth

Many American teenagers engaged in sexual activity with a variety of partners, which was reflected in sexually transmitted infection (STI) rates among teens. Common STIs included HIV/AIDS, gonorrhea, syphilis, Chlamydia, hepatitis, and herpes. Recent estimates indicated that of the 19 million STI infections that occurred in this country annually, half were among adolescents and young adults between the ages of 15 to 24 (National Center for Chronic Disease Prevention and Health Promotion [NCCDPHP], 2009), which was the highest rate of infection among all age groups nationally and among all industrialized nations (Parker, 2001). By the age of 21, one in five Americans received treatment for an STI (Hunter, 2006).

Although HIV/AIDS infection was less common, a 2006 report indicated that one young American was newly infected with HIV every hour of every day (CDC, 2006). Over 20,000 American young people aged 13-25 were newly infected with the virus each year (Parker, 2001), and HIV infection rates increased the fastest among 18 to 24 year old Americans (Hunter, 2006). The CDC estimated that individuals ages 20-24 represented the age group with the largest number of new infections in 2009 (CDC, 2011). Based on these and similar statistics,

adolescents and young adults—school-aged populations—can be viewed as critical groups in terms of potential HIV/AIDS infection.

HIV/AIDS infection rates among youth occurred disproportionately among certain racial and ethnic groups. Although Black youth represented only 16% of the total youth population in the United States, they accounted for 69% of total new adolescent and young adult HIV/AIDS infections in 2006 (CDC, 2006). An additional 23% of youth infections in 2006 occurred among Latino adolescents and young adults, who represented only18% of the youth population in America (CDC, 2006). Combined, 92% of 2006 youth infections occurred among youth of color. The CDC noted that high infection rates among youth of color may have been linked to the fact that one in four Black youth and one in five Latino youth lived in poverty, which indirectly increased their risk for HIV/AIDS infection (Diaz et al., 1994). Despite the fact that HIV/AIDS infections among youth were concentrated among certain pockets of the population, the CDC outlined a set of risk factors that placed all youth at increased risk of HIV/AIDS infection. Those factors included: early age of sexual initiation, unprotected heterosexual sex, men who have sex with men, having a previous or current STI, substance abuse, and poverty (CDC, 2008a). This historical summary and overview of HIV/AIDS statistics provides a sense of the magnitude of the HIV/AIDS pandemic and provides a backdrop for my study.

History of American Sexuality Education

HIV/AIDS education is couched in the broader landscape of sexuality education. Exploring the history of American sexuality education provides important insights into the nature of HIV/AIDS education in the United States, which is valuable for my study.

1900-1960

According to Luker (2006), public sexuality education was "invented" (p. 37) between 1880 and 1920. Early sexuality education was organized by social societies, such as the American Society of Sanitary and Moral Prophylaxis, that were dominated by the wealthy who were largely concerned with social hygiene, eugenics, and purity (Campos, 2002; Luker, 2006; Nelson Trudell, 1993; Silin, 1992). The mission of these organizations was originally to control venereal diseases and decrease other "moral and physical evils," (Campos, 2002, p. 59) such as prostitution (Sears, 1992).

In 1912, the American Social Hygiene Association (ASHA) was formed. It became the most influential and long-lasting of all social hygiene organizations (Nelson Trudell, 1993). Rooted in Progressive ideology, the founders of ASHA believed that their hygiene association would "[encompass] health in all its dimensions: social, mental, spiritual and physical" (Luker, 2006, p. 38). Their efforts were largely inspired by the changing social landscape, as the era of urbanization and industrialization was marked by declining marriage and birth rates and rising divorce rates (Luker, 2006).

ASHA was also particularly influential in promoting sexuality education and social hygiene programs for military service members fighting abroad in World War I (Campos, 2002). Military sexuality education campaigns, like those stateside, focused on decreasing specific sexually transmitted diseases like syphilis and discouraging men from having sex with prostitutes (Campos, 2002). These early military sexuality education campaigns set the trend for problem-centered sexuality education that influenced programs in schools for the general population for decades to come (Campos, 2002; Luker, 2006; Nelson Trudell, 1993; Ridini, 1998).

Some early sexuality educators felt that efforts to educate soldiers during World War I would have been more successful if soldiers received sexuality education training earlier in life since "impressions of sex are set at an early age" (Campos, 2002, p. 64). Subsequently, members of ASHA and other organizations rallied behind the notion that the most appropriate venue for social hygiene and sexuality education messages was the American public school. Endorsements for sexuality education in schools by the National Education Association, American Medical Association, and U.S. Department of Labor Children's Bureau added momentum to the sexuality-education-in-public-schools movement (Campos, 2002). After World War I, sexuality education became commonplace in schools. It expanded beyond focusing on isolated problems like venereal disease and included biological information, preparation for marriage, discouragement of premarital sex, and training for parenthood (Luker, 2006).

Throughout the first half of the 20th century, as sexuality education for public school students became common, there was an increasing emphasis on providing specialized sexuality education training to educators (Campos, 2002). As early as 1921, many prospective teachers were trained to deliver appropriate sexuality education messages to students (Campos, 2002). In 1930, a committee under President Hoover's White House Conference on Child Health and Protection called for "social hygiene training for teachers" (Campos, 2002, p. 73). Studies undertaken in the 1930s by ASHA, the University of Kansas, and the Illinois Biology Teachers Association all concluded that teachers were supportive of teaching sexuality education and that they benefited from specially designed courses that trained them to teach such information to students (Campos, 2002). By 1945, over 22 colleges of teacher education claimed to provide

some form of sexuality education for prospective teachers (Campos, 2002). These surveys

indicated that specialized sexuality education for teachers was not a new concept.

1960-1989

Before the sexual and youth revolutions of the 1960s, sexuality education in schools was

primarily focused on biology, the facts-of-life, and preparation for marriage and family (Campos,

2002; Luker, 2006; Nelson Trudell, 1993). However, as societal and cultural norms regarding

sexuality changed, some 1960s sex educators sought to provide a more holistic form of sexuality

education, which meant the inclusion of homosexuality, sexual pleasure, masturbation, and other

aspects of comprehensive sexuality education (Yarber, 1994). In 1964, the Sex Information and

Education Council of the United States (SIECUS) was formed to promote broader, more

comprehensive sexuality education in the schools (Campos, 2002).

This expansion of sexuality education beyond basic biology and preparation for marriage

and family was immediately controversial. Some critics of comprehensive sexuality education

called SIECUS and their agenda a "'communist front apparatus designed to erode the moral fiber

of youth'" (Campos, 2002, p. 90). Several conservative organizations claimed that any sexuality

education programming in American schools was "illegal, unconstitutional, anti-Christian and

anti-God" (Campos, 2002, p. 91). Many of these groups sought to discredit comprehensive

sexuality education or remove sexuality education from public schools altogether (Nelson

Trudell, 1993; Pardini, 2002; Yarber, 1994). The 1960s and 1970s marked a period in history in

which American sexuality education appeared to become a battleground for a larger social,

political, and ideological conflicts. As Kempner (2007) argued, some conservatives viewed

sexuality education "as an arena in which they could successfully affect [broader] social change"

(p. 128).

Although some groups sought to eliminate sexuality education from schools, the majority of American parents, students, and teachers continued to support sexuality education in the curriculum (Ridini, 1998; Summerfield, 2001). Various surveys of parents in the years 1966, 1972, and 1974 indicated overwhelming support for sexuality education in schools (Campos, 2002). Studies also indicated that the majority of teachers supported sexuality education in schools (Campos, 2002). Surveys conducted by Phi Delta Kappa in 1984 and 1985 suggested that 81% of teachers supported sexuality education for elementary school students and 91% supported sexuality education for secondary school students (Campos, 2002). Parental and teacher support for sexuality education were likely bolstered by perceived teen pregnancy epidemics during the 1970s and 1980s that not only forced parents, educators, and politicians to acknowledge American teens engaged in sexual activity, but also underlined the need for quality sexuality education in public schools (Nelson Trudell, 1993; Yarber, 1994).

The year 1981 was critical for sexuality education in American public schools. Conservative President Ronald Reagan's administration effectively changed the landscape of sexuality education with the passage of Adolescent Family Life Act (AFLA), which provided federal funding solely for abstinence-only sexuality education programs (Summerfield, 2001). Sometimes derisively called "the chastity law" (Hunter, 2006, p. 57) by critics, AFLA required that schools who received federal funds promoted abstinence-only-until-marriage sexuality education (Fields & Hirschman, 2007; Hunter, 2006; Kempner, 2007; Nelson Trudell, 1993; Rothschild, 2007). As government support for abstinence-only sexuality education continued throughout the 1980s and the conservative right upheld its opposition to broad-based sexuality education in public schools, the HIV/AIDS epidemic had taken root in America. In 1986, in response to the AIDS crisis, the U.S. Surgeon General endorsed HIV/AIDS education and

comprehensive sexuality education and even argued that information about gay and lesbian relationships should be included in school programs (Pardini, 2002).

The U.S. Surgeon General was not alone in supporting sexuality education in schools. As early as 1985, merely four years after the first HIV/AIDS cases were diagnosed in the United States, 80% of parents wanted their children to be taught about safe sex, specifically in terms of preventing HIV/AIDS infection (Yarber, 1994). Despite the urgings of the U.S. Surgeon General and the desires of parents, government funding continued to be reserved for school curricula that promoted abstinence-only sexuality education programs, which some critics argued "constitute[d] a lethal form of censorship" (Rothschild, 2007) in the time of HIV/AIDS. Government funding for abstinence-only programs, the continued teen pregnancy epidemic, and the emergence of the HIV/AIDS pandemic as a national health crisis were critical issues in the debates over sexuality education in the mid-to-late 1980s , and they set the stage for contemporary HIV/AIDS education in America.

Contemporary American Sexuality Education

Statistics indicated that American teens engaged in a variety of sexual activities. A 2001 study indicated that half of all high school students engaged in sexual intercourse (Hunter, 2006; Parker, 2001). Further, one in five students had sexual intercourse with four or more partners (Parker, 2001). One-third of American teenage girls became pregnant before the age of twenty, the highest rate of any developed country in the world (Hunter, 2006; The Henry J. Kaiser Family Foundation, 2005). Other forms of sexual activity, such as oral sex, were even more widely practiced than intercourse, and the numbers of adolescent girls who engage in anal sex have reportedly been on the rise because it "function[ed] to preserve their virginity and prevent pregnancy" (Parker, 2001, p. 2).

These numbers served as a critical backdrop for an ongoing debate surrounding sexuality education for American youth. Sexuality education was advocated by many leading doctors, educators, and scholars and existed in one form or another for nearly one hundred years. The majority of American high schools (82%) required some form of sexuality education on their campuses (Parker, 2001). In addition, according to a 2001 report, 76% of middle/junior highs and 57% of elementary schools required some form of sexuality education (Parker, 2001). Many experts suggested that there were several qualities shared by effective sexuality education programs. Effective programs:

1. Offered age and culturally appropriate sexual health information in a safe environment for participants;

2. Were developed in cooperation with members of the target community, especially young people;

3. Assisted youth to clarify their individual, family, and community values;

4. Assisted youth to develop skills in communication, refusal, and negotiation;

5. Provided medically accurate information about both abstinence and also contraception, including condoms;

6. Had clear goals for preventing HIV, other STIs, and/or teen pregnancy;

7. Focused on specific health behaviors related to the goals, with clear messages about these behaviors;

8. Addressed psychosocial risk and protective factors with activities to change each targeted risk and to promote each protective factor;

9. Respected community values and respond to community needs;

10. Relied on participatory teaching methods, implemented by trained educators and using all

the activities as designed (Alford, 2003; Kirby, 2001; UNAIDS, 1997).

Despite the fact that some experts agreed on shared qualities of effective sexuality education programs, scholars, politicians, parents, educators, and students continued to debate about what should be taught in the classroom in regards to sex. As a result of these debates, two main types of sexuality education emerged in American classrooms. These two types of sexuality education are quite divergent and may or may not meet the aforementioned qualities of effective sexuality education programs. The first type of programming is abstinence-only sexuality education, and the second type of program is comprehensive sexuality education.

Abstinence-Only Sexuality Education

The first approach to sexuality education is the abstinence-only emphasis where students are taught that the only way to prevent pregnancy, HIV, and other STIs is to completely abstain from all sexual activity, and that sexual activity should be reserved for heterosexual marriage (AVERT, 2010; Sexuality Information and Education Council of the United States [SIECUS], 2010a). Abstinence-only programs were frequently supported by many politically and socially conservative groups, some religious groups, and until recently, the federal government. As a result of government support, according to a 2001 survey, 86% of American school districts promoted abstinence-only sexuality education (Dailard, 2001). 35% of those school districts prohibited the discussion of contraception, with the exception their failure rates (Dailard, 2001). Although President Obama decreased funding for abstinence-only programs significantly in the fiscal year 2010 budget, abstinence-only sexuality education was historically funded by the federal government, namely through AFLA, which was enacted in 1981. In addition to funding through AFLA, abstinence-only programming was also supported by P.L. 104-193, Title V, and

Title XI of the Social Security Act, also known as the Maternal and Child Health Block Grant, and a grant program called Community-Based Abstinence Education (CBAE). Through these grants and programs, over $1.5 billion was spent on abstinence-only sexuality education (AVERT, 2010; Hunter, 2006) despite the fact that 70% of Americans opposed federal funding for abstinence-only education (Portner, 1997).

A 2004 congressional report found that over 80% of federally funded abstinence-only sexuality education programs included one or more of the following: false information about the effectiveness of contraceptives; false information about the risks of abortion; religious beliefs as scientific fact; stereotypes about boys and girls as scientific fact; and medical and scientific errors of fact (Special Investigations Division, 2004). On top of these instances of misinformation, many scholars argued that abstinence-only programs were fear and shame based, and they promoted the political and religious agendas of the Far Right (Hunter, 2006; Yarber, 1994). For example, in her examination of abstinence-only sexuality education, Hunter (2006) found that one school-based abstinence-only program urged students to "'take Christ along as a chaperon on their dates" (p. 57). In addition, schools in several states held chastity rallies where students were urged to pledge their abstinence to God (Hunter, 2006).

There was also a lack of evidence that abstinence-only programs were effective. SIECUS and several other independent organizations, researchers, and scholars argued that abstinence-only sexuality education did not positively impact teenage sexual behaviors (AVERT, 2010; Kirby, 2007; Hunter, 2006; Parker, 2001; Portner, 1997; Summerfield, 2001). Kirby (2007) noted there was no evidence that abstinence-only sexuality programs delayed sexual initiation, encouraged a return to abstinence or reduced the number of sexual partners. Other studies indicated that abstinence-only programs might have actually deterred condom use among

sexually active teens (Bearman & Brückner, 2001; Brückner & Bearman, 2005; Kirby, 2001).

However, a recent study of urban African-American youth by Jemmott, Jemmott, and Fong

(2010) suggested that abstinence-only sexuality education increased the age of sexual initiation

and decreased numbers of partners. Despite the findings of this single study, which was widely

reported by the national media, the overwhelming majority of studies of abstinence-only

programs produced findings that did not support the overall efficacy of abstinence-only sexuality

education.

Comprehensive Sexuality Education

Since many teens engaged in sexual activity, some critics of abstinence-only sexuality

education argued that it was inappropriate to fail to provide American youth with the information

and tools necessary to protect themselves from unintended pregnancy, STIs, including

HIV/AIDS, or other consequences of unprotected sexual activity. As the age of onset of puberty

decreased, sexual initiation occurred earlier (Hunter, 2006). Conversely, the average age of

marriage increased, which potentially made abstinence-only-until-marriage unrealistic (Hunter,

2006). The second approach to sexuality education, comprehensive sexuality education,

attempted to address the reality of teenage sexual activity. Comprehensive sexuality education

programs had four main goals:

1. To provide accurate information about human sexuality

2. To provide an opportunity for young people to develop and understand their

values, attitudes, and insights about sexuality

3. To help young people develop relationships and interpersonal skills

4. To help young people exercise responsibility regarding sexual relationships,

which includes addressing abstinence, pressures to become prematurely involved

in sexual intercourse, and the use of contraception and other sexual health

measures. (SIECUS, 2010b).

In order to meet these goals, comprehensive sexuality education programs dealt with traditional

foci like biology, puberty, dating, marriage, and STIs, but also included topics such as sexual

pleasure, homosexuality, non-coital sexual expression, masturbation, contraception, and sexual

abuse among other topics (Yarber, 1994). The comprehensive emphasis sought to affirm sex and

sexuality as positive aspects of the human experience, but also prevent unprotected sex while

respecting families and communities (Yarber, 1994).

Comprehensive sexuality education was endorsed by governing bodies and organizations

such as SIECUS, Advocates for Youth, the American Academy of Pediatrics, the American

College of Obstetricians and Gynecologists, the American Medical Association, the American

Public Health Association, the National Education Association, the National Medical

Association, the National School Boards Association, and the Society for Adolescent Medicine

(Collins, Alagiri & Summers, 2002). Although there was a dearth of evidence that abstinence-

only programs were effective, there was credible research that supported the idea that

comprehensive sexuality education positively influenced teens' sexual behavior and reduces

STIs (Alford, 2003; Collins et al., 2002; Kirby, 2001; Kirby, 2005). A 2007 study indicated that

two thirds of comprehensive sexuality education programs had positive effects, such as delaying

sexual initiation, reducing the frequency of sex and in some cases returning to abstinence, and

reducing unprotected sex (Kirby, 2007). Research indicated that comprehensive sexuality

education programs did not encourage teens to initiate sex at an earlier age or have more sexual

partners (Alford, 2003; Collins et al, 2002; Kirby, 2001; Kirby, 2005).

In addition to reducing teen pregnancy rates, delaying the onset of intercourse, and other benefits, comprehensive sexuality education programs addressed drug and alcohol use, which was often a part of teenage sexual activity (Leigh & Stall, 2003). According to a 2007 CDC survey, 23% of high school students who had intercourse used drugs or alcohol before engaging in sexual activity (CDC, 2008d). In another study, 53% of teenagers claimed that using drugs and alcohol were the main reason they did not use contraceptives (Collins et al, 2002). The CDC (2008d) listed substance abuse as a risk factor and barrier to prevention of HIV/AIDS for youth, which meant that addressing drugs and alcohol was an important element of HIV/AIDS prevention programs.

While comprehensive sexuality education was generally considered more effective than abstinence-only programs, a 2002 reported indicated that only 14% of school districts' policies were truly comprehensive in nature (Collins et al., 2002). However, comprehensive sexuality education received a substantial increase in support when President Barack Obama proposed redirecting funds from abstinence-only programs to comprehensive sexuality education programs in his fiscal year 2010 budget. Obama proposed eliminating funding for CBAE, as well as Title V abstinence-only programs (SIECUS, 2010b). The new, federally supported sexuality education programming would fall under the general description of teen pregnancy prevention and would receive approximately $178 million annually. Of that budget, $75 million would be spent directly on comprehensive, evidence-based programs that were proven to delay sexual initiation, decrease teen pregnancy, or increase contraceptive use (Cohen, 2009). $13 million remained reserved for the prevention component of AFLA, and the remaining funds were allocated for grants to test new programs' efficacy (Cohen, 2009). The coming years will be important as the landscape shifts in terms of the type of sexuality education that is funded by the

federal government and the impact of increasing support for comprehensive programs on teenage sexual behaviors and activity. Understanding the major issues surrounding sexuality education was important for my study because it provided some insights into national debates surrounding sex and schools. Many of these national issues and debates are also common in the State of Georgia.

Sexuality Education in Georgia

Sexuality education was regulated by law in Georgia since 1988. Although state law placed the majority of control over sexuality education in the hands of the State Board of Education, Georgia State Law (Code 20-2-143) required students received both sexuality education and HIV/AIDS education, as well as instruction for handling of peer pressure, promotion of self-esteem, community values, and the legal consequences of parenthood. However, abstinence education was formally incorporated in state law in June 2000, when the following statement was added under Rule IDB 160-4-2-12: "Instruction shall emphasize abstinence from sexual activity until marriage and fidelity in marriage as important personal goals." Although the law mandated students receive sexuality and HIV/AIDS education, state law also allowed for parents to opt their children out of sexuality and HIV/AIDS classes and programs.

The State Board of Education formulated standards related to sexuality education in the Georgia Performance Standards guidelines (Georgia Department of Education, 2010), although local boards of education are authorized to supplement the Georgia Performance Standards as they see fit. Georgia law also required that local boards of education established committees primarily of non-teaching parents, in addition to community members and students, to review supplementary sexuality education materials and policies. In some cases, local boards of

education, with the support of community advisory committees, adopted an entire pre-packaged sexuality education curriculum. For instance, in Clarke County, the local school board adopted a comprehensive sexuality education program called *Family Life and Sexual Health (FLASH)* (FLASH Lesson Plans, 2010). Barrow, Carroll, Clayton, Cobb, Coffee, Gwinnett, Hall, Muscogee, and Spalding Counties used an abstinence-only-until-marriage program called *Choosing the Best*. Until recent federal funding changes in 2010, local school systems that received federal funding could only promote abstinence-only materials. In 2006, six Georgia school boards directly received federal funding for abstinence only sexuality education, although an additional fifteen districts used abstinence only materials (Georgia Parents, 2010). Providing an overview of sexuality education in Georgia was important to provide me with the appropriate background information and context for the study. Having explored sexuality education in general, I will now focus specifically on HIV/AIDS education.

HIV/AIDS Education in the United States

Studies since the 1980s suggested that HIV/AIDS education was most effectively taught in the context of a comprehensive sexuality education program (Allensworth & Kolbe, 1987; Noak, 1982). Many comprehensive sexuality education curricula devoted considerable attention to the topic of HIV/AIDS, and many programs had outcome goals related directly to HIV/AIDS (The Administration for Children and Families [ACF] and Department of Health and Human Services [HHS], 2002). For instance, a primary stated goal of one comprehensive sexuality education program, *Safer Choices 1 & 2: A High School Based Program to Prevent STDs, HIV, and Pregnancy*, was to prevent HIV infection (ACF and HHS, 2002). A goal of another comprehensive sexuality education program, *BART: Becoming a Responsible Teen,* was to provide essential information about HIV and AIDS (ACF and HHS, 2002). Further, in a review

of ten commonly used comprehensive sexuality education curricula, The Administration for

Children and Families (ACF) and Department of Health and Human Services (HHS) (2002)

found that HIV/AIDS was mentioned at least seven times, while some programs mentioned

HIV/AIDS as many as 477 times.

The CDC provided funding for HIV/AIDS education since 1988, and in 2000 alone, the

CDC allocated $47 million for HIV/AIDS education in schools (The Henry J. Kaiser Family

Foundation, 2002). All fifty states, with the exception of Ohio and Utah, received some sort of

funding from the CDC for in-school HIV/AIDS education (The Henry J. Kaiser Family

Foundation, 2002). In order to receive those funds, schools and programs had to undergo a

rigorous evaluation to ensure that the content met the standards set forth in *The Guidelines for

School Health Education to Prevent the Spread of AIDS* (The Henry J. Kaiser Family

Foundation, 2002).

In 1998, the CDC developed The *Guidelines for School Health Education to Prevent the

Spread of AIDS* in conjunction with bodies such as the American Academy of Pediatrics,

American Association of School Administrators, American Public Health Association, American

School Health Association, Association for the Advancement of Health Education, Association

of State and Territorial Health Officers, Council of Chief State School Officers, National

Congress of Parents and Teachers. National Council of Churches, National Education

Association, National School Boards Association, Society of State Directors of Health, Physical

Education, Recreation and Dance, U.S. Department of Education, U.S. Food and Drug

Administration, and the U.S. Office of Disease Prevention and Health Promotion (NCCDPHP,

2008). Revised in 2003, *The Guidelines* provided outlines of essential HIV/AIDS information

for various age groups and grade levels. For instance, *The Guidelines* suggested that early

elementary school students understand things like "AIDS is very hard to get. You cannot get it just by being near or touching someone who has it" (NCCDPHP, 2008, section 6). Later, older elementary school students learned information such as "the AIDS virus can be transmitted by sexual contact with an infected person; by using needles and other injection equipment that an infected person has used; and from an infected mother to her infant before or during birth" (NCCDPHP, 2008, section 7). Middle school and high school students learned more in-depth, complicated pieces of information about the transmission and epidemiology of HIV/AIDS, as well as specific information about how to prevent the spread of HIV/AIDS and what steps to take if one believes she or he has been exposed to the virus (NCCDPHP, 2008).

During the past decade, two HIV/AIDS education programs commonly used in schools were *Safer Choices 1 & 2: A High School Based Program to Prevent STDs, HIV, and Pregnancy* and *BART: Becoming a Responsible Teen*. According to a 2001 study, *Safer Choices* increased the use of condoms at last sex, decreased the frequency of sex without condoms, and decreased the number of partners without using a condom (Kirby, 2001). In another study of *Safer Choices*, researchers found that thirty-one months after the baseline survey, students scored significantly higher on HIV/AIDS knowledge assessments, had more positive attitudes towards condoms, and increased perception of their risk for HIV/AIDS than their peers who did not go through the program (ReCAPP, 2009). *BART = Becoming a Responsible Teen* was funded by the National Institute for Mental Health and CDC's Division of Adolescent School Health. One study found that *BART* delayed sexual initiation, decreased the number of sexual partners, and increased condom use (St. Lawrence, Brasfield, Jefferson, Alleyne, O'Bannon, & Shirley, 1995). Another study indicated that *BART* increased knowledge related to condom use and HIV/AIDS

and encouraged participants to share what they had learned with others (McGuinness, Mason, Tolbert, & DeFontaine, 2002).

These programs, like other evidence-based HIV/AIDS prevention programs, demonstrated that in-school HIV/AIDS education could be extremely effective when implemented and delivered properly. However, research indicated that few schools actually gave HIV/AIDS education the proper treatment, even within a comprehensive sexuality education curriculum (Portner, 1997). This was attributed to many factors, including teacher discomfort with material related to HIV/AIDS, parent or community discomfort with the material, time constraints, lack of materials, and lack of teacher training (Portner, 1997). Even in cases where teachers believed they were properly educating students about HIV/AIDS, students were actually only "learning and regurgitating the facts," (Portner, 1997, p. 2) which researchers argued was not good enough (Luker, 2006; Portner, 1997).

HIV/AIDS Education in the State of Georgia

HIV/AIDS education, like sexuality education in general, was part of the Georgia Performance Standards for Health. Although there were multiple standards that potentially included HIV/AIDS, such as "Analyze the potential consequences of having unprotected sex on physical, emotional, and social health," (Georgia Department of Education, 2010) HIV/AIDS was only mentioned twice specifically in the high school standards and not at all in elementary or middle school standards. The specific standards that deal with HIV/AIDS for high school students in Georgia were:

- Compare and contrast local data versus national data on HIV infections among teens and young adults.

- Engage others to develop health campaigns which promote care, consideration, and concern for others. (e.g., HIV, cancer, diabetes) (Georgia Department of Education, 2010).

In addition to meeting these minimum standards set forth by the Georgia Performance Standards, local school boards, under the guidance of a community committee, can add additional information and materials to their HIV/AIDS education curricula. In Clarke County, which followed the *FLASH* curriculum, students began learning about HIV/AIDS in grade 4. If a student received all of the prescribed lessons in the *FLASH* curriculum, he or she would conceivably have received well-rounded, thorough HIV/AIDS education (FLASH Lesson Plans, 2010). *Choosing the Best* was a popular curriculum that was used by Gwinnett County, in addition to Barrow, Carroll, Clayton, Cobb, Coffee, Hall, Muscogee, and Spalding Counties. This abstinence-only until marriage curriculum provided information for students in grades 6, 7, 8, 9, and 10 about STIs, including HIV/AIDS, and how they were transmitted. In addition, the grades 6, 7, and 8 curricula included activities to encourage compassion towards individuals living with HIV/AIDS. The curriculum for 9th and 10th graders called for students to hear first-hand accounts about the consequences of contracting HIV/AIDS from young adults who are living with HIV/AIDS. There was no mention of HIV/AIDS in the 11th or 12th grade curricula, which was devoted to finding one's soul mate and preparation for marriage (Choosing the Best, 2007).

Understanding the current state of sexuality education and HIV/AIDS education in the United States and Georgia, in particular, was important for my understanding of the context in which my study took place since teachers who participated in my study dealt with a variety of educational and curricular concerns. The historical information included in the literature review

also provided a general overview of the historical, political, social, and cultural backdrop for the study. Having examined the history and current status of HIV/AIDS education, in the next section I focus on specific ways in which teachers may face HIV/AIDS in the context of the classroom.

HIV/AIDS Related Classroom Realities

This section of the literature review explores issues that impact classroom teachers in terms of the HIV/AIDS pandemic. These realities include teaching about HIV/AIDS, instructing students living with or affected by HIV/AIDS; managing safety and confidentiality concerns; dealing with stigma and stereotypes associated with HIV/AIDS; grappling with personal feelings about death, dying, homosexuality; and teacher training issues related to HIV/AIDS

Teaching About HIV/AIDS

HIV/AIDS education and sexuality education in general were taught in courses such as health, science, family and consumer science, and physical education (Dodge et al., 2008). However, teachers across disciplines were increasingly called to provide such content to students. Time and curriculum restraints prevented some schools from providing HIV/AIDS or sexuality education in a specialized course or series of classes. In order to attempt to fulfill state or local requirements, teachers were asked to distribute pamphlets, show instructional films, or provide a scripted lecture on the topic (Luker, 2006). Subsequently, a math, science, or other content area teacher was called upon to provide HIV/AIDS education to students, despite the fact that he or she may not have been specially trained to do so and may not have possessed adequate HIV/AIDS-related knowledge. One Florida study indicated that the overwhelming majority (94%) of teachers who delivered sexuality education did so in the context of another course (Dodge et al., 2008). In other words, HIV/AIDS and sexuality education messages were not

necessarily isolated in specialized courses but were instead included in the broader content of another course.

There were calls for HIV/AIDS to be incorporated across the entire curriculum, in the same way that there were calls for reading to be incorporated across the curriculum (Mitchell, 2006). For instance, some math teachers incorporated HIV/AIDS statistics into their lessons, some English teachers took advantage of memoirs, prose, and poetry related to individual's experiences with HIV/AIDS, and many music teachers introduced students to compositions and lyrics that deal with HIV/AIDS (Mitchell, 2006). Students also brought HIV/AIDS into the curriculum in various ways. Green-Anderson (2000) and Weitz (1989) noted that HIV/AIDS often found its way into their classrooms, whether they intended to incorporate the subject or not. In the context of this study, understanding the trend for HIV/AIDS to be incorporated across the curriculum and the salient issue of teacher discomfort was important, given the expectations for all teachers, regardless of subject matter, to be prepared to deal with HIV/AIDS.

Teaching Students Infected With HIV/AIDS

In addition to teaching students about HIV/AIDS, some teachers instructed students who were HIV/AIDS positive. Children living with HIV/AIDS had the right to attend public school, and that right was protected by both the Americans with Disabilities Act (ADA), the Mental Health Administration Act, the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, and the Civil Rights Act of 1991. HIV/AIDS was considered a disability because the virus created physical impairments that limited essential life activities (U.S. Department of Justice, 2010). Individuals were also protected under ADA from discrimination based on actual or perceived HIV/AIDS infection (U.S. Department of Justice, 2010).

In addition to protection under federal law, the National Association of State Boards of Education (NASBE) had clear policies concerning students living with HIV/AIDS. In their official policy concerning students and staff with HIV/AIDS infection, NASBE noted,

> The evidence is overwhelming that the risk of transmitting human immunodeficiency virus (HIV) is extremely low in school settings when current guidelines are followed. The presence of a person living with HIV infection or diagnosed with acquired immunodeficiency syndrome (AIDS) poses no significant risk to others in school, day care, or school athletic settings (National Association of School Boards of Education, 2001).

NASBE's policies asserted that children's educational opportunities, including privileges, class placements, and athletic participation, should not to be impacted by their HIV/AIDS positive status. NASBE called for stringent privacy and confidentiality protection for individuals living with HIV/AIDS, as well as adherence to safety and infection control procedures. In addition, as early as 1985, the CDC recommended that children with HIV/AIDS remain in the regular classroom until they demonstrated neurological deficits or problems related to excretion.

Despite the protection under federal law and the support of NASBE, there were attempts to exclude students living with HIV/AIDS from public schools. Several major court decisions, such as White v. School Board of Hillsborough County (1985), Ray v. School District of DeSoto County (1987), Thomas v. Atascadero United School District (1987), Doe v. Dalton Elementary School District no. 148 (1988), Martinez v. School Board of Hillsborough County, Florida (1989), ruled against the exclusion of students from the mainstream classroom and extracurricular activities on the basis of HIV/AIDS seropositive status,

Students who were HIV/AIDS positive were more likely to attend public schools in the

United States because of advances in medicine, nutritional therapies, and collaborative treatment

programs which allowed children with HIV/AIDS to live long enough to reach school age

(Spears, 2006). A 2001 report indicated that between 7,575 and 17,675 American youth were

infected with HIV, while an additional 4,500 were living with full-blown AIDS (Foulk, Gessner,

& Koorland, 2001). The majority of these children (86%) were infected via mother-to-child

transmission either in utero, during birth, or by breast milk, while an additional 11% were

infected by tainted blood products (Grier & Hodges, 1998). By the late 1990s, experts insisted

that all school personnel would have direct or indirect contact with children who were either

infected or affected by HIV/AIDS (Cobia, Carney, & Waggoner, 1998); it is therefore reasonable

for today's educators to enter the classroom understanding the strong likelihood that they will

instruct students infected or affected by HIV/AIDS.

Although youth with HIV/AIDS were able to live longer, some faced neurological,

developmental, and mental burdens and problems (Spears, 2006). Children who acquired

HIV/AIDS from their mothers were at an increased risk for developmental delays, decreased

motor activity, and the slowing of cognitive functions (Cobia et al., 1998; Coleman, 1991;

Levenson & Mellins, 1992). Commonly, the central nervous system was impacted by the HIV

virus itself, as well as opportunistic infections, strokes or tumors (Spears, 2006). As many as

90% of children with HIV/AIDS had some sort of disruption to the central nervous system

(Spears, 2006). Generalized brain dysfunction, known as encephalopathy, was common among

individuals with HIV/AIDS (Spears, 2006). Some individuals experienced the loss of cognitive,

language, motor, socio-emotional, and other functions, as well as increasing loss of interest in the

surrounding environment (Spears, 2006). Experts suggested that as many of 50% of children

with HIV experienced encephalopathy. In addition to specific problems such as encephalopathy, HIV/AIDS was known to create developmental delays or impair children's brain growth (Spears, 2006). 50% of students with HIV/AIDS had abnormal intelligence scores, while 44% exhibited speech and language disorders (Spears, 2006).

However, some students living with HIV/AIDS were asymptomatic and indistinguishable from their peers (American Academy of Pediatrics, 2000). Whether they were asymptomatic or not, many children living with HIV/AIDS had unique emotional and psychological needs. At the same time children with HIV/AIDS were dealing with the physical and mental difficulties that accompany their seropositive status, they also faced extreme emotional troubles. High anxiety, fear, depression, isolation, grief, and anger were common for individuals with chronic diseases, and these feelings were exacerbated in the young person who did not have the ability to understand what was happening or why it was happening (Cobia et al., 1998; Thompson & Rudolph, 1996). Experts urged that children living with HIV/AIDS be monitored for depression and suicidal tendencies (Cobia et al., 1998; Thompson & Rudolph, 1996). Repeated hospitalizations, doctor visits, multiple medications, and other routines associated with living with a disease such as HIV/AIDS may make the student feel even more isolated or different from his or her peers in the classroom, and teachers may need to be aware of these realities and feelings.

Due to the various physical, mental, and emotional factors that may be associated with a student's HIV/AIDS positive status, there may need to be special interventions at school. Some HIV/AIDS positive students were eligible for special education services, as specified by state and federal legislation (Spears, 2006). In addition, some students living with HIV/AIDS needed additional support services such as speech or language therapy. Counseling or behavior

modification programs were important because feelings of depression, anxiety, fear, and anger may manifest through acting-out, classroom disruptions, aggression, and withdrawal (Cobia et al., 1998; Pizzo & Wilfert, 1991; Speigal & Mayers, 1991). If the child's condition worsened to the point that he or she was unable to attend school or was in the hospital for an extended stay, at-home services were required. Finally, Spears (2006) noted that many students living with HIV/AIDS benefited from a supportive school climate. In the context of my study, understanding these interventions and the need for a supportive school environment is important for me to understand, given the possibility that the teachers who participated in my study may teach students who are living with HIV/AIDS.

Teaching Students Affected by HIV/AIDS

Students do not need to be personally infected with HIV/AIDS to be impacted by the virus. Wilson (1995) noted that when one person in a family was *infected* by HIV/AIDS, the entire family was *affected*. In particular, there were large numbers of uninfected children who were born to HIV/AIDS positive mothers (Brackis-Cott, Mellins, Dolezal, & Spiegal, 2007). While medical advances meant those mothers could live longer lives, their children nevertheless spent their childhoods coping with "a chronic, stigmatized, often fatal disease in a parent" (Brackis-Cott et al., 2007, p. 68). Studies indicated that HIV/AIDS infection was sometimes accompanied by substance abuse or psychiatric disorders (Brackis-Cott et al., 2007). Some youth had complicated feelings related to their family member or friend's illness, and oftentimes those feelings were quite similar to the emotions of the individual who was infected (Bonuck, 1993). These feelings included fear, anxiety, sadness, shame, or anger (Brackis-Cott et al., 2007; Forehand, Steele, Armistead, Simon, Morese, & Clark, 1998; Linsk & Mason, 2004). These feelings stemmed from two separate but interrelated sources: the parent's infection and the

shame and secrecy that may accompany the parent's infection (Linsk & Mason, 2004). In a study of adolescents with HIV/AIDS positive mothers, Murphy, Marelich, Herbeck, and Payne (2009) found that some of the youth participants demonstrated traits such as depression, anxiety/worry, and conduct disorders. Some of the youth also engaged in aggressive behavior and binge drinking (Murphy, Marelich, Herbeck, & Payne, 2009). Other researchers found the children of HIV/AIDS positive parents exhibited withdrawal and isolation issues, social adjustment problems, attention problems, and may be suicidal (Brackis-Cott et al., 2007). These children's psychological and behavioral issues often created the need for teacher interventions in the classroom. Consequently, classroom teachers needed to be sensitive to the difficult and myriad emotions that the children of HIV/AIDS parents face.

In some instances, children whose parents were living with HIV/AIDS assumed adult and parental responsibilities, which some researchers referred to as "parentification" (Tompkins, 2006, p. 113). Children assumed a variety of duties in the household that were reserved for parents in ordinary circumstances, such as caring for younger siblings, cleaning, cooking, and earning money outside of the home. In addition, children were charged with providing essential care for their ill parent(s), such as administering medicine, bathing, toileting, and other daily care measures. Sometimes, the ability to effectively parent was negatively impacted by one's seropositive HIV/AIDS status. Parents infected with HIV/AIDS may have exhibited "maladaptive behaviors that disrupt the parent-child relationship" (Murphy et al., 2009, p. 1676). In addition, family routines and parental monitoring of children were disrupted by a parents' illness or psychological distress, such as depression, that was related to HIV/AIDS infection (Murphy et al., 2009).

In some cases, parents may have formally or informally, temporarily or permanently forfeited their parental rights or duties because of deteriorating health, complicating factors such as substance abuse or death (Linsk & Mason, 2004). One study indicated that nearly 20% of children of HIV/AIDS infected parents lived with grandparents or other relatives (Schable et al., 1995). As the HIV/AIDS pandemic in the United States increasingly fell along racial lines, increasing numbers of youth of color were displaced because of a parent's HIV/AIDS positive status (Linsk & Mason, 2004). As a result, 80% of children orphaned by HIV/AIDS in America were children of color (Mason & Linsk, 2002). Students with parents or friends who are infected with HIV/AIDS may have special needs or considerations, even if they do not face the specific issues, such as parentification or displacement, mentioned here. These considerations regarding a parent or friend's seropositive status is important for the context of this study because the literature points to the fact that such students may have special needs or considerations that may need to be sensitively handled by the classroom teacher or other school personnel.

Safety and Confidentiality Concerns

In developing the focus for my study, I needed to anticipate that safety and confidentiality concerns were likely to be reported among participants. Scientific studies indicated that HIV/AIDS cannot be spread by casual, day-to-day contact, and even activities such as kissing, bathing, and assisting with toileting have posed no threat of transmission (Grier & Hodges, 1998). However, in the context of the classroom, situations involving nose bleeds, scratches and cuts, bleeding gums, and biting were the most common threats for infection, although there were no recorded incidents of transmission in schools or daycare centers (Grier & Hodges, 1998). Fost (1991) argued that school-aged children were more likely to die from contact sports than from HIV infection.

In the event that blood or another substance containing blood is present in the classroom, certain steps must be taken in accordance with Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard, 29 CFR 1910.1030. These steps include following Universal Precautions for Bloodborne Pathogens, frequently referred to as Universal Precautions, such as hand washing, proper disposal of contaminated or potentially contaminated substances, and the use of protective barriers such as disposable gloves (National Center for Preparedness, Detection, and Control of Infectious Diseases, 1999). In studies of educators, however, researchers found that there was little working knowledge of Universal Precautions among participants (Carney & Cobia, 2003; Grier & Hodges, 1998).

In addition to safety concerns, there were confidentiality concerns surrounding students living with HIV/AIDS. Sterken (1995) noted that anxiety and fear of exclusion and discrimination often inhibited parents or caregivers from informing the school of their child's seropositive status. Boulton, Beck, Walters, and Miller (1999) found that parents' greatest fears concerning their child's HIV/AIDS positive status were threats to their children's safety if their status was disclosed. In some cases, children whose status was disclosed at school suffered psychological, mental, emotional, or physical harm (Hanlon, 1991; MacFarlane, 1989; Schmitt & Schmitt, 1990; Zirkel, 1989). Approximately 70% of schools had a written policy concerning confidentiality measures for students with HIV/AIDS (Hollander, 1998). The confidentiality of a person's health information was protected under federal laws such as The Family Educational Rights and Privacy Act (FERPA), commonly referred to as the Buckley Amendment, and Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under FERPA, health-related information should be disclosed only on a need to know basis; however, there was no standard definition of what would constitute a need to know (Chenneville, 2007). It may be important for

school personnel, including teachers, administrators, counselors and school health professionals,

to be briefed on the basic underpinnings of FERPA, HIPPA, and state laws governing

confidentiality measures. In a qualitative study of children living with HIV/AIDS, Blumenreich

(2003) found that children whose statuses were not disclosed at school felt that they were

keeping secrets or living with lies. Bluemnreich (2003) suggested that disclosing HIV/AIDS

positive status may create more responsive, appropriate, honest, and safe spaces for children

living with HIV/AIDS. Ideally, the HIV/AIDS positive child's rights to privacy can be balanced

with the need to provide information that can help the entire school community serve and

support the student in question. I wondered if I would obtain insights into these issues during my

interviews with teachers.

Stigma and Stereotypes

Some research focused on the issues of stigma and stereotyping. In some cases, teachers

demonstrated negative perceptions of children living with HIV/AIDS, often because they

misunderstood the threat to themselves or had unfounded fears about individuals living with

HIV/AIDS (Adams & Biddle, 1997; Jessee, 1993; Stinnett, Cruce, & Choate, 2004; Wadsworth

& Knight, 1996; Wu, 1990). Stinnett, Cruce, and Choate (2004) noted that people living with

HIV/AIDS were regarded with fear and subsequently avoided. People made judgments about

responsibility and blame based on an individual's HIV/AIDS positive status (Stinnett et al.,

2004). In one study, participants were less compassionate towards individuals who contracted

HIV/AIDS through perceived behavioral choices, such as unprotected sex or sharing needles

(Stinnett et al., 2004).

Within the context of the classroom, teachers provided their students with patterns of

acceptable treatment of both the subject of HIV/AIDS and individuals with HIV/AIDS (Silin,

1992; Wadsworth & Knight, 1996). What teachers say and do not say about HIV/AIDS and individuals infected or affected by the disease provides a model for students and the teacher's attitudes may be readily adopted by students, even though they may not fully understand the issue at hand. Silence can be just as damaging as actively promoting stigma and stereotypes. When a teacher avoided the subject of HIV/AIDS, he or she was not only promoting stigma but was also enforcing the notion that HIV/AIDS was taboo (Silin, 1992). In order to confront stigma, it may be important for teachers to better understand and acknowledge their own feelings about issues such as disease, illness, death and dying, homosexuality, and sexuality (Cinelli, Sankaran, & McConatha 1992; Cruce, Stinnett, & Choate, 2003; Ramafedi, 1993; Silin, 1992; Spears, 2006; Stinnett et al., 2004; Wadsworth & Knight, 1996). Cinelli, Sankaran, and McConatha (1992) noted that the AIDS crisis forced teachers to "confront their personal feelings and attitudes about sexual issues" (p. 204). In my study, I anticipated that these issues might emerge in the data.

HIV/AIDS Related Training Programs for Teachers

Increased knowledge about HIV/AIDS was linked with more positive attitudes towards issues related to HIV/AIDS and related issues, as well as more positive attitudes towards individuals living with HIV/AIDS (Dawson, Chunis, Smith, & Carboni, 2001). Increased knowledge about HIV/AIDS was potentially the result of training programs designed to provide educators with specialized HIV/AIDS related training. To ensure that teachers provided quality HIV/AIDS education to American students and handled issues related to HIV/AIDS in the classroom appropriately, they needed specialized HIV/AIDS education training (Cinelli et al., 1992; White & Ballard, 1993; May, Kundert, & Akpan, 1994). There are two primary means through which teachers should potentially receive this specialized training. Prospective

educators can receive training as part of their pre-service education curriculum. In-service educators can receive HIV/AIDS related training through professional development programs.

According to the US General Accounting Office (USGAO), teachers should receive a minimum of 12 hours of HIV/AIDS related instruction (quoted in Maylath & Gray, 1993). The CDC called for HIV/AIDS education to be offered to both pre-service and in-service teachers (Curtis, 2006; Dorman, Collins, & Brey, 1990; White & Ballard, 1993). Several studies suggested that teachers were interested in and even requested specialized training to assist them in delivering HIV/AIDS education and understanding related issues such as sexuality, homosexuality and death and dying (Evans, Melville, & Cass, 1992; Foley & Kittleson, 1993; Gingiss & Basen-Engquist, 1994; Ramafedi, 1993). This was promising because it indicated that teachers may be willing to learn how to adequately handle HIV/AIDS in the classroom.

Unfortunately, many teachers did not receive adequate training on either the pre-service or in-service levels (Evans et al., 1992; Foley & Kittleson, 1993; Spears, 2006; White & Ballard, 1993). Consequently, some scholars pointed to a substantial gap between the recommendations made by organizations like the CDC and USGAO and what was actually happening in American classrooms (White & Ballard, 1993). In the context of my study, I was interested to learn if participants received any specialized training to deal with HIV/AIDS on either the pre-service or in-service levels.

HIV/AIDS education for pre-service teachers.

The responsibility to provide HIV/AIDS training for pre-service teachers fell on colleges of teacher education and their faculty (Cinelli et al., 1992; Foulk et al., 2001; Spears, 2006). Cinelli et al. (1992) urged, "It is the mission of teacher preparation programs to prepare teachers…to meet challenges of today's classrooms—and AIDS is clearly a critical health issue

of today's youth" (p. 208). Foulk, Gessner, and Koorland (2001) noted that HIV/AIDS education should be a requirement for pre-service teachers so that students' needs concerning HIV/AIDS education and HIV/AIDS related issues could be met. Scholars suggested that faculty members in teacher education programs were not only specially charged with providing current and accurate HIV/AIDS education to pre-service education majors, but they were also responsible for "enhancing positive attitudes towards the instruction of HIV/AIDS education in our schools" (Cinelli et al., p. 205).

Many teacher preparation programs were not providing adequate HIV/AIDS education for prospective educators. Rodriquez, Young, Renfro, Ascencio & Haffner (1996) found "For elementary, secondary and physical education certifications, only one percent of institutions required courses covering HIV/AIDS" (cited in Spears, 2006, p. 214). In some cases, states did not require colleges of teacher education to provide HIV/AIDS training for pre-service teachers (Spears, 2006). A 1999 survey indicated that only eight states required pre-service elementary teachers to take a health-related course and only 25 states required a health-related course for pre-service middle school teachers (Spears, 2006). Fetter (1989) argued that most teachers did not have enough formal sexuality education to prepare them to instruct students about HIV/AIDS.

However, two studies indicated that when HIV/AIDS programming was provided for pre-service educators, the results were potentially very positive. Dorman, Collins, and Brey (1990) found that training programs for pre-service teachers increased their knowledge of HIV/AIDS and their support for safe sex practices. The course also decreased in their fear of HIV/AIDS (Dorman et al., 1990).

Similarly, Curtis (2006) found that an online course for pre-service teachers effectively helped pre-service to begin to think critically about HIV/AIDS related issues.

HIV/AIDS education for in-service teachers

In 1990, all 55 United States and territories claimed that HIV/AIDS education was provided for educators, mainly through faculty in-service training days and targeted staff development programming (Maylath & Gray, 1993). However, a 1994 CDC survey of teachers across the United States found that only one-third of teachers had actually received this training during the two years prior to the survey (CDC, 1996). Following the 1994 survey, the CDC immediately called for an increase in participation by teachers in HIV/AIDS in-service education (CDC, 1996).

Maylath and Gray (1993), Lohrmann, Blake, Collins, Windsor, and Parrillo (2001), and Ellis and Torabi's (1992) conducted studies of HIV/AIDS professional development programs, and their findings indicated that in-service HIV/AIDS education had the potential to make a positive impact on teachers, their classrooms, and ultimately their students. Scholars also suggested that in-service training should occur at regular intervals throughout the academic year. Spears (2006) noted that teachers should attend in-service training sessions regularly because the field of HIV/AIDS is "rapidly changing" (p. 222). Information that might have been current during the previous academic year may already be outdated. Gingiss and Basen-Engquist (1994) argued that in-service training programs should be held frequently because of high rates of teacher turnover, attrition and movement between districts, schools and disciplines. Further, due to the competing demands for teachers' time, training sessions should be held frequently in case scheduling conflicts prevented attendance at previous sessions. In the context of my study, I was

interested to see if participants had been provided any HIV/AIDS related professional

development, given the importance placed on such training by organizations such as the CDC.

International Educators and HIV/AIDS

Although this study focused on American teachers, specifically teachers in the State of

Georgia, it was helpful to include international comparisons to highlight shared HIV/AIDS

related experiences and perspectives of teachers worldwide and to place my study findings in a

broader context. In some countries, delivering effective HIV/AIDS education was a premier

national goal. Because of this national emphasis, there was a wealth of scholarly literature

related to teachers' experiences and perspectives related to the HIV/AIDS pandemic. My

purpose for including an international context in this study was not to make direct country to

country comparisons. I wanted to include a global context to highlight the magnitude of the

issue and the fact that there are shared experiences and perspectives across countries that may be

useful to consider in my data. My review of selected international literature on HIV/AIDS

education issues assisted me in identifying both broad trends and issues unique to the United

States.

Several researchers noted that in Sub-Saharan Africa, teachers contracted HIV/AIDS at

alarming rates (Bennell, 2003; Boler & Archer, 2008; Hunter, 2003; Theron, 2007). For instance,

according to a UNAIDS (2006) report, approximately 21% of South African teachers ages 25-34

were living with HIV/AIDS, and similar studies conducted in Kenya, Tanzania, and Ethiopia

underscored the negative impact of the HIV/AIDS pandemic on the teaching force (Asmelash,

2004; Beckman & Rai, 2004; McGreal, 2005; UNESCO, 2008). HIV/AIDS accounted for 77%

of teacher absenteeism in countries with high prevalence rates (UNESCO, 2008). Beyers and

Hay (2007) argued that HIV/AIDS disrupted the flow of academic work, broke down learning,

created a despondent school environment, and created a sense of uncertainty about the future. There have been financial consequences of the HIV/AIDS pandemic on the educational sector, as well. Absenteeism or the death of teachers meant that new teachers had to be trained, which was costly. In Zambia, AIDS-related illness, absenteeism, and death cost the Ministry of Education an estimated US$ 1.3-3.1 million per year (Grassly, Desai, Pegurri, Sikazwe, Malambo, Siamatowe, & Bundy, 2003). Teachers are important members of communities and countries in general. Instability in the teaching sector decreases the overall efficacy of a country's social, political, and economic systems as a whole.

In addition to examining teachers as a high-risk group for HIV/AIDS infection and the impact of teacher absenteeism and death, there were a number of studies that explored international teachers' experiences and perspectives related to the HIV/AIDS pandemic. The following sections of the literature review addresses international teachers' misconceptions and negative feelings towards individuals living with HIV/AIDS, care for students living with HIV/AIDS, knowledge about HIV/AIDS, and the impact of religion and culture, and teacher training efforts. In the context of my study, learning more about the professional experiences and perspectives of teachers in international contexts through scholarly literature helped provide some understanding of the professional impact of HIV/AIDS for teachers around the globe.

Teacher Misconceptions and Negative Feelings

By the end of 2008, 67% of all individuals living with HIV/AIDS resided in sub-Saharan Africa (UNAIDS, 2009). Sub-Saharan African teachers' professional experiences and perspectives about issues related to HIV/AIDS were the subject of scholarly inquiry because of the virulent nature of the pandemic in that region of the world and its impact on all sectors of society, including education. While many studies indicated that Sub-Saharan African teachers

were knowledgeable about HIV/AIDS, they were also reluctant to discuss HIV/AIDS and held

misconceptions and negative feelings about HIV/AIDS and individuals living with HIV/AIDS

(Norr, Norr, Kaponda, Kachingwe, & Mbweza, 2007). In a study conducted in Malawi, where

12% of the population was living with HIV/AIDS (USAID, 2009), one-fifth of the study

participants said that individuals living with HIV/AIDS should not be allowed in public places

(Norr et al., 2007). A survey of Malawian teachers revealed that one-third of respondents

believed HIV/AIDS was a punishment from God and two-thirds believed that it was a "disgrace"

(Norr et al., 2007, p. 245) to have an HIV/AIDS positive family member. Stigmatization in

Malawi appeared to be the product of "moral judgments rather than fear of contagion" (Norr et

al., 2007, p. 240).

Similarly, in Mali, Castle (2004) found that 75% of teachers who participated in her study

believed that individuals living with HIV/AIDS should be isolated to prevent further spread of

infection. Castle's (2004) study was significant because it revealed that, in addition to having

negative feelings about individuals living with HIV/AIDS and personal misconceptions about

HIV/AIDS, some Malian teachers were actually providing inaccurate information to students.

Castle (2004) argued that discriminatory attitudes among teachers in Mali were largely the

product of misconceptions about the transmission and spread of HIV/AIDS. If teachers were

provided with factually accurate information, it was possible that their negative feelings and

attitudes towards HIV/AIDS and individuals living with HIV/AIDS could diminish.

Some educators experienced stigmatization themselves when they attempted to provide

HIV/AIDS education or sexuality education to their students. Some teachers reported being

fearful of broaching sex-related topics or HIV/AIDS in the classroom because they were fearful

of upsetting parents or community members by introducing such content to students (Kiragu,

2007; Mufune, 2008). Kiragu (2007) argued that many educators were not confident about what they could and could not say to their students. As a result, some teachers were so uncomfortable with HIV/AIDS related content they literally hid when it came time to teach students about issues related to sex and sexuality (Mufune, 2008). In the KwaZulu Natal province of South Africa, Bhana (2007) noted that teachers were sometimes stigmatized or ostracized if they spoke openly about sex and were subject to being distrusted by parents and the community at large.

Teacher Knowledge and the Impact of Religion and Culture

A study of South African teachers found that teacher confidence was a motivating factor for becoming involved in a given community's HIV/AIDS prevention efforts (Webb & Gripper, 2010). In 2006, 67% of all Caribbean HIV/AIDS cases were among Haitians (Martell & Mueller, 2006). HIV/AIDS education was not mandated in Haitian public schools, although a 2006 study revealed 58% of educators included some form of HIV/AIDS education in their classrooms (Martell & Mueller, 2006). Teachers who did not include information about HIV/AIDS often cited their own lack of knowledge as a primary reason for not incorporating HIV/AIDS content into the classroom (Martell & Mueller, 2006).

Another factor that affected Haitian educator's decision to include HIV/AIDS education in the classroom was their Vodoun religious beliefs, and it appeared that Vodou influenced some teachers' choice of whether or not to include HIV/AIDS in the classroom (Martell & Mueller, 2006). Haiti has not been the only country where religion played an important role in educators' experiences with HIV/AIDS in the classroom. HIV/AIDS was increasingly prevalent in Latin America, a region of the globe that is predominately Catholic. Some public schools in Belize prohibited the discussion of premarital sex and condoms (Lohmann, Tam, Hopman, Wobeser, 2009). Furthermore, a recent study noted that some Catholic school teachers attempted to

promote abstinence by telling students that HIV/AIDS could pass through condoms and infect

students (McInnes, Orchard, Druyts, Baird, Zhang, Hogg, & VanDeusen, 2010). Overall, in both

Haiti and Belize, the role of religion has been important to address as both an issue that

influences teachers' attitudes about HIV/AIDS and HIV/AIDS education, as well as a hurdle to

implementing HIV/AIDS education programs for youth.

Caring for students living with HIV/AIDS

Some international research revealed that teachers felt emotionally invested in their

students' experiences with HIV/AIDS. Wood (2009) reported South African participants felt

personally traumatized when they learned about their students' experiences with HIV/AIDS.

Since many of the teachers had not received any special training to deal with emotional issues

related to disease and dying, they experienced difficulties in handling their emotions and their

students' emotions (Wood, 2009). The fact that teachers in Wood's (2009) study felt such a

strong personal reaction to the impact of the HIV/AIDS pandemic on children in their classroom

may be in part because some teachers assumed the role of caregivers for learners in the

classroom. In another study of South African pre-service teachers, researchers found that many

prospective teachers looked forward to nurturing and caring for learners, particularly in the

context of HIV/AIDS. Informants drew upon the metaphor of "Mother" (Hattingh & de Kock,

2008, p. 327) when discussing the presence of children infected or affected by HIV/AIDS in

their classrooms and the need to provide a "safe haven" (Hattingh & de Kock, 2008, p. 327) for

those children, a sentiment echoed by teachers in Thailand (Boler & Archer, 2008). Given the

fact that Sub-Saharan Africa has been home to the vast majority of the world's HIV/AIDS

orphans, many teachers may have been called upon, directly or indirectly, to fill the void left by

biological parents. Boler and Archer (2008) suggested that the HIV/AIDS pandemic has pushed

schools into becoming "'centres of caring and support'" (p. 66). In order to provide such care and support, teachers themselves needed additional support or training to deal with the emotional and psychological consequences of taking on such responsibilities.

HIV/AIDS Teacher Training in Other Countries

Just as in the United States, appropriate training was important for preparing teachers to deal with the realities of the HIV/AIDS pandemic. There were numerous international studies related to specialized HIV/AIDS training for educators. Studies in Lesotho, Nigeria, and Uganda suggested that despite having a desire to provide HIV/AIDS education to their students, educators were wary of trying to do so because of lack of training (Mufune, 2008). In Uganda and South Africa, a lack of teacher training was cited as a reason for slow integration of HIV/AIDS education into the national curriculum (Beyers & Hay, 2011; Jacob, Mosman, Hite, Morisky, & Nsubugu, 2007). A study among Vietnamese teachers suggested that they lacked basic communication skills that would be essential for answering student questions related to HIV/AIDS education (Taechaboonsermsak, Tuan, Apinuntavech, 2008). Another study conducted by McGinty and Mundy (2009) explored Namibian pre-service teachers' knowledge, attitudes and concerns and found a lack of both knowledge and confidence among interviewees. Other studies in Tanzania and South Africa point to the success of particular programs that have tried to specially train educators to deal with HIV/AIDS (Peltzer & Promtussananon, 2003; Renju, Nyalali, Andrew, Kishamawe, Kimaryo, Remes, Changalucha, & Obasi, 2011; Wood, 2009).

Factors such as funding and a lack of up-to-date training materials may be factors that impeded the proper training of teachers. In Uganda, HIV/AIDS education seminars for pre-service teachers were cut because of a lack of funding (Jacob et al., 2007). Student motivation

was an issue in terms of HIV/AIDS training programs. In a Namibian study, teachers reported

that sexual and reproductive health courses were not graded and were therefore not taken

seriously by students or teachers (Mufune, 2008).

Outside of Sub-Saharan Africa, the training of teachers was an issue in other countries

and regions. Wight and Buston (2003) noted that many teachers in Great Britain were

uncomfortable with delivering HIV/AIDS related material to students but that quality in-service

training programs improved teacher confidence, motivation, knowledge, and skills needed to

teach students about HIV/AIDS. In Mexico, researchers found that providing comprehensive

HIV/AIDS related training to teachers had an impact on the overall success of a life-skills

program for students (Pick, Givaudan, Sirkin, & Ortega, 2007). In the context of my study,

considering issues such as teachers' misconceptions and negative feelings towards individuals

living with HIV/AIDS, care for students living with HIV/AIDS, knowledge about HIV/AIDS,

the impact of religion and culture, and teacher training efforts in selected international contexts

provided an additional layer of background information for the study, and it allowed me to

understand my findings in the broader context. In the following chapter, I present my

methodology. I describe my research design and theoretical perspective, the details of my

methodology, and the issues and challenges I encountered as I conducted the study.

CHAPTER 3

METHODOLOGY

In this chapter, I explain the methodology and methods that I employed in the study. I discuss the study design, theoretical framework, research questions, data types, participants, sampling, and data analysis techniques. I also attend to questions involving reliability and validity of data, as well as gaps in the data.

Design

I selected a qualitative, emergent, flexible, case study where individual teacher participants represented a "bounded system, or case" (Merriam, 1998, p. 28). The purpose of this qualitative study was to explore selected Georgia teachers' professional experiences and perspectives related to HIV/AIDS and the classroom and to highlight similarities between the experiences and perspectives of participants and teachers in other countries, as reported by other researchers in scholarly literature. I highlighted broader challenges and struggles associated with the impact of the HIV/AIDS pandemic for teachers. I have created a finished product that represents a sampling of some teachers' professional experiences and perspectives related to HIV/AIDS with comparative insights.

I chose to conduct a qualitative study because it allowed me to conduct semi-structured interviews with participants, which in turn allowed me to gain some understanding of my participants' experiences and perspectives on issues related to HIV/AIDS in the classroom. According to Merriam (1998), qualitative researchers are interested in the meanings that people construct and how they make sense of the world in which they live. During the course of the

interview and data analysis process, I was able to understand some of the ways the HIV/AIDS

pandemic has manifested itself in the professional lives of selected teachers. Interviews with

participants allowed me to gain an "emic" (Merriam, 1998, p. 6) or insider point-of-view. For

the most part, teachers who participated in this study were more than willing to allow me access

to their professional experiences and perspectives related to HIV/AIDS. In many ways, I was

treated as an insider—perhaps because of my own status as an educator. I discuss issues related

to teachers' willingness to share their professional experiences and realities in more detail in

Chapters Four and Five.

Theoretical Framework

I drew on critical theory, comparative perspective, and structural-functionalism to form

the theoretical framework for my study. Although I relied on these perspectives to varying

degrees, they combined in an eclectic theoretical framework. Merriam (1998) suggested that a

theoretical framework is a lens through which a person views the world, and that a theoretical

framework functions as scaffolding on which to build a study. In the following section, I outline

elements of critical theory, comparative perspective, and structural-functionalism that I used to

create my eclectic theoretical framework.

Critical Theory

Sipe and Constable (1996) suggested that critical theory was a paradigm that recognized

reality was both subjective and constructed on the basis of power. Critical theorists were

interested in changing the world and asking questions such as "What is just?" (Sipe & Constable,

1996, p. 105) and "What can we do?" (Sipe & Constable, 1996, p. 105). One manifestation of

critical theory is critical pedagogy, which Apple, Au, and Gandin (2009) suggested seeks "to

expose how relations of power and inequality, (social, cultural, economic), in their myriad forms,

combinations, and complexities, are manifest and are challenged in the formal and informal education of children and adults" (p. 3). Some tasks of critical pedagogy included illuminating the ways in which education was linked to exploitation and domination and connecting education with progressive social movements (Apple, Au & Gandin, 2009). Throughout the dissertation process, I attempted to stay cognizant of elements of power and discrimination. Because of a critical perspective that is part of my everyday worldview, I was concerned about issues like racism, sexism, classism, ageism, homophobia, and discrimination on the basis of ability. Since this study included international and comparative insights, it was also important to understand the ways in which power, subjectivity, and competing historical, social, cultural, economic, political, and religious factors compared and contrasted across countries.

Comparative Perspective

Given the nature of globalization and the vast amount of borrowing (Wiseman & Baker, 2005) that occurs between countries' educational, health and government policies, I included comparative insights from research in South Africa, Namibia, Botswana, Uganda, Malawi, Mali, Lesotho, Nigeria, Mexico, Belize, Haiti, Great Britain, Tanzania, Vietnam, and Thailand. I did not make direct country comparisons, but I attempted to understand my findings about experiences and perspectives related to HIV/AIDS and the classroom in light of research in a selection of countries. These shared experiences underscored the sheer magnitude of the HIV/AIDS pandemic and the educational interventions that were meant to counteract the pandemic.

Comparative perspective allowed me to explore the local-global and global-local continuum, which was important considering the fact that HIV/AIDS has very real and different effects on the micro, meso, and macro levels. If I had not included comparative perspective in

this study, I would have run the risk of misinterpreting my findings or of seeing them out of context. The wealth of international scholarly literature added some depth to this study and underscored the similarities and differences that occurred between nations in terms of teachers' professional experiences and perspectives related to HIV/AIDS. It was useful to provide context and comparisons, when appropriate, in order to gain better understanding of the experiences and issues on a global scale.

Structural-Functionalism

Some aspects of structural-functionalism were also important to consider in this research. Structural-functionalists suggested that societies were made up of interconnected entities, such as schools, families, and political systems, that operated together to maintain balance and equilibrium with layers or levels of power and authority (Mooney, Knox & Schacht, 2009). Structural-functionalism was a useful perspective to include in my theoretical framework because education mandates are frequently top-down, and HIV/AIDS education was most often implemented from the top-down, as well.

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Research Questions

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I answered the research questions for my study by conducting one-on-one, semi-structured interviews. Prior to receiving Institutional Review Board (IRB) approval for research involving human subjects, I conducted a review of scholarly literature, as detailed in Chapter Two. Once I received IRB approval, I sought to answer my research questions by conducting interviews. A chart detailing my research questions, data sources, and rationales are included in the Research Matrix included in Chapter One.

The research questions guiding my study are as follows:

1. What are selected teachers' experiences and perspectives on issues related to HIV/AIDS in the classroom?

   a. What are their experiences and perspectives about teaching about HIV/AIDS?

   b. What are their experiences and perspectives about teaching students living with HIV/AIDS?

   c. What are their experiences and perspectives about teaching students affected by a family member or friend's seropositive status?

   d. What are their experiences and views about managing safety and confidentiality concerns related to HIV/AIDS in the classroom context?

   e. What are their experiences and perspectives about dealing with stigma and stereotypes surrounding HIV/AIDS in the classroom context?

   f. What, if any, are their experiences and perspectives about negotiating personal feelings related to issues such as death, dying, homosexuality, and illness related to HIV/AIDS?

   g. What are their experiences and perspectives about HIV/AIDS related pre-service or in-service teacher training programs?

2. How do selected teachers' professional experiences and perspectives illuminate broader challenges and struggles associated with the impact of the HIV/AIDS pandemic for teachers?

How do these selected teachers' professional experiences and perspectives compare to the experiences and perspectives of teachers in other countries, as reported by other researchers in scholarly literature, and reveal universal issues related to HIV/AIDS and the classroom?

Data Types

The primary data types that I used in the study were interviews and field notes, which included contextual notes, personal notes, observer comments, and memos. In this section of the chapter, I provide detail about interviews and field notes and how they were used in the study.

Interviews

I conducted one-on-one, semi-structured interviews with participants. The interviews lasted approximately one hour. The longest interview lasted 79 minutes, and the shortest interview was 49 minutes. I ultimately conducted 14 interviews with 11 different participants (11 initial interviews, plus three follow-up interviews). The interview guide that I used during interviews is included in Appendix B. I discuss participant sampling and demographics in more detail in the Participants section of this chapter.

I conducted interviews at mutually agreed upon locations that were not on school or county property, as outlined in my IRB application. Some of the interviews were conducted at public places like coffee shops or libraries, while others were conducted in participants' homes. Participants signed informed consent documents, as required by IRB standards. Informed consent documents included provisions for audio recording interviews. Although Lincoln and Guba (1985) warned against the use of recording devices because they can inhibit informants, I believed that it was important to audio record interviews to properly capture participants' experiences and perspectives and to record them in total. I used a Sony digital audio recorder that was very small and unobtrusive. Furthermore, I attempted to minimize any obtrusiveness by producing the tape recorder at the beginning of the meeting, explaining why I was using it, and placing it on a nearby desk or table. Ten of the 11 participants agreed to be audio recorded, while one interviewee declined to be recorded. As soon as possible after each interview, I

transcribed the audio recordings of interviews. This allowed me to avoid a back-log of

interviews and it also enabled me transcribe while the interview was fresh in my mind. In

addition to audio-recording and transcribing interviews, I took notes during interviews, as both a

form of back-up in case there was a technical error with the recorder and as a way to record

contextual notes, personal notes and observer comments during interview. These various types

of field notes are discussed in the next section. For the one participant who did not agree to be

audio recorded, I wrote detailed notes during the interview.

I used a specific procedure for transcribing interviews. In most cases, I was able to

transcribe interviews within 48 hours after the interview had taken place. I listened to the

recording in its entirety, making notes about selected segments of the interview that I wanted to

focus on during transcription. On average, these selected segments were seven to twelve minutes

in length. After listening to the entire recording, I went back and carefully transcribed selected

segments word-for-word. I listened to each selected segment at least twice to make sure that I

had accurately transcribed the material. After I created selected transcriptions of the interview

recordings, I read through the transcription and identified material that I intended to incorporate

into the findings chapter of the dissertation. As I wrote the findings chapter, I went back to these

transcriptions numerous times in order to carefully select direct quotes to illustrate key points.

Field Notes

Field notes were a data type and included contextual notes, personal notes, observer

comments, and memos (Merriam, 1998). I maintained a fieldwork journal for the data collection

and data analysis phases of the dissertation study. During interviews, I took notes about the main

ideas participants relayed in case the audio recorder failed. The fieldwork journal included these

notes, as well as contextual notes, observer comments, personal notes, and memos. Field notes

helped me reconstruct essential details of the interview during the transcription, data analysis, and writing phases of my dissertation study. In my field notes, I also recorded logistics and other process elements as I conducted the study.

Contextual notes.

Holloway and Wheeler (2010) suggested that contextual notes are best recorded before interviews or immediately after when information is still fresh in the interviewer's mind. I recorded contextual information before the interviews, such as the time and place of the interview, the overall mood of the interview, and any other contextual details that appeared to influence the overall outcome of the interview. For instance, during one session, the participant and I were sitting in a secluded part of a coffee shop. When someone came and sat down beside us, I could sense that the participant was slightly more guarded in speaking. Recording this information was important when I went back to analyze data to make sense of this participant's words and tone. This type of contextual note also allowed me to make additional observer comments, such as the fact that I learned a coffee shop was not an ideal place to conduct an interview.

Observer comments.

Merriam (2009) noted that observer comments were "comments about what is being observed; with these comments one is actually moving from description to beginning data analysis" (p. 131). I recorded observer comments during and after interviews. When participants seemed uncomfortable, distracted, or flustered by a question, I made a notation in my interview fieldwork journal. Alternatively, when participants seemed particularly energized or enthusiastic about a line of questioning, I made a notation about that, as well. Observer comments also included notations about interruptions, distractions, and other unexpected

interferences. These observer comments helped me keep track of fluctuations in the interviewee's mood and demeanor and helped me recall important interruptions or other activity that took place during the interview. Combined with interview transcripts, observer comments allowed me to reconstruct pivotal moments during the interviews months after they had taken place.

Personal notes.

Ortlipp (2008) suggested that personal notes revealed insights, self-doubts, and questions on the part of the researcher. My personal notes primarily consisted of connections that I made between interviews and my personal reactions to interview data. I recorded some of these notes during the interviews, but I recorded the majority of them after the interviews after I transcribed the data. In some cases, personal notes were a way for me to express my personal reactions to what the participants had said during the interview. I found that writing these feelings down was important for me because a great deal of the data I collected was overwhelming, and I needed a way to process things I had been told. These were also important for me to write as a means of confronting any feelings of bias.

Memos.

Finally, I made memos after interviews. According to Boejie (2010), "Memos can function as a link between thinking and doing and they are comparable with the use of yellow Post-it notes" (p. 70). I created memos about ingredients in the interview that I wanted to cross-reference with other participants. In one instance, two participants worked at the same school, so I made memos to myself to be sure and cross-reference their accounts of incidents for comparison. I also created methodological and theoretical memos (Boeije, 2010). Methodological memos related specifically to the methods that I used or to particular issues

related to my methods or methodologies. I wrote memos about which interview questions were effective and which ones were not effective. I found that two of my interview questions were more or less ineffective, so I wrote memos about this observation. Theoretical memos were related to the theories that underpinned my study. Most frequently, I wrote memos related to comparative perspective and critical theory insights. In several cases, I wrote memos about issues related to power that were expressed during the interview. I also wrote memos when participants said things that were reminiscent of issues expressed in international scholarly literature. Overall, the various types of field notes provided crucial data that I was able to analyze in conjunction with interview data. Collectively, these notes, comments, and memos served to document many details of my research process.

Study Participants, Sites, and Settings

Participants

Using a list of professional contacts, I initially identified 16 participants from a range of school settings and backgrounds using purposeful sampling in order to create some variation among participants. I established the following criteria to help me identify appropriate study participants:

1. Participants must have been currently teaching K-12 in the State of Georgia or must have taught within the last five years.

2. Participants did not need specific experiences with HIV/AIDS in the classroom, but they needed to be willing to discuss their professional experiences and perspectives related to the issue of HIV/AIDS as it related to the classroom.

I developed these criteria because I wanted to limit the participants to teachers in the State of Georgia and teachers who were currently teaching or who had recently taught in order to gain the

most up-to-date insights. I anticipated that many teachers would claim they did not have specific experiences with HIV/AIDS in the classroom, so I stipulated that teachers only needed to be *willing* to discuss their professional experiences and perspectives.

From the initial pool of 16 participants, some individuals ultimately did not participate in study. Three prospective participants who initially agreed to participate did not respond to my formal invitation to participate, despite two follow-up attempts to contact them. Two other prospective participants were willing to participate, but their interest disappeared when I explained that the interview would have to take place off of school property, per a stipulation in my IRB approval, which is discussed in the Sites and Settings section of this chapter. These individuals said that the only time they were available was during their planning hour during the school day. Without their willingness to meet away from school property, it became impossible for me to interview these individuals. Although I do not know the impact that these lost participants might have had on the overall outcome of the study, I was comfortable with the final pool of participants and the wealth of experiences and perspectives they contributed to the study.

The final pool of participants represented individuals from rural, urban, suburban, elementary, middle, and high schools, in both private and public settings.   Participants taught in schools in and around Northeast Georgia and the metropolitan Atlanta area. The participants taught the following subjects: art, social studies, English, and math, and the elementary school teachers provided instruction in a variety of subjects. Of these 11 participants, I knew seven participants on a strictly formal, professional basis, while I knew four participants on a more informal, casual basis. The following chart shows the range of experiences and perspectives of individuals who participated in the study:

Table 1

Participant characteristics

Participant number	Location of school	Level taught	Subject taught	Race/Ethncity	Gender	Years experience	Other	Degree(s) earned
1	Urban	Elem.	Art	White	F	3		BA/MEd
2	Urban	High	Soc. Stud.	White	M	14		BS/Med/EdS
3	Suburb.	Elem.		White	F	10		BSEd
4	Rural	Middle	Soc. Stud.	White	F	4		BSEd /BA/ MEd
5	Virtual	Middle	Math	White	F	9	Virtual Sch./ Social Work	BSEd /MEd/ EdS
6	Suburb.	Elem		White	F	6		BSEd /MEd
7	Suburb.	High	Soc. Stud.	White	F	3		BS/MEd
8	Suburb	Middle	Eng.	White	F	11		BSEd /Med/ EdS
9	Rural	High	Soc. Stud.	White	M	3		BA/MEd
10	Urban	Middle	Eng.	White	F	10	Private / Non-edu. back-ground	BA/MA
11	Suburb.	Middle	Eng.	White	M	7		BSEd /MA/ ABD

Although I wanted to have a sample that represented a wide variety of racial/ethnic, socioeconomic, and religious backgrounds, I decided against soliciting participants solely based on their race or their socioeconomic status. As evidenced in the table above, there was no real racial/ethnic diversity to speak of among participants. Despite the lack of racial/ethnic diversity, there was still a mixture of male and female participants who taught in quite different school settings.

At the onset of each interview, I gathered demographic information, such as the grade level and subject that the participant taught, as well as the number of years he or she had been teaching. I also gathered information about their training to become educators. This information was included in Table 1. It is worth noting that 10 out of 11 participants earned graduate degrees, and four were in the process of earning their terminal degrees in education. The participants had between three and 14 years teaching experience, which resulted in an additional layer of variety among participants. Having these extra pieces of demographic information related to the education level of participants, which I did not have during the prospectus stage of this study, allowed me to gain some additional insight into participants' experiences and perspectives. Additional differences, such as political views and religious backgrounds, provided further contrasts between participants.

I originally intended to use snowball sampling (Merriam, 1998; Patton, 1990) in building my study sample. I intended to begin by interviewing selected professional colleagues who had pertinent experience and backgrounds and then interview other individuals based on the initial participants' suggestions. In the end, I did not use any snowball sampling because I felt confident in my pool of participants and believed I had interviewed a group that provided a satisfactory range of experiences and perspectives based on the types and locations of schools

where the participants taught, the number of years they had been teaching, the subjects they taught, and the types of training they had received. Towards the end of the interview process, I noticed that there were repetition, commonalities, and converging of interview data, which led me to believe that I had reached the appropriate point to begin data analysis. In addition, I did not add additional participants because the individuals recommended by participants did not meet the criteria for participation.

Sites and Settings

After conferring with IRB in October 2010, I decided to conduct interviews away from school property. Since I conducted interviews off campus, it was important that the interviews take place in locations that were convenient for participants. Several participants expressed mild frustration that I would not be able to come to their classrooms to conduct the interview, and I believe that this is one minor indication of the shortage of time teachers face in their daily lives. I attempted to conduct all interviews in quiet places that were amenable to audio recording; however, I tried to let each participant select a site that was convenient for him or her. Even when the participants chose public places, in most cases, we were able to find quiet corners and to proceed with the interview without interruption. In three cases, I went to the participants' homes, which was not my first choice of venue, but I felt it was best to try to be accommodating to the participants.

During the course of interviews, some participants shared information with me that was related to both the interview questions and research questions but was also slightly outside of the direct focus of the study. These additional, related data provided crucial insights into the challenges and issues teachers faced on a daily basis. On the instructions of IRB in August 2011, I called each participant on the telephone to gain their verbal consent to include additional,

related data in my study. The phone call script that I used during these phone calls is included in Appendix C. Further, for this re-consenting procedure, I submitted an amendment to the original IRB application, noting that there had been changes to consent documents for the study. All 11 participants verbally agreed to allow me to include the additional, related data and insights in the study.

Access Issues

My primary concern was with accessing participants and data. Despite the five participants who declined to participate after initial, tacit approval, I gained access to 11 participants who provided me with over 14 hours of interviews.   Because I lived in Northeast Georgia, I was able to travel to meet participants throughout the region at times that were convenient for them. I believe that the ability to travel to meet participants made the entire interview phase of data collection more successful.

Data Collection Procedures

The data collection procedures for the dissertation included the following stages:

1. Review of scholarly literature (October 2009-September 2011)

2. Conduct Interviews (January-March 2011)

3. Conduct follow-up interviews (March-August 2011)

There was some overlap between these three stages, and I reviewed additional scholarly literature based on data gleaned from interviews. I was able to conduct these phases of the data collection process simultaneously because of the constant comparative approach and inductive reasoning, which are discussed later in this chapter.

The Roles of the Researcher

One of the most important aspects of qualitative research is that the researcher is the primary instrument during the research process (Merriam, 1998). As the researcher, I focused on an area of inquiry, designed the study, selected research sites, gained permission and negotiated entry into a site, conducted the interviews, analyzed documents, recorded and analyzed data, and formulated findings (Mertens, 2005).

I kept in mind the issue of insider/outsider roles of the researcher and the importance of establishing trust (Liamputtong, 2010). In general, I was an insider among the participants based on demographics, sociocultural background, and the fact that I knew four participants on an informal basis prior to data collection. My own status as an educator granted me additional insider status with participants. I was also same gender as the majority of the participants, which may have made female participants more comfortable given the fact that sex and sexuality were topics that emerged during the course of the interview. Although I was employed as an instructor at a technical college at the time of the interviews, I was no longer a K-12 teacher, which placed me in the role of outsider. I had to carefully temper my dual role of insider/outsider during the research process, and I remained aware of my multiple roles and the ways in which I navigated the insider/outsider dichotomy with each individual participant. I tried to emphasize my similarities with participants, whether it was our shared educational background or shared teaching background. Although I benefited from being an insider because participants were more apt to trust me and relate their experiences and perspectives, I was also careful to maintain a professional rapport with participants and to critically examine their words and the overall tenor of the interview.

Ultimately, the individual researcher has a great deal of responsibility and power in research. I took it as my responsibility to conduct ethical and thorough research. Since I was dealing with a highly sensitive topic that involved layers of concerns, including confidentiality and emotional concerns, it was imperative that I was sensitive to both study participants and the data that were produced during the course of the study. It was my responsibility to ensure that study participants understood the study before they participated, including measures that were taken to ensure the confidentiality of their responses.

Bias Issues

Since the researcher is such an integral instrument in the qualitative research process, questions of bias naturally emerge. Mertens (2005) noted that there were specific activities that qualitative researchers engaged in to attempt to minimize bias, such as using member checks and self-auditing. I used member checks to clarify several pieces of information with interviewees. In some cases, I made clarifications on the spot, but in other cases, I phoned the participant later to confirm pieces of information. In three cases, I needed to clarify larger portions of data, so I scheduled follow-up interviews. In addition to member checks, Mertens (2005) suggested that researchers self-audit their studies by asking the following questions: Did I draw conclusions prematurely? Was there unexplored data in my field notes? Did I search for negative cases? Did feelings of empathy or personal connections inappropriately color my findings (Mertens, 2005)? I reflected carefully on these questions throughout the data collection and analysis phases of my dissertation, and I was comfortable with my responses to these questions.

In cases where I felt discomfort, I wrote personal notes and methodological memos to document these feelings, and I proceeded to gain clarification or to conduct follow-up interview to eliminate the problem.

Reliability, Validity, and Verification

Despite the fact that my research findings represented individuals' experiences and perspectives that were highly subjective and unique, there were still steps that I took to produce dependable, consistent, and credible findings, as recommended by Creswell (2007) and Lincoln and Guba (1985). These included: triangulation, an audit trail, and detailed description.

Triangulation

I used triangulation to confirm findings emerging from my data (Merriam, 1998). I used multiple interviews and field notes in order to triangulate data by participant, data type, and theme. I viewed triangulation as a tool for providing corroborating evidence (Creswell, 1998) and illuminating various aspects of data and findings, and I used triangulation to clarify gaps, misunderstandings, or miscommunications that occurred in interviews. I created charts that became particularly useful as I triangulated data. After each interview, I filled in a chart with selected main points of participants' responses to each of the 10 interview questions. Using these charts, I made links not only between interviews themselves, but also between interviews and field notes and between interviews and scholarly research conducted by other researchers. These charts were especially useful during the coding process, which is discussed in more detail in the Specific Methods of Analysis section of this chapter. For an example of how these charts served my efforts to triangulate data, see Appendix D.

Audit Trail

I needed to provide detailed accounts of my choices and actions during the data collection phase of this study. Dey (1993) argued, "If we cannot expect others to replicate our account, the best we can do is explain how we arrived at our results" (p. 251). I kept detailed notes throughout the research process, which included explanations about participant sampling,

interview techniques, and data analysis. I also kept a very detailed audit trail so that I would be able to remember details for my own purposes. For instance, in my fieldwork journal, I kept a log of every communication with participants throughout the study. Therefore, I was able to go back and see the date that I contacted the participant, the reason for the contact, and the outcome of the communication. This allowed me to keep track of conversations, but it also allowed me to remember important details, such as the reasons for participant attrition.

Detailed Description

Creswell (1998) suggested that detailed description allows the reader to make a decision for himself or herself if the findings were transferable and credible, and Guba and Lincoln (1981) noted that it is the role of the qualitative researcher to create for the reader "the sense of having been there" (p. 149). By providing detailed description and direct quotations, I attempted to capture participants' experiences and perspectives as they were relayed to me, which hopefully led to a better understanding of the participants' unique situations. Whenever possible, in my write-up, I included direct quotations from participants in order to attempt to preserve their unique perspectives.

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Specific Methods of Analysis

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I employed several methods of analysis of my data. These methods included the constant-comparative approach, and within it coding and inductive reasoning.

Constant Comparative Approach

Glaser (1978) suggested that the constant comparative approach include the following steps which occur simultaneously and not as discrete steps:

1. Collecting data

2. Engaging in sampling, coding, and writing

3. Looking for key issues, events or activities that might become categories (coding)

4. Collecting data that provide diverse dimensions and instances under the categories (axial coding)

5. Writing about the categories

6. Working with data to establish basic relationships (quoted in Bogdan & Biklen, 2003).

In general, once I had transcribed the audio recording of interviews and had written my notes on all interviews, the constant comparative method allowed me to begin with a particular incident, remark, or document and then compare it with a similar incident, remark, or document in the same set of data or in another set of data (Merriam, 1998). For instance, I began to notice that many participants used the phrase "gay disease" when discussing HIV/AIDS. Gay Disease ultimately became a category during the coding process, and I used the constant comparative approach to highlight that phrase when it was used during interviews. Further, I looked to scholarly literature to see what other researchers had experienced in terms of teachers and students claiming HIV/AIDS was a gay disease. By making connections across my own participants and across scholarly literature, I constantly compared instances of the pieces of data that emerged in relation to my research questions.

With this constant comparative approach I employed inductive reasoning. By relying on inductive reasoning, I was able to remain flexible and incorporate unexpected findings or occurrences into my study instead of feeling a need to prove or disprove a hypothesis, which is often typical of deductive reasoning (Creswell, 2007; Hoepfl, 1997; Maykut & Morehouse, 1994). It is important that qualitative researchers go where the data lead them and to be able to move from participant-specific instances to more general issues. For instance, when I noticed that several participants mentioned that students perceived HIV/AIDS to be a gay disease, I was

able to focus on that pattern appropriately as it emerged during the course of my study. I followed the notion of gay disease from the specific mention of the phrase in a single interview to the more general view of the phrase as expressed by other researchers in scholarly literature from the United States and abroad.

Creswell (2007) noted that things change and modifications need to be made during the course of a qualitative study. Towards the end of data analysis when I began to tally the number of times participants discussed certain categories and codes, I realized that certain categories were more prominent than others. I was then able to develop sets of codes on different levels of occurrence. Inductive reasoning allowed me to remain flexible and open to these unexpected trends and patterns so that my study reflected the experiences and perspectives of participants. Next, I discuss the specific processes of data analysis within this approach.

Coding

The process of sorting data and analyzing patterns is known as coding. I used open and axial coding (Strauss & Corbin, 1990). A code is "some sort of short-hand designation" (Merriam, 1998, p. 164) that is applied to data so that patterns can be more readily identified. Bogdan and Biklen (2003) suggested that codes fall into one of the following categories: setting/context, situation, subjects' perspectives, subjects' ways of thinking about people and objects, process, activity, event, strategy, relationship and social structure, narrative and methods. Although I did not expressly set out to code for these specific categories, many of the codes I produced did fall into categories of this kind (see Table 2).

After each interview, I read through my field notes and made memos and personal comments. I created charts based on my field notes where I included the key points of participants' responses to the various interview questions (see Appendix D). These charts

ultimately allowed me organize my field notes and to gain a more comprehensive understanding

of the similarities and differences between participants' experiences and perspectives. Many of

my memos were recorded on these charts, as shown in the sample included in Appendix D.

As I created these charts based on field notes and interview transcripts, I began making a

list of words and phrases that were mentioned repeatedly during interviews. This list initially

included phrases such as, "taboo," "not on radar," "fear of contracting," and "mode of

transfusion." This initial list, which began as a running log in my fieldwork journal, became the

foundation for my final list of codes and categories. After I had conducted an initial interview

with each participant and created a chart based on my field notes and the interview transcripts, I

read through the charts and built upon my initial list of words and phrases that were repeated

throughout my interview notes. These lists of words and phrases became subsumed categories.

This list included the following categories: Africa, Mother/Nurturer, How Transmitted,

Blood/Universal Precautions, Sympathy & Method of Transmission, Gay Disease, Swept Under

Rug, Not an Issue, Confidentiality Concerns, Homosexuality, Time Constraints, and Other

Extreme Situations. Towards the end of the data analysis phase, I added additional categories,

such as Fear of Upsetting Parents/Administration, Stigmatization, Training, Administration, and

Fear of Contracting. After I developed the final list of categories, I created a two to four letter

code for each category. For example, I created the code AFR for the category Africa, and the

code RUG for the category Swept Under Rug. See Appendix E for the list of categories and

corresponding codes from my fieldwork journal.

My final step in developing a system of categories and codes involved assigning a

colored tab to each code. After developing a list of categories and related codes, I assigned each

code a color and then wrote the various codes on colored, adhesive tabs. These adhesive tabs

were placed directly on printed field note charts and transcripts. I read through the charts and

transcripts and placed a colored tab in the margin of the page whenever the related word, phrase,

or idea was mentioned. Appendixes F and G show how I placed the colored tabs directly on the

field note charts and interview transcripts. After placing colored tabs in the margins for every

transcript and field note chart, I made a tally of the number of times each code was used. I

created the following table displaying the number of instances for each of the categories and

codes:

Table 2

Data analysis: categories, codes, and frequencies

Category	Code	Instances (# times mentioned across interviews)
Africa	AFR	7
Mother/Nurturer	MOM	8
Student Questions How Transmitted	HOW	13
Blood/UP	UP	15
Fear of Upsetting Par/Adm	FEAR	10
Importance Of Method of Transmission	TRA	14
"Gay Disease"	GD	5
Swept Under Rug	RUG	4
"Not an Issue"	NON	15
Confidentiality Issues	CONF	8
Stigmatization	STIG	13
Pregnancy/Sex	PREG	7
Homosexuality	HOM	13
Time Constraints	TIME	1
Teacher Training	TRAIN	22
Administrators	ADM	9
Fear of Contracting	CON	5
Other/Extreme Situations	OH	9

Data Analysis

After I created a list of categories and corresponding codes and used colored tabs in order to visually label field note charts and interview transcripts, I wanted to find a way to develop connections between categories by acknowledging patterns and creating themes. Therefore, I used axial coding, which Strauss and Corbin (1990) suggested was "a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories" (p. 96). Axial coding was a useful tool for data display, as it allowed me to display the dimensions of larger issues that emerged in my data. Axial coding allowed me to look across all of the categories and to create larger themes in the data that illuminated the broader challenges and struggles teachers faced in terms of HIV/AIDS, as well as the specifics of responses to the research questions.

The following themes emerged during axial coding: Training, Communication, Fear, Stigmatization, Denial, and Additional/Related Issues. After identifying these themes, I used radial display charts to organize subthemes under each of the main themes. Subthemes were pulled from the content of interview and field note data, as well as existing categories. Because the themes were multi-dimensional, the radial charts are labeled as dimensions of a particular theme, such as Dimensions of Training, Dimensions of Communication, Dimensions of Fear, Dimensions of Stigmatization, Dimensions of Denial, and Dimensions of Additional/Related Issues. Consequently, through this process of axial coding, sometimes also called dimensionalizing (Strauss & Corbin, 1990), the organization and write-up of my findings became clear. I wrote my findings according to these major themes and sub-themes that are shown in radial data displays in Figures 2-7 in Chapter Four. For each theme and sub-theme, I was able to develop findings with quotes from the interviews, selected references from the literature where

they were directly relevant to a particular point, and my own interpretations of the findings. These findings are outlined in the next chapter, Chapter Four.

Gaps in the Data

Given the number of participants and design of the study, I felt reasonably satisfied with the data that I collected. In fact, I collected more data and more powerful insights than I expected that I might collect, and I credit participants' willingness to openly share their experiences and perspectives with me as the reason for the strength of data. In reviewing the specific details of my research questions (see the Research Matrix in Chapter One), I discerned no unanswered questions or sub-questions and no explicit gaps in the data. However, as will be seen in my discussion of the findings, there were some reports of situations confronting teachers that left me wondering how such situations could exist in schools. Although there were no clear cut answers to these questions, I remained troubled by the lack of explanation or justification for teachers being placed in such situations. In future studies, I would be interested in the prospect of including classrooms observations, speaking with administrators and school nurses, or modifying the study design in some other way. The next chapter of the dissertation, Chapter Four, presents the findings of the study.

CHAPTER 4

FINDINGS

The primary findings of this study related directly to the research questions outlined in Chapter One. The themes and subthemes emerged from interviews, field notes, and subsequent open and axial coding of the data. The six themes that emerged were: Dimensions of Training, Dimensions of Communication, Dimensions of Fear, Dimensions of Stigmatization, Dimensions of Denial, and Dimensions of Additional, Related Issues. Figures 2-7 illustrate these six themes. I discuss these themes and subthemes in this chapter. In Chapter Five, I discuss my reflections on international insights and universal issues as part of my overall discussion of the implications of the study.

I separated the six themes into discrete entities for the purpose of detailing the findings of my study. However, the boundaries between the themes of training, communication, fear, stigmatization, denial, and additional, related issues overlapped. For instance, fear permeated nearly every dimension of stigmatization and denial. Similarly, communication, or lack thereof, was an aspect of nearly all the other themes. Identification of themes was useful for the purposes of reporting data findings, but the findings tended to be interrelated across themes. I discuss this issue in more detail in Chapter Five. In the following discussion, I address each of the six themes and their subthemes by referring to the research question that was addressed, by integrating direct quotes from participants, exploring the implications of the particular finding, and by relating the findings to scholarly research where pertinent.

Dimensions of Training

As outlined in Chapter Two of the dissertation, experts agreed that HIV/AIDS related training for teachers was of the utmost importance since teachers faced issues related to HIV/AIDS so often in their professional lives (Cinelli et al., 1992; May et al., 1994; White & Ballard, 1993). Scholarly literature from the United States and other countries indicated, however, that the majority of educators did not receive the suggested minimum training as outlined by the CDC and USGAO (Curtis, 2006; Dorman et al., 1990; White & Ballard, 1993). Some teachers received no training at all related to HIV/AIDS on the pre-service or in-service levels. My participants had similar experiences and perspectives to those of teachers reported in scholarly research. Dimensions of Training related to all three research questions, but most directly related to question 1, part g (see Research Matrix in Chapter One). The theme of Dimensions of Training included not only data related to the types of training teachers received, but also included information about the importance teachers placed on HIV/AIDS in their professional lives (see Figure 2). As noted in Chapter Three, the themes and sub-themes were created based on categories that emerged from coding. For the exact number of instances each category was mentioned during interviews, see Table 2 in Chapter Three. As noted in Chapter Three, the themes and sub-themes were created based on categories that emerged from coding. I discuss the sub-themes of pre-service training, in-service training, and the importance of HIV/AIDS below.
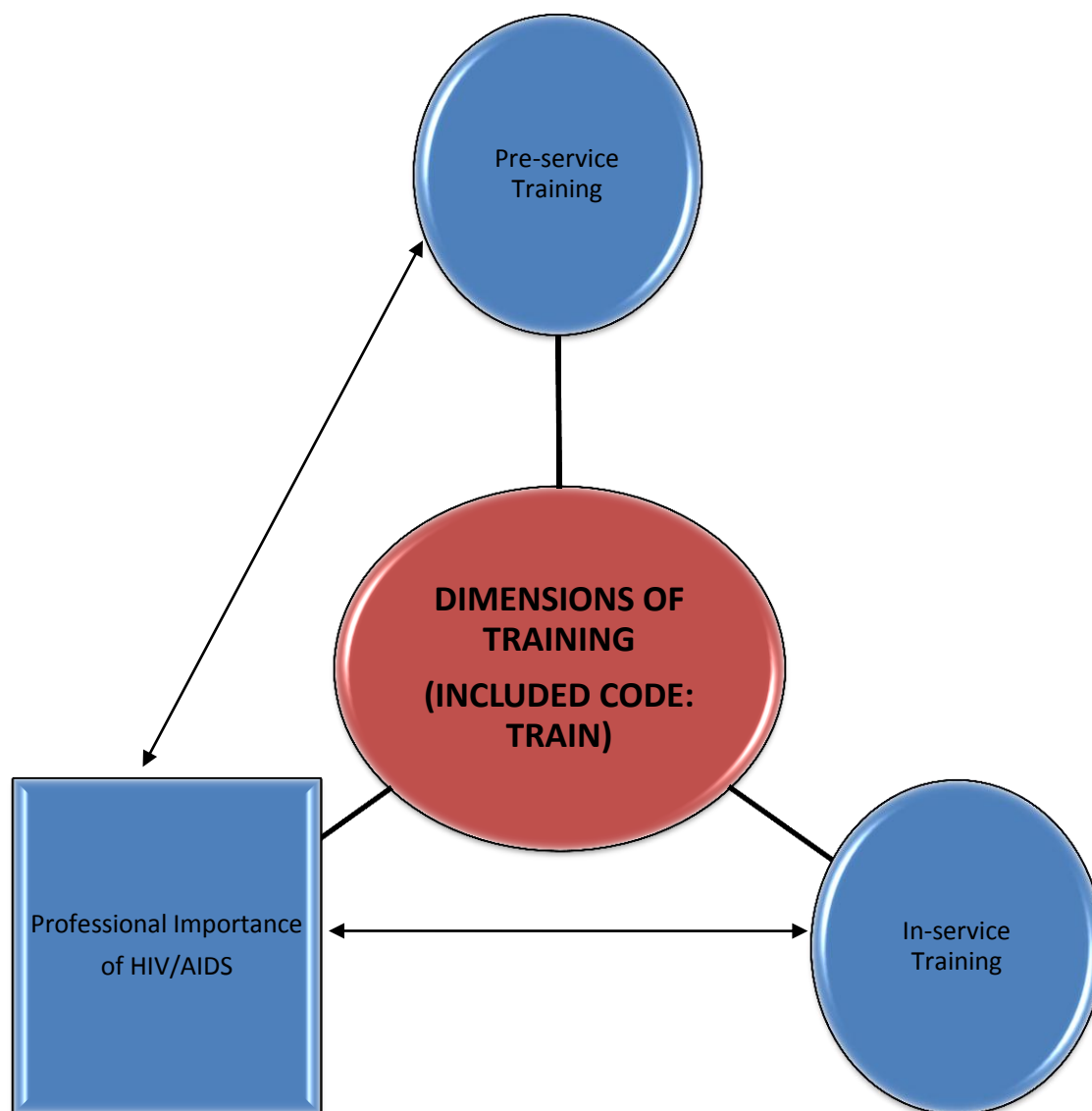
Figure 2: Dimensions of training teachers received on pre-service and in-service levels

Pre-service Training

Pre-service teachers are prospective teachers who have yet begun formally teaching. Only one of the 11 participants received any type of pre-service training in preparation for dealing with HIV/AIDS in the classroom. Considering six of the participants had Bachelor of Science in Education (BSEd) degrees, this figure was particularly surprising given the fact that experts stressed the importance of preparing pre-service teachers to deal with HIV/AIDS in colleges of

education (Cinelli et al., 1992; Foulk et al., 2001; Spears, 2006). The majority of the six

participants had received their BSEd degrees from the same institution, which may explain why

none of them received the training. If their teacher preparation program had excluded pre-

service HIV/AIDS education, it is understandable that the six participants received no training at

all. In the cases where participants found their way to teaching after receiving a Bachelor of Arts

(BA) in other areas, such as Public Relations, Art, or Psychology, it was more understandable

that these individuals did not receive HIV/AIDS training for educators because they were not

education majors. As one participant lamented, "I wish [HIV/AIDS] had been addressed…I had

no preparation whatsoever" (Participant 1, Interview March 1, 2011) to deal with issues like

HIV/AIDS when she began teaching in an economically disadvantaged, urban school.

Eight out of the 11 participants had Master's of Education (MEd) degrees. None of these

participants received any formal, organized training about HIV/AIDS, although two participants

had some interest in HIV/AIDS because of their own interest in issues like sex trafficking, social

justice, and gay rights. One participant recalled discussing HIV/AIDS in a children's literature

course on campus, but the discussion was limited to including books about a range of

experiences in classroom libraries. Another participant remembered that gender was a topic of

discussion in some of his Master's courses, but he did not remember any discussion of

HIV/AIDS. Finally, a female participant noted that sexuality was a topic brought up in her

Master's of Education courses but only as an element of diversity. Although this latter

participant remembered HIV/AIDS being brought into some class discussion, it was always

presented in the context of other countries and the topic was merely mentioned in passing. Five

participants had either earned Education Specialist (EdS) degrees or were in the process of

earning a Doctor of Philosophy (PhD) degree. These participants were unable to recall any

direct instruction about HIV/AIDS, but some did recall people mentioning HIV/AIDS in courses on campus or other students making presentations about their own niche interests related to HIV/AIDS in graduate courses.

Only one participant was the exception: an individual who received a graduate degree in education and social work from a religious institution. This participant took a human sexuality elective where HIV/AIDS was addressed as a critical issue. I was surprised to learn that the only participant who received any formal instruction related to HIV/AIDS was not at the major research institution but was instead at a religious institution. Overall, it was disappointing to see that participants in my study had not received the bare minimums experts recommended in scholarly literature, although the gap in training is noted by researchers in the literature (Evans et al., 1992; Foley & Kittleson, 1993; Spears, 2006; White & Ballard, 1993).

In-service Training

An in-service teacher is an educator who is currently employed in an instructional capacity. Of 11 participants, only one recalled receiving in-service training specifically related to HIV/AIDS. The participant remembered that there was a special presentation for faculty at her school about HIV/AIDS, but it was brief and she was unable to recall any specific details about the presentation. The majority of the other participants recalled presentations about Universal Precautions for Bloodborne Pathogens, and sometimes HIV/AIDS was mentioned in passing during those presentations (see Chapter Two for a discussion of Universal Precautions for Bloodborne Pathogens). However, several participants reported that there was no specific mention of HIV/AIDS during these Universal Precautions presentations. This omission will be discussed in detail in a later section of this chapter.

The nearly complete absence of in-service training was particularly surprising because I interviewed participants who taught in a range of locations: urban, suburban, and rural. Participants from eight different districts reported having received no HIV/AIDS training, which was troublesome given the fact that many of these districts are located in parts of the State of Georgia where HIV/AIDS rates are quite high. As one of the participants from an urban setting noted, "I am very certain that HIV/AIDS impacts my students" (Participant 2, Interview March 2, 2011), so it was problematic that this participant was not provided with any in-service training given his certainty that HIV/AIDS impacted his students. This finding was congruent with scholarly literature from the United States and abroad underscore the lack of in-service training for teachers in terms of HIV/AIDS (Evans et al., 1992; Foley & Kittleson, 1993; Spears, 2006; White & Ballard, 1993).

Importance of HIV/AIDS

All 11 participants claimed that HIV/AIDS was unimportant to them before they began teaching. The lack of importance may have been related to the lack of training participants received about HIV/AIDS. One participant claimed that HIV/AIDS was totally "off the radar" (Participant 9, Interview February 19, 2011), and two other participants admitted that it had never occurred to them to think about HIV/AIDS because they felt the possibility of teaching a student living with HIV/AIDS was very remote. When I asked participants about the current level of importance of HIV/AIDS in their professional lives, the majority of participants said that it remained unimportant, and it was something they did not think about. Although during the course of the interviews, I learned that some of the participants who claimed that they never thought about HIV/AIDS or thought it was unimportant in their professional lives had instructed students living with HIV/AIDS or students who were impacted by a family member's HIV/AIDS

diagnosis. Further, other participants who claimed HIV/AIDS was a non-issue subsequently reported answering student questions about HIV/AIDS on a regular basis. Given the fact that many of the participants dealt with HIV/AIDS in their professional lives, it was difficult to reconcile the fact that they claimed HIV/AIDS was a non-issue for them. The possible reason for this incongruence will be discussed in more detail in later sections of this chapter in the section Dimensions of Denial.

Overall, the data related to Dimensions of Training illustrated that there was a major gap in participants' pre-service and in-service training programs. Not a single participant received the minimum amount of training suggested by the CDC, USGAO, or countless experts, as detailed in Chapter Two. Apparently, the result of the absence of training was that HIV/AIDS became unimportant to classroom teachers, even when they dealt with HIV/AIDS frequently in the classroom. My findings suggest the importance of training for raising awareness about HIV/AIDS for teachers.

Dimensions of Communication

The importance of communication was apparent throughout this study because participants repeatedly addressed communication. The theme of Dimensions of Communication responded to all three of the research questions, but most directly responded to question 1, parts a, d, and e (see Research Matrix in Chapter One). Teacher participants recounted instances when they directly communicated with students, parents, administrators, and other teachers about HIV/AIDS. However, I was also told about many instances in which communication between participants and parents and administrators was lacking in regards to HIV/AIDS. I address the findings in the sub-themes of teaching about HIV/AIDS, fear of upsetting parents and administrators, lack of communication between parents and administrators, direct

communication about student health, lack of communication between teachers, and the notion of

mother/nurturer in the discussion that follows (see Figure 3). See Table 2 in Chapter Three for

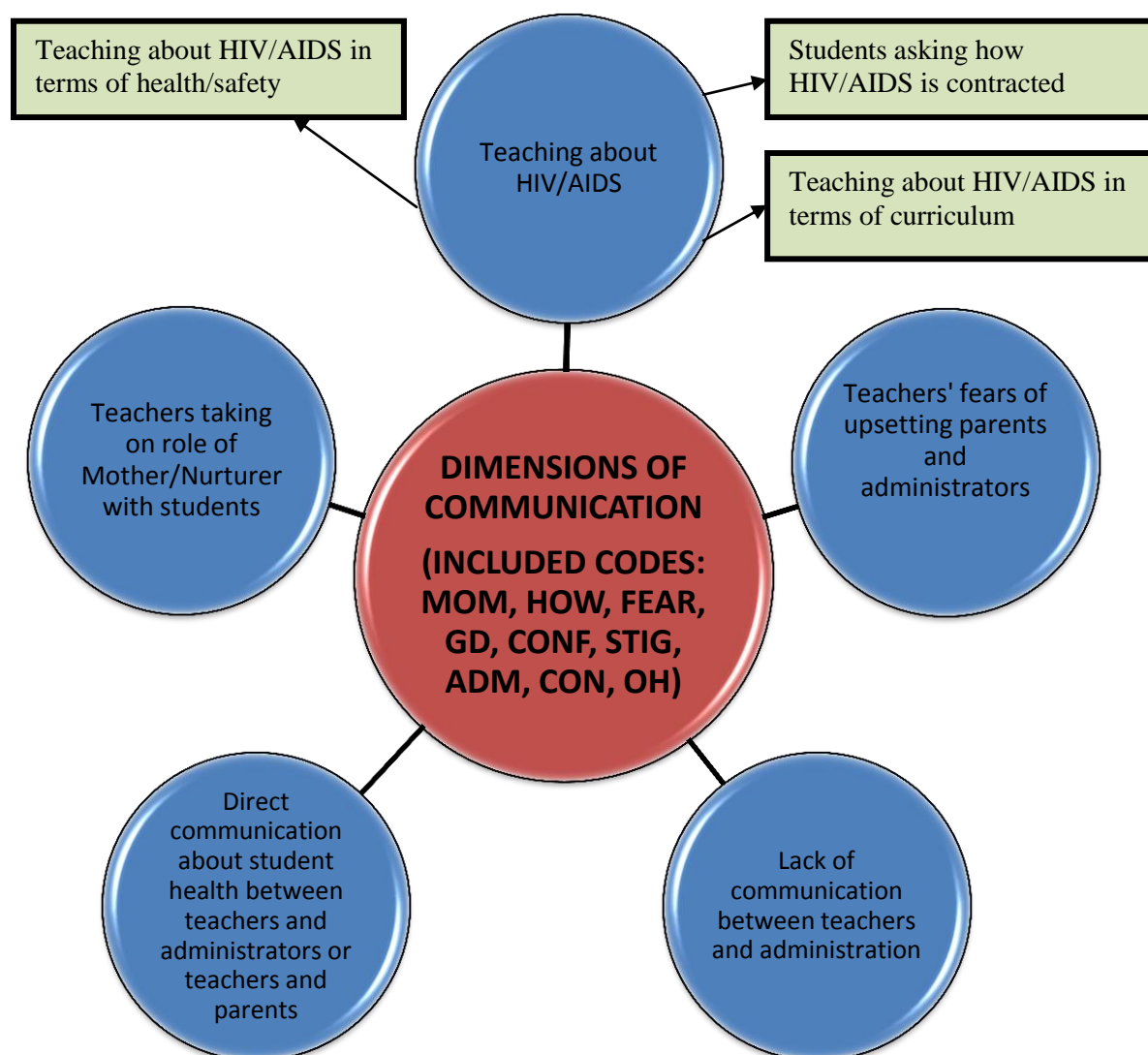the exact number of instances each category was mentioned by participants during interviews.

Figure 3: Dimensions of communication between teachers and students, teachers and parents,
and teachers and administrators

Teaching about HIV/AIDS

One of the most obvious ways teachers communicated with others about HIV/AIDS was by teaching students directly about HIV/AIDS. Seven participants, from elementary through high school, addressed HIV/AIDS in their curricula. Of those seven participants, four social studies teachers (two middle school teachers and two high school teachers) addressed HIV/AIDS in some detail in terms of teaching about Africa. Other teachers addressed HIV/AIDS in more indirect ways. For instance, a middle school English teacher included an article in supplemental reading for students that briefly mentioned HIV/AIDS. A high school history teacher opened each day's lesson with a discussion of famous persons' birthdays. When people like Rock Hudson, Magic Johnson, Freddy Mercury, and Ryan White were listed on the birthday page, this teacher reportedly made a point of explaining who those people were and why they were significant in the history of HIV/AIDS. I was surprised to learn that so many of the participants provided direct instruction about HIV/AIDS, especially since many of them claimed before the interview that HIV/AIDS was not a part of their professional lives. These teachers may have initially considered the curriculum as being separate from their own professional lives, although there might have been additional factors contributing to such discrepancies, such as a desire to distance themselves from the topic of HIV/AIDS, an issue that is discussed in more detail later in this chapter.

In addition to middle school and high school teachers who dealt with specific HIV/AIDS related content, elementary school teachers also addressed HIV/AIDS with their students. One rural elementary school teacher explained how she broached HIV/AIDS with her students, "We have limited conversations in 3rd grade…we never talk about the sexual education part of it. I really generalize…to make sure they aren't scared" (Participant 3, Interview March 7, 2011).

Another suburban elementary school teacher taught her students about HIV/AIDS in terms of Universal Precautions on the playground. She taught students:

> How to be kind and respectful, at the same time protecting yourself. Other people's blood is not something you want to touch because different people have different germs, but that is as far as you go with five and six year olds (Participant 6, Interview February 17, 2011).

Both of these teachers were cognizant of the fact that they needed to provide developmentally appropriate lessons about HIV/AIDS to students, and I was surprised to hear that these teachers were addressing the subject at all, given that HIV/AIDS is not included in Georgia Performance Standards before high school.

In some ways, these two elementary school teachers were more direct with their students about HIV/AIDS than were their middle school and high school counterparts. There was a possibility that these two teachers' personal backgrounds might have influenced their openness with students and willingness to even mention HIV/AIDS. One of these particular teachers had lost a family member to HIV/AIDS, so the issue was more pressing in her mind. I asked her if she believed that her personal experience influenced her decision to discuss HIV/AIDS with her students and whether or not she knew if the other teachers provided the same instruction. She claimed that she did not know, which raised other questions about communication between colleagues and consistency among classroom teachers.

The other teacher in question had a very particular social justice agenda that manifested itself in her classroom in various ways, particularly in the types of children's literature that she made available to students. Although she did not have children's books that related to HIV/AIDS, she did have several books that featured gay parents. The fact that these two

teachers had these particular niche interests in issues related to HIV/AIDS may have influenced their decisions to directly address HIV/AIDS with young children. Throughout the study, as expected, I found that participants' personal backgrounds appeared to influence the ways in which they dealt with HIV/AIDS or handled HIV/AIDS in the classroom. Silin (1992) and Spears (2006) both discussed the importance of honest, frank discussions about HIV/AIDS, particularly among elementary school teachers, so it was heartening to see that these two participants were confronting the issue with their students.

Fear of Upsetting Parents or Administrators

Like teachers in other countries, reported in international literature (Kiragu, 2007; Mufune, 2008), many of my participants felt like they were frequently put in precarious positions when it came to addressing student questions about HIV/AIDS or sexuality in general. During the interviews that I conducted, participants mentioned their fear of upsetting parents or administrators 10 times total across interviews. I designated fear of upsetting parents or administrators as a dimension of communication because it highlighted the fact that communication was often inhibited when teachers were reticent to discuss controversial topics with students. At least two of the participants were formally reprimanded in the past for "crossing the line" (Participant 9, Interview February, 16, 2011) when it came to discussing controversial topics with students, but even teachers who were never reprimanded were still wary of going into too much detail about HIV/AIDS. One male participant argued, "[HIV/AIDS] is shaky ground. You don't want to go too far in discussing details of sexual education. They have their sex ed in health class" (Participant 11, Interview February 20, 2011). Several participants noted that they tried to take a middle ground by dispelling misconceptions about HIV/AIDS

when they arose "without going into too much detail" (Participant 11, Interview February 20, 2011).

However, even dispelling misconceptions made some participants uneasy. A male teacher ceded, "I don't know if parents want me talking to their kids about that sort of thing" (Participant 11, Interview February 20, 2011). Three participants mentioned a specific fear of making students emotionally disturbed or making students cry if they broached the subject of HIV/AIDS. One female elementary school student imagined a parent saying something along the lines of, "Ms. X was talking to my child about AIDS and now my child can't sleep at night" (Participant 1, Interview March 1, 2011). Another participant speculated parents would ask, "Why is this teacher making Tommy come home crying?" (Participant 9, February 16, 2011). Both of these teachers previously faced criticism from both parents and administrators about comments they made in their classrooms, so their fears were real and appeared to highly influence their communications with students, administrators, and parents in general.

While participants across locales pointed out a fear of angering parents and administrators, geography and location of the schools appeared to be a factor in how far teachers are willing to go when addressing HIV/AIDS with students. A male participant who taught at a rural high school argued, "HIV/AIDS is taboo. It's not something to be discussed. It's not something you talk about here. There's a very delicate line, and you can't get away with much" (Participant 9, Interview February 16, 2011). Similarly, a female teacher at a rural middle school offered, "You have to tread lightly because it's a conservative area…you have to be aware of the climate of the area" (Participant 4, Interview March 10, 2011). Both of these teachers were highly cognizant of the cultural norms of the areas where they taught, and they monitored their communications with children based on those norms. An urban teacher, however, noted that his

students were very cosmopolitan, and it would be very rare that a student at his school would not

be at least rudimentarily cognizant and knowledgeable about HIV/AIDS. In this teacher's case,

he seemed less fearful of upsetting parents and administrators and he reported addressing

HIV/AIDS fairly regularly with his students, at least in the context of the curriculum. His

confidence may have been due in part to the fact that he felt his students were worldly or

sophisticated enough to handle information about HIV/AIDS.

Lack of Communication between Teachers and Administrators

In addition to being fearful of upsetting parents and administrators, the participants

expressed frustration with a lack of communication between teachers and administrators.

Through the course of the interviews, this issue emerged nine times total across interviews. The

majority of participants were unsure of how administrators would handle students in the school

who were living with HIV/AIDS. Although a few teachers expressed hope that the administrator

would keep teachers informed about such issues, the majority of teachers believed that lines of

communication would be closed between administrators and teachers when it came to

HIV/AIDS. One participant said that the administration at her school was "so strange and

secretive" (Participant 8, Interview March 29, 2011) and noted that teachers were required to

make appointments to meet with anyone in administration and that the door to their cluster of

offices was locked at all times. The fact that the administration was physically isolated from

teachers made this participant doubt it would be possible for teachers and administrators to

collaborate and communicate about HIV/AIDS. Another teacher said that she doubted the

administration would be proactive when it came to dealing with HIV/AIDS because it was a new

administration that did not always seem to know how to handle things. In one case, a teacher

reported that administrators did not openly divulge health information about students but would instead talk around the issue. She explained:

> The administration talks around subjects. If you ask them things directly, they
>
> don't answer you. They would just say, 'I would make sure that you wear gloves
>
> if that child skinned their knee.' There'd be warnings, but no reason why. They
>
> wouldn't say that about another child (Participant 3, Interview March 7, 2011).

In this case, the administrators only increased speculation about the child's health status and made teachers wary about how to respond to the child if an issue did arise during the school day.

Only one teacher reported that the administration directly communicated with her about a child's HIV/AIDS positive status. She explained, "The kid was homebound a lot, so they wanted me to be prepared" (Participant 5, Interview February 22, 2011). Despite this positive example of effective communication between teacher and administrator, the majority of participants seemed frustrated, and at times even angry, about the lack of communication within the school building. A middle school teacher argued that teachers should be given more information about students' health concerns because it was confidential and therefore teachers would protect the information appropriately. However, this teacher expressed a lack of clarity about confidentiality laws and procedures, so it is difficult to reconcile his confidence in teachers' protecting confidentiality with his overall lack of knowledge about confidentiality measures. In both of these cases, teachers expressed a desire to communicate with one another about particular students' HIV/AIDS status, but they were also concerned about confidentiality.

Although it was impossible to know this without speaking with administrators themselves, it was possible that administrators might feel caught between protecting confidentiality and providing teachers with important information. As noted in Chapter Two of

the dissertation, there was a substantial grey area when it comes to confidentiality measures and information that is on a need to know basis in schools (Chenneville, 2007) . Overall, the perceived lack of communication was a source of frustration and confusion for my participants, and it seemed to weaken the overall relationship between teachers and building administrators. This sentiment is reported by researchers in both the United States and abroad (see, for example, Butt, 2002; Campo, 1993; Hoy & Miskel, 1996).

Direct Communication about Student Health

Although many participants were quick to note that there were major gaps in communication between teachers and administrators, some participants recalled incidents when there had been direct communication between both teachers and administrators and teachers and parents about student health issues. While only one teacher reported being directly told by an administrator that a student was living with HIV/AIDS, that same teacher noted that parents of other students living with HIV/AIDS had informed her of their children's seropositive status. She said, "[The students] were missing school, so I called home and the parents said it was because of HIV. The kid gets sick and they keep them home to get them healthy" (Participant 5, Interview February 22, 2011). This direct style of communication was different from the indirect conversations that other participants reported having with administrators. When parents informed teachers directly, it may have been ideal because it released the administrator from making difficult decisions about who needed to know the student's status. In the case of three participants, they reported learning about a student's HIV/AIDS positive status when they no longer taught the student. In these cases, news of the students' status reached them through informal means, such as in discussions between teachers or conversations with other students. Even in cases where teachers were not directly informed of children's HIV/AIDS positive

statuses, some participants reported that in some cases students' HIV/AIDS positive status was "common knowledge" (Participant 5, Interview February 22, 2011) among both teachers and students. This raised additional issues for teachers, such as dealing with shame and misinformation, which will be discussed later in Chapter Four of the dissertation.

Several participants noted that while they had not engaged in direct communications about HIV/AIDS, there was a great deal of communication about *other* health needs. Participants were well-informed about how to deal with various health concerns, including Tourette's syndrome, schizophrenia, hemophilia, cancer, seizure disorders, asthma, and diabetes. Teachers of students with these conditions were provided a range of training opportunities, including briefing sessions, videos, and conferences. In one case, an expert came to a teacher's classroom to provide sensitivity training to all of the students about a classmate's condition. Some of these mental and physical health concerns and the school response to the concerns will be addressed in more detail later in this chapter. The fact that direct communication existed in regards to some student health concerns was promising, and it showed that teachers, administrators, and parents could work together to provide effective, consistent care to students. Although there seemed to be less direct communication about HIV/AIDS than other health concerns, the communication structure to deal with health concerns appeared to exist in many schools.

Lack of Communication between Teachers

Although some participants reported that teachers gossiping or engaging in idle conversation about students' health statuses, particularly their alleged HIV/AIDS status, many participants noted a lack of communication among teachers on all matters, particularly those related to student health. One reason for avoiding communication between teachers about

HIV/AIDS was a fear of breeching confidentiality. A female middle school teacher explained she did not discuss students' HIV/AIDS statuses because she was fearful of being overheard and of breeching confidentiality (Participant 5, Interview, February 22, 2011). In this case, the teacher felt a desire to communicate with others, but she curbed communication because of her fears about exposing children's health information.

Teachers reported a lack of communication with their peers about important issues in general. One participant, who taught a non-academic subject and therefore only visited each classroom once a week, recalled a particularly troubling episode that highlighted the lack of communication between schools. She entered the classroom, noticed a new student, and repeatedly asked the student his name. The regular classroom teacher was seated at a nearby computer. The participant tried to talk to the new student throughout the entire class period. It was only during the final moments of class that the classroom teacher spoke up and said, "He is Dutch and does not speak English" (Participant 1, Interview March 1, 2011). The fact that the regular classroom teacher in the classroom watched the participant struggle and did not assist signals a lack of in the professional rapport among co-teachers. McCluskey, Sim and Johnson (2011) also discussed this lack of communication and rapport in their research of Australian teachers' feelings of isolation.

The same participant reported other instances of being kept "out of the loop" (Participant 1, Interview March 1, 2011). She explained that it often took months for her to receive vital health or personal information about students, and by then it was often too late because of the highly transient nature of the urban school where she worked. She was not told about a student whose mother was allegedly addicted to crack and suffered severe emotional and psychological trauma. This participant self-identified as an outsider at the school where she worked because of

her race (White) and her social class. As a result of being more or less ostracized from other teachers, the participant reported that she had significantly withdrawn and was apathetic towards teaching. At the end of the interview, she admitted that she was not sure if she could continue teaching and that the difficult relationship with her co-workers was more than partially to blame. This participant's experience indicated that lack of communication between co-workers--and resulting isolation-- could negatively impact not only how well a teacher worked with other teachers but also their professional choices. This finding was also well-documented in scholarly literature (see, for example, Ball, 1987; Flinders, 1988; Mawhinney, 2008; McCluskey, Sim & Johnson, 2011). The isolation of participants and teachers in general will be discussed in more detail in Chapter Five.

Some participants noted that they purposefully curtailed communication with other teachers because they wanted to avoid gossip. A participant explained that another teacher wanted to discuss a student's HIV/AIDS status, but she avoided doing so because "she was talking about of curiosity and not to actually help the student" (Participant 5, Interview February 22, 2011). Some teachers admitted to discussing students in an informal way. In these cases, informal gossip was a way to try to share relevant information. For example, ne elementary school teacher participant said that a group of teachers were discussing various students in the faculty lunch room. Several of the teachers agreed that a student's dad was in a gang. The participant said, "I believe that they know what they are talking about…these teachers seem to know a lot about the kids" (Participant 1, Interview March 29, 2011). This type of communication, if the information was correct, could be helpful. However, if it was incorrect information, students could be incorrectly labeled and stereotyped.

Mother/Nurturer

One subtheme that emerged unexpectedly during the course of the study was that of Mother/Nurturer. This subtheme was related to communication because some participants reported communicating with their students in a very maternal and nurturing way. As noted in the Chapter Two of the dissertation, many researchers described Sub-Saharan African teachers as filling the role of a mother or nurturer in the lives of their students, particularly in places where there were large numbers of AIDS orphans (Boler & Archer, 2008; Hattingh & de Kock, 2008). As I entered the data collection stage of research, I did not expect to see this subtheme emerge at all with my participants, and I surmised that teachers in Sub-Saharan Africa were asked to fill a number of roles that would not translate in the lives of my study participants in Georgia. However, it became clear early during the interview process that several participants did, in fact, act in ways that could be described as maternal or nurturing.

When some participants imagined about their response to students living with HIV/AIDS, they showed a maternal and nurturing side. Some participants made comments about concerns for their *own* health and safety, but some participants' initial reactions were to think about the student himself or herself. Two female participants who taught on the middle school level remarked how immensely sad they would feel if they found out a student had HIV/AIDS. One of the participants explained, "I would feel horrible knowing that they have a disease that there is not a cure for. Knowing their life was going to be that much harder" (Participant 5, Interview February 22, 2011). The other participant noted that she would be "sad because I know the kid is going to die" (Participant 4, Interview March 10, 2011). Another female elementary school teacher explained that she would evoke her own children in dealing with students living with HIV/AIDS, "As a mother, I wouldn't want my son to be ostracized or made to feel different"

(Participant 6, Interview February 17, 2011). All three of these teachers acknowledged the difficulties in the lives of children with HIV/AIDS and their ability to empathize with these children was moving, particularly given the large amounts of data that I collected where individuals with HIV/AIDS were shamed and stigmatized.

Aside from the responses to students living with HIV/AIDS, participants responded to students in a nurturing way on a day-to-day basis. A female elementary school teacher noted that at the impoverished, urban school where she taught, all students were consciously referred to as "babies" (Participant 1, Interview March 1, 2011). For instance, the principal would tell teachers, "Take care of your babies" (Participant 1, Interview March 1, 2011). The participant noted that this was not the case at a more affluent school where she had also been employed, and she believed that it was because of the student body and the many challenges they faced that there was an emphasis on, literally, babying the students. This same teacher explained that she felt a need to help her students. Particularly during her first years of teaching, she took an active role in mentoring students and formed an after-school art club. Unfortunately, because of negative incidents with parents and administrators, this participant admitted to feeling withdrawn. She explained, "I feel drawn away from mentoring. Now I just want to be a… teacher" (Participant 1, Interview March 1, 2011). A female elementary school teacher in a rural county also cited feeling responsible for protecting students. In the case of one student who was bullied because she dressed like a boy, the participant said that she "had to kind of form a barrier around her so people don't say insensitive things" (Participant 3, Interview March 7, 2011). The participant went on to say that she wanted to be vigilant in defending the student in question from the insults and murmurings of other adults, like parents and bus drivers.

Although four of the participants who took on the role of mother/nurturer were female, one male middle school teacher described his own style of nurturing students. He explained:

> I'm not the type of person to say 'That's the counselor's job.' If I find out there's a kid that has some problems, I'll say, 'Hey, man, come here, you cool?' If they want to go there, they go there. If not, I say, 'Let me know' (Participant 11, Interview February 20, 2011).

This male teacher seemed to be filling an important role in his school community, and he was nurturing in a way that was not overly emotional or demanding. His willingness to be present for students in crisis was notable. Overall, these five participants combined to present a face of teaching that echoed some of their Sub-Saharan African counterparts' mothering and nurturing style of interacting with students. Despite the many challenges and other responsibilities they faced, these individuals found ways to empathize with students.

Dimensions of Fear

The theme of Dimensions of Fear addressed research questions 1, 2, 3, most specifically question 1, parts a, d, and e (see Research Matrix in Chapter One). Participants discussed their personal fears related to HIV/AIDS, but they also reported their attempts to diminish students' fears about HIV/AIDS. In some cases, teachers claimed not to be fearful of HIV/AIDS or students living with HIV/AIDS, but they made contradictory statements later in the interviews. These contradictions exposed some of the teachers' very real and possibly more accurate feelings about HIV/AIDS. Findings reported in his section include information related to the following sub-themes: students' fears of catching HIV/AIDS, allaying student fears about contracting HIV/AIDS, and teachers fears of contracting HIV/AIDS (see Figure 4). See Table 2 in Chapter

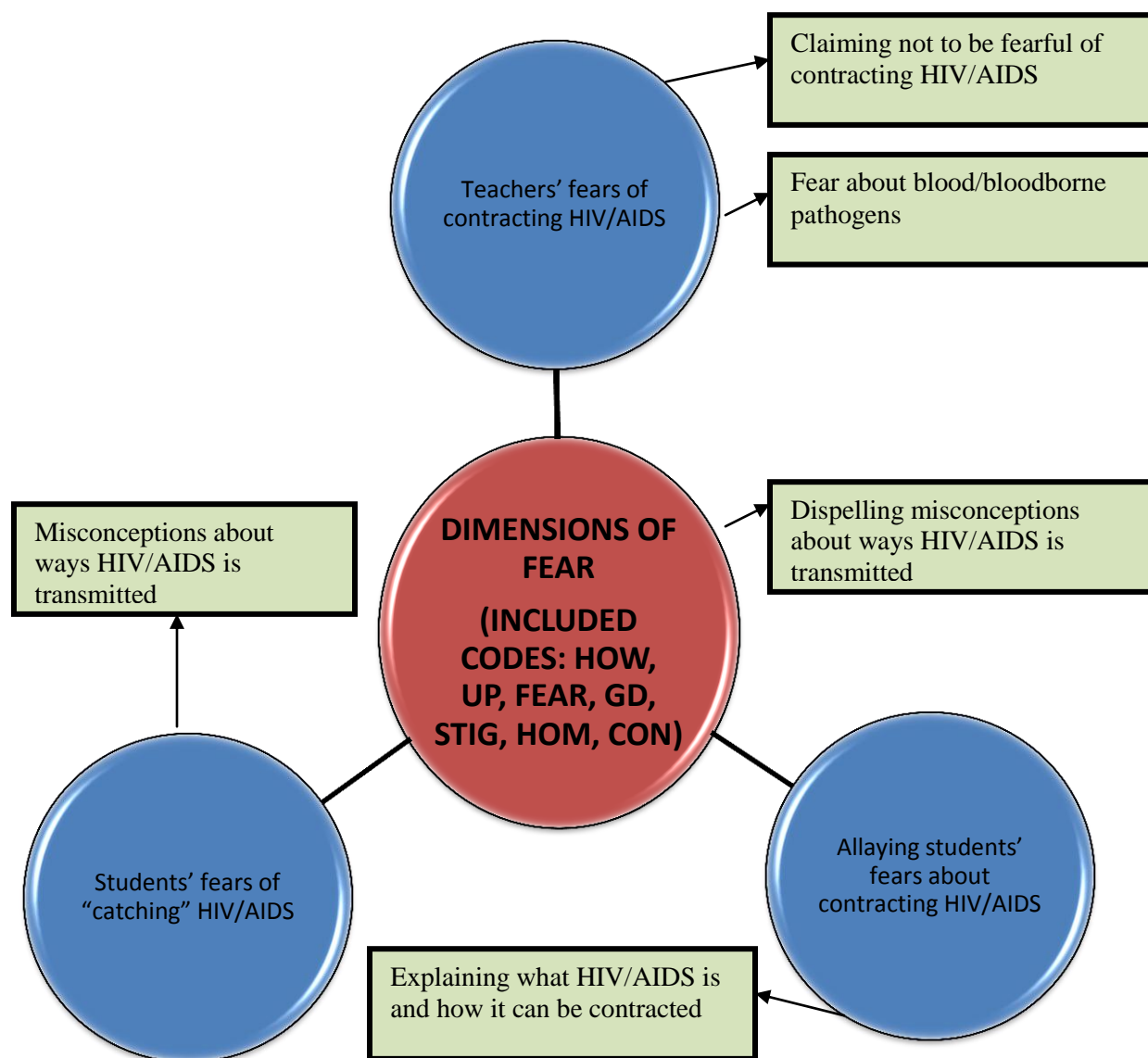Three for the exact number of instances each category was mentioned by participants during interviews.

Figure 4: Dimensions of fear related to contracting HIV/AIDS

Students' Fears of Catching HIV/AIDS

Many participants, regardless of the subjects they taught, reported that students asked them how HIV/AIDS was transmitted and what HIV/AIDS was. Several participants noted that

HIV/AIDS was not an issue for them in their professional lives, but within the course of the interviews, they divulged that students often asked questions about HIV/AIDS. Participants reported student questions about HIV/AIDS 13 times. This was an indication that HIV/AIDS was an important issue for students.

According to one participant, students "have lots of questions about how [HIV/AIDS] is spread" (Participant 4, Interview March 10, 20110). Various participants reported that students asked if HIV/AIDS could be contracted from swallowing semen, sharing a water fountain with an infected person, holding hands with an infected person, or from a dentist. These questions reflected deep misconceptions about HIV/AIDS and how it was transmitted. One teacher admitted that some of her students were very confused, thinking that any time blood was present that one could contract HIV/AIDS, even if no one was HIV/AIDS positive. These types of misconceptions and confusions often resulted in students being fearful of catching HIV/AIDS or being fearful of people who were living with HIV/AIDS. If these students were properly versed in basic fundamental knowledge of HIV/AIDS, they might have understood that transmission occurs through blood to blood contact when one of the individuals present is HIV/AIDS positive. Other researchers reported similar misunderstandings in international contexts (see, for example, Bhana, 2007; Letamo, 2007).

In all of the reported instances where students raised these questions, the questions were asked in non-science and non-health courses. The majority of the participants who were fielding these questions were social studies teachers who addressed HIV/AIDS in the context of a unit on Africa. One participant who taught middle grades social studies noted,

They're supposed to get a basic understanding [of HIV/AIDS] in 7th grade life

science, but they either don't or they like to ask me anyway because I always end

up giving them a lesson on what is HIV/AIDS…how do people get it (Participant

4, Interview March 10, 2011).

That same participant ceded that her knowledge about HIV/AIDS was self-taught from the

Internet because she had to reconcile her lack of formal training to deal with and the numerous

student questions related to HIV/AIDS. Given the vast amounts of inaccurate information on the

Internet, it was troublesome to think that a teacher who dealt with HIV/AIDS so frequently was

using information that may or may not have been accurate.

While some students had questions about how HIV/AIDS was spread, other participants

noted that some of their students were completely ignorant about HIV/AIDS. Although this lack

of fundamental knowledge was understandable among elementary aged children, two middle

school teachers reported that students did not know what HIV/AIDS was at all. One of those

teachers reasoned that there was no reason for the middle school student to know "unless parents

taught them about it" (Participant 5, Interview March 5, 2011). There appeared to be a gap in

student knowledge when schools did not provide sexuality or HIV/AIDS education and parents

did not provide it at home.

Allaying Student Fears of Contracting HIV/AIDS

Several participants noted that they actively tried to allay student fears about HIV/AIDS.

One middle school teacher explained:

Keeping the information coming about how HIV was transmitted provided the

opportunity to have conversations with students. I always tried to deal with it

immediately because it was normally becoming an issue immediately. If I

ignored it, it was only going to get worse (Participant 5, Interview February 22,

2011).

This teacher was particularly direct and aggressive in dealing with HIV/AIDS swiftly in the context of the classroom. Other teachers reported similar stances and agreed that dealing with student misconceptions and fears immediately was most effective.

The majority of participants in the study did not believe that they taught students who were living with HIV/AIDS. Therefore, when they allayed student fears they were dealing in abstracts and the realm of the hypothetical. One participant, however, did have extensive experience teaching students living with HIV/AIDS. In fact, she had taught nine different students living with HIV/AIDS. When she discussed allaying student fears, she was able to relate incidents where she had to handle students' misconceptions and fears in the presence of the child living with HIV/AIDS. In one episode, a student did not want to use a pencil after the HIV/AIDS positive classmate had used it. The participant said that these types of incidents were relatively common, especially since students always seemed to know their classmates' statuses and were quick to stigmatize their HIV/AIDS positive classmates. She dealt with these episodes on the spot using direct language. She said she would ask students, "How is HIV transmitted? Is it transmitted by sharing a pencil? No. So I think you are ok. Use the pencil." (Participant 5, Interview February 22, 2011). This participant's ability to communicate students in this way was potentially the product of her high status in the school. She was well-liked by students, a department head, and a senior teacher. If she had been a newer teacher without as much clout in the school, her responses to student fears might have been different.

Just because a teacher intervened during such instances or attempts to allay students' fears about HIV/AIDS does not necessarily mean that the students were completely at ease. A high school teacher said she felt like her students were relieved when she corrected their misconceptions, but that she also felt that her students remained skeptical. When she told

students HIV/AIDS could not be transmitted by using the same water fountain as an individual

living with HIV/AIDS, she felt like students seemed to think to themselves, "'I'm not going to

share the water fountain just in case'" (Participant 7, Interview February 19, 2011) the teacher

was incorrect in claiming that HIV/AIDS could not be transmitted that way. The fact that

students were unwilling to fully accept their teachers' reassurance spoke to the fact that

misconceptions and subsequent fears about HIV/AIDS were ingrained in students to the point

that even a rational argument based on scientific fact did not change their minds. High school

students who continued to hold these misconceptions and were not reassured by their teachers

were not likely to change their minds completely about HIV/AIDS or individuals living with

HIV/AIDS. This was an indicator that dealing with these misconceptions and fears more

intensely on the elementary and middle school levels was especially important, which was a

sentiment echoed by Silin (1992).

Teachers' Fears of Contracting HIV/AIDS

Although teachers worked towards allaying students' fears, one of the greatest

contradictions that emerged from this study was that some teachers themselves were highly

fearful of contracting HIV/AIDS, even when they claimed that they were not fearful. During the

interviews I conducted, teachers' fears about contracting HIV/AIDS were most frequently

exposed in a particular line of questioning towards the end of the interviews that I conducted.

This question asked how the participant felt about individuals living with HIV/AIDS. Many of

the participants responded that they did not have any fears about teaching students with

HIV/AIDS. Several of them responded with statements such as, "I treat everyone the same"

(Participant 9, Interview February 19, 2011). One female middle school teacher even claimed

that she would reason with herself, "It's just a kid. Go with it!" (Participant 8, Interview

February 28, 2011). Another participant rationalized, "I'm not going to worry about contracting it because I know it is strictly a fluid transmitted disease" (Participant 9, Interview February 16, 2011). These types of responses led me wonder if the participants were not being honest with me, or if they were not being honest with themselves. Several of the participants followed up their claims of being unaffected by a student's status with statements such as, "My only concern is that I would catch it myself," (Participant 11, Interview February 20, 2011) which swiftly contradicted previous claims of confidence in their ability to treat all students the same. It may be difficult to treat a child the same as her peers if you were constantly worried about catching a deadly and debilitating virus from that student. Researchers in the United States and abroad also found teachers to be personally fearful of contracting HIV/AIDS, which is why some teachers avoided contact with individuals living with HIV/AIDS (see, for example, Beyers & Hay, 2007; Castle, 2004; Norr et al., 20007).

Participants' own fears were also subconsciously exposed when they discussed how their co-workers would handle having an HIV/AIDS positive student in their classrooms. Participants were quick to be critical of their colleagues. One middle school teacher felt that many of the teachers at her school would be "hesitant or stand-offish" (Participant 3, Interview March 7, 2011). Another high school teacher said that "there would be a tremendous amount of fear" if there was an HIV/AIDS positive student (Participant 7, Interview February 19, 2011). One teacher even claimed that her co-workers would respond poorly to an HIV/AIDS positive student because of the increase in paperwork that would accompany having such a student in the classroom. She said that other teachers would say things like, "'Oh, can you imagine the hassle of trying to deal with that!'" (Participant 6, Interview February 17, 2011). This response was interesting because it made me wonder if the participant was citing teachers' disdain for

paperwork because she was afraid to tell me about how she truly believed her co-workers would respond.

In all of these instances, I believed that the participants' discussion of their co-workers responses might have revealed something about their own fears and concerns about how they would, in reality, respond to a student living with HIV/AIDS. One middle school teacher in a suburban setting explained teachers' responses to students in the school who were openly living with HIV/AIDS. She noted,

> I think some teachers were afraid. Afraid that they could get it. Afraid that even though they know it's not transferable, they still had fears. 'What if something happens?' (Participant 5, Interview February 22, 2011).

Some participants noted that they were members of a more accepting, forward thinking group of teachers at their schools. One male high school teacher said he was confident in his ability to appropriately respond to a student living with HIV/AIDS because he was a "member of a community of intellectuals" (Participant 2, Interview March 2, 2011). One suburban middle school teacher argued that she and her colleagues would all be comfortable and confident "as long as we were informed and educated and aware of health risks and precautions" (Participant 8, Interview February 28, 2011). Given the aforementioned difficulties related to communication in the school building, it may not have been realistic to meet this condition, which raised the question of how well the teachers would respond without being informed or educated.

Out of 11 participants, one suburban high school teacher provided a very poignant explanation of the range of emotions and feelings that would be set in motion if she was informed about a students' HIV/AIDS positive status. She confessed:

There would be a part of me that's afraid. If for some God awful reason you do slip up, you can't take a couple of pills and be cured. I'd like to think there's a bigger part of me that would want to treat the student the same. But there'd be a part of me that wouldn't want to drink out of the water fountain after them. It feels horrible to say that. I would hope I would be able to keep that away. To keep that concealed. Surely that child—that person—is having enough issues without me piling my own on top of it (Participant 7, Interview February 19, 2011).

I believe that many of the participants in this study would likely agree with this honest and eloquent account of feelings, but for whatever reasons, many of the participants might have been unable or unwilling to admit these similar, competing feelings during the interview. It was also possible that some of the participants had not properly processed the range of responses to having an HIV/AIDS positive student in their classrooms. Overall, addressing student fears and the need for teachers to reconcile the desire to treat students the same--and come to terms with their own fears--was an important theme throughout the dissertation study. Even teachers who wanted to respond to students in the very best of ways were grappling with their own fears and misconceptions, which could possibly hinder their actual response to students in the classroom who were living with HIV/AIDS.

Dimensions of Denial

During the course of the interviews, there were multiple accounts of denial with participants' professional perspectives and experiences related to HIV/AIDS. The theme of dimensions of denial addressed all of the research questions, but it most directly dealt with research questions 1, parts a, d, e, and g (see Research Matrix in Chapter One). In the case of

several participants, I encountered denial before I even began the interview. The majority of participants, in fact all but two, agreed to be interviewed with the disclaimer that they did not have any experience with HIV/AIDS, and they were not sure they would have anything relevant to say to me. Some of the same participants continued to say throughout the interview that they had nothing to say about their professional experiences with HIV/AIDS, and one of the most frequently uttered statements (15 times) across interviews was something along the lines of "HIV/AIDS is not an issue for me" (Participant 9, Interview February 16, 2011) or "HIV/AIDS is not an issue here" (Participant 9, Interview February 16, 2011). In terms of frequency, only the Universal Precautions for Bloodborne Pathogens were mentioned as frequently as the "Not an Issue" denial statement.

The frequency and persistence of denial highlighted some critical issues related to HIV/AIDS and teachers, especially since every participant did, in fact, have at least a minimal amount of experience with HIV/AIDS in the classroom. Even the participants who were so confident they would have nothing to say ended up having some very poignant professional experiences related to HIV/AIDS. It was then essential to contemplate why the participants engaged in denial. Were they consciously denying or diminishing their experiences because of fear, embarrassment, or some other motivating factor? Or, did they simply fail to recognize their own experiences and perspectives were powerful and meaningful?

In addition to questioning the motivation behind the denial, an additional angle was also necessary to consider: the substantial overlap between denial of HIV/AIDS and stigmatization of HIV/AIDS. As Silin (1992) argued, when teachers claimed HIV/AIDS was not an issue, HIV/AIDS was further stigmatized. For instance, one might argue if a teacher claimed that HIV/AIDS was not something that happened in the school community, the underlying assertion

was that HIV/AIDS was something that happened in other places, to other types of people. In

essence, by refusing to admit that HIV/AIDS was an issue everywhere for all people,

stigmatization remained in place and a faulty *us versus them* dichotomy remained in place. A

more in depth discussion of stigma associated with HIV/AIDS is included in the next section of

this chapter. The section below includes a discussion of findings in the subthemes of "Not an

issue," other, more pressing issues to deal with, time constraints, and school nurses denying the

importance of HIV/AIDS (see Figure 5). See Table 2 in Chapter Three for the exact number of

instances each category was mentioned by participants during interviews.
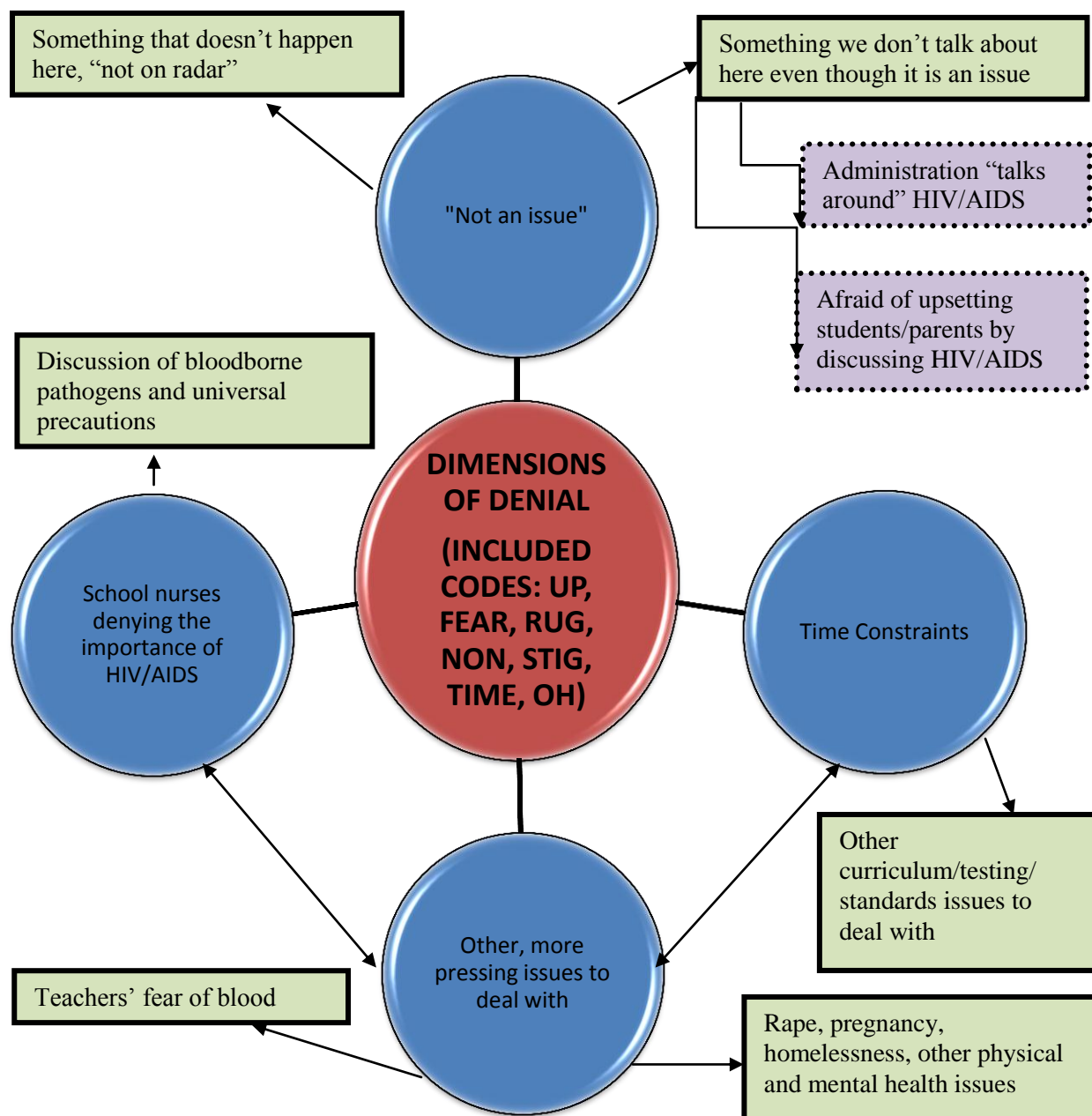
Figure5: Dimensions of denial of the importance and/or urgency of HIV/AIDS in the school

"Not an Issue"

There were two main types of "Not an issue" statements among participants in my study: participants claimed that HIV/AIDS was not an issue because it was something that did not affect their school community; or participants claimed that HIV/AIDS did affect their school

community, but it was relegated to being a non-issue because of the multitude of other pressing concerns. I discuss each of these sub-themes separately because the distinction is important as it changes the essence of the phrase "not an issue."

"Something that doesn't happen here."

During early data analysis, I began keeping track of how often participants used phrases like "not on the radar" (Participant 7, Interview February 19, 2011) or "taboo" (Participant 9, Interview February 16, 2011). One of the most common reasons participants claimed that HIV/AIDS was not an issue was because they believed that HIV/AIDS was not something that affected their school community. In other words, the participants believed there were no students, family members, teachers, administrators, or other school personnel infected or affected by HIV/AIDS. At times, it was difficult to accept participants' assertions that HIV/AIDS was something that was truly off the radar or did not affect their school. In one interview, a female middle school teacher noted, "HIV/AIDS has never really come up. It seems like it hit a peak in the 80's and 90's, and it was all you heard and talked about, and then that's it. It's gone. It doesn't come up" (Participant 8, Interview March 1, 2011). The participant reported that she had never taught any students living with HIV/AIDS, but I happened to interview another individual who taught at the same school, the same grade, and on the same hall. The second participant reported teaching at least eight to nine individuals living with HIV/AIDS at that particular school and repeatedly suggested that it was "common knowledge" (Participant 5, Interview February 22, 2011; March 28, 2011) that these students were living with HIV/AIDS.

Since I had difficulty imagining how two participants had such disparate experiences and recollections, I conducted follow-up interviews with both participants. The first participant reaffirmed her position that she had never taught students living with HIV/AIDS, and the second

participant similarly reaffirmed her experience of having taught eight to nine students living with HIV/AIDS. I asked the second participant, "Was there discussion about these students among teachers on your hall or teachers who taught the same grade level? Do you think that these students' statuses were common knowledge among teachers?" The second participant responded,

> Actually, teachers really didn't talk about it. The school nurse and counselor both
> spoke with me about it, but otherwise we didn't discuss it. We were worried
> about being overheard. There was always so much other stuff going on that it just
> really didn't ever seem to be the burning issue when we were dealing with kids
> who were being abused or homeless (Participant 5, Interview March 28, 2011).

This provided a reasonable explanation for the fact that the two participants reported such different experiences, but there was still a possibility that there were additional layers of motivation behind the first participant's denial.

The same contradictions were present in other interviews, as well. For example, a high school male teacher said, "Professionally, I never really considered [HIV/AIDS]. It's not addressed," (Participant 2, Interview March 2, 2011) but later in the interview he said, "Statistically, I am certain that I have probably had a child over the past ten years with HIV/AIDS" (Interview transcript, March 2, 2011). It is possible that he had never really considered HIV/AIDS until the interview began, but even later in the interview, he said, "HIV/AIDS was a bigger issue earlier in my career" (Participant 2, Interview March 2, 2011), and then he began to recount how his students used to conflate being gay with having AIDS. Overall, this interview was curious, given that this participant was reticent to be interviewed because he believed that he had nothing to say about the topic. Although he claimed that

HIV/AIDS was not an issue, he had a great deal to say about the subject. The root of his denial might be critically examined. Was he consciously making denials because he was uncomfortable with the reality that HIV/AIDS was an issue for him and his school community? Was the topic too uncomfortable for him to discuss with me? I wonder if to some degree, he truly did believe that HIV/AIDS was not an issue because it was not something he dealt with on a daily basis. I wonder if he was, consciously or subconsciously, trying to distance himself from a topic that he considered challenging to face head on, although I can only surmise about the basis for denial. Denial of HIV/AIDS was commonly reported in American and international scholarly literature, so it was not surprising that participants in my study engaged in various degrees of denial, as well (see, for example, Letamo, 2003; Visser & Schoeman, 2004).

Another male high school teacher claimed that HIV/AIDS was not an issue at his school because of the school's rural setting. He suggested:

I don't really think about it. Maybe it would be different if I were in the Atlanta Public Schools…Maybe it was brought up with older teachers who were here when HIV/AIDS was a big thing in the news, but any teacher in the last five to ten years probably hasn't thought about it. At least not in our district (Participant 9, Interview February 16, 2011).

I found this assertion troubling. The participant not only denied the importance of HIV/AIDS in his own professional existence, but he was also willing to dismiss its importance for every teacher in the entire district. This participant highlighted the impact that the news media could have on the importance individuals place on pressing issues. There was a misunderstanding that just because HIV/AIDS was not prominently featured in the media means that it is no longer an issue in the United States. As outlined in Chapter Two of the dissertation, this was far from the

case as infection rates were back on the rise in the United States (CDC, 2008a). Finally, this participant, despite his insistence that HIV/AIDS was not an issue in his district, later explained how he incorporated case studies that dealt with HIV/AIDS into his social studies curriculum. He also claimed to show videos and reports that highlighted the HIV/AIDS crisis among children in Africa. Further, he expressed serious fears of crossing the delicate line in his community when it came to sensitive topics like HIV/AIDS.

In this second male participant's case, I surmise that his denial might have been an attempt to distance himself from the issue of HIV/AIDS. Although he was a very willing volunteer, he seemed uncomfortable during the interview. He continually went back and forth between claiming that HIV/AIDS was a non-issue or that it was taboo. If HIV/AIDS was truly a non-issue in his school community, there would be no need to make it taboo. I also believe that he did not view HIV/AIDS as an issue because it was contained in academic content, even though he felt pressure to tread a thin line in addressing HIV/AIDS. In other words, since he did not personally know of any individual who was infected or affected by HIV/AIDS, it was relegated to a subject to be studied in the curriculum, and thus it was a non-issue.

Other, more pressing issues to deal with.

In addition to the three participants who claimed that HIV/AIDS was not an issue and did not affect their school community, four other participants acknowledged it was at least a marginal concern, but it was treated as a non-issue because of other more pressing issues on the table. One female middle school teacher who had teaching for eleven years explained, "There are so many issues—sexual abuse, rape, molestation, committing crimes, imprisoned parents, pregnancy—it's just not something I can think about. I guess I am just desensitized" (Participant 8, Interview February 28, 2011). Another male middle school who had taught in challenging

school environments for many years echoed her sentiments, "Not that much rattles me anymore" (Participant 11, Interview February 20, 2011). Between these two teachers, they were faced with a range of traumatic school experiences—chasing school intruders, counseling pregnant middle school girls, walking in on students looking at gay porn in the computer lab, and everything in between. They recounted some of the most shocking and emotional stories, so it does not surprise me that these two participants were not fazed by the possibility of a student being infected or affected by HIV/AIDS.

It was not only these two veteran teachers who argued that HIV/AIDS was a secondary concern in the midst of everything else that had to be dealt with at school. One teacher who had been in the field for only three years dealt with a potentially pregnant fifth grader, a boy suffering from abuse in his foster home, another student who was being molested by other minors, and a handful of other issues that included parents in gangs and addicted to crack. These were the types of experiences that consumed teachers' energy outside of trying to teach the curriculum, administer standardized tests, and meet Adequate Yearly Progress (AYP). It was no wonder that the possibility of a student living with or affected by HIV/AIDS fell to the wayside. A more detailed discussion of the range of troubling issues educators dealt with will be included in Chapter Five.

Time Constraints

This category was directly related to the previous category--teachers being so overwhelmed with other issues that they were unable to devote any considerable amount of time to HIV/AIDS. It was difficult to look at the list of tasks that a public school teacher was asked to tackle and not see that time was a critical factor in their lives. Given the number of researchers who cited time constraints as the reason teachers did not address HIV/AIDS (see, for example,

Luker, 2006; Portner, 1997), I was surprised that only one participant in my study said that time constraints were a primary reason he or she did not address HIV/AIDS in depth. However, that participant cited numerous other reasons for not addressing HIV/AIDS on an in-depth level, such as being afraid of upsetting parents and administrators.

Among the teachers who taught curriculum standards related to HIV/AIDS, it appeared that they were, in fact, able to devote a considerable amount of time to HIV/AIDS. For instance, in a 7th grade social studies class, one participant discussed HIV/AIDS in the context of India, Vietnam, and Africa in order to meet the Georgia Performance Standard for Social Studies that related to HIV/AIDS. She noted, "We spend a considerable amount of time talking about [HIV/AIDS]" (Participant 4, Interview March 10, 2011). Other teachers went out of their way to weave HIV/AIDS into their lessons. This was all promising data that showed even in instances where time can be extremely limited, it was possible to include at least a minimal amount of instruction related to HIV/AIDS.

School Nurses Denying Importance of HIV/AIDS

The majority of participants noted that school nurses gave presentations about Universal Precautions for Bloodborne Pathogens at the beginning of the school year. Most participants provided the same rough explanation of these presentations: the nurse spoke to the faculty about the importance of using gloves and calling for help if there was any incident that involved blood or bodily fluids in the classroom. One participant noted, "In the last two to three years, I've seen a change…a big push towards teachers not dealing with [blood or fluids]" (Participant 11, Interview February 20, 2011). However, despite this perceived push towards adherence to Universal Precautions, this same participant noted that the school nurse "has made it clear that HIV/AIDS is probably the least of [our] worries…certain hepatitis can last for days and days"

(Participant 11, Interview February 20, 2011). While it was true that the chance of contracting

HIV/AIDS in the school setting was quite low and there were no reported cases of transmission

at school, as noted in Chapter Two, this nurse did the teachers a disservice by essentially denying

the threat of HIV/AIDS. The reason that the Universal Precautions exist are to prevent the

spread of bloodborne illnesses. To suggest that teachers should disregard particular viruses was

a problematic insight to hear.

Other school nurses denied the importance of HIV/AIDS, according to other study

participants. One elementary school teacher explained that even though HIV/AIDS was never

specifically mentioned in the course of a Universal Precautions training seminar, "In all of our

brains, we were already there" (Participant 6, Interview February 17, 2011). Her statement

signaled that HIV/AIDS was something that some teachers thought about and by avoiding any

discussion of it, nurses were only encouraging denial of something that was already on people's

minds. According to other participants, many school nurses talked about the Universal

Precautions in general terms of safety, without discussing specific threats like HIV/AIDS.

Without speaking to school nurses, which was outside the realm of this study, it was impossible

to know why the Universal Precautions were dealt with in such general, vague ways without any

in-depth discussion of HIV/AIDS. It was possible that the nurses were simply trying to cover a

large amount of material in a short amount of time, or it was possible that the nurses were

purposefully avoiding the topic and denying the importance of HIV/AIDS to avoid igniting

teachers' fears.

Some participants admitted being fearful of HIV/AIDS anytime students were bleeding.

An elementary school art teacher explained, "When a student is hurt in the classroom, I don't

grab them up like I would if I weren't worried about HIV/AIDS" (Participant 1, Interview March

1, 2011). Other elementary school teachers, who were more likely to deal with blood and bodily fluids than their colleagues in middle and high schools, reported making every effort to carry gloves with them at all times, especially on the playground. A middle school teacher recalled that the physical education teacher at her school became pregnant and thus had gloves on her person at all times. As one rural elementary school teacher, "I never think about HIV/AIDS in practice, unless [the students] are gushing blood" (Participant 3, Interview March 7, 2011). These participants' statements spoke to the fact that whether the school nurse addressed HIV/AIDS or not, it was on the minds of teachers. My interpretation of these findings is that denying the importance of HIV/AIDS—explicitly or implicitly through avoidance—did not serve teachers or students well in the end. Without the proper discussion of HIV/AIDS, school nurses were essentially sending the message that HIV/AIDS was not an issue.

Even if nurses did go in depth about the threats and risks associated with HIV/AIDS, as one middle school teacher noted, "They always go over stuff like that…teachers aren't really engaged. It's one more thing on the agenda" (Participant 5, Interview February 22, 2011). It is possible that nurses acknowledged this attitude and decided to take the path of least resistance by covering basic information related to Universal Precautions without scaring teachers with detailed information about HIV/AIDS. Not every participant recalled attending these Universal Precautions training sessions. At least two participants reported not having attended presentations about Universal Precautions, and one participant reported that the only information about Universal Precautions that was provided was a poster in the faculty mailroom. If given the choice of a school nurse not giving a presentation at all or giving one that glosses over HIV/AIDS, it may be preferable to have the live training session even without a proper treatment of HIV/AIDS in that presentation. Given the fact that others have reported on teachers' lack of

understand of the Universal Precautions, however, experts suggested that it was in the best interest of the teaching staff to be fully versed in all aspects of the precautions (see, for example, Carney & Cobia, 2003; Grier & Hodges, 1998).

Dimensions of Stigmatization

Ideas related to the stigmatization of HIV/AIDS and individuals living with or affected by HIV/AIDS were among the most common in this study. The theme of Dimensions of stigmatization addressed all three research questions, particularly question 1, parts d and e (see Research Matrix in Chapter One). Study participants reported there was a great deal of stigmatization surrounding HIV/AIDS by students, teachers, administrators, and parents. By exploring the various types of stigmatization in selected teachers' experiences and perspectives, I learned a great deal about how these teachers truly perceived HIV/AIDS and persons infected or affected by HIV/AIDS. There were over 13 examples of direct stigmatization in the interview transcripts and field notes in which the participant admitted to stigmatizing HIV/AIDS or recalled observing others stigmatize HIV/AIDS. There were over 12 additional examples of indirect stigmatization where participants perhaps unknowingly stigmatized or marginalized persons living with HIV/AIDS through words or actions. In this section, I discuss the findings in the sub-themes of direct stigmatization and indirect stigmatization (see Figure 6). See Table 2 in Chapter Three for the exact number of instances each category was mentioned by participants during interviews.
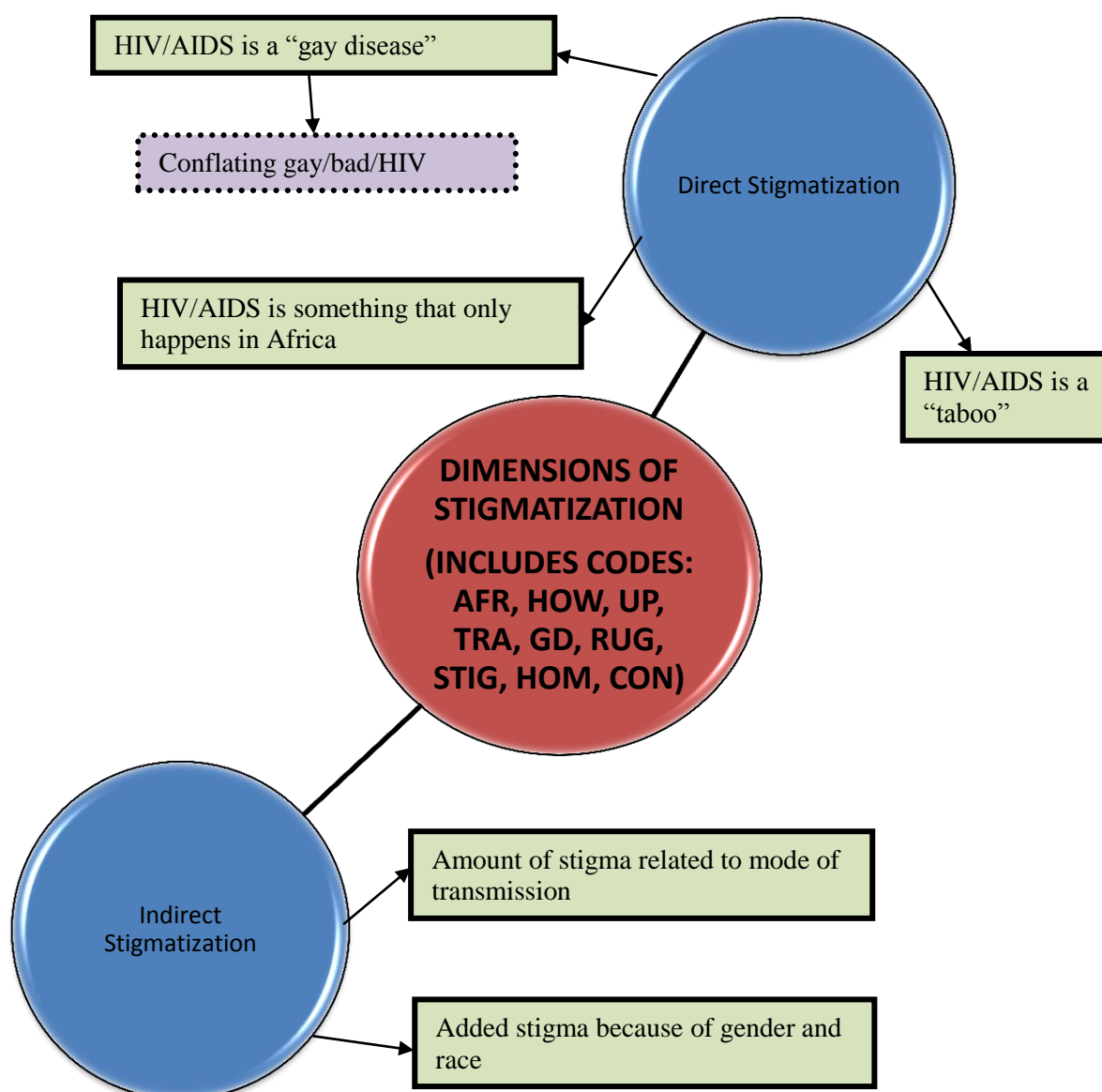
Figure 6 : Dimensions of stigmatization related to HIV/AIDS by students and teachers

Direct Stigmatization

This section addresses the notion of HIV/AIDS as a taboo, as something that happens

only in Africa, as a gay disease, and as something synonymous with bad and gay.

"It's a taboo."

Some participants noted that HIV/AIDS was a taboo in their school communities. One male participant who taught in a rural high school said, "Being a rural county, it's a taboo. It's just one of those things that doesn't get brought up. If you have the belief that's just not something that happens here, it wouldn't be brought up" (Participant 9, Interview February 16, 2011). However, there were over 20,000 of cases of individuals living with HIV/AIDS in the year 2008 in the area where the participant worked (Georgia Division of Public Health, 2010). Further, two neighboring health districts reported thousands of additional individuals living with HIV/AIDS in that area. These statistics were important because they indicated that despite the fact that individuals living in the community felt that HIV/AIDS was "not something that happens here," (Participant 9, Interview February 16, 2011) it *did* happen. The fact that HIV/AIDS remained a taboo in a place that was more or less part of the center of the Georgian HIV/AIDS crisis indicated a serious misunderstanding and lack of knowledge about the nature of HIV/AIDS and the threat of HIV/AIDS. However, it was not surprising that participants engaged in this type of denial because it also commonly occurred in Sub-Saharan African countries where the HIV/AIDS cases were more widespread than in the United States (Boler & Archer, 2008; Visser & Schoeman, 2004).

Other teachers also reported that HIV/AIDS was a taboo. One female participant in a rural county said that HIV/AIDS was very "hush, hush," (Participant 3, Interview March 7, 2011) and four other participants ceded that HIV/AIDS was one of those things that was "swept under the rug" (Participants 1, 4, 6, 7, Interviews February 17, 2011; February 19, 2011; March 1, 2011; March 10, 2011). Although participants directly stated that HIV/AIDS was a taboo or swept under the rug, others alluded to the fact that it was a topic that was simply too

controversial or unsettling to discuss with students. One elementary school teacher worried that

the subject would make her students cry, despite the fact that she taught in an urban school where

she reported students facing things like sexual abuse, drug addicted parents, and neglect. I found

it interesting that she was so fearful of mentioning HIV/AIDS when her students' lives were

wrought with so many other traumas. The mention of HIV/AIDS seemed less frightening to me

than the stories of rape and other abuses she recounted in the interview. Silin (1992) reported

similar denial among teachers in the United States, and Agrawal, Rao, Chandrashekar and

Coulter (1999) discussed the notion of taboo among educators in India.

Finally, the single private school teacher who participated in the study explained that she

led a group of students to Africa for a study abroad experience. She said during the course of the

trip she never mentioned HIV/AIDS, the other chaperones never mentioned HIV/AIDS, teachers

at the host school in Africa never mentioned it, and the students never brought it up. She said

that there was a focus on issues such as clean drinking water and food scarcity, but that

HIV/AIDS simply "never came up" (Participant 10, Interview March 5, 2011). When I pressed

this participant for a justification for why HIV/AIDS had not been discussed at all during the

study abroad trip, she could offer no explanation other than the fact that it just never came up. I

found it hard to accept that this opportunity was missed in educating a group of students about a

critical humanitarian and health concern. Here, one can see the overlap in the themes of denial

and stigmatization.

Something that happens in Africa.

Despite the fact that the United States was the epicenter of the HIV/AIDS pandemic for

several years, there continued to be a popular misconception that HIV/AIDS was something that

was isolated to Africa or something that only happened to Africans or persons of color. While it

was true that the majority of individuals currently living with HIV/AIDS lived in Africa, by perpetuating the myth that HIV/AIDS was isolated to that continent, two levels of stigmatization occurred. First, people allowed themselves to believe that HIV/AIDS was something that happened to *them*, not to *us*. False *us versus them* dichotomies made it easy to layer shame and stigma on people who are not like *us*. In the case of HIV/AIDS, believing that HIV/AIDS was something that happened elsewhere to other types of people allowed people to feel they were not personally at risk of contracting HIV/AIDS. Young people who believed that they were not at risk of contracting HIV/AIDS because it was something that happened in Africa may be less likely to protect themselves from HIV/AIDS.

The other reason that the Africa myth was damaging was because people were tempted to equate HIV/AIDS with Africans. In other words, Africans themselves become stigmatized because they are seen as the sole carriers of HIV/AIDS. As one participant noted, in the context of a lesson on AIDS and Africa, one of her students suggested killing everyone with AIDS. This student's comment pointed to both levels of stigmatization. The student was willing to kill millions of people because HIV/AIDS was something that happened to other people. If the student understood that anyone, anywhere could have HIV/AIDS, it might have been more difficult to hypothetically eliminate an entire group of people. Similarly, this student's comment spoke to the perception that some lives matter more than others. Would that student have been willing to kill off nearly thirty million fellow Americans, or did that only seem like a good solution when African lives were in question? Although it was important to remember that this was simply one student's comment in a single classroom, the underlying stigma and shame are nonetheless important to consider. The account also highlights the pervasive stereotyping and ignorance about Africa in general (Napier, 2010).

One reason that students were led to believe that HIV/AIDS was something that only happened in Africa was because teachers often isolated their lessons about HIV/AIDS to the African continent. Four participants taught about HIV/AIDS solely in the context of Africa or other countries, such as India, Vietnam, and Haiti. Further, all of these participants discussed the spread of HIV/AIDS in these places as the product of sociocultural factors, such as poverty, lack of education, ineffective government, and social norms related to sex. While I felt like it was commendable that these teachers broached these important topics with students, I also believed that it was possible that a discussion of these factors might have led to further stigmatization, "otherization" (Kumaravadivelu, 2008, p. 16), or "fetishization" (Cooper, 1996, p. 6) of people in the countries being discussed. For instance, one male social studies teacher in a rural setting explained,

> I teach them about the social factors that lead to [HIV/AID's] spread in Sub-
> Saharan Africa, whereas in Western Europe, Canada, the United States, you don't
> see it very often because there aren't those sociocultural factors—patriarchal
> society, showing dominance by how many children you have, your sexual
> prowess. The lack of contraception is a social status thing (Participant 9,
> Interview February 16, 2011).

This teacher was trying to engage students in an in-depth analysis of serious social factors, but his analysis of the factors that contributed to the rapid spread of HIV/AIDS was shallow at best. By focusing solely on the sexual aspect of the spread of HIV/AIDS, he was likely simply feeding into the colonial stereotype of the oversexualized African (Kalipeni & Zulu, 2010). Ignoring economic, historical, political, and other factors, he was only contributing to the otherization and stigmatization of Africans and HIV/AIDS. This particular piece of interview data made me

wonder if it would have been better for the teacher in question to have not brought HIV/AIDS up at all. Was it better to provide an inferior lesson that potentially contributed to stigma and misinformation or was it better to ignore the subject altogether? My fear was that, based on the other comments this particular teacher made about the conservative community where he taught, this lesson about HIV/AIDS caused more damage than good in terms of promoting understanding and raising awareness. The overall effect was that Africa and Africans were potentially further stigmatized and cemented as "other" in the minds of students, a finding echoed by Napier (2010) and Petros, Airhihenbuwa, Simbayi, Ramlagan, and Brown (2006).

"Gay disease."

Five participants recounted episodes when students conflated being gay with having HIV/AIDS or incidents when students wrongly believed that HIV/AIDS was a disease isolated among gay men, which was a finding similarly reflected in other studies conducted in the United States and abroad (see, for example, Jones & Abes, 2003; Songwathana & Manderson, 2001; White & Carr, 2005). One middle school teacher pointed out, "There are some children who are taught that AIDS is a disease of gay men. Or God sent AIDS to kill gay men and Africans" (Participant 4, Interview March 10, 2011). Given the conservative nature of this participant's rural school, she admitted that it was often difficult to counter these damaging misconceptions, given her concerns about upsetting parents and administrators. She explained, "I can't just bust out with 'God loves gay people!'" (Participant 4, Interview March 10, 2011). This particular teacher recounted several similar incidents where she was faced with instances of stigmatizing of HIV/AIDS and individuals living with HIV/AIDS, and she seemed to feel hindered in her responses because of the school community and conservative social and political climate of the area.

Other teachers reported that students identified HIV/AIDS exclusively with homosexuals. A male high school teacher recalled that students called HIV/AIDS "the gay disease," (Participant 9, Interview February 16, 2011) and while he did not directly correct the student, he did point out statistics to disprove the students' assertion. Another participant, a current high school teacher and former middle school teacher, explained that middle school students really "grappled with the link between homosexuality and HIV/AIDS" (Participant 7, Interview February 19, 2011). This participant believed that students' misconceptions about HIV/AIDS were "bred by parents" (Participant 7, Interview February 19, 2011). The role parents played in shaping students' understanding of HIV/AIDS was mentioned specifically by three participants. All three of the participants in question taught in the same rural county, although at different schools. It was possible that these rural parents had less experience with HIV/AIDS and therefore were able to hold on more tightly to incorrect ideas about the disease. It was also possible that these parents were more socially or religiously conservative, which might have shaped their beliefs about homosexuality. As one of the rural teachers explained, when it came to HIV/AIDS, "Deep-set cultural ideas are being expressed, especially in the higher class white families. It becomes a social status issue…we don't associate with people like this" (Participant 9, Interview February 16, 2011). Overall, these rural teachers reported having to deal with misinformation and stigma more often than their suburban or urban counterparts. There appeared to be a connection between the conservatism of the area and degree of misinformation and stigma associated with HIV/AIDS.

Conflating gay/bad/HIV.

As previously noted in this section, there was a reported tendency among students to see HIV/AIDS as a gay disease. A natural progression in the minds of students was to conflate being

gay with having AIDS. Two participants recalled students using AIDS itself as an insult. A

male teacher in an urban high school said students said, "'Oh, bro, you're gay! Don't touch me;

I might get AIDS!" (Participant 2, Interview March 2, 2011). A female middle school teacher in

a rural county said that male students were calling out "You have AIDS!" (Participant 4,

Interview March 10, 2011) as a way to insult one another. In both of these cases, students were

purposefully using HIV/AIDS in a derogatory way in order to shame or insult their peers.

Fortunately, in both cases, the participants stopped the behavior immediately and explained to

students why their words were not appropriate. This example of stigmatizing HIV/AIDS by way

of making it an insult highlighted how quick students were to find ways of hurting one another.

When their chosen insult was a particular health diagnosis, there was an added layer of

stigmatization of that diagnosis on top of the insult itself. When a student used AIDS as an

insult, he or she was not merely insulting a peer but was also insulting all individuals living with

HIV/AIDS because their health status was being viewed derogatorily, a finding also noted by

Silin (1992).

Indirect Stigmatization

This section addresses stigma and mode of transmission, as well as additional layers of

stigma based on race and gender.

Stigma and mode of transmission.

As noted in the previous section, there was a tendency among students to perceive

HIV/AIDS as a "gay disease." One of the most interesting pieces that emerged from the

interview data was how concerned participants were with the way individuals contracted

HIV/AIDS. Participants alluded to the fact that they would be less sympathetic towards an

individual who contracted HIV/AIDS through sexual means, particularly through having sex

with a person of the same sex. Similar findings have been reported in scholarly literature, and Reidpath and Chan (2005) argued that contracting HIV/AIDS through means other than sexual contact or injection drug use meant that the diagnosis tended to be more accepted. Others, such as McBride (1998), Herek (1999), and Stinnett et al. (2004), reached similar conclusions.

When asked how they would feel about teaching a student living with HIV/AIDS, several participants noted that they might have questions or concerns about how the student contracted HIV/AIDS in the first place. Three participants specifically mentioned blood transfusions or mother-to-child transmission as possible reasons students might be infected. As one middle school teacher who had experience teaching individuals with HIV/AIDS admitted, "I can't say I wasn't curious about how the students contracted it. Was it from something like a blood transfusion? From their mom at childbirth? Were they sexually active?" (Participant 5, Interview February 22, 2011). Other participants had similar musings, and the implication was that there would be more sympathy if the individual contracted HIV/AIDS by no fault of their own—such as a blood transfusion or from their mother at childbirth. A female high school teacher noted,

> There would be some negative stigmatizing in terms of how the person—the child—contracted AIDS. I think that in the minds of some adults, it would make a difference to how sympathetic they could be. In some sense, I think people would think, 'It's your fault if you got it through unprotected sex versus if you got it through a transfusion', as if either one should be blamed or stigmatized (Participant 7, Interview February 19, 2011).

The overall implication was that the amount of sympathy afforded to individuals living with AIDS was dependant on how they contracted AIDS in the first place.

It was interesting that participants cited blood transfusions so frequently as a potential mode of transmission. According to America's Blood Centers, the odds of contracting HIV/AIDS through a blood transfusion was approximately 1 in 1.5 million, which was less than the odds of being struck by lightning (America's Blood Centers, 2011). It was possible that because of the early attention to blood transfusions at the beginning of the AIDS pandemic in the United States, this particular mode of transmission lingered in participants' minds. However, the fact that participants frequently cited blood transfusion as a mode of transmission seemed to highlight a general lack of knowledge about HIV/AIDS and to signal participants' need to see students' HIV/AIDS diagnosis as the product of something like a blood transfusion, which they felt merited more sympathy. In reality, unprotected sex continued to be the single most common way to contract HIV/AIDS in the United States and abroad. By focusing on non-sexual modes of transmission, it was possible that participants felt they were disassociating HIV/AIDS from sex, which made it more palatable or easier to discuss.

The relationship between transmission and sympathy was also seen in terms of parents who had died from HIV/AIDS. Two participants recalled faculty sentiments surrounding parents who had died of HIV/AIDS. One participant, a female middle school teacher said,

From what we understood, [the mom] did get it sexually transmitted, but I

remember other teachers talking the mom and how it was so unfortunate. She

was such a good mom, she was super involved. It seemed to be more of a case of

a non-informed lover" (Participant 5, Interview February 22, 2011).

The participant needed to justify having sympathy for this mother who died of a highly stigmatized disease by claiming that she was a good mother. In addition, the participant felt a need to make the mother a victim in order to be sympathetic. According to the story, this mother

was tricked, lied to, or otherwise deceived and thus suffered by contracting HIV/AIDS. She was portrayed in a way that made it easy to be sympathetic towards her. Overall, this comment highlighted the connection between sympathy, stigma, and mode of transmission.

Stigma, gender, and race.

As noted in the previous section, the amount of sympathy and stigma participants' felt or would potentially feel for individuals living with AIDS was often dependant on the way the individual contracted HIV/AIDS. Participants also noted connections between the amount of sympathy afforded and the gender or race of the individual in question. A high school social studies teacher admitted:

> Given the overall attitude towards homosexuality, [the faculty] would be more
>
> sensitive to a female [living with HIV/AIDS]. The potential of being homosexual
>
> would be laid on top of the stigma of having HIV (Participant 7, Interview
>
> February 19, 2011).

That same teacher noted that the stigma would be heightened if a student living with HIV/AIDS was a person of color because of the large amount of racism she perceived in the school community. There is considerable literature related to the interplay of race, gender, and HIV/AIDS (see, for instance, Chan, Yang, Zhang, Reidpath, 2007; Conrad, 1986; Fassin, 2001; Kowalewski, 1998), so the fact that such layering of stigma reportedly occurred in Georgian schools was not surprising.

Two male participants evoked basketball star Magic Johnson in the course of discussing gender and subsequent sympathy for individuals living with HIV/AIDS. One participant pointed out that Magic Johnson was "this manly man, this picture of masculinity…then we come to find out he has a disease that many people associate with homosexuality" (Participant 2, Interview

March 2, 2011). This participant seemed to highlight Magic Johnson as a person whose

HIV/AIDS positive status was more acceptable because he was heterosexual. His

heterosexuality, masculinity, and sexual prowess—despite its consequences—appear to have

been lauded in this participant's eyes, based on this comment. Another male participant

incorrectly stated that Magic Johnson contracted HIV/AIDS through a blood transfusion. In both

of these cases, Magic Johnson was portrayed as an acceptable face of HIV/AIDS. Whether he

contracted it from a woman or from a blood transfusion, in both of these participants' minds, he

was decidedly heterosexual and masculine. It was interesting that these male participants held

onto Johnson as a public representative of the HIV/AIDS pandemic. Perhaps they were more

willing to identify and sympathize with Johnson because of his star power, athleticism, and

heterosexuality.

Dimensions of Additional, Related Issues

During the course of interviews, participants shared experiences with me that were not

specifically focused on HIV/AIDS but were related to the study and served the important

function of illustrating the extreme types of situations teachers were facing in their classrooms on

a day to day basis. After careful consideration, I included these additional, related issues because

they raised important questions about what teachers were called to do in terms of dealing with

sensitive student needs and issues. Further, these issues raised the question of why schools were

able to address some difficult issues directly but were unable to deal with HIV/AIDS in an

appropriate manner. The findings in theme of Dimensions of Additional, Related Issues were

linked to research questions 1, 2, 3, and this theme was most directly tied to question 1, parts d, f,

and g (see Research Matrix in Chapter One). This section includes a discussion of the sub-

themes of homosexuality, pregnancy, sexual abuse, traumatic incidents at school, and other

physical health issues (see Figure 7). See Table 2 in Chapter Three for the exact number of

instances each category was mentioned by participants during interviews.
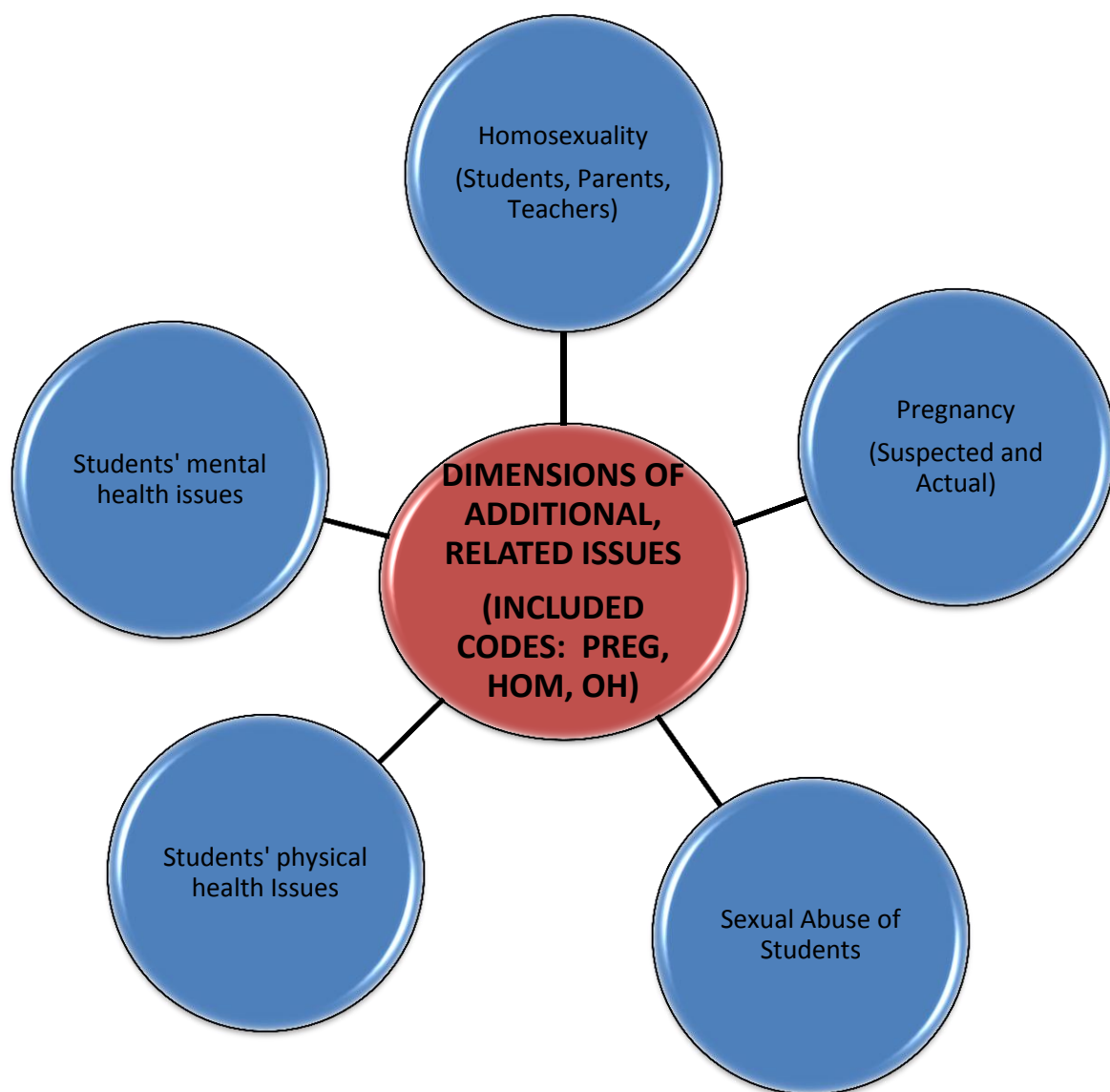
Figure 7: Dimensions of additional, related issues that emerged during interviews

Homosexuality

The reason that I chose to build a research question that addressed homosexuality into the

study was because gay individuals comprised the sector of the American population that was

most at risk of contracting HIV/AIDS. My intention going into the study was to elicit responses

from participants that spoke to instances where they had addressed homosexuality in light of

HIV/AIDS. However, teachers spoke in more general terms about homosexuality, and several

participants related stories to me of moments when they had been called to personally stand up

and protect gay students from bullying, make decisions about how to treat transgender students,

or stand up to other teachers using homophobic slurs.

The findings in this section could have been included in one of the other section,

particularly stigmatization, but the fact that the data that I ended up collecting about

homosexuality were so different from the data that I sought to collect, Dimensions of Additional,

Related Issues is the best section to discuss these findings. This section is divided into three

categories: Gay Students, Gay Parents, and Gay Teachers. Overall, homosexuality was

mentioned 13 times during the interviews, which made it one of the most frequently discussed

issues across interviews.

Gay students.

Participants who taught on all levels (elementary, middle, high school), in all types of

places (rural, suburban, urban), and private and public settings reported teaching students who

were gay, bisexual, or transgender. The youngest student grappling with these issues was a third

grade girl who believed she was born in the wrong body and wanted to be a boy. The participant

who taught this student was in a rural area and reported feeling personally responsible for

"shielding this child" (Participant 3, Interview March 7, 2011) from the negative reactions of

other adults, like teachers, parents, and bus drivers.

Another participant who taught in a suburban school recalled teaching a male student

who only answered to the name Amy. Finally, a third participant teaching in an urban school

reported teaching a third grade boy who told the participant that his mom taught him that "he

was born a girl and God came down and made him a boy" (Participant 1, Interview March 1, 2011). These three participants, all elementary school teachers, dealt with sensitive issues related to student sexuality. Although I knew that some children self-identified as gay at an early age, I did not expect to hear this many stories of elementary aged children grappling with gender and sexuality issues.

Participants on the middle school and high school levels reported many instances of dealing with students' sexualities. Participants who taught middle school agreed that large numbers of students tended to come out of the closet during these pivotal years, and that teaching openly gay students was not at all uncommon. Teachers on the high school level reported similar observations about students' sexualities and their peers' acceptance. Interestingly, participants experiences related to student sexuality were quite similar across locations (urban, suburban, and rural).

Overall, many participants reported dealing with gay students. The participants reported feeling very comfortable with students' sexualities and one female participant displayed gay rights and gay equality stickers in her classroom in a show of solidarity. Unfortunately, this type of solidarity did not seem to be widespread. One participant remarked that the high school where she taught was "openly hostile towards the LGBT [lesbian, gay, bisexual, transgender] community" (Participant 7, Interview February 19, 2011). One teacher in her school even repeatedly called students "faggot" (Participant 7, Interview February 19, 2011) in the faculty lounge. Overall, the aforementioned incidents revealed teachers dealt with highly sensitive student issues related to student sexuality.

Gay parents.

In addition to teaching students who were gay, participants reported instructing students who had gay parents. Although the participants did not necessarily have to interact with the parents themselves, they did have to try and be sensitive to the fact that some students were from different types of families than their peers. One elementary school teacher who taught a student with two moms made sure to include the book *Heather Has Two Mommies* in her classroom library. Another participant who taught middle school in a rural area remembered a male student who was adopted by gay men and came out as gay himself. Finally, one middle school teacher in a suburban school reported that she taught at least one to three students a year that came from homes with gay parents. At the time of the interview, she was teaching a male student who frequently talked about his two dads, and she reported feeling nervous that other students would make fun of him.

Just as with dealing with gay students, participants were charged with a difficult balancing act. In the case of the elementary school teacher who placed the book *Heather Has Two Mommies* in her classroom library, she was trying to be inclusive of one student's family structure, but she was also opening herself up to criticism from others who might not have believed in such inclusivity (Participant 6, Interview February 17, 2011). Balancing these concerns was an added pressure on teachers who may have been navigating this type of situation without any formal training, assistance, or support from administrators. Further, teachers had to deal with their own feelings about homosexuality, which could be based on their social, cultural, political, or religious beliefs. They had to then reconcile those feelings and beliefs with their professional standards. For teachers who were supportive of the LGBT community, this was

probably an easy reconciliation. However, for teachers who were not as comfortable or accepting of homosexuality, being professional and sensitive may have been a challenge.

Gay teachers.

The final area related to homosexuality that emerged from this study was the presence of gay teachers or rumors about gay teachers. As one participant who taught in a suburban middle school noted, students were fairly accepting of gay students, but if a teacher was gay, "it was the end of the world" (Participant 8, Interview February 28, 2011). This participant noted that if a teachers' sexuality was called into question, there would immediately be rumors about that teacher molesting students. One high school teacher remembered a student approaching her and asking if a male faculty member was "straight or curvy," (Participant 7, Interview February 19, 2011). Teachers were not only asked to deal with gay students and gay parents, but they may also have been asked to answer questions about their peers' sexualities or be called to defend one another in the face of an accusation. Depending on how they responded, they could have opened themselves up to a range of consequences, including upsetting co-workers, administrators, parents, or students. Overall, participants frequently mentioned issues related to gay students, parents, and teachers, which signaled that sexuality in general was an important topic in schools.

Pregnancy

Although I would not have been taken aback to learn that high school students were becoming pregnant, I was surprised to learn about girls in elementary school being suspected of being pregnant. Several participants discussed student pregnancy and suspected pregnancy. Pregnancy was directly related to HIV/AIDS because it was physical proof that students were engaging in unprotected sex. If students were engaging in unprotected sex, contracting HIV/AIDS seemed like a reasonably prospective consequence, as well. Students' pregnancies

also raised ethical questions for participants, especially in cases where the student was underage and the suspected sexual partner was older. For instance, an elementary school teacher reported that an elementary aged student believed she was pregnant with her twenty-two year old "boyfriend's" child. Ultimately, the student was not pregnant, but the relationship with the man continued and whole incident was "swept under the carpet" (Participant 1, Interview March 1, 2011) by school administration and the student's parents. This became one of many incidents that were reported to me during the course of the dissertation interviews that were extremely troubling and unsettling.

Other stories of student pregnancy were reported, although none were quite as extreme as the previous one. Three middle school teachers (in different counties) reported that there was approximately one girl each school year that became pregnant. One of those teachers explained,

Our assumption is that they're not [having sex]. We know for a fact that some of them are, but we have this little pretend game that they're not doing any of that. We're just hoping we don't have any illegitimate children by the end of the year (Participant 11, Interview February 20, 2011).

Scholars in both the United States and abroad reported similar types of denial of student sexuality (see, for example, Allen, 2007; Lupton & Tulloch, 1996).

While some teachers were able to pretend students were not sexually active, one high school teacher painted a picture of a school so saturated in teenage pregnancy that it would have been very difficult to pretend students were anything but sexually active. She estimated that there were over 12 girls at the high school who were currently pregnant, while an additional 40 girls were already parents. This number did not take into account the numbers of girls who dropped out after having a child. At this particular high school, there was even an on-site Head

Start program, which the participant noted that other teachers spoke of negatively and called "the nursery down the hall" (Participant 7, Interview February 19, 2011). The large number of girls becoming pregnant at this single school signaled a serious crisis and raised questions about the possibility of other unintended outcomes of pregnancy, such as HIV/AIDS.

Sexual Abuse

When I began this study, I was unprepared for sexual abuse findings. Although I knew that, sadly, sexual abuse was a part of some students' lives, I naively did not expect or anticipate that my participants would have had direct experience with student sexual abuse. I believe that in some cases, the stories that participants recounted about sexual abuse were only tangentially related to HIV/AIDS, but their desire to share these stories highlights the fact that many participants found our interview sessions to be a rare place to unload many of these secret horrors of their professional lives.

An elementary school teacher reported that one of her students was found living in a crack house where he was molested by his brother and others. This student subsequently tried to strangle himself in the school bathroom. A middle school teacher in a suburban school recounted an incident involving a male student with special needs who was "raped repeatedly by two other students" (Participant 8, Interview February 29, 2011). According to the participant, the entire situation was dealt with in a "very hush, hush manner and swept under the rug" (Interview transcript, February 28, 2011) and the faculty was not debriefed. The lack of training teachers received to deal with such events and the complex needs of teachers was examined by other researchers (see, for instance, Johnson, 1998). Sexual abuse raised questions about student's safety and added an additional layer of extreme concerns that classroom teachers are often asked to deal with on a daily basis.

Traumatic Incidents at School

Participants relayed details about incidents that occurred at school that were highly traumatic. Two participants who had taught at the same middle school both recounted an incident where a man entered the school, hid in the bathroom, and then attempted to molest a female student when she entered the bathroom alone. As one of the participants noted,

There's no training for this. You just learn on the job, in the moment. You realize you've got kids coming down the hall from lunch, and you've got some molester outside the building. You just have to deal with it" (Interview transcript, February 28, 2011).

Both of the participants who reported this incident were veteran teachers with 11 and 7 years of experience. Their ability to deal with this situation in such a calm manner was potentially the product of their individual personalities, but may have also been the result of several years of on the job training where they were faced with difficult issues.

The next traumatizing incident that was reported by a participant involved the death of a school crossing guard outside of a middle school. The crossing guard, who was also the parent a child at the school, was killed in a car wreck outside of the school building. The participant remembered, "Her body was still in the road when the busses arrived. Even though she was covered by a blanket, they knew it was a body and they saw her car with the broken windshield" (Interview transcript, February 22, 2011). The participant noted that the school essentially shut down and became a grief center for students. Since this incident happened just before students arrived for the day, the participant and her co-workers had to come up with a plan to help students come to terms with what had happened in only a matter of moments. This episode illustrated the ways in which teachers had to react quickly and sometimes put their own feelings

and emotions on hold in order to try and help their students. All three of these traumatic incidents underscored the fact that schools were places where traumatic things happened. In all three of these cases, the participants had to think quickly and respond to traumatic events to the best of their abilities.

Although the final incident was not nearly as traumatic as the school intruder, I chose to include it in this section because it can best be described as a traumatizing incident, although traumas are certainly relative. An elementary school teacher reported having to deal with students defecating in their pants in the classroom. She explained, "I moved the kids away from the table and called the custodian. I honestly didn't really get close to the stool" (Interview transcript, March 29, 2011). Since this participant was only a student teacher at the time, it was commendable that she was able to handle the situation as well as she did. If there had been some sort of further incident resulting in other students coming into contact with feces or bodily fluids, this situation could have ended much worse for everyone involved.

Other Physical Health Issues

While only a few participants had direct experience with students living with HIV/AIDS, many participants had experience dealing other physical health concerns, ranging from cystic fibrosis, cancer, hemophilia, diabetes, asthma, severe allergies, and seizure disorders. In some cases, participants reported being trained on how to handle health emergencies in the classroom. However, a participant who taught at a middle school expressed a great deal of apprehension about one student's potential health emergency and the lack of training she had received to deal with the situation. She was instructed to "inject an enema into the rectum of a student in order to save his life in the case of an episode" (Participant 5, Interview March 28, 2011). In addition to

having a rare disorder, this student had cognitive challenges. The participant explained that she

was extremely uncomfortable with the entire situation. She explained,

> I mean, really? I am supposed to get a 180 pound Black boy who is about as
>
> sharp as a spoon on the floor, pull his pants down, and stick an enema up his ass
>
> before he dies of a seizure? What am I supposed to do with the other kids? The
>
> whole thing is just insane" (Participant 5, Interview March 28, 2011).

The participant expressed further concerns in a follow-up interview about the consequences of

having to intervene in this way. How was she being put at risk professionally and personally by

being asked to complete such a task? This participant's story was one of the most troubling

pieces of data that emerged during the course of the interviews. On top of the extreme physical

health issue, there were additional concerns such as the cognitive ability of the boy, the sensitive,

highly charged act the teacher was asked to perform, the pressure to act quickly to save the

student's life, and the fear of legal recourse, just to name a few. This particular issue emerged as

a paramount example of an already overburdened teacher being asked to perform tasks outside of

the realm of normal teaching responsibilities. The notion of the overburdened teacher being

asked to do too much is discussed in more detail in Chapter Five.

This chapter of the dissertation dealt with findings that emerged from axial coding of

interviews and field notes. In the next chapter, Chapter Five, I address the implications of my

findings, including international insights and universal issues. I provide a collective portrait of

the overburdened teacher, and I reflect on the role of researcher and teacher isolation, limitations

of the study, and directions for future research.

CHAPTER 5

CONCLUSIONS

The purpose of this qualitative study was to explore selected Georgia teachers'

professional experiences and perspectives related to HIV/AIDS and the classroom in

comparative context regarding the experiences and perspectives of participants and teachers in

other countries, as reported by other researchers. Chapter Four focused on the findings that

emerged from analysis of the data. In this chapter, I discuss the implications of my findings and

universal issues, particularly the ways in which my findings confirmed those in international

literature. In this chapter, I also include a collective portrait of the overburdened teacher,

reflections on the role of researcher and teacher isolation. I also discuss limitations of the study

and directions for future research.

Implications of Findings and Universal Issues

In Chapter Two, I included a review of international scholarly literature related to

educators and their professional experiences and perspectives related to HIV/AIDS in the

classroom, which included literature related to teacher misconceptions and negative feelings,

teacher knowledge and the impact of religion and culture, caring for students living with

HIV/AIDS, and teacher training. These same themes are discussed in this chapter, and I

highlight similarities between the experiences and perspectives of participants in my study and

teachers in other nations, as detailed by other researchers in international scholarly literature.

This section links the thematic findings in Chapter Four to international scholarly literature in order to highlight universal issues related to teachers' experiences and perspectives involving HIV/AIDS and the classroom.

Teacher Misconceptions and Negative Feelings

Teacher misconceptions and negative feelings towards HIV/AIDS and individuals living with HIV/AIDS were common in my study and in studies reported in international scholarly literature. Several international studies highlighted stigmatization in association with HIV/AIDS infection. For instance, Norr et al. (2007) found that stigmatization in Malawi appeared to be the product of "moral judgments" (p. 240), and a survey of Malawian teachers revealed that one-third of respondents believed HIV/AIDS was a punishment from God (Norr et al., 2007). As noted in detail in Chapter Four, stigmatization was a recurrent theme across the interviews that I conducted. Like their Malawian counterparts, some participants in my study appeared to hold at least some moral judgments about individuals living with HIV/AIDS, which was evidenced in the preoccupation with knowing how individuals contracted the disease. Although none of the participants in my study stated that they believed HIV/AIDS was a punishment from God, one participant believed many parents in the community where she taught did hold this belief.

Beyers and Hay (2007) reported that South African teachers avoided any physical contact with individuals living with HIV/AIDS. Some teachers in my study admitted being fearful of contracting HIV/AIDS themselves, and even more participants appeared to have an underlying, unspoken fear of contracting HIV/AIDS. As one elementary school teacher noted, she avoided full contact with students who were bleeding because of her fear of contracting HIV/AIDS even when she had no evidence that the students were infected. Additionally, a high school teacher who participated in my study admitted that she would not want to use the water fountain after an

individual living with HIV/AIDS. These types of avoidances of physical contact spoke to the stigmatization of individuals living with HIV/AIDS and the overall lack of understanding of how HIV/AIDS was transmitted. Even among participants who believed they had never taught a student living with HIV/AIDS, there was still a great deal of fear surrounding contracting HIV/AIDS. Stigma and fear persisted even in the absence of individuals living with HIV/AIDS. In other words, the stigma and fear were divorced from actual cases of infected persons.

An additional layer of negative feelings that were present in my study and in international scholarly literature was teachers' fears of discussing HIV/AIDS with students for fear of upsetting students, parents, school administrators, or the community at large. In international scholarly literature, some teachers reported being fearful of broaching sex-related topics or HIV/AIDS in the classroom because they were fearful of upsetting parents or community members by introducing such content to students (Kiragu, 2007; Mufune, 2008). Kiragu (2007) argued that many educators were not confident about what they could and could not say to their students. These very sentiments were repeated across interviews that I conducted. My study participants had a great deal of insecurity about upsetting students, parents, and community members. Bhana (2007) reported that teachers in South Africa tried to avoid controversy by discussing HIV/AIDS without any mention of sex or sexuality. Some of the elementary school and even middle school participants in my study made similar comments about trying to discuss HIV/AIDS in very neutral, non-sexualized, uncontroversial terms. As Bhana (2007) argued this allowed teachers to sustain the notion of "innocent child" (p. 438). Participants in my study also alluded to the notion of students' innocence. Participants pretended students were not sexually active or ignored students' sexual lives, even when students in the school were pregnant. Recognizing teachers' misconceptions and negative feelings across cultures was important

because it exposed the universal issues of fear and stigmatization surrounding HIV/AIDS. Addressing misconceptions and negative feelings may be important in order to teachers to address HIV/AIDS in a more sensitive, understanding manner.

Teacher Knowledge and the Impact of Religion and Culture

In Haiti and Botswana, researchers found that lack of formal training was a primary reason that teachers faced challenges in dealing with HIV/AIDS in the classroom or teaching students about HIV/AIDS (Letamo, 2007; Martell & Mueller, 2006). In Haiti, teachers who did not include information about HIV/AIDS often cited their own lack of knowledge as a primary reason for not incorporating HIV/AIDS content into the classroom, (Martell & Mueller, 2006) and in Botswana researchers found that a lack of formal training and education was a primary reason for harboring misconceptions about HIV/AIDS and individuals living with HIV/AIDS (Letamo, 2007). As I noted in Chapter Four, the vast majority of participants in my study reported having no formal training related to HIV/AIDS. Only one participant reported actively trying to teach herself about HIV/AIDS using the Internet, while other participants admitted their lack of formal of training and did not seem bothered by this gap in their teacher preparation or ongoing professional development. Some participants in my study failed to recognize their own misconceptions and to see those misconceptions as the product of a lack of training or education. At least one participant provided information to students about HIV/AIDS that was simplistic and likely increased stigma of individuals living with HIV/AIDS, but he was not cognizant of this fact. If he had been provided with a firm base of knowledge about HIV/AIDS, he likely could have instructed students more effectively. Recognizing the dearth of teacher knowledge about HIV/AIDS across cultures was important because it revealed that teachers in a variety of

locales felt ill-equipped to deal with HIV/AIDS, which may underscore the need for improved training.

Another aspect of teacher knowledge was the impact of religion and culture on their HIV/AIDS related beliefs. In Haiti, for example, Vodou beliefs influenced some teachers' choice of whether or not to include HIV/AIDS in the classroom (Martell & Mueller, 2006). In my study, particularly among participants in rural counties, participants recognized the religious and cultural beliefs among parents and community members and tailored their discussion of issues like HIV/AIDS and sex accordingly. Overall, participants in my study were cognizant of the social and cultural norms of the community in which they were employed. The one study participant who was open about her religion and received some of her training at a religious institution had taught the most individuals living with HIV/AIDS, appeared to be the most willing to discuss HIV/AIDS directly with students, and was supportive of individuals living with HIV/AIDS and their unique needs. The impact of religion and culture on how teachers addressed HIV/AIDS across cultures exposed the fact that teachers must navigate sensitive territory when dealing with HIV/AIDS in the classroom. Teachers may need additional support from school administrators in order to balance the need to provide information to students with the religious and cultural norms of the area in any given country.

Caring for Students Living With HIV/AIDS

As noted in Chapter Four, I was surprised participants in my study acted in maternal ways towards their students. This was a trend that I had wrongly believed would have been confined to teachers living and working in places where students had been negatively impacted by HIV/AIDS in excessively large numbers, such as in Sub-Saharan Africa and in Thailand. Even though participants in my study were not necessarily teaching students living with or

affected by HIV/AIDS, the teachers I interviewed dealt with students who had other struggles. The ways participants in my study spoke about their students and their nurturing stance in dealing with those students were echoed in international studies. For instance, Wood (2007) studied South African teachers who reported feeling personally traumatized when they learned about their students' experiences with HIV/AIDS. My study participants also felt personally saddened or affected when they learned about the challenging circumstances in students' lives. Wood (2007) argued that since many of the South African teachers had not received any special training to deal with emotional issues related to disease and dying, they experienced difficulties in handling their emotions and their students' emotions. Given the range of extremely difficult situations that teachers in my study were asked to deal with, it is understandable that they, too, experienced difficulties in handling their emotions layered on top of their students' emotions. Some participants in my study admitted to feeling emotionally overwhelmed when they had been called to deal with situations beyond their capabilities. A middle school teacher recalled the difficulties she experienced after learning one of her students had committed suicide. She remembered sobbing with her students and trying to manage her students' emotions in addition to her own grief was extremely difficult. Recognizing that teachers across cultures were often called to care for their students and attend to their feelings and emotions was important because it exposed another layer of teachers' responsibilities. Even if teachers do not have to care for or nurture students living with HIV/AIDS, it is probable that at some point they may be asked to handle student emotions in one capacity or another.

Teacher Training

In various countries, many researchers conducted international studies about the lack of training for teachers on both the pre-service and in-service levels, and the majority of these

studies pointed to the fact that proper training was instrumental in helping teachers deal with

HIV/AIDS in the myriad ways it emerged in the classroom (Jacob et al., 2007; Peltzer &

Promtussananon, 2003; Pick et al., 2007; Robson & Kanyanta, 2007; Stothard, Romanova, &

Ivanova, 2007; Wight & Buston, 2003). Even in places like South Africa and Uganda, where

HIV/AIDS rates were elevated, specialized training for teachers was not necessarily common.

As previously noted in Chapter Two, Jacob et al. (2007) found that over 75% of Ugandan

educators surveyed had not been specially trained to provide HIV/AIDS education to students.

The only participant in my study who received formal pre-service training appeared more

knowledgeable about and sensitive to issues related to HIV/AIDS. It was possible that some of

her enhanced knowledge and sensitivity was the product of this training, although there were

certainly other facets of this individual's personality and background that could account for this

fact. Although only one participant had actually received any training, three participants in this

study lamented the lack of HIV/AIDS related training and believed that such training would have

allowed them to better serve students.

There were multiple explanations for the lack of training in the United States and abroad,

which could include lack of time, lack of funds, lack of interest, or the absence of an individual

who is capable of leading such a training program. There were other explanations, as well, such

as shame, stigma, lack of understanding of the scope of the problem, and denial. Regardless of

the reason, until teachers are effectively and consistently trained to deal with HIV/AIDS in this

country and abroad "it is unrealistic to expect teachers to present clear, accurate, comprehensive

and non-judgmental sex education" (Stothard et al., 2007, p. 181). Understanding that lack of

pre-service and in-service training for teachers on matters related to HIV/AIDS was a universal

issue signaling that teachers across the globe were placed in the precarious position of dealing

with a situation for which they have not been formally trained. The fact that teachers in places like Uganda and South Africa, where HIV/AIDS education was a national priority, did not receive the proper training made it less surprising that teachers in the United States do not receive proper training either.

Reflections on Universal Issues

Overall, there were multiple areas of overlap between my findings and the findings reported by other researchers in international scholarly literature. HIV/AIDS is a global pandemic, and many of the professional experiences and perspectives of participants in my study and participants in other studies conducted abroad by other researchers were quite similar. It was important to view findings from my study in relation to those in research in other countries because it highlighted some universal issues related to HIV/AIDS and the classroom. These similar experiences and perspectives revealed the powerful nature of HIV/AIDS and also pointed to the "glocalized" (Wellman, 2002, p. 3) nature of our world and the interconnectedness of individuals who are thousands of miles apart. Teachers should feel solidarity with their peers given these overlaps, and despite the isolation many study participants reported feeling in their professional lives, there were ties between teachers across nations when it came to HIV/AIDS and the classroom.

Before I conducted this study, I envisaged that a potential contribution of this study would be to make connections between cultures about teachers' professional experiences and perspectives on issues related to HIV/AIDS. My study demonstrated that there were some universal experiences and perspectives among educators in terms of HIV/AIDS. Highlighting shared experiences and perspectives on the issues could increase overall support for teachers given the similar realities they face in terms of HIV/AIDS in the classroom. While there were

certainly some differences in professional experiences and perspectives across borders, it was my hope that educators would have the opportunity to think critically about their own experiences and perspectives related to HIV/AIDS in a global context through dissemination of the results of studies such as mine, as well as through other means. Finally, it was my intention that study participants and other educators would be able to recognize their own challenges and struggles in teachers' voices from thousands of miles away. The participants in the study were truly battling universal issues. They were not alone in their challenges and struggles, but they were instead part of a global phenomenon. Interestingly, it was teachers' lack of knowledge about what was happening abroad that isolated them. This study is useful because it highlights similarities between teachers' experiences and perspectives, builds solidarity between teachers, and underscores the value of comparative insights in general.

Collective Portrait of the Overburdened Teacher

Although the 11 individuals who participated in this study offered a range of unique experiences and perspectives, one issue became prominent over the course of the 14 interviews that I conducted: the fact that the teacher participants were overburdened. The collective portrait of the overburdened teacher in this section is based on interview data and scholarly literature. Participants dealt with a range of demands, such as preparing students for standardized tests and meeting AYP, in addition to challenging circumstances and situations, like dealing with student pregnancy or abuse. This was not to mention all of the other daily duties, like meeting with parents for conferences, attending faculty meetings, coaching, sponsoring clubs, monitoring the lunchroom, opening car doors for students, and planning the next fundraiser with the parent-teacher organization. When the teachers were not at the school doing this seemingly endless list

of tasks, many of them went home to their own children and families, who brought their own list of needs and concerns to the table.

A composite portrait of today's teacher emerged based on the experiences and perspectives of participants in this study. Viewed collectively, the teachers who were my participants were being asked a great deal, with too little support, time, and resources. It was not surprising that when I initially asked individuals to participate in this study, they believed they had nothing to say about HIV/AIDS. For many of these teachers, HIV/AIDS was truly the least of their concerns, given the other challenges and struggles they were dealing with. HIV/AIDS must be viewed in an appropriate perspective within a suit of issues and challenges for teachers in Georgia, the United States, and abroad. At the same time HIV/AIDS must be recognized as a serious and sensitive issue, it is also important to recognize that HIV/AIDS is one of many diseases and health risks that impacts classroom teachers, families, and societies at large. Teachers must decide which of these issues and challenges they will focus on, which may be difficult given the sensationalization of some issues and preferential attention to some issues by the media. It would be nearly impossible for teachers to fully treat every issue and challenge facing every student in the classroom, so teachers may feel pressure make choices and prioritize in order to function.

While the collective portrait of teachers that emerged from this study was one of an overburdened teacher, the experiences and perspectives of participants also reflected their dedication, their nurturing capabilities, their desire to do the right thing, and their underlying desire serve students well. I was continually amazed at the way participants described the wide-range of their responsibilities and the way they met challenges directly and efficiently. Unfortunately, many teachers met these challenges in isolation without adequate support from

fellow teachers or administrators, and the issue of teacher isolation is discussed in the next section. The fact that teachers are asked to do too much with too little support is not unique to educators in the United States. Elements of the collective portrait of the overburdened teacher may also be true for teachers in international contexts. Even if there are some country-specific issues, like meeting AYP, there are equivalents to these issues in other nations. The strength of this collective portrait is that it very well may be true for teachers across the globe, which provides an additional layer of similarity between teacher participants in my study and their counterparts across the globe.

Reflections on the Role of Researcher and Teacher Isolation

When I began this study, despite my interest in the research problem, I did not expect to become so invested in this project on an emotional level. Prior to conducting interviews I viewed this piece of research solely as an academic pursuit. When I conducted interviews, some participants unleashed volumes about their most complex and challenging experiences. I wondered after several interviews how many months or years the participants had been saddled with the burden of carrying particular pieces of information. The interview, some participants admitted, was therapeutic, and I continued to marvel at the fact that these professional educators had not had a prior outlet, even informally, to express their emotions and concerns. An unexpected outcome of my study emerged. My interviews apparently provided participants with the opportunity to break through the barriers of isolation and to connect with a colleague about issues not typically discussed with their colleagues at work. In turn, I became personally invested in the project.

Methodologically speaking, it was extremely beneficial for me to establish trust and to be able to connect with participants at the onset of interviews by sharing stories of my own K-12

teaching experiences. It was almost as if participants interpreted my own sharing as a signal I would be able to handle the information they were holding, and I might be able to understand because I was an insider. Ironically, the interviews also became a cathartic opportunity for me to release many of the lingering memories and anxieties I had experienced as a K-12 teacher since I had never had the opportunity to share my own challenges and struggles with colleagues either. Overall, the interviews became about more than the transmission of information, and the time I spent interviewing participants was more than research task. I believe that several participants were appreciative of having a safe space to share their experiences and perspectives, and I was appreciative of their willingness to trust me with their accounts. As noted by Creswell (2007) and Liamputtong (2010), such trust is a key ingredient of qualitative inquiry.

The issues of trust and sharing information raised questions about teacher isolation. I pondered the isolation many of these teachers experienced and how the interviews had served the important function of providing them with a place to communicate and share. Teacher isolation was an area of scholarly inquiry in this country and abroad since the 1980s, (see, for example, Drago-Severson & Pinto, 2006; Flinders, 1998; Lortie, 2002; Mawhinney, 2008; McCluskey et al., 2011; Porter & Brophy, 1988; Zeichner, 1993). Flinders (1988) noted that teaching was a lonely profession because there were not many opportunities for teachers to discuss their experiences and perspectives with other adults in the school building. In some cases, teachers had opportunities to connect with one another, but as Flinders (1988) reported, teachers felt the need to engage in self-imposed isolation as "an adaptive strategy" (p. 25) to cope with the demands of teaching itself. Similarly, Porter and Brophy (1988) noted that the various demands on teachers during any given school day "preclude[d] time for serious reflection, so that it [was] easy for them to drift in and out…without being very aware" (p. 82) of what was going on

around them and how their own experiences and perspectives compared to their colleagues. Even in cases where participants appeared to have healthy, functioning relationships with other adults in the school building, instructional and administrative demands prevented them from serious frequent discussion of critical issues like HIV/AIDS.

Zeichner (1993) argued that one result of isolation was that "teachers come to see their problems as their own…which directs the attention of teachers away from a critical analysis of schools…to a preoccupation with their own individual failures" (p. 9). Several participants reported feeling like they were reprimanded, called out, or even accused of things that they felt were unwarranted. It was possible that these feelings were largely fueled by the isolation that they experienced day-to-day in the school buildings. Perhaps if they were not so isolated, they might have felt like criticisms were not so personal. Given the numerous incidents participants reported of challenging and troublesome events, it seemed especially important for teachers to have opportunities to connect with one another to decrease feelings of personal failure and see challenges and struggles as school-wide, community-wide, or even global issues.

Limitations of the Study

As with any study, this one had limitations that should be discussed here. Since this was a qualitative study, there were inherent limitations to generalizability (Mertens, 2005). My study only spoke to the individual experiences and perspectives of the study participants, and even then the findings only represented their versions of events. As a qualitative researcher, I was working with individuals who had their own biases, motivations, and interpretations of events. Prior to beginning the study, I came to terms with the fact that I was only going to be privy to participants' interpretation of events and their unique recollections. An additional limitation of this study was related to the scope of the study itself. While I was able to conduct interviews

with 11 individuals, the study did not have a wide scope. In other words, this study was not a comprehensive survey of all teachers or the entire range of professional experiences and perspectives. The findings of the study represented one piece of a very complex, highly variable puzzle and should not be misinterpreted to stand for all teachers in all places in all situations and are not generalizeable to other situations. However, my findings were an interesting match with many findings in international literature, which provided local counterparts of universal issues. If I had not included the international component to this study, that additional layer of implications would have been lost. The makeup of the sample created limitations to the overall study. Because they hailed from relatively similar upbringings and backgrounds, some of the participants had similar experiences and perspectives related to HIV/AIDS. Although I interviewed teachers from a range of settings, including rural, urban, and suburban schools, many of the teachers were trained at the same institutions. This accounted for the fact that many of their responses when questioned about the HIV/AIDS training they received on a pre-service level may were quite similar.

In reflecting on my study, I learned several lessons about methodology, theoretical perspectives, and my own predispositions and emotional reactions. Methodologically, I learned that interview questions must be carefully constructed in order to elicit honest responses from participants. Upon reflection, at least one of my interview questions (#8) was poorly designed and yielded responses that seemed to lack honesty (see Appendix B for Interview Guide). I also learned that certain locations, like coffee shops, were inappropriate for conducting interviews. In future interviews, even if participants choose public places, I will need to suggest an alternative in order to protect the privacy of the interviewee and the integrity of the interview session.

Prior to conducting interviews, I believed that critical theory would be a primary theoretical influence in this study. However, comparative perspective turned out to be the primary theoretical influence for this study. As I conducted interviews, I often found myself making connections to international scholarly literature. Developing these connections and examining universal issues was an important part of my data analysis, and I realized towards the end of the process that comparative perspective had been extremely helpful in shaping my understanding of how my findings fit into the broader landscape of teachers' experiences and perspectives related to HIV/AIDS. Finally, I learned a great deal about my own predispositions and emotional reactions. After writing the initial draft of the dissertation, I realized that my own reactions to the data were overly influential. Given my longtime interest and personal connection to HIV/AIDS, as mentioned in Chapter One, it was important for me to make a stronger effort to reduce the influence of my emotions for future drafts. In the future, I will continue to work towards maintaining an academic tone and decreasing the intrusion of my personal reactions in the research process.

Having completed my study, I recognize three main issues. The first was the lack of discussion in interviews about the impact of the HIV/AIDS pandemic on the teaching force. As noted in Chapter Two, the teaching force in many international countries has been severely impacted by the HIV/AIDS pandemic (see, for example, Bennell, 2003; Bolder & Archer, 2008; Hunter, 2003; South African Institute of Race Relations, 2006; Theron, 2007). Although I have no idea whether this type of finding would have emerged because of restrictions placed by IRB that limited participants' responses to professional experiences and perspectives, it is important to note that no participant directly or indirectly mentioned the impact of HIV/AIDS on the teaching force. Similarly, the literature from the United States that I surveyed did not emphasize

the impact of HIV/AIDS on the teaching force in the same way that it was emphasized in international scholarly literature. This may be because HIV/AIDS is not as widespread and has not impacted the general population in the same way it has a country like South Africa. However, given the overlaps between the majority of my findings and those in international scholarly literature, this one area of incongruence may serve as important warning for a country like the United States in terms of recognizing the devastating impact HIV/AIDS can have on entire sectors, such as the teaching force.

The second issue that emerged was the importance of including comparative insights. I was surprised to see the large number of similarities between my findings and the findings of other researchers in international contexts. These overlaps underscored the truly universal nature of the HIV/AIDS pandemic, and it was fascinating to see the words of my participants echoed in scholarly research from countries like South Africa, Thailand, and Uganda. These overlaps also pointed to the importance of including international insights in a study such as this one. Given the fact that HIV/AIDS is a global issue, if I had failed to include a comparative component, I would have lost a critical and interesting element of this study.

The third issue that is important to recognize is the additional, related issues that emerged from interviews. I never would have expected that a participant would have told me about dealing with suspected pregnancy among fifth graders or administering enemas to students. This set of data were shocking and became significant because they revealed the extreme types of issues teachers were asked to deal with on a daily basis. These findings also put HIV/AIDS in perspective and made me realize that HIV/AIDS is only one issue in a range of many sensitive challenges that teachers are asked to negotiate.

Directions for Future Research

This study inspired me to engage in several additional threads of inquiry. In terms of this body of research, I would be interested in developing more in-depth single case studies with select participants who seemed to provide a rich set of experiences and perspectives related to HIV/AIDS and the classroom. Conducting additional interviews over an extended period of time, as well as conducting classroom observations, would be beneficial in terms of providing a more in-depth view of these teachers' professional experiences and perspectives related to HIV/AIDS and the classroom. I am also interested in interviewing administrators, counselors, and nurses in order to gain additional insights into HIV/AIDS related challenges and struggles that exist in schools. I became interested in the additional, related issues that emerged from the study, such as gay students, pregnant students, and abused students. I would be interested in conducting further research into how teachers were able to manage these special situations, given the fact that they were already overburdened by curricular and administrative demands and had very little support from other teachers or administrators. Finally, I am interested in conducting further research into teacher isolation and how participants make sense of and rationalize the isolation they feel on a day-to-day basis. This study provided important insights into teachers' professional experiences and perspectives related to HIV/AIDS and the classroom. Taken in conjunction with the experiences and perspectives reported by other researchers in international scholarly literature, this study revealed that teachers across cultures face a range of similar challenges and struggles in the face of HIV/AIDS, which are critical to examine given the stronghold HIV/AIDS continues to have worldwide.

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APPENDIX A

Objectives and Research Questions

Research Question	Objectives
What are selected teachers' experiences and perspectives on issues related to HIV/AIDS in the classroom?	To understand and describe selected teachers' professional experiences and perspectives on issues related to HIV/AIDS in the classroom;
How do selected teachers' professional experiences and perspectives illuminate broader challenges and struggles associated with the impact of the HIV/AIDS pandemic for teachers?	To understand these selected teachers' professional experiences and perspectives in terms of the broader challenges and struggles teachers face in the classroom in terms of HIV/AIDS
How do these selected teachers' professional experiences and perspectives compare to the experiences and perspectives of teachers in other countries and reveal universal issues related to HIV/AIDS and the classroom?	To draw on international HIV/AIDS education research in order to compare the experiences and perspectives of participants in this study with teachers in other countries, as reported by other researchers in scholarly literature.

APPENDIX B

Interview Protocol

<u>Introductory Script:</u>

Thank you for agreeing to be interviewed for my doctoral study. I appreciate your participation. The purpose of this study is to explore selected teachers' professional experiences with HIV/AIDS in the classroom and to create to a collection of teacher portraits that illuminate realities associated with the impact of the HIV/AIDS pandemic for selected classroom teachers. These experiences may include teaching about HIV/AIDS, instructing students who are living with HIV/AIDS or who are affected by a family member or friend's seropositive status, health, safety, and confidentiality concerns, dealing with shame, stigma, stereotypes, and misinformation associated with HIV/AIDS, grappling with personal feelings about death, dying, homosexuality, and teacher training issues related to HIV/AIDS. Although the United States will be the primary context for this study, I intend to include comparative insights that will illuminate broader realities associated with teachers' experiences with HIV/AIDS in the classroom. I would like to emphasize that I am only interested in your professional experiences. Please do not disclose your own HIV/AIDS status to me. Please do not disclose others' HIV/AIDS status to me. Finally, please do not share any identifying information about your students, administrators, co-workers, or other school personnel, which could include names, titles, or identifiable demographic information.

I want to assure you that all of your personal information will be kept confidential, and I will not use your name. I have assigned you a numerical code. Only I have a copy of the code key, and that key is kept in a secret and secured location. I also want to assure you that you can stop any line of questioning should you feel uncomfortable. You are also free to end the interview at any time. At any point during or after this interview process, you can withdraw your participation. All of your interview and observation data would then be destroyed.

I would like to audio-record this interview. I will transcribe the interview, and, if you like, I can send you a copy of the transcription to review and keep for your personal records. If you prefer not to be audio-recorded, please let me know now. You are also free to answer questions "off the record" if that makes you more comfortable at any point during this interview. Do you have any questions? Are you comfortable continuing with this interview? Please sign this consent form, and then we will begin the interview.

Interview Guide:

Give participant consent form to review and sign.

Thank you again for speaking with me today. To begin, please tell me your name, the number of years you have been teaching, your current professional position, including the subject and grade level you teach, and a brief description of the school where you are employed. (Rural/urban/suburban; private/public)

1. Briefly tell me about your training to become a teacher. (B.S.Ed. or B.A? Graduate work?)
2. Looking back on your teacher training program, tell me about how sexuality education or HIV/AIDS education was addressed?
3. Professionally, how important was the issue of HIV/AIDS to you before you began teaching?
4. In your current position as an educator, how important is the issue of HIV/AIDS to you?
5. To what extent (if any) is HIV/AIDS addressed in faculty workshops or in-service training programs?
5. Tell me about instances, if any, where HIV/AIDS has been an issue in the classroom.
6. Tell me about times, if any, where issues like death, illness, or homosexuality have arisen in your classroom?
7. In your current position, share with me episodes where you have witnessed shame, stigma, or misinformation related to HIV/AIDS?
8. How would you characterize your opinion of people with HIV/AIDS?
9. Is there anything that I haven't asked you that you would like to tell me about?

Give participant debriefing statement.

<u>Debriefing Statement</u>

That concludes our interview. Again, I want to thank you for participating in this study. Please review the consent form now and let me know if you have any questions. If you are agreeable, I may need to contact you at some point to clarify things or ask follow-up questions. I will transcribe selected portions of this interview in the next few weeks, and I would like to conduct a "member check" with you so that you can look over the transcript and my interpretation of your words. You can explain, modify, adjust, or provide alternative interpretations of the materials that I send you. Finally, when I have completed my doctoral study, I will provide you with a copy of the findings if you would like. If you have any questions about the interview, my study, or the next steps, I would be happy to answer them for you now. If you think of any questions in the future, please contact me at 404-316-8357.

APPENDIX C

Reconsent Phone Call Script

Hello! This is Mary Michael Pontzer; I interviewed you this spring about your professional experiences with HIV/AIDS in the classroom. I really enjoyed the interview, and I appreciate you taking the time to talk to me.

We talked about many interesting issues related to HIV/AIDS, but you also told me some related, additional information about issues related to sex and sexuality in general.

I just want to make sure that I can use the additional, related information in my study. I want to remind you that all individually-identifiable information is kept entirely confidential unless required by law. In addition, I wanted to let you know that I will destroy the audio recording of our interview after the dissertation is complete.

If you need a chance to think about it, that is fine. Do you have any questions about this study or your participation?

Thank you again for your time and participation!

APPENDIX D

Sample Field Notes Chart

Interview Question	Response	Memos/OC/Etc.
Demographic Data	2.5 years teaching K12, 2 years as TA on Univ. level; Current HS: low income, high minority, title 1 (70-80% AFAM, 15-20% Latino); MS: White, Middle Class (Same MS as ____)	Compare details with ___--why the difference?
Training	BSEd in ___, MED in ____, PhD in progress in _____	
HA, Sex in T. Training Prog.	Never addressed in MEd—not even on "radar" MEd program—didn't address sexuality, but is addressed in _____electives (sexuality presented as an aspect of diversity, HIV/AIDS in other countries)	See _____, _____, _____ who also said "radar" Maybe this is a "safe" way to deal with HIV/AIDS in colleges of education???
Imp. Of HA before began teaching		Already answered in previous question when said that HIV/AIDS not on radar…did not feel need to re-ask
Imp. Of HA now	Day to day not on "radar" (But sensitive to gender, sexuality, protection, promiscuity—students talk about sex in front of teachers—something everyone does, no one concerned about risks) _____ flyers—some teachers didn't distribute because saw as waste of	Again, "radar" Amazing, given the high teen pregnancy rates;

	time, hassle—figured kids would just litter floor—many teachers left the flyers in their mailboxes or put in trash	similar to teachers in South Africa…this is really aggravating. And selfish on the part of the teachers!
Fac. Workshops, In Service	Universal Precautions posters in mailroom—nurse presents about UP at beginning of year—at _____. no discussion of UP; no first aid kit, ___ not aware of any protocol to deal with blood	One of the few participants who didn't get a mini lecture from nurse…
HA in Classroom	World History—students always ask about HIV/AIDS a lot (How to get, safety of water fountain, how did HIV/AIDS happen, monkey bite? Sex with ape?)—many misconceptions, general myths, misconceptions about Africa in general 7th Grade Curriculum— "why don't they just use condoms" have a hard time understanding that there isn't just a simple fix	Interesting which myths persist. See also ____ and _____ who reported similar student questions
Death, Illness	Student killed himself her first year teaching—on purpose or to get high? People sobbing, ___ sobbing, idealization of student, memorializing; faculty concerned about copycats; 1 grief counselor came to talk to students; "had to soldier on" (return to normalcy)—no support for teachers, counseling not widely publicized; difficult to handle as both	Maintaining status-quo…who benefits from such a response? Certainly not students or staff!

	a teacher and a person— still traumatized by funeral Father of student killed, 2 st. with chronically ill parents St. with _____ (504 plan)	
Homosexuality	Both schools hostile towards LGBT community (faculty at ____don't like minorities in general) Female student said to a male student "you gay motherfucker"—___ called into hall to reprimand, told student was a hate crime Student approached ___ and asked if another teacher was "straight or curvy"___ asked why mattered Teacher said to ___ "I have this faggot in my class" when discussing an out male student who was flamboyant; As a MS teacher, the adopted male son of a gay couple came out, but some thought for attention; Student at ____approached ___ about sponsoring gay-straight alliance Teacher at HS who is a famous drag queen— don't confirm to st. Faculty accepts gay teachers for the most part; "you're so gay" more common insult at ____—	Wow—shocking re: minorities, although well-documented in literature. Certainly not unique, but also very distressing knowing the makeup of the school. Interesting the way students discuss homosexuality This is so upsetting. Compare to response of other teachers to gay students. See ___ & _____ especially. See ____, this is very different from account

	"you're so retarded" more common at _____	
Shame, Stigma, Misinformation	When taught middle school, students grappled with link between homosexuality and HA—misconceptions bred by parents; student knew better than to say negative things in front of ____	Influence of parents—see ___
Opinion of PLWA	Other teachers would have tremendous fears, jump to worst case scenarios, would wonder about transmission (MTCT?)—especially with minority students, the treatment on the part of teachers would be more severe/negative—student would have similar response to teachers, but magnified; -____ would have some fear of contracting (even though knows that not possible, would not want to drink out of water fountain after student), would wonder if student was infected thru unprotected sex; In minds of some adults—mode of transmission would make a difference as far as how much sympathy they would have—more sympathetic to female b/c of stigma of being gay attached to males; other t. may lay blame and see as fault of student (shaming is seen with pregnant student—teachers speak	Layering of stigma—very compelling to see this here ____ seemed very honest and earnest here—almost emotional. See also ___, ____, ____, ____ who said very similar things

	about the on campus day care in a derogatory way)	
Other	Over 12 girls currently pregnant 12-40 have children (not including drop outs)—no sensitivity training for t.	Very hard to control emotions—this is much worse than I would have imagined

APPENDIX E

List of Categories and Codes from Fieldwork Journal

AFRICA 7 AFR

MOTHER/NURTURER 8 MOM

How Transmitted 13 HOW

Blood/UP 15 UP

Fear of upsetting PARENTS/ADMIN 10 FEAR

SYMPATHY & METHOD OF TRANS 14 TRA

"GAY DISEASE" 5 GD

SWEPT UNDER RUG 4 RUG

"NOT AN ISSUE" 15 NON

CONFID. CONCERNS 8 CONF

STIGMATIZATION 13 STIG

PREGNANCY/SEX 7 PREG

HOMOSEXUALITY 13 HOM

Time CONSTRAINTS 1 TIME

ADMINISTRATION 9 ADM

CONTRACTING 5 CON

OTHER EXTREME SITUATIONS 9 OH

APPENDIX F

Coded Field Notes Chart

Interview Question	Response	
Demographic Data	2.5 years teaching K12, 2 years as TA on Univ. level; Current HS: low income, high minority, title 1 (70-80% AFAM, 15-20% Latino); MS: White, Middle Class (Same MS as ____)	
Training	**BSEd in ___, MEd in ____, PhD in progress in ____**	
HA, Sex in T. Training Prog.	**Never addressed in MEd**—not even on "radar" **MEd program**—didn't address sexuality, but is addressed in ____**electives** (sexuality presented as an aspect of diversity, HIV/AIDS in other countries)	NUN
Imp. Of HA before began teaching		
Imp. Of HA now	Day to day not on "radar" (But sensitive to gender, sexuality, protection, promiscuity—students talk about sex in front of teachers—something everyone does, no one concerned about risks) _____ flyers—some teachers didn't distribute because saw as waste of time, hassle—figured kids would just litter floor—many teachers left the flyers in their mailboxes or put in trash	NUN
Fac. Workshops, In Service	Universal Precautions posters in mailroom—nurse presents about UP at beginning of year—at _____. no discussion of UP; no first aid kit,	UP

	___ not aware of any protocol to deal with blood
HA in Classroom	World History—students always ask about **HIV/AIDS** a lot (How to get, safety of water fountain, how did **HIV/AIDS** happen, monkey bite? Sex with ape?)—many misconceptions, general myths, misconceptions about Africa in general 7th Grade Curriculum—"why don't they just use condoms" have a hard time understanding that there isn't just a simple fix
Death, Illness	Student killed himself her first year teaching—on purpose or to get high? People sobbing, ___ sobbing, idealization of student, memorializing; faculty concerned about copycats; 1 grief counselor came to talk to students; "had to soldier on" (return to normalcy)—no support for teachers, counseling not widely publicized; difficult to handle as both a teacher and a person—still traumatized by funeral Father of student killed, 2 st. with chronically ill parents St. with _____ (504 plan)
Homosexuality	Both schools hostile towards LGBT community (faculty at

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Other	Over 12 girls currently pregnant 12-40 have children (not including drop outs)—no sensitivity training for t.

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APPENDIX G

Coded Interview Transcript

MMP: Briefly tell me about your training to become a teacher. (B.S.Ed. or B.A? Graduate work?)

Participant: It is not something I think was ever addressed—ever—in my master's program. It was never brought up. It was not something that was on my radar, not typically a high likelihood you'd have a student with HIV/AIDS.

NON

MMP: Looking back on your teacher training program, tell me about how sexuality education or HIV/AIDS education was addressed?

Participant: Sexuality as an aspect of diversity was brought up. HA was brought up in the context of other regions of the world, but never brought up in the context of American schools.

AFR

MMP: In your current position as an educator, how important is the issue of HIV/AIDS to you?

Participant: To my knowledge, I don't have any students with HA and there are none at my school that I'm aware of. In terms of day to day importance, it isn't on the radar. But I think greater sensitivity to issues of gender and sexuality, in that sense, protection and promiscuity are an issue.

PREG

MMP: Do students talk to you directly about being promiscuous?

Participant: Sometimes students talk to me specifically about it. Most often, they talk to each other in the classroom and they don't care who hears it. "If he wants me to suck his dick, he'll have to go down on me first…so and so is doing so and so, but she got caught with so and so." Sex is portrayed by students as something everyone engages in and no one seems concerned about potential long-term or short term risks.

SEX/ PREG

MMP: Is there some sort of sex ed program at the school?

Participant: There is some general sex education through the health courses, and we give out free condoms, but you have to go and ask for them, so I think that's a deterrent. There's a [family planning] facility. Just last week, we were asked to distribute flyers…the flyers are given to all of the teachers, I'd be surprised if any of the teachers really actually distribute them. They're in everybody's boxes. I saw a lot in the trash can

or the recycling bin. The impression that I get from other t is that it's a waste of time, they're just going to ball it up. One more thing I need to do that isn't going to matter anyway. Seen as unnecessary or burdensome. Most of the students crumpled up, threw in recycling bins, asked me to write a bathroom pass on the back. If it helps one kid, then I feel like its worth having to pick them all up off the floor for an hour afterwards. No training, no sensitivity training, it's an unspoken reality in many cases. We have this head start program, 5-8 babies, it's not a nursery in a typical sense, it's a daycare, but they do a lot of early education, it's basically a way to show nurture can overcome nature. You can break the cycle of teen pregnancy and poverty. The teachers speak of it very derogatorily. "Oh yeah, they nursery down the hall…" We have over 12 pregnant students, and even more students who have young children. There's no specific plan or training that's given to us.

MMP: To what extent (if any) is HIV/AIDS addressed in faculty workshops or in-service training programs?
Participant: The most that we have is a universal precautions poster that's stuck on the door leading out of the mailroom. At the very beginning of the year, the nurse did a thing on up, but not in terms of HIV/AIDS.

MMP: Tell me about instances, if any, where HIV/AIDS has been an issue in the classroom.

Participant: Students ask, "Can you get it from drinking out of a glass that someone has drunk out of?" What you think of as the general myths about AIDS, they're at least savvy enough to ask questions. There's a lot of misconceptions about Africa in general. I think it's a mixture, some of them are like, "Ok good," some are even a little skeptical…"I'm not going to do it just in case." Still in their mind they're connected. For the most part, they just seem interested to learn more about it. I've had instances where they've wanted to know "How did AIDS happen?" we've talked about some theories about how AIDS came to the human population—bites, bush meat—you have to deal with that….They ask, 'Well, why don't they just use condoms'. Well, it's not that simple. 'why can't they just find a cure.'

MMP: Have you ever taught a student living with HIV/AIDS? Or a student who has been impacted or affected?

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