

The Social Practice of AIDS Education

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The current legislature finds the Acquired Immune Deficiency Syndrome (AIDS) a threat to California. Since there is no current cure for AIDS or a vaccine, AIDS education is the most effective weapon to combat the epidemic.

—Governor Pete Wilson, *AIDS Prevention Strategies, California Legislature Select Committee on AIDS (1991:16)*

All public elementary, junior high, and high school classes that teach sex education or discuss sex shall emphasize that abstinence is the only 100% effective protection against pregnancy, STDs, and AIDS.

—Education Code § 8506.1, operative July 1, 1989. *Evaluation of California AIDS Community Education Program (1988:23)*

The current debates over AIDS education are some of the most alarming in the history of the AIDS epidemic because they will certainly result in many more thousands of deaths that could have been avoided.

—Douglas Crimp, *AIDS Activist (1989:256)*

In June of 1991 California Governor Pete Wilson approved legislation requiring all public elementary, junior high, and high schools to provide its students with “age appropriate course material about AIDS” (U.S. Public Health Service 1992:3). Certainly Wilson was not the first public official to propose that educational campaigns be implemented in order to prevent the spread of AIDS, nor was he unusual in presuming that education could be used in order to alter behavioral practices which lead to the transmission of disease. Historically, public health officials have often utilized educational approaches in order to check the spread of disease, however the California legislature’s subsequent sanction of required AIDS education marks the first time in California that public education has been proclaimed by law as *the* fundamental strategy by which the war on AIDS would be fought. One of the aims of this paper is to explore some of the unique meanings this strategy assumes and produces when applied to a terrain as complex and contested as AIDS.

The presence of the HIV virus and the various syndromes (AIDS, ARC, etc.) it is widely believed to cause, has significantly redefined certain aspects of sexuality as well as formally routinized sexual practices and the emotions which accompany them. The profound uncertainty and confusion surrounding the initial reportage of AIDS left room for multiple and fluid interpretations of how people might best protect themselves against the disease. However, as AIDS was moved painstakingly towards the realm of the *knowable*, public health

institutions such as the Center for Disease Control, and the National Institute of Public Health began to develop an historically and culturally situated understanding of how an individual might protect himself/herself against the emergent disease. The advancement of this knowledge produced conflicting suggestions about how people should protect themselves against AIDS. The inevitable result was a knowledge by all appearances incoherent and largely inappropriate. One of the consequences of this phenomenon was that discussions surrounding AIDS education began to rapidly condense and take the shape of a solidified discourse excluding what Foucault (Rabinow 1989:229) has termed *lesser knowledge*.

In 1994, this discourse on AIDS education codifies existing constructions of AIDS and demands that the meaning of AIDS be interpreted in a particular culturally constructed manner. The dialectical practice of AIDS education exists as a form of cultural control in student's lives inscribing and training their bodies in a specific manner, dictated by the authors of AIDS education texts.

It is my aim to locate AIDS education within a particular historical and cultural trajectory and further, to identify the ways in which AIDS education operates as a controlling process within American culture. Accordingly, I begin with a section on the history of sex education in order to make visible the ideologies and laws which have significantly contributed to the format of AIDS education. The following sections delineate both the social practices of high school level AIDS education, and student's responses to such education. I focus here on the specific context of my field research: Berkeley Public High School.

A fundamental element in this paper's construction was my belief that an anthropological examination of AIDS education would allow for the broadest possible inquiry into the meanings of AIDS education. As Paul Rabinow has observed, "a basic anthropological axiom is that the significance resides in the whole. A successful anthropological explanation therefore cannot eliminate either the historical (which also imply broad geographical dimensions), the cultural, the social (taken broadly), or most importantly their interconnections" (Rabinow 1975:98). It is precisely with this juncture (the point at which AIDS, education, Berkeley High school, and chaotic student lives collide) that I am most concerned. For it is here that the meanings of AIDS education may be first examined, contested, and re-configured.

Of Bacilli and Habits: the Origins of AIDS Education

"Truth" is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of statements.

Truth is linked in a circular relation with systems, and institutions of power which produce and sustain it, and to effects of power which it induces and which extends it. This can be called a "regime" of truth (Rabinow 1989:74).

In keeping with Foucault's understanding of the way in which truths are maintained and elaborated by particular systems of power, I begin this section with a discussion of the institutions whose productions of truth were instrumental to the establishment of sex education in the United States. Further, I want to propose that the statements generated by sex education

have forged authoritative conceptions of sexuality, gender and moral bodies whose collective resonance can still be felt today. The powerful effects of these formations are located in the key role they have played in the construction of AIDS education.

In 1897, a special commemorative speech was given at the Boston Physician's Annual Meeting which trumpeted the remarkable achievements in medicine throughout the prior sixty years. The keynote speaker marked the discovery of the micro-organic cause of disease and its mode of transmission as the greatest advance in medical history, opening up a domain which "...to the minds of our immediate ancestors seemed almost outside of the knowable" (Mort 1987:63). Certain transformations within the medical domain had, of course, provided the theoretical conditions for this perceived advance. For example, the gradual acceptance of germ theory, following the research of Louis Pasteur, resulted in a rapid isolation of the bacilli present in all major non-viral infectious diseases. Integral to Pasteur's research was an investigation of how the healthy body provided its own defenses against infectious invasions by developing anti-toxins. This knowledge helped produce a concept of the body that is now seen as the site of health and disease. Physicians became increasingly focused on the internal chemistry of the individual, identifying a patient's body as capable of generating both infectious diseases and healthy practices. The original concept of the environmental setting of a disease was assigned a more personal meaning concerned with the life history of the patient. The medicalizing scrutiny of the individual and his/her role as an agent in the maintenance of health or transmission of disease formed a central tenant of medical discourse in the early 20th century (Mort 1987:65).

At the level of policy implementation, there was a growing ambition among physicians to design a program of health education which demonstrated the new scientific concepts derived from recent medical knowledge. Now that the body was viewed as the locus of health and disease, it was reasonable to assume that the habits an individual pursued in taking care of their body would have a substantial effect on their health. A particularly dramatic example of this can be seen in the outbreak of sexually transmitted diseases which occurred in the early 20th century. It was argued that the prevention of such disease could be facilitated or impaired by habits maintained by the individual. The logical question to be addressed by existing governmental health agencies was how were they going to ensure that an individual acquired the correct habits? Specifically, health agencies had a vested interest in generating habits that would keep individuals healthy thereby promoting the collective security and wealth of a nation. After a decade of indecisiveness it was decided that sex education promised the best assurance of regulating sexual habits and behaviors.

The growing hegemony of health education was secured, in part, by the disastrous outbreaks of syphilis among members of the U.S. Army during World War I which helped to brush aside traditionally prudish attitudes toward sex and venereal disease control (Mort 1987:71). In 1920 the federal government formally announced its interest in introducing sex instruction to public schools. Soon after the Bureau of Education recommended that sexual education be used to prevent the spread venereal disease and for ensuring that boys and girls be taught to understand and control their sexual impulses. In response to this recommendation, Thomas Parren, the Surgeon General for U.S. Public Health Services, asserted that

sex education must include all instruction and training that will help form normal and wholesome attitudes in relation to sex. Sex education must not seek to create or awaken interest in sexual behavior, but merely satisfy that which spontaneously arises (U.S. Public Health Service & U.S. Bureau of Education, 1927:33).

The increasing readiness on the part of schools and educators to provide sex education reflected a growing acknowledgment on the part of the educational system that they could no longer just teach reading, writing, and arithmetic. The role of the school was changing and in order to produce "responsible citizens," the availability of a more comprehensive education became essential. In this context sex education functions as a social practice whose task is to indoctrinate a body with the requisite attitudes and sense of responsibilities in order to assure the mental and physical health of a nation.

The U.S. Public Health Service was the institution primarily involved in producing educational material and setting the tone for sex education courses. Every year they sent out a new instruction book designed to inform teachers what they should be teaching their students. The 1934 edition of *Sex Education in Schools*, prefaced its text with the following message:

We must seek to eliminate all sex evils that threaten us and build up a system of sex education that will help us produce the manhood and womanhood we desire. This is an extremely difficult task which must be attended to with great care (U.S. Public Health Service 1934:2)

Public Health campaigns of the 1920's were primarily concerned with eliminating venereal diseases such as syphilis and gonorrhea. The Surgeon General produced and circulated pamphlets about venereal disease which attempted to arouse fear among young men considering pre-marital sexual intercourse. One pamphlet reads:

Manpower is the thing most needed today. We must keep our supply at full capacity. In order to do so, men must avoid venereal disease. Practically all prostitutes and many girls who permit men to have sexual relations with them before they are married, have one or more venereal diseases. Many of them are feeble minded (U.S. Public Health Service 1934:23).

In this pamphlet, the Surgeon General identified a risk group (prostitutes and "loose women") and proposed that our country's security is predicated on preventing the male population from coming into intimate contact with that risk group. Furthermore, because the women are assumed to be "diseased and feeble minded," it is the men who must be taught to "keep themselves clean." In the following chapter the manual outlines one of the main responsibilities of the teacher.

Teachers should constantly be on the lookout for abnormal behavior among their students. Teachers are the most likely to recognize and categorize this behavior, as parents might maintain a more biased impression of their children. Those students whose behavior seems to deviate from the norm should be sent to the school psychiatrist (U.S. Public Health Service 1934:25).

This passage makes explicit reference to the normalizing hierarchies operating within the manual's text. First, a standard of normal behavior is outlined. Subsequently, teachers are privileged over parents as the agents responsible for the recognition of abnormal behavioral patterns, and psychiatrists are deemed as the appropriate authority to cope with such behavior. By placing individuals into this hierarchy, a parent's understanding of their children is dismissed as amateur and inconsequential. Instruction and understanding from outside becomes privileged knowledge.

Although sex education has been vigorously contested, courts have consistently ruled that school boards possess discretionary authority within state constitutional and legislative limits to incorporate sex education into the educational curriculum. Under the Tenth Amendment the Constitution grants states all powers not specifically delegated to federal government. Accordingly, states exercise plenary power over public education which is, in turn, vested in local communities and their school boards. Because sex education received legal sanction and status as a social practice it has necessarily become a productively effective force in our culture. One of the results of this power can be found in the influence of the established claims of sex education on the construction of AIDS education.

AIDS Education: Theories of Prevention

Between 1987 and 1988 twenty-nine states and the District of Columbia passed legislation mandating AIDS education (Haffner 1989:201). The ease with which these policies were passed is particularly striking given that prior to 1987 only three states had passed laws enacting sex education. As AIDS educator Debra Haffner notes, "The push to teach students how to prevent AIDS has changed not only the number of high schools offering sex education but has significantly altered the practice of traditional sex education" (1989:199). A recent review of statutes regarding the enactment of sex education, conducted by the Center for Disease Control (CDC), indicates that as many as 60% of all schools offering prevention programs advocate spending only "one hour per semester on AIDS education" (Haffner 1989:202). Out of eighteen programs reviewed by the CDC, 70% of these programs focus primarily on biomedical information and do not promote much less specify the development of behavioral change (Haffner 1989:203).

The underlying assumption of these prevention programs which center on biomedical information, is that technical facts alone will give rise to and encourage behavioral changes. These strategies are intended to be empowering; they are designed to provide students with the basic facts on AIDS and assume that the student can be trusted to absorb, extrapolate from, and act on the information provided. In some sense, this can be seen as a move away from early sex education which explicitly awarded individuals such as doctors and, to a lesser extent, teachers the authority to know, speak, and disseminate facts on sexuality. Information from a privileged authority was required and there were certainly no manuals or 800 numbers that could be perceived as distinct from or originating outside of a legitimated and accepted institution, such as a school or a government agency.

Information about AIDS has been democratized and made public to the extent that students are considered capable of assimilating the facts and reaching appropriate decisions

beyond the context of school. There is, however, undoubtedly a danger in presenting students solely with what are represented as the undisputed biomedical facts of AIDS and assuming that these facts will result in the desired behavioral changes. Other forms of information must be provided for students as well, such as what activities they can engage in without risking transmission of the HIV virus, where condoms can be bought and how they should be used, and how they might communicate with their boy/girl friend about wanting to practice safe sex. The omission of such crucial information has led to the current situation; while "most of the general public knows they cannot get AIDS from a door handle, few young people take the necessary precautions to prevent the transmission of the HIV virus" (Haffner 1989:34).

Other AIDS education programs are designed solely to warn students about the dangers of sex and advise abstinence from all sexual activity. Half of the programs surveyed by the CDC emphasized the dangers of "intimate contact" with high risk groups such as homosexuals and IV drug users and ultimately cautioned against the activity of sex altogether (Haffner 1989:202). Only 20% of the programs mentioned that sex between uninfected partners could not spread disease (Haffner 1989:34).

This emphasis on discouraging sexual activity is strikingly reminiscent of early education campaigns against syphilis and gonorrhea. In both campaigns fear is used as a constructive tool designed to manage what is perceived as an unruly teenage sexuality. Associating sex with danger circulates both fear and awe of the act itself. It effectively negates the possibility of using sexuality as a space within which to construct a positive identity. Moreover, it makes speaking positively about sex in public taboo, which means that AIDS prevention campaigns are forced to rely solely on distributing the represented biomedical and moral facts.

Another holdover from early sex education courses that found in AIDS education programs is the use of risk group terminology. In both instances the prevention strategies relied on by authorities identifies a population which is deemed at risk and then warns the general population about the dangers of interacting with the population at risk. The bodies of prostitutes, "loose women," homosexuals, and IV drug users are constructed as polluted, immoral, and intrinsically host to disease. A sexually transmitted disease is not explicitly asserted to infect through specifically identifiable acts. Nor does the practice of identifying risk groups maintain that it is through the unprotected engagement in certain acts, and not the interaction with a given group of people, that puts one at risk for contracting HIV.

The connection between disease and morality inherent in the concept of risk groups lies at the heart of many government funded AIDS education campaigns. For instance, in January of 1992, Berkeley High School received a Sexuality Education Manual from the Surgeon General, touted as including the latest information on AIDS education. In the hope of "preventing the spread of AIDS" the Surgeon General advised teachers to teach their students "five key elements" to prevention: seek a mutually faithful relationship with one partner, limit the number of sexual partners you have, do not have intercourse with anyone who has had many sexual partners, do not have oral or anal intercourse, and talk with the person you're seeing about his or her previous relationships (Merki 1988:37).

Not only does this type of pedagogy rely on the remarkable belief that people will tell the truth about their past relationships, underlying it is the notion that as long as an individual maintains a monogamous heterosexual relationship, they will remain free from the threat of AIDS. The morality discourse which has informed sex education since its inception, has significantly shaped AIDS education, to the extent that many prevention campaigns rely on moral counsel as opposed to offering concrete suggestions as to what behavioral practices will prevent infection with the HIV virus.

By 1991, the Center for Disease Control had given notice that it intended to remove the prohibition against material that might be interpreted as “promot[ing] or encourag[ing] IV drug use or sex” (Merki 1988:37). However, Gary Nobel, CDC’s director at that time, went on to say that taxpayers’ money would not be used in order to tell people how to “do something offensive to the general community” (Merki 1988:37). Here, “offensive” can be read as any activities other than those believed to be practiced by monogamous (preferably married) heterosexuals. As the Surgeon General’s teachers manual makes clear, the primary interest lies in promoting this redemptive act, and not in preventing the spread of AIDS. This rhetoric continues to indoctrinate the most basic educational prevention campaigns. It is left to the discretion of the teacher to design and implement comprehensive course material which will compensate for omissions and biases inherent in mainstream prevention education.

The current California Legislature has identified AIDS Awareness as a primary concern. Commencing in the 1992–1993 school year, school districts are now required to ensure that grades 7–12 receive AIDS prevention material (Merki 1988:29). This material must be presented at least once in junior high and again in high school. The material must accurately reflect the latest information and recommendations from the U.S. Surgeon General, the Center for Disease Control, and the National Academy of Sciences.

It is these institutions then, with their particular histories, that are responsible for producing, regulating, and distributing the norms of AIDS education. Consequently, these represented truths are transformed into distinct practices of AIDS education through the actions of students, teachers, and administrators. In order to understand how these practices operate in students’ everyday lives, we must first examine the practice of AIDS education within the specific context of Berkeley High School.

Precise Locations: Berkeley Public High School

The Berkeley Unified High School has a total population of approximately 2,600 students. It is the only public high school in Berkeley; its population and character largely reflect the economically and ethnically diverse makeup of the city of Berkeley. In 1992, out of the 2,622 students who were in attendance at the school, 42% were African American, 40% were Caucasian, 11% were Asian American, 9% were Hispanic, and 4% were of another ethnicity. There are more than 80 languages spoken on the campus on any given day (Berkeley Public High School Census 1991:15).

Through this vast, energetic and truly diverse community I made my way once a week to the site of my own research; room B 142, a class where among other things, *Social*

Living is taught. *Social Living* is a nine week, co-educational course in family life and health education. The course's subject matter includes the development of sexual identity, child birth, birth control, sexually transmitted diseases, AIDS, implications of drug use, and personal values. The format of the course has been designed by its sole teacher, Nancy Rubin, who is primarily concerned with disseminating what she regards as critical information and giving students the opportunity to talk with each other and herself about matters which are of concern to them. Nancy began teaching *Social Living* in 1974. Since that time, her radical reshaping of both the form and content of the course has won both district and parental approval. She is the recipient of numerous teaching awards, bestowed upon her for developing innovative teaching techniques and for her personal commitment to the students.

Much of Nancy's success as a teacher stems from her ability to interact with students on "their level." Many students treat her as they would a counselor, a pastor, or even a friend. She is considered "hip" by her students and regarded as sensitive to what they, as teenagers, are experiencing. However, in order to preserve the status which her students have accorded her she must adopt an attitude that does not appear judgmental of her students' behavior. As students' lives become, in her words, "increasingly chaotic, full of violence, and more and more aggravated by the social ills around them," she, as their "hip and cool" teacher, must maintain an unflappable and accepting position towards the issues her students bring to class. Nancy notes:

I can't be too appalled by what my students say, otherwise they lose respect for me, they'll think I'm out of it. After all this is Berkeley, my students are very advanced for their age in terms of what they have experienced, and everyone knows...that a lot of students have already had sex by the time they get to my class for "sex education."

This quote and the preceding text are intended to convey the distinctiveness of both the high school I investigated and the teacher responsible for AIDS education (and by implication the course material itself). Berkeley High School, while undoubtedly sharing certain characteristics with high schools across the country, nevertheless offered a relatively unique milieu in which to examine AIDS education.

Assuming Unaccustomed Forms

Did you hear about what happened this morning?

No, what?

There was a knifing on the second floor, and there's still blood on some of the lockers.

The janitors seem to find a thousand things to do, other than keep the school clean, I remember when the whole school was supposed to get new desks, and it turned out the ones that had been ordered were sitting in some storage room for three months before the janitors got around to unpacking them.

Not interested in the idiosyncrasies of Berkeley High's janitors, I tried to steer the conversation back to the seemingly more significant event, "Was anybody hurt in the fight?" I asked.

I don't think so but one student was suspended.

This conversation took place in the teacher's cafeteria, where after my first day of participant observation I joined Nancy and Ellen, another staff member, for lunch. I recount the story here because it was my first experience at Berkeley High in which an occurrence that was to me extraordinary, tragic, and anomalous was dismissed as an every day event. There was not a single time that I met with Nancy wherein our conversation was not prefaced by some form of, "You won't believe what happened today." These stories would range in content from the coincidence of three students confiding in her that they were pregnant, to students who wanted to get out of gangs in which they had become involved, to the physical violence that pervaded Berkeley High Students lives. I quickly learned that the staff and students of Berkeley High regard the extraordinary as unexceptional and routine.

What happens when disorder, tragedy, and irresponsibility become normalized as the lived experience of students and teachers is a fundamental question; both in order to provide the background to my classroom observations and also in the consideration of what AIDS education means in the lives of these students. Using a condom and having safe sex in order keep yourself healthy over an extended period of time is a piece of advice which will have significantly less meaning to the student who feels her life is in danger as a matter of course, for whom uncertainty and irrationality act as constant forces, and for whom the body is not something that can be controlled and negotiated but whose destiny—like the rest of life—is left to the discretion of others.

I cannot attest to the individual lived experiences of these students, but as I have tried to make clear the students of Berkeley High come from a variety of ethnic, class and geographic backgrounds, not all of whom recognize disorder as one of the primary forces in their lives. Instead, what I am attempting to do is to graphically depict one of many possible atmospheres in which AIDS education is conducted. With this, at least, tentatively in place I begin my examination of the practices that are used at Berkeley High to educate students about AIDS.

Room B 142, is the setting in which *Social Living* is taught during the six periods of every school day. Though average in size, this classroom is a far cry from an ordinary school room. Posters cover every inch of the walls; rock album covers, art posters, movie stills, AIDS awareness posters, and photographs which graphically celebrate homosexual love, make up only a portion of the decorative display. Desks are arranged in two semicircles centered around a large teacher's desk. Today the large chalkboard, which runs along the front of the room, gives the time of *The Phil Donahue Show*, whose theme is announced as men loving men. Students are urged to watch the show and write a report about it for extra credit.

It is within this unorthodox environment, that Nancy teaches her students about the HIV virus and what they can do to avoid contracting it. Perhaps the most important aspect of *Social Living's* AIDS education, is the systematic attempt to make often stigmatized and mystified topics ranging from homosexuality to proper condom use, appear normal, if not

banal. Students react to this technique with mixed and often powerful responses. Their identity is being challenged and, as demonstrated by the knife fight vignette, when threatened students often choose to fight back. But the space in which social living occurs is an open one. There is little moralizing and student roles are seen as multiple and dynamic rather than prescribed.

The topic of AIDS is woven into everyday experience as something to be attended to but not as an isolated or abstract event. Nancy threads statistics and represented facts about the disease throughout her ongoing dialogue with students as she simultaneously works to normalize the various stigmatized behaviors associated with AIDS.

If you are going to talk about AIDS you should understand homosexuality. I don't want homosexuality or AIDS to come off as being outside the realm of my students lives, these topics are very much a reality in their lives. If you want kids to use condoms they have to be something you are confronted with beyond the time a condom is rolled over a banana.

In addition to the daily practice of attempting to bring AIDS and the behaviors associated with it into the realm of the normal discourse, the issue of AIDS was addressed specifically by a visiting lecturer infected with the HIV virus and a lecturer who spoke on the mechanics of safe sex. In analyzing the discussions it is important to note how AIDS is represented; specifically, in what way does the speaker work towards an understanding of AIDS as generated and embodied within identifiable behavior as opposed to locating causation in the ideation of a stigmatized person? In tandem with this concern is the question of how the students engage with each lecturer.

Re-presentations

The first lecturer to address the *Social Living* class about AIDS was Matt Jones, a 28 year old HIV positive white male, who also identified himself as a recovering alcoholic. Nancy had told me ahead of time that Matt was one of her favorite speakers, "I think kids really listen to him. Because he's young and good looking, they see more of themselves in him than they do in some of my other speakers."

Matt began his presentation by telling the kids, "There is a difference in what being human is like now and before I knew I had AIDS. Before I never looked down the road, we do what we are programmed to do. I had a problem with following the rules, and I feel that my defiant attitude contributed to my acquiring AIDS." Here a student interjected his talk with a question, "do you know how you got AIDS?" "I don't know exactly what it was that gave me AIDS because I did a lot of risky things," Matt began. "There are a bunch of risks associated with life, some of them more dangerous than others. What is a risk? Not using a condom is a risk, doing drugs is a risk, driving drunk is a risk. When I was younger I was an IV drug user, I had anal intercourse with women, and I've gotten three tattoos; any one of these activities could have given me AIDS. I used to treat the women I had relationships with really badly, but since I've been diagnosed with AIDS, its put a whole new spin on things. My current girlfriend and I have a very close relationship."

Another student asked if he had sex with his girlfriend, to which Matt replied, "I still have sex with my girlfriend, we use condoms and practice safe sex. We know exactly what we don't want to have happen, and so we take the necessary precautions." These words were barely out of his mouth before students started throwing out more questions on this topic, such as, "How do you do it? Why do you still have sex if you are HIV positive? Does she think it's okay?" For the most part Matt fielded these questions with patience, emphasizing that it was possible to have pleasurable sexual encounters that were safe for both of the participants involved. He ended the presentation on a hopeful note by saying, "I'm going to keep on playing it 'safe' because who knows, I could live!"

The most interesting facet of Matt's re-presentation, and the one the students were most provoked by, was his attempt to project the AIDS body as a viable one, capable of both sexual and spiritual fulfillment. In *Inventing AIDS*, anthropologist Cindy Patton has argued that, "within our culture, responsibility lies heavily in the hands of the HIV seropositive person to tell his/her potential lover of his status. Implicit in this notion is that there can be no such thing as consent to unsafe sex with a seropositive person" (1990:114). Here, consent to sex with a seropositive person is made impossible because it is seen as synonymous with a death sentence and who would consent to that? This notion conflates a person's identity, as one who is seen as intrinsically capable of passing on the HIV virus, with specific acts through which you can acquire AIDS.

A disruption of this model is possible through speakers like Matt, who in articulating a viable HIV body (one capable of relishing in the pleasures of sex and behaving responsibly in light of their will to live) re-configures assumptions of what it means to have AIDS, and how AIDS can be transmitted. Matt has distanced his identity from the stigmas normally associated with AIDS and moved it into a cultural space in which it is the practices one engages in that are safe or unsafe and not the bodies of those who engage in those practices. Matt's re-presentation is one which celebrates sexuality and to that end opens up spaces in which students may look to define their own sexuality as one enhanced by particular actions (the use of a condom for instance). Within this context, safe sex becomes the responsibility and choice of the individual, not only of those with AIDS.

The next speaker who came to talk about AIDS was Chuck Davidson, a safe sex expert. Chuck was a very lively and humorous speaker. He presented sex as an enjoyable pastime, which could be greatly enhanced by using birth control. He began his presentation by listing all the different types of birth control on the blackboard in order of their effectiveness. He then proceeded to talk about each method, explaining what it did and what the advantages and disadvantages of each method were. All of the information was conveyed in terms which the students could understand. To that end, he tried to make the discussion as interesting and engaging as possible. Throughout the talk Chuck emphasized common sense, "If you don't want to get AIDS, you have to create a barrier between yourself and your partner's semen. It just makes sense!" He also emphasized that students had a choice about what to do, "You have the information to protect yourself, if you don't then that's your choice." The students seemed to take to Chuck instantly, laughing at most if not all of his jokes, and asking questions about the various methods of birth control.

Chuck's presentation urged students to "Take control over your life by exercising the right to use birth control and common sense. If you don't exercise that right you are also making a choice." This rhetoric fits in with our culture's presupposition that individuals are able to maintain control over their own lives. Is this postulate of autonomy reasonable to assume of students at Berkeley High School? From the stories that both Nancy and Berkeley High's Health Educator, Lisa Sterner, have told me, some of the students' lives seem consistently out of control and in that sense lacking autonomy. Do the students believe that exercising control over the issue of birth control will really have a positive affect on their lives? Based upon my understanding of the school environment, which seems both violent and chaotic, this is a pivotal and perhaps unresolvable question.

The tropes employed by the rhetoric of AIDS education such as, "take control over your life: exercise your right to choose" imply that as long as students make the right decisions they will be able to control the circumstances of their lives. This implication masks the reality of Berkeley High School where a growing number of students are forced to grapple with issues often well beyond their control such as gang related violence, substance abuse, and poverty.

Speaking and Listening: Student Perceptions of AIDS Education

The final portion of this paper is directed towards listening for the ways (if any) in which AIDS education has become an effective force in students lives. I approach this issue by drawing upon the conventional methodology of social scientists: collecting and analyzing information gathered from surveys. While the surveys have the pretension of being in some way quantitative in character, I do not wish to imply that they represent a thorough picture of what students think about AIDS education. I am interested instead, in using their responses as a point of departure in my own analysis of AIDS education, and as a body of knowledge with which to engage in dialogue.

Questions will arise; are any of these approaches to AIDS education useful? Will the students really change their behavior? Will the virus be prevented from spreading? These are issues neither the survey, nor my analysis, attempt to directly address. In part, this is because we cannot with certainty know the answer to these questions without devoting a significant amount of time to tracking the increase or decrease of seropositive conversion among Berkeley High students. Nonetheless, these are obviously important concerns, and in response I propose that by listening to how students understand AIDS (particularly for specificities such as how much students say they know about AIDS, what they say they might do in order to protect themselves from AIDS, and what possibilities are opened up for effective engagement with the knowledge), we may also understand how effective AIDS education really is, and how it might be re-configured in such a way as to save more lives.

In June of 1992, I drew up a short survey addressing the students' perceptions of AIDS and the techniques used for AIDS education. This survey was subsequently passed out to six periods of *Social Living* classes. Out of a pool of approximately one hundred and twenty students, eighty surveys were returned to me (see Appendices A and B for the format of the survey and a complete account of the percentiles mentioned below).

The initial question the survey posed was "How much would you say you know about AIDS?" Students were equally divided between "a lot" (48%) and "some" (48%), with only 4% responding "a little." Next the survey asked, "Who in America is now at greatest risk for contracting AIDS?" I was interested here in whether the students' responses to the first question correlated with the correct response to a given fact about AIDS. The largest percentage of students (60%) responded "Men younger than thirty." The correct answer, "Women younger than thirty," was chosen by only 35% of the students. 5% of the students chose, "Men over 30."

The students' assertion that it is men under 30 who are at greatest risk for contracting AIDS, probably reflects the media's consistent portrayal of people with AIDS as gay white men. Bound up in this representation is the belief that AIDS is effectively restricted to a specific population at risk (in this case, a gay white male). While the *Social Living* course has done much to contradict this myth, students still perceive AIDS as something contained to specific social and geographic loci: to a certain extent AIDS is conceived of as existing in other "elsewheres" and will remain so regardless of the behaviors students engage in. This is demonstrated by the number of students who commented after each talk or presentation about AIDS; "Well, its not my problem, I'm not like that." While the students' incorrect replies to the question of who is at greatest risk for contracting AIDS certainly do not negate their assertion that they know "a lot about AIDS," it indicates that this knowledge is likely limited and in some way constructed by the larger discourse on AIDS.

In order to ascertain what individuals student perceive as speaking the "truth" about AIDS, the survey asked, "Out of the following choices, who would you trust to tell you the straight story about AIDS?" The choices were as follows: a doctor, your teacher, someone with AIDS, TV. or radio, Berkeley High Health Clinic, your parents or siblings, or response of your choice. Out of these choices students overwhelmingly chose a doctor as the expert on AIDS (75%). The students second choice was someone with AIDS (54%) and third was the Berkeley High Health Clinic (32%). The students' recognition and legitimation in the "truth" espoused by doctors reflects the dominate biomedical paradigm which has simultaneously constructed both an understanding of and responses to the AIDS epidemic. Within this paradigm a doctor is the authority privileged to disseminate information and to treat AIDS. How does this belief affect a student's engagement with and credulity in lectures on AIDS presented by persons other than doctors? This issue along with student's responses to the question below must be carefully considered when planning AIDS education curricula.

Next, the survey posed the question, "So far information on AIDS has been presented in your *Social Living* Class in a number of different ways; which one of these sources has informed you the most about AIDS?" The three sources which were most frequently mentioned by students were, in descending order; instructions about how to have safe sex, discussion with speakers who are HIV positive, and posters about AIDS in the classroom. It is significant how the students' responses correlate with their opinions about who is most knowledgeable about AIDS. That is, students perceive the doctor as possessing the facts on AIDS, and they respond to the question regarding important information sources by appealing once again to the biomedical framework—where prevention is constructed solely as medicalized, sanctioned safe sex. This narrow understanding of AIDS prevention (in which the

options for prevention are presented as abstinence or using condoms) limits the possibilities for students to protect themselves from the HIV virus. It is important that curricula be constructed in such a way as to broaden both students' perceptions of who has the authority to speak effectively about AIDS and the possibilities available for prevention.

Interestingly, when asked, "Have your feelings about AIDS changed during the course of the *Social Living* class?" 34% responded, "No, I've always been worried about it," while 30% answered, "Yes, I'm more worried about it now." A number of students (16%) replied that they would like to hear more about AIDS. Exactly how "being worried about AIDS" manifests itself is something the survey tried to probe by asking, "Are you afraid you will contract AIDS?" In response to this question 33% of the students replied, "Yes, somewhat afraid", while 17% of the students answered "Yes, extremely afraid!" However, the greatest number of students (41%) replied, "No, I take the necessary precautions and therefore I know that my chances of contracting AIDS are slim."

What necessary precautions do these students take? The crucial question, "What would you do to protect yourself from AIDS?" was asked in a format which required a written response. Before I provide the results of this question I would caution that these replies cannot be taken as assurance that the students will actually employ the methods they mention. Rather, these answers must be understood as reflecting what students have been taught about AIDS and are therefore notable for what they say about the different ways of speaking and thinking about effective prevention of AIDS.

Without exception, the responses to the question, "What would you do to protect yourself from AIDS?" fell within the dogmas articulated by AIDS education. Out of the 80 students who replied to the survey, 21 students reported that they would use some material form of protection, (most often a condom). Typical responses were, "Use a condom!", "Safe sex (use of condoms)," "I would use condoms and spermicides with nonoxidal 9," "Safe sex is the answer," and "Clean needles and condoms." One student expressed the belief that using only a condom might not be enough protection, "Well first of all if I have sexual intercourse I will use protection—like 2 or 3 condoms and maybe condoms with foam. Also I don't drink after other people, because even though they say you can't get it like that, I don't think they know for sure unless they know how to cure it." Unlike the rest of the responses, the students' replies to this question focused strictly on the forms of protection they would use, without mention of the moralizing tropes that have traditionally been bound up with the discourse on AIDS. Almost 40% of the students' comments included concepts of AIDS prevention which on their own would not prevent the spread of the HIV virus. For example, students responded, "I'd stay away from drug users," "I would be very careful who I sleep with," "I'm going to practice monogamy," "I would try and get to know my partner's history." The responses reveal the large number of students who have not accepted the idea that anyone is at risk for AIDS and that the only sure form of protection is to engage in specific behavioral practices which prevent the virus from entering one's body.

A number of students (19%) responded that they would use a condom and/or abstain from sex and drugs. Avoiding drugs was much more frequently mentioned than abstaining from sex, and several students asserted that it was, in fact, unrealistic to suggest that teenagers abstain from sex. One student wrote:

Abstinence is the number one form of protection but that's highly unlikely for many people since sex is a very natural and instinctual thing to do. I do not think many teenagers can quench their hormones forever, BUT the next best thing, the thing that I would do is to have both you and your partner checked before having sex. Wait for the results and proceed with caution. Wear a condom!!!

Over all, students displayed a very tolerant attitude towards sex. Even the student who wrote, "Well, I'm still a virgin and I hope to remain that way until I'm married, but if I did have sex I'd be sure that my partner and I got checked out first and I'd use every precaution necessary" seemed to allow that sex was a possibility for herself as well as other students.

Finally, another student's response, "A. Don't have sex. B. Use a condom. C. Keep away from IV drug users" reflects the conflicting and simplistic messages pronounced by AIDS education: don't have sex and if you do, use a condom. This warning implies that there is no activity which falls between avoiding all sexual contact and the act of sexual intercourse with a condom. Furthermore, that message insinuates that students must choose one or the other of these methods in order to be protected from the HIV virus. It seems the warning can also produce unwarranted confusion as is suggested by one student's response, "I would use a condom and never have sex at all."

Conclusions: the End or the Beginning

There is currently a large discrepancy between the assumptions that AIDS education makes about students' lives and the reality of students' lives. AIDS education, and the safe sex discourse more generally, is based upon the assumption that students are able to effectively control the various circumstances of their lives. Accordingly, avoiding the risk of AIDS is seen as simply a matter of managing one's behavior, by either abstaining from sex or using protection. Furthermore, AIDS education suggests that egalitarian rights exist between men and women. For example, although both male and female students were urged to exercise their "right" to demand the use of a condom while having sexual intercourse, there was no discussion of the possibility that a female student might not possess the authority to demand that her partner use a condom.

My research within the Berkeley High School community indicates that these assumptions of control and equality are erroneous for a significant portion of students. Most striking is the extent to which a large number of students (according to Nancy Rubin and other teachers) do not in fact feel that they have the ability to control all, or even some, aspects of their lives. Nancy remarked that in the past four years her students have felt the effects of "the Persian Gulf War, and the L.A. riots; closer to home we've had numerous fights break out on campus, including one drive by shooting." All of these issues are clearly the result of sweeping social and political circumstances, and I am certainly not suggesting that every perceived social ill should be addressed under the banner of AIDS education.

What I am suggesting is that AIDS education must be examined within a broader context in order to reflect critically on the substrate of assumptions made regarding the student

population it is attempting to educate. As it currently exists, AIDS education acts as a form of social control which diverts attention away from problematizing the social context in which it is embedded. At the same time AIDS education counsels students to accept certain aspects of their lives (such as the high rates of sex among teenagers) as something that is fixed and essential: that the condition is a consequence of modern life. Such a position ironically perpetuates many of the problems facing teenagers today.

Educators play a particular role in this process. Because a certain amount of their clout with students comes from their ability to be regarded as “hip” in relation to student issues, they are hesitant to moralize or question the concerns which students present to them. As a Berkeley High health counselor, and AIDS educator commented, “Sometimes I really have a hard time accepting that a student is, for example, sleeping with her boyfriend who is in a gang and has also been in prison. But then I realize it’s not my job to tell her what to do, it’s to make sure she practices safe sex so she will not become pregnant or contract the HIV virus.” Within current AIDS education discourse, it seems that educators are forced to accept certain conditions of their students’ lives as in some way unalterable, and work from there towards ensuring the students’ safety.

In conclusion it seems apparent that in order to fully understand the meanings of AIDS education (and perhaps, even to develop more successful forms of AIDS education), it is necessary to problematize both the micro-processes around AIDS education—such as the assumptions it makes about the students it is attempting to educate—as well as the larger issues—such as the broader social and political environments in which AIDS education is conducted.

Undoubtedly, there is a role in all of this for anthropologists to play. Most fruitfully this role should seek to mark the arenas in which education (hence discourse) might be re-configured. This is a form of social science which is concerned with the effects of cultural processes (the effects of AIDS education), attempts to open up spaces for the production of other processes or other forms of re-presenting AIDS, and alternative models of AIDS education as opposed to merely commenting on existing cultural construction. I would like to end by suggesting that it is imperative that we continue to open up the discourses around AIDS education as areas for inquiry, for in so doing we open up the possibilities for the social production of ethically responsible and efficacious forms of AIDS education.

Appendix A: Aids Education Survey

To answer these questions use stuff you've learned in the *Social Living* class, and anything you may have known before taking this class.

1. Who in America is now at greatest risk for contracting AIDS? (circle one)
 - a. Men younger than 30
 - b. Men older than 30
 - c. Women younger than 30
 - d. Women older than 30

2. Are you afraid that you will contract AIDS? (circle one)
 - a. Yes, extremely afraid
 - b. Yes, somewhat afraid
 - c. No, I take the necessary precautions and therefore I know that my chances of contracting AIDS are slim
 - d. No, I'm not concerned about it

3. How much would you say you know about AIDS? (circle one)
 - a. A lot
 - b. Some
 - c. A little
 - d. Nothing

4. So far information on AIDS has been presented in your *Social Living* class in a number of different ways, for example:
 - ♦ Posters and photographs in the classroom
 - ♦ Pamphlets and magazines made available at the back of the classroom
 - ♦ Dyola Barnard Branner, the African American story teller (seen by the 4th period class)
 - ♦ Instruction about how to have safe sex, taught by a variety of people
 - ♦ Discussion with a man who is HIV positive (seen by 6th and 7th periods)
 - ♦ Other, please describe

Which of these sources has informed you the most about AIDS?
(circle the ones you liked)

5. Out of the following choices, who would you trust to tell you the straight story about AIDS? (circle as many as you like)
 - a. A doctor
 - b. Your teacher
 - c. Someone with AIDS
 - d. TV or radio
 - e. Berkeley High Health Clinic
 - f. Your parents or siblings
 - g. Other, please describe

6. Have your feelings about AIDS changed during the course of the *Social Living* class? (circle one)
 - a. No, I've always been worried about it.
 - b. No, I've never been worried about it.
 - c. Yes, I'm more worried about it now.
 - d. Yes, I'm less worried about it now.
 - e. I'm tires of hearing about it.
 - f. I want to hear more about it.

7. What would you do to protect yourself from AIDS?

Appendix B: Aids Education Survey Results

A note to the reader:

The percentiles are based on the eighty surveys which were returned to me. In cases where the results add up to more than 100%, it is because students responded to more than one choice. Questions which required written responses are not included here; a complete summary of these responses can be found within the text.

- | | | | | | |
|----|----------|--------|----|--------|----------|
| 1. | a. 65% | c. 35% | 5. | a. 75% | e. 27.5% |
| | b. 2.5% | d. 0% | | b. 24% | f. 19% |
| 2. | a. 15% | c. 41% | | c. 64% | g. 6% |
| | b. 36% | d. 4% | | d. 11% | |
| 3. | a. 49% | c. 4% | 6. | a. 34% | d. 9% |
| | b. 49% | d. 0% | | b. 5% | e. 6% |
| 4. | a. 47.5% | d. 65% | | c. 30% | f. 16% |
| | b. 20% | e. 45% | | | |
| | c. 10% | f. 6% | | | |

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