

New York State HIV Prevention Planning Group

Men Who Have Sex With Men/Gay Men's Committee

**Coming Out of the Closet
for Sexuality, HIV and AIDS:
The Need for Comprehensive
Sexuality Education**

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White Paper/Lavender Paper

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The Need for Comprehensive Sexuality Education

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Committee Mission Statement

The Men Who Have Sex With Men (MSM) Committee works to monitor trends, identify needs and make recommendations related to how the New York State prevention plan can best address the needs of MSM. The MSM Committee solicits broad-based community input based on the values of parity, inclusion, and representation that addresses the diverse needs of various communities that are collectively referred to as MSM; proposes interventions and strategies for programmatic and organizational development to be supported by funders and adopted by service providers; works to identify cross-cutting issues and opportunities for collaboration with other committees; seeks to ensure that adequate federal and state financial resources are devoted to preventing HIV transmission among MSM; and coordinates activities with the New York City PPG and other planning bodies.

Coming Out of the Closet for Sexuality, HIV and AIDS: The Need for Comprehensive Sexuality Education

Background and History

Since the early 1980s, AIDS has been misperceived by many as a gay disease. This has been partially due to a proliferation of misinformation about AIDS itself. It has also stemmed from a fundamental misunderstanding of gay men, which, in its most extreme, is manifest in homophobia. How, and to what degree, we have dealt with sexuality generally is a core issue, the resolution of which has profound implications for HIV prevention, particularly with regard to young people.

As we enter the twenty-first century, we continue to struggle with social norms rooted in antiquity. Many of these are reflective of religious mores perpetuated by social and legal institutions. Sexuality and the very strong taboos associated with it are central to many of the behaviors which society proscribes. Even discussion of sexuality has been discouraged. Not surprisingly, acceptance of non-normative sexual behaviors has been exceptional.

Diverse gender roles and sexualities challenge traditional norms. They do so, in part, by questioning the centrality of reproduction to sexuality. Having reproduction inextricably linked to acceptable sexual expression marginalizes those sexual relationships for which

reproduction is a non-issue. Such a limited perspective clearly leaves homosexuality out of discussions regarding sexual health. The gay man, the lesbian, or any other sexual minority becomes, by implication, unhealthy, even in the absence of clinical disease. We should not be surprised that the social opprobrium visited upon gay men intensified when actual disease could be associated with them.

With the gay movement of the 1960s and 1970s, gay people became more visible and more vocal. There was an active rebellion against those who continued to cast them in a pathological context. With some prodding, the psychiatric community came to this same understanding. The recognition that homosexuality is not “bad” or “evil” or “sick” has been hard-fought, and it is by no means universal—even among many gay men and lesbians for whom internalized homophobia remains a substantial obstacle to self-acceptance. Some religious institutions have held tenaciously to the view of homosexuality as illness. Others have been more enlightened. The nation’s sodomy laws, the current controversy around legally sanctioned, same-sex marriages, and the rise in anti-gay violence are reminders of how far we have yet to go.

We start from the assumption that human sexuality is basic to every human being and that its expression can be as diverse as humanity itself. No one group or perspective can lay claim to sexual correctness. We may well have achieved a truer understanding of sexuality when we see that we are all sexual minorities and that each of us expresses sexuality uniquely. This inclusive view of sexuality, while at odds with one more

grounded in traditional norms, is not without its own set of values; rather it places a premium on the dignity of the individual.

The HIV/AIDS Connection

HIV/AIDS continues to be a threat to men who have sex with men (MSM), especially young gay and bisexual men. In New York State, 235 AIDS cases have been reported among males between the ages of 13 and 19 as of June 30, 2000. Of these, more than one-third (80) were among young MSM. When we look at males between the ages of 20 and 24, the vast majority of whom were infected in adolescence, there were 2,072 AIDS cases. Of these, more than 58 percent (1,217) were among MSM. Young MSM of color are disproportionately represented among these AIDS cases. Of the 1,297 MSM AIDS cases between the ages of 13 and 24 reported in New York State, more than 73% (950) were either African-American or Hispanic.

The Centers for Disease Control and Prevention (CDC) reports that HIV is on the rise among young gay males, particularly those in communities of color. In *Shop Talk* (July 21, 2000, Volume 5 Issue 9), SIECUS reports findings of a cross-sectional, multisite study of young MSM between the ages of 15-22 in which 7.2 percent were infected with HIV. In this cohort, unsafe sex was very prevalent, with 41% of the young men having reported unprotected anal sex in the prior six months. Many of those not currently infected are likely to become so given the extent of unsafe sexual behaviors.

There are undoubtedly complex belief systems and sociological factors which have contributed to these cases. We have seen, for example, that the availability of highly active anti-retroviral (HAART) therapy may influence risk taking and one's perception of a partner's viral load count. (13th International AIDS Conference, Durban, South Africa, 2000) Stigmatized sexuality must also be a focus in looking for the causes for new infections among young men.

The Impact of Sexual Stigma on HIV

How has sexual stigma impacted the epidemic? The answer is clear: "HIV has forced many societies to recognize that same-sex sexual behavior occurs, and that stigmatization and homophobia attitudes simply fuel the fire that spreads the virus." (Dr. Eli Coleman, Ph.D., "A New Sexual Revolution in Health, Diversity and Rights", *SIECUS Report*, Vol. 28, No.2, Dec.1999/Jan.2000.)

Dr. Helene Gayle, in commenting on sexual stigma in communities of color, noted: "The data remind us, once again, of how AIDS tends to affect those most out of reach of social safety nets, beyond the network of voices openly talking about HIV. But talk about it, we must, if we are truly committed to slowing the spread of HIV in minority communities. This will come as uncomfortable news to those who historically have had difficulty in accepting homosexuals in our communities. Intolerance leads to denial and stigma—both of which contribute to the spread of HIV. By not being allowed to identify as even gay or bisexual, some young men may not even perceive themselves at risk for HIV." (Helen D. Gayle, M.D., M.P.H., "They Are Still Our Brothers", White Paper, 1/3/00.)

As we look at the rising number of HIV infections among young people, we can say with certainty that HIV prevention has had, at best, limited successes. It is incumbent upon us to learn from our experiences and to do a better job. Although we cannot rewrite history, we can learn from it and move forward.

What are the issues that we have learned about HIV/AIDS and the gay experience? What can New York State, its school districts, its parents, its PTAs and others do to prevent the past from repeating itself? Where do we go from here?

MSM Committee Recommendation

The MSM Committee, in developing its Mission Statement last year, charged itself with being a learning body which would identify cross-cutting trends and issues relevant to the HIV prevention needs of MSM. It has focused during the past year on young MSM, and it has concluded, after reviewing the literature and hearing from young people themselves that comprehensive sexuality education must be supported and implemented in New York State.

There is a growing movement across throughout State and country which has already recognized the value of this approach, and we add our voices to theirs. Comprehensive sexuality education is an important tool in stopping the spread of HIV/AIDS; and it is a means for building a healthier community. The MSM Committee endorses the view of Susan N. Wilson, Executive Coordinator of the Network for Family Life at Rutgers University's School of Social Work: "We have to muster the courage to advocate for

programs that are meaningful for young people; programs that are grounded in reality rather than adult’s wishes about teenage behaviors. We have to advocate for programs that go beyond abstinence-only, or abstinence-until-marriage; we must stand up to objections in course content; and we must argue for programs that not only provide accurate, relevant information, but also develop behavioral skills, so that teens learn to talk to each other about sex in a responsible, mature, and responsible way.”

Comprehensive sexuality education is a critical component in curbing the HIV/AIDS epidemic in our State, especially among young people, with a special consideration for young males who have sex with other males, not exclusively referred to or identifying as “gay”.

What is Comprehensive Sexuality Education and Why Is It Important?

Comprehensive sexuality education recognizes that there are many choices for sexual expression. It is inclusive of heterosexuality, homosexuality, bisexuality, and the full range of sexual behaviors and relationships. Comprehensive sexuality education is about love and intimacy, accepting all sexual orientations, lifestyles and choices. It is not limited to a reproductive model. It includes the acknowledgment of diverse sexual behaviors, and it breaks down and challenges traditional gender roles. It acknowledges that sex is pleasurable and a means for self-expression. It attempts to meet people where they are sexually—and not where others may want them to be. It is proactive and informational. Comprehensive sexuality education acknowledges that sexuality includes biology, psychology and spirituality.

Comprehensive sexuality education is not traditional “sex ed”, which conjures up images of dogmatic class assemblies, delivered by the staff who are often uncomfortable with the subject matter. It is not limited to education about puberty, reproduction and sexually transmissible diseases. It is certainly not a single-sex gym class of giggling boys and girls led by someone who believes that the positive mention of anything sexual, will encourage sexual behavior.

Talking about sex does not result in more sexual activity, nor does condom availability. (Planned Parenthood Federation of America.) Unfortunately, myths to the contrary abound.

The Controversy over Comprehensive Sexuality Education

Comprehensive sexuality education is controversial. Leslie Kantor, Director of Planning and Special Projects for the Sexuality Information and Education Council of the United States (SIECUS) likens it to a “lightning rod” for heated debate in communities across the country, and increasingly on national and state levels. It is controversial, mostly due to the subject matter itself and many societal factors, including the following:

- ◆ resistance to viewing homosexuality as normal
- ◆ religious and cultural views of homosexuality
- ◆ sensitivity and comfort around the issues
- ◆ inability to talk about sex and use sexual terminology
- ◆ politics
- ◆ parental desire to provide sex education

- ◆ family values
- ◆ homophobia
- ◆ heterosexism and heterocentric norms
- ◆ fear that talking about gay issues will engender homosexuality among young people

Justification for Comprehensive Sexuality Education

A vast majority of Americans support sexuality education. According to a 1999 SIECUS-sponsored Hickman-Brown telephone poll, Americans believe that sexuality education should begin at earlier ages. (*SIECUS Report, August/September, 1996, page 3.*) They also felt it should include the topics of homosexuality, abstinence, love and emotions, safer-sex and sexuality issues above and beyond puberty and reproduction. This rejects abstinence-only-until-marriage education that denies young people information about contraception and condoms.

A 1999 Kaiser Family Foundation study found that over 60% of 10-12 year olds, and 45% of adolescents aged 13-15, talk to their parents about sexual activity and relationship issues. However, the same survey showed that young people learned “a lot” from teachers (40%), followed by parents (36%), then friends/peers (27%). Clearly, school-based comprehensive sexuality education can be an important supplement to family values. Eight out of 10 Americans believe that young people should have access to information to protect themselves from unplanned pregnancies and STDs (including HIV/AIDS), and more than 9 out of 10 support sexuality education in high school. (*SIECUS Report, August/September 1999 page 3.*)

The Comprehensive Sexuality Education Formula

Comprehensive sexuality education has six major attributes:

- 1) Inclusive; 2) Comprehensive; 3) Open; 4) Multi-Faceted; 5) Culturally Competent; and
- 6) Medically Accurate.

1. Inclusive: Inclusion is necessary in order to reach all students. It works towards welcoming to and acknowledging both heterosexual and homosexual practices and individuals. Inclusiveness involves understanding that sexuality is applicable to all people. As sexual beings, we have many ways to express sexuality, including through our sexual orientation, lifestyle, tastes and actions.

In addition, homosexuality needs to be normalized like heterosexuality, so that gay youth can feel included and relevant. If not normalized and included, gay youth can feel left out, and they can conclude that prevention messages are not for them. Ultimately, exclusion leads to low self-esteem. Feelings of low self-esteem can contribute to isolation, unhealthy behaviors, risky sex and suicide.

2. Comprehensive: Comprehensive sexuality education needs to provide a broad spectrum of information and skills, ranging from puberty and reproduction to abstinence, birth control and safer-sex. The key is to meet students where they are and give them each information that they need and want to know. These programs should acknowledge that some young people are sexually active and others are not. Ideally,

comprehensive sexuality education will commence before young people begin experimenting with sex. Responsible comprehensive sexuality education needs to talk about all possible options.

3. Open: Open, honest and informative sexuality education is the best medicine! No issue, topic or question is unwelcome. Even though everyone is influenced by their own values, the emphasis is on individual values and decision-making based on correct information provided in an open and honest manner.

4. Multi-Faceted: Sexuality education is about more than reproduction. It includes the elements of intimacy, love, respect and emotions in relation to each individual and his or her relationships and circumstances.

5. Culturally Competent: Human beings are so rich in cultural diversity. A single cookie-cutter approach does not work in either sexuality education or HIV/AIDS prevention. Individuals need messages that are applicable and with which they can identify. In addition, the values and cultures of all people and their respective communities need to be taken into consideration in determining what the appropriate messages and delivery systems should be.

6. Medically Accurate: Comprehensive sexuality education provides sexual health information and skills-based sexuality education which are medically accurate and include appropriate terminology.

The Problem With “Abstinence-Only-Until-Marriage” Programs

The biggest obstacle to comprehensive sexuality education today is the funding and promotion of “Abstinence-Only-Until-Marriage” programs. Despite its popularity among legislators who may wish to strengthen the relationship between sex/sexuality and morals, abstinence-only programs have not been found to be effective in helping young people postpone sexual involvement, let alone diminish the spread of HIV. Moreover, the emphasis on abstinence-only programs moves the discourse even further away from comprehensive sexuality education at a time when it is most needed to save lives.

The “Eight Points of Abstinence Education” are now formally known as Section 510(b) of Title V of the Social Security Act. This section defines abstinence education, in part, as a program which “has as its *exclusive purpose* teaching the social, psychological, and health gains to be realized by abstaining from sexual activity... [It] teaches abstinence from sexual activity outside marriage *as the expected standard for all school-age children...*[and] teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity...” [Emphasis added.] (See Appendix A for complete text of the statute.)

Clearly, the abstinence-only education stance is incomplete and unrealistic. It mandates that the only acceptable sexual activity is between a husband and wife (man and woman) in a long-term monogamous marriage. Sex out of wedlock is demonized as a root cause of psychological and physical damage to the couple as well as to offspring

This limitation is detrimental, value-laden, and, we posit, offensive to many, including homosexuals, who see it as a condemnation of their existence as sexual beings. It also negates the possibility of their having monogamous, loving, long-term relationships. Abstinence-only-until-marriage programs restrict information and include negative messages of fear and shame, biases about sexual orientation and gender, and inaccuracies about contraception.

Furthermore, a review of the existing published literature on sexuality education in *Public Health Reports* states: “There is not sufficient evidence to determine if school-based programs that focus only upon abstinence delay the onset of intercourse or affect other sexual or contraceptive behaviors”. One in four school teachers is told not to teach about contraception! Despite the growing number of public school sexuality education teachers who have increased their focus on abstinence-only instruction (from 2% in 1998 to 23% in 1999), teachers are covering far less than they believe is needed. Not surprisingly, the teenage pregnancy and STD rates remain high. (Sara Seims, President of the Alan Guttmacher Institute, “Trends Toward Abstinence-Only Sex Ed Means Many U.S. Teenagers are not getting vital Messages About Contraception”, September 26, 2000).

In Support of Comprehensive Sexuality Education

Over 117 national nonprofit organizations support the Comprehensive Sexuality Education movement under the National Coalition to Support Sexuality Education. (*SIECUS Report*, December 1999/January 2000). The Coalition members represent a broad constituency of child development specialists, educators, health care professionals, parents, physicians, religious leaders and social workers reaching more than 30 million young people.

Teenagers who start having intercourse or sexual behavior, either straight or gay, following an inclusive and comprehensive sexuality education program are more likely to use contraceptives and practice safer-sex practices than those who have not participated in such a program. (A. Grunseit and S. Kippas, *Effects of Sex Education*, pages 339-360.)

Presently in the United States, twenty-two states require schools to provide both sexuality and HIV education. New York State only requires a loosely defined curriculum on HIV/AIDS. Of the twenty-six states that require abstinence instruction, only fourteen also require the inclusion of other information on contraception, pregnancy and disease prevention. New York State does not require abstinence-only education, but does participate in the abstinence-only, federally-funded grant match. So it can be asked, “*How can one teach HIV prevention without teaching about sex and all aspects of sexuality?*”

The Cost for New York State's Reality

During the 1999-2000 Planning Cycle of the New York State HIV Prevention Planning Group, statewide joint meetings occurred between committees focusing on men who have sex with men, young people, and communities of color.

On two occasions, panels were convened representing service providers who serve young gay people, and young gay and bisexual men themselves. These brave young people shared their stories. They spoke of barriers to sexual/reproductive health care due to discomfort with providers' homophobia and heterosexism. They also talked about how difficult it is to find someone "like themselves" to talk to, whether they are members of a specific community or teachers.

Among those the committees spoke with, some were disenfranchised and thrown out of their homes for being gay. Some were involved in physical violence due to their sexual orientation or *perceived* sexual orientation. Some participated in vulnerable and risky sex for survival as well as a result of low self-esteem, due to existing negative feelings about being young and gay in New York. Their experiences are not unique.

The voice of gay and bisexual youth in New York today is the best justification for Comprehensive Sexuality Education. Sexuality education needs to be inclusive; it needs to involve a spectrum of conversations about reproduction and relationships; and it needs to accept that sexuality is normal for *all* people.

Comprehensive Sexuality Education needs to stress that love can happen between any two people. It needs to offer the choice and consequences of abstinence, as well as safer-sex methods. It is about empowerment and fairness, openness and normalcy, acceptance and information for all of our young people.

There is an unquestionable link between HIV/AIDS and low-self esteem in young men who have sex with other men. This link should send a powerful message to those working in the area of HIV prevention. Being seen and treated as “different” and as an “outsider” eventually takes its toll, often manifesting itself in a need for love and acceptance. For confused and ignored sexual minorities, validation is often sought and found in connection with another, via sexual activity—without thought or mention of safer-sex, HIV status or condom use. This is the toll due to fear, shame and exclusionary sexual education and value-laden moral messages.

Our young people are looking to us for truth. The new millennium offers an opportunity to address the fallacies of antiquated cultural and social norms, and to replace them with an enlightened approach which responds to the realities of young people and what they need today. This can best be met with a movement toward **Comprehensive Sexuality Education**.

MSM White Paper/Lavender Paper BIBLIOGRAPHY

There are several resources available, in order to better understand “Comprehensive Sexuality Education”. In this “lavender paper”, the authors acknowledge two agencies crucial to the movement:

The Sexuality Information and Education Council of the United States (SIECUS), 130 West 42nd Street, Suite 350, New York, NY 10036-7802.

(Phone: 212.819.9770/fax# 212.819.9776. Website: <http://www.siecus.org>. Email: medwards@siecus.org.) SIECUS publishes a monthly newsletter, “SIECUS Report” and a weekly faxed newsletter, “Shop Talk”.

Planned Parenthood Federation of America (PPFA), 810 Seventh Avenue, New York, NY 10019-5882, Phone: 212.261.4627/fax# 212.247.6269; or 1142 Connecticut Avenue, NW, Suite 461, Washington, DC 20036, Phone: 202.973.6393/fax:202.296.0956

New York State Planned Parenthood affiliates, (including the resources of the author’s Upper Hudson Planned Parenthood, 259 Lark Street, Albany, NY 12210. Phone# 518.434.5678 X142, fax# 518.434.6278; rob@uhpp.org.)

The following works were cited throughout the paper. The authors and committee members graciously thank them for their valuable resource information (by cite order):

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APPENDIX A: Eight Points of Abstinence Education

SECTION 510(b) OF TITLE V OF THE SOCIAL SECURITY ACT, P.L. 104-193

For the purpose of this section, the term “abstinence education” means an educational or motivational program which:

- (A) has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- (B) teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;
- (C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- (D) teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity;
- (E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- (F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;
- (G) teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances; and
- (H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.