

RISK AND HIV: SCOTTISH SCHOOLS’ APPROACHES TO HIV EDUCATION

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INTRODUCTION

Sex education is back on the agenda. Recent years have seen the re-emergence in Scotland of a pro-abstinence lobby in the media, ostensibly influenced by the conservative movement in the United States. The rhetoric touched a cord with those concerned by Scotland’s high levels of teenage pregnancies and increasing rates of sexually transmitted infections (STIs) (Scottish Executive 2003a). It also provides a backdrop to our discussion of HIV education policy and practice.

Our analysis draws on research conducted between 1999 and 2002, as a joint project between the University of Edinburgh and Children in Scotland, and funded by the Community Fund. The research investigated the experiences of children and young people affected by HIV in Scotland and made recommendations to those providing support services to these young people and their families. Initially, the issue of educational support for children and young people was not central to the study. However, as the children and young people reported their experiences, the research team became increasingly interested in the provision of sensitive and effective HIV education in schools. A survey was therefore undertaken of all Scottish secondary schools, to explore school-level policy and practice on HIV education. As part of this survey, schools were asked to identify the HIV

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education packages which they were using, and a content analysis was conducted of these packages. In 2005, a follow-up study was carried out to identify current policies on HIV education at local authority level.

This article outlines the current epidemiology of HIV in Scotland, before going on to examine in more detail the reasons why it was decided to carry out a survey of HIV education. Findings from the schools' survey of 2002 are reported, as well as more recent findings from the local authority survey of 2005. The paper places these findings in a wider sociological context, focusing on risk theory, before finally arguing for a change in the approach to HIV education in Scottish schools.

HIV IN SCOTLAND

HIV was first reported in the United States in 1981. Because of its original identification with the homosexual community, it was commonly termed the 'gay-plague' (Cochrane and Mays 1987, p.3). Within Scotland, it spread quickly amongst those who used intravenous drugs (Robertson et al 1986). Following sharp increases in the 1980s, the rate of new HIV infections fell during the late 1990s; however, new statistics show that HIV is again on the increase in Scotland. The Scottish Centre for Infection and Environmental Health (SCIEH) recorded 365 new diagnoses of HIV in 2003, the largest number ever recorded in Scotland. The cumulative total of known HIV positive individuals is now 4219 (SCIEH 2005). The nature of transmission has changed considerably over the last 10 years. In 1991, 40 per cent of new HIV diagnoses were presumed to be through sexual intercourse between men; by 2004, this had fallen to 34 per cent. Over the same period, transmission through intravenous drug use has fallen from 30 per cent of all new diagnosis to under four per cent. Simultaneously, the percentage of new HIV diagnoses from heterosexual transmissions has increased, from 26 per cent in 1991 to 48 per cent in 2004 (SCIEH 2004). In 2003, the Scottish Executive launched a consultation, 'Enhancing Sexual Wellbeing in Scotland'. In a supporting paper, it is reported that:

Recent epidemiological reports indicate a high prevalence of HIV among people in Scotland who have links with sub-Saharan Africa. Trends in high prevalence areas globally will be reflected in Scotland, including Scottish residents as well as other more transient communities such as

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workers from overseas, asylum seekers and students. (Scottish Executive 2003b)

This development adds a new dimension to those affected by HIV within Scotland: those who have connections with sub-Saharan Africa.

Being HIV positive in Scotland is relatively rare with only 0.1 per cent prevalence in the general heterosexual population (Scottish Executive 2003a). Nevertheless, HIV affects a significant number of families in Scotland. Inglis and Morton (1996) identified 741 children and young people affected by parental HIV in Dundee, Edinburgh and Glasgow, just over half of whom were of primary school age, though it was argued by the authors that the true figure was likely to be significantly higher. With the HIV positive population rising and with risks such as heterosexual transmission becoming more prevalent, it is timely to consider what young people are being taught about HIV transmission, whether we are indeed contributing to prevention and what unintended consequences may arise from the methods currently employed.

CHILDREN AND YOUNG PEOPLE'S VIEWS OF HIV EDUCATION

The primary aim of our study was to find out from children and young people about their experiences of living with parental HIV. During the course of the study, it became apparent that schools were a key location where the private lives of families and the public domain met, and a place where the children and young people struggled to be 'normal'. For example, in the interviews, few young people wanted teachers to know about their parent's illness, because they thought that teachers might treat them differently, while they wanted to be treated the same as other students. Looking back on her school experience, one 17-year old young woman explained:

I wanted to be treated the same. ... I didnae want like anybody, all the rest of my teachers or anything to know, in case they treated me different, in case they thought they had to treat me different.

Moreover, children and young people who took part in the study said that where class discussion of HIV occurred, they could not participate because of the fear that others would realise that they had a personal knowledge of HIV infection, as one 16-year old young man made clear:

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The other kids were like still asking questions that should have been answered and ... I dinnae want to sound like I kent too much about it. Cos all the other kids would have been like 'oohh'.

In some cases, this led to young people being unable to respond to what they perceived to be negative or inaccurate statements about HIV transmission or about those living with HIV. The children and young people also felt that the reality that some students might be HIV positive themselves, or be living with parents or other relatives who were HIV positive, was not acknowledged in the classroom. In addition, they were unable to ask for further information on the likely progression of the illness and possible treatments. These findings led the research team to consider in more depth the issue of HIV education in schools.

FINDINGS FROM THE 2002 SCHOOLS' SURVEY

In order to find out what schools themselves had to say about HIV education, a postal questionnaire was sent to all secondary schools in Edinburgh, Dundee and Glasgow in 2002, the sites of the main part of the study. We wanted to find out:

- what (if any) policies on HIV education were in place;
- where within the curriculum was HIV education located;
- which packages of HIV education were in use in Scottish schools.

The survey received 74 responses, a response rate of 88 per cent, from both denominational and non-denominational schools and from both local authority and independent sectors.

School policies on HIV education

Schools were asked about the existence of HIV education policies, where an HIV education policy was taken to mean any written statement on the preferred ages for delivery of HIV teaching and learning; and any protocol on the content of HIV education. It was found that 40 per cent of all schools surveyed had a policy on HIV education. This figure masks what is a considerable difference in practice between denominational and non-denominational schools. Only 20 per cent of denominational schools declared

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that they had such a policy, as compared with 51 per cent of non-denominational schools.

Three schools stated that they used their local authority policy as their own policy on HIV education, whilst 27 had developed their own policies. Where schools responded that they did not have a specific policy, many went on to explain that the policy on HIV education was integrated into a wider policy: three schools include HIV in their policy on Health, Personal and Social Education and one school included HIV specifically as part of its Sex Education policy.

HIV education and the curriculum

In relation to the place of HIV in the curriculum, some schools reported that they taught HIV in more than one context. Whether or not this was the case, Personal and Social Education (PSE) was by far the most common setting; 95 per cent of schools in the study said that they taught HIV in their PSE classes. Within the 'other' category, a range of subjects were mentioned, including Geography, Modern Studies and General Studies (see Table 1).

Table 1
Subjects where HIV education is taught

	Number	Percentage
Personal and Social Education (PSE)	52	95
Sciences	12	22
Religious Studies	8	15
Other	14	25

Schools were asked to provide more detail about this, and 84 per cent reported that they taught HIV education within sex education; 75 per cent taught HIV education within drugs education; and 7 per cent taught HIV education within anti-bullying initiatives. The majority focused on the provision of knowledge and information about the transmission of HIV (89 per cent), with a significant number (69 per cent) seeing the focus as

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prevention of transmission. Only nine schools stated that support for HIV positive people was a focus of HIV education.

HIV education packages

Respondents were asked to give examples of any materials that they used to teach HIV. Forty three different packages were identified, suggesting a plethora of classroom resources tackling the subject. Two schools reported that they had developed their own materials for use in HIV classes. (It is common practice for schools to use some published materials for sex education classes whilst also developing their own resources 'in house'.)

The most commonly cited packages were:

- 'Escape AIDS'
- 'Taking Sex Seriously'
- 'Your Choice for Life'
- 'Chalkface'
- 'Drugwise'

It is worth noting that it is not easy to gain access to any of these packages. No university or public library holds copies of the packages, and the NHS Health Scotland Library only has reference copies of two packages: 'Escape AIDS' and 'Taking Sex Seriously'. Therefore content analysis could only be carried out on the two available packages. Both packages were developed in the early 1990s, at a time when it was assumed that HIV was most likely to affect those defined as 'high risk', such as intravenous drug users and men who have sex with men. It has already been stated that the epidemiology of HIV has changed significantly over the past decade, not least because of the increasing rates of transmission within the heterosexual population. In consequence, these packages look somewhat dated. For example, 'Escape AIDS', written by Ackroyd et al (1990), includes the following information on how HIV is transmitted:

In Scotland, presently, the most common route is thought to be sharing infected drug-injecting equipment.

During anal intercourse the rectal membrane and the skin of the penis can be torn, thus allowing infection to pass from one individual to another.

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The more sexual partners a person has, the greater the chance of certain infected body fluids, e.g. semen, blood, vaginal secretions passing from one person to another. ('Escape AIDS' 1990)

The focus here is self-evidently on the 'high risk' activities of drug use, homosexual sex, and multiple partners, suggesting that sex itself is not the causal factor. In one video section, the audience is told that 'staying faithful means you can't get AIDS through sex', a statement which is clearly inaccurate given what is now known about HIV and transmission. 'Escape AIDS' also repeatedly refers to 'particular kinds of sexual activity' transmitting the HIV virus, without explaining this term, again suggesting that only some types of sex are risky rather than sex itself.

In 'Taking Sex Seriously', written by Cohen and Wilson (1994), the approach taken to protecting oneself against HIV is to assess risk, with young people asked to rank activities as 'high risk', 'medium risk' or 'low risk'. The activities described include hugging, sharing mugs, kissing and moving onto the 'high risk' activities of penetrative sex and sharing injecting equipment. In contrast to 'Escape AIDS', casual sex is not presented as a causal factor.

Neither package encourages young people to be tested for HIV. In 'Taking Sex Seriously', a list of reasons for not taking the test are provided including difficulties with applying for mortgages or insurance, the stigma of HIV and that 'you may feel better off not knowing and just getting on with your life' (1994, p.85). There is no mention of the overriding argument in favour of increased testing, i.e. that it dramatically reduces the likelihood of passing on the virus (WHO/UNESCO 1994). Instead, positive reasons for taking the test are presented as 'being able to plan for your medical treatment and for your family', reasons which would seem unlikely to appear particularly relevant to most young people. Neither this nor 'Escape AIDS' critically discusses the social impact of HIV on an individual, nor the need to educate people to reduce the stigma of HIV.

In order to bring our assessment of classroom resources up-to-date, and because of its reference within a local authority policy on HIV education (see Table 2), we borrowed a copy of the 'SHARE' package (Dixon et al 2003) from an Edinburgh school. This sexual health package builds on previous learning packs and has been recently revised. It is a two or three year programme which is aimed at 13-15 year olds and is currently in use in many Scottish schools. In this package, HIV appears only in passing, touched on as one of a number of sexually transmitted infections (STIs). It is mentioned

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alongside ‘thrush’ as an STI which is ‘not only sexually transmitted’ (2003, p.99), then emerges later with four questions in a quiz of 36 questions on sexual health. The questions posed are as follows:

What is the virus called which can lead to AIDS?

What are the body fluids that can transmit (carry) HIV and infect a person?

Is it possible to tell if somebody is infected with HIV? Why?

Can you name three really effective ways a person can protect themselves from HIV infection? (2003, pp.162-3)

The answers supplied to these questions are accurate as far as they go. However, there is no discussion at all of being tested for HIV, of living with HIV, of treatment options for HIV, or, perhaps most critically, of the stigma which surrounds HIV. This leads us to suggest that if HIV is taught using this package alone, school students will be seriously disadvantaged in terms of their knowledge and understanding of HIV.

FINDINGS FROM THE 2005 LOCAL AUTHORITIES’ SURVEY

In September 2005, we issued a Freedom of Information request to local authorities, asking for their policies on HIV education. In total, 25 local authorities responded within the 20-day time period. Table 2 shows the responses from this request and the location of any existing policy on HIV education.

Thus only one local authority, Edinburgh City Council, stated that it has a specific policy and programme covering HIV education. The Sexual Health Team works with students in secondary schools, addressing sexual health, sexually transmitted infections and HIV. The programme includes face-to-face input and presentations from HIV positive team members who share their experiences of living with the virus. The programme explicitly covers HIV stigma, prejudice and human rights, including the recent inclusion of HIV in the Disability Discrimination Act.

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Table 2

Local authority HIV education policies

	Local authorities
Specific HIV education policy	1 (Edinburgh)
HIV education policy contained within larger health or sex education policy	13 (Aberdeen City, Clackmannanshire, East Dunbartonshire, East Lothian, Fife, Glasgow, Highland, Inverclyde, Midlothian, Renfrewshire, Scottish Borders, South Ayrshire, South Lanarkshire)
Follow Scottish Executive policy and guidelines	3 (West Lothian, East Ayrshire, Dumfries and Galloway)
No policy	8 (Argyll and Bute, Comhairle Nan Eilean Siar, Dundee, East Renfrewshire, Falkirk, Orkney Islands, Shetland Islands, West Dunbartonshire.)

The largest response from local authorities was that their HIV policy is contained within a wider health or sex education policy. Six of the 13 local authorities who took this approach to HIV education policy sent copies of their health or sex education policies with their Freedom of Information response. There was limited information on HIV contained within these documents (see Table 3).

As Table 3 shows, where HIV or AIDS is specifically mentioned in local authority sex or health education policies, it receives limited attention. Many of the curriculum references are taken directly from the Scottish Executive guidelines (Scottish Executive 2000). No policy provided discusses the social aspects of HIV/AIDS, including stigma and prejudice. Three councils mention further resources, three of which (Escape AIDS, Taking Sex Seriously and SHARE) have been discussed above.

Table 3
Specific mention of HIV within Sex or Health Education policies

Local authority	Document or Policy	HIV Education References
East Dumbartonshire	Strathclyde Regional Council: AIDS Revised Health and Safety Guidelines (1993)	'Escape AIDS has been distributed as appropriate to all educational establishments in the Region. The Director of Education has commended the use of these.'
Fife	Health Promotion Policy (1998)	Knowledge outcome: 'Understand that disease can be transmitted sexually'. Also specific reference to educational resources including Taking Sex Seriously, AIDS and You, Taught not Caught.
Glasgow	Management Circular No. 81 (2002)	Information for parents (taken from Scottish Executive 2000): 'Awareness of sexually transmitted infections and HIV and AIDS and how to keep safe'.
Highland	Sexual Health Education Guidelines (no publication date)	Early secondary sexual health programmes might include: 'awareness of STIs and HIV and AIDS and how to keep safe'. Middle and Upper secondary sexual health programmes might include: 'Responsibilities and strategies for avoiding STDs and HIV and AIDS'.
Inverclyde	Curriculum Guidelines and Policy Information on Health (no publication date)	Level E (secondary 1): 'Explore health-enhancing behaviours in relation to sexual health, e.g. Safe sex practices STIs/HIV. Identify and discuss the personal and social factors which may influence sexual behaviours e.g. Faith, religious beliefs, HIV/AIDS'.
Midlothian	Sexual Health Plan (2003-6)	General references to HIV awareness: 'This action plan will ... incorporate a 'whole population' approach to HIV prevention and sexual health promotion in Midlothian.' No specific reference to HIV within education section, though notes use of the SHARE education package.

HIV, STIGMA AND RISK

We have indicated that the children and young people who took part in our original study reported that HIV education in schools did not give them the information or support that they felt they needed. Moreover, we have suggested that HIV education learning resources often focus on reducing transmission through identifying 'at risk' groups and individuals, the outcome of which is the creation of the dangerous 'other' in society, the HIV positive individual/s. Some commentators, such as Patton (1990), go so far as to claim that there was a deliberate policy on behalf of government to cement the creation of the 'other' by repeatedly stating that there was no evidence that AIDS would move into the 'general' population. This view seems extreme, but it is nevertheless the case that the process of 'othering' has real effects on individuals and society. In a previous article (Cree et al 2004), we have suggested that it is the stigma surrounding HIV which sets it apart from other chronic and life-threatening conditions. Goffman's (1963) classic sociological study argues that stigma is about 'differentness'; the separation of 'self' from 'other' is perpetuated not only by 'normal' members of society, but also by those with the stigmatising characteristics who discredit themselves through self-hatred and shame. So, for example, people diagnosed as HIV positive can themselves believe that they are 'dirty' and internalise the stigma associated with HIV, particularly after experiencing negative reactions from other members of society (Green and Sobo 2000).

Stigma is not, however, a static concept. Parker and Aggleton (1999) point out that stigma is constantly changing within society, because it is fundamentally based on what are *social* processes:

We need to reframe our understanding of stigmatization and discrimination to conceptualise them as social processes that can only be understood in relation to broader notions of power and domination. (1999, p.16).

According to this perspective, we need to consider what forces are in place in the creation of HIV-related stigma. Risk theory provides insight into how social stigma is created. Thus Douglas and Calvez (1990) argue that, faced with an epidemic, the 'central community' tightens its defences to become more punishing and controlling, in an attempt to limit the behaviour of the members of the community and control the spread of infection. When an epidemic is thought to have been caused by deviant sexual practices, a tension

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is created between the central community and 'dissidents' who continue these practices. Members of the central community believe that those who do not accept their view on the causes of transmission are suffering from a lack of information. Their solution is therefore to provide education to the society as a whole, on 'correct' behaviour. This view is mirrored by Alaszewski et al (1998) who argue:

Hazardous behaviours such as smoking are often seen as a product of ignorance or irrationality, inadequate information or failure to use information appropriately. (1998, p.17)

This approach has been clearly visible in relation to HIV education since the emergence of HIV and AIDS in the 1980s. The early public education campaign, 'Don't Die of Ignorance', demonstrates this. It suggested that AIDS was preventable if people just followed simple rules, suggesting that those who were HIV positive had not correctly understood or implemented this information (Green and Sobo 2000, p.197). Taking this further, those who went on to take risks, once in possession of such information, were self-evidently irresponsible and worthy of blame.

But there is another dimension to this discussion. Carter's (1995) exploration of risk proposes that the natural tendency to calculate personal risk ('probabilistic reasoning'), (that is, to consider the likelihood of an event happening), leads individuals to consider sexual *partners* as 'risky' rather than specific activities. We have argued that the HIV education packages used in Scottish schools are built on an assumption that HIV can be prevented through the identification of 'high risk' groups and individuals. This has two important effects. Firstly, students are encouraged (however implicitly) to see those in 'high risk' groups and individuals as blameworthy and secondly, students under-estimate their own personal risk in relation to HIV. This is likely to have serious consequences for the effectiveness of any HIV education.

Further, Bloor (1995) notes that sex is not an individual act: rather it is a social act between two people. Likewise, Scott and Freeman (1995) discuss the notion that sex is predicated on trust between two people; where they trust each other, this becomes what Scott and Freeman refer to as 'a functional substitute for knowledge'. Therefore, rather than relying on the factual evidence on a partner's HIV status, individuals trust one another not to put them at risk. In the complex world of sexual relationships, this innate trust may sometimes be undeserved. Similarly, within a supposedly monogamous

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relationship, the use of condoms suggests that one partner is being unfaithful – a breach of trust so severe that it may, in itself, cause the relationship to end.

Parker and Aggleton (2003) have noted the relevance of stigma to power, where those groups singled out as 'high risk' are disempowered and oppressed. The relationship between HIV infection and intravenous drug use or men who sleep with men has been known for many years. With the combination of increases in asylum seekers and refugees, and a rise in new cases of HIV being recorded as contracted in sub-Saharan Africa, it seems reasonable to suggest that black and minority ethnic communities in the future may suffer HIV-associated stigma. This encourages us to ask: within the UK (as in the USA), will 'race' and HIV become intertwined, creating a society even more racially divided than it is at present?

RISK AND HIV EDUCATION: A NEW APPROACH

The policy implications of this analysis are profound and far reaching. The epidemiology of HIV is changing, requiring a new strategy for HIV education. We believe, with Parker and Aggleton (2003), that the key goal of HIV education should be the development of policies and programmes which effectively reduce human suffering, both for those who may contract the HIV infection in the future and also for those who are currently infected or affected. Yet our research has shown that few Scottish schools or local authorities have policies on HIV education. Moreover, we have argued that programmes of HIV education currently in use in schools in Scotland do little to educate children and young people on HIV, and may, in practice, make the situation worse by demonising 'high risk' groups while at the same time under-playing the personal risk which we all, as sexually active individuals, face.

Given the complexities that surround HIV, some of which have been rehearsed in this paper, we propose that a written policy outlining how schools should approach HIV education should be developed. While there is no evidence on the effectiveness of policies in this area, UNESCO (the Joint United National Programme on HIV/AIDS) argues that in general, school *practices* are only as good as the *policies* that guide them (UNESCO 2004a):

The development of school district policies on AIDS education can be an important first step in developing an AIDS education program. In each

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community, representatives of the school board, parents, school administrators and faculty, school health services, local medical societies, the local health department, students, minority groups, religious organizations, and other relevant organizations can be involved in developing policies for school health education to prevent the spread of AIDS. The process of policy development can enable these representatives to resolve various perspectives and opinions, to establish a commitment for implementing and maintaining AIDS education programs, and to establish standards for AIDS education program activities and materials. (UNESCO 2004b, p.1)

Therefore, the process of creating a specific HIV/AIDS education programme at a local level can be seen as a contribution to greater awareness of HIV related issues and the creation of consensus. Following the same logic, we would argue that HIV education policies should be developed at local and national level.

We also argue that the Scottish Executive must consider a new model of HIV education, focusing on transmission through *all* sexual relationships, not just those whom society deems 'immoral', where all members of society realise that they are at risk and that HIV can infect anyone, in any situation. A systematic evaluation of HIV education programmes and its impacts on HIV transmission and awareness found the following characteristics of successful health education programmes to prevent HIV/AIDS (UNESCO 2004c):

- They focus on a few *specific behavioural goals* (such as delaying initiation of intercourse or using protection) which require knowledge, attitude and skill objectives.
- They provide *basic, accurate information* that is relevant to behaviour change, especially the risks of unprotected intercourse and methods of avoiding unprotected intercourse.
- They emphasize *clear and appropriate values* that will strengthen individual values and group norms against unprotected sex.
- They offer modelling and practice in *communication and negotiation skills* in particular, as well as other related 'life skills' in general.

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- They address *social influences* on sexual behaviour, including the important role of media and peers.
- They use of *participatory activities* (games, role playing, group discussions etc.) to achieve the objectives of personalizing information, exploring attitudes and values, and practising skills.
- They advocate for *extensive training* for teachers/implementers to enable them to master basic information about HIV/AIDS and to be given an opportunity to practice and become confident with life skills training methods.
- They *support* reproductive health and HIV/STI prevention programmes set up by school authorities, decision and policy-makers, and the community at large.
- They make *evaluations* (e.g. of outcomes, design, implementation, sustainability, school, student and community support) from the standpoint of programme improvement and encouragement of successful practices.
- They are age-appropriate, targeting students in different age groups and at different stages of development with suitable messages that are of relevance to young people.
- They are all *gender sensitive*, intended for both boys and girls.

This provides a clear agenda for the development of a national HIV education strategy in Scotland. However, there is little attention here to stigma and prejudice, which were also notably absent from the packages and programmes that we identified in our research. Whilst this may offer no impact on rates of transmission, we suggest that there are social benefits to providing young people with education on compassion and care, designed to reduce the stigma and discrimination experienced by HIV positive individuals and their families. One way forward would be to follow the WHO/UNESCO curriculum guidance, which conforms to the UNESCO characteristics identified above, but also includes activities and learning outcomes to enable young people to identify ways of showing compassion and solidarity towards people with HIV/AIDS (WHO/ UNESCO 1994).

CONCLUSION

The voices of the children and young people who took part in our research led us in directions that we did not expect at the beginning of the study. They told us that they wanted more information on HIV and for HIV education to be inclusive rather than stigmatising. Our subsequent study of school HIV education demonstrated the gaps in current practice and suggested the need for clearer policy direction at all levels of accountability, from the Scottish Executive to school level. We have proposed that new teaching materials on HIV need to be devised, giving accurate information on HIV prevention and treatment and seeking to challenge the current stigmatising attitudes towards the many adults and children in Scotland who are affected by HIV. We have, finally, offered positive suggestions as to how this work may be progressed.

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