FROM SCHOOL TO COMMUNITY: HEPATITIS C STIGMA AND HEALTH EDUCATION IN RURAL SCHOOLS.

By

Charley D. Henderson, B.S.

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Committee Members:

David Dietrich, Chair

Seoyoun Kim

Nicole Taylor

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ABSTRACT

In Texas, abstinence only programs are the primary method of sex education in public schools. Based on the School Health Advisory Council, volunteers from the community help in determining what is discussed in health and sex education. In rural conservative communities, religious morals determine how sex education is taught in public schools. Without proper knowledge and open discussion about sex and viral infections like Hepatitis C, stigma determines negative opinions around these two topics. After interviewing sixteen parents, teachers and school administrators, I found that religion, abstinence only, the preferred class in schools, consent for birth control, and the lack of information for Hepatitis C and SHAC affects what is allowed to be taught in rural Texas public schools. The result of an abstinence only sex education in rural schools is outdated classroom material, no discussion of options for birth control or unplanned pregnancies, and believing birth control is the gateway to immoral sexual intercourse.

INTRODUCTION

Compared to other viral infections such as HIV and AIDS, the Hepatitis C epidemic has not received as much attention. Hepatitis C is a blood borne infection that affects the liver and, if left untreated, can cause chronic health complications or death (CDC 2018; American Liver Foundation [ALF] 2017; NIH 2017; Shepard, Finelli and Alter 2005). Currently in the United States there are an estimated 17,000 reported and unreported new cases of Hepatitis C per year and around 3 million currently living with chronic Hepatitis C (Health and Human Services [HHS] 2018). As the population continues to age, there has been an increase in diagnosis and medical attention. However, there is little research concerning the social implications of contracting Hepatitis C. Many researchers agree there is ambiguity of how Hepatitis C can really be contracted (i.e. Jenkins 2016), and in turn, groups such as IV drug users and those who participate in unprotected sex are targeted as those who are primarily as risk for contraction. Because there is evidence Hepatitis C is linked to contaminated medical equipment and intravenous drug use, education about the virus seemingly focuses on contraction prevention about drug use (Holmberg, Spradling, Moorman and Denniston 2013). Because of this association, the majority of society believe this is the primary source of contraction, creating a stigma to Hepatitis C.

Since most of the individuals diagnosed with Hepatitis C are adults there is insufficient data about the social effects on children or grandchildren. The likelihood of a child eventually knowing a close family or friend who has Hepatitis C continues to grow every year, underscoring a need for education about the virus. Baby Boomers and the

Silent generation are now the parents and grandparents to children and contracting Hepatitis C may affect the child's social image of the person they look up to.

Southern rural communities and schools may not be considering the future effects of disallowing health education programs that could help prevent stigma usually associated with Hepatitis C. For example, Texas no longer requires sex education. However, if sex education is taught in school, the information is usually restricted to promoting abstinence only and consequences deemed immoral from premarital sexual intercourse (Frieh and Smith 2018; Hoefer and Hoefer 2017; Polluck 2017). Without additional sex education to students, a stigma is created about premarital sexual relations and contraction of viral infections such as Hepatitis C in younger adults (i.e. TEA 2014).

Considering the stigma surrounding Hepatitis C and sex education, rural Texas communities are failing to teach sex education in a positive, reassuring environment. Education for Hepatitis C is not fully explored, pinning contraction on drug and sexually related acts. Additionally, funding for schools are not always equal, failing to provide equal opportunity for sex education programs across the state of Texas. In this project I explore the relationship between sex education, Hepatitis C, and the effect the stigma has on the family. The omission of a sex education program in school can potentially affect a student's view on Hepatitis C later in life, and contribute to misguided information about Hepatitis C. With effective sex education, students can present information to family and friends, which can reduce stigma for Hepatitis C. In contrast, a lack of sex education programs may contribute to the creation of stigma. Most sex education research focuses on interviews with children, how the children react to sex education, and the statistics on the effectiveness of sex education classes (i.e. Frieh and Smith 2018; Hoefer and Hoefer

2017; Polluck 2017). Instead of focusing on the children, I will interview parents and school employees to see how the community's view of Hepatitis C is impacted by the missing sex education classes, not just the children. I contend that lack of sufficient sex education contributes to the stigmatization of Hepatitis C.

PREVIOUS RESEARCH

Hepatitis C

The Hepatitis C virus is a fairly recent viral epidemic in the United States. The CDC first discovered Hepatitis in the United States in 1989 (CDC 2014). Due to poor medical sanitation and fewer restrictions on donated blood, the Hepatitis C virus spread rapidly in the United States (CDC 2014). In fact, Hepatitis C officially surpassed HIV/AIDS contraction rates in 2012 (CDC 2018; ALF 2017; NIH 2017; Shepard et al 2005). Hepatitis C is a chronic blood borne infection that affects the liver causing several internal and external physical symptoms. Some of these symptoms include jaundice or the yellowing of the skin and eyes, swollen abdomen that gives the appearance of being pregnant, nausea and vomiting, extreme tiredness, pain in the abdomen, painful joints, itchy skin, unusually dark urine, and clay colored feces.

Hepatitis C symptoms can vary from mild to persistent severe pain that makes it difficult for a patient to fully function. According to the U.S. Department of Veterans Affairs (2018), the physical pain that causes an individual's abdomen to experience sharp pains is the stretching of the outer liver where the Hepatitis C is attacking the tissue or by fibrosis in the liver. Liver fibrosis is caused by the excess protein ECM, that is released when chronic Hepatitis C damages the liver for an extended amount of time (Bataller and Brenner 2005). However, many members of society do not understand the physical stress the body endures from Hepatitis C, and only consider the morality of the virus. Because of society's attitudes towards Hepatitis C, there are also secondary symptoms such as depression due to the mental and physical stress of the virus (ALF 2017).

Although younger drug abusers are beginning to become more prominent among Hepatitis C carriers, Baby Boomers still have the highest diagnosis rate of Hepatitis C (ALF 2017; NIH 2017; Jenkins 2016). Because of the long dormant period of the virus, many of the Baby Boomers symptoms are beginning to surface allowing them to be more aware their contraction of the virus. Hepatitis C can stay dormant for thirty to forty years, so mode of contraction is difficult to determine. Despite the long dormant period, researchers and physicians have suggested certain modes of contraction which include surgeries, especially oral, before the 1980's, blood transfusions, faulty medical equipment and intravenous drug use, and unprotected sexual intercourse. Additionally, there is the low risk of contraction from piercings and tattoos. Considering of the lack of research, the Hepatitis C virus epidemic in the United States in the late 1980's, (Holmberg et. al 2013) and the history of the Baby Boomer generation, social factors associated with Hepatitis C are understudied when compared to the biological research of the virus.

Men are typically affected more than women (i.e. Rieker and Bird 2005; Boffey 1987; Bonacini et al. 2001), however, the Hepatitis C virus can affect any gender, sex, or race. Currently, Caucasians are more likely to be diagnosed with Hepatitis C (Anadrad et al. 2009). However, out of minority groups, African Americans are most likely to be affected, followed by Hispanics (AVERT 2015). Although there have been progressive treatments for many African Americans, advanced Hepatitis C in African Americans do not always allow for the option for a liver transplant (Forde, Tanapanpanit and Reddy 2015). Typically, the unavailable option of a liver transplant is contributed to the prevalence of Hepatocellular Carcinoma (HCC) (Forde, Tanapanpanit and Reddy 2015).

HCC is one of the most prevalent cancers among Hepatitis carriers, killing around one million patients a year, with the majority of deaths among minorities (Andrade et al. 2009).

Despite the personal symptoms Hepatitis C patients experience, close friends and families are often subjected to their own understanding that is interlinked with the patient's experience of having a viral infection. Due to the negative connotation of Hepatitis C (i.e. NIH 2017; i.e. Shepard et. al 2005), the patient is not the only member of the family to absorb the associated stigma. For example, friends and families may experience the financial burden accompanied with Hepatitis C treatment, along with a stigma by association (Zacks et al. 2006). In comparison to the availability of data provided about Hepatitis C patients themselves, information about children and spouses' experience from the virus is lacking (i.e. Weiss and Lonnquist 2015; i.e. CDC 2018; ALF 2017).

In relation to Hepatitis C, stigma can affect the seeking of testing, treatment, and overall healing process of the patient because of the worry of being labelled as a drug user. According to Treloar, Rance and Backmund's (2013) study, it was found stigma impacted diagnosed Hepatitis C patients health outcome. Patients poorly adjusted to having the virus, and in a little less than half of the patients, a psychiatric disorder such as depression developed. However, most of the studies that represent this information are based in urban hospitals (Strauss and Teixeira 2006). Information representing Hepatitis C patients in rural settings are skewed because of the assumption of urban results and data to the rural area.

Hepatitis C in Rural Areas

There is no single definition of a rural area (Douthit, Kiv, Dwolatzky, and Biswas 2015), but it can be described as a location with a population of 8,000 or below, and

distanced two or more hours away from any urban areas. Common attributes include sparse shopping areas, restaurants, few tourists, and heavy reliance on agricultural economics (Monk 2007).

Within rural settings, Hepatitis C patients are limited in terms of where they can receive treatment due to the need to travel relatively long distances for treatment and diagnosis (Jenkins 2016; i.e. Lutfiyya et al. 2007; Jha, Orav, Zheng, and Epstein 2008). Hospitals in rural settings are almost always not as well equipped as urban hospitals, which makes treatment difficult for patients. Many rural doctors are not aware of the recommended screening for Hepatitis C nor the treatment for the virus (Knopf 2017). In an attempt to help educate medical professionals in rural North Carolina, rural doctors voluntarily attended programs to help better educate themselves on Hepatitis C (Knopf 2017). However, it does not appear many other states in the south require their doctors to attend trainings in understanding viral infections such as Hepatitis C. The likelihood of a rural patient having health insurance compared to a patient in an urban area is very low (Georgetown University 2005).

Furthermore, within urban medical facilities there are outside available resources which, in turn, help with prevention methods, diagnosis and treatment (e.g. American Hospital Association 2018). Diagnosis can happen at the local doctor's office or at a clinic, and treatments can happen within a reasonable distance when a patient lives in close proximity. In rural locations, patients sometimes have to drive up to several hours before they are able to receive medical treatment (Jenkins 2016). When considering the physical pain and exhaustion Hepatitis C patients' experience, having to travel the distance may be a significant burden. Transportation barriers, such as not having a backup means to get to

appointments and the burden of having to travel longer distances, can lead to missed appointments and poorer management of the patient's health (Syed, Gerber and Sharp 2013). Rural patients are at a greater risk of health care neglect due to insufficient means to transportation, unlike urban areas where taxis, city buses, Uber, Lyft, etc. are easily available. If the patient does not have a strong support system then secondary illnesses, such as depression, become a concern.

Health Education in Rural Schools

The patient is not the only one affected by the diagnosis of Hepatitis C. Often times the family, including children, carry a social burden from the infection as well (e.g. Walter, Ford, Templeton, Valentine and Velleman 2015; Hoefer and Hoefer 2017). For example, my previous work discovered there is an assumption that kids carry the virus like their parent(s), or the family's reputation as a whole is viewed negatively. More often than not, children are not learning about the viral infection or ways to cope with the diagnosis. In Texas, funding for schools has been cut and rural schools are taking a brunt of the loss (TEA 2014; Polluck 2017). When I discuss rural schools, I am describing schools include Pre-Kindergarten through 12^{th} with an enrollment of less than 200 students.

When compared to general school funding for schools in other states in the United States, Texas has started to lag behind (Hoefer and Hoefer 2017; Polluck 2017). Through 2021, the state of Texas is projected to make a 3.5 billion dollar decrease in funding (Sanders 2018). Since 2012, local funding has increased, but with the state funding continuously decreasing, the disparity between the national and state accounts have dramatically increased. In poorer locations, like rural schools, tax increases for school funding are typically voted down. Rural schools are losing the most money, and in turn,

try to make up by cutting classes that are not required. After such funding cuts, classes like an extensive Health Education that were once offered are not as easily accessed in rural schools. Now, the curriculum is often at the bare minimum that is in accordance to the Texas Educational Agency's requirements.

Rural schools typically do not have the resources to provide extra classes outside of the required courses from the state of Texas (i.e. TEA 2014). When schools are geographically located near or in larger towns and cities, there is an increased opportunity to take electives or a district requirement for classes such as Health Education. Based upon research I previously conducted about Hepatitis C in rural communities, there was concern with how little health education is provided in school, not taught by a teacher willing to teach the course, or a coach that would rather participate in physical activities such as football, basketball etc. as a health class activity. Teachers not wanting to teach in rural areas follow the trends of other job professionals because of the lack of entertainment, stores, and proximity to urban life (i.e. Okulicz-Kozaryn and Mazelis 2016). Additional concerns about teaching a health education class, especially in a school pressed for teachers due to a remote area, is the high demand that students perform well on standardized tests required by the state of Texas. Students begin testing in the third grade, and the district is essentially graded on the students' test results (TEA 2018). Because the district is then relying on the test grades for funding and rating, teaching is geared to taking standardized tests. The poorer, smaller schools are then left with no option but to teach strictly to the minimal requirements provided by TEA, which does not provide rural students the same opportunities as it does for urban students.

In some Texas urban schools, there are classes that provide opportunities in subjects such as forensics, technology, law, finance, or biology. However, when looking at rural schools, the only classes offered follow the state curriculum of four science and English classes, three mathematical courses, fine arts, physical education, three social studies classes, and five electives (TEA 2018). Electives in rural school are typically limited to home economics, agriculture, and welding. Additionally, in several urban areas, health education includes safe sex practices, and information about viral infections. In contrast, rural Texan schools are most adamant in promoting abstinence only sexual education, which does not include chronic viral infections such as Hepatitis C. Among Texan urban and rural schools, less than two-thirds chose to use abstinence only programs (Polluck 2017; Hoefer and Hoefer 2017). According to one rural Texas school from my recent research, the School Health Advisory Council (SHAC) is a district council made of school administration, school nurse, teachers and community volunteers who by Texas law are required to promote abstinence as the preferred choice of contraception for all sexual activity before marriage. SHAC members are also to encourage abstinence more than any other behavior, emphasize abstinence as the only 100% way to avoid pregnancy, emotional trauma and sexually transmitted disease is through abstinence, and allow the district to decide to include teaching methods about other forms of contraception. Other topics such as contraception, condoms, detailed anatomy, and detailed consequences are allowed to be discussed, but with the continued mention of abstinence. It is also Texas law that every district is required to have a SHAC, and to actively meet to discuss topics surrounding health and sex education for the students. SHAC was first issued in 2008 to help maintain

the well-being of young individuals, and get communities and families more involved in the health of the students.

From research conducted through rural schools' websites (2017), the health education programs used in rural areas are minimal. One district chose to follow the curriculum required by the state, and in the briefest amount of time. Additionally, it is rare to have condoms readily available for students and for SHAC to hold open meetings to the public.

Additionally, TEA no longer requires a sex education course in school (Polluck 2017). Sixty percent chose to follow the curriculum set into place by the state's SHAC program. If the school district's SHAC so chooses, they may modify and add education about condoms (TEA 2018). However, the majority of rural areas are avoiding contraception discussion and following the minimum or are among the twenty-five percent of schools that choose to not have a sex education program at all.

However, there are TEA approved health education programs for rural and urban schools. The programs only cover grade levels kindergarten to eighth grade, and are limited on topics the programs are allowed to teach the kids. According to the TEA (2018) website, the programs include Bienestar, CATCH, and The Great Body Shop. The programs claim to be scientific evidence-based programs that are "more effective" than health and sex education programs not on the list, but in fact do not address problems surrounding sexual contact such as sexually transmitted infections and viruses (i.e. Frieh and Smith 2018; Hoefer and Hoefer 2017). The approved topics in these programs include obesity prevention, Type 2 diabetes, and information about cardiovascular disease (TEA 2018).

Despite these programs' claim to be scientific, there is a strong influence of religious morals and beliefs. None of these programs cover topics related to viral infections.

It is important to note that the consequences of not requiring a health or sex education program in Texas schools can be seen through the teen pregnancy rates in Texas. Although the nation's teen pregnancy rate is declining, Texas' rate is declining at a much slower rate (Silverman 2017; Health and Human Services [HHS] 2016). According to the Health and Human Services (HHS) (2016), Texas is in the top five states of the nation's teen pregnancy rate. The high rate has many factors which include not knowing proper sex education, taking preventative measures, and the difficulty for a female to obtain birth control without her parents' permission (Silverman 2017; i.e. Silverman 2017; CDC 2017). Combined with the poverty rates in rural communities, Texas' teen pregnancy decline will continue to be slower compared to other parts of the nation.

Importance

With school funding cuts and the lack of sex and health education classes for rural high school age groups, scientists are noting the lack of research addressing these issues (e.g. Hoefer and Hoefer 2017; TEA 2014; Polluck 2017). Children, especially in high school, are not prepared to address consequences of their actions if protection during sexual activity is not used. Texas rural schools are not teaching what could happen if bodily fluids are mixed, unsanitary objects are used, or even in extremely rare cases, job related viral infections are possibly contracted. Preventing, discussing, and raising awareness about Hepatitis C now, can help prevent contraction in the present and future.

A local mother from my previous research discussed the emotional abuse her daughter received after coming out that her father had in fact contracted the virus.

Despite Hepatitis C suffers being primarily older, studying Hepatitis C in schools is important because Baby Boomers are the leading generation affected by the virus. With an increasing possibility of their parents, aunts, uncles, grandparents, etc. being diagnosed with Hepatitis, children and grandchildren are also becoming more socially aware of the virus' effects. Through research I previously conducted in rural communities about Hepatitis C, I found that more parents are worried that their children are not receiving any information to prevent the contraction of the virus, or what to do if they suspect they have come into contact with a potential carrier's bodily fluids. Without the proper education about the virus, many community members feared being stigmatized by friends and family due to the stigma associated with Hepatitis C and drug use, while the majority did not realize the Baby Boomers are the most at risk.

Several parents and school employees admitted they were not aware of the virus, but if the child was to learn, the parents themselves could learn through their children. In one rural community in particular, the school employee was worried that their students would not properly be able to prevent against the virus. However, being a rural school, the employee feared there was not many options to help teach their kids without deterring from the standardized testing curriculum. Current education about Hepatitis C for the older teens could help in preventing stigma associated with the virus in rural communities in the future.

Researchers who are trying to spread awareness about the virus are not considering the age groups that would be at the age of contraction (i.e. Walter et al. 2015; Frieh and Smith 2018; CDC 2018; ALF 2017; Shepard et al. 2005), which in the future, could help reduce the contraction rates. Because those who are currently being diagnosed fall in the

age category forty-five to sixty years old, their contraction would have been between the ages of fifteen and thirty due to the thirty to forty year dormant period of Hepatitis C. These numbers would suggest a greater need to educate school aged children in their middle to late teens because that is when initial contraction would occur. More importantly, teaching rural school aged children would be vital due to the higher poverty rates in these types of communities.

Discussing the Hepatitis C virus in some rural districts becomes difficult because a lot of the SHAC members are not medical professionals, nor is it required that they be. According to TEA, SHAC members are everyday community members such as stay at home moms, preachers, and nurses. This can be problematic because personal beliefs then dictate how sex education will be taught to the students. This can lead to allowing religious or personal beliefs determine how kids will receive information concerning prevention, protection and treatment towards sex and Hepatitis C.

The research surrounding Hepatitis C and sex education is lacking when compared to other viruses such as HIV or AIDS. HIV and AIDS has been in the United States longer than Hepatitis C, but researchers still compare the viruses to each other (CDC 2018; ALF 2017; NIH 2017). Both viruses are chronic, have long dormant periods, and are life altering, but they are not the same (Shepard et al. 2005). In today's medicine, Hepatitis C is almost completely eliminated from the blood with medication that can cost nearly $100,000, while there are no medications that can eradicate the HIV virus from the blood system (CDC 2018). With HIV, the first symptoms are described as flu-like, and if a person does not take anti-viral medication to help suppress the viral load, HIV then turns into AIDS (CDC 2018). During the AIDS stage of HIV, the flu like symptoms increase

and the patient will also develop swollen lymph glands and their viral load will be high, causing the person to be very infectious (CDC 2018). With Hepatitis C, even when the viral load is high, the virus is easily contained and not as contagious as AIDS.

What's more, continuing to perceive the viruses in similar manners is not benefitting efforts to reduce Hepatitis C stigma. In fact, when comparing the viruses, people tend to falsely assume the same mode of contraction. Where it is more common for Hepatitis C to be spread through botched medical procedures, transfusions and sharing of needles, it is less common to spread the virus through protected sexual intercourse, in contrast to HIV (CDC 2018). Additionally, Hepatitis C does not live outside of the body for as long as HIV, which can survive in a used needle for nearly forty-two days (CDC 2018). Ultimately, HIV and Hepatitis C are two very different viruses and without proper education, teachers are then at risk for misinforming students about Hepatitis C.

If there were a program to help spread awareness about Hepatitis C, children would not be the only ones who would benefit. A small, yet powerful chain reaction would help spread information about the virus to the rest of the community through friends and family (i.e. Andrews 2018). Current information is geared towards adult patients after diagnosis and ignores those at risk of infection (ALF 2017; NIH 2017; Shepard et al. 2005). Recently, national commercials have discussed medicine for Hepatitis C treatment. However, it does not discuss the actual virus and the physical pain, expense of the medication, and learning how to live with a chronic virus.

Overall, Hepatitis C literature fails to connect Hepatitis C, rural communities and schools, and the resulting social effects among adolescents. Thus, the purpose of this research is to determine how Hepatitis C stigma is related to the lack of information

presented to teens about Hepatitis C in their schools. The theory of stigma will help in determining if the lack of sex and health education the cause of Hepatitis C being stigmatized in rural locations. Because school and friends are major functions of socialization (Hoefer and Hoefer 2017), social researchers are possibly missing an important factor that could assist in understanding, preventing, and helping support those inflicted with Hepatitis C.

Theory of Stigma

Research has looked at the effectiveness of sex education in terms of the acceptance or resistance by students. However, very few researchers have chosen to study the stigma that is created by lack of sex education (i.e. Walter et al. 2015; Hoefer and Hoefer 2017). Most existing research looks at the reaction of sex education programs from the perspective of the students. Within these studies, resistance and effectiveness of resisting premarital sex, and teen pregnancies in abstinence only programs are considered (i.e. Frieh and Smith 2018). Instead of looking at sex education programs and teens' desire to learn from an abstinence only program, I am looking at Hepatitis C from Goffman's perspective of stigma. There are several different types of stigma including physical, social and moral (Meisenbach 2010; Griffith and Kohrt 2015). For the study of Hepatitis C and stigma, all three are applicable, but social and moral stigma are more prevalent. How Hepatitis C is perceived goes against morality, especially in rural communities where there is reliance on traditions. Social stigma aims to separate the attribute from society, and community events. Stigma is already created to separate the outsiders from the insiders, so to bear social stigma is not uncommon for Hepatitis C patients and their family (i.e. Meisenbach 2010).

According to Goffman (1963), “stigma is a stain, a mark, and a spoiled identity.” Goffman believed that stigma was created through the language, not the attribute itself. In fact, Goffman stated that the attribute itself is not stigmatizing, but the interaction caused by the attribute results in stigma. In the case of this research, the attribute is Hepatitis C while the interaction is based on the lack of sex education. The attributes themselves are not stigmatizing because it can vary across time, cultures, and meaning, but the interaction in rural schools and communities between the teachers, administrators and students is what creates a stigma capable of damaging a reputation. Goffman states expressions can cause stigma when the formalities of communications interactions are broken. For example, a person reacts to the stigmatized attribute when the attribute itself becomes visible, or knowledgeable to the other party member (Goffman 1963; i.e. Roschelle and Kaufman 2011). Reaction of the stigmatized attribute is based on previous knowledge or preconceived beliefs about the attribute. With Hepatitis C, the stigma can cause distress for the patient and family, which can lead to lower quality of life, poor self-esteem, and discrimination in medical and workplace settings (Martin, Lang and Olafsdottir 2008). Individuals who experience stigma often practice various steps to help improve the damage towards their identity (Goffman 1963; i.e. Andrews 2018). Typically, a person has to work to correct the attribute before the creation of stigma from the language and social interaction (Goffman 1963). Means of stigma management include correcting the misunderstood attribute, mastering the attribute such as determining how the attribute is defined in one’s life, using the stigma as a secondary gain such as using the stigma as excuse for failures, embracing the stigma to help teach others, or hiding one’s feelings about having a stigmatic attribute (Miesenbach 2010).

Using one of these forms of stigma management practice allows the individual being stigmatized to be viewed in the way they are wanting to be portrayed.

When it comes to sex education in schools, there is still controversy and confusion over the practice of abstinence only education. Out of the twenty-six states that are currently allowing sex education in schools, Texas is one of the few to present a negative connotation on sexual intercourse or anything related to sex, which is helping to contribute to the stigma surrounding the conversations of safe sex, especially in conservative rural communities (Hoefer and Hoefer 2017). There is a strong push for abstinence only programs; however, it is surfacing that abstinence only programs are reinforcing stereotypes associated with sex (Frieh and Smith 2018).

Previous research I conducted suggests that, in rural Texas communities, parents are realizing there is a need for their children to have sex education. However, there seems to be a taboo surrounding the discussion of sex, and viral infections such as Hepatitis C. Instead, parents are using the process of normification, exaggerating the power parents now have over the way teachers are able to teach, so sex education will enter the institution of the school and push the stigma of sex education onto the local teachers (e.g. Hoefer and Hoefer 2017). Within the normification process, parents are taking their internalized stigma and placing it on the teachers, by blaming teachers for not teaching their students and children about viral infections and sex. Parents are unintentionally creating more stigma around sex education, consequences of sex, and Hepatitis C because they do not talk about the subjects with their children and rely on the children's schooling to teach their kids about sex education. When the parents allow the only information surrounding these topics to come from teachers, especially in Texas, the information the

students receive often creates more stigma associated with sex and related topics. SHAC programs in Texas push for abstinence only, and if the students do not follow this approach to sex, they are viewed as immoral. When a child or student participates in sexual intercourse, they are then at risk for moral stigma. With abstinence only programs and parents not talking to their children about sex, consequences, and viral infections, the students then create their own misguided opinions. This creates a never-ending cycle of stigma towards Hepatitis C and premarital sex.

METHODS

Previous studies have focused on urban schools, and have used pre-existing data sets to analyze the education within the schools (Frieh and Smith 2018; Hoefer and Hoefer 2017; i.e. TEA 2014, 2018). Of the research that conducted in-person interviews, it was focused only on the children and their sex educational experience. My research differs by going beyond interviewing children and explores the effect of sexual education on the family and community.

Participants

From previously conducted research, I noticed many of the participants agreed sex education needed to be taught to the local junior high and higher schoolers. However, the parents and community members never stated if their child felt the same or discussed having any form of sex education in school. Instead of strictly focusing on the community's opinion of the education system, I wanted to gain a new perspective through those who worked closely within the Texas education system.

I conducted sixteen face-to-face interviews with parents, a school board member, teachers, and school administrators. The interviews helped to gain different perspectives from different levels of the school system. After consideration of the definition of a rural school, I chose to only recruit from 1A district schools, which are also known as "6-man" schools. Every school had 400 or less students, with the average enrollment less than 200 students. Also, each school hosted pre-kindergarten to twelfth grade on the same campus. Within the state of Texas, there are an estimated 600 schools of similar structure, so I chose three from different areas across the state to gain a variety of opinions and experiences. All interviews were conducted anonymously.

The majority of the participants were females (11) and the remaining were males (5). Eight participants were from “School 1,” five participants were from “School 2” and the remaining three were from “School 3.” Each participant and location were replaced with a pseudonym and any specific identifying information used was omitted.

Of the participants recruited, the majority worked within the schools. Only one administrator and one school board member participated in the interviews. The remaining employees were teachers, or served as an employee of the school. Of the interviews, eleven were also parents of current students enrolled in a 1A school. Children of the respondents ranged from fourth grade to a senior in high school.

Recruitment

For recruitment of participants, I used a snowball sampling method to select the participants. I chose to use snowball sampling because the method will allow me to gain access to close-knit communities that described themselves as conservative. Due to the sensitivity of my discussion, snowball sampling allowed better access due to the referencing from participants that were familiar amongst each other, beginning with two key respondents. Of the referrals, only one individual declined to participate within the study. Before collecting data, I summarized the topic of the research, then I had each participant read and sign a consent form. I allowed for another chance for the participant to decline and reminded they did not have to answer anything they were not comfortable answering, nor did they have to finish the interview. Once the participant was ready, the interview began and was audio recorded and stored per Texas State IRB requirements. The shortest interview lasted near fifteen minutes while the longest reached near an hour.

Data Collection and Analysis

I collected data and then categorized themes from my interviews based on Goffman's concept of stigma. Based on Goffman's stigma developing on language and interaction, a negative connotation around premarital sex developed and can be physically seen through the discomfort exhibited in the body language such as with shuffling, body tension, and broken eye contact. Because this is a topic that is not regularly studied, I thought it would be more appropriate to let the data guide me to common themes.

To find where the sex education stigma begins, it is best to start where the primary education occurs- in the schools. When developing questions for the interview, I structured an outline to examine how Hepatitis C stigma is associated with sex education, or the possibility of the lack of sex education programs. I developed questions such as approaching the participants' idea of sex education classes in schools and appropriate ways to talk to a child about topics such as sex, birth control and Hepatitis C. Approaching the lack of information about sex and viral infections in the rural school system with the ability to discuss their own opinion helped in discussing how the family is then affected by the taboo surrounding the topic of sex and Hepatitis C. Questions were worded as open ended to ensure a richer, fuller understanding of their parenting style, opinions of health and sex education, and how their child is socialized about sex in a southern rural school. I designed the questions to be somewhat open ended to give my respondents latitude to address issues they felt were important with this topic. This allowed me to get a sense of the particular issues different respondents felt were important to discuss.

Other studies administered surveys which made it difficult to gauge emotional responses to questions and issues raised in the interview process (Frieh and Smith 2018). By personally interviewing each participant, I was able to observe emotional responses of the participant. Other research has shown body language can represent a number of different themes such as stigma avoidance (Roschelle and Kaufman 2011; Walter et. al 2015; Goffman 1963). When addressing stigma, respondents' answers may not match body language, tone of voice, or other expressions. Being able to read a participant's physical response helped in coding despite the participant trying to hide their real opinions for fear of staining their reputation based on their beliefs. Hepatitis C and sex tend to be sensitive subjects for smaller communities (Andrews 2018), thus coding body language would help decipher how participants really feel. Because I audio recorded the interview, I was able to revisit the tone, answers, and emotions of the participant.

To examine the relationship between sex education and Hepatitis C stigma, I coded for themes that included sex education, Hepatitis C, family, and monetary funds for the school. For sex education, I coded for the mention of a type of program suggested or the desire for a program to be in regular schooling. Not having extra funding for non-abstinence only programs may contribute to the increase of stigma for sex education because there is no other alternative information provided to students (Hoefer and Hoefer 2017; Polluck 2017).

For Hepatitis C, I coded how many times the respondent mentions not knowing anyone with Hepatitis C or not thinking the virus exists in the community. Additionally, I looked for mentions of the belief of there not being a need to learn about Hepatitis C in sex education. Expressions within the interview are also important to code for when

talking about Hepatitis C. As Goffman's theory states, previous knowledge about an attribute can create stigma. If there is very little knowledge about Hepatitis C, preconceived negative views can contribute or create stigma for contracting the virus. Additionally, the created stigma of the attribute Hepatitis C can disrupt regular social interactions between the Hepatitis C carrier and other community members, and possibly the interviewer.

When one person's reputation is tainted by the stigma, it trickles to friends and family, and can increase negative opinions causing a division within the community. Family is coded by the respondents mentioning children, spouse, or parents, along with the family like community. From previous research, there was a continuing theme that the community was "close-knit" and "family-like" but I want to see if the theme stays true considering sex education including the idea of premarital sex. Coding family this way shows stigma does not only stain the reputation of an individual, especially in a smaller community. Additionally, I coded body language for stigma. Body language associated with discomfort about the topic is also considered stigmatizing due to not being able to open discuss sex and Hepatitis C (Goffman 1963; Andrews 2018). Fidgety body movements in the participant when asked a question will account for stigma (Goffman 1963; i.e. Newman and Benz 1998). Coded movements included facial expression, eye contact, posture, as well as the tone of the given answer. Stigma will also include the discomfort of talking about sex, because not discussing sex can inadvertently create moral stigma. All aspects are important to determine if and how Hepatitis C stigma originates from the lack of non-abstinence only programs in rural schools.

I also found it important to code for sex education programs. I coded for any existing programs and if the parents and teachers find the program effective. This can prove to be significant because if parents and teachers do not find the program effective but do nothing to change it, the program may not be taken seriously. I also coded for the qualifications of the sex ed teacher. From previously conducted research, I found a prominent theme of parents concerned about coaches teaching sex and health education, and only participating in physical activity during class, resulting as a "filler" for the course.

I used code weaving in my analysis. Through code weaving, I am able to tie all of the themes, emotions, body language, and phrases to help create the theory within the interviews (Newman and Benz 1998). Code weaving allows the themes and codes to weave together to help in forming a hypothesis (Newman and Benz 1998). With Hepatitis C and sex education, I am looking at how the respondent answers the question, not only verbally, but with eye contact, body language, and repetitive phrases. Here I can then determine if their verbal answer matches their subtle responses as well.

FINDINGS

After completing the interviews, several themes began to emerge. The most important themes included a *heavy religious influence around sex and birth control*, *abstinence only*, *strong push for parental consent for birth control*, *classes for sex education*, if any, and *sex education classes should only be taught in high school*. Other themes revolved around *little knowledge of Hepatitis C*, and even *if SHAC provided information to parents and teachers*. In each of these sections, I analyze how stigma begins to appear through the participants tones' and body movement. After revisiting my previous research (Henderson and Kawakami 2015), there was a common agreement that sex education was needed more in the schools. However, based on the coding process with the new interviews from school employees and current parents, there was a strong desire to not teach sex education past the basics, and that parents are to blame for students not being well informed.

Little Knowledge of Hepatitis C

Over two-thirds of the participants openly acknowledged they did not know, could define, or tell the difference of Hepatitis C compared to other viral infections. Possibly out of embarrassment, when asked what they knew or if they could describe Hepatitis C, they would laugh, look away from me, or cross their arms which is an avoidance strategy during conversations involving a stigmatizing topic (e.g. Goffman 1963; Rochelle and Kaufman 2011). I especially recognized the physical behavior in Eva, a married mother of two daughters, who was had a family member contract a form of Hepatitis. After she explained her family member's situation, she then began asking questions such as, "is C the worst?... I don't know the A, B all of that, so that is why I was asking you."

When I asked participants, who claimed to want more education for their children, they themselves could not answer what Hepatitis C is. Amber, whose son is in high school, bluntly said "no." When I pressed a little further asking if she could tell me any general piece of information about Hepatitis, she began to laugh. She also stated it made her feel "oblivious…it doesn't bother me because I don't know anything about it all!" However, she did feel her son needed to have more schooling about viral infections.

Several parents did agree it would not hurt to teach viral infections to high schoolers. Olivia, who has had several boys in high school, stated she wants her children to "have a general knowledge of it because I don'[sic] think it is things that they have ever heard of. I don't think they know they exist." She did implicitly recognize that Hepatitis C became stigmatized over time through her comment "when I was younger it was something to be scared of…" When learning about viral infections in rural communities, the older generations were taught to fear the viruses. This suggests the information is now either being lost or not passed down to the younger generations, which is resulting in misconceptions about the viruses. Annah who is among the generation most at risk for contraction, agreed Hepatitis C is "a worry with her age group…not sure what it is, all I know is now they are testing people for it all of the time at my age."

Although parents are agreeing there is a need for more education to students and even information to the parents themselves, teachers and administrators are admitting they do not have very much knowledge or training about Hepatitis C. After a younger teacher, Uma, stated she was "not really" familiar with Hepatitis C, she said the staff "takes trainings over it but that is about it."

Uma was not the only teacher in this position. William also could not recall information about Hepatitis C, and showed physical signs of embarrassment by smiling, leaning back in the chair, crossing his arms, then avoiding eye contact. He said, "No (laughs) I do-don't know. I know it's uh…no. no I don't know anything about it. I know you don't want it and that is it." He did not mention taking any trainings about the subject, and asked if it is taught in his school's health education class, he admitted he "couldn't tell ya…" the only way that it is taught in the class is if it's "in the book or it's on a handout, sure it is."

Parents are relying on information about Hepatitis C to be taught in the school, and even a few admitted that it is "not really something we have discussed in the home…" but teachers and administration in rural schools are not familiar enough with the information to be able to "give factual" lesson on prevention, contraction, and symptoms.

In the research I previously conducted, a local rural nurse admitted to diagnosing, but not treating, around thirty patients every month or so. However, in every interview with the exception of one, participants stated they did not know of anyone in the community or school who had the virus. Ismelda was the only person who "has known a few people in the community" who had Hepatitis C, but currently "suspects that they have Hepatitis C," but did not know if "they have openly admitted that." This lack of knowledge could also be considered suggestive of stigma surrounding Hepatitis C, in that individuals diagnosed do not feel as though they can or should talk about it openly.

Religious Influences

Over half of the sixteen interviews mentioned religion being a large factor in discussing sex, birth control, and how it was viewed in the home. Several mothers from School 2 discussed having the "sex talk" with their children grades sixth to tenth, which based on the constant shifting in their chair, made them uneasy. When asked about the most appropriate way to discuss sex education with their children, a common occurrence like Eva was wanting their children to "follow God's plan…and talked about how as humans, we distort it." Eva continued to discuss she was worried the values her family follows would be influenced if taught in-depth about reproduction or birth control. She felt unless she was the one teaching about "values" that her children would be slanted to believe that "it's ok to have sex and those kinds of things," meaning birth control is acceptable possibly even a gateway to the start of having sex.

Other moms from Schools 1 and 2 were worried their children would forget about the morals and values that are taught in the church. They were also taken aback when I asked about sex and birth control in school. Amber discussed how she viewed minors using "birth control as a ticket to premarital sex." Despite agreeing kids are engaging in sexual relations earlier and earlier, she would rather not allow a minor to have oral contraceptives because it does not follow what she believes as a parent, and as an active member of the church. Other than for "kids struggling with their menstrual cycle," she just "didn't know" if she could put her daughter on birth control for sexual relations.

In some cases, a religious upbringing influenced the parenting style around the discussion of sex and birth control. The respondents were following "God's plan" and preferred a Christian based talk in the home when discussing sex. When asked how sex is

treated in the home, Mariann wanted it to be based around knowledge, but also because her daughter "was not perfect…but still a sweet girl…and she 'knows.'" Mariann assumed her daughter knew that waiting until marriage was important for their home values, so there was not a lot of discussion surrounding the topic of waiting to have sex. After his interview, Adam, a father from School 1, mentioned discussion around sex in his home is based on religious preference, and "doing the right thing." By "doing the right thing," Adam, too, meant waiting until marriage to have sex.

Meanwhile, in School 2, Nichole had similar beliefs to Ismelda about pushing for abstinence in schools and the home. When asked her opinions about teaching abstinence only in schools, she replied with "…gets into the political and Christian aspect of it…it should have separation of church and state…regardless of personal beliefs…we have to educate based on facts and not opinions." Nichole noted the controversy with religion in relation to sex and birth control and said she felt the school "doesn't want to deal with a bunch of angry parents thinking they should only learn abstinence because of that religion."

For many, the interviews were mostly light and causal, however, my questions changed the tone, to a stern, almost lecture about what they believed to be good morals in terms of sex, birth control and viral infections in general, or for their children to believe "it's ok to have sex and those kinds of things…nothing that hasn't been talked about in Church" (Eva, School 2).

Push for Abstinence Only

A push for abstinence only was the most popular discussion between parents and their children. After discussing religion, many respondents would then discuss how abstinence only sex education classes were necessary for schools. Not every respondent agreed with the religious influence on sex education for the students. Ismelda, a nurse from School 3, acknowledged "the big focus in public schools is abstinence." She discussed living in a conservative state like Texas has done more harm than good for the children learning about "something [sex] we are programmed to do…if you act like it [sex] is something people don't do, then you are setting your kid up for…negative consequence."

Similar to discussing sex education in terms of religious morals, many of the pro abstinence parents and teachers discussed their opinions in a serious tone. When I pushed further with questions about why choosing abstinence only, eye contact would be broken, cell phones constantly checked, or a distance gaze would ensue. However, despite the feeling of taboo within the discussion, many parents were firm in their answering of wanting abstinence only curriculum.

Adam, when discussing birth control in a school setting, believed "parents…should have pushed it a little harder for their kids to wait till they get married, and influence that more." However, Adam was not the only individual who believed abstinence was the best option to teach children, students and teens about sex. Nine of the fifteen parents openly admitted to teaching abstinence and viewed engaging in sexual activity as morally wrong, or discussed sex in a negative tone. Annah, a teacher from School 2, believed there needed to be more education but "abstinence being the goal." When asked why abstinence needed to be the goal, and not just talking and learning about sex and birth

control, she stated, “education…without having the moral values with it [sex], then it might be…dangerous.” Here, stigmatizing practices are being developed by stating if one does not follow the moral values instilled in the community, then sex and birth control is literally a dangerous act.

In contrast, there were respondents who realized that the push for abstinence only for sex education was “unrealistic.” Uma reflected on her teenage years when discussing having only an abstinence only education. “It is important…especially as a high schooler…all you can get or could happen…parents need to get a grip on what is happening.” Uma did note when she discussed sex with one of her stepdaughters, she emphasized “she hope she wasn’t doing that [premarital sex], but if so, how to protect herself.”

William of School 1, who is a parent of several children and a high-level administrator, thought some parents were being naïve. As a result, it appeared he believed parents were possibly setting themselves up to raise grandkids along with their children. He stated, “you are a fool if…if you don’t [support birth control].” He understood abstinence only programs were failing the students in Texas and “the school’s role is ‘this is sex, this is how it works, this is how you can get pregnant, this is how you can prevent getting pregnant…these are the parts of the anatomy.’” However, he was also very adamant on “just covering the basics.” And not “taking over the parent’s role.”

The Preferred Sex Education

Every participant agreed health, not sex, education was acceptable. Discussion surrounding hygiene and basic anatomy was warranted; however, any information past

just the "basics" was more controversial. Once again, the discussions in class are related to morals, religious, or parents' position. Eva only agreed with a sex education program "you know, if they were geared more toward abstinence, which is more of my preference." However, she was not aware of the current health classes in School 2. Amber seemed upset when asked what kind of health and sex education she preferred for her son. She was quick to respond, "like a real life one. Like talking about true life sex, diseases, precautionary ones, not let's skip over this subject and be fake…As a freshman, he received nothing." Amber wanted a sex education that was realistic, that did not rely on abstinence, and, in general, for sex education to just be discussed at her son's school.

In School 2, many parents were happy with the sex education, and the classes matched their preference. The majority of the respondents wanted only basic information, and for a little more detail provided when the children were in junior high and high school. Nichole, who is on the school board for School 2, was able to provide information of the current health class. She quoted:

> I know they ssstart [sic]…doing…like what I would call a sex ed in like fourth, fifth, sixth and then they do a health ed class and then like a physical education… I know in like the fourth and fifth grade it is very generic. Boys and girls reproductive cycle things like that. But then when they get to 6th and 7th they start to get into specific topics.

In School 1 and School 3, there were similar results. Parents and school employees wanted a health and sex education, but only wanted some information, or no information at all. In another instance Olivia claimed, "I don't really think they get that [health education] other than the brief mentions in their science classes…biology possibly. Um,

I really honestly don't see them have it at all. So for them to have it at all, I would see it as an added benefit."

Additionally, they were not able to discuss what information is currently being taught to the grade level in which the students begin receiving the information. Uma, who has taught at School 1 for a few years, said, "Uhhh they might in high school…elementary they do not." Additionally, they were not able to discuss what information is currently being taught to the class, and had "…noooo idea" what their children were covering in terms of health or sex during the time of the interviews. In other cases, parents and teachers could not pinpoint the exact grade level in which the students begin receiving the information. Uma's statement is important because there are roughly 150 students, and the entire school is shared in one building.

Parental Consent and Birth Control

When I asked about opinions on birth control, I stated I was primarily referring to oral contraceptives and condoms. This is the question that caused several to squirm in their seats, shift back and forth, stutter, and occasionally blush in the face. There was a general agreement that birth control should "begin in the home" and should be talked about "after there was a push for abstinence." There were a few parents that believed birth control should be discussed after discussing abstinence, and years after, believing birth control first or with the sex talk instills "values in them" that would detour from abstinence.

When discussing birth control in a school setting, there were many parents and teachers that believed it should only be spoken about briefly, and not until the later high school years. But the school should have "every right to [to talk about birth

control]…talk about the subject, but I think when it gets down to the nitty gritty, that's the parents deal."

Some participants expressed contradicting attitudes about discussing birth control, birth control for minors, and the topic of sex at school and in the home. I asked one participant if she thought it was okay for teachers to discuss sex, and she replied, "I am going to say yes 'cause I think we should 'cause there is so many people who don't." However, upon further investigation, she was answering from a teacher's perspective. When answering from a parent's perspective, she slightly changed her answer. The answer changed to "if my kids came home and said we learned about 'blah blah' I know I would freak out a little bit." A similar response that echoed several respondents answer included, "I still think they need parental consent. I just feel that like that is something they don't need access to."

Some parents and teachers did recognize that some female minors needed birth control for medical reasons, but did not think minors should have access to oral contraceptives otherwise. Amber viewed birth control for female minors as:

> There are several different reasons for birth control. Um…specifically meaning females…the cycles and stuff like that. I would definitely continue to talk through and think it is not uh, this is not the end all be all, the possibility [for pregnancy and diseases] is still there, whatever factors into that.

Eva also believed that for medical reasons, birth control for minors was acceptable; however, "if you put them on it just because you are scared they are going to get pregnant…you're sending a message."

There were a couple of parents and teachers who did think birth control for minors over the age of thirteen was acceptable, and a part of "real life." Additionally, they thought they should still consult with a parent before gaining access to birth control. For example, Uma continued to recognize that teen sex was occurring: "We could at least help prevent it. I think if there were programs for that where parents consented and the kids would meet." Although she recognized the need for birth control for minors, she still believed parents should consent, and have a group meeting to discuss access in a program.

Other moms like Ashlyn and Nichole thought similarly, but were more relaxed about minors having access to birth control without parental consent. Nichole believed "that if you are able to drive a car, you should be able to buy birth control." Meanwhile Ashlyn just bluntly stated she did not think minors needed their parents' permission to obtain birth control.

Despite some parents agreeing birth control for minors should not necessarily require parent permission, the idea of the school having the ability to supply birth control to students did not set well with many. I even asked about supplying only condoms. In return, William asked me:

> When is there ever going to be a line in the sand in which a school is not responsible for something? You know? We are responsible for day care now, we are responsible for uh the-kids only nutrition for the day. Uh we are responsible for psychological needs. We are supposed…man…we are here to educate them, not give 'em a rubber.

Even Nichole, who had been very open until then "didn't have a problem with condoms." She was more worried about oral contraceptives because of "medical" reasonings. However, she did not think the "kids would feel comfortable because every single one of them [school employees] knows those kids' parents."

Parents, Teachers and Lack of Knowledge of the Student Health Advisory Council

Not only were the parents, teachers and community members generally unaware of Hepatitis C, they did not know what the School Health Advisory Council (SHAC) did, what was required, or if their school had a SHAC program. Once again, out of sixteen respondents only three were able to identify or discuss their district's SHAC. Because Nichole is a member of the school board, she was confidently able to say "yes" to her school having a SHAC, but also went into further detail that she is not a part of it, and because it was new to their high school this year it is "something that needs to be addressed" in terms of supplying parents and community members information about SHAC.

Again, because of his position within the school system, William was also able to claim School 1 had an active SHAC. When questioned about the frequency of their meetings, he admitted it is "not as often as we are supposed to…we have had to do it quite a bit here lately in the last couple of years-twice a year at least cause of uh-Department of Agriculture cafeteria audits." A SHAC is required to meet a minimum of four times a year, but this one was not meeting nearly as much. When pressed further about community involvement within SHAC, they had community members involved "but they moved." Now there no active community members helping in determining the curriculum for health and sex education within School 1. For the curriculum, William

"shows them [auditors] the textbook…they are ok with it. They just don't discuss much [curriculum]." And he firmly believed telling parents "wouldn't make any difference. At all. Nobody was gonna come" but it was "on the website" if any parents wanted more information.

In response, parents from School 1 did not know the SHAC program existed. Mariann was "not aware of" the SHAC program, or that is was a legal requirement for public schools in the state of Texas. When asked if she would be interested in more information or possibly serving on the council itself, she said "anything she could do to help anyone…she wouldn't mind." However, showing how she did not know any information about SHAC, she assumed it was a program to "just comforting someone, or getting them to talk to someone, just any little thing, I [Mariann] don't mind."

The health teachers at School 1 were not even aware of the SHAC program. When asked about the SHAC and knowing if the school had a program, both Coach Adam and Coach Andrews, who teach junior high and high school health education, looked at me with raised eyebrows which suggested they did not know. After I gave a brief definition, Coach Adam and Coach Andrew began talking amongst themselves in a concerned tone. They started asking each other if "they should probably be a part of it [SHAC]" or attend the meetings. Additionally, Coach Andrews thought the material he was having to use in the classroom was outdated. However, he also said because of "funding cuts...wouldn't be getting new material" any time soon.

Ismelda was the only non-school employee who was aware of SHAC and was a volunteer member. Within School 2, she stated their SHAC "will have something that has happened in other schools and they want us to take a look at our policies and things. And

sometimes we will have specific things that will come up that we want to address as a school." However, they also reviewed their health policies and curriculum, and "invite some-some of the student to be a part of that meeting." Because she said they did review health education and curriculum, she was then asked if School 2 discussed sex education curriculum. It was not until "just last year when that really came up." In response, School 2's SHAC invited "senior students to come and talk…about they learned and if they felt it was helpful or not." When properly implemented, SHAC has the potential to create a helpful environment with student engagement, and education about sex and Hepatitis C along with other viral infections. For example, having a variety of SHAC members could provide different opinions for the sex education. Ideally, all members would come to an agreement of what should and should not be taught within the classroom. Additionally, having high school members discuss with the SHAC members what is being learned and what should be implemented within the classroom would give students a voice in the learning process as well.

Parents who previously claimed they wanted more information provided within the school also did not know about the SHAC program. By participating within SHAC, parents would be in a position to influence the curriculum to have a more informative sex education class that also includes viral infections like Hepatitis C. As a result, stigma associated with Hepatitis C and sex could be minimized from the additional education to students and SHAC members.

DISCUSSION

After reviewing parents and school employees' opinions about health and sex education in their rural schools, I have come to determine that despite the verbal agreement of wanting more health and sex education, there is still a taboo surrounding the discussion of sex among minors. I would argue not discussing sex with children is influencing how community members view Hepatitis C after graduating high school, or not having an idea what the virus is. Several of the participants were long term members of the community, and were actually members of the same school in which were associated with through their work or children. However, these same members were not able to even describe the Hepatitis C virus. Almost two-thirds of the participants were certain that birth control, and deep discussion about sex were not meant for the school.

Birth control, Teens and Sex

In the United States, the average age individuals are losing their virginity is between fifteen and nineteen (Harden 2012). Rural communities would not be an exception. The vast majority of adults are blind to what is possibly happening with their teens. There is a strong belief that their kids would follow in their parent's moral footsteps, but few precautionary steps are taken to prevent possible infections and teen birth. Based on my findings, religion is the primary focus for understanding the rights and wrongs of sexual education. Without openly knowing the preventative options, there can be an association to Texas being in the top five states for high teenage pregnancy rates in the United States.

By only assuming their children and students would follow the moral path in which they try to instill at home, adults are creating a closed topic with no other options. Children are not allowed, or feel uncomfortable asking the questions that may help break stigma associated with viral infections like Hepatitis C and sex. Many parents admitted pushing for abstinence only within the home, but thought the very basics of sex education was acceptable in the school. However, by basic sex education, they appeared to mean an additional push for abstinence and only learning about the reproductive system. Birth control was only accepted if it was taught in the later years of high school. Teaching birth control that late in school does not coincide with the American average age of the loss of virginity.

Not only is birth control not a popular topic for their students and children, the mere thought of having the minimum of condoms supplied through the schools caused a lot of physical tension throughout the interview. More than one participant stated if their child or student was going to engage in sexual acts, then they had to be responsible for accessing their birth control, more specifically condoms. Putting the responsibility on the teenagers creates a circular problem because abstinence is taught in the home with no full education about birth control, yet they expected to accept full responsibility of knowing where and how to use condoms.

Supplying condoms in rural schools would seem problematic because of how close the community appears, and because of strong religious morals. When I was conducting the interviews, each participant was able to immediately suggest another participant, contact them, and then send me to visit. With the closeness between the community members, there could be a worry among the children and students the

information will circulate back to their parents. Instead of purchasing or seeking protection, there runs a risk for practicing unprotected sexual intercourse. Here we see teen pregnancy and sexually transmitted infections increase. In rural communities, there would be a great benefit to having a clinic that allows anonymous access to the minimum of condoms for minors attempting to protect themselves during sex.

Every community claimed to have some form of closeness, but also had a high percentage of at-risk kids. At-risk children come from underprivileged, lower income families with both parents working, or a single parent household. Most of the information on sex and viral infections that is received is highly likely to be received at school from teachers and peers. The school is where most meals are consumed, yet it is "too much pressure" for teachers and administrators to teach another life skill such as protection or engage in in-depth discussions in relation to sex and health. With high risk children relying on the school for most of their basic learning skills, and the schools referring to itself as a "family," it would only seem beneficial for the school to at least have the option to discuss sex in terms of what happens to the body, how to properly protect against unwanted infections and viruses, and options in terms of birth control, teen pregnancy and consent. Instead of completely doing away with sex education in public schools or using outdated information, students whose parents would rather not have a child learn in school can opt out. At least the students who do not have the option to discuss sex education at home would be able to have some form of information other than social media and peers.

Material Within the Classroom

Having outdated material also contributes to the stigmatizing of Hepatitis C. The health teachers at School 1 were upfront with the material being almost a decade old. Even within the last few years, education about Hepatitis C has become more updated (CDC 2010; CDC 2017; CDC 2018). For example, antiviral medications now have the ability to nearly eliminate the Hepatitis C viral load. When examining the textbooks that were being used in the classroom, chronic Hepatitis C is still primarily focused in the section referring to IV drug use and unprotected sex instead of examining the Baby Boomers. Additionally, Hepatitis C is only briefly mentioned along with other prominent viral infections in the United States.

Furthermore, the few chapters that address sex education and birth control are not used. Only basic reproductive education is covered, so the whole textbook is not being utilized. One of the biggest concerns that is presented here, the students are self-teaching about sex and viral infections during these skipped chapters. With the outdated material, birth control options are not updated, and then there is a reliance on peers. However, parents and some faculty are concerned about their personal morals being jeopardized, they are not considering the consequences of not fully educating the children on sex education. Parents and teachers avoiding the topics are missing out on self-educating as well because technology, medicine, and Hepatitis C has changed since the adults attended schools themselves.

When I asked about other science classes that may teach Hepatitis C, there was just a guess for the possibility of sex, health and Hepatitis C being taught during biology. However, due to the lack of funding many of the rural schools are receiving (e.g. Sanders 2018), there is not much of a promise the textbooks or handouts are covering more in-

depth about the topics. With parents and faculty protesting the discussion of sex and birth control in health education, there is not a promise that the topics would be covered in a biology class as well. Because health education is not a requirement by the state of Texas, teachers are better able to cater to the parents wishes about not teaching a subject within the classroom. For biology, however, teachers are only teaching the minimum about sex, birth control, and Hepatitis C that meet the requirements for the standardized tests. From the information gathered during the interviews, the majority of classes within 1A Texas schools are taught at the minimum for standardized testing because there is not extra available funding to teach outside of the course and degree requirements.

These issues underscore the need for properly implementation of SHAC programs. When the SHAC program is utilized in the way the state of Texas has it set up, parents are able to have an active voice when deciding what the school teaches about sex and health education. As I mentioned, the majority of the respondents did not know the program existed, or assumed it was just parents and volunteers mentoring children in terms of discussing sex and birth control. After reviewing the website and handbook for each of the three schools which I collected data, the SHAC program is clearly stated in a subsection with each of the handbooks. Once again, parents are saying they want to be more involved and know what the children are being taught, but the majority have yet to take the most basic step by reading the school's handbook.

Stigma of Sex Ed in Rural Schools Contributing to Lack of Hepatitis C Knowledge

Sex education is not the only focus within the class. There is an opportunity to present how teens and young adults can expect and protect themselves. There were a few of the younger parents and teachers under the age of thirty who recognized despite

parents' persistent push for abstinence, the teens actions are not as likely to follow through when it comes to real life scenarios.

Additionally, parents and teachers are admitting that they do not know information about Hepatitis C, and they cannot discuss which class their child or student is learning the information, if they learn it at all. I argue the idea of being more actively involved with their child or student is generally only surface level. Although there were a few outliers within the interviews, most parents are voicing an opinion without fully knowing the extent of what could be talked about or information that is important to help protect the students.

In my previous research investigating how Hepatitis C stigma is created in rural communities, participants between the ages of thirty to thirty-five believed more information about sex, viral contraction and Hepatitis C should be discussed in schools. However, parents from this study are saying discussion of sex, birth control, and in-depth viral infection contraction needs to stay at home. Discussing these topics is centered more around a negative attitude. As a result, there is a prevention of children, teens and students being able to openly discuss questions, concerns and prevention. I feel this would increase the chances of believing Hepatitis C as only being drug and alcohol related, and continue to stigmatize individuals who have contracted the virus.

Without the feeling of being able to openly discuss topics like Hepatitis C and believing contraction can only occur through activities their parents taught them as being immoral, such as unprotected premarital sex, has contributed to future stigma of Hepatitis C. Around seventy-five percent of the participants discussed how they grew up in or near their current location.

With the majority of the respondents being individuals who returned to their hometown to teach and raise their families, I argue parents are possibly recycling outdated information about Hepatitis C. This is especially concerning considering parents stated not knowing any information other than transmission through bodily fluids like semen or blood. Although they believed more education on Hepatitis C was more acceptable than sex or birth control, I do not believe any would actively attend any adult meetings that could possibly educate the parents about the infections, the approaches taken in the classroom, and how to discuss topics like Hepatitis C at home. Based on facial expressions, sighs, eye contact avoidance, and tone of the voice, parents thought it was a good idea, but I did not feel it was not something that personally grabbed their attention of wanting to attend.

Without classes or education for the parents, and continuing to perpetuate a taboo against openly discussing topics that do not follow religious beliefs, Hepatitis C is continuing to be associated with stigma. I especially noticed how talking about the virus, despite not knowing exactly what it was or how it was contracted, made participants excessively shift back and forth in their seats. Just as Goffman (1963) stated, the attribute itself is not the stigma, but the interaction. Through physical response, the participants knew it was something "not good" as one described, but they did not know why, and possibly felt uncomfortable talking to a stranger about it. Not knowing is a part of the language causing stigma, because there is not discussion helping get rid of the negative associations.

Other particular concerns are the association of protection and discussion based on the gender of the child. A common theme that appeared was only associating females

with birth control. Again, Amber was not thrilled for her daughter taking precautionary measures for sexual relations, but her son was only mentioned when I specifically asked about the use and availability of condoms for him. To which she replied, “he’s a goin’ on his own…he can go buy [condoms] on his own.” When asked if the participants knew anyone with Hepatitis C, individuals would respond with male associated pronouns like “he.” When asked about questions with birth control, it was primarily female pronouns like “she.” This would even occur when mothers and fathers who had both male and female school aged children. Here, parents and teachers are placing responsibility on one member of encounters instead of all parties involved. Also, nearly every respondent discussed how children are engaging in sexual encounters earlier and earlier, yet did not believe birth control, including condoms, should be readily available to students. Parents and teachers are creating a double standard for the students by saying they want the children to be protected, know how to access resources, but do not believe should be able to access the protection without parental consent until they at the minimum can drive themselves to do so. Furthermore, having these double standards, along with telling the child they should only be pursuing abstinence, is creating the potential of a toxic relationship as a teenager.

Conclusion

Analyzing information from past and current research, who is at fault for not teaching the children sex, health, and Hepatitis C education? Larger schools are taking steps to help reduce teen pregnancy, and are teaching precautionary steps against viral infections without maintaining an abstinence only outlook. In states that have a rounded sex and health education program, meaning teaching protection, consequences,

abstinence-plus, how to use the protection, etc., teen pregnancy has been reduced significantly. However, rural Texas is struggling to follow suit because of the moral values parents teach at home crossing over into the way schools teach. However, with the emphasis on standardized testing there is not much room left to teach a rounded health and sex education in 1A schools.

Despite the likelihood of it happening anytime soon, if the smaller rural schools were given more opportunity for more education and training perhaps teachers would feel a little more comfortable openly discussing topics such as sex with students. In public schools, there is supposed to be a separation of church from the teachings, and general extracurricular activities (TEA 2018). As seen with the majority of the parents and teachers, there is still a heavy reliance on religious morals that is preventing an extensive sex education for students who could benefit due to their at-risk status. Based on my collected research, the best way to approach a change for more sex education is to have a better awareness of the SHAC program for the community, not skip the in-depth chapters in health class, but also have an option for parents to allow their student to opt out if they feel passionate about their child to not learn the information in the school setting. By doing this, the few kids who would be able to learn about the course would be better educated and in turn, when the discussion is brought up with peers, there is not misconception and facts instead of assumptions would be discussed. There was a general consensus a lot of information is learned through peer interaction, by allowing a few of the students learn, then they can be properly educated and hopefully pass on the information.

If more parents knew about the SHAC program, then instead of assuming and completely doing way with health and sex education, they can have an input of what can be taught, what they do not feel comfortable being in the classroom, and be more involved within the learning process.

There were limitations to my study. The sample size of sixteen is relatively small when comparing to the 2,000 rural campuses in Texas (TEA 2018). Additionally, sixteen interviews spread through three different campuses did not allow me to go as in-depth into the school system. I was only able to get higher ranking administration in two of the schools, and only one in each of those locations. The lack of higher-ranking respondents could be due to the generalizability with using a snowball sampling method. With this study only conducted in the state of Texas, I am limited in the application of the data to other states.

With this study limited to only Texas, I would like to compare the information to other rural schools in another southern states. Although SHACs are limited to the state of Texas, it would be interesting to find a similar program, or to see if one exists at all. Additionally, I would look at the presentation of sex education and parents views. If the findings presented itself with a similar outcome, looking at northern rural schools in the United States would provide a comparison to religious morals dictating sex education in schools. Most importantly, I would be able to determine if stigma with Hepatitis C and sex are more likely to happen in Texas, or if the stigma attached to these topics applicable in other locations.

Texas is among the twenty-six states who promotes an abstinence only teaching style in public school, yet the state also is highly ranked for teen pregnancy. Based on my

findings, students, teachers, and parents are using abstinence only in homes with a heavy influence of religious moral. However, the strict abstinence only discussions does not promote confidence in students asking questions about sex, pregnancy and preventions. The study is important to help bring awareness to sex education, and reduce the taboo around the topic of sex. Implementing a more in-depth sex education will help reduce stigma associated with viral infections like Hepatitis C in rural communities.

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