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ABSTRACT

Health and education matters in Canada are the responsibility of the government of each individual province. These opportunities for improvement in the Canadian system regarding Acquired Immune Deficiency Syndrome (AIDS) education exist. First, a nationally standardized curriculum is needed. Second, more time allocated for AIDS education is necessary. Third, media advertising that makes a strong impression upon the audience needs to be produced. Fourth, public health personnel are concerned about sexually active Christian youth who are not receiving information about reducing their high-risk behavior using modes of protection. Fifth, parents often exclaim that sex education should occur in the home, yet statistics say it is not happening there. Programs of education for special high risk populations such as street youth and Native persons need to be individualized. Canadian school psychologists should make a concerted effort to provide doctors and nurses with tools of education and support so that they can play a greater role in AIDS/sex education programs in schools. (ABL)

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SCHOOL-BASED HIV-AIDS EDUCATION IN CANADA

SYMPOSIUM: AIDS EDUCATION IN SCHOOLS

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The Americal Psychological Association

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AIDS EDUCATION IN CANADIAN SCHOOLS

Canada, a country with a population of approximately 25 million people, possesses an excellent health care system and an efficient public health system which work in conjunction with both public and private school systems. Once the political decisions were made regarding a national response to the AIDS epidemic, the staff members in the schools and local health departments collaborated to provide education programmes in the schools.

Insert Table 1 about here

As of April, 1992, there was a cumulative total of 6,116 reported cases of AIDS in Canada; over half (61%) of those individuals now are deceased (Health and Welfare Canada, 1992). The majority of cases are concentrated in the provinces of Ontario, Quebec, and British Columbia--and more specifically, in the cities of Montreal, Toronto, and Vancouver.

Insert Figure 1 about here

The major risk factor identified in these cases has been homosexual/bisexual activity.

Insert Table 2 about here

By 1993, it is anticipated that the cumulative number of AIDS cases in Canada will total 11,400. It has been estimated that the number of Canadians infected with HIV may be as high as 50,000 (Health and Welfare Canada, 1992).

As of April, 1992, children under 15 years of age represented 70 (1.3%) of the total AIDS cases in Canada (Health and Welfare Canada, 1992). Of that total, 56 were infected through perinatal transmission and 12 were infected through transfusions of blood and blood products.

Insert Table 3 about here

The categorical breakdown of children with AIDS was as follows:

under 1 year of age	36
1 to 4 years of age	23
5 to 9 years of age	4
10 to 14 years of age	7

As of April, 1992, there were 23 cases of AIDS among teenagers 15 to 19 years of age (Health and Welfare Canada, 1992). The majority of AIDS cases in Canada fall in the 30 to 39 years age group.

Insert Table 4 about here

WORLD AIDS RATES 91/92

SELECTED COUNTRIES

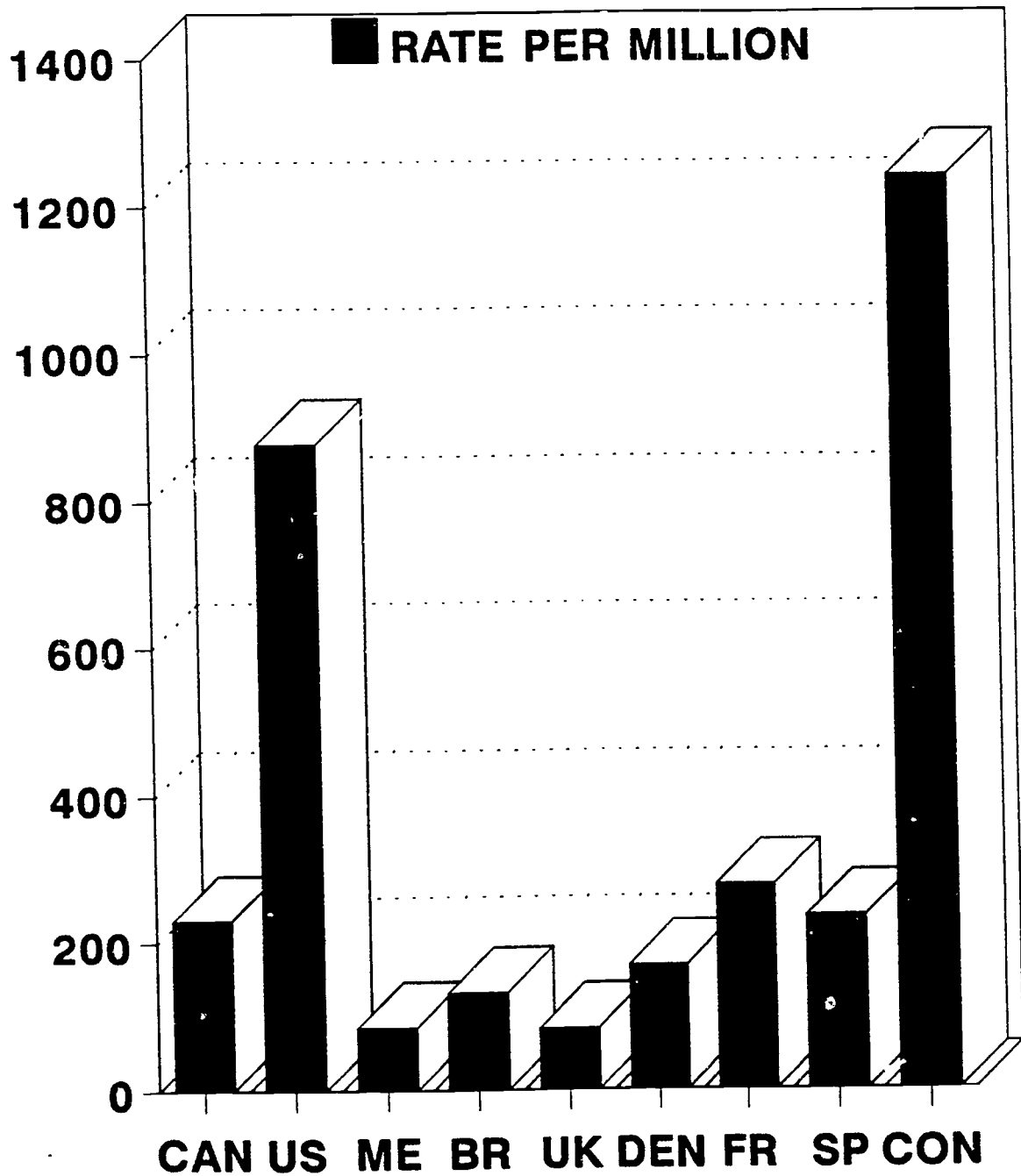


TABLE 1

AIDS IN CANADA

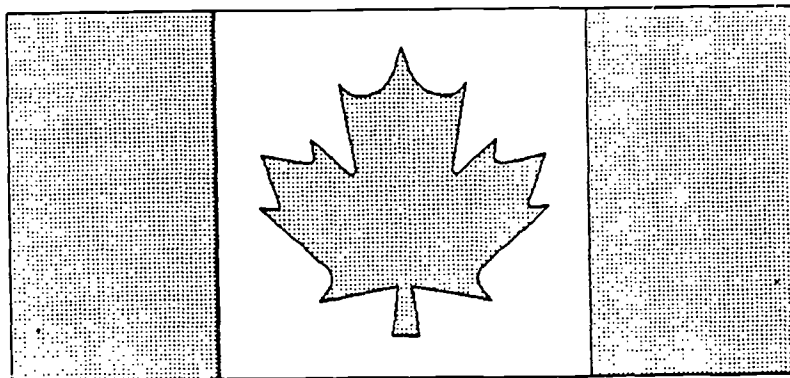
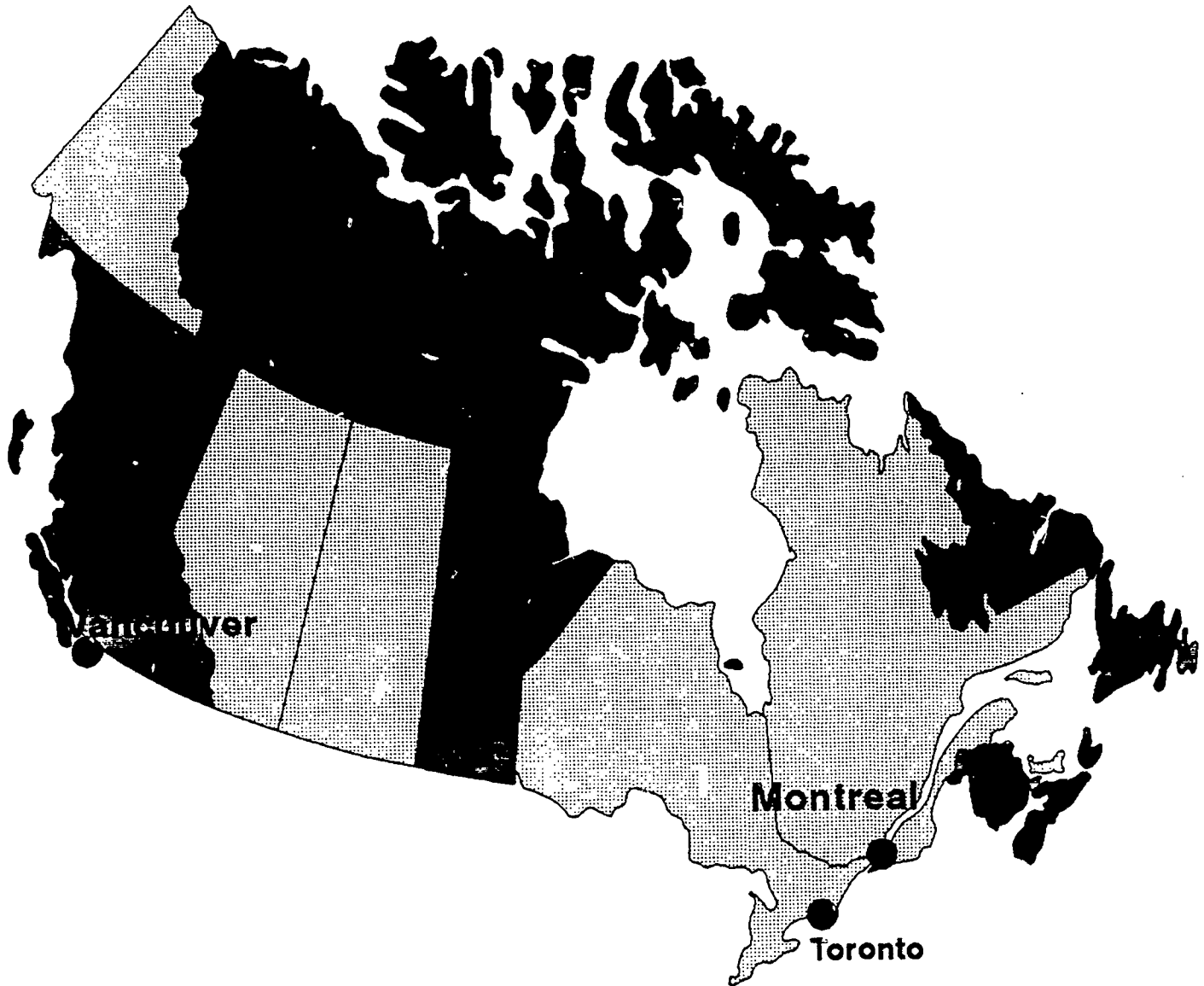


FIGURE 1

RISK FACTORS 1992

CANADIAN ADULT CASES

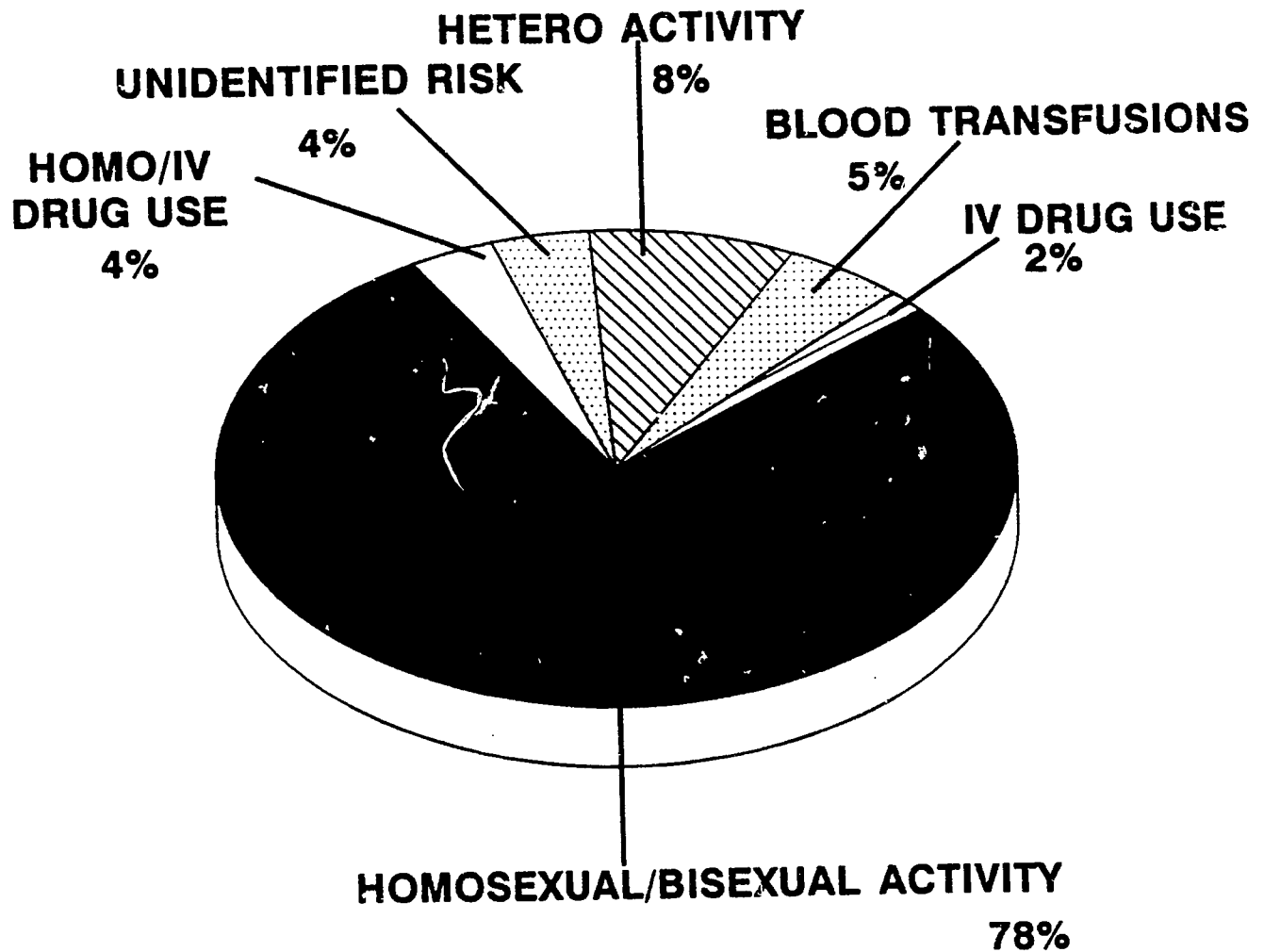


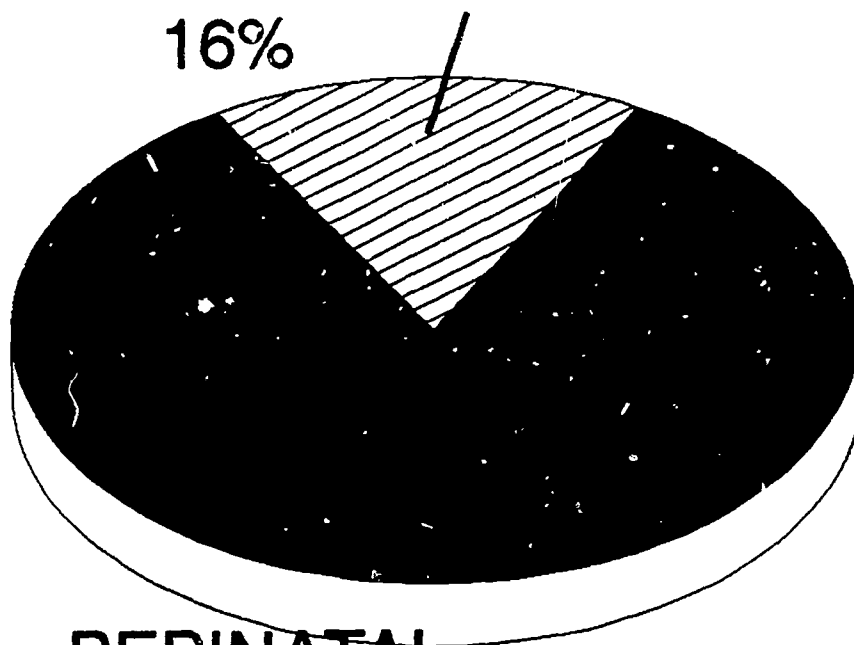
TABLE 2

RISK FACTORS

CANADIAN PEDIATRIC CASES

RECEIPT OF
BLOOD PRODUCTS

16%



PERINATAL
TRANSMISSION

84%

TABLE 3

AIDS IN CANADA 1992

CASES BY AGE AND SEX

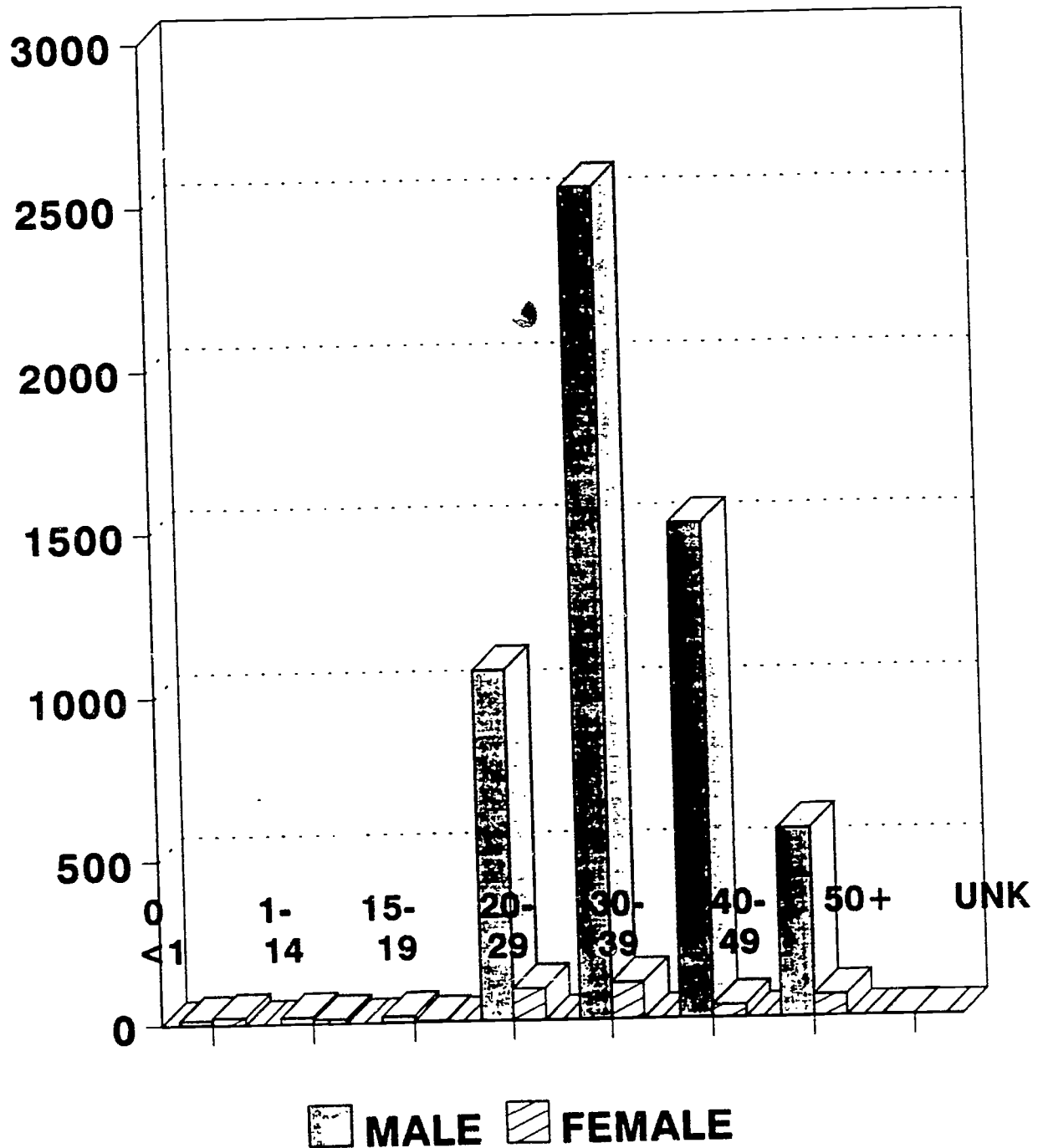


TABLE 4

Canada is divided into ten provinces and two territories. Health and education matters are the responsibility of the government of each individual province. Both the federal and the provincial governments are the two main sources of funding; however, the main focus is provincial funding. Typically, each provincial Minister of Health has an AIDS Advisory Committee comprised of service providers and AIDS activists. The majority of AIDS services actually are provided by non-governmental organizations. Also, at the federal level, there is a national Canadian AIDS Society.

In Canada, human rights are protected by both federal and provincial statutes. Special legislation has not been necessary since human rights tribunals have ruled that persons with AIDS or HIV-positive individuals are covered under existing human rights legislation. Of Canadians surveyed, 77% would permit their child to attend classes taught by an HIV-infected teacher, and 82% would allow their child to attend school with an HIV-infected child (Health and Welfare Canada, 1990e).

In general, personnel in the Ministry of Health and the Ministry of Education have collaborated to set policy for the AIDS curriculum in schools. These guidelines will be followed in both public and private schools since private schools must adhere to approved Ministry standards. A list of suggested curriculum materials is provided by the Ministry (Ontario Ministry of Education, 1987). Each local School Board, then, is permitted to choose its own individual approach to AIDS education provided it follows the provincial directives and utilizes the stated goals and objectives. Even further, each school principal usually has considerable individual power; so, this leads to great variability in terms of what is taught and how it is taught in each Canadian school.

The Roman Catholic private school boards in Canada have chosen to develop their own curriculum materials which emphasize sexual abstinence rather than the use of condoms to prevent infection from HIV (Institute for Catholic Education, 1987).

The Canadian Public Health Association, the AIDS Education and Awareness Programme, and the Life and Health Insurance Companies in Canada in cooperation with The Federal Centre for AIDS, Health and Welfare Canada, and representatives of Provincial/Territorial Departments of Education have developed and distributed a recommended curriculum for school children (The Canadian Public Health Association, 1990, Health and Welfare Canada, 1991c). The public governmental agencies have chosen to take a medical rather than religious orientation to AIDS prevention and emphasize the avoidance of high risk activities. Many public health officials are striving to have condom dispensing machines installed in schools and other areas accessible to teenagers and to implement clean needle exchange programmes in major cities where intravenous

drug use is evident.

Public health officials are balancing their role between prevention and intervention tasks (Anderson, 1991). The results of a survey of Canadian children (Health and Welfare Canada, 1988) indicate that amongst grade nine students in secondary school, 31% of males and 21% of females had had intercourse at least once. The numbers increased to nearly half amongst grade eleven students, and three-quarters of first year university/college students. Alcohol and drug use are related to AIDS in that they impair judgment needed for safer practices. In a 1986 study, 85% of young Canadians 12-29 years of age reported having taken an alcoholic beverage within the past year, and 44% acknowledged having used marijuana (Health and Welfare Canada, 1991b). According to a public health official, other risk factors with this population are intravenous drug use and prostitution. He stated that, in fact, underreporting may be a factor in the statistics which are currently available.

A special ethnic group in Canada which requires attention is the Native Indian population. There are relatively few Indians with AIDS but the proportion of cases is very high because of the related drug, alcohol, and prostitution problems. A recent study (Mickleburgh, 1991) indicated that the rate of infection with the AIDS virus among aboriginals on the streets of Vancouver was 50% higher than among non-aboriginal street people. Dr. Rekart stated that, "Their rate is higher because they are exposed to the virus more than others." Compounding this problem is the fact that Indian reservations (lands segregated for residences of Native Indians) are isolated, have poor sanitation, and are lacking in Native-oriented AIDS education programmes. Curriculum materials have been developed for the Native Indian population which focus not on the disease but instead on a holistic approach and emphasize keeping oneself and the community healthy and safe (Health and Welfare Canada, 1989, 1991a, 1991d, 1991e).

Typically in Canada, the public health nurses provide health education and services in the schools. In many places, the public health department ensures that AIDS education occurs in the schools. The nurses, however, must interface with the school system which means in some locales that they must wait to be invited into a school. Parents, teachers, principals, administrators, and school board officials maintain the authority to determine when nurses will teach, what they will teach, and how much they will teach. Thus, their instruction is individualized for each school and even for each classroom. A government report states that "approximately one third of all parents do not have sufficient knowledge about AIDS to teach their children about the disease and how to avoid HIV infection." A survey of Canadian adults, however, found that 97% support AIDS education in the schools (Health and Welfare Canada, 1988).

Condom dispensing machines are slowly being introduced into public schools. Sixty percent of Canadian adults surveyed support the distribution of condoms in schools (Health and Welfare Canada, 1988). With that, however, there must be further education since only just over half of grade 11 and college/university students surveyed knew that condoms used with spermicidal gel/foam provide protection from the AIDS virus. Only 15% of grade 11 students and 13% of first year university students surveyed acknowledged that a fear of contracting AIDS would prevent them from engaging in sexual activity. Twenty percent of the AIDS cases in Canada fall in the 20-29 years category; because the latency for the virus can be seven or more years, it is probable those individuals were infected as teenagers. Some public health nurses had stated that the Canadian school/university students whom they have seen still view the risk factor of AIDS as confined to homosexual/bisexual activity.

Canadians are traditionally very conservative in their approach to life and are very respectful toward various ethnic/community groups. Media presentations in Canada are very conservative when compared to those of some other countries. Canadian school children who were surveyed indicated that they obtain much of their information about AIDS from television and print material (Health and Welfare Canada, 1988). Further study of media effectiveness and efficiency may be warranted.

Most Canadian students do not believe their parents know enough about AIDS in order to teach them (Health and Welfare, 1988). This generalizes to the population of teachers. Nurses have found that many teachers require education about AIDS as well as instructing about AIDS, and some feel uncomfortable even discussing the subject in class. Good curriculum materials are evolving but still there is no standard for curricula, and each person interprets them in his or her own way. In spite of this, a Canadian study (Health and Welfare Canada, 1988) did find that the more time spent in school on AIDS education, the more correct knowledge children possessed.

More than half of Canadian university/college students continue to live at home while they complete their education. This allows more opportunity, then, for family focused, rather than just individual-focused, education regarding AIDS. A group of children, however, who miss this opportunity are the "street youth." This is primarily a group of white middle-class youth who have gravitated from the suburbs to the "bright lights" of the big city. A combination of high-risk sexual practices and intravenous drug use puts many of these youth at special risk for HIV (Health and Welfare Canada, 1990a, 1990b, 1990c, 1990d). Illiteracy, and therefore limited ability to read information brochures about AIDS, is a problem. To counter this, public health nurses attempt to meet these individuals frequently getting to know them on a personal level so that they can provide them with small bits of

information every time they meet.

To summarize then, let us turn to what can be seen as opportunities for improvement in the Canadian system regarding AIDS education. Firstly, there is a lack of standards in curricula which suggests that there will be gaps in the education which some school children receive. Therefore, we need to move toward a nationally standardized curriculum.

Secondly, In many cases little time is allocated for AIDS education. In one school system, for example, the students receive AIDS education in health education as part of physical education which they take only once anywhere between grade nine and grade twelve. The children are at varying developmental levels depending upon when they receive their education. If students receive the education in grade 9, it may not have a strong impact and be forgotten by the time they are sexually active in grade 12.

Thirdly, Our media advertising is produced so as not to offend anyone. Unfortunately, it also is so bland that it tends not to make a strong impression upon anyone. Other countries produce much more explicit advertising which makes a stronger impact.

Fourthly, some public health personnel are concerned about some Christian youth who are sexually active but who are not receiving information about reducing their high-risk behaviour using modes of protection. If the Church will not permit education about methods of protection, then how can public health officials assist the Church and families to reach their youth who are at risk?

Fifthly, parents often exclaim that sex education should occur in the home; yet, statistics show that it is not happening there. Is that a euphemism for saying simply that sex education should not be discussed, or that sex education should occur in schools? Or, is it a cry from parents for help? If we give parents the tools to teach their own children, will they, in fact, follow through? A study by the National AIDS Information and Education Program reported that 76.3% of parents who stated they knew "a lot" about AIDS discussed AIDS with their children, compared with 19.4% of parents who indicated they knew "nothing" (National AIDS Information and Education Program, 1992). It seems important, then, that we need to include parents in whatever programmes of education we develop.

In addition, we need to individualize programmes of education for special high risk populations such as street youth and Native persons, and we need to concentrate our efforts on these groups.

And finally, according to a Canada-wide study (Health and Welfare Canada, 1983), most Canadians prefer to obtain their information about AIDS from doctors and nurses. Thus, it is my

opinion that Canadian school psychologists should make a concerted effort to provide school doctors and nurses with tools of education and support so they can play a greater role in AIDS/sex education programmes in schools reaching not just students but also parents and educators (Lief, 1988).

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