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ABSTRACT

Designed as a practical guide for English-as-a-Second-Language (ESL) teachers in facilitating adult students' access to information about Acquired Immune Deficiency Syndrome (AIDS), this manual offers materials, techniques, and guidelines for teachers who wish to introduce the topic into their curricula, and some discussion of the ESL teacher's potential roles in helping students get needed information. The manual not intended as a classroom curriculum or a resource about the disease itself. Content is based on the knowledge and experience of health educators working with newcomers in the area of AIDS and reproductive health; quotations and anecdotes from ESL classes and from an immigrant/refugee health program illustrate concepts throughout. An introductory chapter outlines the purpose and use of the guidebook and discusses briefly the role of the ESL teacher. The second chapter discusses the objectives of, need for, difficulty of, and key messages about AIDS education. The next chapter looks at AIDS education in a multicultural context, as both a multicultural health issue and a sexuality issue. Chapter 4 presents a variety of alternative techniques and approaches to AIDS education in the ESL classroom. Substantial appended materials include sample classroom exercises, supplementary materials, and lists of resources. (MSE) (Adjunct ERIC Clearinghouse on Literacy Education)

AIDS EDUCATION FOR ENGLISH LANGUAGE LEARNERS

A Guidebook For Teachers

Sarah Stevens

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AIDS EDUCATION

FOR ENGLISH LANGUAGE LEARNERS

A Guidebook For Teachers

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INTRODUCTION

PURPOSE OF GUIDEBOOK

This manual is intended to be a practical guide for teachers of English as a Second Language in facilitating access to AIDS information for their adult students.

It is not intended to be a curriculum for teaching about AIDS in the classroom. Some teachers may plan to include AIDS information in their curriculum; indeed some may already be doing so. But the actual curriculum for such a course is beyond the scope of this guidebook.

Neither is this intended to be a resource about AIDS itself, although all the basic information that teachers and students need to know will be covered. Many excellent resources on AIDS are available (see Appendix).

We focus on adult ESL (English as a Second Language) classes because most adolescents will receive AIDS education in school. We would, however, encourage teachers and curriculum planners in the general school system -- as well as public health nurses, AIDS educators, and other health professionals -- to see this guidebook as a valuable resource in AIDS education for all newcomers.

It is not assumed that all ESL teachers will -- or should -- be teachers of AIDS information. Because it involves issues both of multicultural health and sexuality, AIDS is an extremely complex topic. Any area of family life, sexuality, or reproductive health education should only be undertaken after careful preparation.

This guidebook will provide specific guidelines for those planning to introduce AIDS teaching in the classroom, but it will also explore many other roles the ESL teacher can play in helping students get the information they need. It will provide, for all teachers, guidelines for responding to the unanticipated questions and incidents that can occur in any classroom setting.

The guidebook will not take a theoretical approach, but rather is based on the knowledge and experience of health educators working with newcomers in the areas of AIDS and reproductive health. Quotations and anecdotes from ESL classes and from the Immigrant/Refugee Health Program of Planned Parenthood Manitoba help to illustrate concepts throughout the guidebook.

We hope that this guidebook will help ESL teachers not only to provide students with factual information on AIDS but, just as importantly, to open the way to community resources. As with many health concerns, lack of information and lack of access to resources are major risk factors for AIDS.

A note on personal pronoun use: To avoid frequent use of the awkward "he or she" construction, we have elected to balance the use of "he" and "she" throughout the guidebook. Except where the gender of a pronoun is dictated by the content at hand, the choice of male or female pronouns is arbitrary.

Dana Summers
The Orlando Sentinel
Orlando, FL

THE ROLE OF THE ESL TEACHER IN AIDS EDUCATION

The ESL teacher has a crucial role in AIDS education. Students see their teachers as much more than experts on the English language. The ESL teacher is in many cases the key, or only, source of information in a new country. She is trusted as an accurate source of knowledge and a guide to Canadian views and values.

Teachers are often all too aware of the limited resources for meeting the needs of newcomers. They know well the barriers -- linguistic and cultural -- faced by their students in accessing information and services in all areas of life. The ESL program itself has long been recognized as a key component in the orientation of immigrants to their new country.

A lack of accurate and culturally or linguistically appropriate information on AIDS, however, poses a risk that must be of concern to all of us. The ESL teacher is in a unique position to assist students in accessing AIDS information -- and in many cases may be the only person available to do so.

TESL Canada Federation believes that the ESL program has a responsibility to address this major health and social concern, but recognizes that "ESL teachers may feel unprepared or reluctant to address the issue of AIDS in the classroom." (See Appendix for full text of TESL Canada resolution.) This manual is one attempt to help teachers enter this new territory.

This is not to say that the teacher must herself be an AIDS educator. A teacher cannot be an expert on all topics, and it is unfair to place on the ESL teacher many new roles, all with no additional resources or training. Teachers can also play a role by facilitating first language instruction, acting as an information and referral agent for students, organizing guest speakers, and ensuring that appropriate print and audiovisual resources are part of any AIDS education effort. (All these roles are discussed in Chapter 4.)

You may find that many newcomers will not perceive AIDS prevention activities as a priority; employment, housing, and language skills are often of more immediate concern. At the same time, most newcomers *do* have concerns about health care in general, and reproductive health services in particular.

We should remember that it is often the less visible and more personal issues which can affect long term adaptation profoundly. Is there a baby expected which was not planned? How is the couple communicating about changes in roles now that he is unemployed and she is working? What is considered appropriate behaviour with a Canadian of the opposite sex? Where can one get information and help for personal or sexual concerns?

The current focus on AIDS has served to highlight the need for appropriate programming in these other areas as well. ESL teachers should take advantage of this opportunity to address broader concerns. In fact, we urge teachers to insist that AIDS education *not* be presented in isolation from other health and sexuality topics.

HOW TO USE THIS GUIDEBOOK

Regardless of what role you might imagine yourself playing in providing AIDS information in your ESL classroom, this manual is for you. AIDS is everyone's concern, and teachers in particular must ensure that they are not agents of misinformation. Whatever your level of comfort with this kind of topic, there *is* something you can do.

First, inform yourself. The next chapter, *AIDS Education: A Primer*, presents the basic facts about AIDS and AIDS education. The facts may be fairly straightforward, but getting them across is not so easy, particularly in an intercultural environment. The section called "Key Messages about AIDS" emphasizes seven fundamental points which every ESL student should absorb.

Chapter 3, *AIDS in a Multicultural Context*, discusses many of the issues which must be kept in mind in dealing with AIDS in a culturally appropriate way. How do people from different cultures understand AIDS in different ways? How might a person's immigrant or refugee experience affect her attitude about health information and medical care? What barriers to information and resources do newcomers face?

This chapter also outlines some factors which influence the effectiveness of health education in a multicultural or intercultural setting. It also discusses AIDS as a sexuality issue: The problems we have communicating about sexual topics in our own language and culture are compounded in a multicultural setting.

Whatever approach you think you might take towards AIDS education in your classroom, please read these two chapters.

Second, find out what you can do. Chapter 4, *Roles of the ESL Teacher in AIDS Education*, is a practical guide to the many alternatives for the ESL classroom -- from how to prepare the class for an outside speaker or field trip (and how to prepare the speaker for your class), to how to plan and conduct a comprehensive program on AIDS. Included here are guidelines for maximizing participation in the classroom and suggestions to help you get comfortable with the language of sexuality which is essential in teaching about AIDS.

Finally, do your part. The guidebook closes with a series of appendices to lead you to the resources -- background reading, curricula, audiovisual aids, local and national organizations -- that can help you carry out an AIDS education program. We include sample exercises and a glossary of terms identified as key during our work in teaching AIDS to ESL students.

We know this might not be easy. It is important for all of us to recognize that the topic of AIDS is not simply a health information issue. Touching on some of our society's most private values -- and greatest taboos -- AIDS is a topic that is stressful for most of us to deal with. Fears often lead to avoidance, for teachers as well as students. Experienced AIDS educators claim that people must be exposed to information five to seven times before it can be fully processed. Facing all the issues around AIDS -- our own sexuality, our values, our fears of mortality -- can also be emotionally demanding. It is hoped that this manual will assist teachers in working through this process, so that they may move into facilitating the process for others.

CHAPTER 2
AIDS EDUCATION: A PRIMER

OBJECTIVES OF AIDS EDUCATION

To prevent the spread of AIDS

The obvious objective for undertaking AIDS education with any group is to help prevent the spread of the disease. Education about AIDS is still our primary tool of prevention.

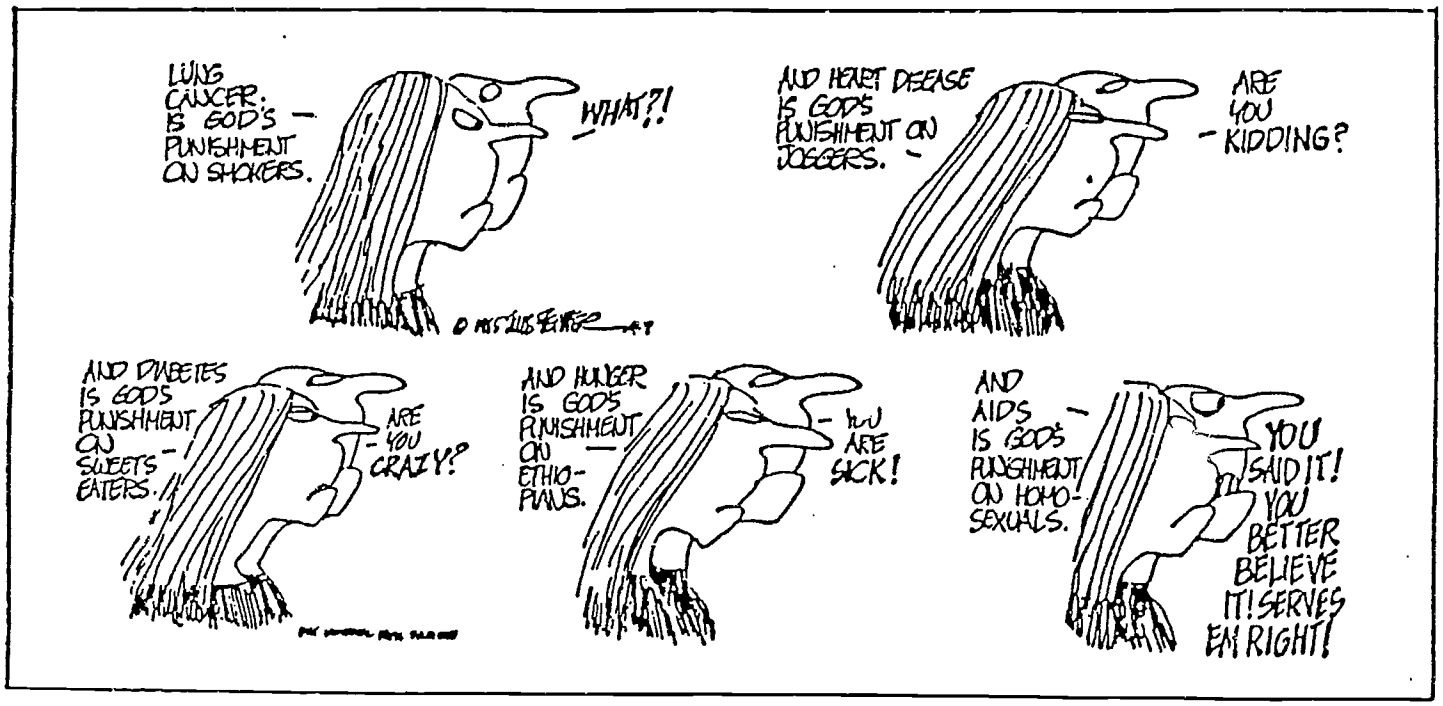
To decrease irrational fears

Because many newcomers are not getting accurate information about AIDS, they may be prey to irrational fears about the disease. They may be afraid of using swimming pools or the washroom facilities at the ESL class. They may be afraid to let their children play with others. They may also be dealing with anxiety that they themselves may be infected. While these reactions are common in the general population (in fact, an anxiety syndrome -- called AFRAIDS -- has been identified among healthy individuals), newcomers find it more difficult to clarify misinformation. Providing clear and accurate information on AIDS can help address and allay these fears.

To promote compassion and support for those infected with the AIDS virus

It is also true that AIDS is a reality in Canadian society. Some students (and teachers) will be well aware of this and may even know someone who is infected with the AIDS virus. Some students (and teachers) themselves are or will be infected. Others may feel that AIDS is not yet an issue in their community.

But it will affect all of us. No community will be immune. For this reason, a major objective of AIDS education must also be to promote compassionate understanding and support for those infected with the virus and for those affected, including their families.



Use these objectives as a teaching guide.
These three overall objectives are a good guide to keep in mind as you develop plans for addressing AIDS education with your students. Each initiative should be clearly directed to meet at least one of these objectives. This would suggest, for example, that detailed explanations of the immune system or discussions of possible opportunistic diseases, while perhaps of interest to some, are not the essential or "core" content which ESL teachers should be attempting to provide. In fact, using these three objectives as guidelines can help to keep this complex subject matter more manageable.

It's okay not to know.
Teachers often feel poorly equipped to deal with AIDS, as they feel there is so much that they themselves do not know. We may feel afraid to say anything if we are not sure of the facts. There may always be questions on AIDS, as on other topics, that we do not have the answers for. *But its okay not to know.* It is *not* necessary to become an "AIDS expert" to be immensely effective in meeting these three objectives.

WHAT DO STUDENTS NEED TO KNOW ABOUT AIDS?

The "facts of AIDS" themselves are not difficult or complicated. Everyone -- teacher and student -- should be aware of the following:

1) **AIDS is a worldwide concern.** AIDS is found in all parts of the world. No country, no race is immune.

2) **AIDS is caused by a virus.** This virus is found in the blood and body fluids of an infected person. However, it can only be transmitted if the blood, semen, or vaginal fluid of an infected person gets into the bloodstream of another person. This can only happen through a few activities.

3) **The AIDS virus cannot be spread by casual contact.** Unlike other viruses, such as cold and flu, the AIDS virus cannot infect another person by passing through the air and being breathed in by another person. It cannot be spread through food. So we are at no risk of infection from casual contact: sitting together, eating together, sharing telephones or toilets, shaking hands or hugging. We are also at no risk from contact with mosquitoes or animals.

4) **There are only a few ways the virus can be transmitted:**

   a) By **sexual intercourse** with an infected person. Throughout the world, this is the most common way AIDS is spread.

   b) By receiving **infected blood** or **sharing needles.** In Canada, blood supplies have been tested and the blood supply has been safe since 1985. In other parts of the world, however, infection from transfusions of infected blood or from improperly sterilized equipment is possible and, in some places, common. The most common route of transmission via infected blood in North America is from sharing needles for injection drug use.

   c) From an **infected mother to her baby,** either before or during birth and through breastfeeding.

5) **The AIDS virus can live in the body for a long time -- up to 10 years or more -- before the person shows any signs of illness.** During this time the person can feel, and look, completely healthy. So there is no way you can tell by looking at a person whether he is infected. And all this time he can pass this infection to other people.

6) **The virus that causes AIDS, called HIV, attacks the body's immune system.** The immune system fights disease. With a damaged immune system the body cannot fight disease. People with AIDS die of unusual diseases that a person with a healthy immune system could easily fight off. AIDS is the end stage of the process of infection with the virus, HIV. (HIV stands for human immunodeficiency virus.)

7) **There is no vaccine to prevent AIDS and no cure for AIDS**, although there are some drugs that can help slow the progress of the disease.

8) **AIDS can be prevented.** Education is our best defense against AIDS. In places like Canada where the blood supply and medical practices are safe, everyone can prevent the spread of AIDS by these measures:
   a) Practice safer sex.
   b) Don't share needles.

9) **There is a special blood test which will show whether a person is infected with the virus.** Anyone who thinks he may be infected should talk to a specially trained counsellor to see if he should be tested and, if tested, to discuss the implications of those test results.

Terms and concepts mentioned here are defined and discussed in detail in "Teaching Points and Background Information on the Facts about AIDS," p. 77. The glossary, p. 142, covers words and phrases used throughout the manual.

SO WHY IS THIS SO DIFFICULT?

Many teachers may feel that because the basics of AIDS are so simple, there is really no difficulty in teaching them to their students. This apparent simplicity is misleading in many ways:

Effective AIDS education must take place within the context of sexuality education.

Unlike many other topics undertaken in the ESL classroom -- such as citizenship, food, or transportation -- sexuality education involves not only **KNOWLEDGE**, but also **COMFORT** and **SKILL**. It is not possible to teach effectively about AIDS without discussing the specifics of reproductive anatomy and sexual behaviours. We can not teach about AIDS unless we are prepared to teach, define, and use words such as penis, vaginal fluids, condoms, and anal intercourse. Any sexuality topic can be challenging even for an experienced educator and requires that the teacher come to terms with his own values and comfort, and often that he develop new approaches and skills.

> *"I was invited into an ESL classroom to do a presentation on AIDS. It went really well and people had a lot of questions. Afterwards the teacher thanked me. She said, 'I just can't believe you can get up in front of a class and discuss things like that. I know it's needed, but I just could never do it.'"*

AIDS education touches many sensitive issues.

In "mainstream" AIDS education and ESL classrooms alike, AIDS confronts us with many controversial issues on which we will not get unanimous agreement. For example, recommendations for condom use must be a part of any discussion of "safer sex." On this topic, some individuals will feel strongly that abstinence is the only preventive measure that should be taught; others in the same class will feel that there is something abnormal about a single man who is not seeking frequent sexual intercourse. Some Catholics will not support condom use because condoms are also a barrier contraceptive; this may create a deep dilemma, for example, for a woman who has doubts about her partner's faithfulness, but feels that it is immoral to request he use a condom to protect her.

AIDS is also a disease which is highly stigmatized and which, although it is a new disease, already carries a legacy of blame and discrimination. In teaching about AIDS, we must be prepared to discuss issues of racism, poverty, violence against women, and homophobia.

Teaching about AIDS requires a good grounding in general health awareness and orientation to health services.

Many students feel that they have not had adequate orientation to Canadian medical and legal concepts relating to health services. This area includes such issues as the rights and responsiblilities of patients and physicians, underlying beliefs about disease causation, health maintainence, and legal concepts such as confidentiality and informed consent.

Preparing your students for AIDS education is a good way to teach about these vital concepts which they will need throughout their interactions with Canada's health care system.

> *"One of the difficulties I found in teaching about AIDS -- even though the group understood English well -- was that many of the students were confused about the rights and powers of physicians, the public health system or the police. One common response was 'Why don't the police just pick them up and put them [people with AIDS] in jail?'"*

CONFIDENTIALITY

For those of us born in Canada, there are safeguards in place to protect our confidentiality. Even a court of law cannot (with some rare exceptions) force a physician, clergy person, attorney or spouse to repeat information given in confidence. Professional standards also help ensure that our rights are protected. Information that a person has been tested for the AIDS virus or is HIV-positive can only be shared with other professionals who have the need to know this fact, and any breach of this is considered professional misconduct.

Newcomers, especially those who are learning English, do not have the same protection in reality. They may not know what their rights are, and a non-professional interpreter may even pass on confidential information. In some cases, service providers themselves are not as mindful of the ways newcomers' rights to confidentiality can be violated; they may, for example, call in an interpreter without the client's permission.

The issue of confidentiality around HIV-testing, in particular, often raises grave concerns for newcomers, especially if they fear the results could affect their immigration status. At the same time, other newcomers may not realize the importance of confidentiality and may fail to pay enough attention in choosing an interpreter, even though a breakdown in confidentiality may have devastating results for them.

AIDS education is a multicultural health issue.

ESL teachers must not only present the facts, but also be sensitive to, and respond to, the complexity of cultural values and beliefs around sexuality and sexual behaviour, death and dying, help-seeking behaviours, communication patterns, and health systems, to name but a few. (This is discussed in detail in Chapter 3.)

Much of the standard AIDS information available for the general public is inappropriate and/or inaccurate for newcomers to Canada.

Consider, for example, information which discusses the risks of "deep" kissing, a practice unknown to many from Asian countries. Or the reassurances that are given regarding the safety of blood transfusion and blood donation -- accurate information for Canada certainly, but not for the large number of immigrants recently arrived from the many countries where blood screening and sterilization of medical equipment are not routine.

Even our (inaccurate) stereotype of AIDS initially as "a gay disease" is not necessarily shared by those from other countries. They may in fact label it as a "western" or "prostitute's" disease, depending on the stereotypes prevalent in their country of origin.

Current AIDS information does not recognize, let alone address, the barriers that newcomers face in all areas of health.

These barriers range from the frustration of not knowing where or how to obtain condoms, to the terrifying risks of breach of confidentiality which can occur when newcomers who do not speak English use untrained interpreters in such a sensitive area.

Giving the same information to newcomers as is provided to those born in Canada is not only inappropriate; it is unjust because it leaves newcomers vulnerable to serious gaps in their knowledge and their ability to access health services.

> *"I just finished doing a workshop for community leaders, an intensive training for trainers course. The response was fantastic. All of the participants had excellent English language skills; many were employed in helping other newcomers. But what surprised me was the widespread lack of basic information -- information on services, on how to access them, on what their options were."*

Anxieties about AIDS may trigger a range of other concerns, especially for women and people struggling with issues of sexual orientation.

Most of our AIDS prevention messages are built on behaviour change and on individuals taking steps to protect themselves. Because of this, many general issues about relationships, rights and power in male-female relationships, and relationship violence may be raised in response to an information session on AIDS. Because of the high rate of infection among gay men, people who have not come to terms with their own sexual orientation may be anxious about AIDS but unable to deal directly with many of the issues facing them.

What we can conclude from all these factors is that there are, particularly when working in a multicultural context, no simple facts about AIDS.

KEY MESSAGES ABOUT AIDS

A student is afraid to use the public telephone at the school. One member of the class verbally attacks another who is believed to be gay. There is an uproar in the whole community because a teacher at the local school is found to be HIV positive. A family is ostracized by its community because a family member is believed to have AIDS. A student in your class has left her husband because she believes he has AIDS. A student in your school is diagnosed with AIDS. How do you respond?

We STRONGLY URGE every ESL teacher to become familiar with the information in this section. No matter what role you decide to play in AIDS education, there are a few key messages that everyone should keep in mind. Even if you feel there is little you can do to deliver effective AIDS education in your classroom, this is the information you can -- and should -- stress whenever questions or concerns arise.

- AIDS IS EVERYONE'S CONCERN.

  One of the most important things teachers can do is to create an open climate which encourages everyone -- married or single, male or female, young or old -- to view AIDS as a concern of every responsible person.

  How can we do this? First, we should avoid presenting AIDS information as optional, as information that will only be of interest to certain people or groups. And second, we can present the information in a "safe" context. One approach many educators have found effective is to introduce the topic as a parental concern. ("What are children learning about AIDS in school?" or "What should we be telling our children about AIDS?")

  Never let anyone put down another student because of a question or interest in AIDS. Let your first response validate any expression of concern: "That's a concern of many people today. I'm glad this came up because its an important topic for all of us to be aware of." We need to talk about AIDS.

  AIDS is a disease which is now found in every part of the world. Outside of North America, the predominance of heterosexual transmission of AIDS means that it is already affecting men and women in equal numbers. This is a particularly important message as the number of cases resulting from heterosexual contact continues to rise here in Canada. No one can say, "I don't need to know about AIDS."

KEY MESSAGES ABOUT AIDS

- *AIDS is everyone's concern.*
- *AIDS is caused by a virus. No one is "to blame" for AIDS.*
- *AIDS is not spread through ordinary social contact.*
- *AIDS can affect anyone: don't make assumptions.*
- *There are specialized, confidential resources for AIDS information and counselling.*
- *A qualified interpreter is crucial for any AIDS education or counselling.*
- *Always get pre-test counselling before being tested for AIDS.*

- **AIDS IS CAUSED BY A VIRUS. NO ONE IS TO BLAME FOR AIDS.**

AIDS is not caused by homosexuality, or by "immoral" or "promiscuous" behaviour. No racial or ethnic group is biologically at higher risk than any other group. AIDS is caused by a virus, and viruses do not discriminate. It is essential that we avoid blaming those carrying the AIDS virus for their infection -- either directly (by labeling it with stereotypes) or indirectly (by talking about "innocent victims"). For if some victims are innocent, doesn't that make others guilty?

If this distinction is not made, it will be difficult to meet any of the three overall objectives. It may encourage those who are not in the so-called "high risk groups" to presume they have no need to take precautions. It may even cause students to "tune out" from basic information (because only "bad" people need to know this). It certainly does not lead to a climate of support and acceptance for those who are infected.

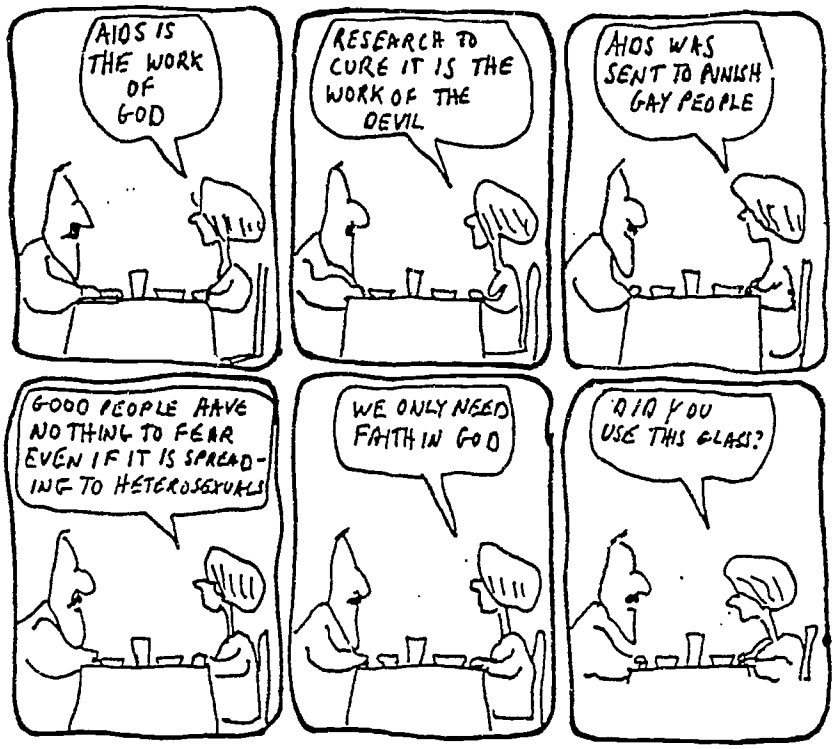
Try to avoid discusssions about where AIDS started. Do we ask where polio started, or smallpox, or tuberculosis? Throughout history, even into this century, communities afflicted by epidemics have blamed racial or ethnic groups for the spread of disease. Discrimination, quarantine, and too often outright persecution -- even torture and death -- have been the result. Unfortunately, many people's reaction to the AIDS epidemic has proven that we have made less progress than we might like to think.

- **AIDS IS NOT SPREAD THROUGH ORDINARY SOCIAL CONTACT.**

> *"One of the students in my class was thought to be gay.*
> *Because of this no one would sit next to him in class:*
> *They were afraid of catching AIDS."*

There is never any justification for denying participation in the class or in society to any person who is infected, or thought to be infected, with the AIDS virus. Because AIDS can never be spread through casual contact, we don't need to be afraid of people who are carrying the AIDS virus. We can safely work with them, learn with them, eat with them, and share the same public facilities. The only way a student or worker can transmit AIDS to a colleague is if they are having sex or sharing needles together. No discriminatory actions should be tolerated.

This is a key fact to bear in mind if we ever have to deal with panic and discrimination (as some ESL classes have) around someone who is known or feared to have the AIDS virus.



- **AIDS CAN AFFECT ANYONE; DON'T MAKE ASSUMPTIONS.**

  One of the most difficult points in doing AIDS education is the long period of time a person can be infected with the virus and still look and feel completely well. Many people assume that if someone is a clean, healthy, "heterosexual-looking" person, he is not infected. Conversely, someone who is poor or badly groomed or "looks gay" may be feared. We can't tell by looking at a person whether she is infected with the AIDS virus.

  We also can't tell by looking at someone whether that person is at risk for AIDS. We don't know about people's private lives. It is very likely that you have gay students, although they may not be open about their sexual orientation. The pleasant older woman in the back row may be married to a man who is involved in several other sexual relationships. We just can't make assumptions about the sexual practices or sexual orientation of our students.

- **THERE ARE SPECIALIZED AND CONFIDENTIAL RESOURCES FOR AIDS INFORMATION AND COUNSELLING.**

When students ask for more than general information, or show that they are genuinely worried about AIDS, it is important to make them aware of -- and refer them to -- specialized resources that can help them in your locale. (See Chapter 4 on the teacher's role as a referral agent.) Even when answering general questions, it is important to initiate discussion of what resources are available in your area (for example, AIDS information lines), and to discuss confidentiality and informed consent around testing and counselling. Many individuals who have personal concerns will be reluctant to share them in a class setting. This is why it is so essential to become knowledgeable about the resources available in your area.

Unlike many other health concerns, the standard response of "talk to your doctor" is all too often not the best course of action with AIDS. Not all physicians are up to date or comfortable with the topic of AIDS; some are reluctant to discuss the whole topic of sexuality. Perhaps more importantly, it is **strongly** recommended that a person **not** undergo AIDS testing without prior pre-test counselling. Few physicians have received training to do this.

An ESL student relates this story:

> *"Shortly after I came to Canada I was feeling unwell. I thought maybe I had rheumatism, so I went to the doctor. He examined me and took some tests and asked me to come back in a few weeks. When I went back he said to me, 'Well congratulations, Mr. A. You don't have rheumatism and you don't have AIDS.' I didn't know he was checking me for that."*

This example, unfortunately, is not uncommon. Not only did the patient not give informed consent for the tests performed on him; but had the results been positive, he would have been completely unprepared for devastating news. As the doctor also did not assess risk behaviours for this particular patient, we may wonder whether his decision to test was based on the fact that the patient was African. Was he reacting to the stereotype that Africans have a higher risk for AIDS?

- **A QUALIFIED INTERPRETER IS CRUCIAL FOR ANY AIDS EDUCATION AND COUNSELLING.**

In most cities in Canada there is no trained health interpreter service. Many health providers, including those providing HIV counselling, recognize the difficulty in working through an interpreter but feel that they have no other option.

What are the risks faced by an individual who uses an untrained interpreter for an AIDS testing or counselling appointment?

- An untrained interpreter will be unlikely to have command of the specialized vocabulary which is essential to transmit needed information. Just as importantly, unless an interpreter has some understanding of the health concepts being interpreted, misinterpretation can easily occur.

- An untrained interpreter may not understand the meaning or importance of confidentiality. Providers of reproductive health care to newcomers can document numerous cases where confidentiality was broken by an interpreter on such sensitive topics as an abortion request or on sexually transmitted diseases. There is no reason to believe that there will be any more protection for those seeking AIDS services. The fear of lack of confidentiality itself may often cause the client to withold essential information from the health professional. (For more on confidentiality, please see p. 11.)

- Few health professionals and counsellors have had experience or training in the use of interpreters. This compounds the difficulty of using an untrained interpreter, as the provider will probably not be familiar with techniques for assisting clarity of communication or be able to recognize problems. Many service providers do not realize that most interpreters are not trained, and so they may not take time to prepare the interpreter or be on the lookout for problems.

- Sharing personal information can leave the client at the mercy of the interpreter if ethical standards are not exemplary. Manipulation, blackmail, or coercion to convert to the interpreter's religion have been documented.[1,2]

- If the interpreter is the "wrong" sex, or is known or suspected to be of a different political persuasion, the client may not share needed information, no matter what the skills of the interpreter. (A skilled interpreter should be able to recognize these barriers -- and either reassure the client about the standards of professional conduct or find another interpreter -- but many interpreters are not trained in this area.)

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1. J. Shackman, *The Right to be Understood: A Handbook on Working With, Employing, and Training Community Interpreters*, National Extension College: Cambridge, England (undated).
2. Case documentation, Immigrant/Refugee Health Program, Planned Parenthood Manitoba, Inc. 1990.

- **ALWAYS GET PRE-TEST COUNSELLING BEFORE BEING TESTED FOR AIDS.**

Of great concern is the common advice, given to those who fear they might be infected with HIV, to "go and get tested" for the virus. This advice seems to be more commonly addressed to new arrivals to the country -- perhaps because of the difficulties in communicating basic information and assessing risk. Many newcomers are likely to rely on settlement counsellors, teachers, and sponsors (who often feel ill equipped to give advice or referrals) for information, rather than on health professionals.

The link which is missing in this advice is pre-test counselling. Pre-test counselling can help the client assess his own risk, weigh the pros and cons of taking the test, help prepare a client for a possibly unhappy result, and clarify inaccurate information. The post-test counselling (offered when the test results are shared) will help that the client understands the results, assist in finding appropriate supports as needed and encourage safer sex and other preventive practices.

Newcomers may also face unnecessary anxiety when the advice to get tested is presented (as it often is) along with a list of potential symptoms of AIDS. These symptoms include excessive fatigue, night sweats, swollen glands, diarrhea, weight loss; these are common symptoms for a number of ordinary diseases, and are certainly very common among new immigrants.

More than one person has committed suicide on hearing of positive HIV results. This risk can be minimized by providing appropriate counselling and information.

CHAPTER 3
AIDS EDUCATION IN A MULTICULTURAL CONTEXT

As we've shown, there are no "simple facts" about AIDS. The following overview is meant to give some sense of the complexities of doing AIDS education in a multicultural setting – including issues of culture, the immigrant/refugee experience, barriers to accessing information and services, and sexuality. It will outline many of the issues that must be kept in mind in dealing with AIDS in a culturally appropriate way.

It is hoped that this section will also provide background for those adapting general AIDS curricula for ESL classes. Many of the models presented here are also applicable to other areas in multicultural education, particularly health education.

AIDS AS A MULTICULTURAL HEALTH ISSUE

An intercultural approach to AIDS education

Many people within the health professions, settlement services, and ESL system recognize that there are additional challenges in undertaking AIDS education in a multicultural society. Not so widely understood is why this is so and how programs can be adapted in order to make them more effective.

Difficulties are often explained simply in terms of "ethnic" differences. People from certain countries have "different" beliefs and practices. However, focusing only on ethnic origin or newcomer status can lead to stereotyping, a denial of the variety and complexity within each culture.

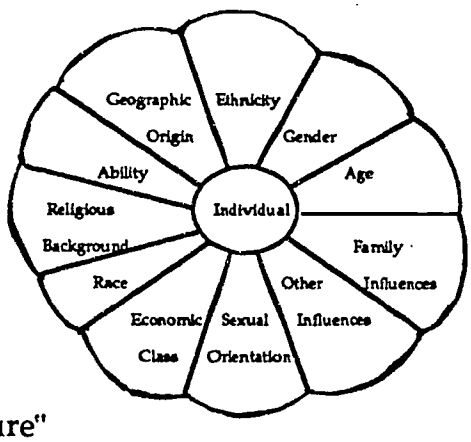
From the outset, it is necessary to distinguish between **culture** and **ethnic group**.

Culture refers to the totality of ideas, beliefs, values, and knowledge of a group of individuals who share certain historical experiences. An **ethnic group**, on the other hand, shares a common language, race, religion, or national origin.

In one country there may be more than one ethnic group: for example, a large proportion of Vietnamese refugees in Canada are ethnic Chinese. At the same time, we may find several cultures within one ethnic group. If we look, for example, at all Salvadoran refugees in Canada, we will find an enormous range in education, socioeconomic status, political orientation, and religion. Even though they are all of the same ethnic group, they would not share the same ideas, beliefs, values and knowledge: they would not all share the same culture. Within this group, even concepts of how the body functions and of how to maintain health may be radically different from one individual to the next.

Enid Lee gives us a useful tool for looking at the many different cultural identities we all have:[3]

This "petal" diagram includes both those cultural factors we are born into and those we take on, either involuntarily or by choice. Ethnic group is certainly an important aspect, as is race. However, our gender (we speak, for example, of "women's culture"), the generation into which we are born, our education, and religion all are other, powerful cultural influences. Later life events -- such as attending nursing school, joining a political party, living in a refugee camp, experiencing racism, or teaching students a second language -- can also give us a shared "culture" with people from many different countries.



The Petal of Culture

What implication does this have for teaching AIDS in a multicultural context? First, it helps remind us not to think of a student, and her sensitivities, simply in terms of her ethnic background. All the older married women with children in your class -- though they may be of many different ethnic origins -- may have more of a shared culture than the married women and single men from just one ethnic group. This gives us some guidance in creating comfortable groupings for discussion. The primary cultural influence in AIDS education may not be ethnic group, but age, gender, education, marital status, or sexual orientation.

Second, sharing such a framework with your class may help deal with a very common block in multicultural AIDS education: the tendency to stereotype one's own culture. (*"The women in my community aren't comfortable talking about sex." "Women in my culture are virgins when they get married." "There are no homosexuals in my country."*) Encourage your class to reflect on gender differences, generational differences, urban-rural differences, religious differences, educational differences, and family differences *within* their own cultures before controversial issues are introduced.

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3. Adapted from Enid Lee, *Letters to Marica, A Teacher's Guide to Anti-Racist Education*, Cross-Cultural Communication Centre, Toronto, 1985.

At the same time, it is true that certain characteristics are found more frequently in certain national cultures, and that values shared by the dominant group within a society will have a profound impact on attitudes and responses to sexuality topics such as AIDS.

Societies differ, for example, in their belief in planning and control. In North America we place great value on the ability -- and responsibility -- of individuals to plan their lives. Pierre Casse describes this as the **Staircase Model.**[4] Life is like a staircase: the goal in life is to get to the top of the staircase. The staircase of life consists of three stages -- learning, working, and finally, enjoying. One must work hard and sacrifice now to reach one's reward in the future. Planning is the key. One is in control, one is responsible, one can choose.

Most western health prevention initiatives assume this model. It is based on persuading the individual to take responsibility for his own health, to plan ahead, and to sacrifice when necessary. The outcome of behaviour is what is important (the top of the staircase), even if there is difficulty along the way. In AIDS education, then, the individual is urged to take responsibility for her own behaviour and to take necessary steps to prevent infection, no matter how difficult. One result is that this model tends to "blame the victim;" it leads to concepts such as "innocent victims," for if someone follows all the rules we believe that she should get her just reward.

Not everyone shares this assumption, however. Others are closer to the **Roller Coaster Model.** Life is like a roller coaster: It goes up, it goes down, you can't control the ride. The key to life is to enjoy the ride, make the best of what comes. You can't choose, there is no point in planning, you are not responsible. The goal in life is to adapt to the twists and turns that come your way.

This view, while found in individuals from every society, is perhaps more prevalent among individuals from developing countries (who are well aware of the hopelessness of widespread poverty) or among refugees whose whole lives -- in spite of careful planning and choosing -- are in complete disarray often through no actions or fault of their own. The belief that the individual does not have much control may be expressed by views that seem fatalistic to others.

In discussing her anxieties about an impending plane trip, one ESL teacher, a "white knuckle" flier, found she had two different responses from her Canadian friends and many of her students: *"My friends tended to reassure me by reminding me of statistics on the relative safety of air travel as compared to car travel. It was all an intellectual argument, and it stressed the fact that I was making a 'responsible' decision. A common reaction from my students however was something like this: 'If you're going to die tomorrow you'll die, even if you stay here and don't take the flight.' They did not see my choice of behaviour having much effect on whether I lived or died."*

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4. Pierre Casse, *Training for the Cross-Cultural Mind*, The Society for Intercultural Education, Training and Research, Washington, 1981.

The Roller Coaster Model also indicates that for many people the individualistic approach to health education so common in North America may not be the most effective. For if life is a roller coaster ride, we are all on the ride together, and focusing on persuading each individual to change his behaviour may not make much sense. In fact, researchers suggest that for some communities the most effective approach -- although slower -- is to work with community leaders to change overall community perceptions and priorities.[5] For example, urging women as individuals to insist on condom use to prevent AIDS will not be effective in many cases. If the cultural norm dictates that decisions on sexual activity are made by men -- if women are not suppposed to know much about sex -- urging women to be assertive individually may actually place them at risk of abuse or abandonment. Far more effective would be to plan educational initiatives on the community level, including both men and women and community leaders. It is important for all educators to keep this in mind when urging behaviour change.

5. R.F. Connor, "A Cross-Cultural Assessment of Health Promotion/Disease Prevention Programs," *Evaluation and Program Planning*, Vol.11, 1988.

Three perspectives on multicultural health

In developing or adapting health education programs for a culturally diverse audience, it is important for educators to consider the varieties of culture and experience which students bring with them to the ESL classroom. We offer here three perspectives from which these factors can be better understood. While this discussion focuses on AIDS education, most aspects would apply to other areas of health education as well.

The impact of the culture of origin on understanding AIDS

Those working with immigrants are well aware of the impact of culture on all aspects of life. This discussion will focus on particular issues which affect health and health education.

It is easy to see that the rate of HIV infection in the country of origin and the awareness of AIDS, its cause, and prevention in that country are of importance in doing AIDS education with newcomers. But there are many other factors to keep in mind if AIDS information (or other health topics) is to be effectively received:

Traditional patterns of sex roles:
Is it acceptable for couples to discuss sexual issues? Does the woman usually work outside the home? Which partner makes decisions about contraception? Are there topics (such as health education) which are considered traditionally a male or female sphere of influence?

Sexuality education:
When does it occur, in what setting, and who does it? Must men and women learn from those of the same sex? Who are the educators -- the school system, the church, the medical profession, or the family? Is a woman supposed to be innocent of all sexual matters until the eve of her marriage? (In some cultures it may be expected that men should be "knowledgeable" about sex and that women should be "innocent," but remember that these men may actually have less accurate knowledge than the women.)

Sexual practices:
What are the knowledge and beliefs around barrier protection (condoms), pre- and extra-marital intercourse, male and female circumcision?

Sexual orientation:
What is the awareness of (and attitudes towards) issues of sexual orientation? Is homosexuality recognized, or is its existence denied in the student's culture? What are the penalties, if any, for homosexual behaviour? How is homosexuality defined?

In some cultures it may be acceptable for a man to have sex with another man if a woman is not available, or for "kicks." In some cases a man who plays the "active" role (who penetrates another man) may not be considered homosexual; or penetration of a man known to be particularly effeminate may not even be considered sex with a "man."

In societies where there is little tolerance of homosexual behaviour, many gay men may marry women, but continue to have same-sex relationships. Differing patterns of bisexual activity have also been found in various cultures.

Beliefs around disease causation and health maintainence:
Does the culture accept western medical theory? Newcomers from China or Southeast Asia, for example, may have a very different view of how the body works, how organs are related to each other, what causes disease, and how to maintain good health.

Patterns of health-seeking behaviours:
Is help first sought within the family? Are traditional or home remedies usually tried before resorting to health professionals? Does the whole family (or mother) accompany an ill person when seeking care?

Taboo topics in health:
Is it considered "bad luck" to discuss certain health problems? Are there beliefs that talking about disease or medical complications will increase the likelihood of their occurring? Are there certain diseases that bring "shame" on the whole family?

Death and dying:
What are individual and family roles in the support and care of a dying person? Are there stigma attached to various illnesses? Do beliefs -- such as the common Chinese belief that the death of a young person brings misfortune to the family -- make discussion or acceptance of AIDS particularly difficult?

Expectations of health professionals:
What are the assumptions in communicating with professionals? Is questioning or asking for more information acceptable? Does admitting that one does not understand or is not happy with treatment cause the professional to "lose face"? Is the non-directive style of counselling popular in North America alienating to cultures represented in your class? Many people expect a counsellor to tell them what to do. Will a difference in expectations create difficulties when seeking advice, for example, on HIV testing?

Legal system:
What are the roles and powers of police, public health authorities, and health care providers? Does a patient have the right to refuse treatment and the right not to be tested without consent? These concepts, based on British common law, are not found in all countries.

Cultural stereotypes about AIDS:
If AIDS is perceived as "a gay, white disease" or "a westerners' disease," do community members feel themselves immune as long as they don't have sex with westerners? If AIDS is perceived as a disease of prostitutes, do those who avoid sex with prostitutes feel safe?

Impact of the immigrant/refugee experience

One perspective often overlooked in health education for immigrants is the impact of the immigrant (and particularly refugee) experience itself. Those working directly with newcomers are likely sensitive to many of these concerns, but it is important to keep in mind that most health professionals do not have this awareness.

Questions to be considered from this perspective include:

What is the HIV infection rate in countries of first asylum?
This may be more important information than the infection rate in the country of origin. Many Central American refugees, for example, have spent time in major American cities, where there is often a high rate of infection. Patterns of infection in countries of prior experience may also play a role in an immigrant's understanding of AIDS. For example, many new arrivals see relationships with prostitutes as the primary risk factor for AIDS, although in Canada this is not viewed with the same importance.

What preventive initiatives may people have been exposed to while in transit?
Some thorough AIDS education initiatives have recently been undertaken in refugee camps, and new arrivals may in fact be much more knowledgable than those who have been in Canada for some time.

Have there been prior problems with access to health care?
Before coming to Canada, many immigrants experienced poor or discriminatory care, which may affect their confidence in and use of health resources here. Coercive or insensitive care may cause distrust of the motives of care givers here in Canada. One health educator related the following story about one of her clients:

> *"A client came to me with a concern about obtaining contraception. I took her to a community clinic, where she had an interview with a very supportive family planning counsellor. She decided to take the birth control pill. Because she was starting the pill a couple of days late in her cycle, she was told to take two pills for each of the first two days. She agreed. Three months later she was pregnant. I discovered she had never taken the pills. When I asked her why, she said that she felt it was dangerous, that western medicine was 'too strong' for the body. She recalled how in the refugee camps, family planning workers had promoted abortion and the use of Depo-Provera for contraception [a drug not approved for contraceptive use in Canada because of side effects]. In fact, the camp residents called these workers 'the people who kill babies.'"*

So the helpfulness of the counsellor in assisting her to start a birth control method she had chosen was interpreted by the client as quite something else. (*"These people who kill babies are giving me twice as much of that dangerous medicine. It is not safe. They don't care about me."*)

What misinformation or discrimination has affected attitudes to AIDS?
Any group that has experienced racial discrimination may be suspicious of education efforts that appear to be targeted at them; they may be wary of being blamed for yet something else. Africans all over the world, for example, have been the subject of discrimination because AIDS was once labelled as a disease which started in Africa. This has often led to barriers in doing AIDS education with some African groups.

What are common views of government-sponsored initiatives?
Because of experiences in their own country, many newcomers may distrust government health education campaigns. Family planning initiatives, for example, are often perceived as population control programs, focused on certain racial or economic minorities. This may lead to suspicions about the real "agenda" in promoting condom use for AIDS prevention.

Whatever their source, suspicions that AIDS prevention programs are "government propaganda" may work against behaviour change, even when individuals have correct information. Said one health educator, "It's not that they don't have the information. The problem is, they don't believe it."

Has there been family disruption?
It is almost a given that family disruption is part of the immigrant or refugee experience, and this has profound implications for health education. In many societies, it is traditionally the role of older women to act as guardians of the family's health and as health educators for the younger generation. This link is lost in many communities where the older generation is left behind.

In particular, there is evidence that young single males who arrive in a new country without family have special health concerns. It may be that they are at higher risk for mental health problems and both unsafe sexual practices and injection drug use -- both risk factors for contracting HIV.[6]

Children of newcomer families find themselves growing up in two cultures -- often rejecting traditional values around relationships, but perhaps not assimilating North American values and safeguards. This will affect young people's response to the prevention messages in AIDS education.

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6. Personal Communication, Reginaldo A. Hernández Viscarra, Cross-Cultural Counselling Unit, Winnipeg., 1991.

What are the perceptions of Canadian sexual standards?
Many immigrants perceive that Canadians are very lax in their standards of sexual behaviour. Often isolated, probably not socializing with all segments of society, but widely exposed to popular media, newcomers are particularly vulnerable to this perception. Some newcomers may also mistranslate behaviours: A woman who talks freely with both sexes is sexually "available," for example. Some may see this "laxness" as permission to engage in risky behaviours, not realizing that these behaviours are not universally acceptable in Canada.

What changes have there been in women's roles?
Changes in the role and rights of women in moving to a new society may affect their sexual relationships and their needs in sexuality education. Some changes newcomers often experience include: working outside the home, greater access to information, and more freedom to date and associate with friends (for younger women particularly). In addition, many immigrant women will be experiencing for the first time legal protection from spousal assault and other rights as an individual under the law.

Has there been torture or sexual abuse?
It is also important to be aware that many refugees (in contrast with other immigrants) have been victims of persecution and torture (including rape and other forms of sexual torture). This occurs not only during detention but also while refugees are fleeing to safety (as in the case of the "boat people" of Southeast Asia). While it is difficult to accurately estimate the incidence of such abuse, a Canadian study found 15% of those who had been tortured reported also being raped. More common were reports of other forms of sexual abuse.[7] Another study found that 80% of female detainees who were tortured were subject to sexual assault. This abuse may have severe psychological and gynecological effects, including the transmission of sexually transmitted diseases.[8]

When doctors have participated in the abuse, as sometimes happens, the survivor's confidence in professionals and her ability to share information and trust in their advice will be profoundly shaken. Because of the number of refugees exposed to sexual violence, it is likely that any class will contain someone who has been subjected to it. Any discussion of sexuality may trigger memories of such trauma, and teachers should alert guest speakers to this fact.

Are there unrealistic expectations of life in Canada and of the powers of modern health care?
Many newcomers, especially if they have been at great personal risk or have suffered with poor or non-existent medical care in the past, have enormous faith in the powers of modern medical care. They may find it hard to believe that, having survived so much danger, they could possibly fall prey to an incurable disease or accident here.

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7. F. Allodi and G. Cowgill, "Ethical and Psychiatric Aspects of Torture," *A Canadian Journal of Psychiatry*, Vol. 27, No. 2, 98-112, 1982.

8. Ole Vedel Rasmussen, "Medical Aspects of Torture," *Danish Medical Bulletin*, Vol. 37, Supp. No. 1, January 1990.

Impact of barriers to access

This aspect of multicultural health care and information is the one which health care providers most often overlook, but the one of greatest concern to newcomers themselves. These barriers are numerous, and they can be described under the following categories:

Information barriers
Newcomers may lack information about AIDS, but more importantly they may not know where to get information or even whom to ask for referral. This lack of information extends well beyond the problem of AIDS itself, to the basic workings of the health and social services systems. ESL teachers must help to remove this barrier for their students.

At the Immigrant/Refugee Health Program, for example, it is commonly found that newcomers' needs for contraceptive information is only discovered after an unplanned pregnancy. Although the women were in contact with settlement workers, they often did not feel it was appropriate (or they found it too embarrassing, especially if the worker was male) to raise their concerns. They were never informed about what contraceptive methods are available, where they could go for information, or where they could get birth control supplies.

Cultural barriers
While many of those working with immigrants are aware of cultural "differences," they may be less aware that differences create barriers. There is little in the way of professional preparation for health care providers in intercultural understanding, and many may be unaware that their assumptions are not shared by the client, or that certain practices may be unknown or considered inappropriate in the client's culture. Some key cultural issues have been discussed on pp. 24 - 25. We must always keep in mind the sensitivity of sexual topics, and those which touch on values around religion, death, and the family.

Physical-geographic barriers
Hours of service, an unfamiliar climate, and lack of transportation or child care may make it difficult for newcomers to access services. In some cities even the AIDS information line is only available during office hours, a time when many ESL students are at work or in class.

Communication barriers
It is impossible to overemphasize the importance of communication barriers in any health area, but particularly in the areas of sexuality or reproductive health, which are intensely private and value-laden. The lack of trained health interpreters poses serious health risks for many new arrivals (see "Key Messages About AIDS," p. 13). The

consequences of lack of informed consent, avoidance of needed care, and misdiagnosis -- which can result from poor communication -- have been well documented.[9,10] Even when a patient is relatively fluent in English, misunderstandings can occur.

One ESL teacher shared the story of a student who talked to his physician about concerns that he might be infected with the AIDS virus. At one point in the conversation, the student inadvertently used the pronoun "he" instead of "she" in discussing sexual partners. Said the student:

> *"Immediately his approach changed, and he started talking to me about anal intercourse. It took me a moment before I realized what I must have said, and I tried to clarify things. But I could tell the doctor didn't believe me: No matter what I said he thought I was a homosexual. He was very helpful, but I was too embarrassed ever to go back to him."*

While this physician is to be complimented on his sensitivity in dealing openly with issues of sexual orientation, this incident illustrates how even a small error in vocabulary can lead to misinterpretation.

Administrative / systemic barriers

Barriers exist not only on a client level but also at a systemic one. Most AIDS prevention initiatives are only available in English or French, whether these are individual counselling services, pamphlets, AIDS information lines, videos, or radio and television programs. Educators and health professionals rarely have the intercultural training to provide culturally sensitive care. The reliance on strict linguistic translation for services not designed for or sensitive to newcomers means that many do not get the information or services they need. The reliance on untrained volunteers to provide such vital services as interpreting for health care means that newcomers often may not receive the same quality of care as do other Canadians.

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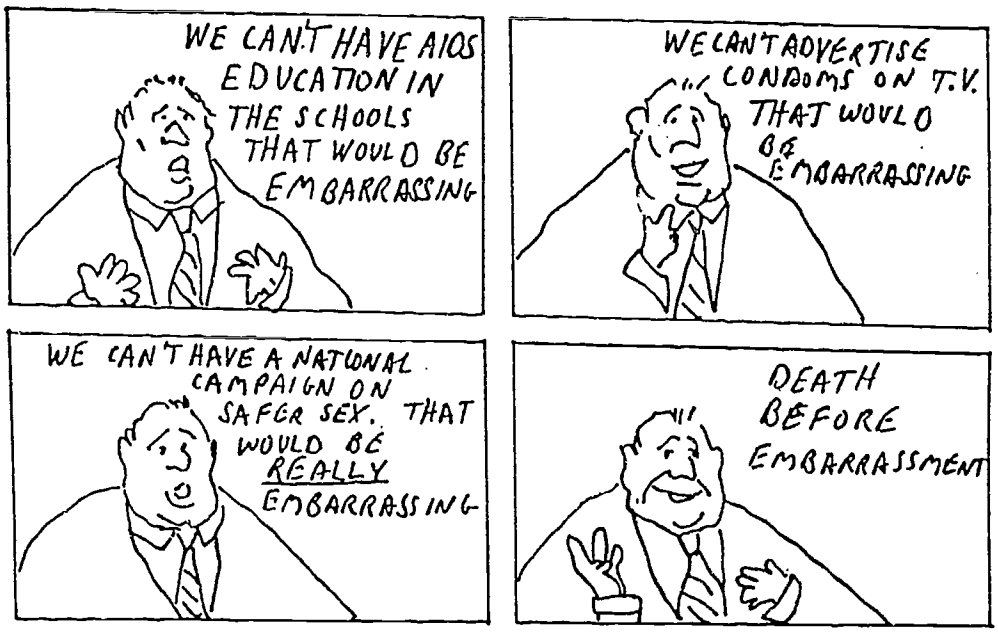
9. J. Shackman, *The Right to be Understood: A Handbook on Working With, Employing, and Training Community Interpreters*, National Extension College: Cambridge, England (undated).

10. Case documentation, Immigrant/Refugee Health Program, Planned Parenthood Manitoba, Inc. 1990.

AIDS AS A SEXUALITY ISSUE



AIDS is not only a health concern, but also a sexuality issue. We can't talk about AIDS without also discussing sexuality. And herein lies the problem: for most of us were brought up to believe that sex was something that "you just don't talk about." Even though our society appears very open about sex -- think of the availability of erotic films and magazines, the content of advertisements, sexuality education within the school system, and our tolerance of adolescent and premarital sexual relationships -- it is not so open and comfortable as it appears. As one young woman explained when asked why she and her boyfriend had not used birth control, *"It was just too embarrassing to talk about, you know. It was easier just to have sex."* Parents, themselves raised in the "don't talk" environment, now struggle to find the words to talk to their own children.

In all sexuality education it is necessary to be direct and specific and to avoid euphemistic expressions. (You've all heard the one about the young woman who was being interviewed by a cousellor: *"Are you sexually active?"* the counsellor asked. *"No,"* she replied. Two months later, the woman was pregnant. *"I don't understand,"* said the counsellor, *"You told me you weren't sexually active."* *"I'm not!,"* she sobbed. *"All I do is just lie there!"*)

Sexuality education with students who do not share a first language requires even more explicit descriptions, and often visual aids, to explain basic concepts. We cannot hide behind euphemisms. This means that the discomfort of addressing sexual topics directly is likely to be magnified in the ESL classroom. Just for practice now, try to explain for your students the term "vaginal secretions."

We are also hesitant to discuss sexuality because we are aware of the deeply held beliefs about this most private aspect of our lives, and because we do not want to offend others or be misunderstood. These hesitations are especially appropriate when working in a multicultural setting.

This does not mean that this earlier conditioning -- and our natural hesitation -- cannot be overcome. One of the best ways is to take courses in sexuality or family life education. Teachers in the K-12 system who teach family life topics are generally expected to undertake additional training and reading -- to clarify their own beliefs and values, as well as to gain background information and group skills -- before teaching about sexuality.

Learning to teach about sexuality means we have to look inside ourselves. It can be quite a journey of self-discovery. We are challenged to understand our own conditioning and the sources of our own values; to reflect on our own behaviour, our own fears, our attitudes about relationships and about differences between people.

Not everyone can or should undertake teaching sexuality topics. No one should let herself be pressured into undertaking this without proper preparation. The next chapter presents guidelines for a variety of roles ESL teachers can play which will help students get the information they need.

Of course questions and incidents about sexuality may come up even though we did not plan them. How do we handle them? First of all, it's okay to say you're not comfortable and feel embarrassed. But at the same time stress that you are glad that the person brought up the topic; that it is important to discuss it. If you need time to gather more information or to plan how to address a more complex subject, say so. But please don't forget to raise it again at the next class.

CHAPTER 4
ALTERNATIVES IN AIDS EDUCATION FOR THE ESL CLASSROOM

This chapter will look at many different ways the ESL teacher can help students gain knowledge about AIDS. We will discuss:

- Facilitating first language learning
- Acting as an information and referral agent
- Using mainstream AIDS education resources: guest speakers and field trips
- Using print and audiovisual resources
- Teaching AIDS in the ESL classroom
    - Before introducing AIDS in the ESL classroom
    - Planning a program
    - During your class
    - Teaching points and background on "the facts about AIDS"
    - After the session
- Summary "Dos and Don'ts" in AIDS education

Each section includes a discussion of the advantages and difficulties of each approach, a "how to" guide, and a cross index of "related issues" covered elsewhere in this guidebook.

One important reminder: AIDS education should *always* take place in the context of other health or sexuality topics. This point cannot be overemphasized.

While it is now generally accepted in the K-12 system that sexuality or AIDS information must be a component of a larger health or family life curriculum (and teachers generally receive additional training to teach sexuality topics), teachers of adults are more likely to be asked to provide a one-shot presentation.

Insist that the necessary building blocks (vocabulary, health and sexuality concepts) are covered before AIDS is introduced. Make sure that the discussion is not limited to the "facts on AIDS" but also covers access and cultural issues. Without this additional content, we run the risk of providing information to students that is, at best, only partly useful.

FACILITATING FIRST LANGUAGE LEARNING

One of the most effective approaches to AIDS education for English language learners is to facilitate the student learning about AIDS in his or her first language.

Advantages: Many experienced health educators believe that it is always preferable and often necessary for students to first learn about AIDS in first language, unless they are advanced (or at least advanced intermediate) English speakers. This is because students may not have a grasp of needed concepts for basic AIDS education. For example, if a student is not aware of "French kissing" or anal intercourse, it can be extremely difficult to teach the concept in English before it is taught in first language. After this initial instruction, further discussions can more easily take place in English.

This approach can also address the difficulties of teaching sexuality issues in a multicultural group: a facilitator who speaks the students' language is more likely to be aware of community concerns and to be sensitive to cultural values and beliefs around not only sexuality, but topics such as terminal illness, death and dying, health maintainence behaviours, and sex roles. Research indicates that on topics of reproductive health, information is best presented by a person of the same race, ethnic group, and gender, and in a language the learner understands.[11]

A presentation in first language can be a short-cut for teaching sensitive vocabulary, as the first language presenter can teach needed vocabulary in both languages. Teachers often find that after a session presented in first language, students show more motivation and confidence in learning related vocabulary in English.

Linking newcomers with resource people who speak their own language can also have long-term benefits for newcomers in other areas of their lives. After health educators of the Immigrant Refugee Health Program have talked with ESL classes about AIDS, a common result is the students' initiating contact with the educators for other health concerns.

Difficulties: First language sessions may be easily arranged if the class is a homogenous group. They are logistically more difficult to organize for students from many language backgrounds. One solution may be to work with other teachers to arrange a special event where there are several invited speakers. For such an activity, of course, it is not necessary to have students grouped by language level, only by first language. This event may be AIDS-specific or may be expanded to cover a number of general health or reproductive health concerns.

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11. Jon Fuller, "Contraceptive Services for Ethnic Minorities", *British Medical Journal*, Vol. 295, Nov. 28, 1987.

Finding appropriate first language speakers can be difficult. It may require some research to identify speakers who are skilled in presenting sexuality material and who are knowledgeable about AIDS. Smaller centres may have no such resource people. And it will be in the most newly established communities -- often the priority for both ESL and health education programs -- that it will be most difficult to identify speakers.

How to:

Seek out and advertise any information or workshop available in your students' first language.

Locate potential speakers for first language presentation. See the Appendix for any ethnospecific resources that may be available in your area. Other places to contact for suggestions: AIDS organizations, sexuality education organizations (such as Planned Parenthoood), ethnocultural associations, ethno-specific nurses associations, your provincial AIDS program or local public health department. Settlement agencies in your area or the family life consultant in your school division may also be helpful. Don't get discouraged if the first few contacts do not yield results. Ask for their ideas of whom you can talk to.

Select a speaker. Questions to help you assess a candidate include:

- *What is the speaker's knowledge of AIDS?* How did she learn -- by reading? (If so, what material? Check that it is not outdated); by formal training or observation of other speakers? (Who was the trainer?) Has she worked formally or informally with health professionals? (If so, get references.) Be aware that medical training is no guarantee that a speaker will be appropriate on this topic. Not all medical people are good teachers, and not all are up-to-date or personally comfortable with the topic of AIDS.
- *What is the speaker's experience in presenting to groups?*
- *What is the speaker's credibility in the community?* This may not be easy to assess but is very important. If speaker is distrusted for any reason, he is generally a poor choice to present such a topic.
- *Is this speaker appropriate for your particular group?* Keep in mind political and gender issues. For example, a single male will generally not be a good choice for a group consisting mostly of married women. A Nicaraguan may not go over well with a group that is predominantly from El Salvador. Remember that the credibility of the information will be affected by the person presenting it.
- *What is the speaker's comfort with sexuality topics?* Be prepared to ask questions that may help assess this; check for judgemental or homophobic attitudes. ("How will you feel defining 'semen' to the group?" "Who is to blame for the spread of AIDS?" Be on the lookout for responses such as "homosexuals," "prostitutes," or "started in Africa.")

Hold an orientation meeting with the guest speaker. Because you may be unable to monitor the content of a first language presentation, agreeing on a program together is vital. You should discuss the following:

- *Information on the participants* -- numbers, age, sex, educational range and cultural background.
- *What preparation has already been done* (information already presented preparatory exercises, ground rules).
- *Your objectives.*
- *Key messages* you want shared with the group. (Share the "Key Messages" handout on p. 14 and review it together.)
- *Outline of topics to be covered.*
- *What vocabulary is needed,* what has been taught, what needs reinforcing, what needs to be explained.
- *Your role.*
- *Follow up arrrangements.*

Remember that many facts about AIDS may also be new to the speaker. Check that the information used by the speaker is not dated. Even though the speaker may also be an immigrant, remember that she may not be aware of some of the issues facing newcomers -- issues such as interpreting risks, legal rights, and cultural bias in AIDS information. Be prepared to spend time going over the speaker's outline and filling in missing information.

An introductory AIDS session presented in students' first language should cover:

- Why is learning about AIDS important?
  Why is this being offered in students' first language?
  Objectives of session.
  Role of speaker.
  Role of teacher.
  Vocabulary to be learned.

- What causes AIDS?
  Simple overview of AIDS as caused by a virus that damages a person's immune system.

- How is AIDS transmitted?
  Clear description and listing of ways AIDS cannot be transmitted.
  Three ways AIDS can be transmitted.
  Different patterns internationally.
  Clear descriptions of risk behaviors.
  Vocabulary in first language and English.

- Can AIDS be cured?
  No cure or vaccine.

- Who can get AIDS?
  Preventing sexual transmission of AIDS.
  Preventing blood borne and needle-use transmission of AIDS.
  International perspective on AIDS prevention.
  Role of education in AIDS prevention.

- Where can students get more information?
  Community resources.
  Testing.
  Confidentiality.
  Need for caution with interpreters.

- Evaluation.
  Review of vocabulary.
  On what topics would students like follow-up?
  Arrangement for follow-up.

Related issues:
Working with an interpreter, p. 38
Acting as an information and referral agent, p. 39
Using print and audiovisual resources, p. 48

WORKING WITH AN INTERPRETER

It may be necessary, when presenting information to beginners or intermediate students, to work with an interpreter. Be aware that relying on an interpreter for such topics is fraught with dangers, as the following experience shows. This was related by the chairperson of a church refugee committee and concerns a 15 year-old girl who was in an ESL program at the local high school:

> *"The school where S. was going called and explained that they were having an 'AIDS Day,' a whole day dedicated to awareness and discussion on AIDS. They asked for my help in finding an interpreter for S. so that she could participate. I found someone I thought was ideal. He spoke English very well and was trained as a physician. Imagine my surprise when I talked to S. after the presentation. She had come away with the idea that 'women have to put something in their stomachs so they don't get AIDS.' She was thoroughly confused. I don't know what happened."*

What may have happened? Perhaps it was inappropriate for a man to interpret on such topics for a single girl. It may have been that, although the interpreter was a physician, he was uncomfortable discussing sexual topics and avoided using direct language in his interpretation. It may even have been that he himself was unclear on the facts of AIDS, or that as an untrained interpreter he had difficulty translating many of the terms accurately. In any event, this young woman came away with as many misconceptions as she had before her "education."

In many ways, a good interpreter for sexuality topics must have the same characteristics as a teacher. She must understand the concepts, have the needed vocabulary in two languages, and be comfortable and respectful in describing sensitive topics. The interpreter must be "right" for the individual or group for whom she is interpreting. In addition, the speaker must adapt her presentation to allow pauses for the interpreter to interpret. An inexperienced presenter may need practice in doing this.

Using a trained health interpreter can often avoid these difficulties, but unfortunately few centres have access to professional health interpreters.

In general, it is preferable, whenever possible, to have a trained facilitator present in first language rather than work through an interpreter. Check to see if a trained health interpreter is available in your area.

ACTING AS AN INFORMATION AND REFERRAL AGENT

Acting as an information and referral agent is not a new role for the ESL teacher. Even for those who choose not to introduce the topic of AIDS into the classroom, acting as a resource to those seeking information and services is a crucial and valuable role. At the very least, anyone who expresses concern about AIDS should be referred to an appropriate service.

The teacher may assume a passive referral role (providing information on community services to students on request) or an active referral role by, for example, including information on AIDS resources as part of a general health orientation session, or by providing to all students handouts which outline available services.

Advantages: Most of those working in the ESL system are already undertaking this role so little change is needed to incorporate AIDS issues and resources. Many more advantages are found in the active rather than the passive referral role, however, as many students who require AIDS information or referral services may avoid the stigma of requesting it.

One result of providing information to all students on community AIDS resources is that a certain level of information is available to the whole class. This approach also "normalizes" the topic of AIDS and helps communicate the message that AIDS is everyone's concern.

Difficulties: Some time may be required for research into what resources are available. In addition, because of fears and embarrassment associated with AIDS or because of language ability, students may not feel confident about taking the next step. They may require additional support and guidance in actually accessing the resource themselves.

How to:
Become familiar with the range of resources in your area. This is not as time consuming a job as it may appear. Many centres will probably have a listing already compiled. Phone your local AIDS information line (many are toll-free and province-wide), provincial AIDS program, or AIDS organization and ask if such a listing is available. Also contact your school division to find out who is responsible for AIDS information in the public schools; that person may be a good resource.

Your list should include: appropriate public health contacts, local AIDS organizations, AIDS information lines, services providing pre-test and post-test counselling, resource centres, gay and lesbian groups, groups of HIV-positive people, and needle-exchange, youth and street outreach programs. It is also helpful to include some national organizations, particularly ethno-specific gay and AIDS organizations and projects. (Resources section of Appendix should help you get started.)

Include not only sources of AIDS information, but also information about gay and lesbian organizations and resource centres. Sexual orientation is an important issue in AIDS education, and many students will have concerns and a need for information. They may not ask for it directly.

Get to know the services available to women in crisis in your area -- counselling, legal, and shelter services. Resources for culturally sensitive mental health and family counselling should also be part of your research.

Try to get background information on each resource, such as hours open to the public, services offered (information only or also pre- and post-test counselling, for example), and services available in languages other than English or French. Check to see if services have experience working with individuals from culturally diverse groups, and whether any of the staff have experience in working with an interpreter.

If you have time, contact key resources, explain your role, and ask them for advice on how your students can best access them. Many services will identify a particular person to ask for or certain terminology which is used within that service. One clinic gave the advice, *"Ask to make an appointment with Linda for a health education session."* This was this agency's way of allowing clients to maintain confidentiality while making an appointment; it also gave clients confidence in phoning, as it was clear who and what they should be asking for.

Introduce this information to students by means of:

- *Providing it as part of a general orientation on health services.* Many teachers are already including such a general orientation in their curriculum. This should include such topics as informed consent and confidentiality. You can then include information on specialized resources such as childbirth-related services or those dealing with sexually transmitted diseases, including AIDS.
- *Posting resource lists or posters from different services.* Posters in various languages are a particularly visible way to give the message that AIDS is an issue of general concern.
- *Distributing handouts to each student.* Providing handouts to all is preferable in that a student can refer to the information in private, and has information in hand should questions or concerns arise later.

Provide some orientation to your list of services in a class setting, so that students may make appropriate contacts. Provide specific information on how and when to access a resource; model appointment-setting behaviours. For example, you might say: *"This information line is open from 9-5 every day and until 9 p.m. on weekdays. A person can phone and ask any question about AIDS. They will not ask your name. The person who answers the phone will only speak English."* Another example: *"This agency is a good place for a person who is worried she might have the AIDS virus. A person can phone and make an appointment to speak to a counsellor. The counsellor will help a person decide whether she wants to take the test for the AIDS virus. When someone phones she should say, 'I want to make an appointment for pre-test counselling.'"*

Encourage and allow time for questions after your orientation. Indicate that you are available to provide more information and clarification, or that you can help individuals access a particular service if they still are uncertain how to proceed.

Remember to review and update your resource lists regularly! AIDS services, and the relevant information about them, may change rapidly.

Know when to refer students. Most ESL students in Canada will be living in a centre with specialized AIDS information and counselling resources. Make use of them. If you are unsure of the cultural awareness of the resource, you may offer to contact the agency on the student's behalf, or even -- if the student requests it -- serve as a liaison with the agency. But don't feel it's your responsibility to provide all the information or support a student may need. (Please see "How can I be helpful?" p. 42.)

Related issues:
Confidentiality, p. 11
Working with an interpreter, p. 38
Barriers to access, p. 29
Planning a field trip, p. 47
How can I be helpful? p. 42

HOW CAN I BE HELPFUL?

Because of the difficulty faced by newcomers in accessing resources, the ESL teacher is often asked for advice and guidance on a range of topics. The sensitivity of issues around AIDS requires special care. If any question falls out of the range of general information on AIDS -- into an area of personal risk or concern -- the student should be referred to an appropriate resource.

One model often used to distinguish the levels of helping and advice that can be provided in the areas of sexuality is the PLISSIT Model.[12] PLISSIT stands for:

P ermission

L imited
I nformation

S pecific
S uggestion

I ntensive
T herapy

Everyone can offer support at the **permission** level. This means that the resource person affirms the concern expressed and responds in such a way that the listener feels he has been heard, and that he was right in his decision to share his concern. So, for example, if a student expresses a concern about being infected with HIV, a response at the permission level might be: "Yes, that's a concern of many people these days." No judgement or shock is shown, and the response invites further sharing.

At the level of **limited information**, general information may be shared. This might be information on places where pre-test counselling is available. Or, if the teacher feels that the student is lacking basic information on HIV transmission, this level may include a brief overview of how the virus can and cannot be transmitted.

A **specific suggestion** may be appropriate also. If the teacher discovers that the student's concerns are based on actual participation in risk behaviours, she may make a suggestion that the student contact a named resource for more information or for counselling to decide about testing.

In no case would it be appropriate to enter the level of **intensive therapy**. No matter how close our relationship with the student, it is not appropriate to enter into the counselling relationship ourselves or provide an assessment as to HIV status.

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12. Jack S. Annon, "The behavioural treatment of sexual problems," *Enabling Systems*, 1975, (1), 56-58.

USING MAINSTREAM AIDS EDUCATION RESOURCES: GUEST SPEAKERS (ENGLISH PRESENTATION) AND FIELD TRIPS

If your students are advanced English speakers -- or if they have a good foundation in the vocabulary, facts, and issues around AIDS in first language -- using mainstream AIDS education resources may be your next step. This section discusses English-language presentations and field trips; the following section looks at using print and audiovisual materials.

Advantages: Experienced AIDS and sexuality educators know the topic and can provide up-to-date information. They also have training and skills in handling sensitive topics, especially those around sexuality.

Use of such resources also encourages links between newcomers and mainstream organizations and empowers new arrivals to function more independently. Knowledge gained can be generalized to other health areas. Experience shows that people are more likely to use a resource to which they have actually been introduced -- whether through meeting an individual or through a field trip to an agency. In training volunteers to provide AIDS information, the Manitoba AIDS Education Project found that public health nurses who made presentations as part of the training program received an increased number of referrals.

Advantages of field trips: It is much easier to "model" various access activities -- making an appointment or responding to requests for medical history -- by "walking through" a simulated appointment. If the contact person is willing, an actual agency setting is also conducive to role-playing.

Difficulties: Many mainstream health professionals lack experience in working with culturally and racially diverse groups. They may also lack sensitivity to the issues of concern to newcomers.

Many newcomers complain that presentations by health professionals are difficult to understand as they often do not know how to speak and present ideas in plain English. The HOW TO section that follows will attempt to address these concerns.

Another major difficulty is the potential lack of follow-up which occurs when a guest speaker is the only resource for a topic. Remember that it requires many exposures to a topic such as AIDS before any learner can fully come to terms with all the issues. This process may well take longer with an ESL student, as many key points may not be completely understood when presented in English.

How to:

Decide what topic or topics you would like to have a speaker cover.

- This may depend on the interests and concerns expressed by your students, and on how a guest speaker will fit into your overall program. You may want to choose a guest to present the "facts about AIDS" and undertake the rest of the topic yourself, or you may choose to have an outside speaker take on the whole program.
- *Be alert to additional topics that need follow-up as well.* After an initial introduction to a topic, a class may show a strong interest in dealing with sexual orientation issues, learning about other sexually transmitted diseases (STDs), or hearing in detail about how pre-test counselling is done in your area. Try to find a speaker who is knowledgeable on the exact topic you need.

Choose a guest speaker:

- *Start* by looking to provincial or local public health associations, AIDS organizations, community clinics, Planned Parenthood, or family life teachers.
- *Get recommendations* from individuals or groups who have heard the speaker do a presentation, especially for multicultural groups or English language learners if possible.
- *Meet with the potential speaker* to discuss your objectives before a selection is made. Try to assess:
  - What is the speaker's experience with ESL groups? Is her usual manner of speech too rapid or too complex grammatically to be easily understood?
  - Does the speaker seem to pick up cues as to whether or not she is being understood?
  - Does she have some knowledge of the international AIDS picture? One community volunteer, for example, phoned a local clinic to ask about the risk of HIV transmission from mosquitoes. The response was ambiguous: if they were Canadian mosquitoes there was no risk, but the clinic contact was not prepared to provide as definite an answer that there was no risk from African mosquitoes.
  - If she has no experience working with newcomers, is she comfortable with the idea? Are there any signs that she is bringing stereotypes which could be damaging? Watch for a patronizing attitude: it is easy for those inexperienced with newcomer groups to equate lack of English language ability with lack of experience or intelligence.
  - Does she equate newcomers with "inner-city" or "high-risk individuals"?
- *Allow enough time for planning.* Arrange to meet with the speaker and provide her with an orientation to your class and your objectives. Clarify what your role will be: for example, you will likely be needed to assist the presenter, facilitate discussion, and "translate" for the speaker, clarifying where needed.

Prepare the guest speaker for your class.

- *Regardless of their experience with ESL groups, all speakers should be informed about the makeup of your class:* size, sex ratio, age range, educational range, countries of origin, first language, religions. Are there any identified concerns

around AIDS or sexuality? Are there individuals who have expressed strong feelings on these issues? How long has the class been together? How does it function as a group?

- *Insist on an orientation,* unless the speaker has a lot of experience in teaching ESL groups. The speaker may be an expert on AIDS, but her knowledge will be of limited effectiveness if presented in an inappropriate way.
- *The orientation should familiarize the speaker with issues in teaching a multicultural group* including:
  - Differing expectations within the group of how discussions are held (need for ground rules, role of facilitator, expectations of teacher);
  - The range of awareness within the group of sensitive issues such as homosexuality;
  - Differing legal, health, and religious codes;
  - How differing cultural beliefs and values will affect individuals understanding of AIDS;
  - The possibility of self-stereotyping within any cultural group (*"In my community we always ..."*).
- *Provide some background reading* on AIDS education in a multicultural setting. Share this manual (for example, Chapter 3) or any other resources you may have available.
- *Provide some basic pointers -- and clear examples for each -- on communicating with ESL students:*
  - Define all vocabulary before use.
  - Speak slowly and clearly.
  - Use active rather than passive voice. (Instead of saying *"The client will be given a time for a follow-up appointment,"* say *"The counsellor will make another appointment for the client."*)
  - Use simple, direct grammar and vocabulary. Try to use terminology that students are likely to know, but avoid slang and idiomatic expressions. Remember that, especially when it comes to sexual vocabulary, students may only know "dictionary" terms if any; many individuals will not know the vocabulary in their own language either.
  - Use short sentences. (*"AIDS is caused by a virus. A virus is a very small germ. The name of the virus is HIV. HIV stands for ..."* This is more effective than *"AIDS is believed to be caused by a virus called Human Immunodeficiency Virus, or HIV."*)
  - Structure your presentation carefully, with clear sections in logical sequence. Stick to one topic at a time. Pause between topics, and signal that you are going to move on to new information. (*"Now I'm going to talk about ways that the AIDS virus can NOT be spread."*) A simple posted agenda will help this.
  - Provide visual support for your presentation, for example by writing key words on the board. Use visual aids (overheads, posters, models) whenever possible.
  - Repeat if you have not been understood, but don't change the words each time.

- Don't confuse simplifying your speech with simplifying ideas. "Talking down" to the group can be offensive to the class.

Plan the workshop together.

- Clarify your role.
- Ensure that the objectives of the presenter are consistent with your own.
- Review what content and vocabulary you will have covered prior to the presentation.
- Ask for an outline of the presentation so you will be prepared to facilitate the discussion.
- Ask to see any audiovisuals or handouts she plans to use. Offer your expertise in assessing their appropriateness for your class. Offer to adapt materials if this is feasible.
- If you plan to teach any vocabulary, go over terms the presenter will be using.
- Make arrangements for time to debrief after the session. Decide jointly what your evaluation procedure will be and what feedback she will need.

Prepare the class for the speaker.

- Clearly explain the topic and objectives of the session.
- Clearly explain the format and your expectations of students: Are they to listen politely until the end of the presentation or are they welcome to ask questions at any time? How should they alert you that they are not understanding the session?
- Complete any preparatory exercises that you have agreed to: climate setting, gathering questions, establishing ground rules, introducing new vocabulary.

During the session, remember that you do have a role to play even when a guest speaker is presenting.

- Introduce the speaker, and show your support and confidence in the usefulness of the topic. Help the students feel comfortable with the speaker and make sure that they are clear about how the session will go, and what is expected of them.
- Monitor the presentation. Interrupt and ask for clarification if you feel it is needed. If the speaker is having difficulty in defining terms simply, jump in and help. Have a few of your own questions ready in case the class is hesitant to start questions.
- Take care not to dominate the session. Your role is to help the students feel comfortable interacting with the speaker. You can make sure that the information presented is understood, but your role is not to direct the presentation.

Discuss follow-up arrangements with the presenter after the session.

- Is she available for individual questions? If so, when and how should students contact her?
- Could she return for a follow-up session?

- Provide honest and supportive feedback about the students' reactions. If this is her first presentation to an ESL group, there may be much room for improvement! Share your appreciation for her efforts and understanding of the difficulties. But provide any constructive comments which will help her in her next presentation to an ESL group.

Arrange field trips.

- Find out where AIDS information and testing are available. If you don't already have contact with any organizations, your provincial department of health (communicable diseases) will know of some. Check on which services have operating hours at the same time as your class or could arrange to be open at that time.
- Contact some of them to determine which may be able to host a tour for your class. Many services will be interested in this idea and may even be looking for ways to connect with the ethnocultural communities.
- You may choose to tour a community clinic, rather than an AIDS-specific resource, in order to incorporate more general health information. If you do so, be sure that services available in the areas of AIDS education and counselling are stressed during the tour.
- Prior to the class visit, provide the tour leader with the same orientation as you would a classroom presenter. If possible, do a "walk through" of the tour yourself, alerting the tour leader to potentially confusing points or concepts, and making suggestions for simplifying, clarifying, or expanding aspects of the presentation.

Consider the feasibility of working with other teachers to offer a workshop to health professionals, especially those involved in community education, on the topic of presenting information to a multicultural or ESL group. This approach has many advantages: it builds a pool of experts with experience and skill in teaching ESL students; it develops a resource for related health topics; and it forges stronger links between the ESL system, newcomer communities and health providers.

Related Issues:

Climate setting activities, p. 57
Ground rules, p. 56
Before introducing AIDS in the ESL classroom, p. 54
Four languages of sexuality, p. 109

USING PRINT AND AUDIOVISUAL RESOURCES

Any role an ESL teacher embarks upon in providing AIDS information to her students will probably include the use of print and audiovisual material. Teachers may choose to display and distribute posters, pamphlets and other print material on AIDS; establish an "AIDS resource centre"; include AIDS materials in an existing resource centre or library; or present audiovisual materials as part of the class sessions on AIDS. Where possible, materials should be made available in both English and other languages spoken by your students.

Advantages: Having information on AIDS readily available to all indicates to students that AIDS is everyone's concern. This may serve as a springboard into discussion of the topic. Making print materials available also enables students to access information privately, which some may prefer to do. Students learn in different ways. Even if information is presented in class there will be some who wish to have written materials.

Audiovisuals in particular can demonstrate clearly certain concepts such as "casual contact", correct condom use, and specific safer sex practices. As with any topic, a picture is worth a thousand words.

Difficulties: Finding material appropriate for English language learners is not always easy. Most English resources are too complex in language level for many ESL students. But simple translation is not the answer. Most resources have a cultural bias: they may make cultural assumptions which will be confusing to those from other countries, or they may omit needed information. Inappropriate material can be worse than no information at all: it may only serve to increase a student's anxiety and misconceptions. If questions and concerns arise after using a print resource, students may not know where to go for more information. This is another reason why teachers should be familiar with local counselling and information services.

How to:
Get on the mailing lists of national, provincial, and local groups who put out newsletters, information sheets, and updates on AIDS.

Put up posters. These can be in English or your students' other languages. A new poster may encourage questions or comments.

Remember that no pamphlet or audiovisual will cover all the information needed by your students. A film, video, or handout should never be used alone or as one shot AIDS education, but only as part of an overall program. Even if it does a good job of covering "AIDS facts," it is unlikely to deal with issues of concern to your students, such as the barriers to health care access. If there are gaps in the information, tell students what isn't covered. Tell them where they can go if they have questions after reading the resources.

Preview any audiovisuals to identify such gaps before they are used in class. Be sure your presentation not only reviews the information in the film, but also fills in the gaps. All AVs need careful selection, introduction, and follow-up with adequate time to clarify missed points and answer questions.

Review all resources for appropriateness for your class, and for ESL students in general. Check that the resource:

- *Is international in scope.* Can it inadvertently give misleading information because it is limited to North American reality?
- *Is sensitive to racial issues.* Try to find resources that have a multi-racial cast, but check carefully what messages are being given: Does it represent Canada's racial and cultural mix? Does it in any way "label" racial groups in terms of their risk of HIV? Some U.S. resources, for example, identify blacks as being at higher risk but neglect to discuss any reasons for this.
- *Deals with both heterosexual and gay issues.* Some resources are designed specifically for one group only.
- *Is at an appropriate language level for your class.*
- *Has clear and unambiguous graphics.*
- *Is not outdated.* Both print and audiovisual AIDS resources can become dated very quickly. Ask an AIDS educator whether the resource may be out of date. Early materials may contain inaccurate or inappropriate information.

AVOID resources that:

- stress complexities of immune system and immune response.
- stress symptoms of AIDS.
- are geared towards any particular "high risk group".
- are designed for school children.

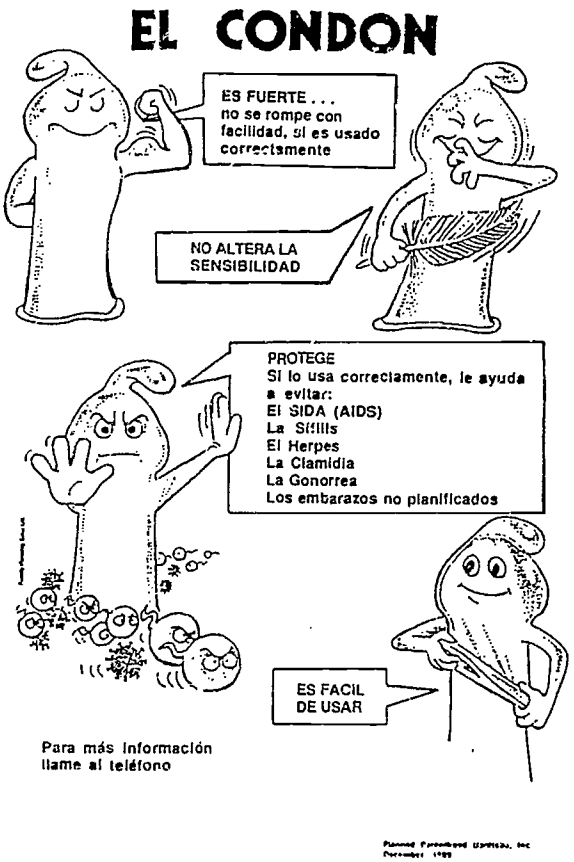
It may be that the only resources you can find at a simple language level are designed for children. Use these only with extreme care: as you know, limited ability to speak English is not the same as limited life experience. Inappropriate use of such resources may cause offence. Some AIDS educators may also suggest using resources designed for special education students (especially those with mental disabilities). NEVER allow these resources to be used without careful preview.

Include resources in the students' first language.

- These may be available from the National AIDS Clearinghouse (please see Appendix, p. 153, for address and phone number), your city or provincial health department, and local AIDS clinics or AIDS organizations.
- Students may also bring you other material from many different sources. Use these with caution: These are often dated, and most are "translations" of English language material. (One exception is a group of resources developed by Planned Parenthood Manitoba. Rather than being translations, these were developed in first language.)

- Before circulating any first language resource, have it reviewed by someone familiar with your students' language and culture. Ask your cultural informant to answer these questions about the material:
  - Is it culturally appropriate?
  - Is it easy to understand?
  - Is it well written (correct grammar and spelling)?
  - What topics does it cover?
  - What does it describe as risk behaviours? Does it talk of "risk groups"?
  - How does it discuss "casual contact"?
  - What is the general tone? Is it judgemental about those infected; does it "blame" any group for AIDS?
  - If it includes any statistics, what country do they refer to and for what date?
  - When was the resource written?

  You may wish to use an "AIDS Resource Evaluation Form", such as the one included in this section.
- For advanced students, you might make an assignment of identifying the differences between English and first language resources.



Be sure to include a handout of local places to go or phone for information and counselling, annotated if possible, so that students can follow up on any concerns and questions. Discuss the handout.

In your resource centre, include print materials for specific groups, such as gay men, parents, and women. This also allows you to provide very explicit materials -- on such subjects as "safer sex" practices -- which people can access privately, but which may be difficult to present in a class setting.

Keep adding new materials to your resource centre, including newspaper articles. AIDS information changes frequently.

Related issues:
Acting as an information and referral agent, p. 39

AIDS RESOURCES EVALUATION FORM

Type of Resource _____ Language _____

Content: Which of these topics are covered in the resource?

What is AIDS?		_____
Is there a cure or vaccine?		_____
How is the AIDS virus transmitted?		_____
No risks from casual contact.		_____
What are risk activities?		_____
Anal intercourse	_____	
Vaginal intercourse	_____	
Sharing needles	_____	
How to protect oneself.		_____
Abstinence	_____	
Mutual monogamy	_____	
Safer sex/condom use	_____	
Don't share needles	_____	
Signs and symptoms		_____
Testing		_____
Recommends pre-test counselling		_____
Where to get information and help.		_____

1. Accuracy of Information
   Is information correct and up to date? (If not sure, check with your Public Health Department or AIDS organization.)

2. Completeness
   Is any important information missing?

3. Reading Level
   How difficult is it to read? How much education does a person need to understand it?

4. Accuracy of Language
Is the vocabulary and grammar correct?

Are the sexual/health words correct?

Is it easy to understand? (If a translation, is the translation clear or confusing?)

Does the meaning change in translation? Does it make the information confusing or inaccurate?

5. Attitude
Does this resource:

Talk down to people _____
Blame groups of people for AIDS _____
Judge or criticize people with AIDS _____
Give a negative idea about certain
people or activities (eg. homosexuals) _____

Does the resource use scare tactics? _____

Could it cause fear or panic? _____

6. Appropriateness

Is the information presented in an acceptable way for people in your community?

Does it recognize cultural beliefs and values?

Does it recognize different patterns of AIDS/HIV infection between countries?

Does it talk about barriers faced by community members in getting information and services (eg. inappropriate information, need for trained interpreters)?

Is it misleading for people in this city/province (eg. does it tell people to phone an American agency or talk of costs for health care)?

Would you recommend this resource for your community? _____
Please explain:

TEACHING ABOUT AIDS IN THE ESL CLASSROOM

The teacher may decide to undertake the teaching of AIDS to her own class. To be effective, teaching about AIDS requires substantial groundwork.

Please note that these guidelines are useful whether the teacher herself or a guest speaker is presenting the topic.

Advantages: The teacher knows her own class. She is ideally placed to present material at their language level. She often has built up a level of trust needed to discuss sensitive topics. She is often seen as a credible source of information and a respected model of Canadian concerns and values. She is available for follow-up after the information is presented, and can return to the topic whenever the need expresses itself.

Difficulties: Most teachers have not had any specialized training in the area of sexuality, and this may be difficult to arrange. Time is needed to allow the teacher to ensure that the information presented is accurate and up-to-date, and to develop skills in presenting it. Many teachers do not feel comfortable or equipped to present on such a topic.

How to: Before introducing AIDS in the ESL classroom

Assess your own readiness

- *Allow time for preparation.* It's not easy to teach about AIDS. Don't let yourself be pressured into something you are not ready for.
- Remember that while having accurate, up-to-date information on AIDS is important, this is not enough. Besides *KNOWLEDGE*, it is necessary -- as with any sexuality topic -- to develop *COMFORT* in discussing the topic and *SKILL* in presenting sensitive information.
- The best way to prepare for this is to *participate in a training course* for AIDS or family life educators. Training may be available from your local school division, department of education, communicable disease division of your department of health, an AIDS organization or Planned Parenthood, or at the university level. Urge your employer to make training available for interested teachers. You have the right to be prepared.
- Use the more obvious need for AIDS information to lobby for a comprehensive approach to health concerns for your students. The same barriers to information and services around AIDS are also faced by newcomers seeking family planning, childbirth and parenting services, as well as resources on other sexually transmitted diseases.
- If formal training is not available:
  - Read. A recommended reading list for ESL teachers preparing to teach about AIDS is included on p. 153.
  - Consult with experienced AIDS educators. Arrange to observe some sessions. Evaluate them critically, observing what changes would need to be made to make the presentation appropriate for your class.

- *Realistically assess your own readiness.* Many manuals for family life teachers and sexuality educators have self assessment exercises. These help teachers measure their own readiness to undertake teaching of sexuality topics. An effective teacher on AIDS should be:
  - comfortable with her own sexuality and the topics to be covered;
  - open-minded and non-judgemental with respect to values, attitudes, beliefs and behaviour which may differ from his own;
  - respectful of differing cultural values, beliefs, attitudes and behaviour;
  - able to relate effectively to students (with honesty, warmth, sensitivity);
  - enthusiastic and willing to learn new information and skills;
  - respected by students and fellow teachers;
  - confident in the importance of AIDS education and the need for its introduction in the context of sexuality;
  - able to encourage discussion, questions, and respect for all points of view;
  - able to present information appropriate to students' abilities;
  - able to listen and to accurately interpret underlying concerns.

Assess the class to determine your starting point and focus.

As with any teaching, it's important in AIDS education to determine the knowledge level, concerns and needs of your class in order to design an effective program. Formal needs assessments are, however, often of limited usefulness for sexuality topics. Unlike less emotionally charged topics, in sexuality we can not expect all students to openly indicate their level of interest. Here are some possible approaches:

- Try to use discussions on already identified concerns -- such as finding a doctor or getting help with a pregnancy -- as a springboard into an AIDS-related discussion. Throw out some questions to assess interest and knowledge level. For example, in a discussion of admission to hospital, the question of blood transfusions may come up, or the teacher can ask whether anyone has any questions about the safety of blood transfusions. You can then volunteer the information that all blood used for transfusions in Canada is tested for HIV, the virus that causes AIDS. You may mention that this is a common concern, now that more people know about AIDS. In discussions about choosing a doctor, you can mention the other, specialized services available, such as public health personnel, community clinics, childbirth education classes, and AIDS information and counselling programs. Ask how many are aware of these health services.
- If students have already raised concerns about AIDS, you may be able to do a more formal needs assessment. You might ask directly what students are interested in learning, although this approach is often of limited effectiveness: many students will claim to have no interest in learning, for example, about safer sex practices for fear of inviting questions about their sexual activity.
- You could instead ask students to express anonymously their feelings about AIDS and the need for AIDS education by using a worksheet such as sample "Personal Opinions About AIDS" (p. 63).

- What may be more useful with such a group is a simple quiz such as the one on p. 64). This will give you a reading of the knowledge level of the group. It may also, if the class has a high level of comfort, provide an opportunity to clarify some key points about AIDS.

Determine "ground rules" for class discussion.

To ensure that everyone in the group feels comfortable participating, programs on sensitive topics such as AIDS should start with an agreement on how the discussion will take place.

Ground rules are especially important in multicultural groups. Besides differences in beliefs and values, each culture has its own rules for the conduct of discussions. What are considered personal or impolite questions may differ widely from one group to another, as do communication styles (for example, directness vs. indirectness, confrontation vs. avoidance of conflict).

Here are some essential ground rules. It's important to model an example of each ground rule as it is discussed.

- *No personal questions.*
  Give an example of what this ground rule means for you.
  > *"As a teacher, I can't feel comfortable talking about topics like sexuality if people ask me personal questions (questions about myself, my own behaviour or decisions). For example, it is O.K. to ask, 'Is it common for Canadian women to have sex before they are married?' But it is not O.K. for you to ask me, or another student, 'Did you have sex before you were married?'"*

  Check that the differences are understood, perhaps asking for another example.

- *The right to pass.*
  This means that no one has to participate on any particular topic. This rule is especially important if the usual rules for language learning in the classroom are that everyone must participate. This rule is important because it increases the comfort level for everyone in the class, and it recognizes that certain topics may be painful for some people.

- *No personal critisism or "putting down" of another person.*
  This can be tied into lessons on discussion styles and polite ways of disagreeing. Give examples of unacceptable ways of disagreeing: *"That's stupid," "That is immoral behaviour,"* vs. acceptable ways: *"I feel differently about that,"* or *"I disagree. I think it is important to..."*

- *Respect for differences -- of culture, religion, and personal values.*

- *Keeping confidences.*
  What an individual shares in the class stays in the class; nothing discussed in the class is repeated outside.

- *Even participation.*
  A few students should not monopolize the discussion. Everyone who wishes to should have a chance to speak.

- *One person speaks at a time; the others listen.*

Establish a safe climate for introducing the topic.

Before introducing any sensitive or potentially controversial topic, it is essential to establish a climate of comfort and sharing. You may already have such a climate in your class which will make your task much easier.

Use a warm-up activity to introduce your classes on AIDS. A warm-up activity can:
- help present AIDS within the context of sexuality education;
- provide an opportunity for students to practice talking about sexual topics in a relaxed setting;
- enable the teacher to monitor both the comfort level and readiness of the class; and
- enable the teacher to monitor the acceptance and understanding of ground rules.

One suggested warm-up activity -- "How Did You Learn?" -- is included in the Appendix. You will also find many other suggestions in various AIDS and family life curricula. Whatever activities are chosen, however, it is important to:
- Adapt the exercise to meet the needs of your group. Some exercises are more appropriate for adolescents; some assume a homogenous shared culture.
- Be sure in your debriefing activity to include discussion of various cultural perspectives and experiences. For example, an activity that discusses dating age or dating practices assumes "dating" is a cultural norm.

Particularly with a multicultural group, any discussion on sexuality should begin with an exercise to help students reflect on their own assumptions about the impact of culture on their values and attitudes. An activity such as "The Petal of Culture" is a good tool to include in the debriefing of an exercise such as "How Did You Learn About Sex?" (see Sample Exercises in Appendix). Many confrontations and blocks to discussion can be avoided if students have some understanding of the range of diversity within their own communities.

Make sure that students have the needed vocabulary to understand reproductive anatomy and sexual practices.

We can't talk and teach about AIDS without using the language of sexuality and reproduction. A glossary of key words, some suggestions for explaining them, and some

diagrams to assist in explanations are found in the Appendix. This vocabulary list was developed by educators with extensive experience in teaching AIDS and other reproductive health topics to ESL students. One of the first challenges in teaching sexuality vocabulary is dealing with your own discomfort. To prepare yourself, try practicing your vocabulary lessons in front of a mirror, or work with a group of interested colleagues, or even friends and family. Get their response, and try again. You may wish to provide a glossary and diagrams ahead of time for students to study on their own, and then invite questions about those that are unclear. However, it is important to make an opportunity to define and use vocabulary appropriately: unlike most other English words, students may not have the opportunity to hear correct pronunciation of this vocabulary in everyday conversation.

AIDS education provides ESL teachers with an exciting opportunity to increase students' vocabulary and to discuss some of the complexities and subtleties in the English language, especially language used in discussing values, attitudes and behaviours. A useful exercise to this end is the "Four Languages of Sexuality" activity (see Sample Exercises in Appendix). This exercise separates sexuality language into four categories: "medical" language; childhood or "baby" language; "street" language; and indirect or euphemistic language. In English, medical language is generally considered the "proper" language to use for teaching, although this is not true of all cultures and languages. Be aware that many of your students will not know "proper" reproductive vocabulary in their first language, and they will not likely have had much exposure to the different "languages" used for sexuality in English. Please also see the section on p. 69, "Watch Your Language!"

Ensure that students share basic health and sexuality concepts.

AIDS should never be taught in isolation from other sexuality and health topics. This may require that the teacher allot significant time to ensure that certain concepts are clearly understood before the topic of AIDS is introduced. These include:

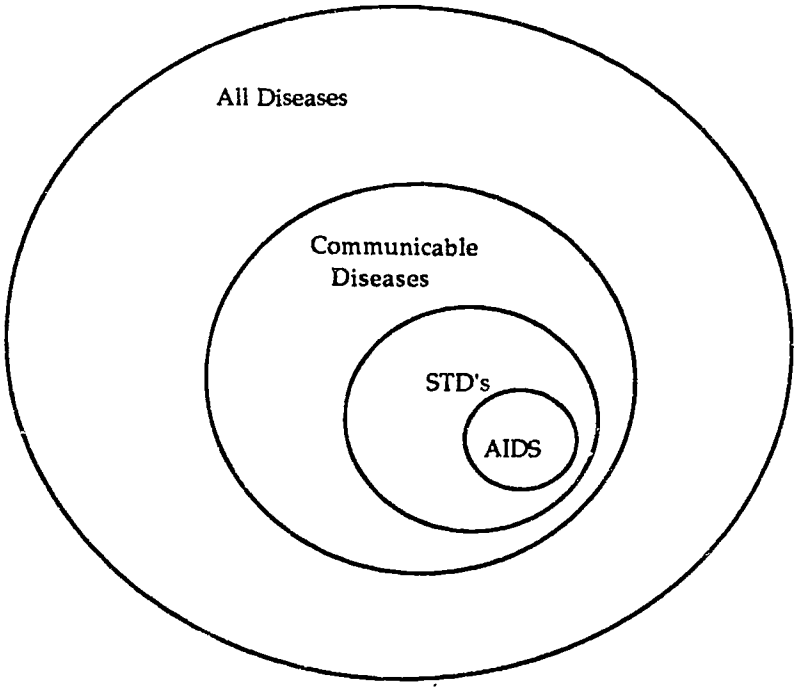
- *The meaning and function of the immune system.* A detailed description of the functioning of the immune system is not required or even useful. However, all students should understand the concept of the immune system and what it does. (It defends the body against diseases.)
- *The definition of a virus.* Again, this is not meant to be a medical description, but to clarify the virus as a "very small germ." Give examples of other diseases caused by viruses (flu, chicken pox, measles, polio, the common cold). Stress that each disease is caused by a specific virus. It is also important for students to understand that antibiotics are not generally effective in fighting viruses.
- *Communicable and sexually transmitted diseases (STDs).* Students must understand the concept of a communicable disease and the different ways diseases are spread in order to feel confident about, for example, the risks of transmission through casual contact.

Define the term "communicable disease," and explain that different communicable diseases can be transmitted in different ways. Explain that the way in which any particular virus is spread does not change over time.

Some viruses (such as colds, flus, and chicken pox) are spread through the air, by activities such as coughing and sneezing. There is little that people can do to protect themselves from these viruses. However, when exposed to the same virus not everyone will get sick, and some people will get sicker than others. Other communicable diseases are spread through food and water (for example, cholera). Still other communicable diseases can only be spread through direct, intimate contact with an infected person. Sexually transmitted diseases, including AIDS, are in this category. These diseases cannot be spread through casual contact or through food and water.

Take advantage of the interest in AIDS to provide information about STDs in general. Most points about transmission and prevention are true for all sexually transmitted diseases.

This diagram, "Communicable Diseases", may be a helpful teaching tool. A full-page version is included in the Appendix.



Communicable Diseases

- *The range and practice of various sexual behaviours.* This topic cannot be ignored. Students must understand the meaning of anal and oral sex, as well as vaginal intercourse. The teacher must also stress the fact that there are many different ways that people express their sexuality; while some behaviours are not as common as others, there are many different behaviours that can be practiced. (Be prepared for shock or denial that such behaviours are ever practiced by "normal"people or by "people in my community." It may be necessary at this point to remind the class of your ground rules of respect for differences.)

- *Sexual orientation.* It is estimated that 10% of the adult population is homosexual.[13] The prevalence of HIV infection among gay men in North America makes it essential to include discussion of sexual orientation in a discussion of AIDS. Expect this to be a difficult and highly charged topic. Be prepared to hear that "homosexuality does not exist in my culture." Think about how you will deal with such comments. You cannot, as a responsible professional, accept these stereotypes, but it will often require deft negotiation to handle the discussion. In any event, stress that homosexuality in itself is not a risk factor for AIDS, but having intercourse without a condom, especially with many different partners, is. It is the practice of anal intercourse without a condom which puts homosexual men at risk.

  (For additional discussion of popular myths on homosexuality, please see "Fact Sheet on Homosexuality," p. 75. Risk behaviours for HIV transmission are discussed under "Teaching Points and Background on the Facts About AIDS," p. 77.)

- *Canadian standards in health care.* Students should understand their rights within the Canadian health care system: the right to change doctors, the right to a second opinion, the right to informed consent, the right to refuse treatment, and the right to respect and confidentiality.

Identify groupings and format that facilitate comfort and sharing.

Use your own judgement as to whether students will feel comfortable in staying as one group for all parts of the discussion. Some factors to consider are:

- How long has the class been together?
- How large is the class?
- How did students respond to your initial exercises?
- Have they been comfortable and willing to share on other sensitive topics?
- Do a few people (or does one gender) dominate class discussion?
- What attitudes (about sensitive topics such as AIDS, homosexuality, racial minorities, the role of women) have already been expressed, and how have others responded?

13. A.C. Kinsey, W.B. Pomeroy, C.E. Martin, *Sexual Behavior in the Human Male*, W.B. Saunders Co., Philadelphia, 1948.

While it may be difficult to arrange, try to cluster the class in small groups for at least some activities. If there is a lot of diversity in the class, perhaps a few teachers can integrate classes in order to develop groups which will be workable.

Don't assume, though, that the best grouping is one where all the participants are of the same ethnic group. Dividing the group into male and female will often work better. Be sensitive to issues such as marital status, age, and religious affiliation. Keep in mind that the gender of the presenter may affect the workings of a group.

Groups need not be homogenous, however. Homogenous grouping may not be necessary if there has been good response to the climate-setting activities, and if you feel there is a good deal of openess in the class. There are also many benefits to having diverse groups for certain activities: the climate-setting exercise "How Did I Learn," for example, is often more instructive with a diverse group.

Related Issues:
AIDS as a sexuality issue, p. 31
AIDS as a multicultural health issue, p. 20

BEFORE INTRODUCING THE TOPIC OF AIDS IN THE ESL CLASSROOM

- Assess your own readiness before beginning:
  - knowledge
  - comfort
  - skill
- Assess the knowledge level, concerns, needs of the class to determine your starting point, and focus.
- Determine "Ground Rules", or agreements about how discussion will take place.
- Establish a safe climate for introducing the topic.
- Make sure that students have the needed vocabulary to understand reproductive anatomy and physiology, and sexual practices.
- Ensure that students share basic health/sexuality concepts.
- Identify groupings/format that facilitate comfort and sharing.

PERSONAL OPINIONS ABOUT AIDS

These are personal opinion questions. There are no wrong answers! Please answer as honestly as you can. Do not put your name on this paper.

1. I think people with AIDS _____

_____

_____

_____

2. Learning about AIDS in ESL class is:

   a. A good idea. Really important.

   b. A bad idea. A waste of time.

   c. Other _____

   _____

3. Is there any way AIDS has affected you, or might affect you in the future?

_____

_____

_____

_____

_____

Adapted from Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome, Marcia Quackenbush and Pamela Sargent, Revised Edition, 1988.
Prepared by Planned Parenthood Manitoba, Inc. 1991

AIDS QUIZ

A. Can these activities transmit the AIDS virus? ✓ your answer.

	Yes	No	Don't Know	
1.	___	___	___	Eating food prepared by a person infected with the AIDS virus.
2.	___	___	___	Mosquitoes
3.	___	___	___	Sharing a toilet with someone who has the AIDS virus.
4.	___	___	___	Having sex with a person infected with the virus.
5.	___	___	___	Sneezing or coughing.
6.	___	___	___	Sharing needles for drug use.

B. ✓ the correct answer.

1. Who can get AIDS?

   _____ gay men
   _____ prostitutes
   _____ any one
   _____ don't know

2. What is HIV?

   _____ A disease that many people with AIDS get.
   _____ A test to see if a person has AIDS.
   _____ A type of sexual activity.
   _____ The virus that causes AIDS.

3. Which of these activities NEVER spreads AIDS <u>in Canada</u>.

   _____ having sexual intercourse without a condom
   _____ donating blood
   _____ sharing needles for drug use

4. The immune system

   _____ is an illness
   _____ is a drug
   _____ fights off infection and other diseases
   _____ don't know

5. Who is at high risk of getting AIDS?

_____ children with a homosexual teacher
_____ babies born to parents who use injection drugs
_____ people who stay in a Canadian hospital
_____ don't know

C. ✓ your answer.

1. Most people with the AIDS virus look and feel healthy.

❑ Yes ❑ No ❑ Don't know

2. Condoms can help protect a person from AIDS.

❑ Yes ❑ No ❑ Don't know

3. A person can be legally fired from their job if she or he has the AIDS virus.

❑ Yes ❑ No ❑ Don't know

4. There is a cure for AIDS.

❑ Yes ❑ No ❑ Don't know

5. Most people get the AIDS virus from sexual activity.

❑ Yes ❑ No ❑ Don't know

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AIDS QUIZ
ANSWER KEY

A.
1. No
2. No
3. No
4. Yes
5. No
6. Yes

B.
1. (c) any one
2. (d) the virus that causes AIDS
3. (b) donating blood
4. (c) fights off infection
5. (b) babies born to parents who use injection drugs

C.
1. Yes
2. Yes
3. No
4. No
5. Yes

How to: Planning a Program

Clarify your objectives.
First, remember that in educating about AIDS we have three major objectives:

- To prevent the spread of AIDS;
- To decrease unnecessary fears; and
- To promote a caring, compassionate community for those infected with HIV.

Next, list specific objectives for your program and for each presentation in that program. These might include: student knowledge of community resources, development of specialized health vocabulary, or orientation to health concepts such as informed consent.

Develop an outline.
A good general rule is to introduce the topic over the period of several classes. This is because most students will require additional vocabulary development and because it is essential to build in basic health concepts, access issues, and climate setting activities. Remember also that it will take several exposures to the information before students will have worked through all of their issues about AIDS.

Your program might look like this:

Class 1:
Introduction to topic of sexuality and sexual vocabulary
Why sexual vocabulary is important to many aspects of students' adaptation, including proficiency in English
Ground rules activity
Warm up activity
Discussion of culture and sexuality ("Petal of Culture" exercise)

Class 2:
Discussion of types of sexual languages ("Four Languages of Sexuality" exercise)
Reproductive anatomy (sample diagrams and activity in Appendix)
Vocabulary practice

Class 3:
Groundwork for teaching about AIDS:
AIDS as communicable disease, sexually transmitted disease
Basic health concepts
Sexual behaviours
Sexual orientation
Access issues in Canadian health services

Class 4: Facts about AIDS:
- AIDS as worldwide issue
- What the virus HIV does
- Transmission - three ways HIV is transmitted
  - how it is not transmitted
- Prevention
- Community resources for AIDS - information
  - services

Class 5: Review
- Questions and Answers
- Follow-up activities (e.g. "Finding answers to questions about AIDS," p. 122)

By spreading the topic out over several classes, you give students the chance to work through new and potentially demanding material. It gives you an opportunity to review and reinforce basic concepts. It also lets you build in many language activities and concepts that are transferrable to other areas.

Identify your own strengths and weaknesses. Research your material. Feel confident in what you are about to teach. The facts of AIDS are not difficult to master. You will probably find that you need to spend more time reading about, thinking about, and discussing such topics as sexual orientation, specific sexual behaviours, and your own attitudes and values.

Prepare yourself for using new vocabulary. Identify new vocabulary to be taught in each session. Give yourself a trial run. Practice in front of a mirror, or work with a group of interested colleagues, or even friends and family. Get their response.

Find or develop handouts and audiovisual resources. A few are included in the Appendix. Many found in other AIDS curricula can be adapted for ESL needs.

Try to include discussion activities and the opportunity for work in small groups. It is much less threatening for students to discuss issues and practice new vocabulary in small, particularly same-sex groups.

Consider introducing the "Question Box" (p. 120) before or during each session. This technique encourages the participation of less confident class members, and it makes it easier for all students to ask the "difficult" questions.

Related Issues:
Sample activities, p. 108
Key messages about AIDS, p. 13
Watch your language!, p. 69
Using print and audiovisual resources, p. 48

Watch Your Language!

"AIDS" vs. "HIV infection"

Strictly speaking, AIDS refers only to the end stage of HIV infection. An individual may be ill for many years with HIV-related conditions and not be diagnosed with AIDS. This is because a formal diagnosis of AIDS is made only on the basis of a positive test for HIV and the presence of one of many life threatening infections or malignancies. A person can die of an HIV-related illness and never be diagnosed with AIDS.

More importantly, if we are concerned about prevention, it is important to stress in our teaching that most people with HIV infection have no symptoms, although they can still transmit the virus to others. This is why it is important to differentiate between being infected with the virus that causes AIDS (HIV) and actually "having AIDS."

"husband / wife" (and "boyfriend / girlfriend") vs. "partner"

It is common to use the terms husband and wife when describing sexual relationships, but this is not appropriate when discussing AIDS. Many people are having sexual relationships with partners to whom they are not married, and many relationships are with those of the same sex. Use an inclusive term such as "partner" instead.

Use of personal pronouns: he/she, you

Take care in using the personal pronouns. Try to use both "he" and "she," or alternate usage. Using only the male pronoun generically, quite common in English, may reinforce stereotypes that AIDS is only a gay disease.

Avoid using the pronoun "you" in discussing sexuality, especially in responding to questions. Use of "you" can be perceived as accusatory and may increase the level of discomfort in the discussion. The contrast is easy to see, for example, in: *"You can buy condoms in any drugstore,"* which may imply that the listener needs to buy condoms, vs. *"A person can buy condoms in any drugstore,"* which is more neutral.

Describing an infected person: "victim" vs. "person living with AIDS (PLWA)"

As is common with many serious and frightening diseases, it is easy to use the word "victim" to describe a person with AIDS or infected with HIV. This should be avoided. Use instead the expression "person living with AIDS" or "person infected with HIV."

Avoiding value laden words.

In general, try to monitor your presentation for value laden words. Some common examples in AIDS/HIV education are:

- Use the expression "drug use" instead of "drug abuse;" say "injection drug user" instead of "drug addict."
- Avoid the words "normal" or "abnormal" to describe sexual practices or sexual orientation. (For example, don't talk about "normal sexual activity," or homosexuals vs. "normal people.") This can be a great opportunity to help your students expand their vocabulary. The "Okay For Me / Okay for Others" activity (see Sample Exercises in Appendix) combines this vocabulary practice with an exercise to help students examine their own values and attitudes.
- Avoid use of the word "promiscuous." Explain that this is a value laden word that expresses the speaker's judgement about the number of sexual partners a person has. The judgemental nature of this word is exemplified in the joke: *"What is the definition of promiscuous?"* Answer: *"Anyone who has more sexual partners than I do."* Instead, use the expressions "person with more than one sexual partner" or "many sexual partners."

"sex" vs. "sexuality"

Clarify the meanings of these two words before beginning your presentation on AIDS. While the word "sex" can refer either to gender or to the act of sexual intercourse, the word "sexuality" is used in a much broader context.

Sexuality can be defined as those aspects of the whole person -- including thoughts, experiences, learning, ideas, values, and imaginings -- that have to do with being male or female. Almost everything we do is influenced by our sexuality: our relationships with others, how we dress, our choice of career and hobbies, how we decorate our home. Sexuality has a social component (which is determined by culture), a psychological component (which can vary from individual to individual), a moral or spiritual component, and a biological or physiological component (which is the same for all cultures and peoples).

Many teachers and students find that by defining and discussing the broader, non-genital, meaning of sexuality, they are more comfortable acknowledging and talking about sexuality as a part of their lives.

How to: During Your Class

In this section, we suggest some strategies to help your presentation on AIDS be as effective as possible. The following section ("Teaching Points on the Facts about AIDS") discusses specific content issues.

Be clear about why you think it is important for you, as the ESL teacher, to talk about AIDS and why you are making this special effort.

A common response to AIDS education initiatives within newcomer groups has been a suspicious one: *"Why are you making special efforts to give us this information? Do you think we are to blame or engaged in high risk behaviours?"* This response may be more common in groups who have experienced racial discrimination, or who have suffered political persecution in their country of origin.

Stress that we are undertaking AIDS awareness not because we perceive newcomers as being of greater risk, but because anyone who lacks accurate, up-to date information may be at greater risk. Emphasize the principle that all residents in Canada have the right to the same quality of information, but in the area of AIDS, language barriers mean this equity of information is not a reality. Approach AIDS education as a "right to information" issue. Stress lack of accurate information as a risk factor.

Treat AIDS as you would any vital social issue. Model an attitude of interest and openness. If you express an attitude of concern as a concerned citizen, this will help your students feel comfortable in raising questions about AIDS without fear of raising suspicion that they themselves may be infected.

Don't be afraid to admit your own discomfort or embarrassment. If necessary say something like, *"This is difficult for me because when I was growing up I was taught that people shouldn't talk about topics like this."*

In discussion, be prepared to remind the group of the ground rules they established. Do not permit racist, anti-gay, or stereotypical comments to go unchallenged in the discussion.

Be prepared to intervene to clarify the difference between fact and opinion. (*"That you believe homosexuality is immoral is an opinion. Not everyone shares the same opinion. However, it is a fact that homosexuality can be found in every culture."*)

Be explicit. Do not use euphemisms. To be effective in teaching about AIDS we must speak explicitly. Do not use general expressions such as "having sex." Explain, or show diagrams of anal, oral, and vaginal intercourse.

Use graphics wherever possible. Many sexual and reproductive health topics are extremely difficult to explain clearly without graphics. This is especially true for English language learners. Graphics are essential in teaching reproductive anatomy, as well as in demonstrating condoms and condom use.

In describing a condom, for example, a line drawing is better than a verbal description alone; a photo is better yet. Even better is to bring in some sample condoms and have the class examine them. Best is to actually demonstrate condom use on a model penis (or banana!). Use the most explicit methods appropriate for your group and allowable by your jurisdiction.

In working with students who have a low level of education, especially literacy students, the use of three-dimensional teaching aids is recommended; two dimensional diagrams may not be effective.

You may find that graphics on some sexual practices, for example, anal intercourse, are difficult to find. We include in the Appendix some examples of drawings which you may use at your discretion. *The Joy of Sex* series of books (including *The Joy of Gay Sex*) by Alex Comfort is another easily accessible source of clear drawings of various sexual practices.

Remember that even though students may feel somewhat embarrassed, most will appreciate the opportunity to learn vocabulary that is not easy to pick up on their own.

- Stress the practical implications of learning this aspect of the language: it is necessary for doctors visits, for reading, for communicating with their own Canadian-reared children who will be taking family life topics in school, and for professional aspirations (such as nursing or teaching).

- By normalizing the need for students to have sexual vocabulary, we can remove much of the embarrassment. This is one of the reasons that promoting a core health education component in the ESL curriculum, one that includes reproductive health, is so essential.

Be alert to the types of questions students ask. As in other areas of sexuality, the intent of a question is not necessarily what it seems on the surface. Some questions will be simply seeking information: *"What are the chances of getting AIDS if you have sex and don't use a condom?"* This same question may actually be seeking reassurance: *("If you tell me the chances are low, then I probably don't have AIDS.")* The same question could even be an indirect way of seeking permission to continue certain behaviours: *("If you tell me the chances are low, I've got an O.K. to go on as I have been.")*

How should you handle these different types of questions?

- *Information-seeking questions:* Answer as best you can. If you are not sure of the answer, promise to get more information and get back to them. For advanced students, you may also refer them to an outside resource for more information.

- *Reassurance-seeking questions:* Provide what reassurance you can, but be careful! Be wary of the tendency to over-reassure. For example you can feel quite confident in reassuring a student that she cannot possibly get the AIDS virus from sitting next to someone in class. But it is not appropriate to reassure this same woman that, just because there is a low rate of AIDS in your city, she "probably has nothing to worry about" if she believes her husband has other sexual partners.

- *Permission-seeking questions:* Try to avoid becoming an unwitting accomplice to possibly risky behaviours. The question (such as the example above) could be an indication that you need to reinforce the notion of individual responsibility in AIDS prevention.

- Other questions or statements may be used simply for their *shock value: "All homosexuals should be executed."* These are more commonly presented by younger students.

  For questions you feel are designed to shock or disrupt the class, remind the student of your ground rules. Do not rise to the bait. Answer the question calmly.

  Do not assume, however, that because a student uses street language that his or her intention is to shock. It may be that the student is genuinely seeking information but lacks the appropriate vocabulary to ask the question in another way. In this case use the opportunity to teach appropriate vocabulary.

- *Know when to refer students to outside resources.* Please review "How Can I be Helpful?" p. 42.

Be alert for signs that things are not working out. Some signs are:
- people taking long trips to the washroom.
- uncomfortable silence from part of the group. (But remember that just because some students are not participating does not mean they are not learning or supportive of the topic.)
- only one gender participating in the discussion. (You may want to separate the sexes to encourage more participation.)
- class members being intimidated by one or two people.

You may also become aware that, while the discussion generally is going well, a particular individual is having difficulty.

Any reference to sexual activities may trigger painful memories in some students. In Canada today we are becoming only too aware of the frequency of sexual abuse of children and the rate of sexual assault. This abuse is likely to be even more common with refugee students who, while still in their own countries or in the process of fleeing to Canada, were at increased danger of sexual assault and even torture. Other students may, simply because of their upbringing, find it difficult to cope with such a discussion.

This does not mean that we should avoid sexual topics, but rather that we should be alert to any signs of distress and avoidance shown by individual students. It is for this reason that a ground rule such as the "right to pass" (see p. 56) is so important for sexual discussions. You may want to talk to the student privately after class.

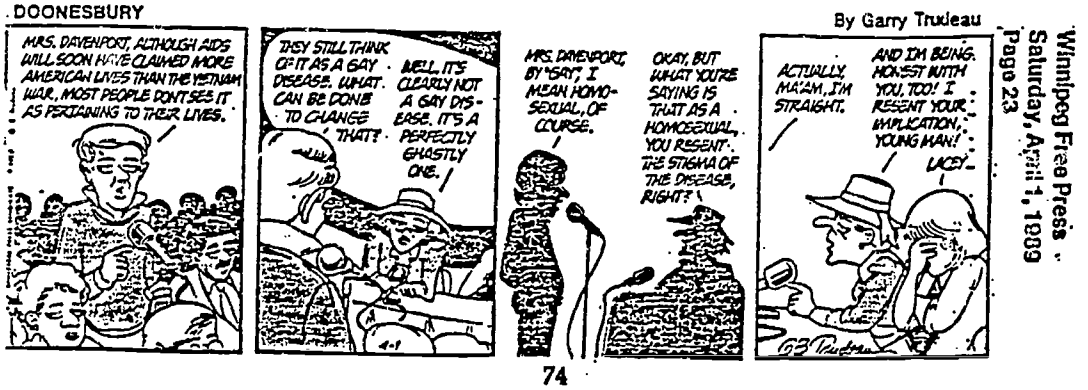
Be prepared to follow up on any related concerns that arise. AIDS cannot be dealt with in isolation, and for many people, other issues must be explored before they can begin to change their behaviour to protect themselves from AIDS.

- One common issue that often arises is the ability of women who are in relationships to insist on their right to protection. *"What about a woman who suspects her husband is not faithful? What should she do?"* is a common concern, and it raises very complex issues about relationships, cultural expectations of sex roles, and basic rights to protection. This kind of situation cannot be dealt with by a simple answer such as *"To be safe, she and her husband would have to use condoms for sexual intercourse."* There are problems in their relationship that need to be overcome, and in some cases the woman's insistence on condom use may even lead to her being abused.

  When tl s issue arises,
  - Acknowledge the difficult situation that many women are in.
  - Outline the rights women have under the law.
  - Discuss resources women can access for relationship concerns.
  - Indicate your availability for private discussion.
  - Check out the interest in having a "womens only" group to discuss women's concerns.
  - Invite in a speaker who can do a workshop on negotiating skills.

- Some other related concerns that may arise are:
  - Other sexually transmitted diseases,
  - Resources for family planning and childbirth,
  - Communicating with children about sexuality,
  - Concerns around sexual orientation.

Related issues:
Watch your language!, p. 69
AIDS as a multicultural health issue, p. 20
Fact sheet on homosexuality, p. 75



FACT SHEET ON HOMOSEXUALITY

Because the majority of AIDS cases in North America have so far been among homosexual men, we must, in teaching about AIDS, deal with issues of sexual orientation. Homosexuality is perhaps one of the most sensitive and emotionally charged issues in sexuality education.

Many of your students will come to class with some definite myths and misconceptions about homosexuality. Many of these myths must be addressed in doing AIDS education. You may also find some students who have never heard of homosexuality and find the concept difficult to comprehend.

In responding to questions and clarifying information for your class, keep in mind that you likely have "invisible" gay students who may be fearful of exposure and of AIDS. How are these students going to react to what you are saying?

MYTH: ***"People are either completely heterosexual or completely homosexual."***
FACT: Some people prefer to have sex only with a partner of the opposite sex, some prefer a partner of the same sex, and some are attracted to both sexes. Research by Kinsey in 1948 indicated that sexuality is more accurately described not as a dichotomy but a continuum. Only about 20% of the population falls at either end of the spectrum (exclusively heterosexual or exclusively homosexual). The vast majority of people are somewhere in between -- that is, capable of experiencing some level of sexual arousal from persons of both sexes. Those who are equally attracted to both sexes would be described as bisexual. Many people (almost 40% of North American men) have had at least one homosexual experience to orgasm, but this does not mean they consider themselves to be homosexual.[14]

MYTH: ***"There are no homosexuals in my country. Homosexuality is a 'western' perversion."***
FACT: Anthropologists have found homosexuality in almost every culture. No matter whether the culture condemns homosexuality, tolerates it, or even values it, the percentage of homosexuals in every society is approximately 10%. If it is dangerous to reveal one's homosexuality, it will logically remain hidden. This may lead to the perception that "there are no homosexuals in my culture." Similarly, the costs -- to oneself and one's family -- of having one's homosexuality known may result in homosexual persons moving to larger centres where there is more anonymity. In Canada, ethno-specific gay organizations are found in larger cities.

MYTH: ***"Homosexuality is unnatural."***
FACT: Homosexual behaviour has been found in almost all species of animals, and becomes frequent among the more highly developed species.

MYTH: ***"Homosexuality is a mental illness."***
FACT: As a result of research in the 1970's, the American Psychiatric Association and the American Psychological Association have officially removed homosexuality from the list of mental disorders. Similarly, there is no evidence that particular childhood experiences "cause" homosexuality. The parental or family backgrounds of homosexual persons are no different than those of heterosexual persons.

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14. A.C. Kinsey, W.B. Pomeroy, C.E. Martin, *Sexual Behavior in the Human Male*, W.B. Saunders Co., Philadelphia, 1948.

MYTH: *"You can tell a homosexual by how he or she looks, dresses and acts."*
FACT: A very small percentage of homosexuals fit the effeminate male or tough female image. Most are members of an "invisible" minority. Stereotyping gay and lesbian people is as harmful as stereotyping racial and ethnic minorities.

MYTH: *"Homosexuals are to blame for the spread of AIDS."*
"AIDS is only a gay disease."
"AIDS is God's punishment on homosexuals."
FACT: Patterns of infection in other parts of the world show clearly that AIDS is not just a gay disease. The increase in heterosexual transmission in North America -- especially the increasing number of women infected -- also refutes this. Once the virus that causes AIDS is in any population, it will spread without regard for the sexual orientation (only the sexual behaviour) of the individual.

MYTH: *"Homosexuals are child molesters."*
FACT: The vast majority of incidents of child sexual abuse are committed by heterosexual males against female children. It is estimated that there are 10 girls molested for every boy.

MYTH: *"Homosexuals choose to be homosexual."*
FACT: Most homosexual individuals do not feel that they have chosen to be homosexual. Who would choose to be a target for discrimation, ridicule or violence? Rather than talk about homosexuality as a preference (which implies that another choice can be made), it is more accurate to think of it as an orientation -- the way a person *is* and not something that can be altered by making a different choice. Many homosexuals say that they have known from a very early age that they are different from other people, that they didn't have the expected attraction to the opposite sex. Many have tried every means possible -- prayer, counselling, aversion therapy -- to change, to become heterosexual; but in most cases without success. We do not know what "causes" homosexuality, any more than we know what "causes" heterosexuality.

MYTH: *"Homosexuals want to be women. Lesbians wish they were men."*
"Homosexuals like to dress up in women's clothes."
FACT: It is important to distinguish between a homosexual, a transsexual, and a transvestite. A transsexual is a person who believes that the body she or he was born with does not match his or her real gender. For example, a man may believe that in spite of his body, he is really a woman. This is a serious and uncommon psychological issue. Many transsexuals will consider surgery to become members of the opposite sex. A transvestite is a person who gets sexual pleasure from dressing up in the clothes of the opposite sex. While some transvestites enjoy sexual activity with the same sex, the majority are heterosexual. In fact, many married men enjoy wearing female clothing.

MYTH: *"Lesbians are only that way because of a bad experience with men."*
FACT: Many lesbians have not had bad experiences with men. On the other hand, many heterosexual women have had bad experiences with men, but this did not change their sexual orientation.

How to: Teaching points and background on the facts about AIDS

This section presents a detailed guide to "the facts about AIDS" presented on p. 8. Included under "Teaching points" are elaborations, cautions, and approaches we suggest you use in teaching about AIDS. Items headed "Background information for teachers" are just that -- background for teachers to refer to when questions come up.

> *1) AIDS is a worldwide concern. AIDS is found in all parts of the world. No country, no race is immune.*

Background information for teachers:

AIDS is a new disease. Although there is some evidence of cases dating back to the 1950's, the disease first appeared in Canada in 1979.

Canada is considered to have a fairly high rate of infection. The number of persons diagnosed with AIDS (as of July 1991) in Canada is 5,229. Of these, 261 are women, 61 are children. Approximately 3/4 of the total cases are homosexual or bisexual men. .[15]

The World Health Organization identifies two major patterns of infection. In "Pattern 1" countries (Canada and the U.S.A. are in this category), the disease has been found primarily among homosexual men. In "Pattern 2" countries (including many African countries), transmission is primarily heterosexual, and men and women are affected equally. It is important to note, however, that in Pattern 1 countries, the rate of heterosexual transmission is on the rise.

An exact picture of the worldwide AIDS problem is difficult to obtain: "official" statistics in some countries are suspiciously low, much lower than the estimated number of infections. This may be a result of government denial of AIDS in that country, or a lack of resources to accurately document all cases. As of July 1990 the WHO estimated there are 8-10 million people in the world infected with HIV.[16] (For more information, see Appendix, "AIDS Worldwide: Background Facts and Sources.")

15. "Surveillance Update: AIDS in Canada", Federal Centre for AIDS, Ottawa, July 8, 1991.
16. *WHO Weekly Epidemiological Record*, Geneva, No. 85, 1990.

2) ***AIDS is caused by a virus. This virus is found in the blood and body fluids of an infected person. However, it can only be transmitted if the blood, semen, or vaginal fluid of an infected person gets into the bloodstream of another person. This can only happen through a few activities.***

Teaching points:

The name of the virus which causes AIDS is HIV.

AIDS stands for:	
Acquired	- not born with
Immune	- the body's protection against disease
Deficiency	- a lack of
Syndrome	- a group of symptoms and signs

HIV stands for:	
Human	- only found in people
Immunodeficiency	- the immune system is weakened
Virus	- a very small germ

Many students will want to know the full meaning of these terms, but keep in mind that it is not necessary to understand these terms in order to understand the basic concepts of AIDS and HIV.

It is important to clearly describe the difference between infection with the virus that causes AIDS (HIV) and the end phase of infection (AIDS). This is explained under point 5.

A	Acquired	Not born with.
I	Immune	The body's protection against disease.
D	Deficiency	A lack of.
S	Syndrome	A group of signs and symptoms of disease.

H	Human	In people.
I	Immunodeficiency	Attacks the immune system.
V	Virus	A very small germ.

3) ***The AIDS virus cannot be spread through casual contact. Unlike many other viruses, such as those which cause colds or flu, the AIDS virus cannot infect another person by passing through the air and being breathed in by another person. It cannot be spread through food or water. So we are at no risk of infection from casual contact: eating, sharing phones or toilets, shaking hands, or hugging. We are also at no risk from contact with mosquitoes or animals.***

Teaching points:

Spend some time going over the concept of casual contact, with concrete examples. Expect to return to this many times, as there are many myths and misconceptions about this topic.

Stress that while there are millions of cases of HIV infection in the world, not one has been shown to have been caused by casual contact. Researchers are very confident about this.

Because the AIDS virus cannot be spread through casual contact:

- There is no reason not to respect the basic civil rights of infected individuals. Quarantine, an alternative in some communicable diseases which are spread by casual contact, makes no sense for AIDS;

- There is no risk to those caring for persons with AIDS. (Health care workers do confront a low risk of infection in caring for persons with AIDS, but this is not "casual" contact.) There is no reason to avoid associating with those friends, family members, or colleagues who are infected.

Review the concept of communicable disease (p. 59), and the different ways in which communicable diseases are spread.

Concern about mosquito transmission may be great among persons who come from countries where diseases such as malaria are spread by mosquitoes. *No* case of mosquito transmission has ever been found, nor is it physiologically probable.

4) *There are only a few ways in which the AIDS virus (HIV) can be transmitted:*
   a) *By sexual intercourse with an infected person. Throughout the world, this is the most common way the virus is spread.*

Teaching points:
Any sexual activity which carries the possibility of the blood, vaginal secretions, or semen of an infected person getting into another person's body is dangerous. This includes vaginal and anal intercourse and, probably, oral sex. The most risky behaviours are anal and vaginal intercourse. The virus can be spread from men to women, from women to men, and from men to men.

Take care how you introduce and describe homosexuality: rather than using terms such as "homosexual," it is better to refer to men who have sex with men, or women who have sex with women. Remember that not all men who have had sexual experiences with men either are, or would define themselves as, homosexual. Definitions of homosexuality differ from one culture to another.

Do not refer to anal intercourse as homosexual sex. Heterosexual couples may practice anal intercourse, and not all homosexual men do.

Learning that AIDS is not confined to gay men or prostitutes may precipitate a crisis of anxiety for many women as they may not have realized that they themselves might be at risk for AIDS. (See also pp. 74 and 100.)

As with most other sexually transmitted diseases, the risk of a woman being infected by a man are significantly greater than that of a man being infected by a woman. If you think about the sexual anatomy of men and women for a minute, this makes a lot of sense: if the infective agent is present in vaginal fluid and semen, the fact that semen is deposited into a woman's body during intercourse increases the risk of transmission. The receptive partner (whether a man or a woman) is actually at greater risk of being infected than the insertive partner.

Women with bisexual husbands are also at risk. Because it is "unacceptable" to be homosexual in many societies, a number of men who have sex with men are at the same time married to women. If a bisexual man has not "come out" to his female partner, he may find it difficult to suddenly start using condoms with her, an omission which places her at risk for AIDS if he is infected.[17]

In discussing each of these major routes of transmission, be sensitive to differing patterns worldwide. Sexual transmission in many areas of the world is primarily heterosexual. Wherever there is a high rate of heterosexual transmission, you will also see a greater number of cases of perinatal (mother to baby) transmission because of the greater numbers of infected women.

17. "Women and AIDS: A Challenge for Canada in the Nineties", Minister of Supply and Services, Ottawa, 1990.

4) There are only a few ways in which the AIDS virus (HIV) can be transmitted:
b) By receiving infected blood or sharing needles and syringes.

Teaching Points:

In Canada, blood supplies have been tested and the blood supply has been safe since 1985. In other parts of the world, however, infection from transfusions of infected blood or from improperly sterilized equipment is possible and, in some places, common. The most common route of transmission via infected blood in North America today is from sharing needles for injection drug use.

Using "street" drugs or drugs that are not medically prescribed (illegal) is dangerous to a person's health, but it is not a risk for contracting AIDS unless needles are shared or the drug use leads to risky sexual practices. Stress that messages about the risk of contracting HIV from injection drugs refer to "street" drug use, not from medical procedures.

Stress that SHARING NEEDLES IS A HIGH RISK ACTIVITY. When an HIV positive person uses a needle for injecting drugs, some of his blood stays in the needle. This infected blood will then be injected into the bloodstream of the next user.

Background information on transmission:

Blood and blood products
Blood and blood products were not tested for the AIDS virus in Canada before 1985. A small number of people who received blood transfusions and a larger number of hemophiliacs (who require blood products derived from a large number of donors) became infected during this period. Since 1985 all donated blood is tested for the virus; in addition, anyone who has reason to suspect he may be infected is discouraged from donating. This makes the risk of receiving an infected blood or blood product transfusion extremely small, certainly smaller than the risk of refusing a needed transfusion. Blood products needed by hemophiliacs are now heat-treated, which destroys the virus.

Medical procedures
Needles (syringes) used in Canada for medical purposes are safe because they are always new and used only for one patient (disposable). This is why it is completely safe to donate blood in Canada. Other medical equipment is sterilized to kill all germs.

The risk from blood products and medical procedures is real in many other countries. If students have concerns about medical procedures which took place before they arrived in Canada, they should be referred for pre-test counselling.

Students who are returning to their home country for a visit, or who are travelling outside of Canada, should be referred to their public health department for more information.

Questions about other routes of transmission

Students may also raise questions about other ways the virus could possibly be transmitted through infected blood. These include:

? *organ transplants:* Organs are tested before use, so the risk is very small.

? *from health care providers:* This can only happen if 1) blood from an infected health care provider gets directly into the blood stream of a patient, or 2) blood from an infected patient is passed to another patient because of poor sterilization. To date, only one such incident (unfortunately involving five patients) has been documented.

? *from patients to doctors:* There has been a small number of such cases. Transmission can occur through a "needle-stick" injury, in which the health professional accidentally jabs himself with the needle used on a patient, or during surgery if, for example, a surgeon cuts herself and has contact with the patient's blood.

? *touching the blood of an infected person:* Infected blood must enter the bloodstream of another person in order for the virus to be transmitted. It is possible, but highly unlikely, that a person could become infected by having infected blood splashed directly on an open cut or onto mucous membranes.

? *swallowing blood* (for example, a restaurant employee with HIV cuts himself and bleeds on the food): The virus cannot survive outside the body. Even if swallowed, the virus would be destroyed by the body's digestive juices. No case of this means of transmission has ever been found.

? *from saliva, urine or feces:* Even though the virus can be found in small amounts in these other body fluids, the amounts are too small to cause infection. No case has ever been documented. It is estimated, for example, that to be infected by the saliva of an infected person, seven litres of saliva would have to be injected directly into the bloodstream. This explains why we do not need to worry about contact with saliva.

? *from bites:* Thereotically, there could be a risk of transmission of HIV from bites by an infected person because of the possibility of blood in the saliva (for example, bleeding gums). There is no actual evidence, however, that bites are risky.

4)	***There are only a few ways in which the AIDS virus (HIV) can be transmitted:***
	c) From an infected mother to her baby, either before or during birth, or through breastfeeding.

Teaching Points:

Women who are infected with HIV can transmit the virus to their infants during pregnancy or at birth.

Because of this, it is often advised that women who believe they may be infected get tested for the AIDS virus before planning a pregnancy. HIV-positive women are advised to postpone pregnancy not only because of the risk to the baby, but also because of the physical stress of pregnancy itself. If infection is discovered during pregnancy, a woman has the option of terminating the pregnancy.

There is also increasing evidence of transmission to infants through the breastmilk of an infected mother. In North America, it is recommended that women who are infected with HIV not breastfeed.

The risk of perinatal infection depends on the stage of the mother's disease, but overall about one-third of infected mothers will transmit the virus to their infants.

HOW AIDS SPREADS

The virus (HIV) that causes AIDS is present in body fluids including: blood, semen, and vaginal fluids.

The virus spreads when the infected fluid from one person gets into the blood of another person.

This mainly happens in three ways:

UNSAFE SEX

SHARING NEEDLES USED FOR INJECTING DRUGS

AN INFECTED MOTHER TO HER BABY DURING PREGNANCY, BIRTH OR BREASTFEEDING

Before 1985, some people in Canada got HIV from blood transfusions.

General points on teaching about transmission:

Stress that sex, drugs and pregnancy do not in themselves carry the risk of infection. The risk is a result of sexual activity *with an infected person,* sharing needles *with an infected person,* or the likelihood of blood *from an infected mother* entering an infant before or during birth.

Try to avoid adding to the population of the "worried well": Always keep in mind that some or even many of those in your class will have placed themselves at risk at some time. The great majority of these people will not be infected. Keep a balance in your presentation: we want people to be concerned enough about the real risks of infection to protect themselves in the future. We do not want to precipitate a crisis of anxiety or guilt for any past behaviour.

Be prepared to discuss issues of legal rights surrounding AIDS. In Canada, people infected with HIV are protected under the law against discrimination. They cannot, for example, be fired from their jobs or refused service, just because they are infected. They cannot be incarcerated just because they are infected, and it is not permitted for those who know that someone is infected (such as doctors or public health officials) to tell others.

This may be hard for some students to accept and they may feel that it is irresponsible to allow HIV-infected individuals to be "at large," possibly to infect others. Some educators have found that such concerns often require quite a bit of discussion and clarification. You may have to clarify the roles and powers of police and public health authorities in Canada. In addition, try to stress the following:

- *People who are known to have AIDS or to be HIV-positive are just a fraction of the total number of infected people.* Those who know they are infected, and those who are ill actually pose less risk to the general public, as they know that precautions must be taken. Those who look and feel well, but are infected, may not take precautions although they can still infect others.
- *If those who are known to be infected were quarantined or publicly identified, it would give a false sense of confidence to the public.* Remember that most people who are carrying the virus do not know they are infected. This leads to the next point:
- *It is the responsibility of each person to protect himself* and, if he is or believes he might be infected, to protect others. Encourage the class to think about taking personal responsibility rather than focusing on removing the individuals known to be infected. Review the options available to each person (abstinence, mutual monogamy with an uninfected partner, getting tested with partner for the virus, safer sex). See p. 93.
- *There are legal sanctions against people who knowingly spread the AIDS virus.* Remember that a person can be criminally charged for deliberately infecting someone else.

5) ***The virus that causes AIDS attacks the body's immune system. The immune system fights disease. With a damaged immune system the body cannot fight some infections and some cancers. People with AIDS die of unusual diseases that a person with a healthy immune system could easily fight off.***

Teaching points:

Clearly describe the different phases of infection with HIV.

- ***In the first stage the person is infected with the virus (is HIV positive) but has no symptoms of the disease (is asymptomatic).*** This stage can last from several months to well over 10 years. Because this is a new disease, we do not know yet how long this phase may last in some people.

- ***In the second stage, the person begins to show some symptoms of the disease.*** It is NOT important to teach "symptoms" of HIV infection. These early symptoms are similar for many other common illnesses and conditions. If you are asked, these symptoms include:

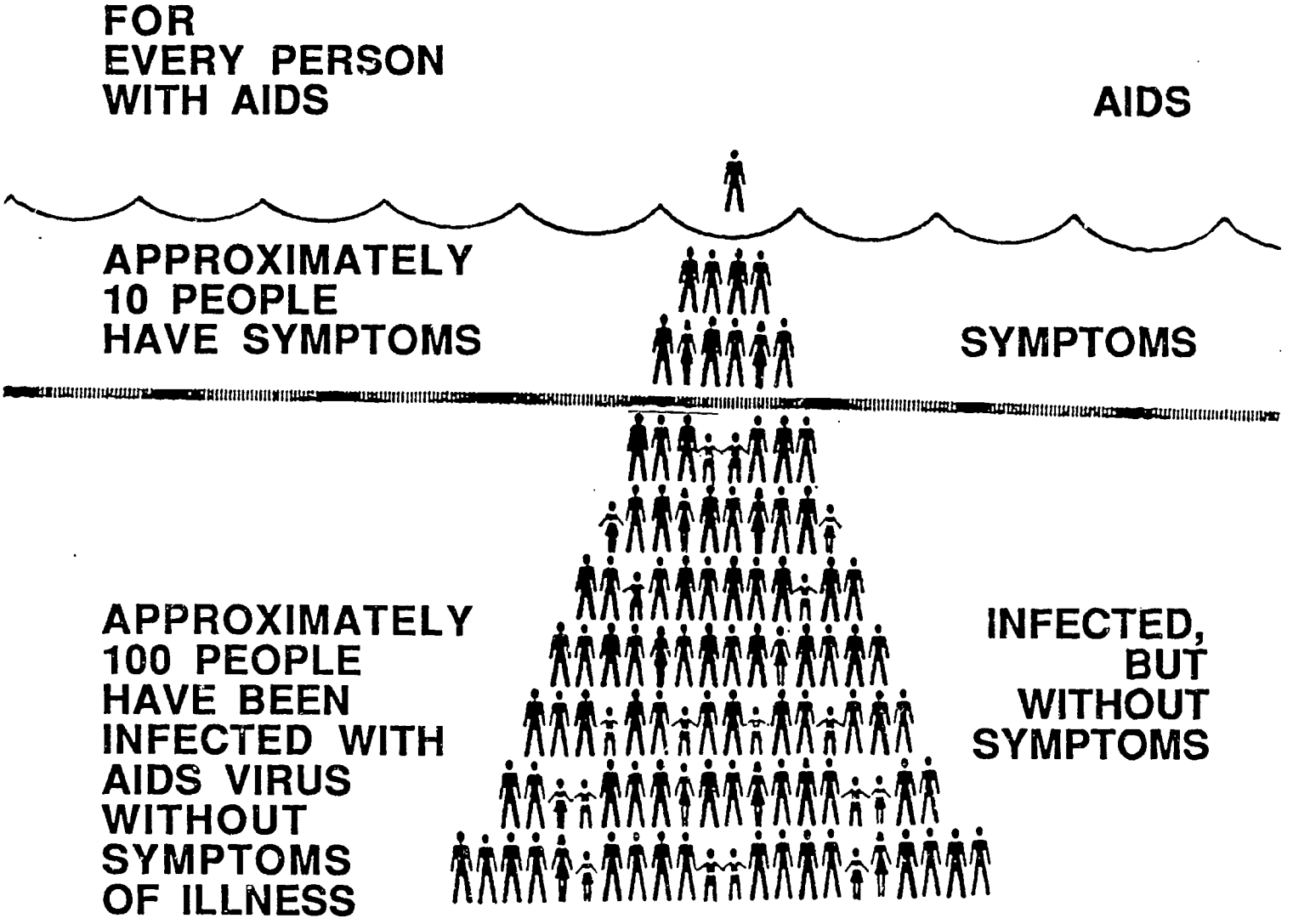
persistent fatigue	enlarged lymph glands
unexplained weight loss	nightsweats or fevers
severe diarrhea	thrush

  Symptoms in women may also include: chronic respiratory infection, menstrual irregularities, and vaginal yeast infections.

  Do not emphasize symptoms of HIV infection. Unless you stress the severity and chronic nature of these conditions, emphasizing symptoms may cause many individuals who are suffering from common illnesses or stress to panic, believing that they are infected. Stressing symptoms may also give false assurance to those who are infected but asymptomatic; having no symptoms, they may feel no personal need to modify behaviours which could be spreading of the virus.

- ***In the third stage (AIDS), people become very ill with rare diseases.*** A diagnosis of AIDS must meet strict criteria: in addition to testing positive for HIV, a person must also be diagnosed with one or more of several specific life-threatening conditions. Persons infected with HIV may die of other conditions before they are even diagnosed with AIDS.

  The number of people with HIV infection is much greater than the number of people with AIDS, as the following diagram illustrates:


FOR
EVERY PERSON
WITH AIDS
AIDS
APPROXIMATELY
10 PEOPLE
HAVE SYMPTOMS
SYMPTOMS
APPROXIMATELY
100 PEOPLE
HAVE BEEN
INFECTED WITH
AIDS VIRUS
WITHOUT
SYMPTOMS
OF ILLNESS
INFECTED,
BUT
WITHOUT
SYMPTOMS

6) ***The AIDS virus (called HIV) can live in the body for a long time -- up to 10 years or more before the person shows any signs of illness. During this time a person can feel, and look, completely healthy. So there is no way you can tell by looking at people whether or not they are infected. And all this time they can pass this infection to other people.***

Teaching points:

This is a very important point. Students often feel that they can tell by looking whether a person is infected or "at risk" for sexually transmitted diseases, including AIDS.

Background information for teachers:

The average length of time a person is HIV positive before developing AIDS is now estimated to be 11 years. This figure has changed several times as our knowledge of AIDS has developed, and it is likely to change again in the future.

What is AIDS?

AIDS is a disease.
A virus causes AIDS.
The virus lives in the blood and other body fluids.
People with AIDS can't fight some diseases.
There are drugs and treatments for AIDS but no cure yet.

What is the virus that causes AIDS?

HIV is the virus that leads to AIDS.
This virus attacks the immune system of the body.
A person can have the HIV virus, but not have AIDS.
A person with HIV can look and feel healthy.
A person with HIV can pass it on to others.

7) There is no vaccine to protect against AIDS. There is no cure. However, there are some drugs that can help slow the progress of the disease.

Teaching points:

This is one of the major differences between AIDS and most other sexually transmitted diseases. Because there is no cure, prevention is vitally important.

Be careful to strike a balance between presenting AIDS as a fatal disease and AIDS as a lifelong chronic condition. People with AIDS are living longer today because of new drugs and treatments. If a person is diagnosed early he can get care which may prolong life. This is one reason why it is important for people who fear they are infected to get tested.

Beware of scare tactics. If we only stress the terminal nature of the disease, we may cause people to despair; they may not take precautionary measures. We may also inadvertently present such a frightening prospect that we cause people to "shut down." People can only handle so much fear in a learning situation before they block out information. Scare tactics are usually not effective in the long run, because they work only as long as the fear continues. An individual living with fear will often rationalize that the information does not apply to him in order to reduce anxiety to manageable levels.

Background information for teachers:

Two drugs which can prolong life in some persons infected with HIV are now being used in Canada; these are commonly called AZT and ddI. There are also treatments for specific HIV/AIDS-related diseases.

8) AIDS can be prevented. Education is the best defense against AIDS. In places like Canada where our blood supply and medical practices are safe, everyone can help prevent the spread of AIDS by these measures:
a) Practice safer sex

Teaching points:

Clearly identify all the options a person has to protect herself in sexual relationships (and -- if she is or believes she may be infected -- to protect others).

- *Abstinence* (not having penetrative sex) is the safest. But this is not for everyone.

- *Mutual monogamy* is also a good alternative, and it is a value in many cultures. A couple is monogamous if both partners only have sex with each other. Of course, this is only a protection against AIDS if both partners are HIV-negative and if neither partner shares needles for injection drug use.

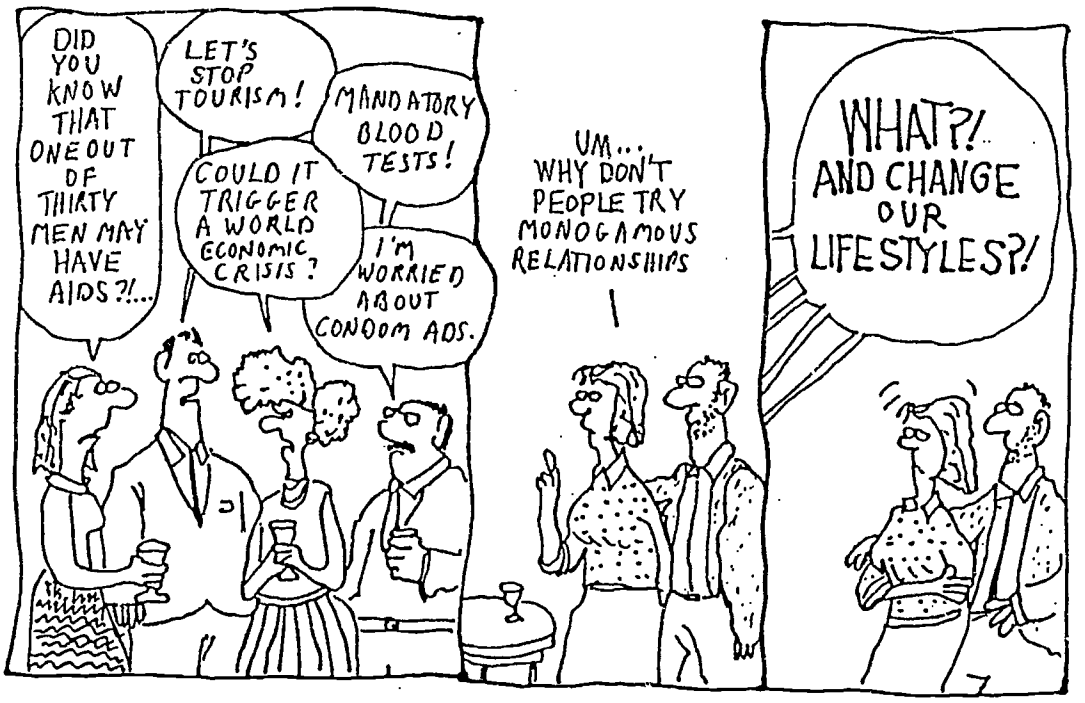
  Remember that many people, even in married relationships, are not sure that their partner is not infected. This may be due to previous sexual relationships, extra-marital relationships, or injection drug use. In this situation,
  - both parties can arrange to be tested and then stay faithful to each other; or
  - they can decide to use condoms and practice safer sex. (Of course, these actions assume open and honest communication in the relationship. This point highlights the complexities of AIDS prevention.)

- *Safer sex* . Safer sex refers to sexual practices in which there is no risk of exchanging blood, semen, or vaginal fluids with a partner. Consistent use of condoms for all penetrative sexual activity is one of the most important safer sex practices.

  We need to be explicit about specific sexual practices and identify those which are high risk, low risk, or no risk. Using a term such as "having sex with" is not specific enough. The key messages about "safer sex" are listed below. It is important to present these in class. If students want more specific information, refer them to an AIDS organization or a local workshop on "safer sex" practices.

State explicity that:

- Both anal and vaginal intercourse without a condom are high risk activities for transmitting the AIDS virus.
- Any sexual activity in which blood, semen, or vaginal fluids could be exchanged with a partner are high risk.
- The receptive partner is always at greater risk than the insertive partner.
- Oral sex without a condom may not be entirely safe, but the risk is believed to be low.
- People who have sexual relationships with more than one person should always use condoms.
- People who are not sure that they are not infected, or that their partner is not infected, should always use condoms and practice "safer sex".



- ***It's not enough just to tell people to use condoms.***
  While many students will be experienced with condoms, many will not know what they are. A larger number will not know where to get them, and an even larger number will not know how to use them properly.
  - *Tell students where to buy condoms, where free ones are available, how to ask for them.* Condoms are available without prescription in any drug store and some supermarkets. Advise students not to buy condoms from vending machines. (They are often stale-dated and may have deteriorated.) Check whether there are free condoms available in your community.

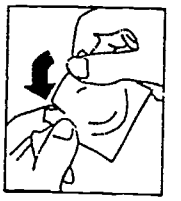
- *Only latex condoms* are recommended for prevention of sexually transmitted diseases. Condoms are sold either lubricated or unlubricated; lubricated are recommended. Teach the word "lubricated" and how to tell if the condom is lubricated with a "spermicide." If additional lubricant is needed, only a water-soluble (such as KY jelly) or spermicidal jelly should be used; petroleum jellies such as Vaseline can cause the latex to deteriorate. (See Appendix for English Express insert.)
- *Model how to ask for condoms.* Tell students that condoms are available in packs of 3, 6, 12, etc. Demonstrate how to check for the expiry date on a box of condoms.
- *Provide specific information on how to use condoms properly.* (See p. 96.) Demonstrate proper condom use by showing pictures, photos, or better, pass a real condom around the class. Some videos such as "AIDS: Changing the Rules" (1987) demonstrate condom use.
- *Tell students that these guidelines are effective not only in preventing transmission of HIV but other sexually transmitted diseases as well.* These STDs are more common than AIDS, and the same barriers to information exist.

INSTRUCTIONS FOR CONDOM USE

Buy latex condoms. Check the expiry date on the box.

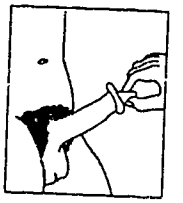
Use as follows:

1. Open the condom package carefully to avoid tearing.

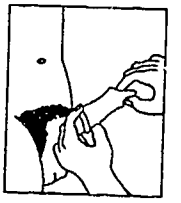


2. Either partner can put the condom on the penis before any genital contact.

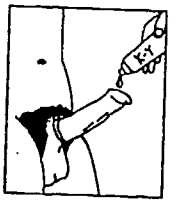
   Pinch the air from the tip of the condom to leave space for the semen. Air left in the condom tip will cause it to burst.



3. Unroll the condom right down to the base of the erect penis.



4. Avoid Vaseline and oil-based products. Use a water-based lubricant such as K-Y jelly or Lubafax to prevent the condom from deteriorating. For additional protection use a spermicide containing nonoxynol 9 such as Delfen or Emko.



5. After the man comes, pull out the penis while it is still hard, holding firmly the base of the condom. Remove the condom, being careful not to spill semen. Throw it away into the garbage. Use condoms only once.

Adapted from the pamphlet "Women and AIDS: Choices for Women in the Age of AIDS," Health and Welfare Canada, 1990
Prepared by Planned Parenthood Manitoba, Inc. 1991

8) AIDS can be prevented. Education is the best defense against AIDS. In places like Canada where our blood supply and medical practices are safe, everyone can help prevent the spread of AIDS by these measures:
b) Don't share needles

Teaching points:

If a person does use injection drugs, he should never share needles or syringes.

Other instruments that pierce the skin pose a potential risk: equipment use for tattoo, acupuncture, and ear piercing should be sterilized properly. There is no need to stress this point; no cases of transmission by these routes are known to have occurred in Canada.

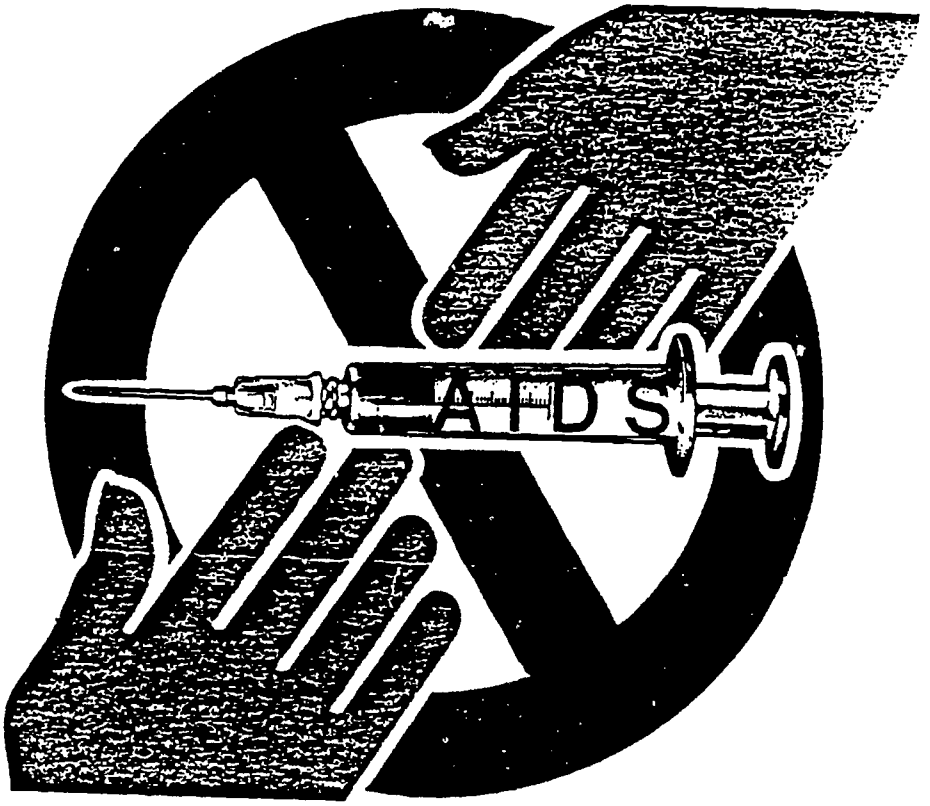
Point out to students that sex and drug use can be interrelated. Using drugs may lower a person's inhibitions about sexual activity, decrease his sense of caution about any risks involved, and lead to a failure to use appropriate precautions. This applies to alcohol and other mood-altering drugs, as well as to injection drugs.

Background information for teachers:

Many cities now have needle exchange programs in which injection drug users can exchange used needles for new ones. Find out whether there is such a program in your area.

Cleaning needles and syringes with household bleach can make them safe to use again. For more information, please see the following pages.

USED NEEDLES



SPREAD AIDS

Canadian Public Health Association

INSTRUCTIONS FOR CLEANING NEEDLES

The best strategy for preventing transmission of AIDS through needle use is not to use needles!

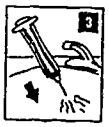
NEVER share needles with anyone.

Cleaning needles with bleach will kill HIV, the AIDS virus, in used needles. It will not damage needles and syringes. This is how it is done:

1. Pour bleach into a glass.

Fill the syringe.

Empty the syringe.



Fill again.

Empty again.

2. Fill glass with clean water.

Fill the syringe.

Empty the syringe.

Fill again.

Empty again.

Adapted from the pamphlet "Women and AIDS: Choices for Women in the Age of AIDS," Health and Welfare Canada, 1990
Prepared by Planned Parenthood Manitoba, Inc. 1991

General points for teaching about prevention:

Talk of risk behaviours, not risk groups. Anyone can become infected with the virus. Because the first cases of AIDS were found among certain groups of people in North America (e.g. homosexual men, hemophiliacs, immigrants from Haiti and some African countries, injection drug users), early AIDS prevention material was directed to certain "risk groups." This approach has proven to be misleading and dangerous. By discussing risk groups, we are not only labeling certain groups of people -- which can lead to blaming -- but also giving a message that people who are not in "risk groups" have nothing to fear. Anyone who engages in risk behaviours (unsafe sex or sharing needles) is at risk for AIDS.

Address the special concerns of women. Many women are also under the impression that as long as they are monogamous, they are not at risk. The realization that she may be at risk -- because her partner has not been monogamous -- may precipitate a crisis of anxiety and powerlessness. Many women may feel that they have no options to protect themselves, and many indeed do face violence from their partners if they raise concerns or insist on condoms.

Many immigrant women, in particular, are financially dependent on their husbands. If her husband is her sponsor, a woman may even fear being deported if she were to leave him.

These issues are far-reaching and cannot be dealt with simply by presenting facts about transmission. The teacher has a vital role in facilitating group discussion and problem solving, and in referring women who need counselling about their individual situations.

Help people understand the concepts of risk by using concrete examples. Because AIDS is such a frightening topic, many students will have trouble putting the risks of contracting the virus into perspective. Use examples that they can relate to.

For example, in explaining "minimal risk," you could ask what the chances would be that a plane would crash on top of the building while you are teaching. Most students will tell you it won't happen. Ask again if it is possible (even if highly unlikely)? Most will admit that it is possible. Relate this to the risks of getting AIDS from wet kissing: that is, nobody can guarantee that it won't happen, but in the entire history of ESL teaching, a plane has never crashed on an ESL classroom. And while nobody can guarantee that it can never happen, in all the cases of HIV infection in the world, none are known to have occurred through wet kissing.

Similarly, there have been a few cases of transmission through surgery (low risk). However, the chances of being in a car accident on the way to the hospital to have the surgery are greater than contracting HIV through medical procedures in a Canadian hospital. We do not usually go around worrying about freak plane crashes or about dying in a car accident on our way to the hospital.

Background information for teachers:

In AIDS research four categories of risk have been identified to help clarify the level of risk (theoretical and documented) associated with various activities:

- ***High risk*** - There is a high theoretical risk of transmission with a lot of evidence of transmission (e.g. intercourse with an infected partner without using a condom).

- ***Low risk*** - There is theoretical risk of transmission and some cases have been identified (e.g. sex, using a condom, with a partner whose HIV status is unknown).

- ***Minimal risk*** - There is a theoretical risk of transmission, but no actual cases have ever been identified (e.g. wet kissing).

- ***Safe*** - There is no theoretical risk and no evidence of transmission (e.g. hugging, sharing washrooms).

9) *There is a special blood test which will show whether a person is infected with the virus. Anyone who thinks he may be infected should talk to a specially trained counsellor, to see if he should be tested and to find out what the results mean.*

Teaching points:

A person can request counselling and testing from his physician, a local STD clinic, and some community clinics. He can also ask a local AIDS organization for advice on where to go for a test.

Do not advise students to "get tested" for AIDS. Students should ALWAYS be advised to get pre-test counselling before being tested.

A teacher should provide information on where counselling and testing can be obtained, and also specific, clear directions on how to make an appointment. (See "Acting as an information and referral agent," p. 39.)

When someone decides to have his blood tested for the AIDS virus, he has the right to ask what safeguards are in place to protect his confidentiality and who will have access to the results. Discuss confidentiality (see p. 11), and stress that one has the right to confidential counselling and testing. Make sure that students are aware of their right to informed consent -- that is, not to undergo any procedure without fully understanding and agreeing to it. (See Glossary, p. 142 for more on informed consent.)

If an interpreter is needed for the appointment, stress the importance of choosing an interpreter carefully. An interpreter for an AIDS/HIV appointment should:

- understand confidentiality and be committed to maintaining it, and;
- have a good knowledge of AIDS/HIV concepts and vocabulary to ensure that accurate information is transmitted.

A positive test result means that antibodies to HIV have been found in the person's blood. (The test will not show positive until at least 6-12 weeks from infection.) This means the person is infected with the virus; it does not mean he "has AIDS." A positive test does not indicate when the person will develop symptoms, or if and when the person will develop AIDS.

A negative test result can mean one of two things:

- The person is not infected with the virus; or
- The person is infected, but there has not been enough time for the antibodies to show up in the blood. Because it takes several weeks to several months for the body to produce antibodies to the virus, it is possible for an infected person to test negative. For this reason, if an individual has engaged in any risk behaviours in the last six months, he may wish to return for a follow up test.

The test results will be kept confidential and not released to other people.

Caution students that some life insurance companies insist on an HIV test. Because many newcomers apply for life insurance soon after arriving in Canada, teachers should discuss this point. Applicants are not required to take the test, but the life insurance company can then refuse coverage.

Practices between companies vary: some may send the applicant to a lab, others may send a nurse to the applicant's home. Pre-test counselling and protection of confidentiality do not appear to be a priority with some companies. Therefore, recommend to students that anyone who believes she could be infected should speak to a pre-test counsellor and arrange to be tested by an independent clinic before agreeing to the test by the life insurance company.

Background information for teachers:

In all provinces and territories of Canada AIDS is a "reportable disease." This means that all cases of AIDS must be reported to the public health department. A few also require reporting of HIV infection. Some require names with reporting, others use a code number. Ask your local public health department what is required in your area.

In a few locations in Canada, it is also possible to get anonymous testing, for which no name or identifying information needs to be given.

Test results are usually available about 10 days after testing.

How to: After The Session

Evaluate. Get an evaluation from your students, and critically assess your own performance. You should look at evaluating both students' satisfaction with the class (Did they find it useful? Were they comfortable discussing the topics?) and their knowledge. Both are important.

- For feedback on satisfaction, you could use an evaluation form such as the one on p. 105. In addition, ask yourself: How involved were the students in the discussion? Did they ask questions? Was there respect for differing views? Was there open discussion on both thoughts and feelings?

- The best way to assess whether there has been a gain in knowledge as a result of your program is to give a pre test and a post test, such as the one on p. 64. Remember that because of the many sensitive and emotionally charged issues involved in teaching about AIDS, as well as new vocabulary, students may require review of key concepts even if the topic is clearly presented. It is common for students to leave the class with misconceptions.

- To evaluate yourself, consider asking an experienced AIDS educator to sit in on your class. On p. 106 is a sample checklist for an observer (or the teacher himself) to evaluate skills.

Discuss incidents and questions with other educators; get their feedback on your response.

Provide handouts of community resources and written information to students to review in private.

Encourage use of the Question Box (p. 120) to identify other questions.

Be clear about plans for follow-up: Are you available for individual follow-up? Will there be a review period in the next class? Will there be follow-up on related issues raised in class?

Stay current. Update your own knowledge as new discoveries are made, and share these with your students. Share recent articles; inform students of upcoming documentaries and other events which will help them keep current on information about AIDS.

Related issues:
Acting as an information and referral agent, p. 39
Using mainstream AIDS education resources, p. 43
Using print and audiovisual resources, p. 48

CLASS EVALUATION

Please ✓ your answer.

1. The class had:

   _____ the right combination of lecture and discussion
   _____ too much lecture
   _____ too much discussion

2. Was today's session informative and useful?

   _____ Yes _____ No

3. Did you learn what you wanted to learn from today's session?

   _____ Yes _____ No

4. What did you like about today's session? _____

   _____

   _____

   What didn't you like about today's session? _____

   _____

   _____

5. Please ✓ your answer:

   Did the teacher know the topic? ____ Yes ____ No

   Was the teacher easy to understand? ____ Yes ____ No

   Was there enough time for questions? ____ Yes ____ No

   Was the teacher's level of English ____ too high ____ good ____ too simple

6. Comments:

EVALUATION OF TEACHER SKILLS: CLASSROOM OBSERVATION OR SELF APPRAISAL

Below is a list of questions about the teacher's performance. Please answer each question using this 5-point scale.

1 - not at all
2 - a small amount
3 - a medium amount
4 - a large amount
5 - a great deal

1.	How enthusiastic was the teacher about teaching this class?	1	2	3	4	5
2.	How involved were the students in the class?	1	2	3	4	5
3.	To what extent was the information presented in the class accurate?	1	2	3	4	5
4.	How much were the students encouraged to ask questions?	1	2	3	4	5
5.	How much did students ask questions?	1	2	3	4	5
6.	How much did the teacher encourage students to talk about their thoughts and feelings?	1	2	3	4	5
7.	How much did the students talk about their thoughts and feelings?	1	2	3	4	5
8.	To what extent did the teacher appear to listen carefully to the students?	1	2	3	4	5
9.	How much did the teacher talk at a level that the students could understand?	1	2	3	4	5
10.	How much did the teacher summarize the major points made during the class?	1	2	3	4	5
11.	How comfortable did the teacher appear to be in discussing sexuality topics?	1	2	3	4	5
12.	To what extent did the teacher discuss potentially embarrassing topics in a way that students still felt comfortable?	1	2	3	4	5
13.	To what extent did the teacher show warmth and concern toward the students?	1	2	3	4	5
14.	To what extent did the teacher show respect toward the students?	1	2	3	4	5
15.	To what extent did the teacher gain the trust of the students?	1	2	3	4	5
16.	To what extent did the teacher get along well with the students?	1	2	3	4	5
17.	To what extent did the students show respect toward each other?	1	2	3	4	5
18.	To what extent did the teacher encourage the discussion of all points of view?	1	2	3	4	5

Source: Adapted from Family Life Education: Keys to Sucess, Planned Parenthood Federation of Canada, 1989. Prepared by Planned Parenthood Manitoba, Inc. 1991

DOS AND DON'TS IN TEACHING ABOUT AIDS: A SUMMARY

DO:	*DON'T:*
Do look at all the alternative ways of making AIDS/HIV information available to students.	Don't feel you have to handle the topic by yourself.
Do assess and monitor your own knowledge level, comfort and objectivity.	Don't teach or discuss AIDS in isolation from other health or sexuality topics.
Do encourage an atmosphere of inquiry which gives a message that everyone should be concerned about AIDS.	Don't make assumptions about the sexual orientation or sexual practices of students.
Do be prepared to deal with political and racial issues.	Don't label certain groups of people as being at risk for AIDS.
Do stress lack of information as a risk factor.	Don't stress descriptions of symptoms of HIV infection.
Do make yourself aware of the range of community resources.	Don't forget to discuss access issues as well as AIDS facts.
Do facilitate students learning about AIDS in their own language.	Don't offer advice or reassurance.
Do refer people who are concerned about AIDS.	Don't be afraid to admit your own lack of knowledge or discomfort.
Do share lists of AIDS information sources so students can access information confidentially.	Don't use the pronoun "you" in giving information.
Do have posters and pamphlets in all languages in your classroom.	Don't use indirect or euphemistic expressions or descriptions.
Do be prepared to use graphics and demonstrations.	Don't encourage or accept stereotypes of what is culturally appropriate.
Do deal with issues of sexual orientation.	
Do be aware that sexual topics may trigger traumatic memories.	
Do discuss specific issues of concern to women.	

APPENDIX

SAMPLE EXERCISES

The exercises on the following pages are preparation activities designed to increase sensitivity to cultural and individual differences among students and to stimulate thinking about personal and social values.

All of these exercises have been used successfully with multicultural ESL groups: they are "tried and true." They also provide a structure for language practice and an opportunity for teaching new and sensitive vocabulary. At the end of most of these exercises, you will find a list of key sexual vocabulary relevant to the activity.

Of course, we expect teachers will choose and adapt exercises to meet the needs and language levels of each class. Some will be appropriate only for advanced students.

These exercises are not intended to be a complete curriculum, nor were they developed specifically for teaching about AIDS. We hope this will encourage teachers to adapt other AIDS and sexuality curriculum ideas for use in their ESL classrooms.

The exercises included are:

The Four Languages of Sexuality.
Purpose: To discuss different categories of language which people use to talk about sexuality, and the advantages and disadvantages of each.

How Did You Learn About Sex?
Purpose: A warm-up activity to introduce sexuality topics; to encourage self-awareness about one's own sexual education; to promote discussion of similarities and differences in sexual education across cultures.

The Privacy Circle.
Purpose: To encourage awareness of individual differences as to what topics are considered private and with whom information will be shared.

The Petal of Culture.
Purpose: To encourage students to recognize the diversity *within* cultural and ethnic groups.

The Question Box.
Purpose: To encourage frank sharing of questions about AIDS.

Okay For Me / Okay For Others.
Purpose: To assist students in clarifying: a) their attitudes about sexual behaviours; b) what behaviours are a matter of personal choice; and c) what behaviours are not permitted by society.

The Four Languages of Sexuality

1. Introduce the exercise by explaining that in every language there are different categories of words for discussing sexuality. Each of these types of speech has advantages and disadvantages.

   Medical language uses scientific or medical words. This category could also be described as words that doctors would use: e.g. urinate.

   Childhood language uses words that are taught to small children to describe body parts or body functions: e.g. go pee-pee. These words vary not only between cultures, but among families in the same society.

   Street language refers to language that is generally considered vulgar or rude. A person would not use street language in front of polite company: e.g. piss.

   Indirect or euphemistic language avoids referring to the activity or body part directly: e.g. visit the powder room, see a man about a horse. Every language has euphemistic expressions for sexuality and body functions, but they may not be the same in all languages.

2. Ask the class for other examples, and as a group try to come up with alternate words that fit each category.

   Some examples might be penis (medical), wee-wee (childhood), prick (street), thing (indirect); OR sexual intercourse (medical), screw or fuck (street), make love, sleep together (indirect).

   You may find that equivalent words do not exist for each category. Some words may not be easily categorized.

3. Going through each category, ask the class to identify advantages and disadvantages of each kind of language. Issues raised will probably include the following:

   Medical
   Advantages: neutral, not emotional, have a specific and well defined meaning, are less embarrassing.
   Disadvantages: not everyone knows these words, may be intimidating.

Childhood
Advantages: adults usually find them less embarrassing, may be easier to pronounce, may allow private functions to be discussed in public.
Disadvantages: no shared vocabulary, child starting school may not be able to express himself, often no other vocabulary taught so person may be embarrassed by not knowing other words.

Street
Advantages: direct, may be easily understood, often the only language known by some people.
Disadvantages: cannot be used without upsetting some people, often uses violent or exploitive imagery.

Indirect
Advantages: can avoid upsetting people, can be used in public and polite company.
Disadvantages: often confusing, can lead to misunderstanding. Not appropriate for teaching (e.g. *"A girl can get pregnant if she 'sleeps with' a boy."*)

4. Explain that the language you will be using will generally be in the medical category. In some cases, however, you may choose to use expressions that are more commonly understood (e.g. pee rather than urinate).

5. Ask the class what categories of sexuality vocabulary are most acceptable in their own languages.

6. Explain that there are often not exact translations in all languages for some of the words and expressions relating to reproduction. In fact, everyone in the class may not share the same understanding of how the body is constructed.

How Did You Learn About Sex?

Before introducing this activity, decide whether all or some of the following questions are to be discussed. (* = optional questions)

How did you learn about sex?
Was this the same for all boys/girls in your culture?

Could you talk to your parents about sex? What was their response?
What were their beliefs about sexuality education for boys? For girls?
Were these beliefs shared by everyone in your society?

** Were you allowed to date?*
What rules did your family give you about dating? About your relationships with the opposite sex?
What were the customs or practices in your society?

** How old were you when you heard about:*
Menstruation or wet dreams?
Masturbation?
Homosexuality?
Sexually transmitted diseases?
Birth control?
Abortion?
Divorce?

Where did you get your information?
Were any practices discouraged or illegal?

Think about the messages you got about sexuality when you were a child.
What messages do you still value today? Why?
What messages would you NOT want to give a child today? Why?

1. Introduce the activity.

2. Give each person a copy of the handout. (Alternatively use an overhead or write questions on the board.)

3. Put students into small groups, preferably four or five in a group. Try to make groups which you think will feel comfortable with each other and work well together.

4. Explain that you wish the group to discuss each question, one question at a time. Everyone who wants to is to have the opportunity to talk.

5. Read the questions out loud. Define any new vocabulary. You may ask one person in each group to facilitate the discussion.

6. Allow 20 - 30 minutes for discussion. Circulate to the groups, acting as a resource where necessary.

7. Ask everyone to come back into the large group. To debrief you may:
   - Ask each question again, getting input from each group, or:
   - Ask each group to summarize important points from its discussion.

8. Lead a group discussion around some of the following questions:
   - Did they enjoy doing the exercise? Why or why not?
   - How comfortable did they feel discussing these topics? (Was there any difference between mixed and same-sexed groups?)
   - What similarities did they find within the group? What differences?
   - Did males and females have different experiences? What were some other reasons for these differences?

   You will probably find that, with prompting, students will recognize that many of those from the same country have had different experiences and that there are many similarities between those from different countries. You may also take this opportunity to illustrate the ranges in Canadian experiences, as well as to identify stereotypes about Canadian culture.

9. A good follow-up activity is a discussion of the "Petal of Culture".

Key sexual vocabulary

abortion
birth control
dating
divorce
homosexuality, homosexual (gay, lesbian)
menstruation
sex education
sex
sexuality
sexually transmitted diseases
values
wet dreams

HOW DID YOU LEARN ABOUT SEX?

How did you learn about sex?

Was this the same for all boys/girls in your culture?

Could you talk to your parents about sex? What was their response?

What were their beliefs about sexuality education for boys? For girls?
Were these beliefs shared by everyone in your society?

**** Were you allowed to date***

What rules did your family give you about dating? About your relationships with the opposite sex?
What were the customs or practices in your society?

**** How old were you when you heard about:***

Menstruation or wet dreams?
Masturbation?
Homosexuality?
Sexually transmitted diseases?
Birth control?
Abortion?
Divorce?

Where did you get your information?
Were any practices discouraged or illegal?

Think about the messages you got about sexuality when you were a child.

What messages do you still value today? Why?
What messages would you NOT want to give a child today? Why?

Privacy Circle

1. Describe the purpose of the activity: to explore individual differences as to what information about ourselves we consider private and with whom we will share this information.

2. Give each student a copy of the handout. (Or alternatively, draw the diagram on the board, and ask students to copy it.

3. Explain what is meant by each of the categories on the handout. Each circle represents a group of people as labelled. The dot represents no one, not even yourself. (Please see note below.)

4. Explain that there are certain things which people only tell to their close friends and other things which people will tell to anyone. Each person has different ideas about what is private: about what they will discuss and with whom.

5. Explain that you will be asking the class a number of questions. Each question will have a number. You will ask them to put the number of that question in each circle of people *with whom they would share that information.* Stress that this exercise is private. They will not be asked to show this paper to anyone.

6. Explain that you are going to give a practice question and demonstrate on the board how to do the exercise.
"Question number one: 'Who would you tell what you ate for breakfast this morning?'" Repeat the question. Now demonstrate with an example, such as: *"Many people might say, 'I will tell anyone what I ate for breakfast!' In that case, they would put a number one in every circle -- Self, Family, Friends, and so on."* Demonstrate on the board. *"But maybe someone is on a diet. He might be embarrassed to tell his family or friends that he had six donuts for breakfast! But perhaps he would tell his doctor, or he might tell a stranger on the bus. This person would put a number one only in the circle for Strangers and Professionals. He would not put a number one in the other circles."* Check that the example is clear.

7. Explain any new vocabulary.

8. Explain to students that not all questions will apply to each individual. In fact, they may find it hard to imagine themselves in certain situations. In this case, they are to imagine who they think they would tell.

9. Read your choice of the following questions: To whom would you tell:
   - what political party you support?
   - your method of birth control?
   - how much money you make?
   - why you are here in Canada?
   - that you had sex before you were married?
   - that your partner is violent and hits you?
   - that you think you are a homosexual?
   - your weight?
   - that you are unable to have children?
   - how many sexual partners you have had?
   - that your mother or father is an alcoholic?
   - that you masturbate?
   - that you think you might have AIDS?
   - that you cannot read?

10. Discuss the following questions in a large group:
   - In which circle(s) did you put most of your responses?
   - Was it difficult to decide where to put some of your answers? Why?
   - What circumstances might have changed your answer?
   - Who did you include as "family"?
   - What kinds of questions are most private to you?
   - Are there certain kinds of questions which you would feel comfortable discussing with anyone? What kind?

This exercise should demonstrate that different people consider different things private and personal. Each person makes different choices as to whom to talk with about certain concerns. Especially when discussing sexuality, we must show care and sensitivity in what we ask other people or expect them to share.

Note: Participants may ask how it is possible to NOT share a concern with yourself. You can explain that sometimes things are so upsetting, we don't even admit to ourselves that they may be true. One example might be that of a woman who notices a lump in her breast but avoids going to the doctor for two years: the idea of cancer is so frightening that she doesn't let herself admit that this might be the reason for the lump. A second example might be that of a person who has sexual throughts or feelings for someone of the same sex. If he lives in a society where homosexuality is taboo, the person may deny (even to himself) that he has such feelings. Ask the group how these examples might relate to AIDS and denial.

Key sexual vocabulary

AIDS
birth control
denial
homosexual (gay, lesbian)
masturbate
monogamous, faithful
sexually transmitted diseases
sterile, infertile
taboo

Follow-up activity

Depending on the group, "Privacy Circle" can serve as a lead-in to a discussion of community resources. Follow up by defining the category of "professionals." Ask what professionals or services students know of with whom they could share concerns such as: sexually transmitted diseases, AIDS, problems with alcohol or drugs, spousal assault, infertility, need for birth control information.

This approach enables you to provide information to the whole group on services about which individuals may feel embarrassed to request information directly.

The Petal of Culture

1. Describe the purpose of the activity: to help students understand the many different aspects of an individual's culture.

2. Begin by defining and contrasting the terms CULTURE and ETHNIC GROUP (p. 20).

3. Present the "Petal" diagram and discuss each category giving an example of each (eg. gender: *"The experience of a man and woman can be very different even if they grow up in the same society and even in the same family."* (See p. 21.)

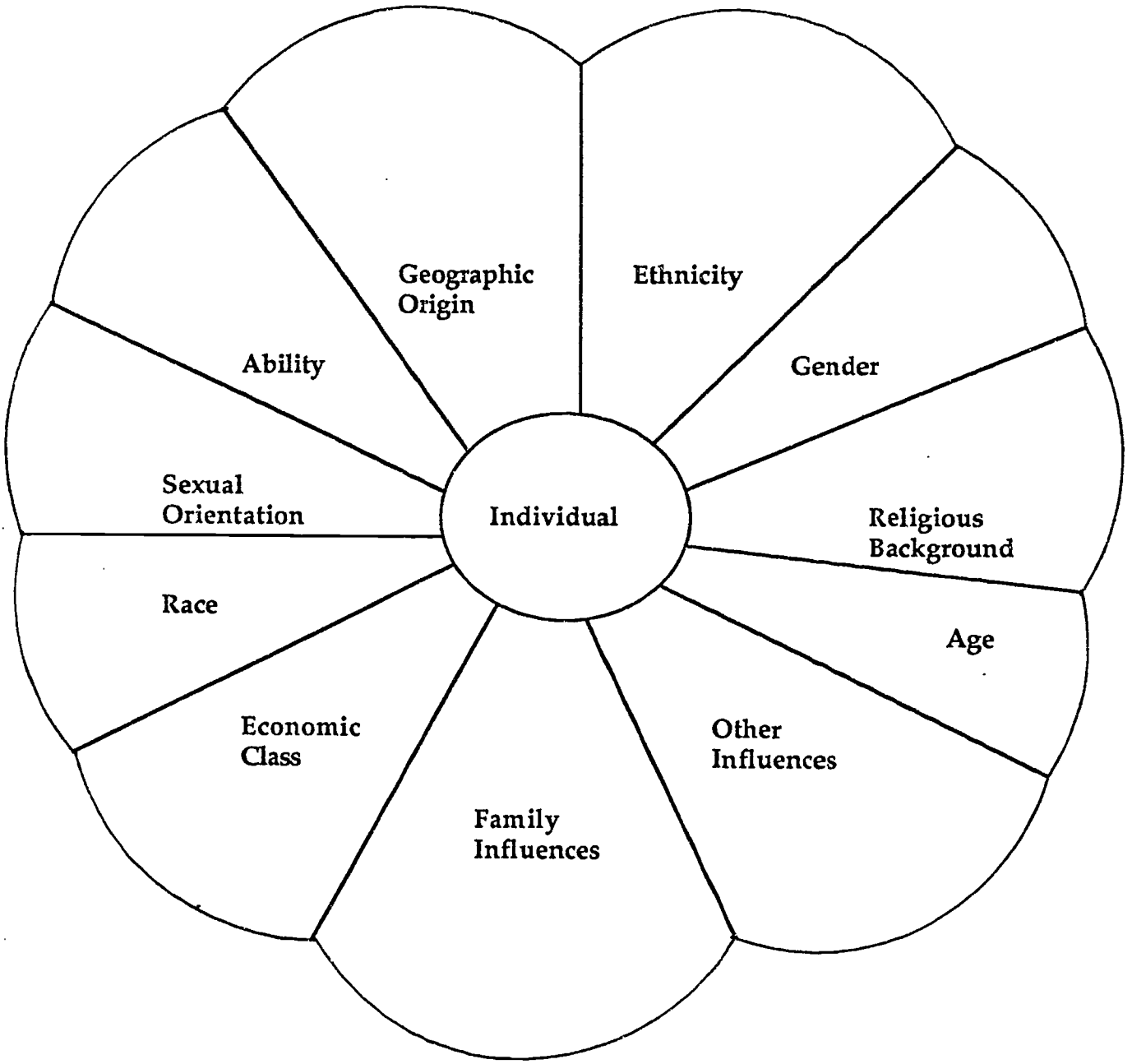
4. Use several examples from the Canadian context, French, English culture (ethnic group), geographical (prairies vs. maritimes vs. large urban centre), range of religious beliefs, etc.

5. Use personal examples where appropriate (*"My sister got married young and has lived all her life in the same small town. My brother left home when he was 18 and travelled for many years. He lives with his girlfriend in Montreal. My sister thinks this is wrong. I know this is one of the reasons they disagree on so many things."* or *"My husband was raised on a farm, I grew up in the city. His family was very religious, mine was not at all religious. Even though we are both of Ukranian background, we found we had a lot of different values, etc."*)

6. Encourage students to discuss how this model can explain some of the differences they have with friends and family.

7. Conclude by pointing out that ethnic group and country of origin are just two of the many factors that shape our ideas and values. There is much diversity among individuals from the same country; there is not ONE value, practice, or idea that applies to everyone from the same country. Values, attitudes and practices around sexuality is one area where there is diversity even among people from the same country.

THE PETAL OF CULTURE



The Question Box

The goal of the Question Box in dealing with sexual topics is to enable shy students to have their questions asked and answered, and to enable all students to raise questions they may consider embarrassing.

Because sexuality questions are sensitive, we suggest the following guidelines for presenting this activity. These guidelines will provide the confidentiality needed for students to feel it is safe to ask a question without anyone being able to identify the source of the question.

Part 1

1. Have a special box prepared. It should be in a secure place and closed, to maintain a sense of privacy.

2. Hand out to each class member identical pieces of paper. If the group is small, you may also want to hand out identical pens or pencils.

3. Ask everyone to think of a question they have about AIDS and to write it down. If some students have no question, ask them to write a question a) they have been asked, or b) that they know that a friend, workmate, neighbour or child has about AIDS. Stress that you would like everyone to write at least one question.

4. Ask students to fold their papers in half and deposit them in the question box.

Part 2

It is recommended that you uprovide yourself with some time in private to read the questions and prepare your answers. For this reason you may wish to introduce the activity to the class before you plan to discuss AIDS, or just before a break. You may also gather questions in preparation for a guest speaker, if this is agreed upon beforehand.

5. Answer one question at a time. If there are similar questions, you may wish to group them, and answer them together. Read the question, paraphrasing as necessary (correcting grammar, for example) to make the question clear. Answer the question simply. Then add any related information you feel is appropriate.

6. Check to see that your answer was clear. Ask the class if they need more information related to that question.

7. Often the meaning of a question may be ambiguous. In this case, after reading the question, explain that you are not sure whether the writer means "a" or "b". Then answer both possible questions. (Please review the guidelines on types of questions, p. 72.)

8. If inappropriate language is used, read the question calmly. Then rephrase the question using appropriate vocabulary and explain why you did so.

9. If personal questions are asked, you are NOT required to answer them. Remind the class of the ground rules. You may wish to respond to the question in a general sense.

10. Don't be hesitant to admit that you don't have the answer to a particular question. Promise to research the information and report back. Another option for advanced students is to have them phone an AIDS information line or community resource and report back to the class. A sample activity sheet is found on p. 122.

FINDING ANSWERS TO QUESTIONS ABOUT AIDS

1. Think of a question you have about AIDS that has not been answered in the class. Write the question:

---

2. The AIDS information number is _____. Call this number and ask your question. Write the answer to the question:

---

3. What was the person who answered your call like? Helpful? Clear? Hard to understand?

---

4. Would you call this number again if you had another question about AIDS? Why or why not?

Adapted from *Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome.* Marcia Quackenbush and Pamela Sargent. Santa Cruz, CA: Network Publications. 1988.

Okay For Me / Okay For Others

This activity should only be used with a group that has had some prior activities related to sexuality and discussion of sexual topics. It may be particularly useful to include in a more comprehensive AIDS program, especially after some initial discussion of the range of practices, beliefs and values around sexuality.

1. Give each student a handout.

2. Explain that the purpose of the activity is for each student to think about different sexual activities, and his or her own beliefs about the permissibility of these activities: Are they okay for everyone, okay for others but not for themselves, or are they "not okay" for anyone?

3. Write one example on the board and show the students how to record their responses.

4. Define any new vocabulary.

5. Ask the students to do the activity by themselves first. They do not have to show anyone their papers.

6. Then have the students discuss the activity in small groups. Remind them of the ground rules, especially about personal questions and respect for differences.

7. Back in a large group, introduce the following terms as ways of categorizing behaviour:
   normal/abnormal
   typical/atypical
   legal/illegal
   moral/immoral
   safe/unsafe

8. Again in small groups, if possible, have students share their ideas about the list of behaviours, but this time using the evaluative terms you have just introduced. For example, do they feel masturbation is typical or atypical, moral or immoral, and so on.

9. You may also use this activity as an assessment of students' knowledge about AIDS and other sexually transmitted diseases. Ask the group to identify which behaviours are "unsafe", i.e. pose a risk of transmitting HIV or other sexually transmitted diseases.

10. *Summarize* the exercise by pointing out that different people have different ideas of what activities are okay for them. Just because a behaviour is not practiced by most people (i.e. it is atypical) does not make it abnormal or immoral. Conversely, some common activities may be unsafe, or they may pose a risk of transmitting the AIDS virus (e.g. not using a condom). Encourage tolerance for other points of view about sexual activity. Explain that there are exceptions, however: all behaviours should involve consenting adults. Point out that two behaviours on this list (sex with a child and forcing a person to have sex) are against the law.

Note: This activity often generates a great deal of discussion. The teacher should come prepared to provide information on sexual abuse legislation and reporting procedures, sexual assault, and issues of the legal rights of married women.

Key sexual vocabulary

abortion
abstinence
anal intercourse
bisexual
condom, contraception, birth control
erotic, pornographic
fantasy
group sex
homosexual (gay, lesbian)
legal, illegal
masturbation
moral, immoral
normal, abnormal
nudity
oral-genital sex, oral sex
pre-marital, extra-marital
prostitution
safe, unsafe
sexual assault
sexual abuse
transvestite
typical, atypical

VALUES QUESTIONNAIRE

OKAY FOR ME		OKAY FOR OTHERS
_____	Sex before a "marriage" relationship.	_____
_____	Sex with a child.	_____
_____	Oral-genital sex.	_____
_____	Abortion	_____
_____	Nudity in the home.	_____
_____	Thinking about sex (sexual fantasy).	_____
_____	Watching erotic movies.	_____
_____	Not having sex (abstinence).	_____
_____	Men having sex with men.	_____
_____	Women having sex with women.	_____
_____	Bisexual activity.	_____
_____	Men dressing in women's clothing (transvestite)	_____
_____	Inter-racial sexual relationships.	_____
_____	Having sex without a condom.	_____
_____	Masturbation.	_____
_____	Anal intercourse.	_____
_____	Prostitution.	_____
_____	Group sex.	_____
_____	Forcing someone to have sex.	_____

TEACHING REPRODUCTIVE ANATOMY

In AIDS education, teachers must ensure that students share a basic understanding of reproductive anatomy and concepts. Several diagrams are included on the following pages to help you in this task.

The minimum vocabulary for AIDS education includes:

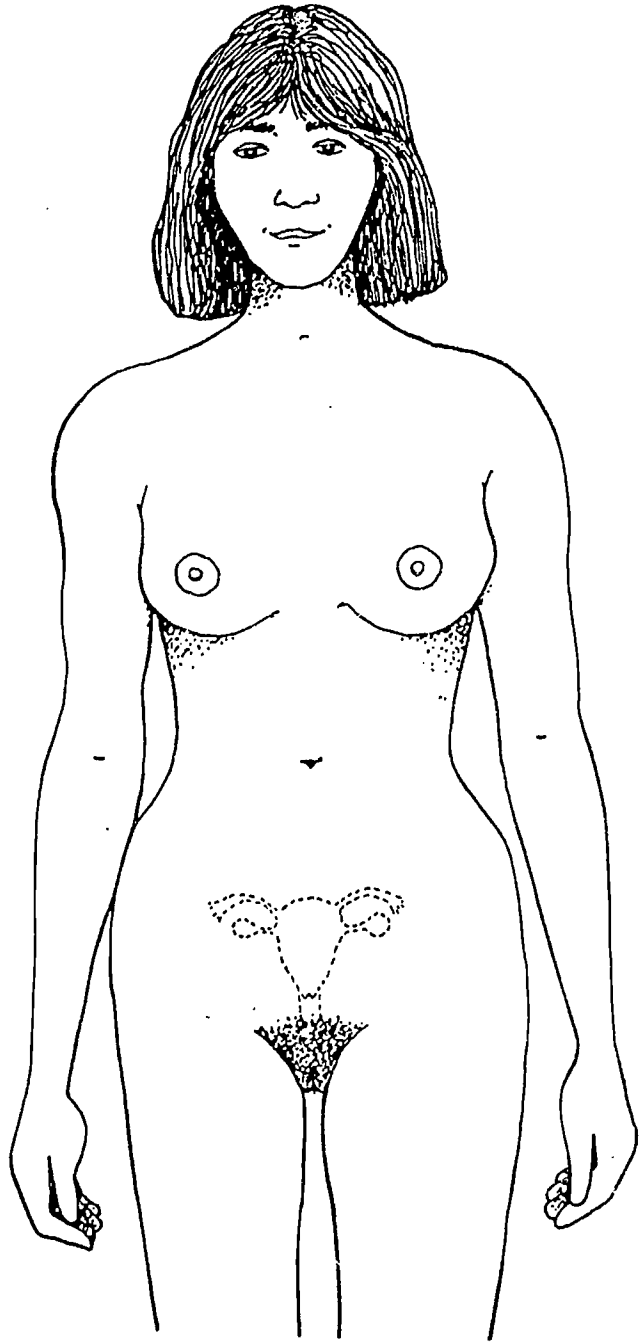
Male	*Female*
penis	vagina
semen	vaginal secretions
ejaculation	vulva
anus	anus
vaginal intercourse	menstruation, menstrual blood
anal intercourse	vaginal intercourse
	anal intercourse

The diagrams provided are more detailed than you require for teaching this minimum vocabulary. How much information you present will depend on the language level of the class and the interest shown in the topic. We have found that many students are eager to learn more extensive vocabulary related to reproduction.

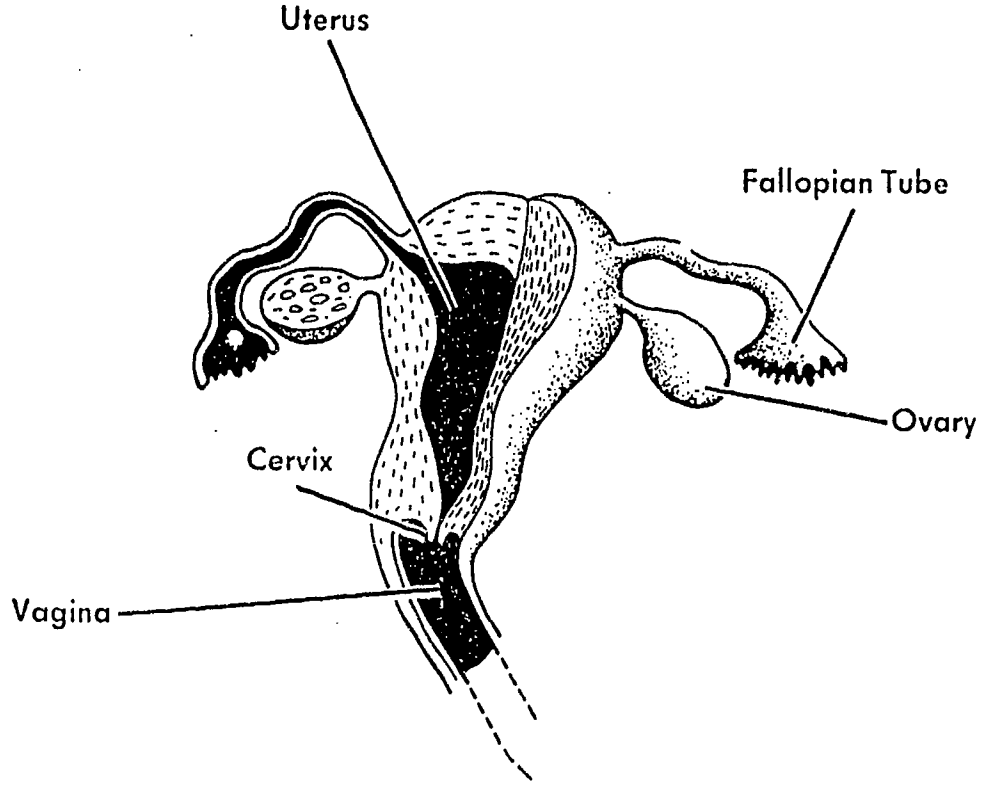
Please note that many diagrams available in family life or sexuality curricula do not include labeling of the anus. This reflects our own taboos, but it does not generally present a problem for most English language speakers: they can generally understand what is meant by anal intercourse without diagrams. This is not true of English language learners, however. We have included diagrams which show the anus.

In introducing diagrams of reproductive anatomy, especially to students with less formal education, it is important to first "place" the organs to be discussed in their position within the body. For this reason, we suggest you start with diagrams such as the ones on p. 128 and 129, rather than that on p. 131. Identify which view of a person the drawing presents (for example, *"In this picture, we are looking at a man from the side . . ."*). Point out easily identifiable landmarks, such as the back or belly, and start with the reproductive organs which people can see (penis, labia), before describing organs and functions which are not visible.

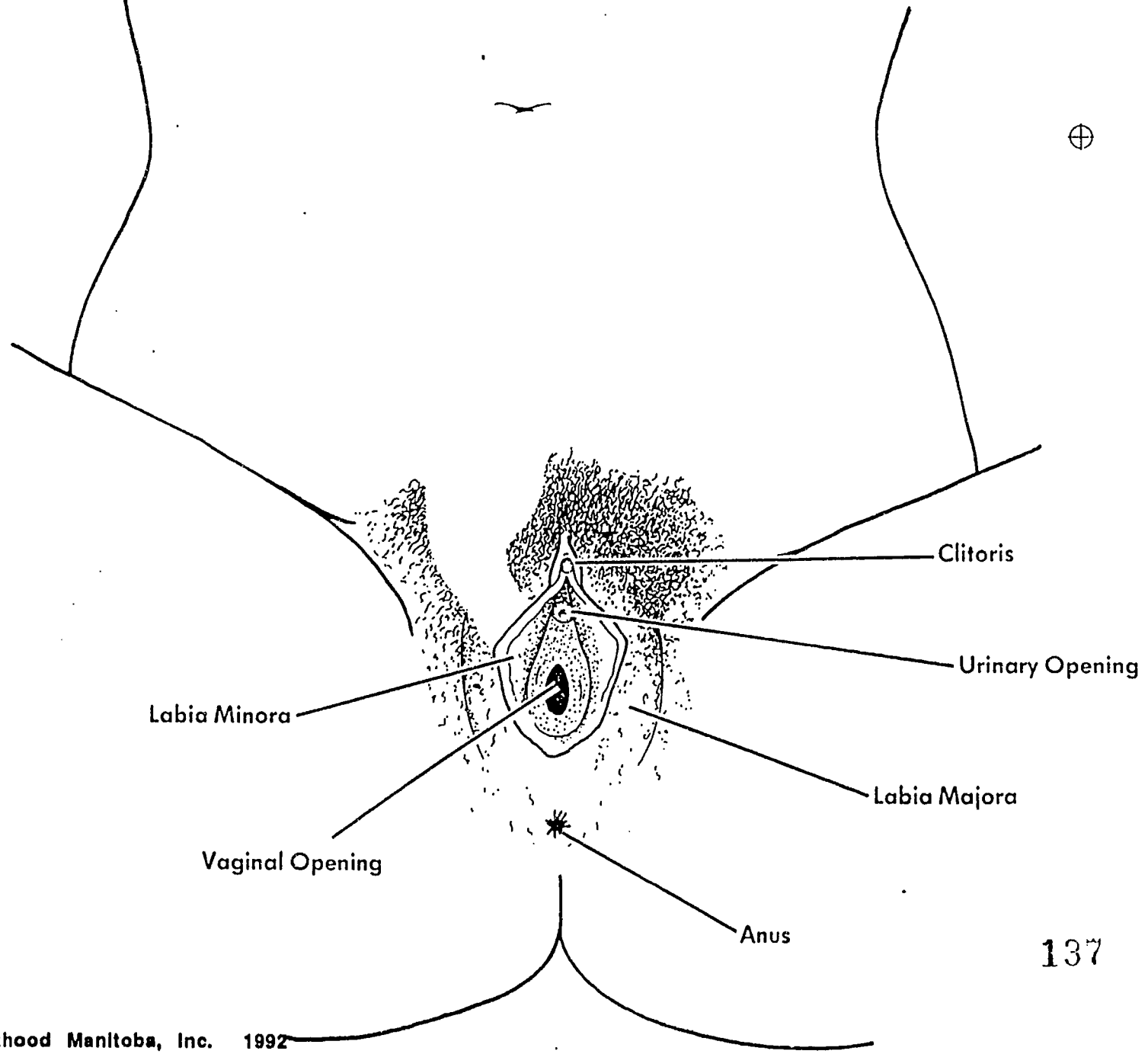
FEMALE REPRODUCTIVE ANATOMY



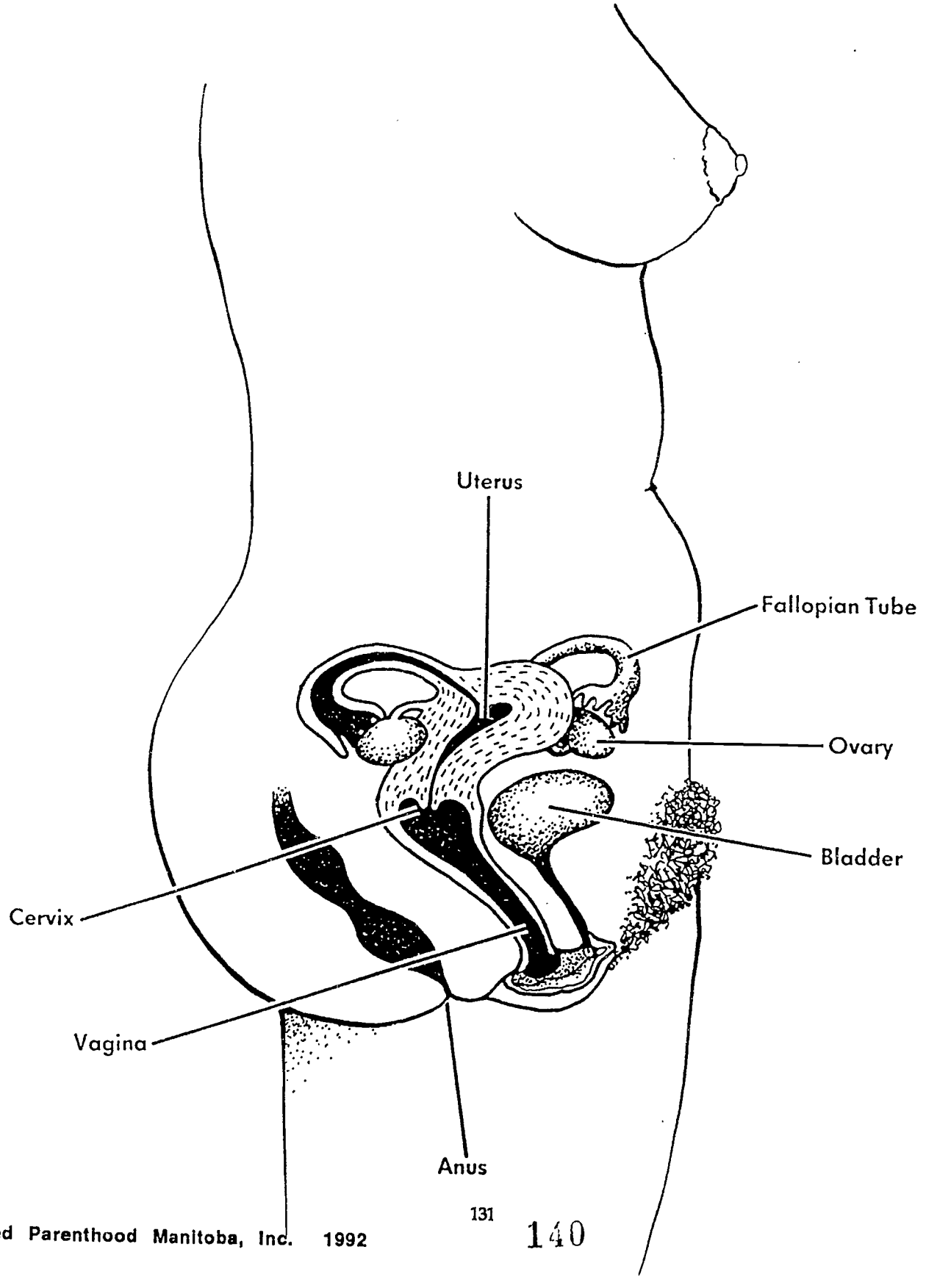
INTERNAL AND



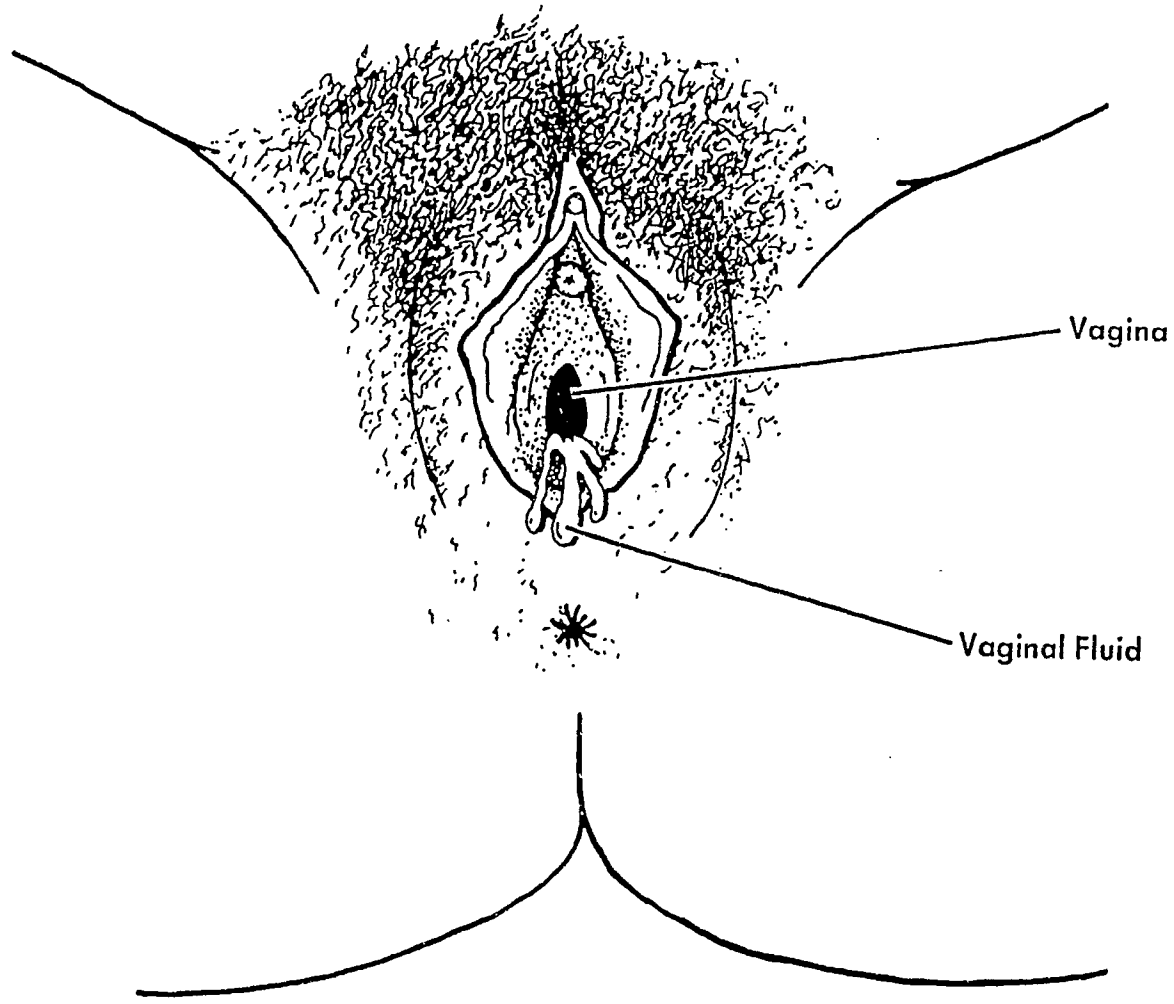
EXTERNAL FEMALE REPRODUCTIVE ANATOMY



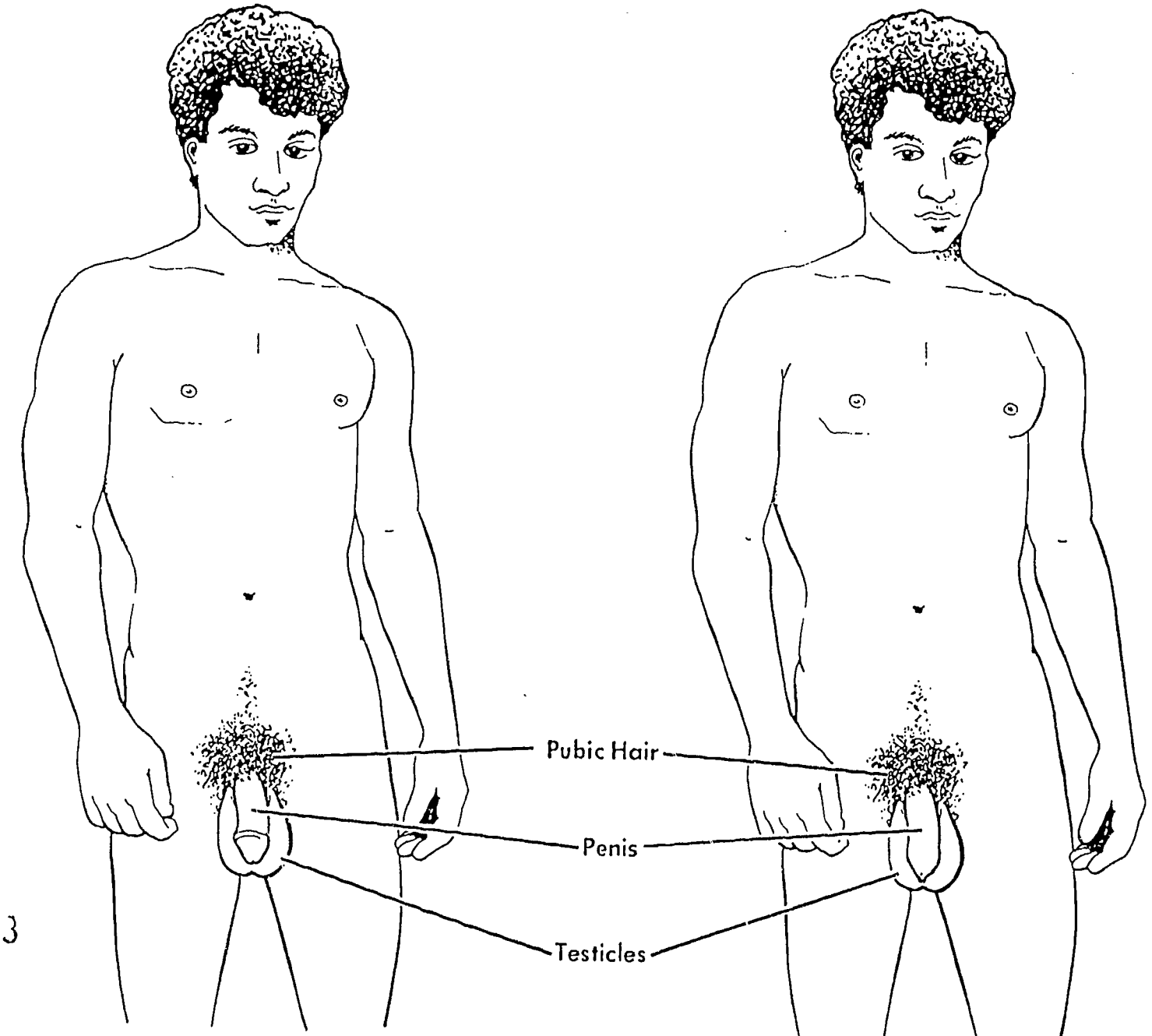
FEMALE REPRODUCTIVE SYSTEM



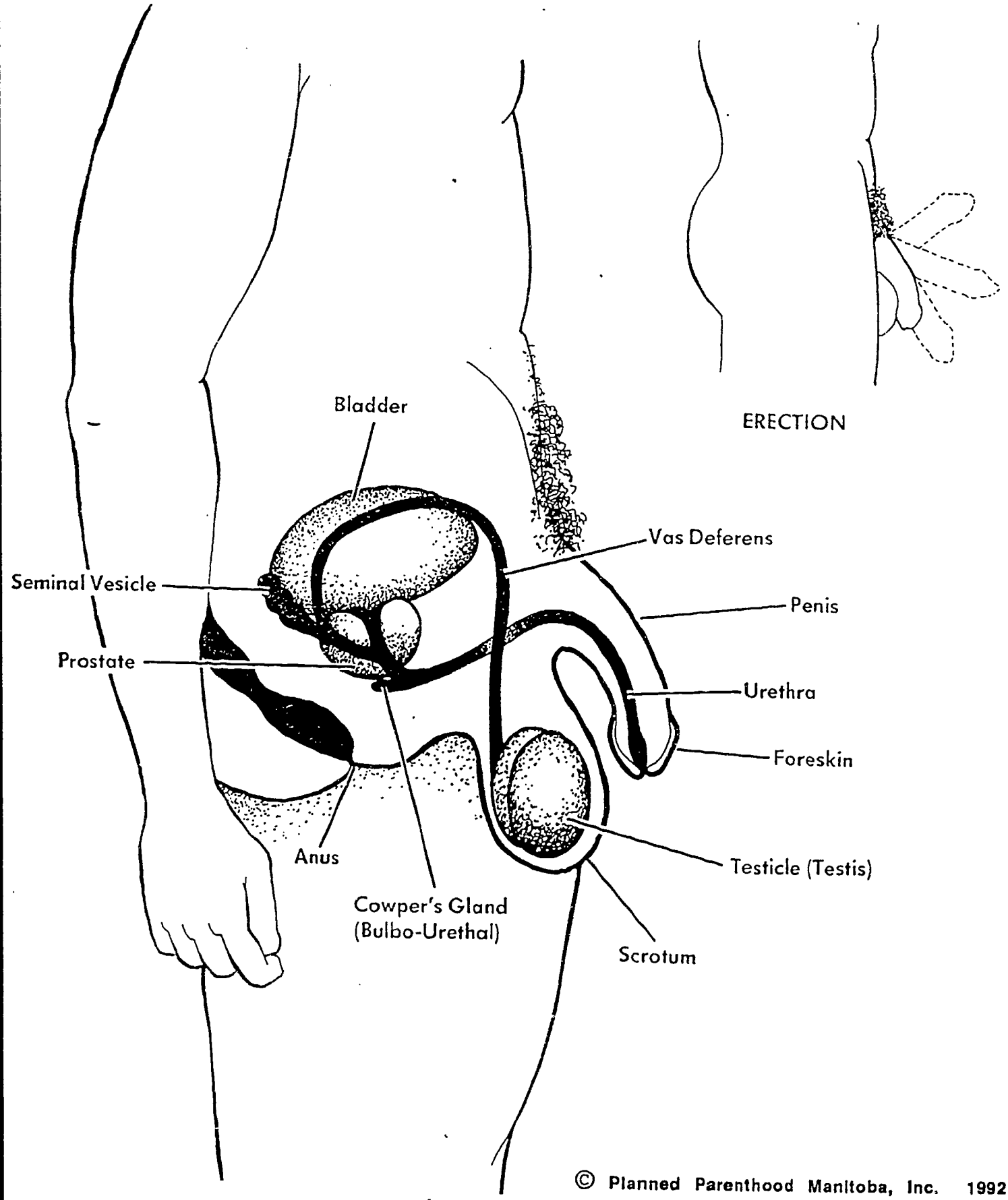
VAGINAL FLUID



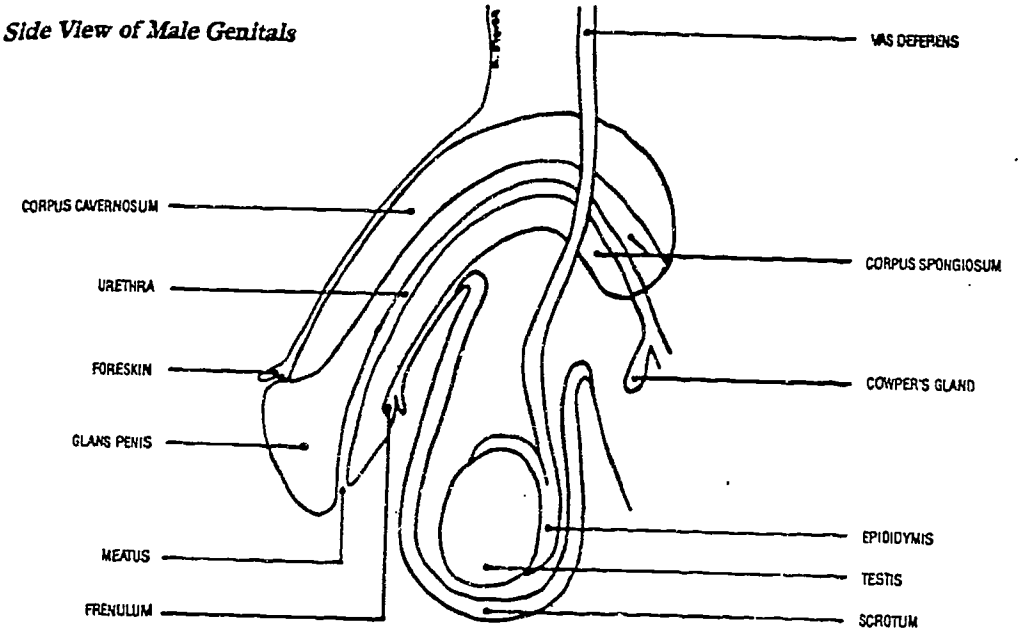
MALE REPRODUCTIVE ANATOMY



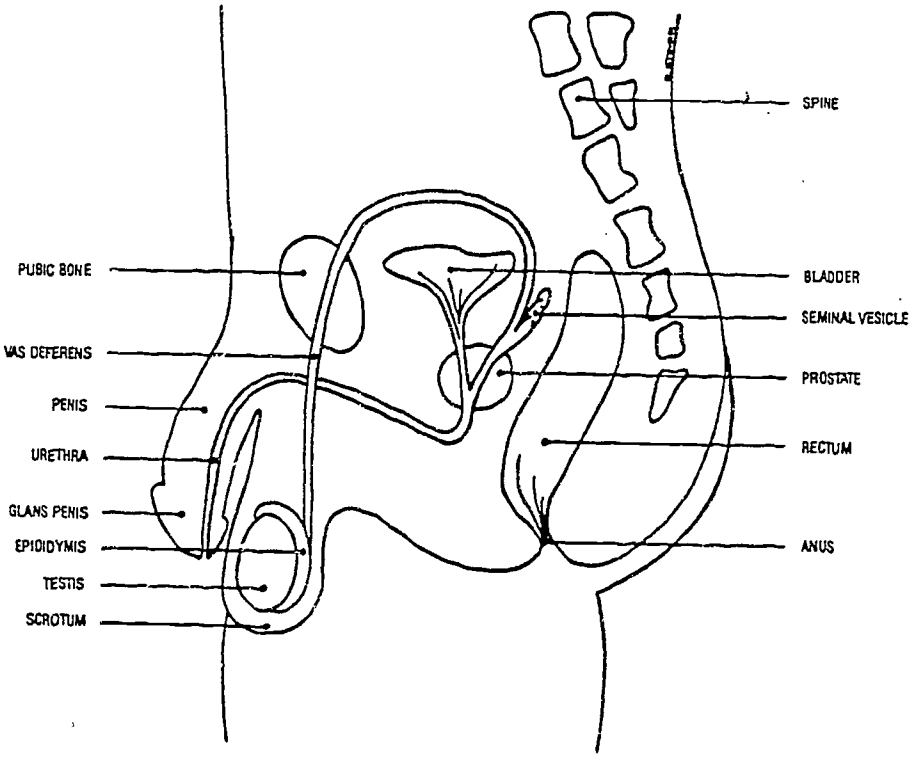
MALE REPRODUCTIVE SYSTEM



Side View of Male Genitals

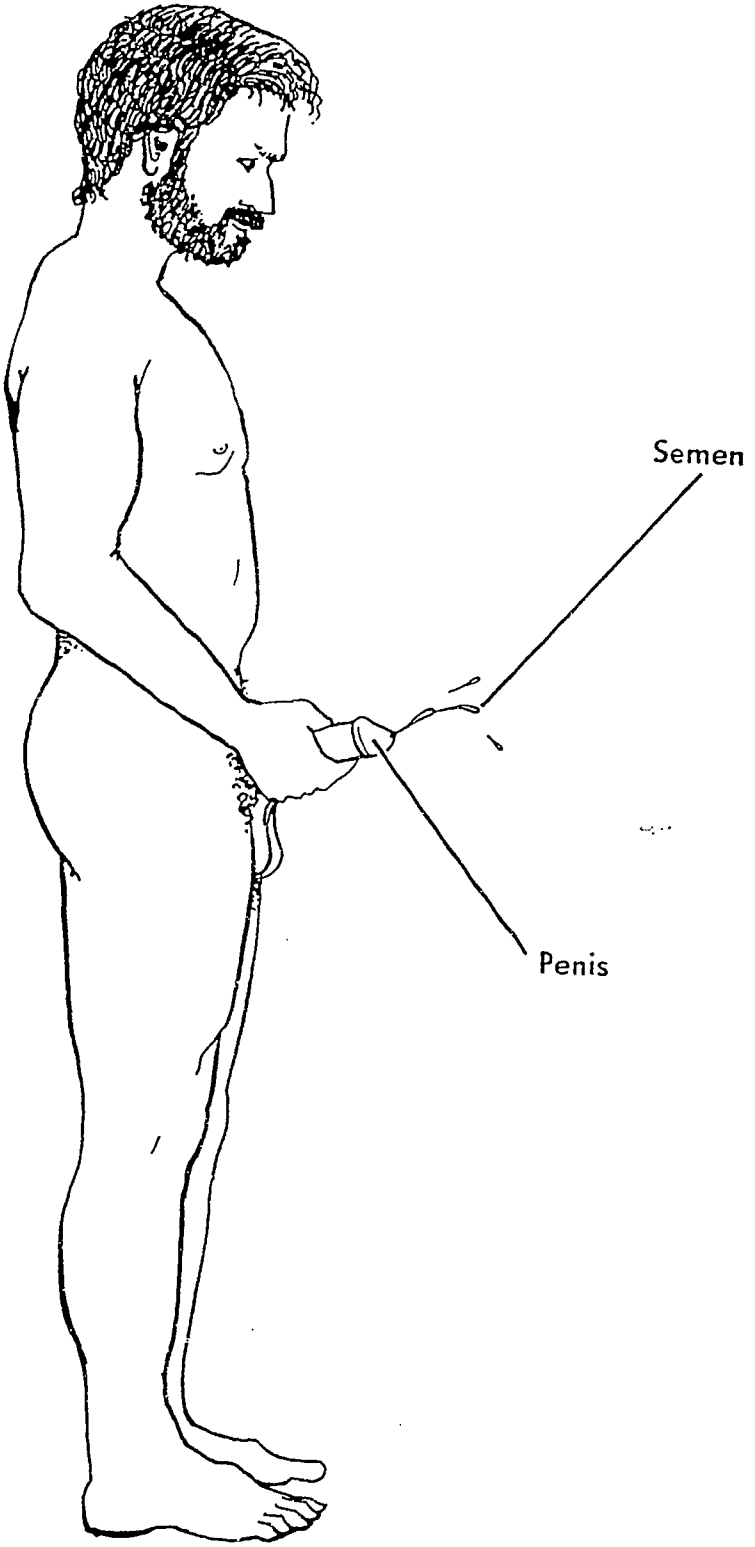


Side View of Male Reproductive System

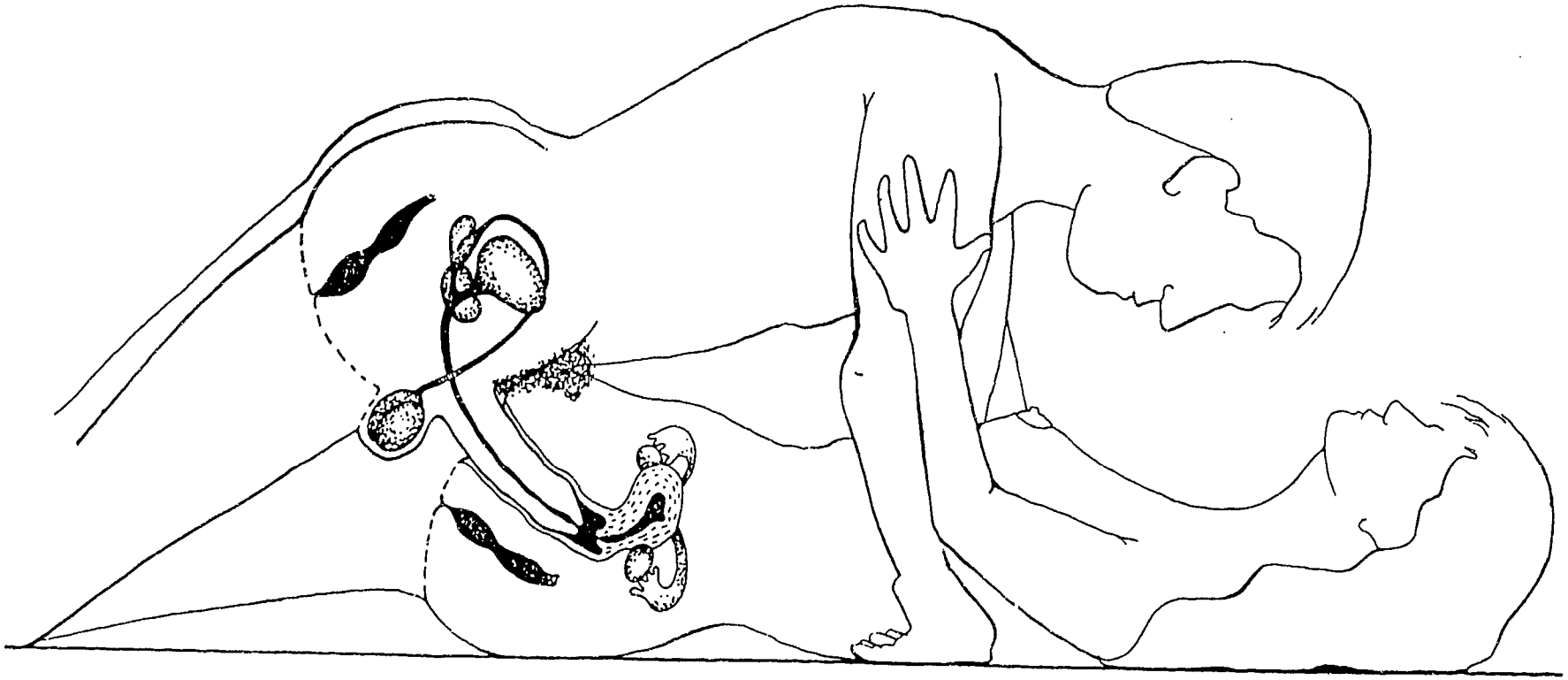


Source: Kathy McCoy and Charles Wibbelsman, *The New Teenage Body Book*, The Body Press, Los Angeles, CA, 1987

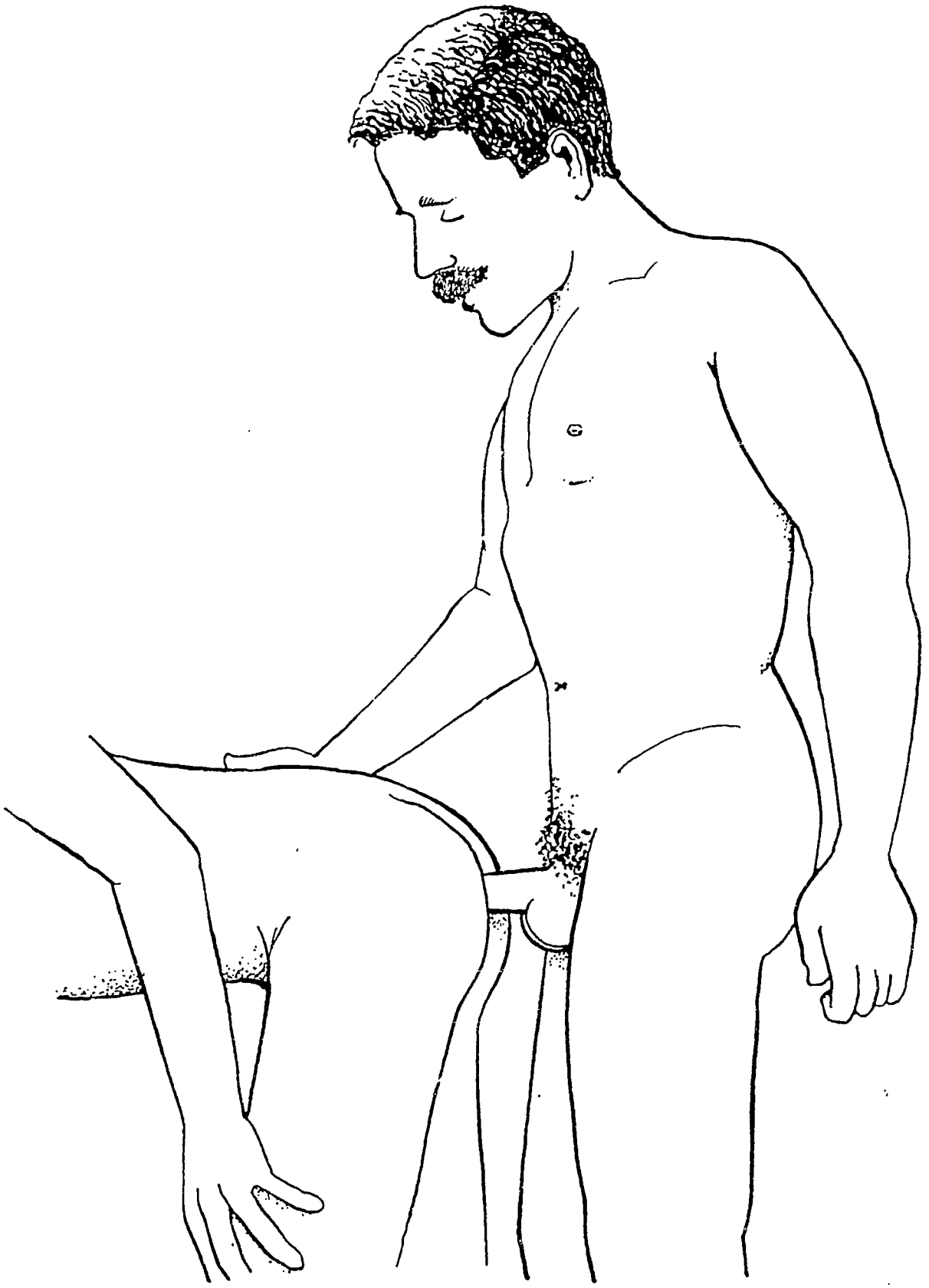
MALE EJACULATION



VAGINAL INTERCOURSE (SEX)



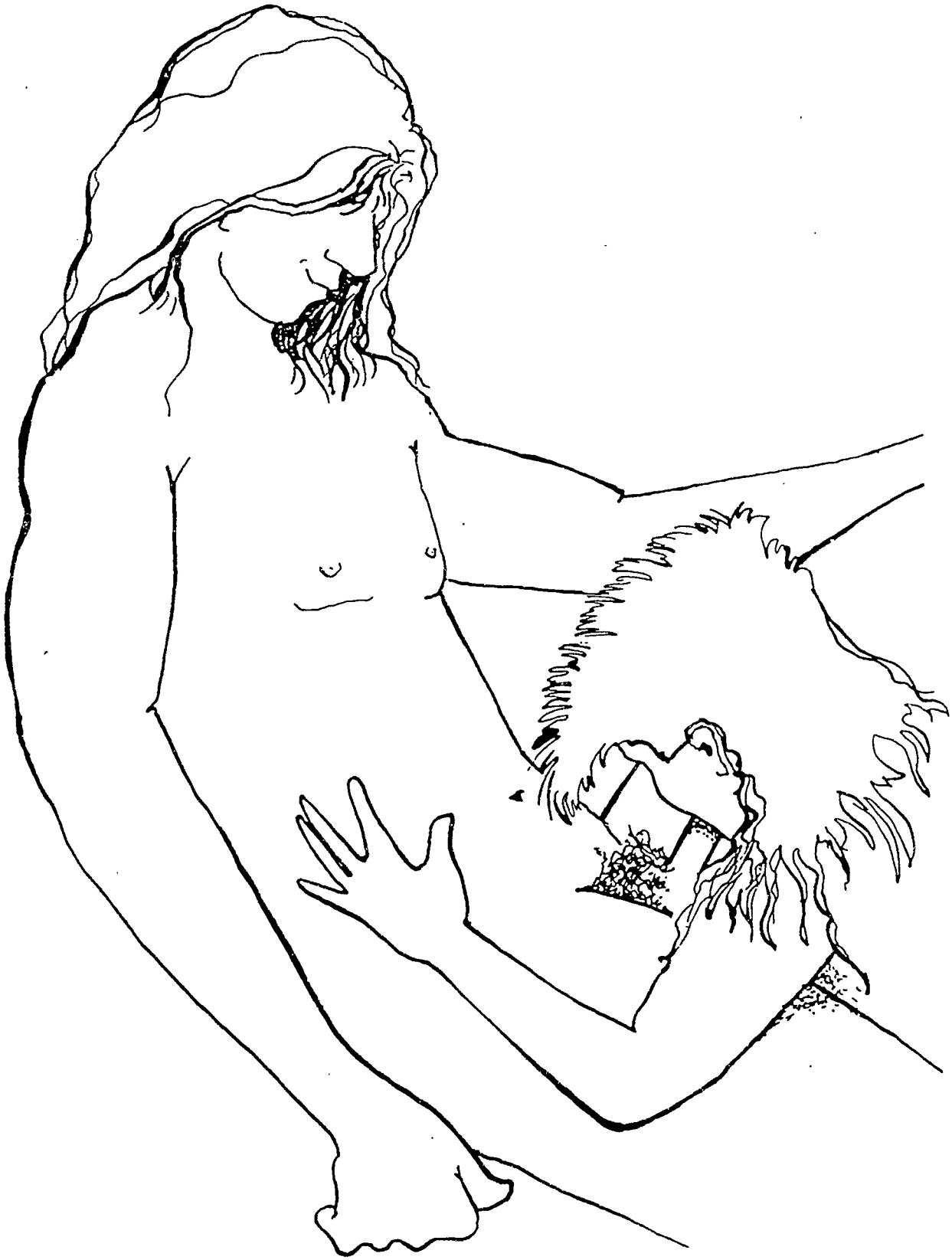
ANAL INTERCOURSE (SEX)



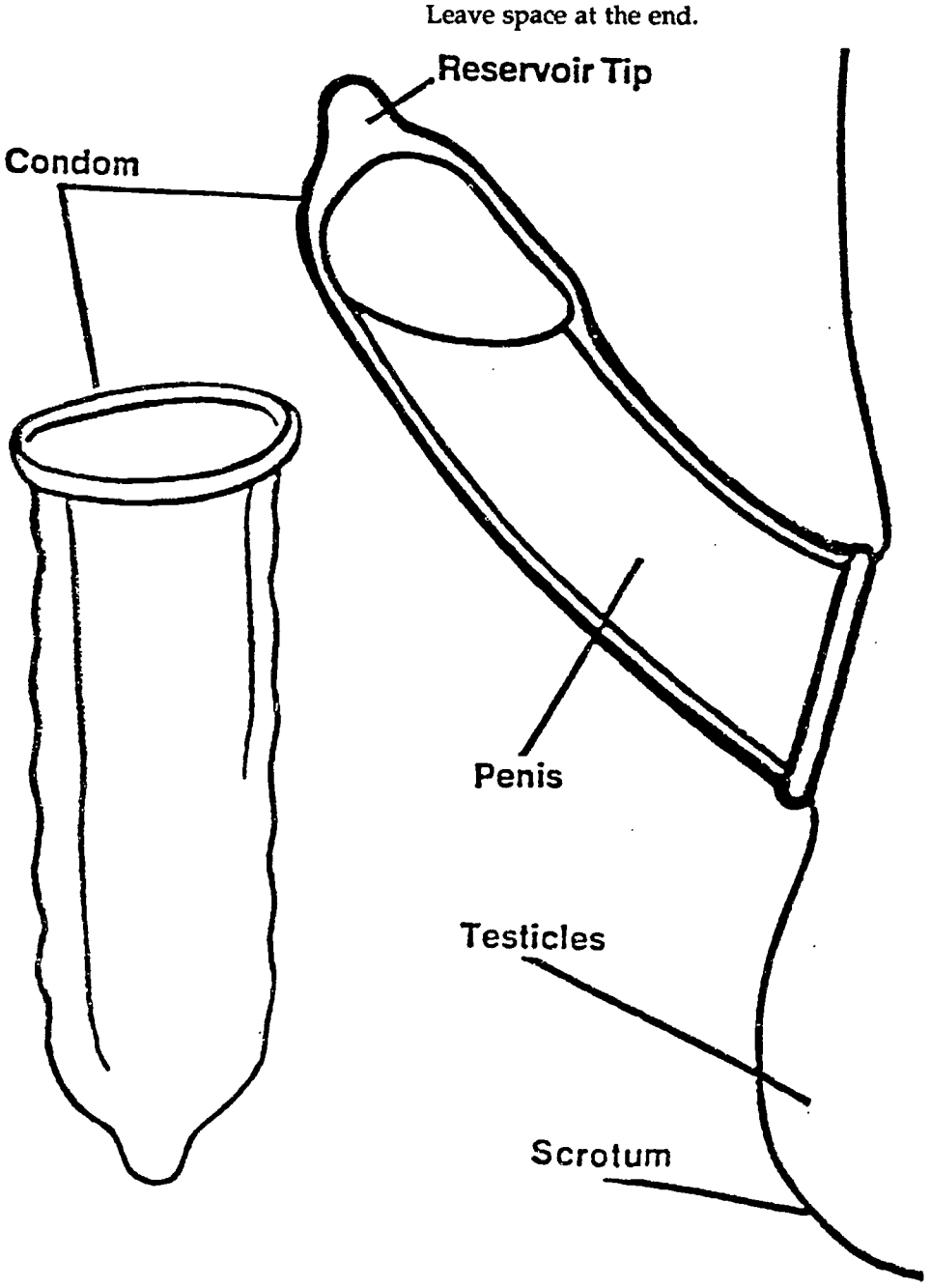
CUNNILINGUS

(ORAL SEX)

FELLATIO
(ORAL SEX)



USING A CONDOM



GLOSSARY

abstinence	-	not having sexual intercourse
AIDS	-	the initials stand for Acquired Immune Deficiency Syndrome. This is a serious illness caused by a virus called HIV.
anus	-	the opening to the rectum
anal intercourse	-	sexual intercourse by inserting the penis in the anus of a man or woman
anonymous	-	not carrying a person's name or any other identifying information
antibodies	-	substances in the blood which are produced by the body's immune system in fighting a germ in the body. If an antibody to a certain virus is in the blood, we know the person has been exposed to that virus.
ARC	-	the initials stand for AIDS Related Complex, a phrase used at one point to describe a person who is infected with the AIDS virus and has some symptoms, but has not developed AIDS. This expression is now out-of-date and not recommended.
AZT	-	(azidothymidine; also known as zidovudine) one of the drugs used to treat AIDS; may prolong the life and improve the quality of life of persons with HIV infection
asymptomatic	-	not showing any symptoms of a disease
balls	-	slang word for testicles
bisexual	-	a person who is sexually attracted to both men and women
bladder	-	the organ of the body which holds urine
body fluids	-	secretions and excretions from the human body, e.g. urine, semen, blood, tears, sweat
casual contact	-	ordinary, non-intimate, day-to-day contact between people

cervix	-	the opening between the vagina and the uterus
circumcision	-	*male* - surgical removal of the foreskin of the penis. This practice is common in North America and among the Jewish and Islamic faiths, but it is not so commonly found in other parts of the world. *female* - removal of the clitoris and/or other external genital organs. This is very rare in Canada but common in some parts of the world.
clitoris	-	a highly sensitive part of the female genitals. The purpose of the clitoris is to provide sexual pleasure for the woman.
coming out	-	an expression that describes the process of a gay or lesbian person being open about his or her homosexuality. A person may "come out" only to certain people or to the whole community.
communicable	-	capable of being passed from one person to another
condom	-	a very thin rubber (latex) covering for a man's penis during intercourse. It collects the semen and prevents it from entering the partner's body. It is used to prevent pregnancy and as protection from sexually transmitted diseases.
confidentiality	-	the practice of keeping information private
contact tracing	-	a method used by public health officials to identify and notify persons who have been sexual partners of someone identified with certain sexually transmitted diseases
contraceptive	-	a method or device to prevent pregnancy
Cowper's gland	-	glands which secrete pre-ejaculatory fluid in the man
cunnilingus	-	oral sex on a woman's genitals
cure	-	something which enables a person to recover from a disease or condition
ddI	-	(didadosine) one of the drugs used to treat people with AIDS

double standard	-	having one standard of behaviour for men, another for women
erection	-	the penis becoming stiff and hard
ejaculation	-	the discharge of semen from the penis; *premature ejaculation* describes ejaculation which occurs before a man wants it to. The verb is *ejaculate*; also "come" or "cum" (slang).
epidemic	-	any disease which is found at a greater than expected level in the population
erotic	-	describes anything which is found to be sexually stimulating. Something which is erotic is not necessarily pornographic.
extra-marital	-	outside of marriage. Extra-marital sex refers to a sexual relationship, while married, with someone other than your spouse.
fallopian tube	-	tube leading from the ovary to the uterus; carries the fertilized egg (ovum) to the uterus from the ovaries.
fidelity	-	the practice of having sex with only one person; the practice of being faithful to your sexual partner
fellatio	-	oral sex done on a man; "blow job" (slang)
foreskin	-	the fold of skin that covers the end of an uncircumsized penis
french kiss	-	a kiss with mouths open and tongues touching
gay	-	describes a homosexual, usually male. Most homosexual men prefer this term, so it is preferred.
genitals	-	the sexual parts on the outside of a person's body; often referred to as "private parts." (In medical language external genitals refers to the outside of the body; internal genitals, to sexual organs inside the body.)
glans	-	the sensitive end or head of the penis
helper T cells	-	white blood cells that help fight disease; also called CD4 cells

hemophilia	-	a disease in which the blood does not clot normally
hepatitis B	-	a disease carried in the blood; it can also be transmitted sexually
heterosexual	-	a person who is sexually attracted to people of the other (opposite) sex; "straight" (slang)
HIV	-	initials stand for Human Immunodeficiency Virus. This virus is the cause of AIDS.
HIV positive	-	showing the presence of antibodies to HIV. A person is HIV-positive if he or she is infected with HIV and has a positive HIV antibody test.
HIV negative	-	not showing the presence of antibodies to HIV. A person who is HIV-negative may or may not be infected with the virus. He or she is not immune to infection in the future.
homosexual	-	a person who is sexually attracted to people of the same sex; see also *gay* and *lesbian*.
hymen	-	thin membrane which may partly cover the opening to the vagina in a woman who has never had intercourse
impotent	-	unable to get an erection
immune	-	biologically protected from getting a certain disease
immune system	-	a body system that protects a person from disease. The immune system fights the spread of infection within the body.
incest	-	sexual intercourse between two people who are close relatives
incubation period	-	the time between a person's first exposure to infection and the appearance of symptoms
infection	-	the presence of a disease-causing germ in or on the body

informed consent	-	a legal concept which includes not only the principle of *consent* for treatment, but that the consent that was given was *informed*. In order for consent to be informed, the person giving consent must first be aware of: why the proposed treatment or procedure is needed; the effects of treatment, including risks or side effects; alternatives to the proposed treatment or procedure (including taking no action); awareness of what will happen if treatment is refused.
insertive partner	-	in sexual intercourse, the partner who inserts the penis (or finger or sex toy) into the other partner's anus or vagina. (See "receptive partner.")
injection drugs	-	drugs which are injected directly into the bloodstream; includes I.V. (for "intravenous") drugs.
Kaposi's sarcoma	-	a rare form of cancer often seen in persons with AIDS
labia	-	the folds of skin around the opening to the vagina
lesbian	-	a female homosexual. This, like the word "gay" to describe male homosexuals, is the preferred term.
lubricant	-	slippery substance that allows easier insertion of the penis into the vagina or anus. Vaginal secretions serve as a lubricant. Commercial lubricants can also be purchased. Only water-based lubricants should be used for sexual intercourse.
masturbation	-	manual stimulation of the genitals for sexual pleasure · hand job, jerking off (slang)
menstruation	-	the monthly discharge of blood from the uterus in women
monogamy	-	the practice of having only one sexual partner and remaining faithful to that partner. *Mutual monogamy* refers to a sexual relationship in which both partners are monogamous; i.e. they only have sex with each other. *Serial monogamy* refers to the practice of having only one sexual partner at a time, but having several partners in succession. This is not true "monogamy" and offers no protection against AIDS.
mucous membranes	-	the lining of the vagina and mouth

nonoxynol 9	-	a spermicide that also helps protect against sexually transmitted diseases
opportunistic diseases	-	cancers and infections which are able to affect people whose immune systems are weakened
oral-anal sex	-	touching a partner's anus with the mouth
oral-genital sex	-	touching a partner's genitals with the mouth; commonly called "oral sex". See also "fellatio" and "cunnilingus".
orgasm	-	the climax of sexual pleasure, accompanied by muscular contractions
ovary	-	the female gland which stores and releases eggs (ova)
penetration	-	insertion of the penis, fingers, or object into the vagina or anus
penis	-	the external male sex organ, used for urinatiion and for intercourse
perinatal	-	the period before and after the time of birth
PLWA	-	initials stand for "person (or people) living with AIDS"; preferred way of referring to those ill with AIDS
pneumocystic carinii pneumonia	-	one of the opportunistic diseases often found in people with AIDS; also called PCP, this is a severe lung infection
pornographic	-	sexually explicit and demonstrating or promoting force, violence or degradation
pre-ejaculatory fluid	-	a clear fluid which is secreted from the penis when the penis is erect. This is present before the man ejaculates.
premarital	-	before marriage. Pre-marital sex refers to sexual intercourse before marriage.
pre-test counselling	-	counselling which is provided to assist an individual make a decision about whether to be tested for the AIDS virus (HIV antibody test) and to prepare the client for the result.

post-test counselling	-	counselling which is provided at the time that the result of the HIV antibody test is shared with a person
prevention	-	actions taken to keep an illness from occurring
prostitute	-	a person (male or female) who provides sexual services for money
quarantine	-	the practice of keeping persons with a certain disease segregated (separate) from others in society, in order to prevent the spread of that disease
rape	-	forced sexual intercourse; now legally recognized as one type of "sexual assault"
receptive partner	-	in sexual intercourse, the partner into whose anus or vagina something (penis, finger, sex toy) is inserted. (See "insertive partner.") In vaginal intercourse between a man and a woman, the woman is the receptive partner, the man is the insertive partner. In anal intercourse between two men, either partner could be receptive or insertive; in anal intercourse (with penis) between a man and a woman, she is receptive.
risk behaviours	-	behaviours which put a person at increased risk of a certain disease or condition
risk groups	-	a category of persons with increased risk of contracting a disease. This term is no longer recommended for use in AIDS education.
safer sex	-	for AIDS prevention, "safer sex" refers to sexual practices in which there is no risk of exchanging blood, semen, or vaginal fluids with a partner. Consistent use of condoms for all penetrative sexual activity is one of the most important safer sex practices. (The term "safe sex" was used with this meaning in early AIDS prevention activities, but "safe sex" now refers only to abstinence or mutual monogamy between uninfected partners, i.e. sexual practices in which there is absolutely no risk of transmitting HIV because the virus is not present.)
saliva	-	fluid found in the mouth
scrotum	-	the sac of skin that holds the testicles

semen	-	the white fluid that comes out of the penis when a man ejaculates
seroconversion	-	the time when a person's HIV status changes from negative to positive. This can happen weeks or months after exposure to the virus.
sex toy	-	any device used to increase sexual pleasure
sexual abuse	-	sexual activity with a child
sexual assault	-	forced sexual activity
sexual intercourse	-	usually refers to the insertion of the penis into the vagina (vaginal intercourse), the anus (anal intercourse), or the mouth (oral sex)
sexual orientation	-	a person's sexual attraction generally to people of a) the opposite sex, b) the same sex, or c) both sexes
sexually transmitted diseases	-	any disease that can be passed to another person during sexual activity
STD	-	the initials stand for sexually transmitted diseases
sperm	-	the male reproductive cell; present in semen
spermicide	-	a chemical substance, used as a contraceptive, that kills sperm
sterile	-	infertile; unable to bear children
symptom	-	a change in the body indicating that infection or disease is present. Medically, "signs" refers to visible indicators, "symptoms" to indicators which can be perceived but not seen.
syndrome	-	a pattern of signs and symptoms that appear together
syringe	-	a device used to inject drugs directly into the blood or under the skin
taboo	-	describes behaviours that are forbidden by a society

testicles	-	the two egg-shaped organs that hang below a man's penis in the scrotum; where sperm are produced
transfusion	-	a medical procedure to transfer blood (or blood products) from one person into the veins of another
transsexual	-	a person who feels trapped in the body of the wrong gender and believes that he or she is really the other sex
transvestite	-	a person who gets sexual pleasure from dressing in the clothes of the opposite sex
transmitted	-	passed from one person to another
treatment	-	medicine or other action which is taken so that an illness will improve
uterus	-	organ of a woman's body where the fetus grows
terminal illness	-	a disease resulting in death
urethra	-	a tube which carries urine from the bladder to outside the body
urine	-	liquid waste produced by the body; commonly referred to as "pee"
vaccine	-	a substance which stimulates the body to produce anti-bodies which will protect against a specific infection
vagina	-	sexual organ of a woman extending from the vulva to the uterus; where the penis is placed during sexual intercourse. It is also called the "birth canal" as this is the passage a fetus must pass through during the birth process.
vaginal intercourse	-	the sexual act in which the penis is placed into the vagina; commonly called "sexual intercourse"
vaginal secretions or vaginal fluids	-	the liquid found in the vagina. The vagina is always wet; more fluids are produced during sexual excitement.
values	-	deeply held beliefs. We learn values from our culture. Values can change throughout our lives.

vas deferens	-	tubes which carry sperm from the testicles to the penis
VD	-	the initals stand for "venereal disease," an old term now replaced with the phrase "sexually transmitted disease"
virgin	-	a person who has never had sexual intercourse
virus	-	a very small germ that can make you sick
vulva	-	the external genitals of a woman
wet dreams	-	(slang) the ejaculation of semen by a man while sleeping. Medical term is "nocturnal emissions."
withdrawal	-	sexual intercourse in which the man withdraws his penis from the vagina before he ejaculates
worried well	-	describes those who are not infected with the AIDS virus, but are anxious that they may be. Sometimes this anxiety results in actual symptoms; also call AFRAIDS

DRAFT POSITION STATEMENT - AIDS EDUCATION

WHEREAS TESL Canada Federation is an organization which promotes programs that aim to provide learners of English as a second language the opportunity to participate fully in Canadian life; and

WHEREAS TESL Canada Federation recognizes the unique position ESL teachers have in access to learners that are difficult to reach via traditional channels; and

WHEREAS TESL Canada Federation realizes that AIDS is a serious disease with diverse social implications and is often misunderstood by the general public; and

WHEREAS TESL Canada Federation acknowledges that research has suggested that current AIDS education appropriate for ESL training are minimal and that ESL teachers may feel unprepared or reluctant to address the issue of AIDS in the classroom;

THEREFORE BE IT RESOLVED that the TESL Canada Federation support the developoment of a role for AIDS education in English as a second language training programs;

BE IT FURTHER RESOLVED that the TESL Canada Federation promote teacher training in AIDS education via existing avenues such as newsletters and publications, conferences and seminars;

BE IT FURTHER RESOLVED that the TESL Canada Federation endorse the publishing of articles on AIDS in Canadian graded language newspapers and promote this practice on an ongoing basis;

BE IT FURTHER RESOLVED that the TESL Canada Federation act to promote the use and availability of the teachers' guide on AIDS education produced by the *ESL and AIDS Education Project* and undertake to sponsor, where possible and feasible, the development of additional related materials;

FINALLY BE IT RESOLVED that the TESL Canada Federation circulate this resolution to its affilitate provincial ESL organizations and interest sections, to other professional organizations, and to apropriate public officials.

We in the TESL Canada Federation strongly believe that this resolution is an important component in ensuring that learners of English as a Second Language in Canada are able to access information appropriate to their needs and essential to their well being and thereby ensuring they are 'part of the picture' by participating fully in Canadian life.

RESOURCES FOR AIDS EDUCATION

First, an important address:

National AIDS Clearinghouse
Canadian Public Health Association
400 - 1565 Carling Avenue
Ottawa, Ontario
K1Z 8R1
Telephone: (613) 725-3769
Fax: (613) 725-9826

Many different pamphlets, posters, books and videos are available through the AIDS Clearinghouse, mostly at no cost. In addition, the Clearinghouse can provide information on where to get items about AIDS in over 50 languages. They welcome all types of requests for AIDS information.

In this bibliography, items available from the National AIDS Clearinghouse are marked with an *.

Suggested reading for teachers

Background reading in sexuality

It is suggested that all teachers read an introductory sexuality textbook before beginning any specific AIDS curriculum. A few good ones that are generally available are:

Bruess, C.E. and Greenberg, J.S. 1981. *Sex Education: Theory and Practice.* Belmont CA: Wadsworth Publishing Co.

Crooks, R. and Bauer, K. 1980. *Our Sexuality.* Menlo Park CA: Benjamin/Cummings Publishing Co., Inc.

Gordon, S. and Snyder, C.W. 1986. *Personal Issues in Human Sexuality.* Toronto: Allyn and Bacon, Inc.

McCary, S.P. and McCary, J.L. 1984. *Human Sexuality.* Belmont, CA: Wadsworth Publishing Co.

Books and reports about AIDS

Canadian AIDS Society. 1989. *Safer Sex Guidelines: A Resource Document for Educators and Counsellors.* Ottawa: Canadian AIDS Society.

Canadian Council for Multicultural Health. 1980. *A Consultation with Cultural Communities on the Subject of AIDS.* Ottawa: Canadian Council for Multicultural Health.

Gordon. G. and Klouda, T. 1989. *Preventing a Crisis: AIDS and Family Planning Work.* London: International Planned Parenthood Federation, Macmillan Publishers.

* Grieg, J. 1987. *AIDS: What Every Responsible Canadian Should Know.* Toronto: Summerhill Press.

King, A.J.C., et. al. 1988. *Canada Youth and AIDS Study.* Kingston: Queens University.

Toni Lauriston. 1990. *Creating a Cultural Dialogue: AIDS Education in the Multicultural Community.* St. Stephens Community House. Toronto.

* Minister of Supply and Services. 1990. *Women and AIDS: A Challenge for Canada in the Nineties.* Ottawa.

* Minister of Supply and Services. 1991. *AIDS Education and Prevention in Ethnocultural Communities: Report on National Consultation Meetings, December 1989 and January 1990.* Ottawa.

Ornstein, Michael D. 1989. *AIDS in Canada: Knowledge, Behavior and Attitudes of Adults.* Toronto: University of Toronto Press.

SIECCUS (Sex Information and Education Council of the U.S.). *Cultural Diversity and Sexuality: AIDS Information and Education.* New York: SIECCUS Report Vol. 18, no. 3. Feb/Mar, 1990.

Backgrounders about AIDS

Many background articles about AIDS are available through libraries and resource centres. The following useful factsheets published by Health and Welfare Canada are included in the Appendix:

Information About AIDS Education and Prevention in Ethnocultural Communities
AIDS and Canadians: Background Facts and Sources
AIDS: The Global Challenge
AIDS Worldwide: Background Facts and Sources

In addition, we have included the following selected bibliography on AIDS and ethnocultural issues from the CPHA National AIDS Clearinghouse.

CANADIAN PUBLIC HEALTH ASSOCIATION
ASSOCIATION CANADIENNE DE SANTÉ PUBLIQUE
1565 CARLING, SUITE 400, OTTAWA, ONTARIO, CANADA K1Z 8R1
(613) 725-3769 TELEX 21-053-3841 FAX (613) 725-9826

National AIDS Clearinghouse

Selected bibliography on AIDS and Ethnocultural Issues

Andrea J. Rapkin and Pamela I. Erickson.
Original papers: Differences in knowledge of and risk factors for AIDS between Hispanic and non-Hispanic women attending an urban family planning clinic. AIDS (journal) 1990, 4:889-899

Antoine-L-B. Pierre-L. Page-J-B.
Exclusion of blood donors by country of origin and discrimination against black foreigners in the USA. AIDS, 1990, 4, (8), 818.

Askari-E. Alexander-D-L.
AIDS and the minority health care worker. AAOHN-J. 1989 Mar. 37(3). P 109-13.

Bakeman-R. Lumb-J-R. Jackson-R-E. Smith-D-W.
AIDS risk-group profiles in whites and members of minority groups. New England Journal of Medicine, 1986, 315, (3), P. 191-192.

Bakeman-R. Lumb-J-R. Smith-D-W.
AIDS statistics and the risk for minorities. AIDS Research, 1986, 2, (3), 249-252.

Bindels-P-J-E. Jong-J-T-L. Poos-M-J-J-C. Leentvaar-Kuijpers-A. Jager-J-C. Coutinho-R-A.
The epidemiology of AIDS in Amsterdam, 1982-1988. Nederlands Tijdschrift voor Geneeskunde, 1990, 134, (8), 390-394.

Bowles-J. Robinson-W-A.
PHS grants for minority group HIV infection education and prevention efforts. Public Health Reports, 1989, 104, (6), 552-559.

Brown-L-S-Jr. Primm-B-J.
Intravenous drug abuse and AIDS in minorities. AIDS and Public Policy Journal, 1988, 3, (2), 5-15.

Brown-L-S. Murphy-D-L. Primm-B-J.
Needle sharing and AIDS in minorities. Journal of the American Medical Association, 1987, 258, (11), 1474-1475.

Buckett-W-M. Conlon-M-H. Luesley-D-M. Lawton-F-G.
Attitudes of a multiracial antenatal population to HIV screening 'letter. Br-Med-J 'Clin Res . 1988 Feb 27. 296(6622). P 643.

Buning, E.
AIDS-related interventions among drug users in the Netherlands. International Journal on Drug Policy, 1990, 1, (5), 10-13.

Coutinho-R-A. Boer-K. Schutte-M-F. Van-der-Velde-W-J. Muder-Folkerts-D-K-F. Van-Doornum-G-J-J.
Prevalence of HIV among pregnant women in and around Amsterdam in 1989. Nederlands Tijdschrift voor Geneeskunde, 1990, 134, (26), 1264-1266.

Cruickshank-J-K. Richardson-J-H. Newell-A-L. Rudge-P.Dalgleish-A-G. Morgan-O-St-C. Knight-J. Porter-J. Klenerman-P.
Papers: Screening for prolonged incubation of HTLV-I infection in British and Jamaican relatives of British patients with tropical spastic paraparesis. The British Medical Journal. 1990 Feb 3. 300(6720). P.300-304.

DAquila-R-T. Peterson-L-R. Williams-A-B. Williams-A-E.
Race/ethnicity as a risk factor for HIV-1 infection among Connecticut intravenous drug users. J-Acquir-Immune-Defic-Syndr. 1989. 2(5). P 503-13.

Des-Jarlais-D-C (Editor).
AIDS and intravenous drug use. AIDS and Public Policy Journal, 1988, 3, (2), 52pp.

DiClemente-R-J. Boyer-C-B. Morales-E-S.
Minorities and AIDS: knowledge, attitudes, and misconceptions among black and Latino adolescents. Am-J-Public-Health. 1988 Jan. 78(1). P 55-7.

Eskander-G-S. Jahan-M-S. Carter-R-A.
AIDS: knowledge and attitudes among different ethnic groups. J-Natl-Med-Assoc. 1990 Apr. 82(4). P 281, 284-6.

Flaskerud-J-H. Nyamathi-A-M.
An AIDS education program for Vietnamese women. N-Y-State-J-Med. 1988 Dec. 88(12). P 632-7.

Friedman-S-R. Sotheran-J-L. Abdul-Quader-A (et al.).
The AIDS epidemic among blacks and Hispanics. Millbank Quarterly, 1987, 65, (Suppl. 2), 455-499.

Gayle-J-A. Selik-R-M. Chu-S-Y.
Surveillance for AIDS and HIV infection among black and Hispanic children and women of childbearing age, 1981-1989. MMWR-CDC-Surveill-Summ. 1990 Jul. 39(3). P 23-30.

Gillies, Pamela and Manuel Carballo.
Editorial review: Adult perception of risk, risk behaviour and HIV/AIDS: a focus for intervention and research. AIDS (journal) 1990, 4:943-951

Ginzburg-H-M. MacDonald-M-G. Glass-J-W.
AIDS, HTLV-III diseases, minorities and intravenous drug abuse. Alcohol-Subst-Abuse. 1987 Spring. 6(3). P 7-21.

Glaser-J-B. Strange-T-J. Rosati-D.
Heterosexual human immunodeficiency virus transmission among the middle class. Archives of Internal Medicine, 1989, 149, (3), 645-649.

Glaser, M W.
Haitians can give blood 'letter. Am-J-Nurs. 1988 Mar. 88(3). P 290.

Gyurik, Thomas P.; Stehr-Green, Jeanette K., M.D.; Jason, Janine M., M.D.
Correspondence: Racial Differences In Care Of Patients With Hemophilia.
The New England Journal of Medicine. 1988 June 30. 318 (26). pp 1761-1762.

Hopkins, D R.
AIDS in minority populations in the United States. Public-Health-Rep. 1987 Nov-Dec. 102(6). P 677-81.

Horgan, J.
Affirmative action. AIDS researchers seek to enroll more minorities in clinical trials. Sci-Am. 1989 Dec. 261(6). P 34.

Johnson-A-M. Wadsworth-J. Elliott-P (et al.).
A pilot study of sexual lifestyle in a random sample of the population of Great Britain. AIDS, 1989, 3, (3), 135-141.

Judin JP, Teahan C, Tseng W-S.
Cross-ethnic attitudes and knowledge about AIDS in Hawaii. IV International Conference on AIDS. Stockholm, 1988:1:9119.

Laraque-Danielle. Kanem-Natalia. Mitchell-Janet.
Correspondence: The Difficult Road For The Minority Researcher. The New England Journal of Medicine. 1990 Jun 21. 322 (25). p 1823.

Laumann-E-O. Gagnon-J-H. Michaels-S. Michael-R-T. Coleman-J-S.
Monitoring the AIDS epidemic in the United States: a network approach. Science, USA, 1989, 244, (June 9), 1186-1189.

Lewis-D-K. Watters-J-K.
Human immunodeficiency virus seroprevalence in female intravenous drug users: the puzzle of black women's risk. Social Science and Medicine, 1989, 29, (9), 1071-1076.

Lindan-C-P. Hearst-N. Singleton-J-A. Trachtenberg-A-I. Riordan-N-M. Tokagawa-D-A. Chu-G-S.
Underreporting of minority AIDS deaths in San Francisco Bay area, 1985-86. Public-Health-Rep. 1990 Jul-Aug. 105(4). P 400-4.

Marin, G.
AIDS prevention among Hispanics: needs, risk behaviors, and cultural values. Public-Health-Rep. 1989 Sep-Oct. 104(5). P 411-5.

Menendez-B-S. Drucker-E. Vermund-S-H.
AIDS mortality among Puerto Ricans and other Hispanics in New York City, 1981-1987. Journal of Acquired Immune Deficiency Syndromes, 1990, 3, (6), 644-648.

Menendez-B-S. Vermund-S-H. Drucker-E. Blum-S.
Race/ethnic-specific AIDS risk in New York City, 1981-87 'letter. Am-J-Public-Health. 1989 Dec. 79(12). P 1679-80.

Miller-G-J. Pegram-S-M. Kirkwood-B-R. Beckles-G-L. Byam-N-T. Clayden-S-A. Kinlen-L-J. Chan-L-C. Carson-D-C. Greaves-M-F.
Ethnic composition, age and sex, together with location and standard of housing as determinants of HLTV-I infection in an urban Trinidadian community. Int-J-Cancer. 1986 Dec 15. 38(6). P 801-8.

Moran-J-S. Aral-S-O. Jenkins-W-C. Peterman-T-A. Alexander-E-R.
The impact of sexually transmitted diseases on minority populations. Public-Health-Rep. 1989 Nov-Dec. 104(6). P 560-5.

Politzer-R-M. Davis-C-H.
HIV/AIDS surveillance: revelation at the margin. AIDS and Public Policy Journal, 1990, 5, (1), 29-31.

Rapkin, Andrea and Pamela I. Erickson.
Original papers: Differences in knowledge of and risk factors for AIDS between Hispanic and non-Hispanic women attending an urban family planning clinic AIDS (journal) 1990, 4:889-899

Rhodes-F. Wolitski-R-J.
Perceived effectiveness of fear appeals in AIDS education: relationship to ethnicity, gender, age, and group membership. AIDS-Educ-Prev. 1990 Spring. 2(1). P 1-11.

Rieder-H-L. Snider-D-E-Jr. Cauthen-G-M.
Extrapulmonary tuberculosis in the United States. American Review of Respiratory Disease, 1990, 141, (2), 347-351.

Rieder-H-L. Cauthen-G-M. Comstock-G-W. Snider-D-E-Jr.
Epidemiology of tuberculosis in the United States. Epidemiologic Reviews, 1989, 11, 79-98.

Rosenman-Kenneth-D. Aoki-Susan-K. Felton-Charles-P. Smith-Jeanne-A. Ehrlich-Martin-H. Morse-Dale-L. DiFerdinando-George-T Jr. Smith-Margaret-H-D. Trump-David-H. DiStasio-Anthony-J II. Davies-P. Nisar-M. Stead-William-W. Senner-John-W. Reddick-William-T. Lofgren-John-P.
Correspondence: Racial Differences And Mycobacterium Tuberculosis Infection. The New England Journal of Medicine. 1990 Jun 7. 322 (23). pp 1670-1673.

Samuel-M. Winkelstein-W Jr.
Prevalence of human immunodeficiency virus infection in ethnic minority homosexual/bisexual men 'letter . JAMA. 1987 Apr 10. 257(14). P 1901-2.

Samuels-J-E. Hendrix-J. Hilton-M. Marantz-P-R. Sloan-V. Small-C-B.
Zidovudine therapy in an inner city population. J-Acquir-Immune-Defic-Syndr. 1990. 3(9). P 877-83.

Schilling-R-F. Schinke-S-P. Nichols-S-E. Zayas-L-H. Miller-S-O. Orlandi-M-A. Botvin-G-J.
Developing strategies for AIDS prevention research with black and Hispanic drug users. Public-Health-Rep. 1989 Jan-Feb. 104(1). P 2-11. (Review).

Selik-R-M. Castro-K-G. Pappaioanou-M.
Distribution of AIDS cases, by racial/ethnic group and exposure category, United States, June 1 1981-July 4 1988. Morbidity and Mortality Weekly Report, 1988, 37, (Suppl. SS-3), 1-10.

Shedlin-M-G.
An ethnographic approach to understanding HIV high-risk behaviors: prostitution and drug abuse. NIDA-Res-Monogr. 1990. 93. P 134-49.

Snider-D-E-Jr. Salinas-L. Kelly-G-D.
Tuberculosis: an increasing problem among minorities in the United States. Public Health Reports, 1989, 104, (6), 646-653.

Stoneburner-R-L. Des-Jarlais-D-C. Benezra-D (et al.).
A larger spectrum of severe HIV-1-related disease in intravenous drug users in New York City. Science, USA, 1988, 242, (Nov. 11), 916-919.

Sullivan-L-W.
Shattuck lecture: the health care priorities of the Bush Administration. New England Journal of Medicine, 1989, 321, (2), 125-128.

Tuberculosis in minorities-USA.
Morbidity and Mortality Weekly Report, 1987, 36, (6), P. 77-80.

Watter, J K and Diane K. Lewis*
Correspondence: HIV infection, race, and drug-treatment history. AIDS (journal) 1990, 4:697-702.

Wellings-K. Kapila-M.
Multi-lingual AIDS. THS Health Summary, 1988, 5, (5), 4.

Woo-J-M. Rutherford-G-W. Payne-S-F. Barnhart-J-L. Lemp-G-F.
The epidemiology of AIDS in Asian and Pacific Islander populations in San Francisco. AIDS. 1988 Dec. 2(6). P 473-5.

Classroom Resources

As AIDS is a relatively new disease, there is little in the way of resources designed specifically for the ESL student. A wealth of excellent material is available, however, much of it free of charge. We hope that this manual will encourage those working with ESL students to spearhead a drive for more appropriate resources -- materials which are both culturally sensitive and simply written for English language learners.

Curricula and activities about AIDS

This is by no means an exhaustive list. Some suggested resources are:

Brick, P., et. al. 1989. *Teaching Safer Sex.* Hackensack, New Jersey: The Center for Family Life Education, Planned Parenthood of Bergen County, Inc.
This is geared to younger people, but has some good ideas.

Canadian Public Health Association. 1991. *A Resource Manual for AIDS Educators.* Ottawa: Canadian Public Health Association.
A Canadian resource with good background information and activities which can be adapted for ESL students.

Houston, J., and Lehmann, A. 1989. *AIDS: Train the Trainer -- A Resource Manual for the Workplace.* City of Toronto Department of Public Health.

Hubbard, B.M. 1989. *Entering Adulthood: Preventing Sexually Related Disease.* Santa Cruz, CA: Network Publications.
Good activities, geared to adolescents.

Quackenbush, M. and Sargent, P. 1989. *Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome.* Santa Cruz, CA: Network Publications.
An excellent resource; many of the activities are simply written and require only minor adaptation to meet the needs of ESL students.

Some other resources you may find useful

Abbey, N., Brindle, C., Casas, M., and Mantiella, A.C. (ed). 1990. *Practical Guidelines: Family Life Education in Multicultural Classrooms.* Santa Cruz, CA: Network Publications.
Presents guidelines for developing culturally appropriate family life education, primarily for adolescents. Chapters for both teachers and administrators. Sample lessons included are designed for Latino students.

Breen, M.J. 1988. *Taking Care.* Thorn Press Limited.
This is one of the few resources on health written in plain English. It focuses on women's health concerns and has a chapter on AIDS.

Matiella, A.C. 1990. *Getting the Word out: A Practical Guide to AIDS Materials Development*. Santa Cruz, CA: Network Publications.

This guidebook discusses many issues in AIDS resource development, including creating culturally sensitive materials, low literacy materials, adapting and translating materials, and evaluating AIDS education materials.

Waxler-Morrison, N., Anderson, J.M. and Richardson, E. 1990. *Cross Cultural Caring: A Handbook for Health Professionals in Western Canada*. Vancouver: University of British Columbia Press.

This handbook provides a much-needed overview and guidelines for those working with newly arrived communities.

Werner, D.B. and Bower, B.L. 1982. *Helping Health Workers Learn*. Palo Alto, CA: The Hesperian Foundation.

Although designed as a resource for training community health workers overseas, this resource has many excellent ideas for presenting health concepts simply and appropriately.

Print/audiovisual material

Because pamphlets can become out of date very quickly, we do not list specific pamphlet names in this bibliography. Contact the National AIDS Clearinghouse (address on page 109) for an updated list of materials in English, as well as in the first languages of your students.

Your provincial department of health may also be able to provide pamphlets and booklets on AIDS. Some provincial and city health departments (including the City of Vancouver Department of Health, Manitoba Health, and the Ontario Department of Health) have AIDS materials available in languages of newcomer communities as well.

Contact AIDS organizations in your area. They often have posters and pamphlets available, as well as resource people who may be helpful in the classroom or in helping you plan a program. Your provincial department of health should be able to provide you with a list of organizations.

The following pages list contact information for videos on AIDS for ethnocultural communities.

Directories for teaching resources

Health and Welfare Canada. *AIDS Resource Directory.* January 1991. Lists resources developed by or funded through Health and Welfare Canada.

Planned Parenthood Federation of America. *A Comprehensive Guide to AIDS Information: More Than a Hundred Ways to Teach About AIDS.* "Reference Sheet #9. New York: PPFA. (810 Seventh Avenue, New York, NY 10019).

Dunham, John. 1990. *Canadian AIDS Directory.* AIDS Committee of Toronto.

IDERA. 1990. *Women and AIDS: A Resource Guide.* Women and AIDS Project, Vancouver Health Department.

CANADIAN PUBLIC HEALTH ASSOCIATION
ASSOCIATION CANADIENNE DE SANTÉ PUBLIQUE
1565 CARLING, SUITE 400, OTTAWA, ONTARIO, CANADA K1Z 8R1
(613) 725-3769 TELEX 21-053-3841 FAX (613) 725-9826

Videos on AIDS for Ethnocultural Communities
Cassettes-vidéos sur le SIDA pour les communautés ethnoculturelles

Prices are for information only. Please check with each distributor for firm quotes before ordering.
Les prix indiqués ont donnés comme information seulement. Veuillez communiquer directement avec chaque distributeur pour le prix exact.

1. Di Ana's hair ego.
South Carolina AIDS Education Network, 1990.
Purchase $199.00; Rental $70.00
Black community.

DEC Film and Video
394 Euclid Ave.
Toronto,ON tel: (416) 925-9338
M6G 2S9 fax: (416) 324-8268

2. Women and AIDS : a survival kit.
San Francisco : University of California, 1989.
Purchase $195.00 (US); Rental $35.00 (US).
Mixture of ethno groups.

University of California
Extension Media Centre
2176 Shattuck Ave.
Berkeley, CA 94704 tel: (415) 642-0460

3. The Best defense.
Sausalito, CA : Focal Point Productions, 1988.
Purchase $229.00
Hispanic community, Injection Drug Users.

Intermedia
1600 Dexter Ave. N.
Seattle, WA
USA 98109 tel: (206) 282-7262

4. AIDS Project Los Angeles.
SIDA...a todos nos afecta.
Purchase $25.00 (US)
Hispanic Community.

AIDS Project Los Angeles
3670 Wilshire Blvd., Suite 300
Los Angeles, CA
USA 90010
tel: (213) 738-8200

5. AK SIDA atansyon pa kapon.
Montréal : Association des médecins haitiens à l'étanger, 1989.
Purchase $250.00 (Cdn).
Communauté haitienne.

Suzon Faustin Jean Pierre
GAP-SIDA Inc.
2577a Jean Talon
Montréal, PQ
H2A 1T8
tel: (514) 722-1511

6. Are you with me?
Purchase $65.00
Black Youth.

Select Media Inc.
74 Varick St., 3rd Floor
New York, NY
USA 10013
tel: (212) 431-8923
fax: (212) 431-8946

7. Seriously fresh.
Purchase $65.00
Black Youth.

Select Media Inc.
74 Varick St., 3rd Floor
New York, NY
USA 10013
tel: (212) 431-8923
fax: (212) 431-8946

8. Mi hermano. My brother.
Hispanic community.

American Red Cross
National Headquarters
1730 E St., NW
Washington, DC
USA 20006
tel: (202) 639-3223

9. Unmasking AIDS.
London : International Planned Parenthood, 1990.
Purchase approx. $100.00 (Cdn).

AIDS Prevention Unit
International Planned Parenthood Federation
Regent's Court, Inner Circle, Regent's Park
London, England
NW1 4N3
fax: 071-487-7950

10. Fighting chance : a video on Asians and HIV.
Toronto : Gay Asian AIDS Project, 1990.
Purchase approx. $100.00 (Cdn).
Asian community.

Michael Balser
V Tape
183 Bathurst St.
Toronto, ON
M5T 2R7
tel: (416) 863-9897
fax: (416) 360-0781

11. The colour of immunity.
Toronto : BlackCAP, 1990.
Purchase approx. $100.00 (Cdn).
Black youth.

Michael Balser
V Tape
183 Bathurst St.
Toronto, ON
M5T 2R7
tel: (416) 863-9897
fax: (416) 360-0781

12. **Bolo bolo.**
Toronto : South Asian AIDS Coalition, 1990.
Puchase approx. $100.00 (Cdn).
South Asian community.

Michael Balser
V Tape
183 Bathurst St.
Toronto, ON tel: (416) 863-9897
M5T 2R7 fax: (416) 360-0781

13. Se met ko : Haitian Women's Program/AFSC, 1989.
Purchase approx. $160.00 (US); Rental $35.00 (US).
Communauté haitienne.

Available on: Video against AIDS : Program 2.
V Tape
183 Bathurst St.
Toronto, ON tel: (416) 863-9897
M5T 2R7 fax: (416) 360-0781

14. Ojos que no ven : eyes that fail to see.
San Francisco : Adinfinitum Films, 1987.
Purchase $350.00 (US); Rental $50.00
Hispanic community.

Latino AIDS Project
2401 24th St.
San Francisco, CA
USA 94100 tel: (415) 647-5450

15. Other faces of AIDS.
Maryland : Maryland Public TV, 1989.
Purchase $60.00 (US).
Hispanic and Black communities.

PBS Video
1320 Bradock Place
Alexandria, VA
USA 22314 tel: 800-424-7961

16. 'Til death do us part.
Washington : Durrin Films, 1988.
Purchase $350.00 (US); Rental $57.00 (US).
Black youth.

Durrin Films
1748 Kabrama Rd. NW
Washington, DC
USA 20009 tel: (202) 387-6700

17. Don't point your life in the wrong direction.
North York : North York Public Health Dept., 1989.
Purchase $6.50 (Cdn) and postage.
Black youth. Rap video.

AIDS Program
North York Public Health Dept.
5160 Yonge St.
North York, ON tel: (416) 224-6777
M2N 6L8 fax: (416) 224-1061

18. Don't play share. AIDS.
North York : North York Public Health Dept., 1990.
Purchase $6.50 (Cdn) and postage.
Black youth. Rap video.

AIDS Program
North York Public Health Dept.
5160 Yonge St.
North York, ON tel: (416) 224-6777
M2N 6L8 fax: (416) 224-1061

Organizations

The following pages list contact information for:

- AIDS telephone hotlines by province
- National government sources of information on AIDS, including regional offices of Health and Welfare Canada
- National organizations
- Provincial government AIDS information sources
- Ethnocultural and community AIDS organizations

These contact lists are provided by the CPHA National AIDS Clearinghouse, but this information can become dated. Be sure to update your contact lists regularly by contacting the CPHA as well as local sources. Many local project initiatives are underway.

AIDS HOTLINE NUMBERS

Alberta

Alberta Health - STD Control
Edmonton: (403)427-2830
Throughout Alberta:
1-800-772-AIDS

British Columbia

British Columbia Ministry of Health
Vancouver: (604)872-6652
Throughout BC: 1-800-972-2437

Manitoba

Manitoba Department of Health
AIDS Infoline
Winnipeg: (204)945-AIDS
Throughout Manitoba: 1-800-782-AIDS

Newfoundland

Newfoundland Department
of Health Disease Control
(709)576-3430

New Brunswick

New Brunswick Department of Health
(506)453-2536
AIDS New Brunswick: (506)459-7518
Throughout NB: 1-800-561-4009

Northwest Territories

AIDS Information Line
(403)873-7017
Throughout the NWT:
1-800-661-0795

Nova Scotia

Nova Scotia Department of Health
Epidemiology Division
(902)424-8698

Ontario

Ontario Ministry of Health
AIDS Section
(416)668-6066
Throughout Ontario:
English & other languages:
1-800-668-2437
French: 1-800-267-7432
Schedule:
Italian & Spanish, Thursday 5-10 p.m;
Portuguese, Hungarian & French,
Thursday 7-10 p.m.;
Chinese, Friday 4-10 p.m.;
Greek, Tuesday 5-10 p.m.
In Toronto: 392-2437

Prince Edward Island

Prince Edward Island
Department of Health
(902)368-4530

Quebec

Quebec Department of Health
(418)643-9395
Throughout Quebec:
1-800-463-5656

Saskatchewan

Saskatchewan Health
Education Line
(306)787-3148
Throughout Saskatchewan:
1-800-667-7766

Yukon

Yukon Ministry of Health
Whitehorse: (403)668-9444
Throughout Yukon:
1-800-661-0507

National government sources of information on AIDS

Health and Welfare Canada
Health Services and Promotion Branch
Bureau of AIDS Information and
Education Services
301 Elgin Street, 2nd Floor
Ottawa, Ontario
K1A 0L2
Phone: (613) 957-1772
Fax: (613) 954-5414

Health and Welfare Canada
Health Promotion Directorate
Ontario Region
2221 Yonge Street, Suite 605
Toronto, Ontario
M4S 2B4

Phone: (416) 973-6484

Health and Welfare Canada
Health Promotion Directorate
Pacific Region
425 - 750 Cambie Street
Vancouver, British Columbia
V6B 4V5
Phone: (604) 666-3100

Health and Welfare Canada
Health Promotion Directorate
Atlantic Region
Suite 1110, 5251 Duke Street
Halifax, Nova Scotia
B3J 1P4
Phone: (902) 426-2700

Health and Welfare Canada
Health Promotion Directorate
Prairies Region
Room 603, 213 Notre Dame Avenue
Winnipeg, Manitoba
R3B 1N3
Phone: (204) 983-2554

Direction de la promotion de
la santé
Santé et Bien Etre Social
Région du Québec, Montréal
Complex Guy Favreau
200, boul Réné Levesque
Tour Est, Salle 210
Montreal, Québec
H2Z 1X4
Phone: (514) 283-4589

Canadian Human Rights Commission
320 Queen Street
Place de Ville, Tower A
Ottawa, Ontario
K1A 1E1
Phone: (613) 995-1151
Fax: (613) 996-9661

National organizations

Canadian Public Health Association
National AIDS Clearinghouse
1565 Carling Avenue, Suite 400
Ottawa, Ontario
K1Z 8R1
Phone: (613) 725-3769
Fax: (613) 725-9826

Canadian AIDS Society
170 Laurier Avenue West, Suite 1101
Ottawa, Ontario
K1P 5V5
Phone: (613) 230-3580
Fax: (613) 563-4998

Canadian Hemophilia Society
850 - 1450 rue City Councillors
Montreal, Quebec
H3A 2E6
Phone: (514) 848-0503
Fax: (514) 848-9661

Canadian Labour Congress
Workplace Health and Safety
Department of Field Services
2841 Riverside Drive
Ottawa, Ontario
K1V 8X7
Phone: (613) 521-3400
Fax: (613) 521-4655

Canadian Foundation for AIDS Research
120 Bloor Street East, First Floor
Toronto, Ontario
M4W 1B8
Phone: (416) 972-9998

Canadian Ethnocultural Council
AIDS Committee
251 Laurier Avenue West, Suite 1100
Ottawa, Ontario
K1P 5J6
Phone: (613) 230-3867
Fax: (613) 230-8051

AIDS Information and Education Services
Health and Welfare Canada
Finance Annex Building
2nd Floor, Room 290
Tunney's Pasture
Ottawa, Ontario
K1A 1B4
Phone: (613) 957-1774

Conféderation des Syndicats
Nationaux, Service de formation
1601, Avenue de Lorimier
Montreal, Québec
H2K 4M5
Phone: (514) 598-2228
Fax: (514) 598-2089

Provincial government AIDS information sources

Reproductive Health Consultant
Newfoundland Department of Health
P.O. Box 8700
West Block, Confederation Building
St. John's, Newfoundland
A1B 4J6
Phone: (709) 576-3112

Atlantic/Lunenburg-Queens Health Unit
1600 Bedford Highway
Bedford, Nova Scotia
B4A 1E1
Phone: (902) 424-8100

Health Promotion
P.O. Box 488
1690 Hollis St.
Halifax, Nova Scotia
B3J 2R8
Phone: (902) 424-5910

AIDS Coordinator
Community and Public Health
5th Floor, 15 Overlea Boulevard
Toronto, Ontario
M4H 1A9
Phone: (416) 965-2168

AIDS Program
Communicable Disease Control
Manitoba Health
3rd Floor, 800 Portage Avenue
Winnipeg, Manitoba
R3G 0N4
Phone: (204) 945-1063

Alberta Provincial AIDS Program
7th Floor, 10030 - 107th Street
Edmonton, Alberta
T5J 3E4
Phone: (403) 427-0836

Northwest Territories
Government of Northwest Territories
Yellowknife, NWT
X1A 2L9
Phone: (403) 920-3160

Yukon AIDS Program
Jim Skookum Friendship Centre
3159 Third Avenue
Whitehorse, Yukon
Y1A 1G1
Phone: (403) 668-4465

Family Life Education Program
Yukon Department of Health and
Human Resources
H-2, Box 2703
Whitehorse, Yukon
Y1A 2C6
Phone: (403) 667-5202

New Brunswick Dept. of Health
and Community Services
Box 5100, 4th Floor
Carleton Building
Fredericton, New Brunswick
E3B 5G8
Phone: (506) 453-2323

Laboratory and Disease Control Branch
Saskatchewan Health
3211 Albert Street
Regina, Saskatchewan
S4S 5W6
Phone: (306) 787-3148

B.C. Centre for Disease Control
828 West, 10th Avenue
Vancouver, British Columbia
V5Z 1L8
Phone: (604) 660-6172

Centre Québecois de Coordination sur le SIDA
3655 rue St. Urbain, 4th Floor
Montreal, Québec
H2X 2P4
Phone: (514) 873-9972

Health Education
B.C. Ministry of Health
1515 Blanshard Street
Victoria, British Columbia
V8W 3C8
Phone: (604) 356-1897
Fax: (604) 356-8071

P.E.I. Department of Health and Social Services
P.O. Box 2000
Charlottetown, Prince Edward Island
C1A 7N8
Phone: (902) 368-4996

Ethnocultural and community AIDS organizations

British Columbia

AIDS Vancouver
P.O. Box 4991
Vancouver Main Post Office
Vancouver, BC
V6B 4A6
or
1272 Richards Street
Vancouver, BC
V6B 3G2
Phone: (604) 687-2437
Fax: (604) 687-4857

Vancouver Persons With AIDS Society
1447 Hornby Street
Vancouver, BC
V6Z 1W8
Phone: (604) 683-3381
Fax: (604) 683-3367

Multicultural Health Education Program
Vancouver Health Department
1060 West 8th Avenue
Vancouver, BC
V6H 1C4

AIDS Vancouver Island
106 - 1175 Cook Street
Victoria, BC
V8V 4A1
Phone: (604) 384-4554
Fax: (604) 380-9411 (call first)

Alberta

AIDS Calgary Awareness Association
300 - 1021 - 10 Avenue S.W.
Calgary, AB
T2R 0B7
Phone: (403) 228-0155
Fax: (403) 229-2077

Outpatient Speciality Program
Foothills Hospital
1403 - 29th St. N.W.
Calgary, AB
T2N 2T9

Calgary Council on AIDS
c/o Calgary Health Services
P.O. Box 4016, Postal Station C
320 - 17th Avenue S.W.
Calgary, AB
T2T 5T1
Phone: (403) 228-7430

AIDS Network of Edmonton Society
10704 - 108th Street, 2nd Floor
Edmonton, AB
T5H 3A3
Phone: (403) 429-AIDS
Fax: (403) 424-5659

Saskatchewan

AIDS Saskatoon
P.O. Box 4062
Saskatoon, SK
S7K 4E3
or
309 - 220 - 3rd Avenue South
Saskatoon, SK
S7K 1L9
Phone: 1-800-667-6878
Fax: (306) 244-2134

PLWA Network of Saskatchewan
2305 Adelaide Street East, West Entrance
Saskatoon, SK
S7K 4J1
or
P.O. Box 7123
Saskatoon, SK
S7K 4J1
Phone: (306) 373-7766

AIDS Regina, Inc.
2221 - 14th Avenue
Regina, SK
S4P 0X9
Phone: (306) 525-0905
Fax: (306) 525-0904

Manitoba

The Village Clinic
668 Corydon Avenue
Winnipeg, MB
R3M 0X7
Phone: (204) 453-2114
Fax: (204) 453-5214

Body Positive Coalition
c/o Village Clinic
668 Corydon Avenue
Winnnipeg, MB
R3M 0X7
Phone: (204) 452-7704

Post-Secondary AIDS Committee
University of Manitoba Counselling
474 University Centre
Winnipeg, MB
R3T 2N2
Phone: (204) 474-8592

Planned Parenthood Manitoba, Inc.
206 - 819 Sargent Avenue
Winnipeg, MB
R3E 0B9
Phone: (204) 982-7800
Fax: (204) 982-7819

Winnipeg Gay/Lesbian Resource Centre
Box 1661
Winnipeg, MB
Phone: (204) 284-6208

AIDS Shelter Coalition of Manitoba
668 Corydon Avenue
Winnipeg, MB R3M 0X7
Phone: (204) 453-0045

Ontario

AIDS Committee of Ottawa
267 Dalhouse Street, Suite 201
Ottawa, ON
K1N 7E3
Hotline: (613) 238-4111
Fax: (613) 238-3425

AIDS Committee of Thunder Bay (ACT'B)
P.O. Box 3586
Thunder Bay, ON
P7B 6E2
or
283 Bay Street
Thunder Bay, ON
P7B 1R7
Hotline: (807) 345-7233
Fax: (807) 345-4539

Peterborough AIDS Resource Network
P.O. Box 1582
312 George Street North, Suite 202
Peterborough, ON
K9J 7H7
Phone: (705) 749-9110
Fax: (705) 749-6310

AIDS Committee of Windsor
P.O. Box 7186
Windsor, ON
N9C 3Z1
or
1050 University Avenue West
Windsor, ON
N9A 5S4
Phone: (519) 256-AIDS (2437)
Fax: (519) 973-7389

Trillium
c/o Canadian AIDS Society
1101 - 170 Laurier Avenue West
Ottawa, ON
K1P 5V5
Phone: (613) 230-3580
Fax: (613) 563-4998

Hamilton AIDS Network for
Dialogue and Support
P.O. Box 120, Station "A"
Hamilton, ON
L8N 3C8
or
Suite 900, 143 James Street South
Hamilton, ON
L8P 3A1
Phone: (416) 528-0537

AIDS Committee of Durham Region
110 Oxford Street, Unit 77
Oshawa, ON
L1J 6G4
Phone: (416) 723-8201
Fax: (416) 723-8201, press *

AIDS Committee of London
301 - 343 Richmond Street
London, ON
N6A 3C2
Phone: (519) 434-8160
Fax: (519) 434-1843

AIDS Committee of Niagara
P.O. Box 158
541 Glenridge Avenue
St. Catharines, ON
L2R 6S5
Phone: (416) 984-8684

Ontario (continued)

AIDS Committee of Cambridge, Kitchener, Waterloo and Area (ACCKWA)
886 Queen's Boulevard
Kitchener, ON
N2M 1A9
Phone: (519) 741-8300
Fax: (519) 744-4359

AIDS Committee of Guelph and Wellington County
73 Delphi Street, Room 202
Guelph, ON
N1E 6L9
Phone: (519) 763-2255

Vitanova Foundation
90 Winges Road, Suite 202
Woodbridge, ON
L4L 6A9
Phone: (416) 850-2404

Gay Nippissing Phone Line
Box 1362
North Bay, ON
P1B 8G6

York University Council on AIDS Prevention
Room 105, Central Square
Ross Building
4700 Keele Street
Downsview, ON
M5J 1P3
Phone: (416) 736-5688

Kingston AIDS Project
P.O. Box 120
Kingston, ON
K7L 4V6
or
113 Johnson Street
Kingston, ON
K7L 1X9
Phone: (613) 545-1414

AIDS Committee of Sudbury (ACCESS)
174 Larch Street, Suite 300
Sudbury, ON
P3E 1C6
Phone: (705) 688-0505
Fax: (705) 688-0423

ANSWER
P.O. Box 1026
Wawa, ON
P0S 1K0

Algoma AIDS Committee
Box 46, RR #2, Rupert Acres
Sault Ste. Marie, ON
P6A 5K7

Canadian Council for Multicultural Health
1017 Wilson Avenue, Suite 407
Downsview, ON
M3K 1Z1

York Regional Health Unit
22 Prospect Street
New Market, ON
L3Y 2S9

Ontario (continued -- Toronto)

AIDS Committee of Toronto (ACT)
202 - 464 Yonge Street
Toronto, ON
M4Y 1W9
Phone: (416) 926-1626
Fax: (416) 926-0386

Toronto AIDS Drop-In Centre
Box 544, Station A
Toronto, ON
M5W 1E4
or
201 Church Street, 2nd Floor
Toronto, ON
M5B 1Y7
Phone: (416) 360-8165

YOUTHLINK - Inner City
151 Gerrard Street East
Toronto, ON
M5A 2E4
Phone: (416) 922-3335
Fax: (416) 922-1282

AIDS Cultural Network
91 Bellevue Avenue
Toronto, ON
M5T 2N8
Phone: (416) 392-0807
Fax: (416) 392-0712

Alliance of South Asian AIDS Prevention
310 1/2 Bloor Street
Toronto, ON
M5S 1W1
Phone: (416) 966-2727
Fax: (416) 929-3821

Toronto Persons With AIDS Foundation
Suite 210B, 464 Yonge Street
Toronto, ON
M4Y 1W9
Phone: (416) 925-7112
Fax: (416) 926-0386

AIDS Action Now
321 - 517 College Street
Toronto, ON
M6G 1A8
Phone: (416) 591-8489
Fax: (416) 952-6674

Black Coalition for AIDS Prevention
c/o Harambee Centres Canada
P.O. Box 221
55 McCaul Street
Toronto, ON
M5T 2W7
Phone: (416) 971-7588
Fax: (416) 599-0759

Gay Asian AIDS Support and Education Project
P.O. Box 752, Station F
Toronto, ON
M4Y 2N6
Phone: (416) 926-0063

Hispanic Council of Metro Toronto
AIDS Education Project
58 Cecil Street
Toronto, ON
M5T 1N6
Phone: (416) 340-2552

Ontario (Toronto continued)

St. Stephen's Community House
AIDS Information Dissemination and Education Service
203 Augusta Avenue, 2nd Floor
Toronto, ON
M5T 2M2
Phone: (416) 977-7223
Fax: (416) 925-2271

Gay Asian AIDS Project
c/o AIDS Committee of Toronto
202 - 464 Yonge Street
Toronto, ON
M4Y 1W9
Phone: (416) 926-0063

Toronto Chinese Health Education
Community AIDS Alert
c/o University Settlement Recreation Centre
23 Grange Road
Toronto, ON
M5T 1C3

Access Alliance
Multicultural Community Health Centre
103 - 25 Leonard Avenue
Toronto, ON
M5T 2R2

Second Look Community Arts
211 - 736 Bathurst Street
Toronto, ON
M5S 2R4

Trinity Theatre
525 Adelaide Street East
Toronto, ON
M5A 3W4

Immigrant Women's Health Centre
301 - 750 Dundas Street West
Toronto, ON
M6J 1T8

COMBAT
302 - 394 Euclid Avenue
Toronto, ON
M5G 2S9

SEAS Centre
603 Whiteside Place
Toronto, ON
M5A 1Y7

AIDS Hotline
12 Shuter Street
Toronto, ON
M5B 1A1

Street Health AIDS Project
323 Dundas Street East
Toronto, ON
M5A 2A2
Phone: (416) 863-1610

AIDS Assist
c/o Holy Blossom Temple
1950 Bathurst Street
Toronto, ON
M5P 3K9
Phone: (416) 789-3291

Ontario (Toronto continued)

Barret House
412 Queen Street East
Toronto, ON
M5T 1T3
Phone: (416) 869-3619

The Works
660 Dundas Street West
Toronto, ON
M5T 1H9
Phone: (416) 392-0520

Quebec

Mouvement d'Information et d'Entraide dans la Lutte contre le Sida à Québec (MIELS)
575 St-Cyrille Blvd. West
Quebec, PQ
G1S 1S6
Phone: (418) 693-8983

Mouvement d'information, d'éducation et d'entraide dans la lutte contre le Sida (MIENS)
P.O. Box 723
Chicoutimi, PQ
G7H 5E1
or
387-B Racine Road East
Chicoutimi, PQ
G7H 5E1
Phone: (418) 693-8983

Point de Repère
561 - 565 Saint-Vallier Est
Québec, PQ

Sidaction Trois-Rivieres
C.P. 1142
Trois Rivieres, PQ
G9A 5K8

Centre des ROSES de l'Abitibi Témiscamingue
326 Larivière
Rouyn-Noranda, PQ
J9X 4H6

Centre haïtien de regroupement et d'intégration à la société
8170 Gouin, est
Riviéres-des-Prairies, PQ
H1E 1B7
Phone: (514) 648-6990

Intervention Régionale et Information sur le Sida (IRIS/Estrie)
P.O. Box 1766
Sherbrooke, PQ J1H 5N8 or
135 Jacques Cartier Blvd. South
Sherbrooke, PQ J1J 2Z9
Phone: 1-800-567-7391
Fax: (819) 569-8894

Action-Intervention Jeunesse
226 Alps, Room 210
Laval, PQ
H7G 3V8
Phone: (514) 668-1230
Fax: (514) 668-6860

Quebec (continued)

Comité Sida-Aide Montréal (C-SAM)
3600 Hotel de Ville Avenue
Montreal, PQ
Phone: (514) 282-9888
Fax: (514) 282-0072

Groupe haitien pour la prévention du Sida
2577E Jean Talon est
Montreal, PQ
H2A 1T9
Phone: (514) 722-1511
(514) 722-5655

McGill Centre for Medicine, Ethics and Law
McGill University
2020 University Road, 24th Floor
Montreal, PQ
H3A 2A5
Phone: (514) 398-7400
Fax: (514) 398-4668

Centre for Research Action on Race Relations
Intercultural AIDS Network
3465 Cote des Neiges, Suite 801
Montreal, PQ
H3H 1T7
Phone: (514) 939-3342

Lesbian and Gay Services of Concordia
1445 de Maisonneuve West
Montreal, PQ
H3G 1M8
Phone: (514) 848-3565

Gay and Lesbian Association of McGill
Room 417, Union Building
3480 McTavish Blvd.
Montreal, PQ
H3A 1X9
Phone: (514) 398-6822

Chez Ma Cousine
4156 Debullion Road
Montreal, PQ H2W 2E5
Phone: (514) 849-6770

Centre D'Etudes sur le Sida
Montreal General Hospital
980 Guy Road, Suite 300 A
Montreal, PQ
H3H 2K3
Phone: (514) 932-3055
Fax: (514) 932-1502

Centre d'Information Sida
CLSC Metro
1550 Maisonneuve West, Room 703
Montreal, PQ
H3G 1N2
Phone: (514) 934-0052

Centre de prévention et de
dépistage anonyme
1199 Bleury, Room 200
Montreal, PQ
H3B 3J1
Phone: (514) 861-6644

CACTUS
1209 St. Dominique
Montreal, PQ
H2X 2W4
Phone: (514) 861-6644
(514) 954-8869 (after 2030 hrs)

New Brunswick

SIDA Nouveau-Brunswick/AIDS New Brunswick
65 Brunswick Street
Fredericton, NB
E3B 1G5
Phone: 1-800-561-4009
Fax: (506) 453-1723

SIDA-AIDS Moncton
P.O. Box 275
Moncton, NB
E1C 8K9 or
100 Arden Street, Suite 427
Moncton, NB
E1C 4B7
Phone: (506) 859-9616

AIDS St. John Inc.
116 Coburg Street
Saint John, NB
E2L 3K1
Phone: (506) 652-AIDS

Newfoundland

Newfoundland and Labrador AIDS Committee
P.O. Box 626, Station "C"
St. John's, NF
A1C 5K8
Phone: (709) 579-8656
Fax: (709) 579-0559

Nova Scotia

Metro Area Committee on AIDS (MACAIDS)
5224 Blowers Street, Suite 206
Halifax, NS
B3J 1J7
Phone: (902) 425-2437
Fax: (902) 429-0176

Nova Scotia Persons With AIDS Coalition
P.O. Box 1374
Postal Station North
Halifax, NS
B3K 5H7
Phone: (902) 429-7922
Fax: (902) 422-6200

Nova Scotia Advisory Commission on AIDS
1740 Granville Street, 6th Floor
Halifax, NS
B3J 1X5
Phone: (902) 424-5730

Black Outreach
c/o Nova Scotia PWA Coalition
Box 1374
Postal Station North
Halifax, NS
B3K 5H7

Valley AIDS Concern Group
P.O. Box 305
Wolfville, NS
B0P 1X0

Canadian Council for Multicultural Health
5 Rufus Avenue
Halifax, NS
B3H 3J5

Organizations offering AIDS information specifically to ethnocultural groups: a selected list

Immigrant/Refugee Health Program
AIDS Education Project
Planned Parenthood Manitoba, Inc.
206 - 819 Sargent Avenue
Winnipeg, Manitoba
R3E 0B9

Black Coalition for AIDS Prevention (BLACK-CAP)
P.O. Box 221
McCaul Street
Toronto, Ontario
M5T 2W7

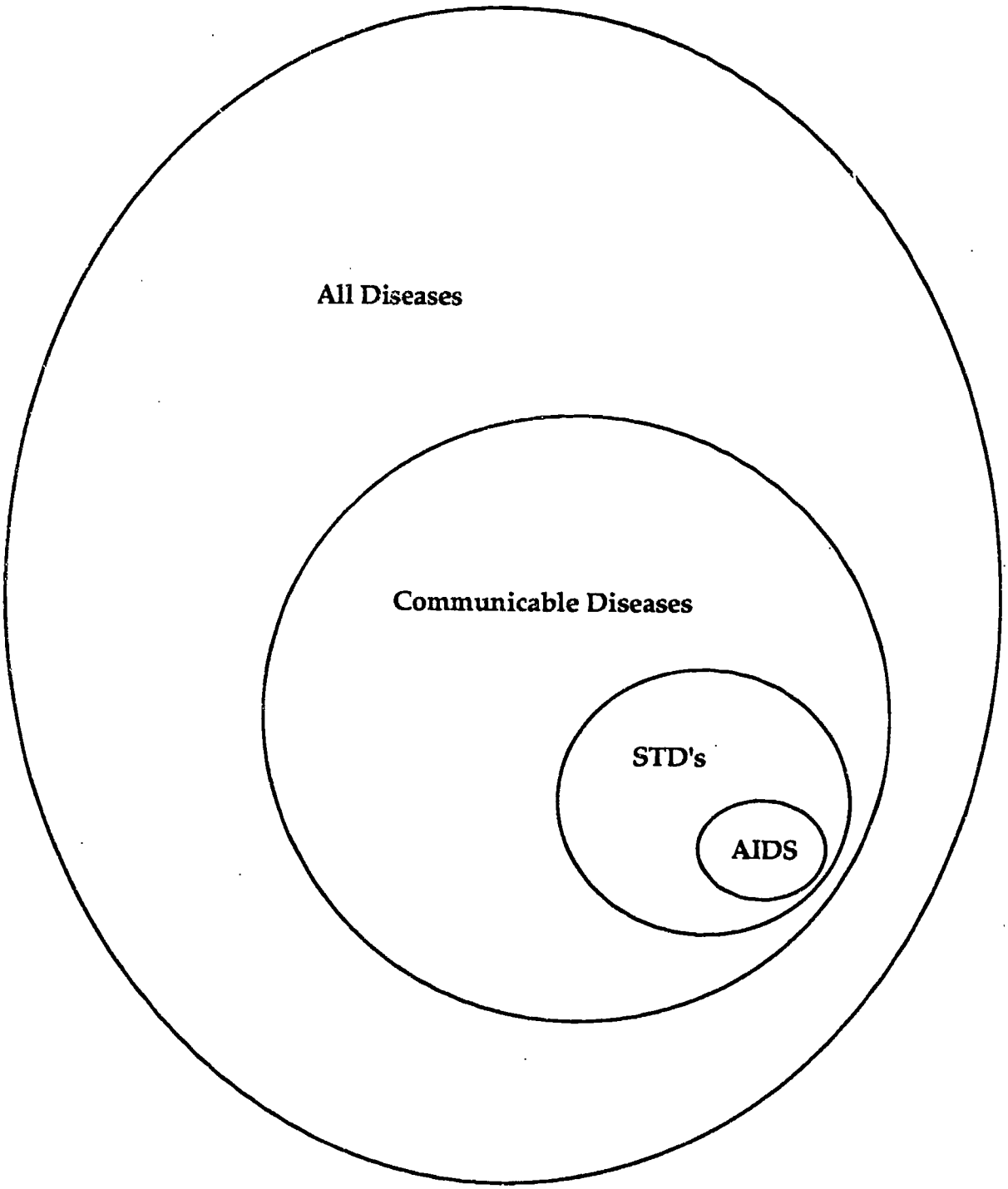
Gay Asian AIDS Project
c/o AIDS Committee of Toronto
P.O. Box 55, Station "F"
Toronto, Ontario
M4Y 2L4

Immigrant Women's Health Centre
Suite 301, 750 Dundas Street West
Toronto, Ontario
M6J 3S3

St. Stephen's House
AIDS Programme
93 Harbord Street
Toronto, Ontario
M5S 1G4

South Asian AIDS Project
c/o AIDS Committee of Toronto
P.O. Box 55, Station "F"
Toronto, Ontario
M4Y 2L4

COMMUNICABLE DISEASES



AIDS Information and Education Services
Health Services and Promotion Branch
Health and Welfare Canada

301 Elgin Street
Ottawa, Ontario
Canada
K1A 0L2

Telephone (613) 957-1774
Facsimile (613) 954-5414
Telex 053-3679

Services d'information et d'education
sur le SIDA
Direction Générales des Services et de
la Promotion de la Santé
Santé et Bien-être social Canada

301, rue Elgin
Ottawa (Ontario)
Canada
K1A 0L2

Téléphone (613) 957-1774
Facsimile (613) 954-5414
Télex 053-3679

INFORMATION ABOUT AIDS EDUCATION AND PREVENTION IN ETHNOCULTURAL COMMUNITIES

AIDS (Acquired Immunodeficiency Syndrome) is affecting all sectors of society in Canada, including ethnocultural communities. Like all Canadians, members of these communities who engage in unprotected sexual intercourse or who share needles to inject drugs are increasingly at risk of becoming infected with the HIV (Human Immunodeficiency Virus) that causes AIDS. It is therefore essential that effective AIDS prevention and education programs reach members of ethnocultural communities.

In responding to the need for cross-cultural AIDS prevention and education, it is important to ensure that particular communities or groups are not singled out and discriminated against or blamed for AIDS. It also must be recognized that, while there are usually shared beliefs, values and experiences among people from a given ethnocultural group, quite often there is also widespread intra-ethnic diversity. This diversity is created by such factors as religion, level of education, length of time in Canada, size of the community in Canada, socio-economic status, and type of community (e.g. rural or urban). AIDS prevention and education must therefore, be responsive to the particular characteristics of the people for whom it is intended and sensitive to their concerns in order to be effective.

The purpose of this document is to provide background information which may assist with development of AIDS prevention and education programs which respond to the unique needs of ethnocultural communities in Canada.

CANADA'S ETHNOCULTURAL COMMUNITIES

- Canada is rich in ethnic and linguistic diversity. Slightly more than one-third of Canadians report a non-English, non-French, non-Aboriginal background.[1]

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Health and Welfare Canada
Santé et Bien-être social Canada
Canada

- Prior to the 1960s, about 80% of immigrants to Canada came from Europe, with another 10% coming from the U.S.A. During the 1960s and 1970s, the proportion of immigrants from other areas of the world began to increase. Between 1981 and 1986, 64% came from Asia, South and Central America and Africa.[2]

- Immigrants, or first generation Canadians, make up approximately 15% of the total Canadian population. This proportion has remained unchanged since the 1950s. However, the immigrant population has increasingly consisted of people from areas of the world with cultures and languages which are non-European or non-Western.[3]

- Immigrants are highly urbanized, with over 53% of them living in Toronto, Montreal and Vancouver. People of non-European origins make up one-third of Toronto's immigrant population, and one-half of that of Montreal and Vancouver.[4]

- In 1986, 6.3% of the population of Canada, or 1.6 million persons, were considered to be members of visible minority groups, also known as people of colour.[5] Almost 65% of these lived in Toronto, Montreal and Vancouver, with another 12% in Winnipeg, Calgary and Edmonton.[6]

- 3.5 million Canadians report mother tongues other than French or English, and 2.3 million speak languages other than French or English at home.[7]

- Forty-eight percent of immigrants who came to Canada between 1981 and 1986 were unable to communicate in either French or English.[8]

- The number of adult Canadian women (over age 15) reporting an inability to speak either official language is almost twice as high as the number of adult men.[9]

AIDS AND HIV INFECTION IN CANADA

- 4,647 cases of AIDS had been reported in Canada as of January 7, 1991. Fifty-seven percent, or 2,755 of these people are known to have died.[10]

- Because the time between infection with HIV and the development of AIDS can be ten years or more, AIDS case statistics on their own do not provide an accurate picture of the present day problem. AIDS is the final stage of HIV infection - the end result of years of viral damage to the immune system. That AIDS case statistics do not provide are the number of people with HIV, that is, the number who have the potential to develop AIDS. It is estimated that the number of Canadians currently infected with HIV could be as high as 50,000.[11]

- Among adults, men account for approximately 95% of AIDS cases and women for about 5%.[12]

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- Among men, 86% of AIDS cases for which a risk factor was identified had homosexual/bisexual contact as the risk factor; 5% had heterosexual contact as the risk; 4% were recipients of blood transfusions; 4% had a combination of sexual contact and injection drug use; and 1% had injection drug use alone as the risk factor.[13]

- Among women, 66% of AIDS cases for which a risk factor was identified had heterosexual contact as the risk factor; 27% had received a blood transfusion; and 7% had injection drug use as the risk factor.[14]

- For cases where heterosexual activity was the risk factor, about 45% of the female cases and 65% of the male cases were people who came to Canada from a country where there is a high rate of HIV infection and the predominant means of transmission is heterosexual contact.[15]

- Adults constitute 99% of AIDS cases in Canada. However, there have been 57 children diagnosed with AIDS. Thirty-nine of these pediatric cases have died.[16]

- HIV can be transmitted from a woman to her infant, during pregnancy or at birth (perinatal transmission). Eighty-four percent of the cases of AIDS in children resulted from this mode of transmission. The remainder of pediatric cases were recipients of blood transfusions.[17]

- Approximately 90% of male AIDS cases and 56% of female cases, for whom this information is available, are Caucasian. The remainder come from a range of other backgrounds.[18]

- The risk factor for just over 50% of non-Caucasian AIDS cases (where a risk factor was identified) was heterosexual contact. Homosexual/bisexual contact accounted for approximately 30% of non-Caucasian cases; perinatal transmission for about 10%, and blood transfusions and injection drug use for less than 5% each.[19]

THE GLOBAL PICTURE

- In most of Africa and parts of the Caribbean, transmission of HIV has occurred primarily through heterosexual contact. As a result, roughly equal numbers of men and women are infected. Large numbers of children have also been infected, through perinatal transmission.

- In North America, Western Europe, Australia and most other western industrial countries, homosexual or bisexual contact between men has been the predominant mode of transmission. But there is a clear trend towards increased transmission through injection drug use and heterosexual contact.

- In Asia, the Middle East, Eastern Europe and the Soviet Union the incidence of AIDS has been relatively low until very recently. However, many countries in these regions are now experiencing dramatic increases in infection rates in men, women and children.

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- It is estimated that, as of summer 1990, 3.5 million people in Africa; 2.5 million in the Americas (including Canada and the U.S.); 0.5 million in Europe; 150,000 in Asia; and 30,000 in Oceania had been infected with HIV.[20]

- The number of cases of AIDS is estimated to be 375,000 in Africa; 250,000 in the Americas; 45,000 in Europe; 2,500 in Oceania; and 1,200 in Asia.[21]

- It is estimated that, world-wide, fifteen to twenty million people will be infected with HIV by the year 2000, with an estimated five to six million cases of AIDS.[22]

ETHNOCULTURAL AIDS EDUCATION AND PREVENTION

There is very little information available about the prevalence of HIV risk behaviours among members of Canada's various ethnocultural communities. Nevertheless, unprotected sexual activity seems to be the norm among most sexually active Canadians from all backgrounds.

In order to make informed decisions and choices about protecting themselves from HIV infection, people need accurate, credible information about the risks they may face. They also need information, skills and support to help them adopt and maintain protective behaviours such as condom use. Access to prevention and education programs and services can be hindered by cultural, linguistic, social, political, and geographic differences between many ethnocultural communities and the larger Canadian society.

The following are some of the **barriers** to effective AIDS prevention and education that members of ethnocultural communities may face:[23]

- Denial that AIDS is an issue for the community, and lack of acceptance that members of the community would ever engage in high risk behaviours;

- Difficulties in accessing and understanding information and services, due to such factors as linguistic differences, literacy, lack of knowledge about available services, and different health beliefs and practices;

- Lack of receptivity to information and education about sexuality and prevention of sexual transmission of HIV, because of such factors as differing views about sexuality and sex roles, sensitivities and cultural prohibitions against open discussion of sex;

- Reluctance of individual community members to admit participation in high risk behaviours, which may be strongly disapproved of and could result in expulsion from family and community;

- Traditional gender roles and responsibilities which can hinder adoption of protective behaviours;

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- Fear of blame by larger society that certain groups are responsible for the AIDS epidemic, and fear that stigmatization and discrimination might result if AIDS is acknowledged as an issue for the community;

- Perceptions of a lack of power to change political, economic and social circumstances which are barriers to adoption of protective behaviours; and

- Lack of priority placed on AIDS prevention by most ethnocultural communities, especially immigrant and refugee groups which have more pressing concerns such as establishing themselves in employment or business, finding housing, locating and accessing needed services.

For the most part, AIDS is not considered to be an issue for ethnocultural communities by organizations and professionals working in the AIDS area. This creates further barriers.

- AIDS-related services seldom recognize or respond to the ethnic and cultural diversity of the communities and populations they serve. These services almost never include representatives of ethnocultural communities in program design, delivery or evaluation.

- Professionals and other staff working in the AIDS field very often lack knowledge and sensitivity to cross-cultural issues.

- Data about ethnocultural populations and their characteristics, especially information about knowledge, attitudes and behaviours related to prevention of HIV infection, are generally not available. Thus, policies and programs do not reflect the needs and priorities of the population.

- Very few culturally sensitive and linguistically accessible HIV education materials are available.

Although the issues outlined above can create significant barriers to effective HIV prevention and education in ethnocultural communities, the following factors provide important opportunities which could facilitate prevention.

- The federal Multiculturalism Act of 1988 gives official recognition to the diverse ethnocultural nature of Canadian society, and the necessity for programs and services to respond to that diversity.

- Many ethnocultural groups have a tradition of strong extended families and close-knit communities. These family and community structures could be important supports to adopting and maintaining protective behaviours, once community members understand and accept the importance of the behaviours.

- There are existing networks of special interest and advocacy organizations and increasing numbers of ethnocultural organizations and services which could be involved in AIDS education and prevention.

- Organizations and programs specifically devoted to AIDS prevention and education in ethnocultural communities are starting to emerge.

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- Broad based AIDS and other health organizations are beginning to recognize the importance of developing cross-cultural programs and initiatives.

- There is growing public awareness that HIV infection is a serious issue for all Canadians, including members of ethnocultural communities.

Action is needed on several fronts to ensure that AIDS education and prevention are accessible to members of ethnocultural communities. AIDS education programs serving a wide clientele, including members of ethnocultural communities, require a cross-cultural component to be effective with everyone in the diverse communities they serve. Special programs and materials developed and delivered by ethnocultural organizations to meet their own unique needs are also required. In addition, linkages and cooperative working relationships between broad based AIDS programs and ethnocultural organizations are essential. This cooperation and collaboration promotes sharing of knowledge and skills, and helps ensure the best possible use of expertise and resources.

Although AIDS prevention and education is important for all communities, particular attention may be appropriate in certain situations. For example, communities with many first generation Canadians who have come from areas of the world with high rates of HIV infection will need programs which recognize this. communities with members who do not comfortably speak either official language, and/or who have health practices and beliefs which differ substantially from those of the larger Canadian society, need access to culturally sensitive and linguistically appropriate AIDS education. Communities with members who are recent refugees will need HIV prevention programs which recognize the stressful circumstances from which they have come, and the difficulties they may experience in adapting to their new lives in Canada.

CONCLUSION

The AIDS epidemic is affecting more and more Canadians, including members of ethnocultural communities. Because there appears to be no immediate hope of a vaccine or cure, education and prevention are essential if further transmission is to be halted. Although reported rates of AIDS are still low in most communities, unprotected sexual intercourse is widely practiced, and the likelihood of contact with HIV infected persons is increasing. Effective prevention and education must be undertaken now, to help ensure the future health and well-being of all Canadians, including members of ethnocultural communities.

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AIDS AND CANADIANS: BACKGROUND FACTS AND SOURCES

- As of January 1991, there were 4,647 cases of AIDS reported in Canada.[1]

- Most of these AIDS cases (45%) occurred among persons between the ages of 30 and 39.[2]

- 59 percent of the people with AIDS have died.[3]

- The number of reported AIDS cases doubled in the past 24 months.[4]

- It is estimated that the number of Canadians currently infected with HIV, the virus that causes AIDS, could be as high as 30,000 to 50,000.[5]

- It is predicted that by 1993, the cumulative number of AIDS cases in Canada could be as high as 13,000.[6]

- Per capita, British Columbia has the highest rate of reported AIDS cases. Ontario has the largest number of AIDS cases (1,501) and Quebec is second with 1,388. AIDS cases have been reported in every Canadian province and territory.[7]

- Adult men account for 94 percent of AIDS cases and adult women account for 5 percent. Children make up the remaining one percent.[8]

- Most of the cases of AIDS are the result of unprotected sexual intercourse. Sexual contact between men accounts for almost 80 percent of adult AIDS cases. Sexual contact between women and men (heterosexual contact) caused about 8 percent of adult cases. But 60 percent of the women with AIDS were infected by heterosexual contact.[9]

- Fifty-four children under the age of 15 have contracted AIDS. Most of them (84%) were infected before or during birth. The remainder were infected through blood or blood products.[10]

- Fourteen cases of AIDS among teenagers aged 15 to 19 have been reported in Canada. Because it can take up to 10 years for AIDS to develop after a person is infected by HIV, many people with AIDS who are now in their twenties were infected as teenagers.[11]

- Street youth are believed to be at high risk of contracting HIV. A recent survey showed that 94 percent of street youth are sexually active while 32 percent of them never use condoms when engaging in sexual intercourse.[12]

- 40 percent of female and 10 percent of male cases with AIDS are people from visible minority communities. Heterosexual contact was the means of infection in just over half these cases. Sexual contact between men accounted for another 30 percent. Transmission from mother to child before or during birth caused about 10 percent.[13]

- Nearly 70 percent of Canadian men and over 45 percent of the women who contracted AIDS through heterosexual contact came to Canada from countries with large numbers of HIV-infected people, where the primary means of transmission is sexual contact between men and women.[14]

- Researchers from York University conducted a national study in 1989 on Canadian adults' knowledge, attitudes and behaviour regarding AIDS. They found that most Canadians know the basic facts: the difference between HIV infection and AIDS, how HIV is transmitted, and the methods of preventing HIV infection. However, knowledge about AIDS varies from group to group. Most of those surveyed had not adopted behaviours which would protect them from HIV transmission.[15]

- Researchers from Queen's University conducted a study of youth and AIDS in Canada in 1989. About one third of boys and one fifth of girls they surveyed were sexually active by grade nine. Nearly half of grade 11 students were sexually active. Only 15 percent of grade 11 students said fear of AIDS would prevent them from having sex. Most of the youth surveyed had a negative attitude about condom use. About one quarter of sexually active students never used a condom.[16]

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AIDS - THE GLOBAL CHALLENGE

Reported AIDS cases worldwide doubled in the past twelve to eighteen months, according to WHO, the World Health Organization. WHO closely monitors the global AIDS epidemic. By mid-1990 about 150 countries world-wide had reported a total of more than 250,000 people with AIDS. WHO believes the true figure is closer to 800,000.

Concern and discussion about AIDS is occurring throughout the world. International conferences on AIDS occur regularly, and public education programs operate in many countries. All this attention may seem odd in light of the fact that malnutrition, diarrhea, measles, and other preventable diseases claimed the lives of 140 million children since the AIDS epidemic began. But the facts about AIDS make the global concern understandable.

The number of people with AIDS today does not reveal the full extent of the problem. The spread of HIV infection follows a well-known pattern. The full-blown disease we call AIDS is the final stage of infection. After HIV, the virus which causes AIDS, enters the body, AIDS may not develop for up to ten years or more. AIDS cases reported today result from HIV infection that occurred in the early eighties. Thus, the number of people infected with HIV is much larger than the number who have AIDS. And many more are being infected every day.

Thailand illustrates the way the AIDS epidemic spreads. The first reports of HIV infection occurred in the mid-1980s. The country reported only two cases of AIDS in 1987 and two more in 1988. By 1990, it had reported only 100 cases. However, WHO estimates the number of people infected with HIV at about 100,000. By the time these people develop AIDS, many thousands more will be infected.

What this adds up to in the global sense, says WHO, is a pandemic. It is estimated that by mid-1990, HIV had infected 8 to 10 million people worldwide: 3.5 million in Africa; 2.5 million in the Americas; 500,000 in Europe and about 200,000 in other areas. And the numbers are growing. WHO projects that by the year 2000, there will be 5 to 6 million cases of AIDS and 15 to 20 million people infected with HIV.

HIV passes from one infected person to another through the exchange of semen, vaginal fluids or blood. This can happen during unprotected sexual intercourse. Sharing needles or syringes to inject drugs is another major source of infection.

In North America, HIV first infected men who had sex with other men. WHO says the rate of new infections in this group is slowing down. However, the number of new AIDS cases and AIDS deaths remains high as a result of the HIV infections acquired in the early eighties.

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In Europe and the Americas, injection drug users were next to experience HIV infections in great numbers. In Africa, HIV infection spread primarily through sexual contact between women and men. It appeared first in the urban elite and skilled workers, then in people living in slums and other poor areas. In the Caribbean, tourism workers first experienced the HIV epidemic, followed by inhabitants of slums. In many Asian developing countries like India and Pakistan, the large number of injection drug users pose a significant risk for the spread of HIV infection.

Canada has experienced rates of HIV infection and AIDS much like other developed countries. Health and Welfare Canada estimates that HIV infects 30,000-50,000 Canadians.

Almost all persons with AIDS in Canada are adults. But the epidemic has not spared the very young. Infants may be infected before birth or during the birth process, if their mothers have HIV infection. Since 1979, 54 children in Canada have developed AIDS. For 85 percent, infection happened before or during birth because they were born to HIV-infected mothers. The rest received the virus through blood transfusions. Thirty-nine of these children had died by January 1991.

In Canada, heterosexual activity was identified as the risk factor in 60 percent of women and 5 percent of men with AIDS. Nearly 70 percent of these men and over 45 percent of the women came to Canada from countries where a large number have HIV infection. In these countries of origin, the primary means by which AIDS spreads is sexual contact between men and women.

Strong links exist between poverty and AIDS, both in developed and developing countries. Because women everywhere are more likely than men to be poor, they are especially vulnerable. HIV infects three million women world-wide, and most of these are of childbearing age. The Canadian International Development Agency (CIDA) says that the HIV infection rate for women in parts of Africa is up to four times the rate for men.

Globally, the number of women infected with HIV may surpass the number of infected men as early as the mid-1990s. AIDS is already the leading cause of death for women aged 20 to 40 in major cities of sub-Saharan Africa and the Caribbean. HIV infects about 10 percent of pregnant women living in the slums of Port-Au-Prince in Haiti.

The vulnerability of women to HIV infection has far-reaching consequences for children. WHO states that 10 million children worldwide will be infected with HIV by the year 2000. Another 10 million uninfected children will be orphaned as their mothers and fathers die from AIDS.

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The global AIDS epidemic has important implications for Canadians, many of whom travel widely or host visitors from around the world. All Canadians need to know the risks they face and the measures they can take to protect themselves, both at home and abroad. This is as true for members of Canada's diverse ethnocultural communities as it is for everyone else. Many members of ethnocultural communities do not seem concerned about AIDS. However, global experience shows that the risk is real for all. Once HIV enters a community, it can spread quickly. The best defense against AIDS is collective action to organize education and prevention at the community level.

Action to prevent the spread of HIV infection in Canada, and to provide health and social services for those with AIDS, occurs at all levels of government. Non-government and community organizations also contribute greatly. The federal government supports research to find better treatments and to search for a vaccine. There is also support for studies to learn more about knowledge, attitudes and behaviour related to sexuality, sexually transmitted diseases and AIDS. This information is needed to develop effective educational approaches for the Canadian public. Some of these studies will take place in ethnocultural communities.

At the global level, many initiatives have been taken to tackle AIDS. In 1987, WHO created a special program to coordinate a global strategy for the control and prevention of AIDS. By 1989 this Global Programme on AIDS had become the largest of WHO's special programs, with an annual budget of over US $90 million. Canada is the fourth largest contributor to this program, giving over C $19 million between 1987 and 1990.

Canada has also committed almost $80 million through CIDA to support projects around the world aimed at preventing the spread of HIV and AIDS. These projects promote sexual health through health education, and promote the development of policies and services that help people protect themselves from AIDS.

To mobilize and focus the worldwide effort to stop the spread of the AIDS epidemic, the World Health Organization has designated December 1 of each year as "World AIDS Day." This international day promotes open channels of communication, and highlights AIDS prevention and control activities already underway. It thus encourages coordinated global action against the spread of HIV.

The first World AIDS Day in 1988 emphasized global mobilization against AIDS. The second, in 1989, focused on youth and AIDS. In 1990, women and AIDS provided the theme. The day highlighted the important role women play in preventing HIV infection and in providing care to people with AIDS. It also stressed their vulnerability, and the need for collective action.

AIDS WORLDWIDE: BACKGROUND FACTS AND SOURCES

- By July 1990, over 250,000 AIDS cases were reported to the World Health Organization (WHO) by over 150 countries.[1]

- WHO estimates that in reality there are 800,000 cases of AIDS worldwide. The number of cases is doubling every 12 to 18 months.[2]

- By mid-1990, approximately seven million people were infected with HIV: 3.5 million in Africa, 2.5 million in the Americas, 500,000 in Europe and about 200,000 in other areas.[3]

- By the year 2000 it is projected that there will be 5 to 6 million cases of AIDS around the world, and 15 to 20 million persons will be infected by HIV.[4]

- The United Nations Development Program (UNDP) predicts that the number of HIV-infected women may surpass the number of infected men as early as the mid-1990s.[5]

- WHO estimates that approximately three million, or one third of the HIV infected persons are women.[6]

- The vast majority of HIV-infected women in developing countries contracted HIV through sexual intercourse with men.[7]

- In some African cities, 30 percent of women in the reproductive age group are infected. The HIV infection rate for women in parts of Africa is up to four times the rate for men.[8]

- WHO estimates that 10 million children worldwide will be infected with HIV by the year 2000. Another 10 million uninfected children will be orphaned as their mothers and fathers die from AIDS.[9]

- In 1987, the World Health Organization created its Global Programme on AIDS to coordinate worldwide efforts for the prevention and control of HIV infection. The annual operating budget is over 90 million U.S. dollars. Canada is the fourth largest contributor.[10]

- Many developing countries have been suffering from an epidemic of sexually transmitted diseases (STDs) for decades. Presence of other STDs facilitates the transmission of HIV during sexual intercourse.[11]

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VIVIENDO JUNTOS
LIVING TOGETHER

These calendars and greeting cards were produced by members of the Spanish-speaking community in Winnipeg, in partnership with Planned Parenthood Manitoba, to raise funds for AIDS education.

The watercolor paintings, which represent 12 Latin American countries, were donated to this AIDS education project by artist Tomás A. Guevara Mata, who came to Winnipeg from El Salvador in 1993.

"I paint and draw the Latin American folklore of our century... a portrait of our living reality depicted with an array of colours and mysteries that form unforgettable memories. These memories are carried wherever we go as part of our Latin American cultural heritage. Our rich inheritance helps us to endure the struggles of this reality and treasure our future of Living Together."

Planned Parenthood Manitoba is a non-profit community-based organization which educates, advocates and provides leadership on sexuality and reproductive health issues. Members of Winnipeg's Spanish-speaking community developed the calendar to be used as an educational resource within their community. Their work, support and commitment have made the production of these materials possible.

VIVIENDO JUNTOS • LIVING TOGETHER
◆◆◆◆◆◆◆◆◆◆◆◆ CALENDAR ◆◆◆◆◆◆◆◆◆◆◆◆

Tomás Mata's beautiful imagery captures the essence of life in twelve Latin American countries. This calendar, which is both Spanish and English, includes information on each country as well as factual information about AIDS. Printed on recycled paper.

VIVIENDO JUNTOS • LIVING TOGETHER
◆◆◆◆◆◆◆◆◆◆ GREETING CARDS ◆◆◆◆◆◆◆◆◆◆

Four watercolor images from the calendar have been used to create these lovely greeting cards for any occasion. Eight cards and envelopes per package. Blank inside. Printed on recycled paper.

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