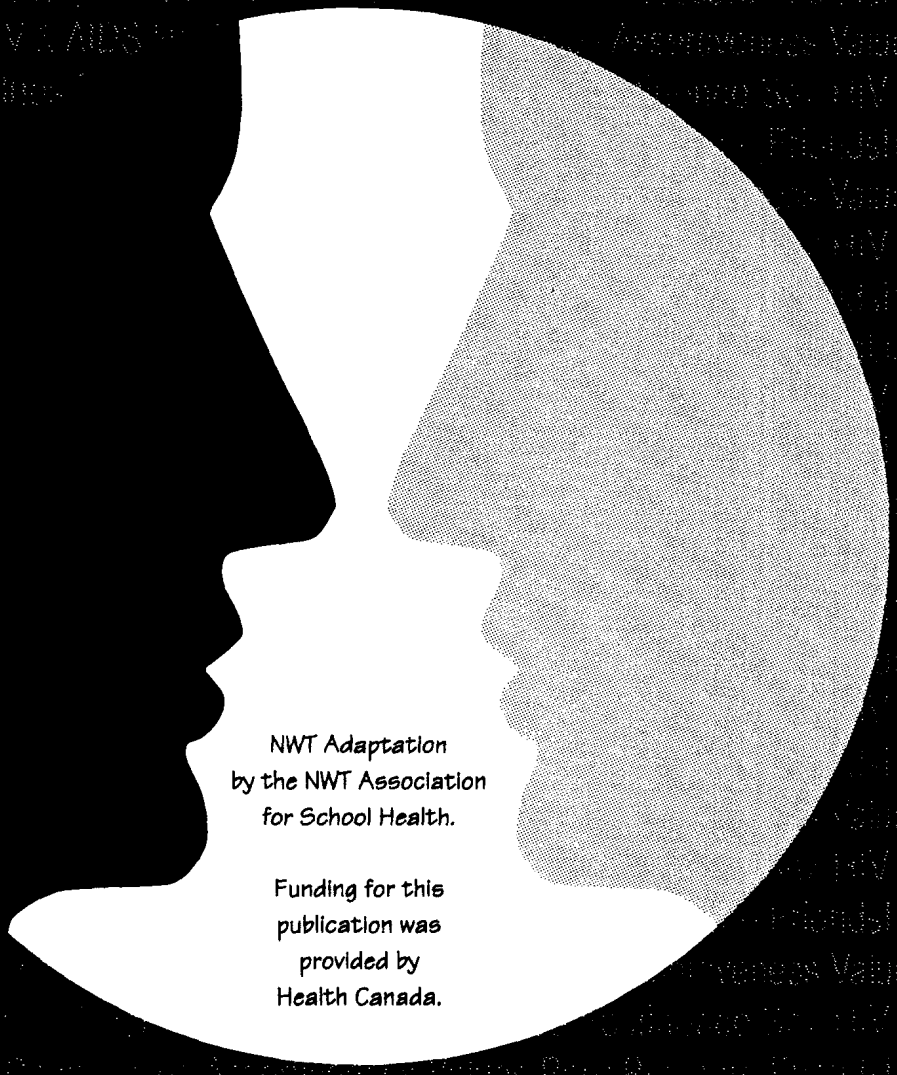
SKILLS FOR HEALTHY RELATIONSHIPS

Northwest Territories
School Health Program

TEACHER RESOURCE BOOK



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SKILLS FOR HEALTHY RELATIONSHIPS

A Program about Sexuality, AIDS and other STDs

TEACHER RESOURCE BOOK:
BACKGROUND/REFERENCE
NWT Version, 1998

The original manual, "Teacher Manual I", was produced by the Social Program Evaluation Group, Queen's University. The project was sponsored by the Council of Ministers of Education Canada. The project was funded by the National Health Research and Development Program and the AIDS Education and Prevention Program through the National AIDS Contribution Program under the National AIDS Strategy, Health and Welfare Canada. This NWT adaptation has been produced by the NWT Association for School Health, with funding from the HIV/AIDS Prevention & Community Action Program (PCAP), of Health Canada and the sponsorship of the Department of Education, Culture and Employment, Government of the Northwest Territories.

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Introduction

Skills for Heathy Relationships (SHR) focuses on sexuality, HIV/AIDS and other STD. **SHR** has been carefully conceptualized through detailed reference to the literature and the efforts of health education advisors and teachers across Canada. It involves a comprehensive approach to AIDS/STD/sexuality education using teaching strategies that include cooperative learning, multi-level instruction, peer leaders, role playing, video scenarios, and parental involvement. There are four units:

- AIDS/STD Information;
- Responsible Behaviour: Abstinence;
- Responsible Behaviour: Safer Sex; and,
- Health Enhancing Supports.

The content differs from many existing curricula in that there is a special emphasis on skill development, peer support for responsible behaviour and parental involvement. It consists of 23 activities which may be completed individually, as a class, or working in small groups with peer leaders. Five additional activities are recommended to be completed with the students' parents or guardians. The original **SHR**, pilot tested on 2000 Grade 9 students in four provinces, was a 20 hour program. However, NWT teachers and nurses who pilot tested **SHR** reported that completing the program in 20 hours was unrealistic. Student interest is high, consequently discussion and group work often require more time than is allotted. In addition, factors such as multi-level classes or instruction in a second language may require extra time. For delivery of the entire program, teachers would be advised to block 25 - 30 hours of class time.

This **SHR** program has been adapted to reflect the cultural diversity of the NWT. The revisions made were based on the feedback received from teachers and health educators who pilot tested the program in 1995. An Adaptation Review Committee made up of Inuit, Dene, Metis and non-Aboriginal representatives from the education and health field guided the changes to the program. Revisions focussed on updating the information on HIV/AIDS and other STD statistics, with specific reference to the NWT. In addition, the action scenarios presented in the Student Manual were adapted to better represent the cultural diversity and situation of northern youth. In keeping with the inclusive education mandate of the NWT Department of Education, Culture and Employment, the section "Adapting SHR To Meet Diverse Student Needs" has been added (see section F - "Teaching Approach", item 3). This section suggests methods to adapt SHR activities to multi-level groupings and diverse learning abilities, and gives concrete examples of adaptations for four of the student activities - 8,9, 10 and 11. Finally, a section was added to the

Background Information on northern cultures and lifestyles. Its purpose is to provide teachers with some understanding of Dene, Metis and Inuit culture and health issues, from both historical and contemporary perspectives. A conceptual model representing the perceptions of peoples of the NWT is also provided. Suggestions are made about how to integrate parents, elders, local health care workers and other interest groups from the community into the delivery of **SHR**.

Each community is unique and teachers implementing this program are advised to adapt the materials to suit the needs of their particular group of students. In order to do this teachers will need to seek support from and network with community members to ensure that **SHR** is delivered in a culturally appropriate manner, one that, by reflecting students' reality back to them, will reinforce their cultural pride and awareness of cultural values and enhance their self esteem.

This **Teacher Resource Book** is, essentially, background material for you to refer to in preparation for teaching ***SHR*** *or* parts of it. This manual

- provides an introduction;
- lists the general and specific objectives;
- describes the teaching strategies you may use when you present the activities in class; and,
- outlines background information. Specific topics include northern cultures and lifestyles, developing a culturally appropriate ***SHR*** program, a conceptual model for ***SHR*** in the NWT, information about HIV/AIDS and other STD, and adapting SHR to meet diverse student needs.

The **Teaching Guide:** which provides a **guide to Student Activities** is a separate document containing material to help you guide the students step by step through each of the activities you use. An overview of the ***SHR*** video is provided there. Masters for overhead transparencies and other student materials are provided at the end of activities.

Components of the *SHR* Program

Complete ***SHR*** documentation is:

- **Teacher Resource Book**: necessary background information

- **Teaching Guide**: a guide to the student activities

Please note that the "Approximate Time" estimates are from the original version and may not reflect the time you need for the activity.

- **Student Manual**: 23 activities that form the core of the SHR program

- **Parent/Guardian Guide**: parent information and activities to complete with students

- **Peer Leader Guide**: training manual for peer leaders

- **Challenging Homophobia**: an addendum to the SHR program which adds scenarios from the perspective of students who may be gay, lesbian or bisexual. It is an attempt to make the SHR program more inclusive and reflective of all students.

- **the *SHR* Video**: youth actors portray scenarios to be used in conjunction with the student activities; interviews with persons living with HIV

- "**Your Turn To Do The Talking**": a video produced especially for parents - -to introduce the SHR program to them, and to involve them in the sexuality education of their children.

- **Facilitation Guide** for "Your Turn To Do The Talking": a format for a parent meeting around sexuality education.

- "**Putting It All Together**": an interactive multimedia **CD**, which gives an overview of the entire "Skills for Healthy Relationships" program. It addresses possible concerns of teachers and administrators, indicates how the program deals with student issues, and outlines how the SHR program fits into the context of the NWT School Health Program.

Role of SHR Teachers

The involvement of teachers who wish to implement the program as designed implies that the teacher will

- organize and attend a parent meeting;
- select and train peer leaders prior to presenting ***SHR*** or selected activities (the training is recommended for at least three hours);
- teach all or most of the 23 activities to the students *(**SHR*** was designed originally for Grade 9s, but it may be decided that some of the activities are appropriate for students in other grades; the NWT advisory group to the SHR program has suggested that the content of the SHR program is suitable for, and necessary to many NWT students at the Grade 7 and 8 level).
- encourage students to discuss ***SHR*** and the **Parent/Guardian Guide** with their parents or guardians and involve them in completing the five activities together;
- evaluate student performance; and,
- help to evaluate ***SHR*** to make changes appropriate to your context.
- optimally, be able to attend inservice training on the SHR program

A. OVERVIEW OF *SKILLS FOR HEALTHY RELATIONSHIPS* (SHR)

In this section,

1. a rationale for ***SHR*** and more background about the project are presented,
2. the objectives and,
3. conceptual framework are outlined, and
4. the four units are described.

1. Rationale and Background

Until a vaccine against HIV, the virus recognized as the cause of AIDS, and/or a cure for AIDS are discovered, the principal strategy for prevention and control of AIDS will be education programs aimed at reducing the frequency of behaviours known to place people at high risk of contracting HIV. Adolescents are a crucial target group for such programs and for those to prevent the spread of other sexually transmittable diseases.

High proportions of adolescents are sexually active, many with a number of sexual partners (Beazley, Warren, King and Wright, 1993; Macleans, 1993; Bibby & Posterski, 1992; King et al., 1988). Sexually transmitted diseases are prevalent among them, as is non-compliance with safer sex practices. Studies show that young Canadians, in substantial numbers, drink alcohol and experiment with drugs (e.g., King and Coles, 1992; King et al., 1988; King, 1986). Substance abuse lowers inhibitions toward sexual behaviour and increases the probability that safer sex practices will not be adopted. Certain groups of young people are at particularly high risk to contract sexually transmissible infections: the homeless (including street youth), prostitutes, and those who use drug injection needles or share needles for ear piercing or tattooing (Radford, King, & Warren, 1989).

The general characteristics of adolescents tend to place them at risk. Many younger adolescents, in particular, do not project into the future to consider the consequences of their actions. Teenagers tend to be concrete rather than abstract thinkers and to have difficulty estimating probable risks and future events.

Teenagers tend to feel immortal and invulnerable and, consequently, to believe that they will not be adversely affected by the risks they take. They may understand intellectually how dangerous it is to drink and drive, to try drugs, to have sex without protection; however, an absolute faith in their immunity to danger - - "It won't happen to me" - - allows them to downgrade the risk as it applies to their own behaviour.

Adolescents, especially those in the early and middle teen years, often feel great pressure to be like their peers, especially those in the "in" group. The behaviour associated with the popular group may be high risk; many will take their chances and conform in order to belong.

Responding to the need for AIDS and other STD prevention programs and the need to educate adolescents about AIDS and other STD, the Social Program Evaluation Group (SPEG) at Queen's University took the initiative to have this educational program developed. The impetus came from the findings of the **Canada Youth and AIDS Study** (King, et al., 1988) which revealed that although adolescents are relatively knowledgeable about AIDS and somewhat less knowledgeable about other STD, many take risks that could result in their contracting and transmitting HIV and other sexually transmitted organisms.

The Federal Centre for AIDS, which existed at the time, encouraged SPEG to develop the proposal for this project by providing preliminary funding while promoting the involvement of the Council of Ministers of Education, Canada, who endorsed and supervised the project. The proposal was accepted and funded by NHRDP, the National Health Research and Development Program of Health and Welfare, Canada.

An advisory group of representatives from all provinces' and territories' ministries/departments of education and health have overseen the project and a sub-group, comprised of five ministry/ department of education curriculum department members, monitored the development and evaluation of the pilot implementation of ***SHR*** in four provinces.

2. General Objectives

The general objectives of ***SHR*** are the following:

1. Students who have not engaged in sexual intercourse will delay sexual intercourse until they are ready to engage in a responsible, mutually protected relationship;

2. Students who have had sexual intercourse will stop engaging in sexual intercourse until they are ready to establish a responsible, mutually protected relationship;

3. Students who do not abstain from sexual intercourse will engage in AIDS- and other STD-preventive behaviours; and,

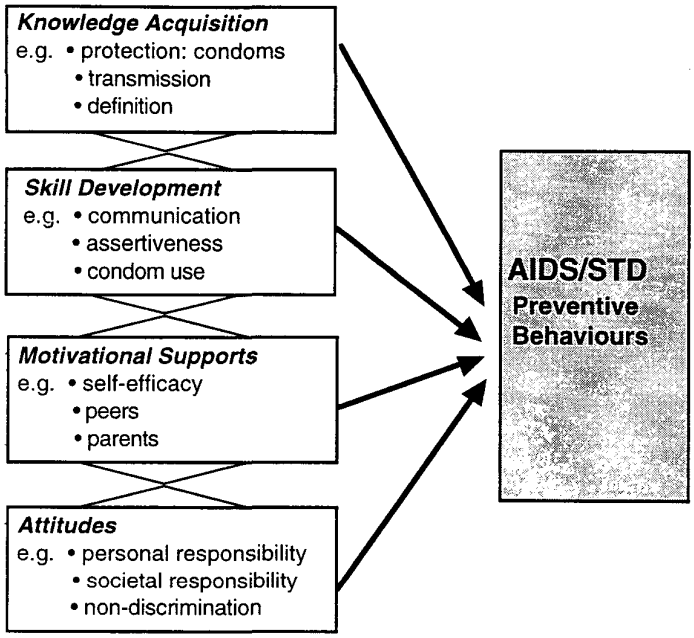
4. Students will

- gain AIDS- and STD-related knowledge;
- act as positive role models for risk reduction behaviours in promoting health-enhancing peer group norms;
- develop positive attitudes toward STD prevention and AIDS-related issues;
- develop the skills (interpersonal, cognitive, self management and practical) necessary to maintain an HIV/AIDS/STD-free lifestyle and to apply those skills in real-life situations where appropriate;
- develop the motivational supports for risk reduction (e.g., self-efficacy, positive relationships, support from parents and peers);
- develop compassion and support for people with HIV and AIDS; and,
- develop an understanding and non-discriminatory attitudes towards people of different sexual orientations.

3. Conceptual Model

Some will find that the multi-dimensional approach to health education taken in ***SHR*** is quite unique. The objectives outlined in the previous section indicate our intention to develop four aspects of behaviour in this series of activities. A widely accepted principle of health education holds that instruction designed to affect voluntary adoption of health-conducive behaviour must not only impart knowledge, but also address skill and attitude development. The conceptual model for ***SHR*** reflects that tenet and adds an additional component -- motivational supports (see Figure 1). The students, as they work through the activities, learn facts about sexually transmissible infections, practise skills and consider attitudes related to responsible sexual behaviour. One of the primary teaching strategies recommended is cooperative learning in which peers are given opportunities to support each other. In every classroom activity in ***SHR***, the students use a number of general interpersonal skills and in many activities they are asked to focus on a particular one related to helping a small group function effectively. Through the involvement of their parent(s) or guardians) in other *SHR* activities, students are encouraged to develop effective communication and support at home as well.

FIGURE 1: CONCEPTUAL MODEL



The aims of ***SHR*** in relation to the four components: knowledge; skills; attitudes and motivational supports, as well as the specific objectives related to them, can be found in Appendix A. In addition, ***SHR*** activities which address the specific objectives are listed.

4. Skills for Healthy Relationships Activities

The ***Skills for Healthy Relationships*** activities are presented in four units.

Unit 1 - Transmission

(Three classroom activities and one activity which may be completed by the students with their parents/guardians.)

The unit is primarily knowledge-based. It introduces ***SHR*** and the facts about the sexual transmission of infection. A video of scenarios on HIV/AIDS/STD complements Activity 1, an activity comprised of a number of information vignettes; they are followed by a test based on their contents. Also covered in this unit is the concept of estimating risk infection and opportunities for the students to begin to consider where responsibility for preventing the spread of sexually transmissible infection lies.

Unit 2 - Responsible Behaviour: Abstinence

(Seven classroom activities, one which includes an action plan and one activity which students may complete with their parents/guardians.)

This is the first of two units on responsible behaviour. Students learn what abstinence in the context of sexual behaviour means, discuss delaying decisions for and alternatives to sexual intercourse, and acquire skills to deliver assertive messages in everyday situations (for example, to tell a partner they are not ready to have sexual intercourse). Video sequences are designed to complement three of these activities.

Unit 3 - Responsible Behaviour: Safer Sex

(Eight classroom activities, one action plan and one activity which students may complete with their parents/guardians.)

In this unit, the students learn skills and information they will need in the future. They begin by assessing and expanding their knowledge about condoms. Students are then given the opportunity to consider general attitudes about condoms and explore their own feelings and attitudes. Information is provided about where to obtain condoms and how to use them. (During one activity students practise placing a condom on a wooden demonstration model of a penis). They consider who should take responsibility for the various aspects of condom use and practise the assertive skills learned in Unit 2 by writing scripts and role playing them to communicate their choice to use a condom. Video sequences accompany three of the activities in this unit.

Unit 4 - Health-Enhancing Supports

(Five classroom activities, one which includes an action plan, and two activities which students may complete with their parent(s)/guardian(s).)

The students have the opportunity to learn the effects of discrimination and prejudice and what it means to be tolerant, show empathy and be compassionate. They may learn how their behaviours -- both positive and negative -- can influence the behaviour of others. They can practise making statements that support those who choose responsible behaviour. Video sequences accompany two of the activities in this unit.

B. PROGRAM EVALUATION

This section describes briefly how the demonstration program was evaluated and highlights some of the results.

The independent evaluation of the implementation and outcomes of ***SHR*** in its experimental form (then 20 hours in length) was carried out in one school jurisdiction in each of four provinces -- Manitoba, Ontario, Quebec and New Brunswick. The team who worked on the evaluation included Drs. Richard Beazley and Wendy Warren (Co-Investigators) and Dr. Alan King (Principal Investigator). The evaluation had two phases: the purposes of one phase were to assess the appropriateness of (1) ***SHR's*** components and content and the feasibility of implementing them; (2) the evaluability of the program; and (3) how it was actually taught by the 52 teachers involved. Evaluating appropriateness and feasibility was done through a theoretical assessment of ***SHR****'s* components and content with the help of curriculum specialists and practising teachers, and through pilot testing individual activities with the help of 210 teachers and 977 students in three provinces. The second part of the implementation evaluation enabled the evaluators to document how ***SHR*** was actually delivered and the extent to which actual delivery matched planned delivery.

The second phase entailed an evaluation of the reaction of students, teachers, administrators and parents to ***SHR*** and its impact on students. A pretest-post test comparison group design was used to assess the impact of ***SHR*** on the knowledge, attitudes, skills and motivational supports of over 2000 students. The further impact of the experimental program on these variables and on students' sexual behaviours was assessed using two delayed post tests, one administered in the fall of 1992, while the students were in Grade 10, and the other administered in the fall of 1993, with the students in Grade 11.

For the impact evaluation, comparison school jurisdictions were selected in each of the four provinces on the basis of demographic characteristics that were similar to those of the demonstration school jurisdictions in which ***SHR*** was implemented. The comparison groups of students experienced their school jurisdiction's regular AIDS and sexuality curriculum. ***Skills for Healthy Relationships*** was well received by the 52 teachers who were involved in implementing it with their Grade 9 students and by the students themselves. Parents who were involved also expressed favourable views about the experimental program and their children participating in it. Twenty-three of the 25 administrators favoured ***SHR*** being taught in their schools. There is evidence that it is successful in changing student knowledge, behavioural intentions and some other attitudes in a positive way and in helping students develop assertive

communication skills. ***SHR*** evaluation results revealed no harmful, short-term effects on students. The analysis of the follow-up data from the students in Grades 10 and 11 will reveal the extent to which ***SHR*** influences their sexual behaviours.

Revisions were made to the demonstration version of ***Skills for Healthy Relationships*** on the basis of feedback received from teachers, administrators, parents, and most importantly, the students involved in the evaluation. The most notable changes are: a reduction in the number of student activities from 28 to 23 to reduce the length; a refinement of the steps to the assertive message; a reduction in opportunities for practising the assertive message; the alteration of some scenarios to make them more appropriate; a diminishing of learning journal entries and some questions redesigned to be more specific to certain activities; and, revisions to the video scripts and a refined video production of higher quality sequences more directly related to the companion activities.

The developers believe the changes made to the original ***SHR*** have created a more contained and effective program that can be easily adopted or assimilated into an existing health education curriculum.

C. INSERVICE TRAINING

District Education Authorities and Divisional Education Councils will determine inservice needs in their own jurisdiction.

D. PARENT/GUARDIAN INVOLVEMENT

An important aspect of ***SHR*** is the involvement of the students' parents and guardians. The aim of involving them is to contribute towards their knowledge of HIV/AIDS/STD and help strengthen communication between them and their son or daughter so that they will influence their responsible behaviours and be supportive of their health-wise decisions.

During the evaluation of ***SHR***, after the experimental program was delivered to their sons or daughters, a random sample of 203 parents/guardians were contacted by telephone. Those who had actually experienced ***SHR*** activities with their children (35%) and even those who were only aware of ***SHR*** (26%) were very positive about it and its perceived beneficial effects.
In this part, a rationale for involving parents/guardians is given, the need for and the content of a meeting with them is discussed, and the **Parent/Guardian Guide** is introduced.

1. Rationale

Since parents play such a key role in child and adolescent development, it is hoped that they share with teachers the responsibility for educating their children about HIV/AIDS and sexuality. The potential for parent involvement, however, can only be realized if parents and guardians possess adequate knowledge, positive attitudes and the skills to communicate with their children and agree to do so. The ***SHR*** **Parent/Guardian Guide** is meant to help expand their knowledge, attitudes and the relevant skills. Teachers who have the necessary knowledge, skills and sensitivities in teaching about sexuality and HIV/AIDS/STD can also help parents who take on the responsibility. The developers of the ***SHR*** believe it is essential to involve parents/guardians in the program as do other proponents of HIV/AIDS and sex education programs (CDC, 1988; Basch, 1989).

Some have pointed out that parents generally do not object to discussion of the controversial issues as long as all points of view are considered (Lohrmann, 1988). And yet some critics fear that explicit education about protection against HIV and STD will encourage earlier decisions to relinquish abstinence. In a review by the World Health Organization of 19 research studies evaluating the effects of sex education (Baldo, Aggleton and Slutkin, 1993), in no study was there evidence that sexual activity among adolescents receiving sex education increases. Six studies showed that sex education leads either to delay in the onset of sexual activity or to a decrease in it (e.g., Furstenberg, Moore and Peterson, 1985; and Kirby et al., 1991). Ten studies revealed that sex education increases adoption of safer practices by sexually active youth (e.g., Dawson, 1986; and Zelnik & Kim, 1982).

Rather than risk pregnancy, HIV infection or STD, many parents realistically would rather have their children learn how to protect themselves if they choose to have intercourse. This is supported by another recent study which found that 97 percent of Canadian parents support the teaching of AIDS education in the schools (Verby & Herold, 1992).

2. Parent/Guardian Meetings

Skills for Healthy Relationships requires a commitment from parents or guardians to carry out its objectives. To encourage parent/guardian understanding of ***SHR*** and to gain their support in building and maintaining communication with their son or daughter about sexual matters, it is suggested that a meeting sponsored by the school, or school jurisdiction be held before ***SHR*** begins. It is important to anticipate possible objections to the controversial content, elaborate on the research objectives and the program evaluation outcomes, and fully inform the parent/guardians(s) about their part in being asked to do selected activities at home with their son or daughter. Anticipating that some parents/guardians will not attend the meeting, every effort should be make to contact, inform, invite parents to the meeting, as well as encourage further communication about SHR. A detailed letter could be sent home, inviting further communication about ***SHR***. In many communities of the north it is appropriate to call parents to inform them, or to carry out home visits. Networking or partnerships can be helpful in getting the information out, so that the role of communicating with parents about SHR may be taken on by the teacher, classroom assistant, or school-community counsellor.

It would be preferable that these meetings are held at the school so that there is ample opportunity for interaction with the teachers delivering ***SHR***. It may, however, be more convenient to hold the meetings at a central location, such as the school jurisdiction offices.

3. *SHR* Parent/Guardian Guide

At the beginning, of ***SHR***, you should ensure that the **Parent/Guardian Guide** reaches each home. Not only does the guide provide parents/guardians with some basic information related to HIV/AIDS and other STD so that they can increase their knowledge but also it contains the activities which they are encouraged to do with their son or daughter.

At the designated times during the course of ***SHR***, it is recommended that you urge the students to ask their parent(s)/guardian(s) to complete, each of the five activities with them. Engaging parents in interacting with their son/daughter about ***SHR's*** content will increase their possibility of maintaining effective communication and the opportunities for parental support in the child's decisions about health behaviours. The objectives of these activities are to improve communication between parents and students, give parents and students the opportunity to

consider their level of assertiveness together and to learn more about HIV/AIDS and other STD. These activities are also referred to in the introduction to the **Teaching Guide**.

A parent video, "Your Turn To Do The Talking", has been produced by the NWT Association for School Health, with sponsorhip from Health Canada and the Department of Education, Culture and Employment, GNWT. It is intended to be an introduction for parents to the principles and content of the SHR program. As well, the video can be an alternative to the written **SHR Parent/Guardian Guide**, in instances where English language literacy may present a problem. The advisory committee felt strongly that the video, "Your Turn To Do The Talking", be accessible to all NWT parents, in hopes of educating about HIV/AIDS and other STDs--and especially in hopes of fostering dialogue between parents and their children on the topics of sexuality and relationships.

E. SELECTING AND TRAINING PEER LEADERS

Peer leaders are an important component of ***Skills for Healthy Relationships*** not only to address the motivational supports component of the program but also to provide assistance in the development of skills. This aspect of ***SHR*** was very well received by most of the teachers involved in the evaluation.

A **Peer Leader Guide** is included as part of the materials. It describes the content of a training session to be held outside the class, before the ***SHR*** student activities begin, with a number (usually 6 to 8) of students selected to be peer leaders. The length of these sessions held in the evaluation varied between three and six hours; a minimum of three hours is recommended. The number of peer leaders will depend on the number of small groups you select to work together during many of the ***SHR*** activities. (Some of the teachers who implemented the experimental program found it useful to train a couple of extra peer leaders who could substitute for others who were absent or not working well).

A peer leader would assist in the learning process by doing the following:

- helping the teacher and the students through the more complex activities;
- role playing specific cooperative, assertiveness and condom-related skills;
- modeling these skills during a small group's interaction;
- helping the small group work together effectively; and,
- supporting peers in adopting responsible, healthy behaviours.

1. Rationale

Social learning theories suggest that the planned use of high profile role models with whom the audience can identify can produce a desired effect. Young people have a tendency to emulate the behaviour of those they like or admire. If the adolescent peer culture encourages assertiveness and the delay of first sexual intercourse and dictates that protected sex is the norm, many should comply with these norms.

Involving trained adolescent leaders in the presentation of material, knowledge and skills can be

an effective means of delivering messages aimed at altering their peers' behaviours.

Learning is enhanced because

- learning becomes fun;
- communication between peers is improved;
- reinforcement of desirable behaviours increases;
- the teacher has help in presenting the lesson and more time to help individuals and single groups; and,
- peer leaders develop skills that are beneficial to them in the future.

2. Criteria for Selection of Peer Leaders

It is suggested that the class be involved in helping to select peer leaders. The process of nominating four to six potential peer leaders adds to the sense of commitment by class members *to* ***SHR*** and can guarantee for many that at least one of their choices will be among the ones you have selected. Of course, it could be to every student's advantage to experience the training, as many teachers pointed out during the inservice workshops; nevertheless, the presence of peer leaders, many of whom had been selected by both classmates and the teacher, seemed to have positive effects both from the teachers' and peer leaders' point of view.

Select individuals from the class who are

- concerned about the welfare of peers;
- able to listen and to understand others;
- flexible -- able to adjust to new situations;
- self-confident;
- dependable; and,

- have leadership potential.

Peer leaders should be

- well-liked by other students and teachers;
- "well-rounded" students but not viewed as "goody-goodies" by their contemporaries; and,
- both male and female, if possible.

3. The Peer Leader Training

Arrangements for the peer leader training sessions should be made in consultation with your department head and/or the resource person from the school jurisdiction. It is preferable that you, the classroom teacher, be directly involved in the session so that a close rapport can develop between you and the peer leaders. Even though it may be more efficient for one teacher to deliver sessions for all peer leaders if there is more than one class involved in ***SHR*** in your school, it is important that you stay in touch. During the evaluation, some guidance counsellors carried out or assisted with the Training and the teachers appreciated the opportunity to work with them and gain from their experience.

Three hours is the recommended minimum training time; during the evaluation, some teachers found that four to five hours were more appropriate. It would be best to schedule the training outside class time. Details are left to teachers; however, the equivalent of a full period or longer for a given session is recommended. Shorter periods would likely not be effective. Some teachers who tried out ***SHR*** combined the peer leader training with an evening's social event and commented that this worked well to build rapport.

Your training session with the peer leaders may be structured as indicated in the **Peer Leader Guide:**

1. introduce ***SHR*** and its purposes;
2. discuss the peer leaders' role;

3. demonstrate or explain the most difficult activities for which peer leaders could be of assistance (7 are referred to in Table 1, p. 19 and in the **Peer Leader Guide);**

4. demonstrate and promote handling group problems and practising communication skills (Peer Leader Activity 1);

5. demonstrate and promote the development of communication and empathy skills Peer Leader Activities 2 and 3);

6. model and promote the practice of Cooperative Skills (Peer Leader Activity 4); and,

7. train the peer leaders to support responsible behaviours (Student Activity 25).

a. Introduce *SHR*

The **Peer Leader Guide** contains most of the material that you might want to use during the training session. Transparency masters and classroom charts and cards have been designed to accompany ***SHR*** materials and can be found in Appendix B. When introducing ***SHR***, you may find it helpful to use the overheads to outline the objectives and the units.

b. Peer leader role

It is suggested that you give the peer leaders their copies of the Student Manual at this point and describe their role (using the overhead).

The peer leader's role is as follows

- understand ***SHR*** objectives;
- help students with difficult activities;
- model the skills:
  - assertiveness
  - condom use
  - cooperative skills
- help groups function;
- support responsible sexual decisions; and,
- support health-wise behaviours.

c. The difficult activities

The activities which may present difficulties to the students because of complicated aspects are listed in **Table 1** below. Note the activities which we recommend that you (1) demonstrate by having the peer leaders work through the difficult parts; and (2) explain while they review them.

TABLE 1: DIFFICULT ACTIVITIES

Unit	Activity #		Name of Activity		Explanation/ Demonstration
1	2		Estimating Risk Part 1 Part 2 Part 3		 Demonstration Explanation Explanation
2	9 10		Practising Assertiveness Responding to Persuasion		Demon stration †Explanation†
3	17 18		The Line-Up Condom Practice		Explanation Demonstration†
4	23 25		Equality for All II Support for Responsible Behaviours (see Section I, **Peer Leader Guide**.)		Explanation Demonstration†

! These activities involve watching a sequence of the video.

d. Groups and communication

Explain that they will be working most of the time during ***SHR*** in a small group of four to six students. Show them how to help their group function. They should be familiar with the "rules" for group discussions (e.g., avoid "put downs", everyone has the "right to pass", and personal information divulged in discussions is to remain confidential).

Activity 1: **Dealing with Roles in Groups,** in the **Peer Leader Guide,** will help you train the peer leaders to become aware of some different roles group members play and to handle problems they may encounter in their small groups.

We suggest you have the peer leaders next do Activities 2 and 3 from their **Peer Leader Guide** in groups of four. Activity 2 : **Communication Check** is designed to build personal communication skills important in being an effective group member. Activity 3: **Empathy Skills** is designed to develop empathy for the other person.

e. Cooperative Skills and Cooperative Structures

Teach the peer leaders about task skills and working relationship skills (i.e., **Cooperative Skills)** so that they can model them during a group activity. Refer to the ones selected for focussed practice (see Table 4 in this manual. They can also be seen in the **Peer Leader Guide).** You may wish to use the overheads of the five T-Charts (see Appendix B) in demonstrating the Cooperative Skills. The Cooperative Skills T-charts state sample verbal and nonverbal behaviours; others could also be appropriate. Some teachers in the evaluation found that laminated index cards of the T-Charts were useful to peer leaders during the class activities. To teach these skills, you could work with the peer leaders (and have them work with the students in their group) to fill in a blank T-chart while agreeing on appropriate examples of behaviours and statements.

- Show the skill by modeling it or having a peer leader model it in a simulated interaction in front of the group;
- List the nonverbal ("looks like") behaviours that demonstrate the skill;
- List the verbal ("sounds like") behaviours that demonstrate the skill;
- Ask the students to practise the skill prior to and during the group's discussion in a particular activity;
- Evaluate the peer leader's performance of the skill; and,
- . Ask the students to give feedback to others in their group about their progress with the skill.

During ***SHR*** activities, encourage the peer leaders to have their small group consider which skills they need to improve. The T-chart skills are only selected ones which, throughout your ***SHR*** sessions, the peer leaders could help their groups practise systematically by covering each one or practise selectively as their group indicates they lack a given skill.

Cooperative Structures are methods of organizing the group in order to promote discussions on the group task. The five recommended ones are presented in **Table 5** and as overheads in the **Peer Leader Guide.** Familiarize the peer leaders with the structures which you will use in certain activities so that they can explain them to their group. Both the Cooperative Skills T-Chart and the Cooperative Structures are listed beside the relevant activity number in **Table 2: Peer Leader Tasks** which is duplicated in the **Peer Leader Guide.**

f. Peer leaders support peers in adopting responsible behaviours

One of the objectives for training and using peer leaders is to prepare them to model healthy, responsible behaviours for their peers and to support them in adopting these behaviours. By doing Activity 25: **Supports for Responsible Behaviours,** the peer leaders will develop support skills and be able to help their group experience the activity.

Another objective is for peer leaders to direct fellow students to professional sources if they require such help as counselling or medical advice on birth control and protection against STD.

g. Group self-evaluation

The peer leaders are asked to lead the group discussion and summarize each member's evaluation of the group performance and cooperative skills (see the evaluation form at the end of the **Student Manual).**

TABLE 2: PEER LEADER TASKS

Activity #	Cooperative Skills T-Chart		Cooperative Structure		Other Peer Leader Tasks†
2.	Listening Actively*		• Numbered Heads Together		understand instructions
3	Disagreeing in an Agreeable way		• Numbered Heads Together		help group reach consensus
5	(each group's choice)		• Brainstorming • Numbered Heads Together		-----
6	Criticizing Ideas Not the Person Expressing Them		• Think-Write-Pair-Share • Brainstorming		-----
7	(each group's choice)		• Brainstorming • Numbered Heads Together		-----
8	(each group's choice)		• Numbered Heads Together		demonstrate/model passive, aggressive and assertive behaviours
9	Encouraging Others		• Pairs-Check		model **Steps to Deliver an Assertive Message**
10	Listening Attentively		• Pairs-Check		-----
15	(each group's choice)		• Numbered Heads Together		model replacing negative thoughts with positive ones
16	(each group's choice)		N/A		
17	(each group's choice)		• Numbered Heads Together		helps coordinate volunteers at front
18	Encouraging Others		• Brainstorming • Numbered Heads Together		put condom on a penis model (for class and group)
19	(assertiveness skills)		• Three-Step Interview • Numbered Heads Together		model delaying, negotiating, refusal skills
20	(each group's choice)		• Pairs-Check • Numbered Heads Together		-----
22	Disagreeing in an Agreeable Way		• Numbered Heads Together		-----
23	(each group's choice)		• Numbered Heads Together		-----
24	Summarizing for Understanding		• Numbered Heads Together		-----
25	Encouraging Others		• Numbered Heads Together		help group role play

! **Model the cooperative skill** and **help the group work effectively** are tasks you will perform as well as others listed below for the designated activities.* Listening Actively is a skill that should be practised in <u>all</u> activities.

4. Feedback and Evaluation

We suggest that you provide feedback to the peer leaders (see **Feedback to Peer Leaders** in Appendix B). The peer leaders are asked in the **Peer Leader Guide** to use a similar form to evaluate themselves. Your feedback could entail a discussion about their self-evaluation as well.

It will be useful for you to have continuing contact with the peer leaders during the course of ***SHR****;* periodic meetings would help you to reinforce their skills training, maintain communication and feedback and deal with questions they may have.

5. Peer Leader Certificate

To recognize the time and energy devoted to this part of their course, peer leaders should receive a Peer Leader Certificate upon completion of ***SHR*** (see end of Peer Leader Guide). It is suggested that the certificate be presented to the peer leaders at a private gathering (i.e., principal's office) by the principal and/or teacher in charge of ***SHR***. The teachers who did so during the evaluation said that the event was well received. Some held a special social event at the school jurisdiction offices and reported it successful.

F. TEACHING APPROACH

In this section we will describe in detail teaching strategies you may use to present ***SHR*** activities to the students.

In the first part below we suggest general methods of creating a classroom atmosphere in which sensitive topics can be positively discussed. Given the subject matter of ***SHR*** and the interpersonal dynamics among students and teachers, uncomfortable situations may arise. If you are prepared for these situations, you and the students will be able to handle them and perhaps even use them to help the students understand the objectives of each activity.

In the second part we deal specifically with cooperative learning. The **Teaching Guide** describes the strategies to be used to guide students step by step through the activities.

1. General Teaching Approach

No two adolescents are the same, but most are experiencing similar feelings and pressures as they develop towards adulthood. In response to these feelings and pressures, they experiment, test limits and work at defining a sense of individuality. Determining a sexual identity is a major development in their maturing process. Each student moves toward adulthood at his/her own pace, and consequently, students even in the same grade are at widely differing levels of physical, emotional, intellectual and social maturity.

In this section we

- consider how students might react to the subject matter being discussed;
- suggest how you might reach an understanding with the students about classroom atmosphere before beginning ***SHR****;*
- outline a number of strategies to diffuse potentially disruptive situations as they arise; and,
- discuss what you might do if you are approached for help by a student who believes he or she might have been exposed to HIV or have contracted an STD

a. How students might react

Each of the adolescents you are teaching will bring a very different perspective to ***SHR***. Their knowledge about sexual matters and their response to discussing the issues raised will vary greatly. Students may

- be embarrassed to talk about the issues raised and try to remain silent;
- ask baiting questions;
- use frank "street" language;
- go beyond the course content and, to shock or amuse, explicitly describe sexual behaviours;
- ask you very personal questions about your private life; and/or,
- unwittingly make comments that open themselves to peer criticism or ridicule.

b. Reaching an understanding

The aim of these suggestions for your general approach is to create an atmosphere in the classroom in which all the students will feel they can participate comfortably. **Whatever approach you choose to use, be sure it is clear to the students before you begin *SHR*.**

After briefly mentioning that they will be discussing AIDS and other sexually transmitted diseases and that ***SHR*** is based on students' individual participation in class and in small groups, you might make the following points:

- you expect the students to treat each other in a positive way and be considerate of each other's feelings;
- students are not to discuss their own or anyone else's behaviour;
- everyone should avoid talking about students' comments outside the classroom;
- to ensure that all the students, those who are outspoken and those less inclined to express their thoughts publicly, understand the concepts and ideas raised in ***SHR***, you might consider setting some specific standards of classroom conduct. For example, suggest that students

- avoid interrupting each other and raise their hands when they wish to speak;
- listen to each other and respect each others' opinions;
- are exempt from answering personal questions (establish a "right-to-pass" rule); and,
- understand that the teacher, too, has the right to pass on personal questions. It is a good idea, at the beginning, to exempt yourself from answering every question the students might ask you, and to prepare yourself for possible questions that are too personal or which, if answered, would result in your facing disciplinary action.

Ensure that the students realize how important it is to respect each other's privacy. The goal is to learn how they can prevent the spread of AIDS and other sexually transmitted diseases by learning how to protect themselves from contracting the infectious organisms that cause these diseases.

- ***Encourage them to talk freely about the facts and skills they are learning.***
- ***Discourage them from singling out individuals.***

c. Dealing with uncomfortable situations

In this section we suggest some strategies you might use to deal with personal questions, explicit language and other inappropriate behaviours.

- learn board policy regarding responding to controversial questions, for example, questions pertaining to sexual activities, such as oral and anal sex;
- model and reinforce acceptable behaviour throughout ***SHR****;*
- respond to statements that denigrate or reinforce stereotypes of groups of people; for example, statements that imply that some groups of people are more likely to contract HIV, by encouraging students to reflect on the implications of what they have said;
- be prepared to handle difficult situations assertively. This may mean cutting off students who introduce subjects to embarrass or shock others. Direct the students back to the objective of the activity;

- explicit language should be "corrected" - - restate the sentence using acceptable terminology; try to avoid criticizing students who may use explicit or offensive language without realizing that there are more appropriate terms;

- avoid being overly critical to encourage as many students as possible to express their opinions openly and honestly. Ask carefully worded clarifying questions;

- avoid making value judgements. Present both sides of a controversial issue;

- remember that students have the right not to respond when sensitive questions or issues arise. Keep in mind that students from some ethnocultural backgrounds are discouraged, at home, from speaking freely about sexuality; and

- a number of strategies are built into ***SHR*** to allow students to keep their thoughts confidential:

    - certain activities are done privately
    - the students, at the end of Unit 2 and throughout Unit 3, keep a learning journal, which is seen only by the teacher (if you so decide) and evaluated only to ensure that their entries are reflective and linked to the activities.

We believe teachers who know the course content well will present the activities with greater confidence and are more likely to avoid difficult situations. New research on AIDS and other STD is being conducted and findings are published continuously.

- It will be in your interest to keep abreast of the latest, reliable information. It is a good idea, during the weeks you are teaching ***SHR***, to scan newspapers for articles about AIDS and STD. If you are aware of what is being reported you will be better prepared for questions students may ask.

- Many of the issues related to sexually transmissible infections are controversial. For example, there are no clear answers yet on some aspects of HIV transmission, and there is no consensus on the issue of mandatory testing or policy regarding disclosure of positive test results. The purpose of several class discussions will be to have students understand the complexity of these issues, and to make them aware of the need to learn more in order to make informed judgements about such topics.

d. Helping the anxious student

Anticipating how you might respond to any students in the class who believe they have been exposed to HIV or have an STD will make you more approachable and more helpful to these students. It is important that you do not behave in such a way that students who are worried do not seek your advice. Your responsibility in teaching ***SHR*** includes learning, in advance, what resources are available in your community and what services they offer.

It is recommended that you listen to the student who approaches you without imposing your values, moral judgements or opinions and without asking leading or suggestive questions about his or her behaviour. Convey your concern about the student's health, and, when appropriate, tell the student what you know about the professional sources of assistance available. Offer to start the process of contacting the one the student chooses.

Continue your support by confidentially asking the student periodically if he or she needs more information, has taken any action, or is still concerned about anything related to your conversation.

2. Specific Teaching Approach: Cooperative Learning

The primary methodology recommended throughout most of ***SHR*** is cooperative learning. In this section we

- outline the principles and conditions on which cooperative learning is based;
- explain the cooperative skills and cooperative learning structures emphasized in ***SHR;***
- describe the role of students and teacher; and,
- explain how to compose the small groups.

a. Principles of cooperative learning

Cooperative learning is a teaching method whereby students work with a small number of their fellow students to learn a skill or to try to understand a concept. By the time the students begin ***SHR***, most will have collaborated with one or a few other students to complete a group project or planned activity. They may not have worked in a small group in such a way that each member of the group specifically learns how to do something or grasps the meaning of an idea or concept. This is the essential element of cooperative learning: the members of the group are responsible for their own learning and for the learning of each individual in the group. Each individual must succeed. In other words, each must help every other member of the group if the group itself is to be successful.

b. Cooperative Skills

Students, while engaged in cooperative learning, can learn what is intended from the task assigned to them. They can also develop a series of group or cooperative skills, which some cooperative learning practitioners categorize as task skills and working relationship skills (see Table 3 which follows). As the students interact, use of these skills helps them to work together effectively to achieve the goal set for the group.

Task skills are used to complete the assigned work. Working relationship skills help the group function. Throughout ***SHR*** it is suggested that you concentrate on those which are indicated by a checkmark (√) and are presented in Table 4 as Cooperative Skills T-Charts and in the Peer Leader Guide as overheads. The other skills in the lists are also necessary to effective group work, and should be acknowledged.

TABLE 3: COOPERATIVE (GROUP) SKILLS

Task Skills	Working Relationship Skills
√ listening actively	√ criticizing ideas not the person who expresses them
√ summarizing for understanding	√ disagreeing agreeably
• questioning	√ encouraging and supporting others (e.g., praising)
• elaborating on ideas	• inviting others to talk/participate
• following directions	• sharing feelings
• staying on task	• keeping the atmosphere calm
• keeping track of time	• acknowledging contributions
• sharing information and ideas	• mediating
• asking for help or clarification	• showing appreciation
	• checking for agreement

*** Five skills are noted with a √ as the cooperative skills to be focused on during group work.**

Cooperative Skills can be developed with practice in group settings. During nine of the student activities, five particular Cooperative Skills are suggested for emphasis (see the Cooperative Skills T-Chart for each of the activities in your **Teaching Guide**. The total number of skills emphasized in ***SHR*** has been reduced in this revised version at the recommendation of teachers involved in the evaluation. During the peer leader training and the small group (classroom) activities, we suggest that you encourage the students to pay particular attention to how they can use and improve these skills as they work through the assigned activities. You could also encourage the groups to select the skills (these and other task or working relationship skills)

which they feel the need to work on. The peer leaders can help their groups identify such skills and practise them during particular activities. The list of Peer Leader Tasks (Table 2) indicates activities in which groups could choose a Cooperative Skill on which to concentrate.

TABLE 4: COOPERATIVE SKILLS T-CHARTS

The number/s in the right hand corner of the title bars in the following charts, refer/s to the student activities in which the skill is best emphasized:

SKILL: LISTENING ACTIVELY	all activities
Looks like ...	**Sounds like ...**
• looking at the speaker • leaning forward • concentrating on what is being said • smiling, nodding appropriately • using open body language	• *Could I hear more about that?* (asking for more information) • only talking when necessary • avoiding interrupting • staying on topic

TABLE 4: COOPERATIVE SKILLS T-CHARTS (Cont'd)

SKILL: SUMMARIZING FOR UNDERSTANDING	24
• having eye contact with all group members	• *These are the main points of our discussion as I see them.*
• assuming open body posture	• *Our major ideas seem to be ...*
	• *Is what I've said clear? I can repeat it for you.*
	• *Here are my thoughts about what our main points of discussion are. Are there any you wish to add?*

SKILL: DISAGREEING IN AN AGREEABLE WAY	3,22
Looks like ...	**Sounds like ...**
• minimizing gestures	With a calm, controlled voice:
• maintaining eye contact	• *That's a possibility. Would you consider ...?*
	• *I understand your position, however would you ...?*
	• *Yes, I see that. What about looking at it from the point of view that ...?*
	• *I guess we agree to disagree.*

TABLE 4: COOPERATIVE SKILLS T-CHARTS (cont'd)

SKILL: CRITICIZING IDEAS NOT THE PERSON	9, 18, 6
Looks like ...	**Sounds like ...**
• smiling, nodding appropriately as you listen • concentrating on statements by the other person • using open body language • looking at the speaker but also at others	• *I don't agree with that idea; would you listen to mine?* • *Fine, that is one viewpoint but what about this idea?* • *That idea may have merit because of ... but it may not be the best because...* • *Yes I see that, but would you consider this ...*

SKILL: ENCOURAGING OTHERS	25
Looks like ...	**Sounds like ...**
• smiling • maintaining eye contact • signalling thumbs up • giving a pat on the back • nodding approval • giving a "high five"	• *Awesome!* • *Good job.* • *That's excellent!* • *You got all the steps right.* • *Super!* • *I like your idea.* • *What you've said is great.*

c. Cooperative Structures

Cooperative structures are methods for organizing the cooperative learning group in order to promote discussion on the task. (See the five Cooperative Structures recommended in Table 5.) Where appropriate, a particular structure is suggested for emphasis within a specific student activity in the **Teaching Guide**. The peer leaders should help apply the recommended Cooperative Structures.

TABLE 5: COOPERATIVE STRUCTURES

Name	Description	Function*
1. Numbered Heads Together	1. Number the students in each group beginning with #1. 2. Group huddles to discuss the task & arrive at a consensus/decision/answer. 3. Ask one member of each group for the group's response (e.g., only 2s).	• comprehending • reviewing • checking for knowledge
2. Pairs-Check	1. Students work in pairs within groups of 4. 2. In pairs, they alternate role playing and coaching or giving feedback. 3. Compare solutions/answers with the other pair.	• practising skills
3. Think-Write-Pair-Share	1. Individually, students think about the problem or questions posed. 2. They write a solution. 3. The discuss it with a partner. 4. Each pair shares with the group. 5. Groups share with class.	• generating ideas • revising ideas • reasoning • applying ideas
4. Brainstorming	**Rules:** • Defer judgement. • Encourage zany ideas. • Quantity counts. • Build on ideas.	• creativity
5. Three-Step Interview	1. In pairs, students interview each other. 2. Reverse roles. 3. One pair joins another to make a group of 4. 4. Student introduces partner's ideas. 5. Extend to class sharing.	• sharing ideas, thoughts

* The use of Cooperative Structures generally is to encourage individual involvement, cooperation, additional support and the development of interpersonal/communication skills.

d. Role of the student

The student's role is to

- be a listener;
- depend on others; and,
- be responsible for his/her own and others' learning.

When ***cooperative learning*** is well planned, students will benefit in the following ways:

- students become motivated to learn;
- students develop more effective communication skills;
- students can learn effective problem-solving skills and high-level thinking skills;
- students develop responsibility for their own learning and the learning of others;
- students learn respect, caring, empathy, helpfulness; and,
- students can attempt to break down intolerance of others.

e. Role of the teacher

Your role is to

- facilitate learning;
- model the skills and coach the students; and,
- observe, and, at least, help peer leaders assess and give feedback to students on the skills and on the group process.

Group work, in and of itself, does not produce cooperation or higher achievement and positive social skills development. The students must be prepared for the challenge of working together to learn and the teacher must understand and create conditions in the classroom that will promote cooperative learning.

By using small, cooperative learning groups, you will:

- be able to integrate students (especially those with special needs) into groups where members will be encouraged to help each other learn;

- be at liberty to circulate from group to group, watch the excitement and help individual groups, where necessary;

- have help from the peer leaders, in ***SHR***, in explaining procedures to ensure understanding of individuals within groups; and,

- become a coordinator and consultant who helps the students help themselves.

f. Group size and composition

You may be using base groups throughout ***SHR***. That is, the membership of each group will remain the same. (You may have to make exceptions and change the group membership if individuals cannot get along, but try to minimize changes.) The purpose of base groups is to encourage peer support for learning over the long term.

We recommend that the optimum size is four members per group. Most activities have been designed for an even number of students per group. Six or more members will be too many to allow for all individuals to share their information or role play within reasonable time limits. If you have too many students to create groups of only four students, keep to a minimum the number of larger groups. It is better to ensure that pairs exist within a group so that at least the first part of those activities to be completed in pairs is carried out. Having pairs share is a bonus--desirable if at all possible. Explain that the odd numbered student can observe, follow criteria as set out in an activity or be assigned criteria by you, and report to a pair about his/her contributions: the role of observer can alternate.

Select the groups on the basis of social and academic heterogeneity, attendance patterns, and student involvement in the process where possible.

Ensure that you select students with a mix of gender, academic ability, ethnicity, personality and background, if possible. As the students work together they should develop an appreciation and

respect for others different from themselves and whom they otherwise may not have grown to know.

Begin your selection process as follows:

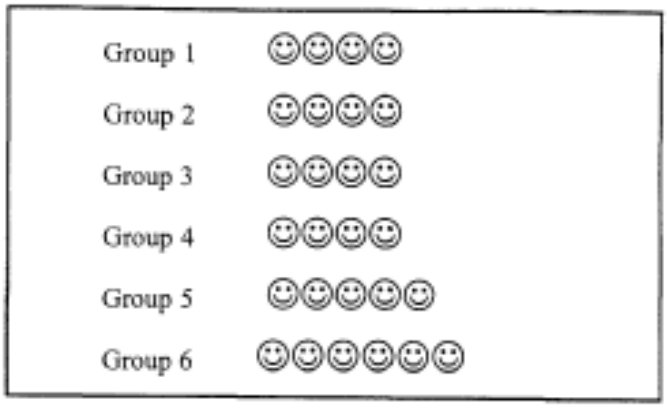
1. Compute or record the current achievement level of each student. If possible, average the last three marks assigned to each student or check the student records for averages. Alternately, ask the students to record their average mark from the previous grade.

2. Create a list of student names ranked from highest average (score) to lowest and note the special characteristics of each (ethnicity, personality characteristics--e.g., outgoing, quiet), where possible.

3. Divide the list roughly into quarters by average mark.

4. Choose groups of four by selecting one (ideally) or two from each section (quarter) of the list. Try to avoid placing students who have similar other characteristics (minority ethnocultural and other backgrounds, gender, personality); in the same group. If you cannot form all groups with four students, create a group of six and one of five. For example, in a class of 27, with 19 girls and 8 boys, and eight visible minority students, you will have six groups--four groups should each be composed of four students with one visible minority student in each group, one group has five and the last has six students. Two visible minority students are in each of these last two groups.

Group Size Example



g. Conditions for cooperative learning

The following general conditions promote cooperative learning:

i. *Positive interdependence*

- "Sink or swim together" attitude. All members must help each other to learn the assigned material.

- Positive interdependence is achieved by

  - using Cooperative Structures (see Table 5, p. 33);

  - assigning group roles if problems are encountered - e.g., reader, checker, reporter, encourager, praiser

- group reward - e.g., for high achievement, cooperation

ii. Individual accountability

- Group's success depends on the individual learning of each member.
- Individual accountability can be achieved by
  - emphasizing that every member is responsible for the final outcome;
  - randomly selecting one person's product to represent the group (e.g., Numbered Heads Together);
  - having students teach what they have learned to someone else (e.g., Think-Write- Pair-Share);
  - having group members assess each other's contributions within the group and provide feedback to one another; and,
  - providing feedback to individuals and groups, where possible.

iii. ***Interpersonal/Cooperative Skills*** (see Table 4: Cooperative Skills T-Charts)

- Through verbal and nonverbal interactions, group members should exhibit trust and the skills of communicating directly, accepting and supporting one another, resolving conflicts and encouraging each other's efforts to contribute to the learning.
- You have already considered guidelines for developing the peer leaders' Cooperative Skills. Generally, the development of these skills is achieved by
  - explaining what the skill looks like and sounds like and when it should be used;
  - practising a skill over and over again in role-playing and real situations;

- having students assess how frequently and how well they are using the skill;

- having students discuss, describe and reflect on the use of the skill during regularly scheduled times; and,

- having students persevere long enough to go through the stages of awkwardness using the skill.

iv. ***Group processing***

It is your role to encourage the groups to evaluate their own group process to determine how well the group is functioning and to assess individual contributions. Eventually, groups should assess their group interaction when it becomes natural to do so.

- Effective group processing (i.e., assessing group interaction) is achieved by
  - emphasizing positive feedback;
  - ensuring comments are specific, not vague;
  - maintaining student involvement in processing how the group has been functioning; and
  - communicating clear expectations about group processing; and
  - insuring equal involvement by all group members.

3. Adapting SHR to Meet Diverse Student Needs

Suggestions for adapting four of the 23 student activities (8, 9, 10 and 11) to meet the needs of students in multi-level classes, are presented in this section. This has been done to provide examples of how the SHR program can be used when working with students of diverse needs.

These generic ideas can suggest possibilites for adapting other SHR activities to meet the particular requirements of individual students in your class.

Adaptations are presented below for activities 8, 9, 10 and ll. Please refer to the appropriate teacher and student activity pages as you read through the suggestions below:

a. Activity 8 Adaptations

Suggestions for teaching to meet diverse student needs:

1) For the ***various scenarios in this lesson***, both for teaching, and for student work, work with the peer leaders and other students to act out the scenarios, rather than reading- -so that the activities are more realistic and holistic--and to accommodate students with limited reading skills.

2) For the ***scenarios on student pages 3 and 4***, divide students into groups of three. To promote cooperation, have all three hand in one response that they all agree on.

3) For the ***teacher overhead 8: p.2***, consider separating the overhead into three segments, so there is less to read and look at, or block out sections on any one overhead.

4) A ***large paper copy of overhead 8: p.2*** could be prepared and displayed as a visual reminder. The three segments (i.e. passive, assertive and aggressive) could be identified with either an X or √, or the universal symbol for "don't" or "no"- -a circle with a stroke through it.

5) For the ***follow-up activity on student manual page 5***, an additional rule could be that all students have the opportunity to contribute an idea, before a student who has already had a turn contributes a second idea. One way to do this, as well as to show how conversation flows, is to use a ball of string or yarn. The student speaking holds the ball, then rolls the ball to the next speaker while keeping hold of their piece. As the discussion flows, a web forms; you can also quickly see who has had a turn, and who hasn't.

b. Finding advantages is easier than finding disadvantages, which should be taken into account in the student groupings. A more challenged student would participate in the advantageous group, for example.

c. If the student selected as timer has difficulty telling time, s/he could use a kitchen timer set for the length of the activity.

6. ***All students benefit*** from watching their peers model appropriate behaviour and language, even students who are not able to take a full role in scenarios.

7) For *severly disabled students* who are striving to make appropriate choices, "yes" or "no" responses to simple scenarios or questions might be appropriate.

8) ***School-Community Counsellors, or guidance counsellors****,* if available, could be asked to assist with any or all of the assertiveness activities (*# 8, 9, 10, 11).* Not only would they be a support to the teacher because of their background, they would also be available to free the teacher up to discuss concerns with individual students.

Other Follow-Up Activities for Students

These may also serve as alternate activities for comprehension or practice of the terms, "passive", "assertive", and "aggressive".

1) Use the words "passive", "assertive", and "aggressive" in context, either in writing or orally.

2) Given a statement/short exchange, have students identify it as passive, assertive, or aggressive. If not already assertive, have students suggest an assertive response.

3) Demonstrate an understanding of the terms using dance, gestures, facial expressions or other body language.

4) Identify a story, song or poem which illustrates one or more of the terms.

5) Find an advertisement, or media message which illustrates one or more of the terms.

6) a. Using a generic board game and a set of cards, students take turns drawing a card with one of the terms on it -- for example, "passive". The student has to demonstrate an appropriate example of passive behaviour, either through a statement, expression, etc. Other students decide if the person was right. If so, they move forward. If not, they remain in place.

b. Another variation, would be for students to draw cards that have a passive, aggressive or

assertive message or expression on them. They move ahead if the message is assertive, back if it's aggressive, and remain in place if it's passive.

7) Given a series of photographs, students have to decide if the message in each photo is passive, aggressive or assertive, and explain their reasons. Alternatively, students could be asked to collect examples of photos showing these concepts.

8) Make the video segment available for students to view again if they wish additional reinforcement. This applies to lessons 9 and 10 as well.

b. Activity 9 Adaptations

1) a. ***Overheads 9: p.3 and 9: p.5*** contain a lot of information for some students to read. The steps (the left-hand column) could be made into a poster as a separate visual for students to refer to later in the activity, and in other activities- -Activity 10, for example, uses the same overheads.

b. Each of the key steps, and examples (the two left-hand columns) could be a separate overhead so students have less to view on any one overhead.

c. The speech balloons, where Jon and Jim speak, could be numbered to clearly show the sequence of the conversation, and allow students to see the relationships between the balloons and steps.

d. When the script is fully developed ask the peer leader to act it out with you so that students can experience the finished product.

2) When using ***overhead 9: p.6***, the peer leader and another student can model the various behaviours as they are discussed. Key points on this overhead (eye contact, appropriate gestures, etc.) can be highlighted for clarity.

3) a. For ***Part II, Action Scenarios, student manual p.7,*** ask students to reflect on their scenario for a moment before beginning to speak, to allow students time to reflect on an appropriate response.

b. Scenarios could be simplified, or shortened or mounted on index cards rather than having a large amount of small print on one page.

c. For some students, additional simple scenarios and tight script may facilitate their participation/answer. For example:
Scenario: Jon owes you money. You would like it back.
Response: 1. "I feel _____"
(happy, frustrated, lonely)
2. "Please _____"
3. "Is that O.K.?"
4. other person answers
5. "Great."

4. ***Ask a colleague*** to come to your door during class, interrupt, and sound rather loud, angry, and threatening. Respond with the appropriate assertive message and enhancements. Discuss with students afterwards.

5. To help students remember the steps, develop a ***mnemonic device*** such as:
FROT (*f*eelings, *r*equest, ask *o*ther's feelings, *t*hanks)

Other Follow-Up Activities for Students

1) Students can play a card game to reinforce the steps FROT. Using blank cards, write examples of either feeling statements, making the request, asking how the other person feels, or accepting with thanks, on the various cards. Since there are four `suits'- -feelings, request, others' feelings, and thanks- -students can play rummy, or any game with which they are familiar, in which you have to collect cards of the same suit.

2) Document a scene from a play, story or TV show in which the assertiveness steps are illustrated. If you are not able to find an exact illustration, point out, or have students point out, where it varies from what you have learned in class.

3) Match headings with comments, by drawing lines from a heading in column A to an appropriate comment in column B.

COLUMN A	**COLUMN B**
Feelings	That's really great.
Request	Is that O.K. with you? .
Asking how the other feels	I get upset when you're late.
Accepting with thanks	Could you please be on time?

c. Activity 10 Adaptations

1) Before starting the lesson, ensure that all students understand the terms "persuasion" and "distraction". One way to do this would be to have the peer leader act out the terms as part of the ***'Ready'*** section of the lesson.

2) Develop a ***glossary*** for use throughout SHR. In this lesson, terms such as "persuasion" and "distraction" could be added to the glossary. The glossary could be begun at the start of the SHR program, then developed and added to, as students progress through the program.

3) For ***overhead activity 10: p.5***, reuse the overheads and visuals developed for activity 9. For both the teacher-led activity, as well as the student version (page 5), the speech balloons should be numbered to clarify the order in which they flow. Numbering the speech balloons is also suggested for at home ***(teacher activity 10: p.7, and student page 7.)***

4) **Part II, Action Scenarios** could be put on cards, in simplified steps, or point form, for easier reading. Also, simplified scenarios could be developed.

5) Students with ***limited language, or cognitive disabilities*** could handle "yes" or "no" choices, as well as the concepts of saying "No" (i.e. refusing), or "leaving" the situation (i.e. delaying).

6) a. The first part of the ***follow-up, student page 12***, could be done as a group. For each skill, for example refusal, each person reflects on how difficult or easy that skill is for him/her. The classroom space represents a continuum from "not a problem" being one end of the room, and "this is the hardest thing I can imagine" being the other end of the room. After reflection, students physically move to the spot on the continuum that represents their feelings about their ability to refuse. With everyone standing along the line, students can be invited to share their reasons for selecting that spot. (The continuum concept may be reinforced for some students by actually taping a line of masking tape from one end of the room to the other. Not putting any gradations on the tape allows students more freedom to put their own interpretation on where they should stand.)

b. Teacher observation of where students stand on the continuum (i.e. how students assess their own skill levels) could be used to select groupings for follow-up question 2. Heterogeneous groupings of students with varying strengths and weaknesses will allow students to gain perspective on how others would answer these questions.

Other Follow-Up Activities for Students

1) Students could mime or act out charades to portray a scenario without words. Others would have to guess what they are dramatizing.

2) a. Ask students for real-life scenarios that they have faced or are facing, and discuss assertive options for them.

b. If students are reluctant to share this type of personal dilemma openly, they could be invited to submit anonymous scenarios to the teacher for discussion as a class, or in small groups. An anonymous "Question Box" would be one way to invite these and other highly meaningful opportunities to address student needs.

3) Students could select a song, poem, or scene from a TV program or movie that illustrates the concept of this lesson--i.e. distracting or persuading, or refusal, negotiating, delaying- - and share it with the class for discussion. Alternatively, they could prepare a personal

reaction to their selection. They could also rewrite the piece if they didn't like the choices in the selection.

4) Have students submit a paper, or other reaction to the conflicting messages of, "Just Do It." (a Nike slogan) and "Just say no." (an anti-drug slogan), messages both aimed at young people.

d. Activity 11 Adaptations

1) For students whose program is modified, or who have had an IEP written for them, teacher assistance in selecting a ***goal, student page 4,*** is key to setting a meaningful, realistic goal. For some students, goals may not specifically relate to assertiveness, or at least not as taught in these lessons. The goal should relate to something already identified in the student's IEP--for example, "yes"/"no" choices, wants, needs and likes. This activity would provide an opportunity to reinforce those goals, while allowing the student to see that others are working on `similar' goals.

2) ***Overhead activity 11: p.3***, could have key words highlighted for clarity, and a summary of important points.

3) a. After students have had an opportunity to reflect on and begin developing their ***action plan, student page 2,*** they could choose a partner to ask each other the questions on page 3, "Things To Look For".

b. To help students stick to their plan, they could chart their progress, either by graphing it, marking each day off on the calendar, having mini-celebrations along the way--anything to motivate them and reinforce their progress.

4) Students are asked to keep a ***journal,*** which allows them choices about how to respond--they don't just have to write. In addition to the suggestions, student manual page 5, students could identify an existing symbol which is meaningful to them, and inspires them to keep on track, for example an existing song or a photograph.

G. STUDENT EVALUATION

You may wish to evaluate each student in a formal way; each will also receive informal feedback about their group's performance as well as about their own skills in the group through self-evaluation. The formal method recommended includes administering two knowledge tests (see Appendix C), assessing products (one Action Plan, two Learning Journals and worksheets in the **Student Manual),** assessing participation (in the class as a whole) and having group members assess the development of Cooperative Skills in their small group.

1. Formal Evaluation

The formal methods suggested are outlined in **Table 6**.

Sample mark sheets have been prepared in the **Student Evaluation Summary** found in Appendix B.

TABLE 6: FORMAL EVALUATION

	First part of *SHR*		Second part of *SHR*	
Source of Mark	**%**	**Evaluated by:**	**%**	**Evaluated by:**
1. Knowledge Test (see Appendix C)	20	Teacher	20	Teacher
2. Product Assessment				
Action Plan Activity #26	–	–	10	Teacher
Learning Journals #15, 18	–	Teacher	10	Teacher
Student Manual	–	–	10	Teacher
3. Assessment of Class Participation				
Contributions to Whole Class	–	–	10	Teacher
Cooperative Skills in Groups**	5	Student/Teacher*	15	Student/Teacher*
TOTALS	**25**		**75**	**= 100%**

* Teacher can consult with each student to confirm/adjust the student's own evaluation, if appropriate.
** See **Evaluation of Cooperative Skills** and **Group and Cooperative Skills: Evaluation by Student**, Appendix B.

2. Criteria for Formal Evaluation

The criteria for formally evaluating the students are as follows:

a. Knowledge tests (see Appendix C)

Skills for Healthy Relationships Test #I

- true/false and short answer questions

Skills for Healthy Relationships Test #2

- multiple choice, rank ordering and short answer questions

b. Products assessment

Action Plan (Activity 26)

- completeness of task
- relevance of content
- legibility

Learning Journals (Activities 11, 13)

- personal reflections related to the class activity
- completeness
- legibility

Student Manual Activities Worksheets

- completeness
- legibility

Optional Section

- follow up activities suggested on p.41, p. 42

c. Class participation

Contributions to Whole Class

- arriving promptly for class
- being prepared for class
- paying attention and listening in class
- participating in class discussion
- being sensitive to others' feelings
- demonstrating ability to work independently

Skills Development (Group/Cooperative Skills, Assertiveness)

- listening actively
- disagreeing in an agreeable way
- criticizing ideas not the person expressing them
- summarizing for understanding
- encouraging others
- assertiveness

3. Informal Feedback

You will provide informal feedback to the peer leaders at least halfway through ***SHR*** and at the end. Group members will give each other feedback about the way they have worked within the group. (See **Feedback of Group Performance** form at the end of the **Student Manual**.) The peer leaders are asked to summarize the group member responses about how well the group functioned. In addition, each student will assess how he/she has performed the Cooperative Skills and worked in the group (see **My Group Skills/Performance** form at the end of the **Student Manual**).

TABLE 7: INFORMAL EVALUATION

	First part of *SHR*		Second part of *SHR*	
Feedback (Names of forms)	Form found in:	Feedback provided by:	Form found in:	Feedback provided by:
Feedback of Group Performance*	**Student Manual** at end	Each group member	–	–
My Group Skills/ Performance (Private)	–	–	**Student Manual** at end	Self
Feedback to Peer Leaders**	**Peer Leader Guide**	Teacher	**Peer Leader Guide**	Teacher

* Peer leaders will be asked to summarize feedback provided by group members.

** Peer leaders are also asked to assess their own skills/behaviours with an adapted version of your form (see **Peer Leader Guide** for their form called **Peer Leader Feedback to Self**).

An evaluation form to be used in assessing each student's development of Cooperative Skills is included in Appendix B.

H. BACKGROUND INFORMATION (Cultural)

1. Northern Cultures and Lifestyles

The background information on northern cultures and lifestyles provides the context for delivering ***SHR*** in northern communities. It explains the history and present socio-economic and psychosocial situation of Dene, Metis and Inuit of the Northwest Territories. In this section of the Teacher Manual, information will be presented on the following topics:

- Traditional Life of the Dene, Metis and Inuit
- The Importance of the Extended Family
- The Importance of Traditional Values - Past, Present and Future
- Traditional Medicine
- The Impact of Colonialism

a. Traditional Life of the Dene, Metis and Inuit

Traditionally, the Dene and Inuit lived off the land following a seasonal round of activities which maintained them economically, spiritually, socially and politically. The land, its animals, plants and waters provided food, medicine, clothing and shelter. The people lived in small hunting/trapping and fishing camps based on the extended family. Most activities were carried out under the guidance of a senior man who had expert skills in hunting and trapping, wisdom, and sometimes spiritual power. Decisions were made by consensus. Sharing and cooperation were necessary for survival and served as a major form of community solidarity. It was from service to family and community that men and women derived their sense of worth and pride. Every person was worth something, not only to himself, but to the entire community. At the time of European contact, the Dene and Inuit had well functioning social and political systems which included an understanding of how their world worked and how intertwined the human world was with the spiritual, animal and physical ones (Chance 1990; Ross 1992; Ryan 1994, 1995).

The Metis of the NWT are descended from three merging cultures - Red River Metis, Euro-Canadian and Dene (Koosel, Kritsch and Lennie 1992). The Metis lifestyle was closely patterned after their aboriginal ancestors, living off the land hunting, fishing and trapping. These bush skills combined with their knowledge of western technology and their ability to speak English and/or French, as well as an Aboriginal language, made them ideal interpreters, traders, guides and trading

post managers. They also played a major role in the transportation system of the western subarctic. With their mixed heritage, the Metis were equipped to operate in both worlds and succeeded in building and sustaining a unique way of life (Overvold 1976).

b. The Importance of the Extended Family

The extended family was, and remains today essential to the existence of most Dene, Inuit and Metis, both socially and economically. Traditionally, close kinship ties ensured that the group was protected from hunger or abandonment because relatives cared for each other by sharing resources and services. Among the Metis, marriages between families all throughout the Mackenzie region created an intricate network of kin who could be called upon for various needs. Traditionally, it was often close relatives who helped raise children and provided important guidance and teaching to young people at the time of puberty and throughout adolescence. Among the Inuit, a woman's first born child was often given to her parents. This allowed her to learn from her mother about how to raise a child. At the same time, the adoption provided her parents with a young child for them to care for once all of their own children were grown up. Although people now live in permanent communities, households often include at least two and sometimes three generations of close relatives (Koosel, Kritsch and Lennie 1992; Ryan 1994; Apak, personal communication 1995).

c. The Importance of Traditional Values - Past, Present and Future

Shared values and beliefs are at the heart of all cultures. In order for a culture to survive, it must pass on its values and beliefs to the next generation. All cultures change over time. Some change may be welcome, such as improved technology, that makes life easier for people. Other types of change may be forced, and result in the destruction of a culture, such as the loss of language and traditional means of subsistence. The Dene, Metis and Inuit of the Northwest Territories have experienced a great deal of social, economic and political change since the arrival of the first Europeans over two hundred years ago. Loss of their Aboriginal languages, traditions and means of subsistence have resulted in devastating psycho-social and economic consequences, threatening their very existence. However, in spite of these impacts, Dene, Metis and Inuit peoples have faced these challenges head on. Traditional values and beliefs are finding their place alongside modern technology and medicine and the global economy. Over the past decade, there has been a resurgence of interest in researching traditional values and beliefs. The relevance of traditional values and beliefs for education is widely recognized. In addition, the wisdom of the Elders is

increasingly being sought to help solve contemporary social, health, legal, economic and environmental problems.

The Dene Traditional Justice Project which was carried out in Wha Ti (Lac La Martre), NWT researched traditional Dogrib justice and values. Most of these values identified in the study are also shared by other Dene, Metis and Inuit cultures. They are presented below as outlined in the book Doing Things the Right Way, (Ryan 1995 pp.66-70).

Respect

In the past, one of the most important aspects of good relationships, good partnerships, and a good life was respect. Adults respected each other, younger people respected elders, children respected parents. Everyone respected the animal spirits, the group leaders and the medicine people. Respect was taught early and became expected behaviour. Respect is probably the primary value from which all others flowed because, without respect, the balance between people, the land, plants, animals, and spirits could not have been maintained.

Moral and Spiritual Beliefs

In traditional times, there was a deep sense of morality based on spiritual connections with the animal world and an understanding of how human and animal worlds met at a spiritual level to ensure the survival of both. There was a major tradition of "connectedness" with spiritual forces which helped maintain human life. It was a partnership in which people respected and appreciated their animal guardians. In return animals allowed themselves to be taken. As in most partnerships, this only continued if both partners acted "properly" - thus, the many rules on how to treat game.

Self-discipline

In traditional times, roles and responsibilities were clear and the majority of individuals were expected to behave properly. This required self-discipline. The underlying belief for these expectations was that if everyone did their own jobs properly, the group would survive and prosper. Otherwise, everyone was in danger.

Self-reliance

In traditional times, people took pride in their skills. They had the security of knowing that they could cope alone on the land if need be. Both men and women understood that they had strength and competency. They made great efforts to pass these skills and knowledge to their children.

Sharing

In traditional times, people shared. They shared "things" like meat and fish, but they also shared knowledge, feelings, perceptions, and expertise. They shared thoughts about important matters as they met to discuss when to move camp, where to go, and how to find the animals.

Knowledge and Understanding

In the past, the society worked well because people had a shared understanding of how the world worked. Young people were taught those beliefs by parents and grandparents and important knowledge was passed down from generation to generation. By the time young people reached puberty, they understood their place in the group, their responsibilities and their importance. They also clearly understood what might happen if they did not follow the rules and continue to respect the environment, the leaders, and themselves.

In addition to the traditional values outlined above, both the Dene curriculum Dene Kede (1993) and the Inuit curriculum Inuuqatigiit (1995) describe the traditional roles and expectations of men and women and how young girls and boys were taught their roles in life by the extended family.

d. Traditional Medicine

The Dene Traditional Medicine Project in Lac La Martre (see Ryan 1994) identified the important principles of the traditional medical system of the Dogrib people. Again, many of these principles outlined below are shared by the Inuit and to some extent by the Metis as well (Apak, personal communication 1995).

The traditional medical systems of the Dene and the Inuit were rooted in their understanding of the spiritual world and the ecological natural world. Plants and animal parts provided the ingredients for herbal remedies for a host of illnesses and conditions. Spiritual healing was used for serious illnesses and injuries that could not be cured by the average adult but needed curing done by a person with a "special gift". The land was protected by respect and reciprocity which were maintained by strong principles of stewardship. Because their world views were holistic, all

parts of the system were interrelated. Plants and animals were living things and if one used a plant or killed an animal for meat and medicine, it had to be done with respect, reciprocal exchange and spiritual acknowledgement. The natural world had to be cared for properly and any breach of the rules of stewardship, such as mistreatment of animals or not leaving a gift of certain plants (for the Dene) or not saying a prayer (for the Inuit) would result in serious consequences for both the individual and the community. For example, animals could refuse to be taken again and plants could refuse the use of their healing power (Ryan 1994; Apak, personal communication 1995).

In many ways, Western medicine is focused on disease rather than wellness. Illness in an individual is perceived as separate from his/her collective cultural context. There is little understanding that health and illness are directly connected to the way one perceives the world, defines illness and health, preserves life and handles death. By contrast, Dene and Inuit traditional medicine is focused on well-being which is not simply the absence of disease but is the result of balance between the individual, the group, the human, animal and spiritual worlds. Illness is caused by a lack of balance and harmony; it is a result of a breach of respect and reciprocity between people, plants and animals. It is a result of an individual's actions. When a person was sick, the whole camp assumed responsibility for dealing with a serious sickness or injury by helping collect and prepare medicine, by providing comfort and company, by supervising treatment and by calling on the persons with spiritual powers to heal if plant and animal remedies failed. Long before Western medical practitioners arrived, Dene and Inuit lived healthy lives on the land and used their land-based knowledge of plants and animal parts, along with their spiritual powers, to heal themselves (Ryan 1994).

e. The Impact of Colonialism

The contact period, beginning in the late 1700s for the Dene and in the 1800s for the Inuit, brought guns, the fur trade, the whaling industry and other trade items through the establishment of outposts by European traders and missionaries. By the 1920s, outposts had been established at key points across the Canadian north run by Europeans and, in the subarctic, supplied by the Metis. With few exceptions, each of these tiny settlements included one or two missionaries, traders, and a detachment of the Royal Canadian Mounted Police. In some areas residential schools were established, typically run by Catholic and Anglican missionaries. Children were often removed from their families for months and sometimes years and forced to learn a new language and culture. With the development of the fur trade in the NWT, the Indigenous economy

changed to one of cash plus subsistence, and resulted in fundamental changes in the trapping customs, mobility and the productive roles of men and women. Men dominated the cash economy, while both men and women continued to work within the subsistence economy. With the arrival of the Europeans also came unfamiliar diseases to which Indigenous peoples had little immunity. The resulting epidemics decimated large numbers of the northern population. Alcohol and tobacco were introduced along with nurses and doctors and prescription drugs. During the 1950's and 1960's many children and adults were sent south for treatment of tuberculosis. Often people never returned. Those who did, sometimes after an absence of several years, could no longer speak their language or function effectively in their own culture. Despite these changes, most Dene and Inuit continued to spend most of the year living in small, widely dispersed camps with seasonal visits to the mission/trading post settlements to acquire provisions and participate in religious activities. Traditional medicine continued to be used sometimes separately and sometimes in combination with Western medicine. Between the late 1940s and 1960s, depending on the region, mounting concerns over the need to provide better health care, education and other government services, led to further permanent settlement in communities and the imposition of federal government administration (Ryan 1994: Burch Jr. 1986).

With settlement in communities, loss of land and the arrival of more non-Indigenous peoples, traditional social, political, religious, medical and economic systems began to weaken further with the imposed ways of doing things. The importance of the collectivity, and the need for all individuals to contribute to the well-being of the group, to be governed by consensus and protected through harmonious balances, began to erode (Ryan 1994).

The imposition of more and more government services and the distribution of welfare payments created a dependency that served to undermine both individual and community control of the lives of the Dene and Inuit. Early childhood separation through residential schools or displacement to southern hospitals to receive medical treatment, meant that several generations of Indigenous people grew up not knowing their own language and cultural practices. This process of assimilation devalued Dene and Inuit cultural identities and their sense of pride and self worth. Some children in residential schools suffered physical or sexual abuse at the hands of those entrusted with their care. This resulted in enormous tolls of psychological damage, some- times setting the stage for continuing cycles of abuse in the lives of the victims that would continue for generations.

Long absences away from home also meant that many young people grew up without ever having experienced normal family life, including personal nurturing, positive role modelling, trust, positive self development and spiritual development. In addition, the separation of family members further undermined the traditional roles and strengths of the extended family -- in particular, connection to the land, and the skills required to maintain that fundamental relationship, provided Aboriginal peoples with economic, physical and spiritual sustenance, which was a vital part of their identity. When children were wrenched from their families and taken to residential schools, this sustaining connection was severed.

Young people often went from childhood to adulthood without having had the opportunity to pass through the important phase of adolescence. Traditionally, this was a time when training and guidance regarding the roles and expectations of men and women were provided by elders and other members of the extended family. With the breakdown of traditional support systems, many Dene and Inuit reached adulthood ill equipped to deal with interpersonal relationships and the challenges of parenthood (Isaac and Boulanger 1995; Apak, personal communication 1995).

The ultimate results of colonialism and an institutional upbringing are all too evident in contemporary Dene and Inuit society. After several generations, these impacts manifest themselves in such dysfunctional behaviour as alcoholism and other substance abuse, child neglect, spousal abuse, criminal activity, violence and suicide (Ryan 1994; Isaac and Boulanger 1995).

The Metis have experienced similar historical psychosocial factors owing to a lack of an economic base, a history of residential schooling, and generations of early familial separation. Additionally, Metis were de-valued by both non-aboriginals and status Indians for being different, and 'not belonging'. Health services were not provided for the Metis by the federal government as was the case for the Dene and Inuit. For many Metis, being part of the mainstream health care system had its consequences in non-existent health intervention. Currently, the host of social ills and the burden of ill health that shadow the lives of the Dene and Inuit also plague the Metis and are not dissimilar in their manifestation (Isaac and Boulanger 1995).

2. Developing a Culturally Appropriate *SHR* Program

This section suggests alternative approaches for the delivery of ***SHR*** by teachers in collaboration with different members of their communities. Information will be presented on the following topics:

- Taking Back Control
- Establishing a Community Advisory Committee (CAC)
- The Role of the CAC

a. Taking Back Control

How can the cycle of dependency and hopelessness be broken for Dene, Inuit and Metis peoples of the NWT? The solution lies in taking back control of health care delivery at the community level. While traditional medicine may not be able to deal with such major diseases as alcoholism, cancer, tuberculosis, AIDS and STD, Western medicine needs to acknowledge the important cultural aspects of health and illness. Preventive programs should be developed that involve local people in defining the health needs of their communities in cooperation with health care professionals.

Northern society today is constantly changing with the impact of technology and the influx of new ideas from elsewhere. Part of the process of cultural change involves the interaction of the old and the new ways. In the past, many Indigenous values and traditions were suppressed or disregarded under colonialism. Today, with the resurgence of cultural pride, these values and traditions are being re-examined and in some cases re-instated as guiding principles of social conduct in some Indigenous communities. While not all traditional values and practices will be considered appropriate in a modern context, it is important for students and their communities to evaluate which ones can be taken forward and built upon as a means to achieve the social and personal control necessary to adopt healthy lifestyles. If young people understand who they are and what their roles and responsibilities are in their community, they are more likely to have better self esteem and establish good relationships with other people, that will allow them to move into adulthood with pride and dignity.

In the next section we examine ways to involve the community in establishing a preventive AIDS and STD program through ***SHR*** that includes the integration of traditional and contemporary values into the learning experience of young Dene, Metis and Inuit.

b. Establishing a Community Advisory Committee (CAC)

Because AIDS, STD and sexuality are community issues, it is important for the school to establish strong links with the community. Positive learning can happen best when there is an educational partnership between the student's family, the community, educators and the school system. What is taught in the school has to be reinforced in the family and in the community, if the program is to be effective. No one partner can be expected to achieve all the objectives. Most teachers are not trained counsellors or health practitioners, nor are they usually from the community. Therefore, you must know what resources are available in your community to support students in learning about and in dealing with AIDS and STD. It is essential that students who require help can be immediately referred to the appropriate support people. Your school and community can best identify potential partners and their various roles and responsibilities in helping students to learn about AIDS, STD and sexuality in a culturally appropriate manner.

One way to establish a partnership among community members and agencies would be to create a Community Advisory Committee (CAC). CAC's have been very successful in a variety of community based research projects to document Dene traditional knowledge about the environment, medicine, government and justice (see Johnson and Ruttan 1993; Legat 1994; Ryan 1994, 1995). The role of the CAC's in these projects was to provide direction to the outside professional and local research staff and to ensure that the research was carried out in a culturally appropriate manner that met the needs of the community. The CAC also provided direct instruction to research staff about particular research topics in which they had special expertise (e.g., language and knowledge of local ecology or traditional medicine). Membership was dominated by Elders because of the historical/cultural focus of the research but it may also include representatives from other community interest groups (e.g., Hunters and Trappers Association, band/hamlet council) depending upon the nature of the study. Decisions are made by consensus and the CAC meets regularly with the research staff to monitor progress and provide ongoing support.

We suggest that a similar body could be created to help deliver the ***SHR*** program. It could be established jointly by the school and the local band council, hamlet office or Metis local and include as members parents, representatives from women's groups, drug and alcohol workers and the Community Health Representative (CHR). Elders should also be involved. In addition to their knowledge of traditional values and rules of conduct regarding health matters, their

participation on such a committee helps restore their traditional role as teachers and advisors. Through careful planning, a clear definition of each person's role, and the use of consensus decision making, a CAC could become a very effective medium in the promotion of community cooperation, support and autonomy in tackling important health care issues.

c. The Role of the CAC

How would a CAC operate in regards to the adaptation of the ***SHR*** program? Once the CAC is formed, the first step would be for you to inform the members about the objectives and the teaching approach of ***SHR*** and the types of information to be provided to students. The role of the CAC would be to provide you with direction regarding the teaching of particular topics. For instance, ***SHR*** promotes abstinence as an important form of responsible behaviour to prevent the spread of AIDS and STD. Suppose the CAC decided that while traditionally, the promotion of abstinence may have been the cultural norm for young people before they got married, in today's world it is not a realistic goal. Having decided this, the CAC's role would be to tell you how this topic should be approached with students. Another example would be ***SHR's*** promotion of assertiveness as an effective way to gain self- respect within the context of building healthy relationships. Among some groups, the word "assertiveness" might be associated with being pushy or aggressive, which might be considered inappropriate behaviour, especially for young women. "Respect for oneself and others" might be a more appropriate term to use. Once again, it would be up to the CAC to provide you with direction on how to deal with this topic.

The CAC might also decide that there are alternative ways to learn about AIDS, STD and sexuality other than the approaches suggested in ***SHR***. For example, the use of traditional learning circles of Elders and other members of the community might replace the use of Peer Leaders and the participation of only Parents/Guardians in the program. In addition, the CAC might decide that individuals within their community are best suited to deliver some parts of the program given their technical knowledge of a subject combined with their in-depth knowledge of the community and its values. For example, drug and alcohol workers could focus on how the use of alcohol and other types of substance abuse affect all aspects of a person's wellbeing, and in particular, impair a person's ability to think clearly and make responsible decisions regarding the practice of safer sex. Depending upon their experience and comfort level, the CHR might be included in the delivery of some of the background information about AIDS and STD, strategies for their prevention and details about support services available within and outside the community. Perhaps a social worker or a member of a women's support group could talk to

students about physical and sexual assault. Elders might want to talk to students about traditional values and concepts of health and wellbeing.

One of the key roles of the CAC would be to decide how the traditional values outlined earlier could be incorporated into a modern value system for the community that promotes harmonious physical, mental, emotional and spiritual wellbeing. For instance, how could traditional values about sharing, respect and caring for all members of the community be extended to include people who are gay, lesbian and bisexual. Likewise how could the community support people who have or are caring for people with HIV/AIDS How could traditional values about self-reliance, self-discipline and respect for oneself and others be made relevant again in a way that would allow young people to feel good about themselves and voluntarily form healthy relationships and practice safer sex. By the same token, are there traditional beliefs and practices that inhibit gender equality and respect and tolerance for different lifestyles that need to be re-examined in light of more contemporary community values? By including both men and women of different ages, educational backgrounds and interests, it is more likely that both traditional and modern values will be debated and evaluated in a productive manner.

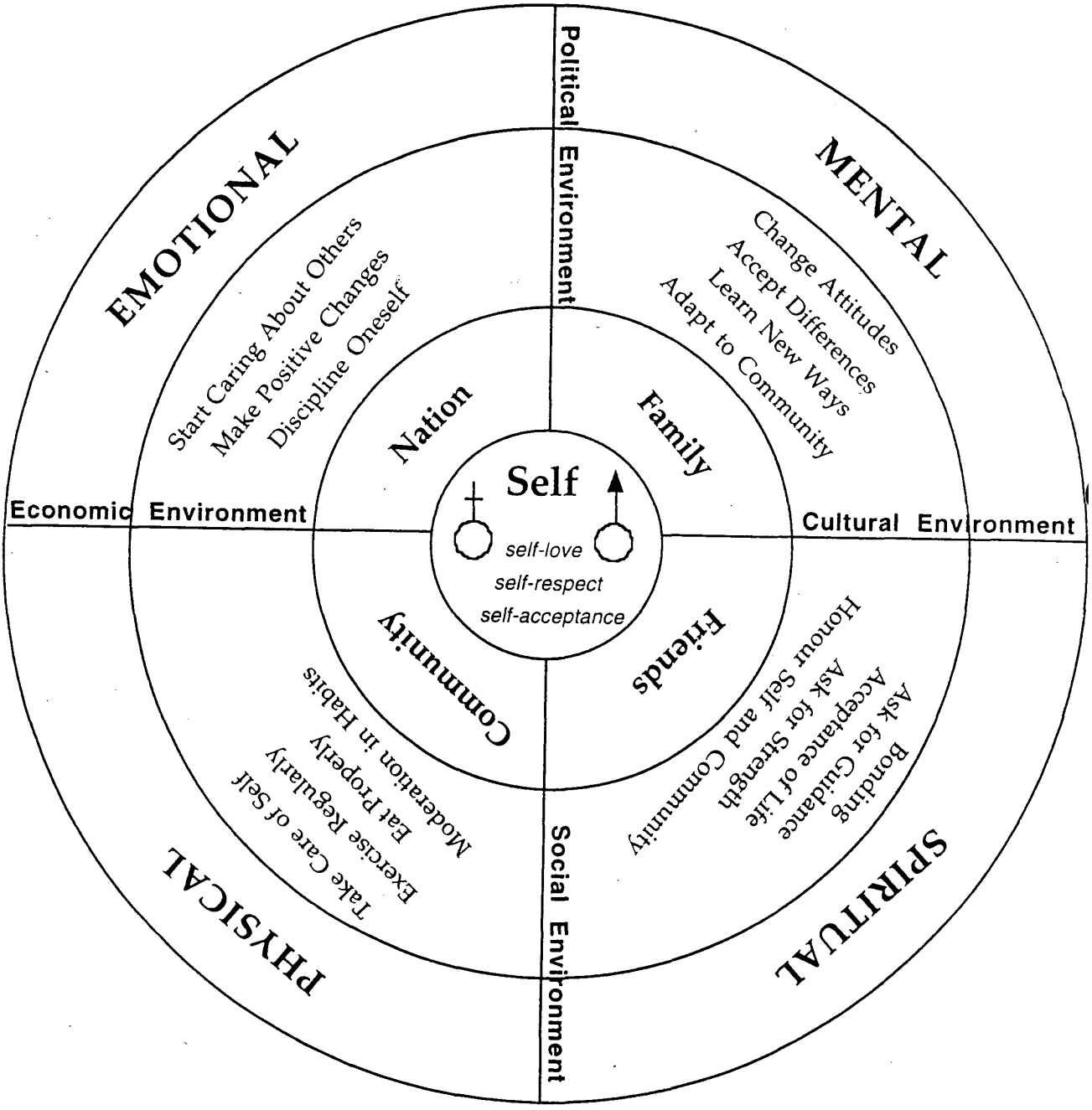
As a teacher, your role will be to facilitate your students' learning about AIDS, STD and sexuality and assist them in making healthy choices regarding these issues. We hope that by working with a CAC you will find direction in delivering ***SHR*** and that individual members will contribute to the students' learning. Finally, we hope that by taking a community-based approach to health care, you will promote self-responsibility and self- determination in your community.

3. A Conceptual Model for *SHR* in the Northwest Territories

This section presents a conceptual model based on the perceptions of the different Indigenous cultures of the Northwest Territories. It is meant to support the foregoing disussion. It is not meant to replace but to complement the model presented in section A3.

Figure 2:

Conceptual Model for SHR in the Northwest Territories



a. Framework

Indigenous peoples are currently involved in a resurgence of holistic health care. Many indigenous professionals, including health workers, social workers, physicians, educators, therapists and community developers espouse what has been shared with them by traditional teachers and healers. The Medicine Wheel or Circle of Life Program presents a healing approach for the individual, family, community and nation in relation to the spiritual, emotional, physical and mental (intellectual) aspects of human existence within the context of the cultural, social, economic and political environments (Isaac and Boulanger 1995).

The basic framework of the Medicine Wheel includes the following:

- The spiritual essence is located in the east part of the wheel, and represents the part of self which is connected to all things. It is the primary inner vision or awareness of this unity that makes it the place of beginnings or infancy and the spring season. The east is also the direction for learning about sharing and love. The east spiritual direction is related to the cultural environment (spring season, yellow race).

- The emotional aspect located in the south of the circle is that part of self which is all trusting, feeling and discovery, and which is connected to youth. This is the place of learning about honesty and trusting. It has a direct relation to the social environment (summer season, red race for Native peoples).

- The physical aspect represented in the west encourages nurturance of the body and environment, and looking within. The cycle of life and death is acknowledged here, and is symbolic of endings and new beginnings. It is the place of adult stages and relates to economic environments (autumn season, black race).

- The mental aspect (intellectual) is represented by the northern part of the circle. It is symbolized by the seeking of knowledge, understanding and wisdom, and the translation of this into action. This is the place of the elder and compassion, and the political environment. (winter season, white race).

This model for healing is humanistic and person centred. It extends beyond the parameters of physical ill health to include socioeconomic, psychosocial and spiritual issues. The Medicine Wheel is appealing in its nonhierarchical, nonintrusive, community based features that encourage experiential processes of self-responsibility and self-determination (Isaac and Boulanger 1995).

While the Medicine Wheel is commonly associated with First Nations Peoples, its humanistic and holistic approach, makes it appealing to both Indigenous and non-Indigenous peoples of the NWT, seeking alternative health care models. For this reason, it forms the basis of a conceptual model for the northern ***SHR*** program. Other components of the ***SHR*** model are adapted from **A Conceptual Framework for Reproductive Health Promotion** (Central East Region Reproductive Health Network: 1993) and the **Medicine Wheel** (B.C. First Nations AIDS Society: 1994).The framework for the model is healthy living and communities in balance. This is achieved through the promotion of spiritual, emotional, physical and mental wellbeing. The concept of self is central to the framework. This includes all people who are heterosexual, gay, lesbian and bisexual. Each person interacts with family, friends, community and the nation. All of these groups and collectives have an impact on how a person feels about herself/himself and how they behave towards others. Communities in balance keep the circle strong by working together, caring, supporting and healing all members. Critical to the framework is the utilization of different health promotion strategies within each of the four aspects of healthy living. New strategies that evolve with time may be incorporated into the framework. Strategies can be implemented by individuals, families, communities and nations depending on need. Finally, the cultural, social, economic and political environments impact on all aspects of health promotion and the choices people make.

I. BACKGROUND INFORMATION (HIV, AIDS and STDs)

The material in this section was current at the time of printing. However, as research and data collection are ongoing, information on HIV/AIDS is continually being revised. For up-to-date information about HIV/AIDS, STDs and HIV antibody testing, contact your local Health Centre, doctor's office, or the Department of Health and Social Services.

The following web sites are also sources of accurate and up-to-date information and statistics:

- ***Canadian AIDS Society: www.cdnaids.ca/***
- ***Laboratory Centre for Disease Control, Health Canada: www.hc-sc.gc.ca/hpb/lcdc/bah/epi/epi_e.html***
- ***The University of Alberta Health Centre has a "Health Information Page" on the web, at: www.ualberta.ca/~jhancock/HealthEd.html It offers interactive programs on relevant subjects, and has the following titles available for downloading to your computer: "AIDS in Canada" and "Itchin', Burnin', and Squirmin': STDs and You".***

Increasingly, public health departments and community-based agencies are working to integrate their HIV/AIDS and STD strategies more effectively. Although there are some differences, most safer sex advice for preventing HIV is equally effective in preventing other sexually transmitted infections (Canadian AIDS Society 1994).

The background information on HIV/AIDS and other STDs provides the basis for Unit 1 to be taught by means of video, teacher presentations, information sheets, overhead transparencies and tests. In this section of the **Teacher Resource Book,** information will be presented on the following topics:

- Definitions
- Incidence
- Transmission
- Prevention
- Symptoms
- Testing
- Sources of Help

1. Definitions

HIV and AIDS are part of the same condition, but AIDS is a later stage.

a. What is HIV?

HIV stands for Human Immunodeficiency Virus. HIV causes AIDS. There are many strains of HIV because the virus continually changes. Blood tests can detect the presence of antibodies to HIV. Once a person is infected with HIV, they are infected for life.

HIV slowly destroys a person's immune system. The average time from infection with HIV to the development of AIDS is 11 years. Experience to date shows that everyone who is HIV-infected develops AIDS and eventually dies.

b. What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome

Acquired	-	HIV is passed from person to person
Immune	-	relating to the body's immune system, which provides protection from disease-causing organisms or pathogens
Deficiency	-	lack of response by the immune system to disease-causing organisms; a weakened ability to fight infections
Syndrome	-	a group of symptoms and signs occurring together indicating that a person has a particular disease or condition

AIDS is a condition caused by HIV that attacks and, over time, destroy the body's immune system. A person has AIDS when the virus has done enough damage to the immune system to allow severe infections and cancers to develop. At present, there is still no cure for AIDS.

c. HIV and the body's immune system

HIV damages the body's immune system by destroying helper T-cells. These are the cells that alert the body to the presence of an infection. With the loss of helper T-cells, the immune system, not informed of the infection, does not respond. Infections, known as "opportunistic infections" develop. The most common illnesses that northerners living with AIDS get are Tuberculosis, and Pneumocystis Carinii Pneumonia (PCP), a type of pneumonia. Kaposi's sarcoma (KS), a type of skin cancer, is found less frequently in northerners.

Another way to think about the role of helper T-cells is to imagine the body as a castle, with defending armies inside (the immune system), attacking armies outside (infections), and sentries watching the castle walls. These sentries are the helper T-cells. A spy (HIV) comes into the castle and destroys all the sentries (helper T-cells) of the defending armies. No sentries are left to warn the defending armies when infections attack. The defending armies are not alerted to the invasion and the immune system is overwhelmed by the attackers. (See Supplementary Overhead Activity 1 in the Teaching Guide).

d. What are antibodies?

The body's immune system develops antibodies in response to foreign organisms. Usually, the antibodies to a particular organism strengthen the immune system against another attack by that organism. However, the antibodies developed by the immune system in response to HIV or most STD-causing organisms **do not assist** in defending the body against a future attack by these organisms. The antibodies remain in the blood and can be detected by the HIV antibody test (the ELISA test).

To tell if a person is infected with HIV, a nurse or doctor can take a blood test, maintaining confidentiality, after the person agrees or consents to this. The test detects antibodies to HIV. It takes between six weeks and six months for the immune system to produce antibodies after a person has been exposed to HIV. Refer to the section on *Women, Children and HIV/AIDS* for more information on the testing of babies born to HIV-infected mothers.

If a test is NEGATIVE, it means:

- You are not infected with HIV; or,
- You are infected, but your body has not yet had time to produce enough antibody to make the test positive (this is the window period--the virus, as yet undetected, is still present and can

be passed to others).

If a test is POSITIVE, it means:

- You are infected with HIV and can pass the virus on to others.

e. The Stages of HIV Infection

(from "Finding Out: What You Need To Know", Correctional Service Canada)

HIV infection starts off without any signs of being sick. Slowly the immune system breaks down and the person starts to get mild signs of infection (like swollen glands, night sweats). Later the immune system becomes weaker and the person gets illnesses and becomes sick. The longer someone has HIV, the more likely he or she will get diseases. There are 3 stages to HIV infection:

1) living with HIV (the virus);
2) getting signs of having HIV illness; and
3) having AIDS

These stages might not happen the same way for everyone who has HIV. Some recently infected persons may first present with acute illness, a pattern which has appeared often in HIV-infected persons in the Northwest Territories. They have fever, sweats, swelling of lymph glands and other symptoms within weeks of becoming infected with HIV. The symptoms usually go away within three to six weeks. The person still has HIV and can infect others.

Stage 1

HIV slowly breaks down your immune system. A person can look and feel very healthy for many years and not know that he or she is infected with HIV. They may have no signs of having the virus (except in a blood test). This stage is called "symptom-free HIV infection" or "asymptomatic", and may last ten years on average. If the person has not had an HIV antibody test, s/he will not know about the infection.

Stage 2

Over time, HIV will make the immune system weaker. This stage is called "mild to moderate HIV infection", which means that a person will get diseases which s/he can get over and will feel better again. However, it will take longer for a person to get over infections or illnesses than it used to. HIV infection may present in many ways. People who have this stage of

HIV infection may have:

- sores or infections on the lips or inside the mouth;
- "thrush" (yeast infections covering areas inside the mouth and throat or on the tongue);
- Candida (yeast infections in the vagina) or P.I.D.s (pelvic inflammatory diseases);
- swollen lymph glands (under the arms, behind the neck, in the crotch or groin area);
- diarrhea, on and off for many weeks;
- skin sores and rashes anywhere on the body;
- herpes (if a person already had herpes before becoming infected with HIV, the herpes will show up more often than usual on the genitals (penis or vagina) or lips;
- feelings of extreme tiredness and weakness all the time;
- "low-grade" fever (feeling feverish for many days or weeks);
- occasional night sweats (soaking the whole bed);
- significant weight loss without dieting (loss of more than 10 pounds).

Some of the above symptoms are also found with other, less serious infections. If a person is concerned, s/he should see the community health nurse or a doctor.

Stage 3

When the immune system is very weak, a person gets AIDS and may show some of the following "opportunistic diseases" often seen in AIDS:

- Kaposi's Sarcoma (KS, a cancer usually of the skin; found mainly in men who have sex with men, although both HIV-infected men and women in the NWT have developed KS);
- PCP (a lung infection, pneumonia);
  Candida of the esophagus (yeast infections at the bottom of the throat near the stomach);
- cancer of the cervix, in women;
- "wasting" (losing a lot of weight);
- dementia and infections of the brain (problems with thinking and remembering);
- tuberculosis (TB).

With time and medication, a person can get over some of the serious illnesses and feel relatively well again. Medications are available to stop or help slow the progression of some of these diseases. Today, people with AIDS are living longer than people who had AIDS several years ago.

f. Women, Children and HIV/AIDS

Although men and women tend to have similar signs of HIV illness, women have some which are not found in men. HIV-infected women may notice changes in their menstrual periods (they may become very painful and/or irregular); pelvic inflammatory disease which can include unusual discharge from the vagina, pain during sex, bleeding between periods, and fever; hormonal changes (hot flashes and certain kinds of vaginal infections); and vaginal yeast infections which can become persistent. Northern HIV-infected women have also exhibited lung infections, particularly Tuberculosis and Pneumocystic Carinii Pneumonia (PCP).

Instances of AIDS in children (younger than fifteen years) make up 1.1 % of the total number of cases of AIDS reported in Canada, (figure adjusted for reporting delay; Laboratory Centre for Disease Control, 1998). Most of these children were born to mothers who were HIV-infected. The remainder were infected through the transfusion of blood or blood products before November 1985. In the Northwest Territories, two children have been infected near the time of their birth.

All babies born to HIV-infected mothers will test positive for the HIV antibody for months after they are born. This does not mean that they are all infected with HIV. Rather, the mothers's antibodies are passed on to the baby through the umbilical cord. Gradually, these antibodies will go away. Twenty to thirty percent of babies born to mothers with HIV also become infected. These babies develop their own antibodies to HIV and will continue to test positive. Babies born to HIV-positive mothers are tested often, until they are eighteen months to two years of age. A recent American study involving HIV-infected pregnant women showed that the transmission of HIV was reduced from 25% to 8%, in those women who took the drug ZDV (Connor et al, 1994).

The most common symptoms of HIV infection in children are: failure to grow at a normal rate; weight loss; many ear or nose infections; diarrhea; bloated abdomen from a large liver or spleen; swelling of the lymph glands; thrush in the mouth; or pneumonia. The disease often progresses

more rapidly in children with AIDS, than in adults with AIDS. (Building Bridges to Healthy Relationships, GNWT Dept. of Health and Social Services, 1996)

g. What are STDs?

STD stands for sexually transmitted disease. STDs used to be known as venereal diseases. More than 20 different STDs, including HIV, have been identified. Gonorrhea and chlamydia are the most common STDs among adolescents and young adults living in the NWT. Less common STDs include genital warts, genital herpes, pubic lice (crabs), and syphilis.

STDs are caused by viruses, bacteria, fungi and parasites. Viruses cause several STDs. HIV, genital warts, Hepatitis B and genital herpes are caused by viruses. Bacteria cause the following STDs: gonorrhea, chlamydia and syphilis. Scabies and pubic lice are parasites.

Certain STD infections, if not treated soon enough, can lead to long-lasting health problems in both males and females. For example, complications of chlamydia and/or gonorrhea may produce pelvic inflammatory disease (PID), tubal pregnancy, and permanent infertility in both males and females. Women who develop cancer of the cervix often have genital warts. Generally, the health problems associated with STDs are more serious for females. For a concise overview of these diseases, including symptoms, complications and treatments see the following chart, "Comparing Sexually Transmitted Diseases", adapted with permission from Health News, October 1992, University of Toronto.

Comparing Sexually Transmitted Diseases — Table 8

DISEASE	SYMPTOMS & OUTLOOK	COMPLICATIONS	DIAGNOSIS & TREATMENT
Chlamydia Bacterial infection--very common, in teens. 50-80% go without symptoms. Spreads via anal, vaginal or oral sex with infected partners. Often occurs together with gonorrhea.	Symptoms (if any) include painful urination, vaginal or penile discharge, abdominal pain, genital itching. But often mild, unnoticed in carriers, can disappear without treatment.	In women, leading cause of pelvic inflammatory disease (PID), ectopic pregnancy, infertility. In men, can produce urinary tract diseases and prostatitis. Babies of infected mothers prone to eye infections, pneumonia.	Diagnosed by culture or other tests. Antibiotic treatment a reliable cure (if caught early).
Gonorrhea (the "clap") Bacterial infection transmitted by oral, vaginal or anal sex. Prevalent In young women, teens. Untreated, can result in PID and infertility. Up to 50% of women and men have no symptoms.	Symptoms (if any) within 7 days of contact: painful urination, thick vaginal or penile discharge, bleeding between periods, sore throat (if contracted via oral sex), rectal pain or discharge (if contracted through anal sex).	May lead to tubal scarring, PID, ectopic pregnancy (outside womb, dangerous for mother.) Can cause permanent sterility in both sexes. Eye infection and possible blindness in infected newborns.	Diagnosed by smear and lab culture. Antibiotics a reliable cure but some strains now resistant to standard antibiotics (eg. penicillin) so require *cefixime, ceftriaxone* or other new drugs.
Genital Warts (Condylomata) Caused by human papilloma virus (HPV). Highly contagious, spread by intimate bodily contact, especially sexual activity. Often accompanies other STDs.	Warts--tiny flat growths on and around genitals--usually itchy, pinkish, flat, irregularly surfaced, may increase in size. Often undetectable in woman in vagina or on cervix, except by physician.	Certain HPV strains linked to cervical cancer in women (and possibly penile cancer in men). Infants born to mothers with HPV may develop warts	Removal advised--chemically, by freezing or with lasers. Women should have regular Pap smears to detect HPV infection and early cervical cancer changes.
Hepatitis B Virus passed on via blood, semen, vaginal secretions, saliva, needles, razors, toothbrushes. Can go from mother to infant at birth. Groups most at risk: those practicing anal sex, those with many partners, injection drug users, babies of infected mothers.	Usually subclinical with few or no symptoms. Possibly flu-like malaise, fever, fatigue typically lasting 6 weeks, perhaps jaundice/skin and eye-white yellowing. May linger in body unnoticed.	50-90% of infected children and 10% infected as adults become lifelong carriers, at risk of cirrhosis and liver cancer. Unsuspecting carriers can infect others. Fulminant, rapidly fatal form in one per 100 cases.	Detected by blood tests for viral markers. No cure. *Effective* safe universal vaccine program recommended for all at risk--especially healthcare workers and those living with or close to known hepatitis B carriers.
Herpes Viral infection due to Herpes virus types I or II. Spreads via oral, vaginal or anal sex, kissing. Can spread silently, via asymptomatic people. Most easily transmitted by direct contact with active sores or genital secretions.	Symptoms within 10 days; slight fever, tingling, shooting pains, swollen lymph glands, then painful blisters, anywhere on genitals--mainly penis, vulva or anal areas. Subsides without treatment, but can recur. First outbreak usually worst, but sometimes unnoticed.	Virus remains permanently in nerves, stays dormant for months or years. Newborns may get herpes during birth, resulting in central nervous system damage or death. Caesarian delivery may be advised for babies of infected mothers.	Diagnosis for blisters (scraping or culture) *Acyclovir* tablets, not a cure, ease symptoms and reduce length of attack and its severity. Herpes support groups helpful in combatting psychological problems.
Syphilis (the "pox") Spirochete infection. Curable in early stages. Affects mainly those in their 20s. Transmitted by oral, genital, anal contact. After a decline, case numbers rising again in North America, mainly related to drug use or "exchange of sex for drugs"	Painless sore (chancre) appears 3-6 weeks after infection on genitals, mouth or rectal area, most obvious in men, hardly noticed in vagina. Heals without scarring. About 4-10 weeks later, 2nd stage: fever, rash, which disappears but may reappear.	If untreated, chronic, occasionally fatal. Third stage appears up to 30 years later with brain and spinal cord damage, blindness, insanity. Untreated can cause miscarriage and birth defects; infants of infected mother may be born with syphilis (congenital)	Even if no symptoms, can diagnose by simple blood test; test results usually positive by time chancre (ulcer) appears. Antibiotics, taken as prescribed, a dependable cure in early stages.
Trichomonas Protozoal infection; most frequent in those with many sex partners; often accompanies other STDs.	For symptoms; possibly irritated, tender vulva; burning on urination, perhaps copious, possibly foul-smelling yellowish green, frothy, foamy, discharge.	Frequent "ping-pong" reinfection of sex partners. Both need treatment.	Swab/slide examination may reveal twitchy-tailed organisms. Treatment is oral *metronidazole* (Flagyl)--also for sex partner(s). During pregnancy, use *clotriamazole* instead.

2. Incidence

a. Reported cases of HIV infection, AIDS and other STDs

It is possible to have HIV and other organisms that cause STDs in the body without having any symptoms of AIDS or other diseases.

- HIV may be present in body cells for an undetermined number of years before it begins to damage the immune system.

- Medical experts indicate that about 50 percent of people with STDs do not have any symptoms. Women in particular often do not have symptoms for some STDs.

i. Worldwide:

Statistics from the World Health Organization (as of March 1998)

• Total number of people worldwide, newly infected with HIV in 1997:	5.8 million
• Number of people living with HIV/AIDS:	30.6 million
• Number of AIDS deaths in 1997:	2.3 million
• Total number of AIDS deaths since beginning of epidemic:	11.7 million
• Total number of AIDS orphans since beginning of epidemic:	8.2 million

ii. HIV/AIDS in Canada

Year	# of Positive HIV Tests
1997	1,966 (all provinces and territories except Quebec, for which data not available)
1996	2,838 (all provinces and territories)
1995	3, 070 "
1985-1994	33, 175 "

iii. High Numbers of Current HIV Infections Not Diagnosed

A total of approximately 39,000 Canadians had tested positive for HIV up to the end of 1996. An estimated 13,000-15,000 individuals of this total have died of AIDS, to the end of 1996 (adjusted for reporting delay and under-reporting). *At the end of 1996 there was an estimated 11, 000-17,000 Canadians living with HIV infection, who were not aware that they were HIV positive.*

iv. Positive HIV Test Reports by Exposure Categories

Percentages of all Positive HIV Test Reports by Exposure Categories

(Rows do not add up to 100% since categories are not mutually exclusive. All provinces and territories except for Quebec (data unavailable)

Year	Female	Injection Drug Use (IDU)	Men Who Have Sex With Men (MSM)	Heterosexual
1997	21.8	33.2	37.6	21.8
1996	21.7	30.7	39.9	18.4
1995	19.6	26.9	44.0	16.2
1985-1994	9.8	8.4	74.6	7.4

v. Identified AIDS Cases

A cumulative total of 15,528 AIDS cases in Canada were diagnosed before Dec. 31, 1997. Adjusting the number of case reports for delays in reporting AIDS to the Laboratory Centre for Disease Control, Health Canada (LCDC), the total number of AIDS cases in Canada is estimated to be approximately 20,000. Of these, 170 of the reports of AIDS were in children (under the age of 15). There were 11,373 AIDS-related death reports, and this figure also, is likely an underestimate due to reporting delays and underreporting.

vi. AIDS Among Aboriginal Populations

Of the 15, 528 AIDS cases reported, 255 were indicated as Aboriginal. Adjusting for reporting delay, the number of Aboriginal AIDS cases was estimated at 332 by the end of 1997.

vii. Decline in AIDS Cases

The overall trend in the reported number of AIDS cases continues a decline that first began in 1994. In comparison to 1996, there was a 54.1 % decrease in the number of reported AIDS cases

in 1997. The decrease in the number of reports of new AIDS cases may be due to a few reasons: improved antiretroviral treatments and drug preventive medicines that delay the onset of the syndrome of disease symptoms which defines AIDS; and also to decreased reporting by physicians and health care workers.

Although reports of AIDS cases are declining, primarily due to treatments, the HIV epidemics in Canada continue, and are affecting new populations, primarily women and intervenus drug users.

viii. AIDS in Females:

The proportion of reports of AIDS in females has been on the rise for the past seven years. In 1997, female cases reached the highest level for that category since monitoring of the epidemic began; reports of AIDS in females made up 14.1% of annual AIDS diagnoses in Canada.

b. HIV/AIDS and STDs in the Northwest Territories

In the Northwest Territories, the first HIV infections were identified in 1987. Since then, an average of 3-4 new cases per year have been reported. As of December 31, 1997, a total of 31 cases of HIV infection had been reported.

The age profile at which HIV has been diagnosed:

Age Range	0-9	10-14	15-19	20-29	30-39	40-49	50-59	60+
# of HIV Infections	2	0	0	7	12	8	1	1

The two young children noted in the 0-9 age range above, appear to have been infected through their mothers around the time of birth.

Because AIDS has an average 10 year incubation period, the fact that no infections have been seen in persons ages 10-19, does not mean that there are none there.

The Northwest Territories Department of Health and Social Services reports that the actual number of cases of HIV infection is probably higher than the number of reported cases.

i. Status of NWT AIDS Cases (as of dune, 1998)

- Deaths: There have been 13 AIDS-related deaths to date in the NWT.
- 8 NWT residents are presently living with AIDS.
- 11 persons known to have had AIDS in the NWT, are listed as `lost to follow-up', which usually means that they have moved out of the Territories.

ii. STDs in Children in the NWT

	1992	*1993*	*1994*	*1995*	*1996*	*1997*
Gonorrhea	2	4	0	1	0	0
Chlamydia	4	5	14	22	15	5

iii. STDs in Teens in the NWT (13-19 yrs.)

(% of total in brackets)	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*
Gonnorrhea	74 (27%)	41 (22%)	43 (30%)	36 (27%)	23 (19%)	17 (11%)
Chlamydia	297 (32%)	375 (39%)	342 (34%)	323 (35%)	311 (35%)	323 (31%)

iv. Births to Teens in the NWT

1992	*1993*	*1994*
232 (15.4%)	247 (17%)	239 (16%)

v. Patterns of Transmission of HIV/AIDS

The transmission pattern of the HIV/AIDS pandemic varies in different areas of the world. The transmission pattern for HIV in African countries is predominantly among heterosexuals. For much of the 1980s the transmission pattern for HIV in western European and North American countries was among homosexually active men and injection drug users. *Heterosexual transmission is a common risk factor in the reported cases of HIV infection in the Northwest Territories.*

The transmission pattern of the HIV epidemic is changing in Canada as well as in other countries. HIV transmission from male to female is more efficient than originally believed. Heterosexual transmission in the United States showed a 44 percent increase from 1990 to 1992. Today, in

some areas of North America, the percentage of increase in reported cases of HIV infection has been greatest among young women. STD clinics in Miami, Florida report that the HIV infection rate among 15-19 year olds is increasing at a rate of seven percent per year. There are experts who believe that in North America the rate of HIV infection will approach the Third World 1:1 male to female ratio. The greatest increases in cases are likely to occur in populations that are socially and economically disadvantaged.

Canadian AIDS and HIV research studies and surveillance activities throughout Canada indicate that there is a recent increase in three risk categories: men who have sex with men, injection drug users and 'other'. The 'other' category includes heterosexuals and those with no identified risk, and excludes blood and blood products.

c. Other STD in Canada

Sexually transmitted diseases are a serious health problem among young people in Canada. Before 1980, the rate of gonorrhea cases in Canada was highest in adult males. Health Canada currently states that the highest rate of reported cases of gonorrhea in Canada is now among 15 - to 19-year-old females. While the rate of gonorrhea in adult males has been decreasing, it has been increasing in young adult males and in young females. In fact, not only do 15- to 19-year-old females have the highest rate of gonorrhea in Canada, they also have the highest rate of overall STD infection. In those provinces where chlamydia cases are reported, there are an even greater number of chlamydia cases than of gonorrhea among 15- to 19-year-old females.

Many people do not know they have an STD such as chlamydia or gonorrhea, because they do not have any symptoms or the symptoms disappear quickly. These people do not go to a doctor or health clinic for help and these cases are never reported. Thus, the number of reported cases of chlamydia and gonorrhea does not indicate the true number of infected people.

3. Transmission

a. Transmission of HIV

To cause infection, HIV has to enter the bloodstream. It is introduced into the bloodstream in semen, or vaginal fluids, blood or blood products. Other body fluids such as the mucus and saliva of an infected person contain the virus, but not in large enough concentrations to cause infection in another person.

The virus is transmitted from person to person

- during unprotected sexual intercourse with an infected person;
- through the sharing of contaminated needles, syringes and other contaminated

instruments;

- during pregnancy and birth, and possibly breastfeeding, if the mother is infected.

- in infected blood, blood products or body tissue and organs introduced into the body by transfusion and donation.

The following information briefly explains the four ways HIV is most commonly spread from one person to another. A discussion of how other STD-causing organisms are spread follows.

i. Unprotected anal or vaginal sexual intercourse with an infected person
is the most common means by which HIV is transmitted in Canada. In 1991 James Chin of the World Health Organization estimated that two thirds of the PLWAs (People Living With AIDS) in the world acquired the disease through vaginal sex. Anal sex accounted for a substantial proportion of the remaining cases.

How sexual intercourse can transmit the virus
During heterosexual and homosexual anal intercourse and during vaginal sexual intercourse. HIV in the semen or vaginal fluid can enter the bloodstream of an uninfected person through broken or damaged skin/tissue or directly infect immune cells in vaginal walls; the penis or the large intestine. The reason that anal intercourse is extremely high risk is that the tissue of the rectal walls is very susceptible to abrasion and infection. HIV can enter the bloodstream of an uninfected person through tears in the mucous membrane of the rectum.

ii. Contaminated needles/syringes
HIV-contaminated needles or syringes can transmit the virus directly into the bloodstream. HIV is spread by infected blood in shared needles and syringes. (Hepatitis B, can be spread the same way.)

How contaminated needles can transmit the virus
A small amount of infected blood in an improperly cleaned needle or syringe enters the bloodstream of the person who next uses the needle or syringe. For example, people have been infected by

- **Drug-injection needles**
  Injection-drug users (including steroids) who share drug-injection needles and syringes are most at risk of being infected in this way. This is the second most common means of transmission of HIV in Canada.

- **Other needles/instruments**

  Contaminated needles used for tattooing, ear piercing or ceremonial blood bonding, and contaminated razors can theoretically spread HIV and Hepatitis B and C.

  NOTE: In Canada, there is no danger of infection from blood donation. The needles used when blood is donated are sterilized or new.

iii. Infected blood or blood products

In the past, some people became infected from transfusions of blood or blood products. In Canada (as of November, 1985), the United States and Western European countries, all blood and blood products used in transfusions are screened for HIV and Hepatitis B antibodies before use. Today, there is a minimal risk of contracting HIV through transfusions.

iv. Mother to child transmission

Some research has indicated that 20 to 30 percent of mothers infected with HIV, in turn infect their babies. A recent American study involving HIV-infected pregnant women show that the rate of HIV was reduced from 25% to 8% in those women who took the drug ZDV (Connor et al 1994, 1173). Most children born to HIV infected mothers will not be infected. HIV can move from the blood or secretions of the infected mother to the blood of the child during pregnancy or childbirth, or through breastfeeding. The child, born infected, may develop AIDS and will carry the HIV throughout his/her lifetime.

b. Transmission of other STD-causing organisms

The virus, bacteria, fungi and parasites which cause other STD are also spread when infected semen, vaginal fluids or blood enters the bloodstream or comes into contact with mucous membranes. Under most circumstances they will not be spread by:

- sneezing, coughing or spitting;
- hugging or holding hands;
- swear, tears, urine or bowel movements;
- dishes, eating utensils or food;
- insects or animal bites;
- using toilets, sinks, bathtubs, swimming pools, telephones or water fountains;
- using someone else's comb or make-up; or,

- being near an infected person in school or other places

Kissing is not listed. Hepatitis B can be spread through infected saliva. Open sores or blisters may indicate a sexually transmitted disease. They harbour the infection-causing organism which can be transmitted from the sore to another person. A person with herpes and open sores or blisters in or around the mouth can spread the virus by kissing someone who also has open mouth sores. This is similar to the way a cold sore may be passed from one person to another.

Pubic lice and scabies may be transmitted on towels, bed linen and clothing. These parasites, which live on the skin, can also be transmitted sexually.

4. Prevention

People with healthy self-esteem respect themselves and avoid behaviours that put themselves and others at risk. HIV and other STD are transmitted primarily by certain sexual behaviours and needle-sharing. Sexually transmitted infections can be avoided almost entirely if the behaviours during which the infection can be transmitted are avoided.

Both those who avoid risky behaviours and those who reduce risky behaviours further protect themselves by making sure that alcohol and other substance abuse does not alter their ability to think clearly and make responsible decisions.

A person can protect himself or herself from HIV infection and other STD ***almost completely***

- *by avoiding behaviours during which HIV and STD can be transmitted;*
- *by abstaining from sexual intercourse;*

  The surest way of avoiding the sexual transmission of HIV and other STD is sexual abstinence. Abstinence means not having vaginal, anal or oral sex; it does not mean avoiding all intimate contact.

- *by having sexual intercourse only with a partner who is not infected and has never had sexual intercourse with anyone who is infected;*

  Cautionary note: It is not possible to tell if a person has HIV infection or STD by his or her appearance. STD symptoms may not be apparent. Also, not everyone is honest about drug use, sexual behaviours or sex partners.

- *by never sharing injection needles and syringes, ear piercing and tattooing needles, razors, and other instruments that can pierce the skin.*

A person can protect himself or herself from HIV infection and STD ***to a lesser degree***

- *by reducing behaviours during which HIV and STD can be transmitted AND using specific preventive methods; and,*
- *by having one sexual partner, AND using condoms properly and consistently.*

  A latex condom used consistently during vaginal, anal and oral sex is an effective means of protection against infection with HIV and many other STD-causing organisms. Condoms are not 100 percent effective. They can break and they must be used properly to be completely effective. Some people have experienced an allergy to latex or the spermicide, nonoxynol-9. Allergic reactions causing rashes, blisters or breaks in the skin provide opportunities for HIV transmission.

A person can protect himself or herself from HIV infection and STD ***to a still lesser degree***

- *by limiting the number of sexual partners AND using condoms properly and consistently.*

The more partners a person has, the greater the chances that one partner will be infected with HIV or STD-causing organisms.

Those who choose to reduce rather than avoid risky behaviour should also

- avoid having sexual intercourse with those who do not use condoms properly and consistently;
- avoid having sexual intercourse with those who use injection drugs;
- ask a partner for a sexual history; and,
- take an HIV antibody test and encourage their partner to do likewise.

Douching or using the birth control pill will **not** prevent STDs.

a. Estimating risk for HIV infection

Those who reduce rather than avoid risky behaviours put themselves in the position of estimating their probability of being infected with HIV as a result of a particular behaviour or combination of behaviours.

There have been attempts to rate specific behaviours according to risk. In 1994, the Canadian AIDS Society revised ***Guidelines for Safer Sex*** which categorize certain behaviours as high, low, minimal or no risk for HIV infection. The guidelines help in promoting an understanding the risks and skills in estimating one's own personal risk, especially when students are given the opportunity for discussion led by knowledgeable teachers.

A better way to consider risk is to be informed of the theoretical risk of certain behaviours. When experts refer to the theoretical risk of infection they mean an infection may be possible by this means, but that no cases of infection by this particular form of transmission have ever been documented. For example, wet or open-mouth kissing has a theoretical risk of HIV infection. HIV can live in saliva but there are no proven cases of HIV having been transmitted during wet or open-mouth kissing. It is possible that further research will result in a change of the theoretical risk status of a behaviour.

b. Potential for Risk: Sexual Behaviour Among NWT Youth

The "Canada Youth and AIDS Study", undertaken on a national basis in 1988, reported that NWT young people are far more sexually active than other young Canadians: This continues to be evidenced by high numbers of STDs and births to young women in the NWT.

The 1996 study, "Health Behaviours, Attitudes and Knowledge of Young People in the Northwest Territories", indicated the following significant information:

- the numbers of Grade 7 and 8 students who had engaged in sexual intercourse, ranged from 9% of the students in one school jurisdiction, to a high of 48.5% of the students in another;
- only about half of NWT young people who reported that they often had sexual intercourse, usually used some form of protection to guard against pregnancy or STDs, including HIV/AIDS;
- while most students responded correctly to knowledge questions on AIDS and other STDs, only 59% of students knew that AIDS cannot be cured, no matter how early it is detected;
- the high level of sexual activity among NWT students confirms that knowledge alone is not enough to influence students' behaviour;
- about one-fifth of female students in grades 9 and 10 reported that they had been forced to have sexual intercourse.

While it is evident that high levels of potential for risk exist among the sexual behaviours of NWT students, the study pointed out another fact that should be noted while preparing to teach SHR: students in the NWT reported that the school, rather than the family, has been the main source of information for students about sex, birth control, HIV/AIDS and other STDs. This highlights the significance of the role teachers play in promoting sexual health and emphasizes the importance of encouraging and inviting families to become partners in the teaching of sexuality education.

5. Symptoms of STD and HIV Infection

Frequently people who have an STD, even HIV infection, do not have any symptoms. Although they look and feel healthy, they have STD-causing organisms in their body, which they can transmit to others. There is no set of symptoms or even a single symptom that occurs only with

HIV infection. Many other infections, both STD and non-STD, can result in symptoms similar to HIV infection.

Different people are likely to display different symptoms when infected by HIV. In some cases, the symptoms of one person living with AIDS may be very different from those identified in other persons living with AIDS. This is true for women as well as for men.

An abnormal discharge from the penis or vagina is a symptom often associated with STD. Males may have a burning feeling when urinating. Females are more likely to experience pain in the lower abdominal or groin area. They may have abnormal vaginal discharge and might experience pain when having sex. There are non-urinary tract symptoms such as fevers, skin rashes, weight loss or general malaise. If a person experiences any of the above symptoms and has been participating in any behaviours associated with STD transmission, he or she should stop having sexual intercourse and go to a doctor or health clinic for a check-up.

The symptoms of sexually transmitted diseases develop at different rates, or not at all. They may appear as early as two days after infection, as in the case of gonorrhea, or take many months to develop, as in genital warts. A person who has symptoms of any kind may begin to worry that he or she has AIDS or another STD. However, **there is no possibility of HIV or other STD unless he or she has been participating in behaviours associated with STD transmission.**

6. Testing

A person who suspects that he or she may be infected with HIV or another STD must stop their risk-taking behaviour to protect themselves from getting another STD and to protect their partners. Even if no symptoms are present, he or she should go to a nurse or doctor at a health centre or doctor's office. STD tests, including an HIV antibody test may be recommended. There are no charges for these tests. All tests and results are confidential. STD treatment drugs are often free. In the Northwest Territories, HIV antibody testing is performed by nurses at community health centres, hospitals or public health clinics and by doctors at health centres or hospitals or in their clinics or offices.

The nurse or doctor does the pre- and post-test counselling. Partner notification is done to let sex or drug-sharing partners of HIV-positive persons (or those with other sexually transmitted diseases) know that they have been exposed to HIV/STD. In the N.W.T. The methods used include the following:

- The infected person can tell all known partners; and/or
- The nurse or doctor can tell all identified partners without naming the infected person; and/or
- The Regional Medical Health Officer or Chief Medical Health Officer can assist with the follow-up of partners.

All matters remain confidential.

A person should seek professional counselling from a doctor or other health professional when considering having an HIV antibody test. The doctor or professional counsellor will determine the need for a test, will explain the test procedure, and will discuss the emotional and social consequences of testing. A person may decide to be tested for HIV for the following reasons:

- Using injection drugs
- Having multiple sex partners
- Participating in anal sex
- Suspicion or knowledge that a partner has HIV, is bisexual, has had multiple sex partners, does not use condoms every time or has used injection drugs
- Personal fear or anxiety.

The ELISA screening test detects antibodies to HIV in the blood. **A sero-negative test** result means that HIV antibodies were not found in the blood at the time of the test. The formation of HIV antibodies takes time and varies from person to person. A person can produce an HIV-negative result and yet be HIV-infected if the test is done during the "window period" (the time between when a person contracts the virus and develops the antibodies). It usually takes between three and six months before the test can detect the antibodies.

The long window period means that a person must refrain from any risky behaviours immediately and for at least three months before being tested. The nurse or doctor may recommend a retest after six months of HIV preventive behaviours.

If the first ELISA test is positive, it is repeated. If the second test is positive, a confirmatory test (Western Blot) is done. A confirmed **sero-positive HIV antibody test** result means that there are HIV antibodies in the blood. The person is infected with HIV. In the Northwest Territories, the names of HIV-positive persons are reported to the Chief Medical Health Officer.

A person with confirmed HIV infection is referred to health professionals for counselling and appropriate treatment. They may also be referred to a community-based AIDS organization. It is important that this person understand that he or she can transmit HIV even though there may no signs or symptoms of HIV infection.

New tests and test procedures continue to be developed and refined.

7. Sources of Help

a. Information sources

Information sources about AIDS or other STDs are

- community health centres
- local public health departments
- doctors and nurses
- teachers who teach about AIDS and STDs
- local AIDS telephone hotlines
- hospitals
- local community AIDS organizations
- parents or guardians
- religious leaders
- school community counsellors
- community health representatives
- alcohol and drug workers

It is important to access a variety of AIDS and other STD-related information sources. Often the media cannot provide extensive detail in the time or space allowed for the item of information or news. Many media information sources try to capture the attention of the listener, reader or viewer by isolating and emphasizing a particular piece of information and viewpoint. If the item is taken out of context from a more detailed report, the accuracy of information provided by the media may be in question. Experts in the Northwest Territories generally recommend that a representative from the regional health board or from the Department of Health and Social Services or, or an informed doctor or nurse be contacted to confirm and perhaps even explain the information provided by the media.

i. HIV/AIDS Information and Support

In the Northwest Territories, information about HIV/AIDS may be obtained from the following community-based organizations organizations:

- AIDS Yellowknife
  P.O. Box 864
  Yellowknife, NT X1A 2N6
  Tel: (867) 873-2626

- Reproductive Health Consultant
  Govt. of the Northwest Territories
  Dept. of Health and Social Services
  1-800-661-0782

- AIDS Helpline (services in English and Inuktitut)
  1-800-265-3333 (Nunavut)
  1-800-661-0844 (Western Arctic)

AIDS Yellowknife trains facilitators who are then available as volunteers to make presentations to community groups. AIDS Yellowknife also runs a peer education program. Trained youth create and perform skits and mini-dramas, on the topics of HIV/AIDS and other STDs, sexuality, and relationships. They present these awareness sessions to school and community groups.

- Community Health Representative
  Health Centre
  Igloolik, NT XOA OLO Tel: (867) 934-8837

- Coordinator
  Ingamo Hall AIDS Awareness Project
  Ingamo Hall Friendship Centre
  P.O. Box 1293
  Inuvik NT XOE OTO Tel: (867) 777-2166 or 777-3231

b. Help for people with HIV/AIDS

An individual who is HIV- positive may become anxious and depressed. He or she needs the support of family and friends. People living with HIV or AIDS may feel isolated, emotionally distressed and financially burdened. There are people living with HIV and AIDS who have been mistreated, rejected and harassed by others. One cannot get HIV by being near a person with HIV or AIDS; therefore, it is easy and helpful to maintain normal friendly contact with anyone who has HIV infection or has developed AIDS.

c. Helping partners and families of persons living with HIV/AIDS

The close relatives of a person who is HIV- positive or living with AIDS need acceptance and support. These family members may find that their friends are uncertain about what to do. People may not know how to help parents and brothers and sisters of a person living with HIV/AIDS.

Responses that are not very helpful to those who have a relative with HIV/AIDS include:

- blaming the HIV-infected person for being selfish, careless or thoughtless for getting infected. The fact that a person has HIV or AIDS cannot be changed.

- ignoring the fact that the person has a family member living with HIV/AIDS without showing support.

A person is likely to appreciate knowing that someone outside the family is interested in and cares about the person living with HIV/AIDS.

There are a number of things that a person can do for someone who has a family member living with HIV/AIDS:

1. Ask about the person. Show an interest in the person's health. Be willing to listen to the concerns of family members.

2. Ask if you can help. Offer to help in any way you can.

3. Take time to talk and visit with the family member living with HIV/AIDS. Touch the person, hold hands and hug or kiss him or her if it is appropriate.

4. Offer to stay with or visit alone with the person living with HIV/AIDS. This will give family members the opportunity to do other things or take a break.

5. Include the person living with HIV/AIDS or the entire family in some of your regular activities. This might mean going for a pizza, a show or a hockey game. Ask about and respect any limitations that might exist.

6. Bring along another friend who has not visited before.

7. If the person living with HIV/AIDS is a parent, ask about and offer to help care for any children. This can provide time for other family members to visit. It might also provide time for the person living with HIV/AIDS to rest.

8. Help to celebrate holidays, special days--and life. Offer to help decorate for the special occasion. Bring flowers or a special gift.

9. Actively help others to accept and support the person living with HIV/AIDS.

10. Inform yourself about HIV and AIDS. Be knowledgeable about opportunistic infections, treatments including alternative and supplementary treatment options. Know symptoms for different opportunistic infections and HIV/AIDS related illnesses. There is normally a great deal of information available and it becomes exhausting for the person living with HIV/AIDS to keep abreast of it all. Being an information resource demonstrates your concern as well as practically assisting the person living with HIV/AIDS and those around him or her.

Actively supporting the family of a person living with HIV/AIDS shows acceptance of the person living with HIV/AIDS and that he or she is important.

The family should not have to worry about what their friends think. If friends show acceptance and support, the family can tell that they are concerned. The family then can put their energy into caring for their family member.

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APPENDIX A

- AIMS AND SPECIFIC OBJECTIVES

- SPECIFICATIONS FOR WOODEN DEMONSTRATOR MODELS, CONDOMS, CONDOM BOXES
(for student activities 16 and 18)

SPECIFICATIONS FOR

WOODEN DEMONSTRATOR FOR STUDENT ACTIVITY 18:

CONDOM PRACTICE

Description: Molded wooden model of a penis on a base, flattened to stand.

Dimensions:

Base: 50 cm in diameter (2 inches)
25 cm in height (1 inch)

Shaft: 140 cm in height from base to tip (6.5 inches)
30 cm in diameter at base (1.5 inches)

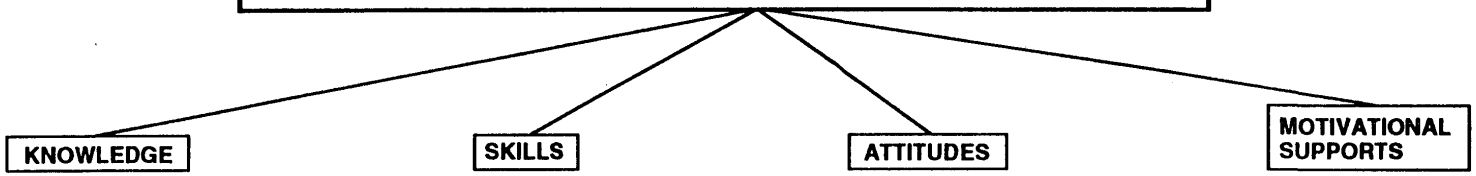
SPECIFICATIONS FOR

THREE CONDOM BOXES FOR STUDENT ACTIVITY 16:

GETTING A CONDOM

Description: In Activity 16, the students observe, discuss and assess aspects of three types of condom packages. Samples should be selected to represent a range of available condoms, including lubricated, non-lubricated, and at least one with added spermicide. Inside each box should be a minimum of one condom and a set of instructions as supplied by the manufacturer.

AIMS OF *SKILLS FOR HEALTHY RELATIONSHIPS*

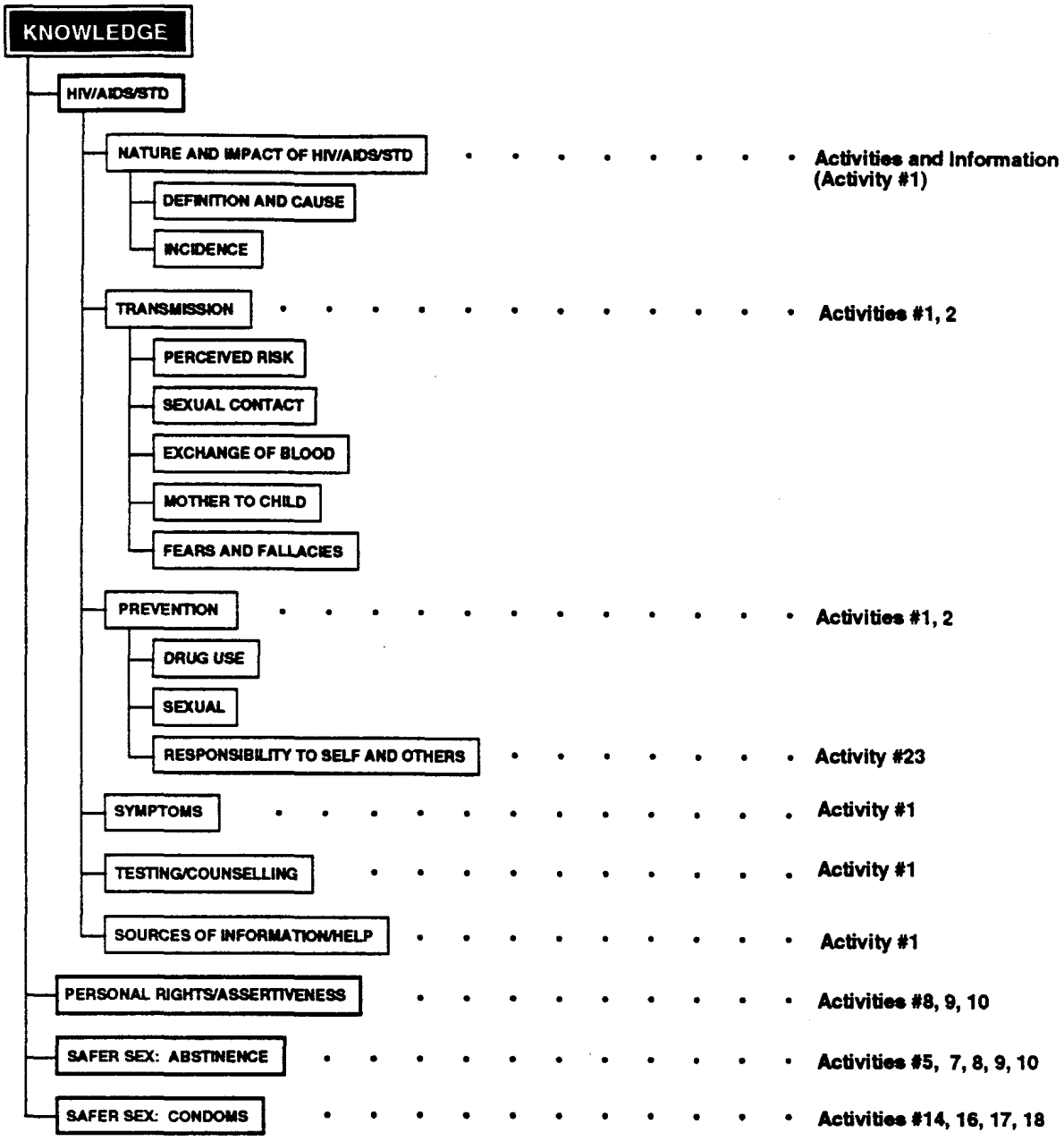


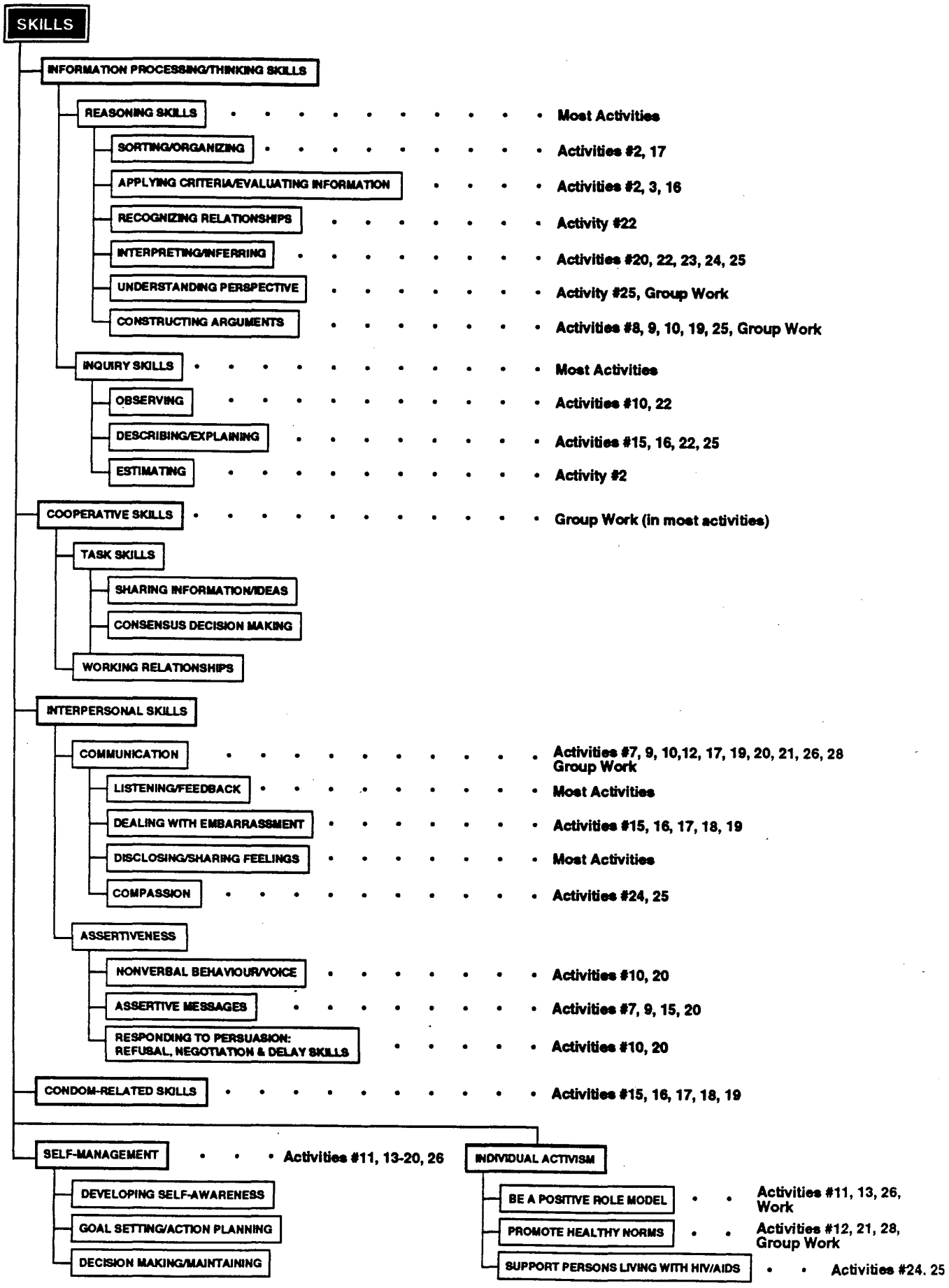
- HIV/AIDS and other STD
  - Nature and Impact
  - Transmission
  - Prevention
  - Symptoms
  - Testing/Counselling
  - Sources of Information/ Help
- Personal Rights/ Assertiveness
- Safer Sex: Abstinence
- Safer Sex: Condoms

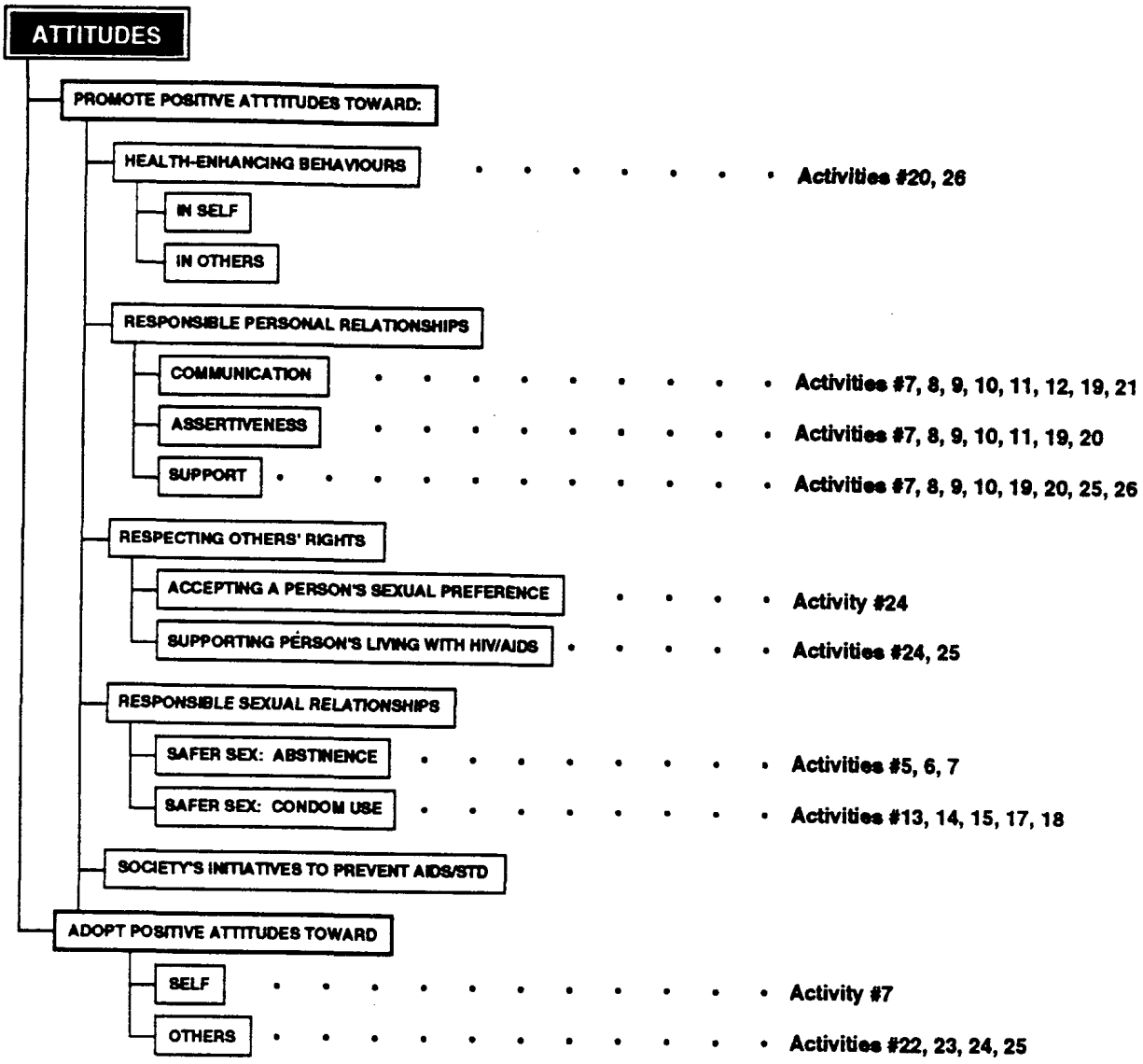
- Information Processing/ Thinking
- Cooperative Skills
- Interpersonal Skills
  - Communication
  - Assertiveness
- Condom-Related Skills
- Self-Management
- Individual Activism

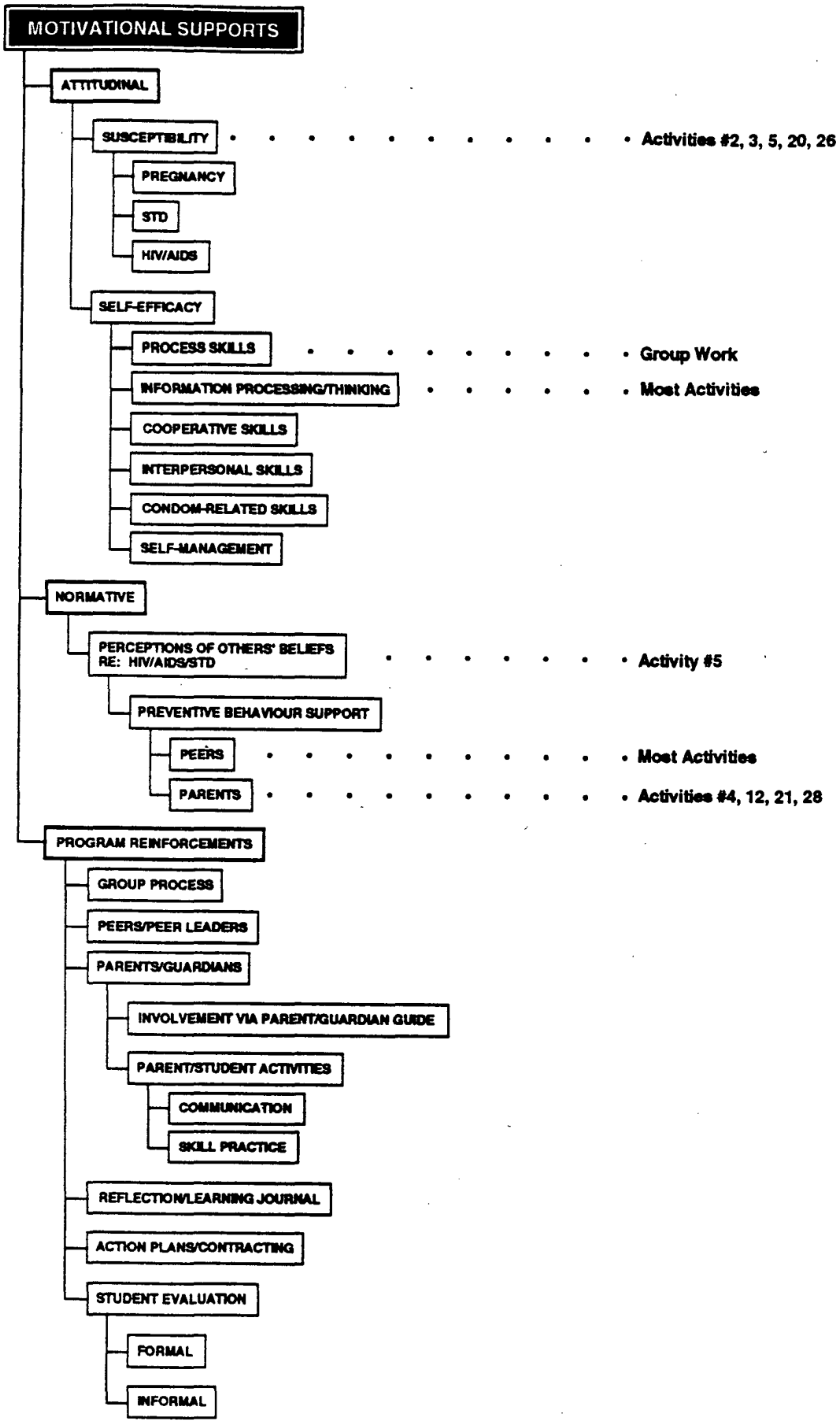
- Promote Positive Attitudes Toward:
  - Health-Enhancing Behaviours
  - Responsible Personal Relationships
  - Respecting Others' Rights
  - Responsible Sexual Relationships
  - Society's Initiatives to Prevent AIDS/STD
- Adopt Positive Attitudes Toward Self and Others
- Adopt Tolerance Towards Homosexuals
- Adopt Compassion Towards People Living with HIV/AIDS

- Attitudinal
  - Susceptibility
  - Self-Efficacy
- Normative
  - Perceptions of Others' Beliefs about Responsible Behaviours re HIV/AIDS/STD
- Program Reinforcements
  - Group Process
  - Peers/Peer Leaders
  - Parent(s)/Guardian(s)
  - Reflection/Learning Journal
  - Action Plans/Contracting
  - Student Evaluation


KNOWLEDGE
HIV/AIDS/STD
NATURE AND IMPACT OF HIV/AIDS/STD
DEFINITION AND CAUSE
INCIDENCE
TRANSMISSION
PERCEIVED RISK
SEXUAL CONTACT
EXCHANGE OF BLOOD
MOTHER TO CHILD
FEARS AND FALLACIES
PREVENTION
DRUG USE
SEXUAL
RESPONSIBILITY TO SELF AND OTHERS
SYMPTOMS
TESTING/COUNSELLING
SOURCES OF INFORMATION/HELP
PERSONAL RIGHTS/ASSERTIVENESS
SAFER SEX: ABSTINENCE
SAFER SEX: CONDOMS
Activities and Information (Activity #1)
Activities #1, 2
Activities #1, 2
Activity #23
Activity #1
Activity #1
Activity #1
Activities #8, 9, 10
Activities #5, 7, 8, 9, 10
Activities #14, 16, 17, 18


SKILLS
INFORMATION PROCESSING/THINKING SKILLS
REASONING SKILLS
Most Activities
SORTING/ORGANIZING
Activities #2, 17
APPLYING CRITERIA/EVALUATING INFORMATION
Activities #2, 3, 16
RECOGNIZING RELATIONSHIPS
Activity #22
INTERPRETING/INFERRING
Activities #20, 22, 23, 24, 25
UNDERSTANDING PERSPECTIVE
Activity #25, Group Work
CONSTRUCTING ARGUMENTS
Activities #8, 9, 10, 19, 25, Group Work
INQUIRY SKILLS
Most Activities
OBSERVING
Activities #10, 22
DESCRIBING/EXPLAINING
Activities #15, 16, 22, 25
ESTIMATING
Activity #2
COOPERATIVE SKILLS
Group Work (in most activities)
TASK SKILLS
SHARING INFORMATION/IDEAS
CONSENSUS DECISION MAKING
WORKING RELATIONSHIPS
INTERPERSONAL SKILLS
COMMUNICATION
Activities #7, 9, 10,12, 17, 19, 20, 21, 26, 28 Group Work
LISTENING/FEEDBACK
Most Activities
DEALING WITH EMBARRASSMENT
Activities #15, 16, 17, 18, 19
DISCLOSING/SHARING FEELINGS
Most Activities
COMPASSION
Activities #24, 25
ASSERTIVENESS
NONVERBAL BEHAVIOUR/VOICE
Activities #10, 20
ASSERTIVE MESSAGES
Activities #7, 9, 15, 20
RESPONDING TO PERSUASION: REFUSAL, NEGOTIATION & DELAY SKILLS
Activities #10, 20
CONDOM-RELATED SKILLS
Activities #15, 16, 17, 18, 19
SELF-MANAGEMENT
Activities #11, 13-20, 26
DEVELOPING SELF-AWARENESS
GOAL SETTING/ACTION PLANNING
DECISION MAKING/MAINTAINING
INDIVIDUAL ACTIVISM
BE A POSITIVE ROLE MODEL
Activities #11, 13, 26, Work
PROMOTE HEALTHY NORMS
Activities #12, 21, 28, Group Work
SUPPORT PERSONS LIVING WITH HIV/AIDS
Activities #24. 25


ATTITUDES
PROMOTE POSITIVE ATTTITUDES TOWARD:
HEALTH-ENHANCING BEHAVIOURS
Activities #20, 26
IN SELF
IN OTHERS
RESPONSIBLE PERSONAL RELATIONSHIPS
COMMUNICATION
Activities #7, 8, 9, 10, 11, 12, 19, 21
ASSERTIVENESS
Activities #7, 8, 9, 10, 11, 19, 20
SUPPORT
Activities #7, 8, 9, 10, 19, 20, 25, 26
RESPECTING OTHERS' RIGHTS
ACCEPTING A PERSON'S SEXUAL PREFERENCE
Activity #24
SUPPORTING PERSON'S LIVING WITH HIV/AIDS
Activities #24, 25
RESPONSIBLE SEXUAL RELATIONSHIPS
SAFER SEX: ABSTINENCE
Activities #5, 6, 7
SAFER SEX: CONDOM USE
Activities #13, 14, 15, 17, 18
SOCIETY'S INITIATIVES TO PREVENT AIDS/STD
ADOPT POSITIVE ATTITUDES TOWARD
SELF
Activity #7
OTHERS
Activities #22, 23, 24, 25


MOTIVATIONAL SUPPORTS
ATTITUDINAL
SUSCEPTIBILITY
Activities #2, 3, 5, 20, 26
PREGNANCY
STD
HIV/AIDS
SELF-EFFICACY
PROCESS SKILLS
Group Work
INFORMATION PROCESSING/THINKING
Most Activities
COOPERATIVE SKILLS
INTERPERSONAL SKILLS
CONDOM-RELATED SKILLS
SELF-MANAGEMENT
NORMATIVE
PERCEPTIONS OF OTHERS' BELIEFS RE: HIV/AIDS/STD
Activity #5
PREVENTIVE BEHAVIOUR SUPPORT
PEERS
Most Activities
PARENTS
Activities #4, 12, 21, 28
PROGRAM REINFORCEMENTS
GROUP PROCESS
PEERS/PEER LEADERS
PARENTS/GUARDIANS
INVOLVEMENT VIA PARENT/GUARDIAN GUIDE
PARENT/STUDENT ACTIVITIES
COMMUNICATION
SKILL PRACTICE
REFLECTION/LEARNING JOURNAL
ACTION PLANS/CONTRACTING
STUDENT EVALUATION
FORMAL
INFORMAL

APPENDIX B

EVALUATION FORMS

- Student Evaluation Summary
- My Group Skills/ Performance
- Group and Cooperative Skills: Evaluation by Student
- Evaluation of Cooperative Skills
- Feedback to Peer Leaders

Student Evaluation Summary

	1st Part				2nd Part					
Student Name	Test - 20%	Group Skills - 5%	Total - 25%	Test - 20%	Action Plan - 10%	Learning Journal -10%	Student Manual - 10%	Class Contribution - 10%	Cooperative Skills -15%	Total - 75%
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
16.										
17.										
18.										
19.										
20.										

Student Evaluation Summary

Student Name	1st Part				2nd Part					
	Test - 20%	Group Skills - 5%	Total - 25%	Test - 20%	Action Plan - 10%	Learning Journal -10%	Student Manual - 10%	Class Contribution - 10%	Cooperative Skills -15%	Total - 75%
21.										
22.										
23.										
24.										
25.										
26.										
27.										
28.										
29.										
30.										
31.										
32.										
33.										
34.										
35.										
36.										
37.										
38.										
39.										
40.										

My Group Skills/Performance

Please circle the number which best represents your skills/performance in group activities.

RATING SCALE	
4 = Excellent	1 = Needs improvement
3 = Very Good	
2 = Okay	0 = Major difficulty

1.	I have made it a point to listen as much as I talk.	0	1	2	3	4
2.	I try to look others in the eye when speaking to them.	0	1	2	3	4
3.	I try not to interrupt when others are speaking.	0	1	2	3	4
4.	I encourage others to participate in the discussion.	0	1	2	3	4
5.	I try to do my share when working on a group activity.	0	1	2	3	4
6.	I use "I messages" instead of "you messages", especially when expressing my feelings.	0	1	2	3	4
7.	I tell the group when something is bothering me.	0	1	2	3	4
8.	I try to respect others' feelings even when I disagree with them.	0	1	2	3	4
9.	I try not to be aggressive to get my way.	0	1	2	3	4
10.	I praise others when appropriate.	0	1	2	3	4
11.	I try to share my ideas and feelings.	0	1	2	3	4
12.	I try to cooperate more than compete with others.	0	1	2	3	4

Complete the following unfinished sentences.

A. My two greatest strengths from the above list are:
1.
2.

B. The two skills I have to work on from the above list are:
1.
2.

Group and Cooperative Skills:
Evaluation by Student

STUDENT NAME:

The following evaluation sheet is designed to help you assess your cooperative skills. Each skill is listed below with a list of criteria to help you determine your mark.

A mark out of 10 should be given for each of the six skills. The total score should then be divided by 6 to get a final mark out of 10.

A. Disagreeing in an Agreeable Way

- *calm, controlled voice*
- *eye contact*
- *"I" or "my" statements*
- *respect for others' position*

1-10

B. Listening Attentively

- *listening without interrupting*
- *leaning forward*
- *staying on topic*

1-10

C. Assertiveness Practice

- *followed steps of procedure*
- *written scripts complete and accurate*
- *parent and action lessons completed*
- *willingness to role play scripts*

1-10

D. Criticizing Ideas and <u>not</u> the Person Expressing Them

- *smiling, nodding while listening*
- *concentrating on statements by others*
- *using open body language*

1-10

E. Summarizing for Understanding

- *open body posture*
- *quick, clear summary of ideas and thoughts*
- *ask for feedback on your summary*

1-10

F. Encouraging Others

- *nonverbal – smile, thumbs up,*
- *pat on back, nod of approval*
- *verbal – "right, super, good job, excellent"*

1-10

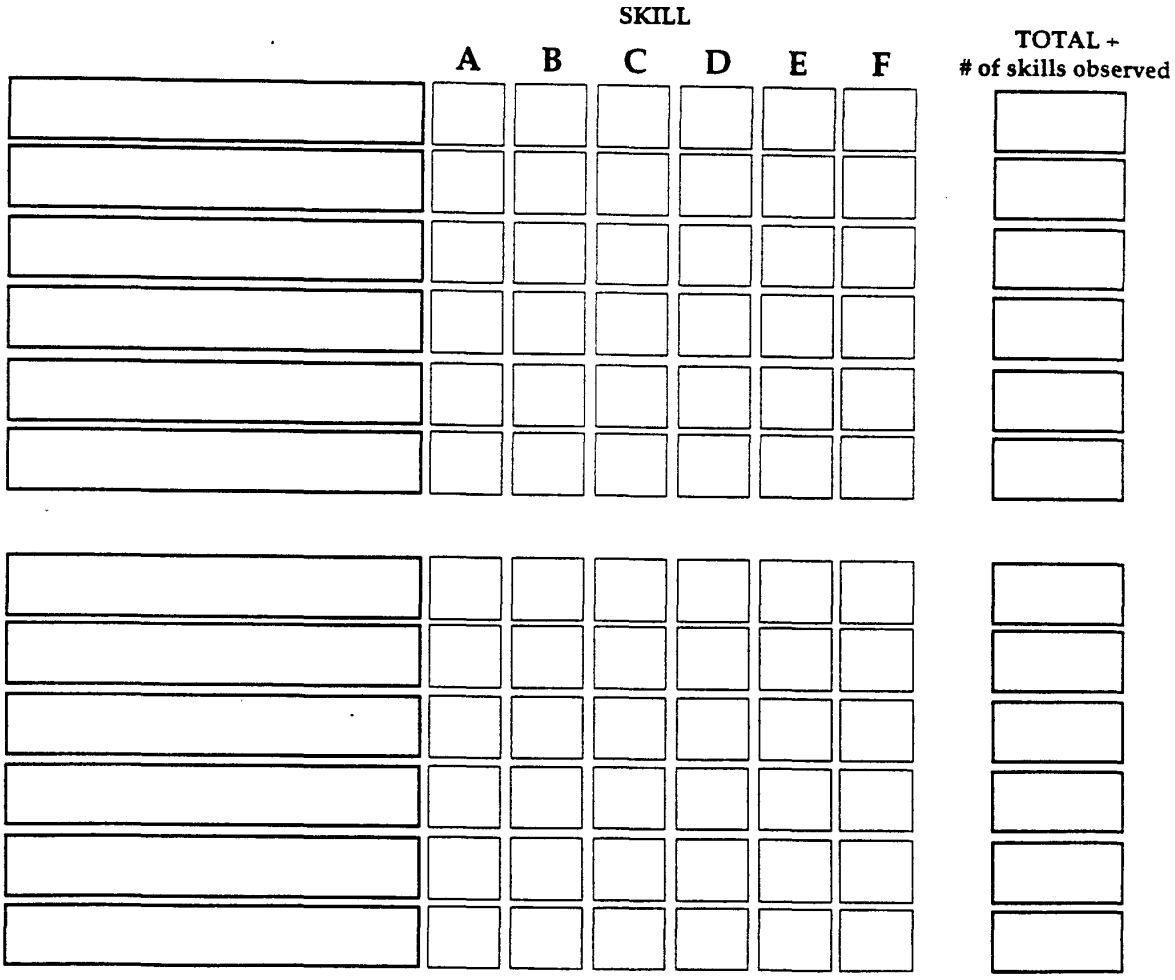
Final Mark =

<u>Total Score</u>
Divided by 6 =

Evaluation of Cooperative Skills*

A. Encouraging Others
B. Disagreeing in an Agreeable Way
C. Listening
D. Criticizing Ideas not the Person
E. Summarizing for Understanding
F. Assertiveness

Evaluating cooperative skills is more practically done by the peer leaders in consultation with each student in the group. Use this form only if you are able to assess individual students for at least 3 selected skills. Assign a mark out of 10 for each skill observed for each student in a group. Divide the total score by the total number of skills observed to obtain a final stark out of 10.



*For the criteria, see *Group and Cooperative Skills: Evaluation by Student* which follows.

Feedback to Peer Leaders

Where you have made observations, provide feedback to each group's peer leader on the following skills. Use the rating scale below.

RATING SCALE

4 = Excellent
3 = Very Good
2 = Good
1 = Needs improvement
0 = Major difficulty

Skill	Name 1.	2.	3.	4.	5.	6.	7.	8.
A. Was prepared and informed.								
B. Modelled skills effectively.								
C. Encouraged others to participate.								
D. Was respectful and tactful with others.								
E. Did not dominate the group.								
F. Effectively dealt with group problems.								
G. Kept discussion moving.								
H. Kept group on topic.								
I. Was open minded.								
J. Listened to all statements and concerns.								
K. Provided individual support.								
L. Spoke distinctly and audibly.								
M. Gave praise and was generally positive.								
N. Contributions were brief and clear.								
Overall Rating								
One thing to work on (record letter from above)								

APPENDIX C

TEST #1 and Answers
TEST #2 and Answers

Skills for Healthy Relationships
TEST #1

Name:_____

Date: _____

Mark the sentences T if they are true, F if they are false.

(*10 marks*)

____ 1. It is possible to tell if a person has a sexually transmitted disease by his or her appearance.

____ 2. Having several sexual partners increases a person's risk of getting a sexually transmitted disease.

____ 3. A person who has developed AIDS can be cured with proper medical treatment.

____ 4. The cause of AIDS is unknown.

____ 5. Most people produce antibodies within two weeks of becoming infected with HIV.

____ 6. Over time, HIV damages the body's immune system leading to serious illness.

____ 7. People with HIV develop symptoms of the infection before they can transmit the virus to others.

____ 8. Only a small percentage of the people who contract AIDS die from it.

____ 9. There is only a slight risk of getting AIDS by donating blood in Canada.

____ 10. You cannot get AIDS from casual contact such as going to school with a person who is living with AIDS.

11. State the four ways the AIDS virus is transmitted.

(4 marks)

_____

_____

_____

_____

12. Jan and Dave have been seeing each other for three months. A few months ago they decided to have sexual intercourse without a condom. Jan had never had sex before and Dave had had a few sexual partners before Jan. After they had sex, Dave noticed that he had symptoms of a sexually transmitted disease. He decided to tell Jan about his symptoms. When he discussed the situation with Jan she said she felt fine and did not have any symptoms. List three things Jan should do.

(3 marks)

13. There are many ways to show physical affection without having sexual intercourse. Explain three benefits of showing physical affection without having sexual intercourse. Give three examples of ways young people can show physical affection without having sexual intercourse.

(3 marks)

(3 marks)

Examples:

14. Define the term assertive..

(3 marks)

15. An assertive style of communication can lead to some awkwardness, particularly at first, however over time a person will become aware of the benefits. State four benefits of assertive communication.

(4 marks)

16. You are cruising around with friends in one of their parent's cars. Two of your friends are drinking beer and you start to feel uncomfortable with the amount of drinking going on. Every time the subject of going home comes up, your friend who is driving says "You're a bunch of wimps! Relax and let's just have a good time!" You decide to tell the driver that you want to go home now.

    State the four steps to deliver an assertive message. Illustrate each step by writing a complete assertive script for the scenario above.

(4 marks)

Step 1

Step 2

Step 3

Step 4

Script:

(4 marks)

Step 1

Step 2

Step 3

Step 4

17. Nancy and Jim have been dating for a few months. Nancy feels that she is ready to have sex with Jim but Jim feels he is not ready for the possible consequences of sexual involvement including sexually transmitted diseases and pregnancy. Jim states assertively that he is not ready for sexual intercourse. Nancy disagrees with Jim's assertive message. State three different ways Jim could respond assertively to Nancy's objections below and give a verbal response for each.

(3 marks)

1. _____
2. _____
3. _____

Examples of verbal responses:

(3 marks)

1. _____
2. _____
3. _____

18. a. Explain why preparing a written action plan for a specific goal is important.

(2 marks)

_____

_____

_____

b. List four components of a good action plan.

(4 marks)

_____

_____

_____

TOTAL MARKS = 50

Skills for Healthy Relationships
TEST #1 ANSWERS

Mark the sentences T if they are true, F if they are false.
(10 marks)

F **1.** **It is possible to tell if a person has a sexually transmitted disease by his or her appearance.**

It is not possible to tell if a person has an STD by his or her looks. Many people who have an STD do not have symptoms or visible signs of the disease. Anyone can get an STD as a result of the behaviours he or she engages in.

T **2.** **Having several sexual partners increases a person's risk of getting a sexually transmitted disease.**

The more sexual partners a person has, the greater the chances that one of those partners will be infected with HIV or STD-causing organisms.

F **3.** **A person who has developed AIDS can be cured with proper medical treatment**.

At the present time, there is no cure for AIDS. Researchers are currently looking for a cure for AIDS as well as a vaccine for HIV. However, neither a cure nor a vaccine is expected for many years, if ever.

F **4.** **The cause of AIDS is unknown**.

At present, most research indicates AIDS is caused by HIV, the human immunodeficiency virus. HIV can attack and, over time, destroy the body's immune system.

F **5.** **Most people produce antibodies within two weeks of becoming infected with HIV.**

It usually takes up to three months to develop antibodies to HIV. In fact, for some people it can take up to six months or longer to develop HIV antibodies after a person is infected with HIV.

T **6.** **Over time, HIV damages the body's immune system leading to serious illness.**

HIV attacks and, over time, damages the body's immune system. Over time the damage to the immune system allows infections and diseases to develop.

F **7.** **People with HIV develop symptoms of the infection before they can transmit the virus to others.**

Frequently, people who are infected with HIV do not have any symptoms. Anyone infected with HIV, whether they have symptoms or not, can transmit HIV to others. Although they look and feel healthy, they are infected with HIV which they can transmit to others.

F **8.** **Only a small percentage of the people who contract AIDS die from it.**

Most, if not all people who develop AIDS die from it. Some people will die much sooner than others. With the availability of new treatments, people living with AIDS may be able to extend their lives.

F **9.** **There is only a slight risk of getting AIDS by donating blood in Canada.**

In Canada, there is no danger of HIV infection from blood donation. This is because the needles used when blood is donated are sterilized or new.

T **10.** **You cannot get AIDS from casual contact such as going to school with a person who is living with AIDS.**

HIV cannot be transmitted by casual contact. HIV is not transmitted by going to school with, or being close to, a person living with AIDS, hugging, kissing, holding hands, shaking hands, massage, animal or mosquito bites, drinking from a public drinking fountain, swimming in a public pool, using a public telephone, etc.

11. **State the four ways the AIDS virus is transmitted.**

(4 marks)

- sexual intercourse with an infected person
- sharing a needle with an infected person
- infected mother to newborn
- exposure to contaminated blood

12. **Jan and Dave have been seeing each other for three months. A few months ago they decided to have sexual intercourse without a condom. Jan had never had sex before and Dave had had a few sexual partners before Jan. After they had sex, Dave noticed that he had symptoms of a sexually transmitted disease. He decided to tell Jan about his symptoms. When he discussed the situation with Jan she said she felt fine and did not have any symptoms. List three things Jan should do.**

(3 marks)

- practice abstinence

Question #12 continued

- practice safer sex

- go for a test

- tell her partner(s)

- seek up-to-date information from reliable sources

- eat a healthy diet and get adequate rest (general health)

13. There are many ways to show physical affection without having sexual intercourse. Explain three benefits of showing physical affection without having sexual intercourse. Give three examples of ways young people can show physical affection without having sexual intercourse.

(3 marks)

Benefits: results in a warm, close relationship which is a basic need of everyone but avoids the physical, emotional and social risks associated with sexual intercourse (i.e. pregnancy, poor reputation, STD, AIDS, family conflicts, guilt, feeling of being used).

(3 marks)

Examples: hold hands, hugging, special look/smile, arm around each other, kissing

14. Define the term assertive.

(3 marks)

- to clearly communicate your personal rights without infringing on the rights of others

15. An assertive style of communication can lead to some awkwardness, particularly at first, however over time a person will become aware of the benefits. State four benefits of assertive communication.

(4 marks)

- improves confidence and self-esteem

- communicates your personal rights

- increases honest and open communication

- does not result in fights/arguments with others

- increases respect from others

16. You are cruising around with friends in one of their parent's cars. Two of your friends are drinking beer and you start to feel uncomfortable with the amount of drinking going on. Every time the subject of going home comes up, your friend who is driving says "You're a bunch of wimps! Relax and let's just have a good time!" You decide to tell the driver that you want to go home now.

State the four steps to deliver an assertive message. Illustrate each step by writing a complete assertive script for the scenario above.

(4 marks)

Step 1 Explain your feelings and the problem.

Step 2 Make a specific request.

Step 3 Ask how the other person feels about your request.

Step 4 Accept with thanks.

Script:

(4 marks)

Step 1 "I feel uncomfortable because I don't chink we should be drinking and driving."

Step 2 "What I would like to do now is to go home."

Step 3 "What do you say?"

Step 4 "Thanks for respecting how I feel."

17. Nancy and Jim have been dating for a few months. Nancy feels that she is ready to have sex with Jim but Jim feels he is not ready for the possible consequences of sexual involvement including sexually transmitted diseases and pregnancy. Jim states assertively that he is not ready for sexual intercourse. Nancy disagrees with Jim's assertive message. State three different ways Jim could respond assertively to Nancy's objections and give a verbal response for each.

(3 marks)

- delay

- negotiate

- refuse

Examples of verbal responses:
(3 marks)

a. "Let's wait until we're both ready."

b. "Let's be physical in other ways that don't involve sexual intercourse, that way we'll both be happy."

c. "No, I'm not ready yet."

18. a. Explain why preparing a written action plan for a specific goal is important.
(2 marks)

A written plan outlining the actions you will take to work toward your specific goal will increase your commitment to achieving your goal.

b. List four components of a good action plan.
(4 marks)

- setting a specific goal

- establishing a timeframe

- identifying obstacles

- deciding who can help

- identifying benefits

- planning a reward

- writing a contract agreement

TOTAL MARKS = 50

Skills for Healthy Relationships
TEST #2

Name: _____

Date:_____

Circle the letter of the correct answer.
(5 marks)

1. The only sure way to prevent getting AIDS through sex is

a. abstinence
b. sex with protection
c. early withdrawal

2. The best device to protect against HIV transmission is

a. a natural condom
b. a latex condom
c. a diaphragm

3. To use a condom correctly

a. pinch the tip to remove air before putting the condom on the penis
b. unroll the condom before putting it on the penis
c. slip the condom off while the male is pulling out of the vagina

4. To protect oneself against HIV/AIDS and other STD, the effectiveness of using condoms is increased when

a. the condom is carefully inspected for holes before use
b. an oil-based lubricant is used
c. the correct steps for use are understood and practised beforehand

5. To maintain effectiveness, condoms should be stored

a. in a warm place
b. in a cool place
c. in a private place

6. Arrange the following list of steps to use a condom in the correct order, by placing the appropriate letter from the left-hand column beside the number in the right-hand column.

(14 marks)

	Description of steps	**Correct order of steps**
a.	intercourse	1. _____
b.	open package	2. _____
c.	ejaculation	3. _____
d.	hold back pubic hair	4. _____
e.	hold rim of condom	5. _____
f.	lubricate condom	6. _____
g.	slide condom off	7. _____
h.	unroll condom on penis	8. _____
i.	loss of erection	9. _____
j.	pinch the tip to remove air from the condom	10. _____
k.	withdraw penis	11. _____
1.	arousal and erection	12. _____
m.	dispose of condom	13. _____
n.	discuss condom use	14. _____

7. Penny and Craig have been seeing each other for several months and have discussed using a condom if they have sexual intercourse. Craig feels that a condom is not necessary and each time they talk about it, he argues against using one.

a. List 4 reasons he may give for not needing to use a condom.

(4 marks)

i. _____

ii. _____

iii. _____

iv. _____

b. **For each reason listed, write a positive statement that changes the argument against condom use to a reason in favour of condom use.**

(4 marks)

i. _____

ii. _____

iii. _____

iv. _____

c. **What three ways could Penny respond assertively to Craig's argument against condom use?**

(3 marks)

i. _____

ii. _____

iii. _____

8.a. **If a couple decides to have sexual intercourse and not use a condom, list 4 other things they could do to reduce their risk of contracting a sexually transmitted disease.**

(4 marks)

i. _____

ii. _____

iii. _____

iv. _____

b. **For each action listed in (a), state one reason why it may not give 100% protection against sexually transmitted diseases.**

(4 marks)

i. _____

ii. _____

iii. _____

iv. _____

9. When purchasing condoms, list 5 important factors to consider in making a selection.
(5 marks)

i. _____

ii._____

iii._____

iv._____

v._____

10.a. Label each of the following statements as prejudicial (P) or discriminatory (D).
(6 marks)

_____ a. Only gay people get AIDS.
_____ b. A young boy with AIDS is not allowed to go to school.
_____ c. People who develop AIDS get what they deserve.
_____ d. A person stops being friendly with a person who has AIDS.
_____ e. A person with AIDS is not allowed to work.
_____ f. People who are HIV positive are not allowed in a public swimming pool.

b. Briefly state why you believe it is important to raise awareness and educate people to stop prejudice and discrimination.
(2 marks)

_____

_____

_____

11. On the weekend two of your close friends attended a large party where there was drinking and drugs. You hear that a lot of the people can't remember much about the evening and some of the people there were having sex. One of your friends is telling you how he/she met this new person who is really "cool". He/she cannot remember much about the evening other than getting home by 4 a.m. Your other friend tells you that he/she had felt uncomfortable and went home early from the party. List 3 statements you could make to show support for your friend who decided not to stay at the party.

(3 marks)

i. _____

ii._____

iii._____

12. Robbie is a person from your school who has been diagnosed HIV positive; therefore, he is capable of transmitting the virus to others. However, he has not developed AIDS and remains in a fairly healthy state. Robbie, after an enjoyable summer vacation, eagerly looks forward to returning to school in September. List 4 things you could do to show compassion and support for Robbie when he returns to school.

(4 marks)

i. _____

ii._____

iii._____

iv._____

v._____

Skills for Healthy Relationships
TEST #2 ANSWERS

Multiple choice--circle the letter of the correct answer.
(5 marks)

1. The only sure way to prevent getting AIDS through sex is

a. abstinence

2. The best device to protect against HIV transmission is

b. a latex condom

3. To use a condom correctly

a. pinch the tip to remove air before putting the condom on the penis

4. To protect oneself against HIV/AIDS and other STD, the effectiveness of using condoms is increased when

c. the correct steps for use are understood and practised beforehand

5. To maintain effectiveness, condoms should be stored

b. in a cool place

6. Arrange the following list of steps to use a condom in the correct order, by placing the appropriate letter from the left-hand column beside the number in the right- hand column.
(14 marks)

Description of steps		**Correct order of steps**	
a.	intercourse	1.	n
b.	open package	2.	l or b
c.	ejaculation	3.	b or l
d.	hold back pubic hair	4.	j
e.	hold rim of condom	5.	d or h
f.	lubricate condom	6.	h or d
g.	slide condom off	7.	f
h.	unroll condom on penis	8.	a
i.	loss of erection	9.	c
j.	squeeze air from condom	10.	e
k.	withdraw penis	11.	k
1.	arousal and erection	12.	g
m.	dispose of condom	13.	i or m
n.	discuss condom use	14.	m or i

7. Penny and Craig have been seeing each other for several months and have discussed using a condom if they have sexual intercourse. Craig feels that a condom is not necessary and each time they talk about it, he argues against using one.

a. List 4 possible reasons he may give for not needing to use a condom.
(4 marks)

(Possible answers)

i. Penny is on the pill so they don't need to use condoms.

ii. AIDS is a gay disease.

iii. Craig/Penny has never had an STD.

iv. Craig/Penny has not had other sexual partners. They are faithful (monogamous).

b. For each reason listed, write a positive statement that changes the argument against condom use to a reason in favour of condom use.
(4 marks)

(Example statements).

i. "I'd like to use a condom also. It protects us both from infections."

ii. "That's not true. Anyone can get AIDS."

iii. "One of us could be infected without knowing."

iv. "I just don't want to take any chances. One of us could have been infected by another means like through sharing needles or having a transfusion."

v. "We may be faithful now but one of our previous partners could have been infected."

c. What three ways could Penny respond assertively to Craig's argument against condom use?
(3 marks)

i. Delay

ii. Negotiate

iii. Refuse

8.a. If a couple decides to have sexual intercourse and not use a condom, list 4 other things they could do to reduce their risk of contracting a sexually transmitted disease.

(4 marks)

(Possible answers)

i. Ask about each other's sexual and drug history.

ii. Be monogamous.

iii. Get an HIV/STD test.

iv. Not share injection needles/syringes or other instruments.

v. Use spermicidal foam during sexual intercourse.

vi. Wash after sexual intercourse.

b. For each action listed in (a), state one reason why it may not give 100% protection against sexually transmitted diseases.

(4 marks)

(Possible answers)

i. Your partner may not know that he/she is infected or that one of his/her partners were infected. Your partner may lie.

ii. You or your partner may have had past partners that were infected.

iii. You/your partner may have had the test during the window period or become infected after the test was done.

iv. You/your partner could still become infected during sexual intercourse.

v. Spermicidal foam provides much less protection than a condom.

vi. Washing may help but it is <u>not</u> 100% protection and is much less effective than other methods.

9. When purchasing condoms, list 5 important factors to consider in making a selection.
(5 marks)

(Possible answers)

i. reservoir tip or no reservoir tip

ii. lubrication (lubricated vs non-lubricated vs spermicidal lubricant)

iii. expiry date

iv. material made of (latex vs natural membranes)

v. price

10.a. Label each of the following statements as prejudicial (P) or discriminatory (D)
(6 marks)

P	a.	Only gay people get AIDS.
D	b.	A young boy with AIDS is not allowed to go to school.
P	c.	People who develop AIDS get what they deserve.
D	d.	A person stops being friendly with a person who has AIDS.
D	e.	A person with AIDS is not allowed to work.
D	f.	People who are HIV positive are not allowed in a public swimming pool.

b. Briefly state why you believe it is important to raise awareness and educate people to stop prejudice and discrimination.
(2 marks)

Responses will vary

- in order to promote equality/fairness

- to increase understanding and compassion

- to support human rights

11. On the weekend two of your close friends attended a large party where there was drinking and drugs. You hear that a lot of the people cannot remember much about the evening and some of the people there were having sex. One of your friends is telling you how he/she met this new person who is really "cool". He/she cannot remember much about the evening other than getting home by 4 a.m. Your other friend tells you that he/she had felt uncomfortable and went home early from the party. List 3 statements you could make to show support for your friend who decided not to stay at the party.

(3 marks)

Example statements:

i. "I think it's great you didn't stay. I would have felt uncomfortable too."

ii. "Way to go. That way you weren't pressured into doing anything you didn't want to do."

iii. "I would have left too; you made the right decision."

12. Robbie is a person from your school who has been diagnosed HIV positive; therefore he is capable of transmitting the virus to others. However, he has not developed AIDS and remains in a fairly healthy state. Robbie, after an enjoyable summer vacation, eagerly looks forward to returning to school in September. List 4 things you could do to show compassion and support for Robbie when he returns to school.

(4 marks)

(Possible answers)

i. Invite him to a social event (e.g. a dance or movie).

ii. Talk to him about what it is like being infected with HIV. Talk about his feelings and fears.

iii. Ask if there is any way you can support him. Ask him if he wants help with anything.

iv. Include him in your group.

v. Show you care about him.

TOTAL = 58 MARKS