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AIDS And Adolescence

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For many years the focus of family life education in the United States has been the prevention of teen pregnancy. With over one million teens getting pregnant each year and an alarmingly high rate of sexually transmitted diseases, obviously our educational methods and resources have been sadly lacking. AIDS is now added as a deadly threat to adolescents. As a result, AIDS education is a primary goal, mandated not only by local districts but also by state education departments. We have an opportunity to teach adolescents about sexuality so that they can make safe choices.

We have made incredible strides in understanding AIDS at the scientific level—the epidemiology, transmission, illnesses caused by HIV infection, and methods of treatment. However, the epidemic continues worldwide and there is no vaccine or cure. Education continues to be the best weapon of defense.

AIDS Education Issues

AIDS education provokes strong emotions in the public school setting. Several problems confront AIDS educators. (Volberding, 1988).

- From its earliest days, AIDS has been associated with stigmatized issues, homosexuality, drug abuse, sexually transmitted diseases, promiscuity. The HIV infection has affected groups
1. whose behavior is condemned by society. This is not to overlook those who contracted the infection from blood transfusions and newborns who contracted HIV from their mothers. These children have a more sympathetic response from society.
 2. AIDS is incurable and contagious through blood and bodily fluids and this has led to irrational fear not unlike previous plagues in history. Fears about AIDS have made some students uncomfortable in the classroom in such a way that it has interfered with the learning process.
 3. Sex education in this country has been controversial. As a society, we are uncomfortable talking about sex even though it is used and promoted constantly in the mass media. Television is pro sex without being pro prevention or protection. Explicit descriptions of sexual behavior continue to be offensive to many.
 4. Our discomfort with the issues of death and dying also creates a problem for AIDS education. AIDS affects families and a loss of a family member has strong implications for children.

5. Accepting adolescent sexuality as a normal part of growth and development is also a problem for our culture. The age for the onset of menarche has declined (Schowalter and Anyan, 1979) and the age for marriage when sex is acceptable has increased. There is a space of many years when sexual experience is to be deferred.

The bane of sex education is the common assumption that sex education promotes, rather than prevents sexual activity. However, not offering sex education hasn't worked, and current research refutes the claim that education isn't effective as prevention.

AIDS education is not easy because it brings into conflict issues of public health and safety with public morality and values.

In New Haven, a problem-solving curriculum called social development is mandated for all ninth graders. One emotionally powerful week is currently devoted to AIDS education. The goal is to give students a chance to not only think about the issues but also to have enough time to understand their feelings about AIDS. Students from Yale University Medical School and School of Public Health, AIDS and health care specialists, videotapes, and a person with AIDS are a part of this week. My goal in this curriculum is to add to that experience. Instead of appearing suddenly in the curriculum I would like to set the AIDS week in a framework, to give teachers and students added materials and information to make the week as useful educationally as it can be.

In our ninth grade social development program students come from many different cultural, racial, and ethnic backgrounds. The amount of family life or sexuality curriculum that they have been exposed to is equally diverse. Our curriculum must meet New Haven adolescents where they are - not only developmentally and cognitively but also as students in an urban environment with a very diverse knowledge base. Quotes from several of my students this spring typify this problem. "I know a lot and I was not surprised about what they said. I had AIDS week when I was in middle school two years in a row." He knows it all. Or, "I'm confused about AIDS and homosexuals. They say homosexuals are the cause of AIDS. But what if two homosexuals have sex and neither of them has AIDS. Homosexuals have been around since the beginning of time, but there was never a case of AIDS before the early 80's." He's missing the germ theory. Or, "I learned thing I never knew and I learned that AIDS AIN'T NOTHING TO MESS AROUND WITH." Or, "We learned alot more than what we already knew and this helped many of us to make the right decision." That's what we like to hear but what will be her choice in the moment of sexual decision making. Adolescents may know transmission facts and still be confused. The goal of AIDS education is to build a good information base that will promote behavioral changes that affirm sexual abstinence or effective use of condoms.

AIDS History

In June of 1981, The Center for Disease Control reported the first clues to the mystery that became the story of the HIV disease syndrome. For students beginning highschool now, it means that AIDS has been part of their lives since they were four or five years old. Many do not know those early years of discovery and the struggle and fear, even hysteria, for those early patients, scientists, doctors, health care workers, families, neighborhoods, and school systems. Telling that story often helps calm current fears because it parallels on adolescent's alarm, knowledge, and then understanding.

The first reports were of an outbreak of a rare pneumonia (*pneumocystis carinii*) and of a rare cancer (Kaposi's

sarcoma) in a group of homosexual men in Los Angeles in 1981. Both diseases affected those with weakened immune systems. An alarm was sounded as no cure was known, no explanation for the onset, and only theories about transmission. As the number of cases increased, fear ruled.

However, by 1982, epidemiologists figured out how the disease was transmitted and by 1984 the new virus was discovered. A test was devised to find the virus in blood the next year and checks for the blood supply were developed. Currently, there is not a cure but therapies and drugs have been developed that prolong and improve the quality of patients lives.

One doctor and research scientist who has been working in AIDS research for this ten year time span is quoted in *The New York Times* , “With my head I know we have made major strides, I know that. But with my heart, I know we haven’t begun yet.” (Kolato, 1991)

From the initial group of homosexual men, others began to show signs of illness. There was surprise and consternation as children and infants become ill. Drug abusers were another early risk group. Some of the means of transmission become clear—blood, mothers were giving it to their children in utero, and children with hemophilia were contracting the Virus from the blood products they received. (Shilts, 1987)

Victims from these early risk groups did not receive much sympathy until Ryan White and other celebrities gave AIDS a more human face. It is fascinating to ask adolescents today what they know of Ryan’s story and how he acquired AIDS. It is often a good reflection of their understanding and presents many issues for discussion, both medical and social. Teens certainly identify with his story and his struggle. The tale of discrimination that he endured is particularly poignant. Teens understand particularly well how important it is not to be different.

In New Haven, the history of AIDS followed a slightly different track from the notional one, and it continues to do so. Very early the virus became an issue for drug abusers. Consequently, New Haven has an extremely high proportion of women and children with AIDS. As the children grew to be school age, the question of being mainstreamed in a regular classroom came to a head. Fear was rampant in other parts of the country and challenges were being made in the courts as to how infectious AIDS would be in a classroom setting.

The Connecticut Civil Liberties Union sued the New Haven School District on behalf of several entering kindergarten children. They sued for the right for these children to be in school. While the case was being litigated the children were educated by a certified teacher in the offices of the New Haven Urban League. Also, during this time, Dr. Dow and the Board of Education mandated that all administrators, faculty, staff, students, and parents have AIDS education. The case was settled before it came to trial and the children have been enrolled successfully for several years now.

Adolescents At Risk

In 1986 Surgeon General Koop, in a widely publicized report, called for prevention efforts targeted on the next “at risk” population-adolescents. Teens are capable of all the risky behaviors that adults do, but combine them with their cognitive, emotional, and physical developmental issues. The number of adolescents with AIDS is low, less than five percent of the total cases reported. As of June 7, 1991 there were 208 cases reported for this year. (MMWR, 1991) Of the teenagers infected 46 percent are white, 34 percent are Black, 18 percent are

Hispanic. The new cases are overly represented in urban areas in minority populations.

Although the number of cases is low, they are deceptive because one fifth of persons with AIDS are in their twenties. The latency period between HIV infection and the onset of symptoms and illness can be as long as ten years. Therefore many of these AIDS patients acquired the virus in their teens. Also, a greater proportion of teens than adults with AIDS are female and members of minority groups, and have contracted the Virus heterosexually.

The profile of AIDS cases in the general population in Connecticut is different from the overall national profile. Connecticut continues to have the highest rate nationwide of AIDS in children and ranks fifteenth among states for HIV infection for women of child-bearing age. Our minority population makes up fifty-five percent of those infected, although they represent only fifteen percent of the general population. Nationwide, women are ten percent of those infected but in Connecticut women are twenty percent of the AIDS population and women are almost thirty percent of those with AIDS in New Haven. (Morris, 4/23/90) There is a clear and ominous heterosexual transmission pattern in our community.

In the midst of these gloomy statistics, there appears to be a window of opportunity for prevention. Those who have looked for HIV infection in high risk groups in New Haven have not found alarming numbers. We have an opportunity for educational interventions.

Adolescent behavioral factors that put them at risk for HIV infection are well known. Teen pregnancy, sexually transmitted diseases, drug and alcohol abuse, runaways and prostitution are all issues in the public eye that are viewed with alarm and as out-of-control.

Even with the threat of AIDS being highly publicized, today's teens continue to be sexually active. In the last ten years the percentage of sexually active teens has risen dramatically and the age that they begin has fallen. The Teen Pregnancy Coalition of Connecticut recently reported that the pregnancy rate for ten to fourteen year olds increased by 100 percent from 1980 to 1987 in this state. The rate for the fifteen to nineteen year olds rose by twenty-three percent.

Connecticut is fifth in the country in its rate of teen pregnancy and it's a problem for suburban, rural, and urban communities. Twenty percent of birth in New Haven in 1990 were to teen mothers. The New York Times Connecticut section on July 7th had a major article about the concern with the continued rise in teen pregnancy. However not one mention was made about the threat of HIV infection in this population. We compartmentalize our interventions and educational programs for risk-taking behaviors.

Conceptually, sexually transmitted diseases are similar to HIV infection for adolescent. With both of them a teen doesn't want to believe that they will contract them and they know that their partner wouldn't have one. The statistics for STDs are startling and little known in the school community. Teenage pregnancy is visible but sexually transmitted diseases are not. Once again it is a stigmatized topic that also connotes promiscuity. Twenty-eight percent of reported cases of gonorrhea in New Haven during the first three months of 1990 were adolescents. The statewide STD rate increased 900 percent between 1986 and 1980 for fifteen to nineteen year olds. (Spinner,1990) Clearly this is a risky behavior, sexual intercourse without barriers, that needs educational intervention.

We target AIDS as a STD particularly with teens, but drug abuse is another risk-taking behavior that is common in the adolescent population. Sharing needles is a clear transmission route for HIV infection. School surveys show that teens use drugs but unfortunately, these numbers don't reflect the true picture because

the surveys are done with a school population. There is an enormous adolescent school dropout population that abuses drugs, particularly in inner cities. This is certainly evident in New Haven where the actual dropout rate is disputed but generally acknowledged to be substantial. For ninth graders in the school year 1990-1991 the average number of days out of school was thirty-nine, almost eight weeks. Consequently, the prevalence of drug use among teens is not known nor is the number of those that inject drugs intravenously. IV drug use is the second largest transmission category for AIDS at present in the United States and a concern is that it is a bridge to the heterosexual population.

Many factors impede reaching adolescent about drug abuse. Denial, lack of awareness of personal risk, mistrust, the addictive nature of the risk-taking, lack of space in treatment programs are all major intervention problems.

AIDS and HIV

AIDS (Acquired Immune Deficiency Syndrome) is caused by a virus (Human Immunodeficiency Virus).

A cquired—something you get or develop

I mmune—system in the body to fight foreign material such as bacteria or transplanted tissue

D efficiency—a lack of something

S yndrome—a set of symptoms, signs and other findings that frequently accompany each other

AIDS results from the damage done to the immune system by the HIV infection. The virus makes the immune system less able to fight off infection. Because the system fails, a person with AIDS develops a variety of life-threatening illnesses. This process may take many years (up to ten or more).

Terms are important in the preventive education of this disease because adolescents believe that you look sick and feel sick when you have an illness. The focus is changing from the term AIDS to HIV infection so that teens understand the full range of the disease—beginning with infection by the virus and concluding with AIDS.

AIDS—is the result of a long process that begins with HIV

HIV—the virus is a germ that causes the illness

HIV infection—when the virus enters the blood stream and begins to damage the immune system

HIV+—one has a positive blood test showing that they have antibodies to the virus while one is not sick, one can still pass the infection on to others

What is the difference between HIV and AIDS? One is the cause, the other the effect: a person will not develop AIDS unless he or she has been infected with HIV. If we prevent HIV infection, we prevent future cases of AIDS.

How does someone get AIDS? When the virus, HIV, is spread through blood-to-blood or sexual contact with someone who has the virus, the end result of the HIV infection is AIDS. The most common ways that people

become infected with HIV are:

- ¥ through sharing needles or syringes with someone who has the virus: some blood containing the virus is passed from one person to another
- ¥ through having sex vaginal, oral, or anal with someone who has the virus
- ¥ through exposure of a baby to an infected mother's blood during pregnancy or delivery, or rarely, through breast feeding
- ¥ through receiving blood transfusion, or certain blood products infected with the virus. (This is rare, since 1985 the American blood supply has been tested for HIV.) (CDC, 1990)

How do you get HIV through sex? It is spread through sexual intercourse from male to female, female to male, or male to male. HIV can be in an infected person's semen, blood, or vaginal secretions. It can enter the bloodstream through normal cells or unseen cuts or sores.

How do you get HIV from sharing needles? Blood from an infected person can stay in a needle or syringe and then be transmitted to the next person who uses it. It can happen regardless of what it is that's being injected.

Who can get AIDS: Anyone who does risky behaviors. It's not who you are, but what you do.

Who are the adolescents with HIV infection at present? Many of the teens who are infected now are hemophiliacs. It is a rare, inherited bleeding disorder of males in which blood clotting is abnormal. It is treated with either a product made from human blood from donors, or a product made through recombinant genetics, both of which allow normal clotting to occur. These young men acquired the illness from blood products they received prior to 1985. Ryan White is the best known example of a teen with hemophilia who died of AIDS. Some children who acquired HIV infection from their mothers are beginning to reach the early teen years. The third group acquired HIV infection from their own risky behaviors, sex with someone who was infected or sharing needles with someone who was infected. If teens are conscious of these behaviors they can protect themselves.

The ways by which one cannot get HIV infection are also important to know. AIDS/HIV are not casually transmitted. One will not contract HIV infection in the normal course of daily contact with friends, at school or at work. HIV doesn't live in the air or on things that people touch. HIV is not spread by:

- ¥ coughs or sneezes, sweat or tears
- ¥ holding or shaking hands, hugging, touching someone with the HIV infection
- ¥ swimming pools, hot tubs, showers, locker rooms, bathtubs, or toilet seats
- ¥ mosquito bites the virus does not live in a mosquito and is not transmitted through a mosquito's salivary gland not from bed bugs, lice flies, or other insects
- ¥ eating in a restaurant or using a public phone

The virus does not survive outside the human body, one doesn't get HIV infection through "casual contact."

Currently, the issue of the dentist in Florida who is believed to have transmitted the virus to several of his

patients is getting lots of attention. As I write this, the United States Senate has passed two proposals pertaining to health care workers and HIV infection. One would mandate prison terms of at least ten years and fines of up to \$10,000 for health care workers who knew they had AIDS but failed to inform patients on whom they had performed invasive procedures. Another proposal that passed would direct states to require health professionals engaged in invasive procedures to be tested for AIDS infection. It would bar those infected from performing invasive procedures unless they received permission from a panel of experts and informed their patients. States that didn't comply would risk loss of federal health financing. Neither of these proposals have passed in the House of Representatives.

This issue would certainly stimulate discussion in a classroom. It would bring up the question of testing. How often would health care workers have to be tested. Adolescents like the concept of testing because it seems concrete. But what does testing actually mean? A positive test means that you have the HIV antibodies in your blood. A negative test isn't so clear. It means you do not have antibodies in your blood but you may still have the virus in your blood. It can take up to eight months for your body to make the antibodies after you get the virus. A negative HIV test means that you do not have the virus only if you have not been exposed to the virus over that time span.

Another issue that caused consternation in the classroom was the news item about allergy to latex. One student's mother walked into class and announced that she was never using condoms again. It behooves teachers to be up on the current news about AIDS and I have included a lesson for students to bring in current articles.

The definition of AIDS is also under debate. Since HIV infection attacks the immune system, opportunistic infections take many forms. The standard definition of AIDS is being rethought, because the characteristics of the illness that are required for inclusion often are not those that women get when they are infected with HIV. The definition was developed years ago when most of the cases were men, and it's meant that it has been harder for women to be declared eligible for various benefits when they have the illness. The issues include: when an HIV infection becomes AIDS and when AIDS becomes disabling. Women rarely get Kaposi's sarcoma, but they do get cervical cancer which is not included in the standard AIDS definition.

Recently, an international conference on AIDS in Florence, Italy, produced a staggering forecast of a world AIDS epidemic. *The New York Times* outlined several of the AIDS mysteries under investigation: (Altman, 6/25/91)

- ¥ Geography—why does the HIV infection spread faster in some countries than others
- ¥ Survival—why do some infected people live years while others get sick quickly and die
- ¥ Infection—where does the virus enter the body and how does the infection begin
- ¥ Defenses—why is the immune system ineffective against HIV
- ¥ Drugs and Vaccines—why does drug resistance develop and how can the vaccines be tested
- ¥ Kaposi's sarcoma—why mostly in gay men
- ¥ viral strains—how many strains must researchers study

Is there a cure for AIDS? No. There are medicines that help people with HIV infection live longer but there is no cure. There is cautious optimism about the development of an AIDS vaccine. There are several being tested now but only for safety, not for effectiveness.

AIDS Curriculum

Since education is viewed as the primary mode for prevention for adolescents, no expense is being spared in the development of curriculums. There are myriads of curriculums developed and being developed for every age group and to fit into many different subject areas. Unfortunately, information alone is not enough to persuade teens to protect themselves. Many teens know the basic information now about AIDS and how it is transmitted but they are not changing their behavior. What teens need to know about AIDS seems to be well established, it's the way they internalize that information so that they can make conscious decisions to protect themselves that is vitally important. AIDS curriculum is more than knowing why and what to teach it is also knowing how to teach, and how to get what's taught translated into action.

One curricular mode gives a general basic overview of AIDS and its transmission. The basic premise is sound: you can protect yourself from HIV' infection. M. Quackenbush states the concepts for this mode as being 1) HIV infection is caused by a virus, not a lifestyle, 2) HIV infection is not casually transmitted, 3) anyone can contract it if they have sex or share needles with an infected person. (Quackenbush,1988)

Another mode stresses not only the basic information about AIDS but also the setting in which the teaching is done. Some of the strategies mentioned for successful AIDS education of this variety are: 1) the context of the community values and diversity should be considered, 2) teaching should begin early in the school life of a child and continue, 3) adequate teacher preparation, 4) the curriculum should be developmentally appropriate, 5) acknowledge and include the range of potentials of human sexuality, 6) promote positive health values, and 7) it should support responsible decision-making. (Dodds, Volder, and Vivian, 1989) These are admirable and important strategies for successful AIDS education but there is a more comprehensive view that I find challenging and possible in the context of our ninth grade social development curriculum.

We ask adolescents to make a complex set of health and personal decisions, each of them crucial to their well-being, at a time in their lives when they are struggling with their own identity, just beginning to think about the future, and questioning those adults that have the information they need.

It is William Fisher's (Fisher, 1990) contention that too many curriculums contain irrelevant information and that adolescents are not "provided with a precise script for preventive behaviors in their social milieu." He also believes that pregnancy prevention, sexually transmitted diseases, and HIV infection are related behaviorally and produced by similar factors. These include:

- ¥ unwillingness to acknowledge in advance sexual activity and preventive needs.
- ¥ failure to seek out relevant preventive knowledge.
- ¥ unwillingness to buy contraception/condoms in public.
- ¥ failure to discuss and negotiate prevention methods before sexual involvement.
- ¥ failure to do prevention in the moment it's needed.

This integrated approach to the problem makes sense to me. To compartmentalize these issues makes it harder to include them in a school curriculum for all the reasons mentioned previously. To integrate the strategies for working with these issues means that we can be more focused on decision-making and can combine the educational and health resources.

The problem-solving model of the ninth grade curriculum with its five step approach is an ideal way of practicing preventive behaviors. We ask teens to 1) Stop, calm down and think, 2) Say the problem and how you feel, 3) Set a positive goal, 4) Think of lots of solutions, 4) Think of the consequences, and then 5) Go ahead and try the best plan. The students learn this framework before the AIDS week begins and it seems the perfect setting for practicing what Fisher calls his preventive strategies.

Fisher starts with the premise that adolescents must be helped to acknowledge their sexuality and make a self-assessment of their risk for pregnancy, STD, and HIV infection. Even though the sexual messages that are given to teens are very ambiguous they must get the message that sexuality is a part of life. The next step is to learn the relevant preventive behaviors for who they are. They may want to learn those things they can do to set a limit short of intercourse or they may want to learn safer sex techniques. A crucial step is to bring the decision into a conscious step—to choose to do prevention. Following that they need to practice how to negotiate with a partner what they want and then how they can do the preventive steps in a public setting. For instance, they may want to carry out a role play about going to buy condoms. Once they have done these steps, then they have to be able to practice them consistently, not just when it is convenient or when they feel like it. This is not an easy task for teens who are often caught up in the moment. Finally, they may change what they want and they have to be able to shift from one preventive mode to another.

Some issues related to successful curriculums are out of our control. Some teens see pregnancy as a solution for the very desperate conditions in their lives.

AIDS Education in the Classroom

We are fortunate to have the problem-solving model of the social development curriculum in which to teach clear information about AIDS. Students learn to consider a life experience and how it feels and then to consider solutions and consequences before they act. Also built in is a chance to practice new behaviors with role-playing. Every AIDS education specialist mentions this as crucial because students can know all the facts but unless they recognize the risk and behave accordingly how much they know doesn't matter. It can all be irrelevant information unless there is a way of practicing preventive behavior in their social milieu. (Fisher, 1990)

One major factor in an AIDS instruction curriculum is the need of a safe environment for discussion and interpersonal trust of someone who is comfortable with the material. The classroom atmosphere is critical because students need to share what they know, what they don't know, and what they think they know. They have to feel that their opinions have value, and they have to take a few risks in the process.

At the beginning of the AIDS week the review of a set of ground rules for the class is a good idea. On a list of suggestions for helping students feel safe would be:

- ¥ no putdowns,
- ¥ be sensitive to other's feelings,
- ¥ you have a right "to pass" not say anything,
- ¥ what's said in the room stays in the room,

¥ there are no “dumb” questions.

Students sometimes generate others.

A teacher must remember the tremendous diversity found in a ninth grade class in terms of maturation, ethnic and cultural background, and education. Another way of looking at a class for AIDS week was developed by the American Red Cross (1987). They suggest visualizing a classroom as some students:

- ¥ may be infected with the virus,
- ¥ may have a family member with AIDS,
- ¥ may have had a family member die of AIDS,
- ¥ may abstain from sexual activity,
- ¥ may use illegal drugs,
- ¥ may be sexually active,
- ¥ may have an alternative lifestyle,
- ¥ may have very different cultural values.

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Shilts, R. *And The Band Played On*. New York: St. Martin's Press, 1987. This book on the early days of AIDS reads like a mystery. There are more technical books on the history of AIDS but this one tells the story very vividly.

Curriculum and Preventive Guides

American National Red Cross, *AIDS Prevention Program for Youth*. This is a comprehensive, yet lively, overview of AIDS issues, basic information, creative activities and prevention strategies.

Yarber, W. L. *Looking Into AIDS*. Bloomington, Indiana: Phi Delta Kappa, 1989. A standard AIDS curriculum handbook.

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Books

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HIV infection.

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White, R. and Cunningham, A. M. *Ryan White: My Own Story* . New York: Dial Books, 1991. Ryan White tells his personal account, how he got AIDS, his struggles and legal battle to return to school, and his life as a spokesman for AIDS.

Prevention Guide

Department of Health and Human Services, Public Health Service, Center for Disease Control. *AIDS PREVENTION GUIDE* . Rockville, Maryland: National AIDS Information Clearinghouse, 1991. This folder is filled with basic information written in a clear and interesting way. It includes many common questions that teens ask.

Films

These are available through M. Kavanagh at the Social Development office or through Planned Parenthood

“Don’t Forget Sherry”—American Red Cross An excellent, open-ended video that enables teens to ask questions of themselves about their own risk-taking behaviors.

“Teen AIDS in Focus”—Three teens tell their stories of living with AIDS. Their honesty is very compelling to other teens.

“Seriously Fresh”—Select Video Adolescent black males explore ways of insisting on safer sex and condom use.

“Vida”—Select Video The same story is told two ways in this film, once in Spanish and then in English.

Lesson I

Goal To determine what information and what misinformation students already have

To see AIDS as more than just a illness AIDS also brings up emotional issues, sexuality, death, and intolerance

Objective To introduce the subject of AIDS and to clarify the focus of the curriculum and to see how the issues are related.

Procedure Ask the students to brainstorm what comes to mind when they think of AIDS. Then, question the student to see how their ideas are related to others. Develop on the board the themes that surround AIDS.

(figure available in print form)

Summary AIDS is a complicated topic with a wide range of issues and emotions.

Lesson Plan Terms

Goal To familiarize students with the terms they will be using during AIDS education

Procedure Hand out the sheet of terms and definitions for them to match. After they complete it, use the sheet for discussion. This is an activity to learn the terms, not to grade.

- | | |
|-----------------------------|--------------------------------------------------------------------------------------|
| 1. Immune | ___ male-female sexual attraction |
| 2. Hemophilia | ___ sexually transmitted disease |
| 3. Intravenous | ___ something you get or develop |
| 4. Heterosexual | ___ takes advantage of a immune system weakened by HIV |
| 5. STD | ___ enters the body and bloodstream directly through a vein |
| 6. Syndrome | ___ sexual attraction directed toward the same sex |
| 7. Abstain | ___ system in the body to fight foreign material such as bacteria |
| 8. Antibodies | ___ postpone sexual activity |
| 9. Acquired | ___ a type of cancer that people with AIDS have more often than other people |
| 10. Homosexual | ___ a rare, inherited bleeding disorder of males in which blood clotting is abnormal |
| 11. HIV | ___ protein substances made by the body in response to an invading germ |
| 12. Kaposi's Sarcoma | ___ the virus is the germ that causes AIDS |
| 13. Opportunistic Infection | ___ a set of symptoms, signs that frequently accompany each other |

Lesson Plan In the News

Objective To familiarize students with the current issues about AIDS and to raise questions for the experts during AIDS education week

Procedure Ask students to bring in articles about AIDS from current newspapers and magazines. The teacher should have several on hand as well.

Discussion Where do we hear about AIDS? News?, movies?, soap operas?, Cosby show? others? What messages do we get from the media about AIDS?

Categorize the articles they bring. For instance, they may have articles on local or national statistics, articles of human interest about someone with AIDS or HIV infection, articles on research or new developments in regard to vaccines or drugs, or articles about issues of employment, housing, or jobs for AIDS patients.

Divide the students into groups and have each group take a topic and report on it. They must read the articles and develop a report to give to the rest of the class.

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