AIDS EDUCATION IN MIDDLE SCHOOL

AIDS EDUCATION IN MIDDLE SCHOOL

By

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A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfilment of the Requirements

for the Degree

Master of Arts

McMaster University

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MASTER OF ARTS (1994)
(Sociology)

McMASTER UNIVERSITY
Hamilton, Ontario

TITLE: AIDS Education in Middle School

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SUPERVISOR: Dr. Dorothy Pawluch

NUMBER of PAGES: vi, 110

ABSTRACT

AIDS education for adolescents has become a major concern. Not only are adolescents one of the fastest growing groups of individuals becoming infected with HIV, they are also one of the most challenging groups to reach with this vitally important information. Although previous studies have found that the content of an AIDS educational curriculum is important, they also show that teachers' presentation styles have a significant impact upon the effectiveness of lessons about AIDS. This study of twelve health and physical education teachers teaching about AIDS, looked at how their perceptions and attitudes about the task at hand influenced their teaching strategies. The study found that these twelve teachers had a variety of concerns about their roles as AIDS educators, and that their concerns impacted their level of commitment to teaching about AIDS. Through classroom observations and in-depth interviews, three distinct categorizations of commitment by the teachers were found: teachers who were "enthusiastically committed", teachers who were "unenthusiastically committed" and teachers who were "uncommitted".

ACKNOWLEDGEMENTS

Eternal praise and glory to my Heavenly Father and the Lord Jesus Christ. I live in you.

I wish to express my heartfelt gratitude to Doctor Dorothy Pawluch who, with enthusiasm, confidence and patience, acted as my thesis supervisor, as well as mentor and friend. I would also like to thank my committee members, Doctor R. Jack Richardson (Sociology) for his warmth and constructive support, and Doctor Roy Cain (Social Work) for his expertise and guidance. Sincere appreciation to the teachers who participated in this study. I am grateful to you all.

Much love to my parents, Albert and Evelina, whose support and encouragement has been unwavering. Just so you know..."the train is still on the track".

Many thanks also to Benita and Dean Hopkins, and to Deanna Barnes. Your confidence is inspiring.

Finally, to my husband Gord, whose faith helped to make my efforts possible...I thank you. You have my love, my respect and my admiration.

For Elysse, Lauren, and Rhiannon.

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CHAPTER ONE

AIDS Education in Middle School; An Overview

INTRODUCTION

In the last ten years, Acquired Immune Deficiency Syndrome (AIDS) has become a major health concern. Between November 1985 and January 1993, in Ontario alone, there have been over 14,000 confirmed cases of infection with Human Immunodeficiency Virus (HIV) in the general population (Ontario Ministry of Health, 1993). AIDS, referred to as "the plague of the twentieth century", is currently the leading cause of death of 25 to 49 year old men and 20 to 39 year old women (Cannon 1992).

To date, there are no known cures or vaccines, and no particularly effective method of treatment for those who have contracted the virus. But we do know what causes AIDS and, therefore, how to protect ourselves from it. HIV is transmitted through the exchange of blood or blood products, and therefore, prevention involves the careful avoidance of infected fluids.

Despite our knowledge about how AIDS might be prevented however, infection rates continue to escalate,

particularly among women and adolescents. Many members of these groups continue to needlessly expose themselves to HIV, and unless a cure or successful method of treatment is discovered, many more will pay the ultimate price for their actions. This makes it imperative to look more closely at education, and at our efforts to inform and educate young people, in particular, about the dangers of the virus and how infection might be avoided.

The purpose of this thesis is to examine education programmes for adolescents. More specifically, I look at educators involved in teaching AIDS-related lessons to twelve and thirteen year-old students in middle school. The teachers were all employed by one Board of Education in Southern Ontario, though they taught at different schools. I talked to the teachers and observed them in their classrooms over the time period November 1990 to June 1993. When I first began my study, I was interested in looking at AIDS education from the perspective of both the teachers and the students. However, as I became familiar with the complexity of the interaction between the two perspectives, I realized that examining both would be difficult, if not impossible within the space of this thesis. I decided, therefore to focus on teachers. I intend to look at the student perspective in a future study.

My intention in this thesis is to discuss the AIDS curriculum, what materials it contains, how teachers feel

about the curriculum, and how they go about the business of presenting AIDS-related information to their young charges. I have organized the thesis around these central questions and the thesis is structured in the following fashion. In the remainder of this chapter, I discuss the theoretical framework and the methods I employed. This is followed by an overview of the relevant literature on AIDS education. In Chapter Two, I look at both the curriculum itself, and how it came to be adopted by the school board. Chapter Three deals with the range of issues and concerns that the AIDS curriculum raised for the teachers, and focuses on how teachers talk about the curriculum. Chapter Four deals with how these concerns were reflected in their actual classroom behaviours. Central to both Chapters Three and Four is the distinction I draw between teachers who were enthusiastically committed to their role as AIDS educators, those who were haltingly or unenthusiastically committed and those who were clearly uncommitted. Chapter Five provides a review of the key issues as well as a discussion concerning the findings of this study as they apply to current work in the sociology of education. Future considerations are also discussed.

THEORETICAL FRAMEWORK

This study of these teachers' approaches towards AIDS education is informed by a symbolic interactionist

perspective. Developed by Herbert Blumer and his associates, symbolic interactionism asserts that individuals' experiences are shaped and molded by their interpretations of their experiences. Further, these interpretations, as formulated by individuals from and during social interaction, are used by individuals to achieve specific goals (Jacob 1987). According to Blumer (1969), humans' actions are rooted in the meanings that we attach to objects and/or events. We do not respond to our environments from a purely instinctual level, nor do our actions spring simply from previous conditioning. Rather, our responses are linked directly to how we interpret our experiences in our symbolic environments.

> The actor selects, checks, suspends, regroups and transforms the meanings in the light of the situation in which he is placed and the direction of his action. Accordingly, interpretation should not be regarded as mere automatic application of established meanings but as a formative process in which meanings are used and revised as instruments for the guidance and formation of action. (Blumer, 1969, p.5)

Ritzer (1983) discusses three points that are critical to symbolic interactionism. First, there must be a focus on the interaction between the actor and the world. Neither the actor nor his or her environment can provide meaning alone. Rather, it is through social contact and interaction that meaning is found. Second, both the actor and the world are understood as being dynamic, and not static processes. They

are each involved in a continual process of change and/or development. Since both are perpetually transformed, meaning is derived through, and because of the transformations. Third, there is tremendous importance placed upon the actor's ability to interpret his or her social world. Meaning comes only from the interpretation of the interactions that take place between the dynamic social actors and from the context within which they interact.

The work of Charles H. Cooley, John Dewey, W.I. Thomas and George Herbert Mead have provided much of the theoretical basis for the symbolic interactionist perspective. Mead, who provided much of the core for symbolic interactionist theory, called his basic concern "social behaviourism" (Ritzer 1983:173). While he acknowledged that behaviours easily and physically observed were important, he also asserted that surreptitious facets of behaviour were equally significant. A summary of Mead's position is provided by Bernard Meltzer:

> For Mead, the unit of study is "the act" which comprises both overt and covert aspects of human action. Within the act, all the separated categories of the traditional, orthodox psychologies find a place. Attention, perception, imagination, reasoning, emotion, and so forth, are seen as parts of the act... the act, then encompasses the total process involved in human activity (Meltzer, 1964 in Ritzer, 1983:173).

Clearly, for Mead, individuals bring with them to each

social interaction or "act", a whole series of understandings, previous experiences, emotions and perceptions. Through each subsequent interaction, the individual has more associative experience to interprete, and each interaction functions as the latest portion of a continual process.

Mead also asserted that the humans' mental capacity, which provides the ability to use language in response to stimulus, was also of tremendous significance (Ritzer, 1983:174). Some behaviourists argued that there was little difference between animals and humans, yet Mead's contention concerning language provided testimony about this most important qualitative difference. While he described a dog fight as merely a "conversation of gestures", one dog eliciting the other's reponse without the intervention of mental deliberation, he asserted that most human interaction involves mental intervention. For humans, gestures often become "significant symbols" that may have numerous meanings. The meanings rise out of the context of the situation. Ritzer provides the example of a raised fist: in a dark alley, a raised fist clearly spells out trouble, while on a busy street corner, it may simply mean the hailing of a cab (Ritzer, 1983:177).

Mead's assertions about mental interventions and verbalizations are especially important to symbolic interactionists.

> The verbal significant symbol was particularly important to Mead, because we can almost always hear ourselves, although we may not always be able to see our physical gestures. What we say affects us as well as those with whom we are communicating. Thus, as we are speaking, and before the other person has a chance to react, we can decide whether what we are saying is likely to elicit the desired reaction. If we decide that it is not going to elicit the response we want, we can quickly clarify our meaning (Ritzer 1983:178).

Symbolic interactionists contend then, that behaviour is not "caused" by either internal forces such as instinct or by external ones such as culture. Rather, they argue that behaviour rises through "a reflective and socially derived interpretation of the internal and external stimuli that are present" (Meltzer, Petras, and Reynolds 1975:2). As well, symbolic interactionists largely follow Mead in his understanding of the "self", one that has two parts, the I and the Me.

> The I is the impulsive tendency in individuals... The Me represents the incorporated "other" within the individual, that is, the organized set of attitudes and definition prevailing within the group. "In any given situation, the Me constitutes the generalized other and, often, some particular other. Every act begins in the form of an I and, generally ends in the form of a Me. For the I constitutes the initiation of the act prior to its coming under the control of the definitions or expectations of others" (Meltzer et al 1975:61). The self is seen as a flowing process of interaction between

the I and the Me (Meltzer et al:63).

Symbolic interactionists understand that both the actor and his or her environment cannot easily be separated. While behaviours by the actor begin with the I, the internal and impulsive part of ourselves, we cannot help but shift into the Me, in a sense conforming to, or at least consulting with what others expect of us. This dance between the initial impulse of I, and the internalization of external forces, the Me, coupled with moment by moment interpretations of our interactions, is what ultimately shapes much of our observable behaviours.

In order to conduct research, symbolic interactionists most often use life histories, autobiographies, case studies, letters, interviews, and most especially, participant observation (Jacob 1987:30). The point of the data collection is to get "inside the experience of the actor" (Blumer quoted by Meltzer et al 1975:57-58). While research is being conducted, we make notes about our observations, and subsequently put together "theoretical notes that are self-conscious, controlled attempts to derive meaning from any one or several observation notes" (Schatzman & Strauss 1973:101). Jacob (1983) quotes Schatzman and Strauss for further clarification:

> In these early efforts the researcher "plays" with data, relating observations to one another, developing new concepts,

> and linking these to ones in the literature. These short notes are then linked together and expanded into longer "analytic memos" for increasing conceptual development...In following these steps researchers seek to identify and discover "significant classes of things, persons and events and the properties which characterize them" (Schatzman and Strauss 1973:110).

Using symbolic interactionism to look at teachers who present AIDS educational lessons to students in middle school allows for the research to not only report on what appears to be going on in the classroom, but also to delve deeper into the covert issues at play for the teacher. Symbolic interactionism has allowed the understanding that although each of the teachers who participated in this study functioned as an educator in their own unique way, their behaviours, both in their differences and similarities, are reflections of their perceptions about their role as "AIDS educator". If we make the symbolic interactionist's assumption that their behaviours began as I, the impulsive part of their selves, then subsequently as Me, the incorporated "other" part of their selves, we can understand that their actions are products of both internal feelings and attitudes as well as those expectations that have been imposed upon them from external and social sources. In other words, the observable behaviours in the classroom are the ultimate product of the I, the Me, and the ever-dynamic interpretation of social

interactions, inside and outside of the classroom. Sara Delamont's work in the sociology of education supports these premises:

> Symbolic interactionists are found both in sociology and social psychology departments, for the set of theories they espouse transcends that division. In general they study situations of face-to-face interaction rather than producing theories about whole societies, or conducting artificial experiments. Educational institutions are therefore exactly the sort of topic for an interactionist approach (Delamont 1976:15).

On a more specific note, symbolic interactionism has enabled the classification of the teachers who participated in this study into three distinctive groups. Although their externally observable behaviours may appear to be the major impetus that allowed for classification of "enthusiastically committed", "unenthusiastically committed" and "uncommitted", it is more correct to say that it is their belief systems, impacted by both internal and external sources, that have resulted in their perceptions about the appropriateness of AIDS education for young adolescents. It is these perceptions that help to guide their observable classroom behaviours.

METHODOLOGY

My interest in AIDS education for middle school students rose out of my experiences as an occasional teacher

for the Board of Education. As a "supply", I had the opportunity to teach health education lessons at several middle schools in the city, and became intrigued by classroom dynamics, particularly during sexual education lessons. I became familiar to the students, and perhaps because I was not the threatening "regular" and evaluating teacher, I found that the students rarely held back both their thirst for and interest in information about sex. My experiences in these health classrooms provided me with the impetus to examine the education these young students were receiving about HIV and AIDS.

GETTING INTO THE CLASSROOM

The logical starting point for my study was to gain access to the AIDS education classroom. Because I had come to know a number of physical and health education teachers, I discussed my plans with them, and asked whether or not they would allow me to sit in and observe their AIDS lessons. Each of the six (three male and three female) teachers I approached supported my efforts wholeheartedly, and they invited me to begin my work with them. One of the three female teachers I originally approached, suggested that I speak with two other physical and health education teachers she thought might be interested in participating, and it was through these

recommendations that I managed to ultimately find the twelve interviewees included in this study.

Once I found willing teachers, I spoke with their principals in order to secure permission to be in each school. I though that if I managed to set up an enthusiastic and supportive network within the schools, approaching the Board of Education with names and dates might make the process of formal approval more expedient. It did. I drafted a letter to the Board of Education's Associate Director of Education outlining my study plans and objectives (see Appendix A). I was able to obtain the Board of Education's permission to conduct my study in their schools. The only conditions the Board set, were that I not introduce any new material to students, and that I not identify anyone by name, or use the names of the schools, teachers or students in my thesis. The final organizational step was to determine when each of the teachers would be presenting the AIDS material to their classes and to set up a schedule for my observations.

I began my research by reviewing the Board-supplied health curriculum. The HIV and AIDS lessons fall at the end of the curriculum, and according to the guidelines provided for teachers, approximately two hundred minutes should be set aside for these classes. After I became knowledgable about what was contained in the curriculum, I began the classroom observations.

Rather than setting up a hypothesis to test, I followed the grounded theory or inductive approach (Glaser and Strauss, 1967) that a symbolic interactionist framework suggests. Since I was interested in discovering how teachers approach AIDS education, what kinds of teaching strategies they employed, and how students respond to the information presented to them, I felt it was important to go into each classroom without pre-conceived ideas about what I might find. My initial intention was simply to get a feel for the classroom activities as a whole. I was interested in observing how each teacher spoke to their students, how they went about introducing the information to them, how (or if) they encouraged their students to be active participants in their own education, and how they responded to their students' questions and comments. I took extensive field notes while I observed these classes, and I paid particular attention to what the teachers said, and how, and when and why students responded.

Each class differed significantly from the one before, and it was only after I had experienced a series of classes, presented by different teachers, that patterns began to emerge. It became clear that the teachers employed a range of different styles in the health classroom, that some were more comfortable with, and committed to, presenting the information, that others were less so, and that their styles,

strategies, and comfort or enthusiasm levels had a significant impact upon the presentations of the AIDS-related materials.

I observed more than one class for each teacher because I felt it was important to be aware of the varying approaches necessary for different classes. Some groups of students are more mature, or keen about the material than others and teachers responded accordingly. Because I was most interested in the differences in teachers' approaches and convictions concerning teaching about AIDS, I attempted to be as attentive to their own variances in style as possible. While some of the teachers carried on with little attention paid to me in the room, others invited me to participate in their classes. Most often, my participation was encouraged when students asked difficult or potentially embarrassing questions. The teacher often responded with "why don't we ask Mrs. Cook about her thoughts on that". I was happy to become a part of the class, and it was usually during these question and answer periods that I was able to gather the richest data. As students would ask me questions, I would attempt to provide the best answer I knew, but I would also ask a number of questions of my own. Their responses, and the responses of their teachers (both verbal and non-verbal) provided significant insight about AIDS education in the middle school classroom.

INTERVIEWS

I supplemented my observations with in-depth, informal interviews with the twelve teachers. All of the teachers who allowed me access to their AIDS education classrooms also consented to being interviewed. Although I had a few pre-determined questions I hoped to have answered, I began each interview with "can you please tell me about teaching about AIDS?" and then probed into those issues that presented themselves during our conversations. I was usually able to discover how and why they began teaching health and physical education in the first place, and whether or not they enjoyed their work. These points were important because they influenced the way in which the teachers approached their work, and the level of enthusiasm they had for "the job" also had a significant impact on how they went about teaching the AIDS lessons.

I sensed little reticence among the interviewees when it came to expressing their thoughts about the appropriateness of sex and AIDS education for students in grade eight. Those teachers who believed AIDS education was appropriate at this age level, were enthusiastic about their role as educators in general, and specifically about the contribution they were making as AIDS educators. These interviews were particularly lively. But the teachers who had reservations about what they

were doing, or who felt that AIDS education was clearly premature or inappropriate, were also fairly open about their doubts and criticisms. I believe the reason they were so open with me was related to our common experiences in the classroom. I had also been "a teacher" (albeit an occasional one) and there were many commonalities we were able to share. I had also taught with a number of these teachers in their schools. They might have been somewhat more reserved, and perhaps not as willing to reveal their true feelings if I had been a complete stranger.

I was able to interview six of the teachers at least twice, and in some cases three times. Although the interviews were usually conducted one-on-one, on two occassions I was able to interview both the boys' and girls' health and physical education teachers for one school at the same time. These interviews yielded interesting comparisons of teaching styles that I found to be particularly helpful. I also made a few follow-up telephone calls to the interviewees for clarification when I began organizing my data.

While conducting my research in the schools, I made a special effort to speak with each principal. As an occasional teacher, it had been my experience that the atmosphere or mood of a school was largely a reflection of the attitude or personality of its principal. Light-hearted principals often had jovial staffs, and those who ruled their halls with a

solid hand often had staffs who approached their classroom duties more solemnly. I felt it was particularly important to speak with the principals, since a number of the teachers had made special mention that having a supportive principal made their jobs significantly more pleasurable. It may also be true that the level of support the teachers received from their principal might have helped to determine how freely the teachers felt they could be in talking to me.

Although their questions and comments per se are not included in this thesis, I had numerous conversations with students about their lessons on HIV and AIDS. Some of the conversations took place during scheduled AIDS lessons (their teachers would defer to me) while others occurred more spontaneously, in hallways before or after class. I was also afforded the opportunity to circulate a self-designed questionaire to over two hundred and fifty grade eight students whose classes I had observed. The content and findings of this questionnaire are beyond the scope of this thesis. However, I felt it was important to mention these exchanges since the comments offered by students provided me with a wealth of information that relates directly to their teacher's strategies as well as classroom efforts.

REVIEW OF RELEVANT LITERATURE

There is a vast and quickly growing body of literature on the subject of AIDS education. Much of this literature focuses on the importance of reaching young people early with information about AIDS and how they might prevent themselves from becoming infected.

AIDS is not a gay man's disease, nor is it one that only effects individuals who use intravenous drugs and share dirty needles. HIV and AIDS are threats to all persons who have experienced more than one sexual partner, or whose partners have, and to all individuals whose professions, conditions and/or lifestyles involve contact with blood or blood products. Recently, adolescents have become one of the fastest growing groups in society becoming infected with HIV. Petosa and Wessinger (1990) outline the situation facing today's adolescent;

> About twenty-one percent of diagnosed cases of AIDS are between the ages of 20-29. Since the incubation period for AIDS can exceed six years, a number of these cases were contracted during adolescence...(and) as the number of HIV carriers increases, the lifestyle practices of adolescents will place them at significant risk of infection.(1990:128)

Professor Stanley Read, who is the Director of the AIDS program at the Hospital for Sick Children, argues for the early and intense education of schoolchildren "before they

become teenagers and start going through that phase of being immortal and immune and infertile and all the other "i" words" (Todd 1993:11). According to Read, education that comes after infection, is education that comes too late. Instead, adolescents require an appropriate AIDS curriculum that will help them to help themselves. DiClemente (1989) provides clarification;

> To make a reasonably well-informed decision about risk behaviours associated with HIV acquisition, adolescents need timely, accurate and unbiased information. Good decisions are rarely made with inadequate or incorrect information. The objective of HIV prevention programmes should be to encourage health-promoting behaviours and eliminate or reduce high-risk sexual and drug behaviours. Adolescents cannot be coerced into changing behaviour patterns; but, by providing clear and developmentally appropriate HIV information, we can provide an 'informational impetus' which, as a direct consequence, may result in the reduction or elimination of high-risk behaviours. (1989:76)

Bell (1991) reviewed a series of statistics that clearly demonstrate that somewhere between 30 and 65 percent of adolescent males and females are still engaging in "promiscuous" sex. She asserts that if students are encouraged to participate in their own education concerning HIV/AIDS, and are enabled to establish "norms of mutual protection and self respect that would allow them to change behaviours and preserve their social identification", success through education can be achieved (1991:138). Such success

may be demonstrated by the acceptance of regular comdom use as a normal and appropriate part of sexual activity. Bell's point is that by doing so, adolescents will not only protect themselves and their partners from HIV infection, but they will also have begun to establish new sexual norms for all others in their same age cohort.

Grover (1990) notes that many young people hold a false sense of security regarding their own personal risk of infection;

> Their physical resilience and feelings of invincibility are being tested against the very real risks of unprotected sexual intercourse and drug use. The current emphasis on abstinence will only drive sex deeper into adolescent culture where misinformation and magical practices too often take the place of effective prevention. It is time we admitted the reality of teenage sexuality.(1990:176)

Statistics reveal that adolescents are having unprotected sex. This behaviour is demonstrated by the continual escalation of both teenage pregnancy and sexually transmitted disease (Bell & Holmes 1984, Remafedi 1988, Petosa & Wessinger 1990, Wass, Miller & Thornton 1990, Boyer & Kegeles 1991). Currently in the United States, 15-19 year old heterosexuals are registering the highest rates of gonorrhea infection. These young people are not using effective protective measures from STDs, since condom use prevents their transmission (Grover 1990). Maticka-Tyndale (1992) discovered

that many individuals believe they can protect themselves through careful partner selection rather than through condom use. As one respondant offered; "What do you think, I don't have sex with just anyone! No, only with a girl who cares about me and who I care about, and I trust her" (1992:245). Petosa and Wessinger noted similar concerns when they discovered that students still hold "serious misconceptions...that you cannot contract HIV from someone who does not have visible symptoms" (1990:134). This is particularly problematic since only 40 percent of Petosa and Wessinger's respondants knew that AIDS is fatal. As well, some confusion exists about avoiding infection through participation in only "regular sex" as opposed to less conventional practices (Maticka-Tyndale 1992). These students have mistakenly assumed that having heterosexual vaginal sex, and avoiding anal or homosexual intercourse will keep them protected.

The literature also focuses on the type of educational programmes needed for young people. The stress is on accurate and unbiased educational programmes that offer clear and straightforward information (Shayne & Kaplan 1988, Brown, Fritz & Barone 1989, Ashworth et al 1992, Carabasi, Greene & Bernt 1992). Brown, DiClemente & Beausoliel (1992) suggest that educational programs be proactive, and that they emphasize role playing and discussions within groups so that

students may be taught condom-use skills, (sexually oriented) communication/negotiation skills, and be allowed the opportunity to increase their abilities to be assertive, even in the face of pressure from peers.

DiClemente (1989) argues that what must also accompany these programmes is a comfortable and unhurried environment where an honest exchange can take place between the educator and his/her students; "Teachers have a vital role to play in this mission. When properly trained, they can become powerful change agents in influencing adolescents to avoid high risk practices" (1989:76). Avoiding frank discussions in the classroom about sex and sexual practices does little to further the adoption of safer-sex behaviours and to curb the spread of HIV. It should also be noted that in order to prevent the mobilization of fear-induced defense mechanisms and to encourage behavioural change, the programme should offer the information in a non-threatening manner. Scare tactics simply do not work, and when they are employed, the adolescent is more likely to deny the existence or probability of risk within their own circumstance than they are to adopt safer-sex practices (Petosa & Wessinger 1990). Instead, graphic demonstrations such as those which employ condom-clad bananas can be used to facilitate learning (Shayne & Kaplan 1988). Adolescents require open-minded educators with a commitment to providing their students with a comfortable

environment within which to discuss the realities of sexual activity in the age of AIDS. Shayne and Kaplan (1988) further find that it is "important for AIDS educators to repeat information, challenge misinformation and confront confusion in an accepting manner" (1989:189). DiClemente (1989) agrees and provides guidelines for this very important teaching role:

> If teachers deliver AIDS information, they too must be trained...to commuicate this information. Unfortunately, teachers who feel uncomfortable discussing sexuality and specific sexual behaviours are not likely to be effective communicators or facilitators of frank, open discussions... Overcoming these biases and inhibitions are crucial to fostering an atmosphere where adolescents are encouraged to candidly discuss such sensitive personal topics as their sexual behaviour (1989:73).

Shayne and Kaplan (1988) point out that both the AIDS educational material, and the way in which it is presented, are of consummate importance if the material is to be accepted and the recommendations adopted. They argue that "educators need to overcome the embarrassment and shame that can prevent youth who lack knowledge from taking effective precautions" (1988:189). Teachers who are embarrassed to use terms such as penis, ejaculate, vaginal fluid, and condom, will appear embarrassed, and will subsequently send their students mixed messages regarding the appropriateness and normalcy of human sexuality. In other words, presentation is (virtually) everything.

DiClemente (1989), Shayne and Kaplan (1988) and Petosa and Wessinger (1990) also recommend that teachers receive some training before they step into the AIDS education classroom. These lessons should include a review of up-to-date, factual material concerning HIV and AIDS. As well, teachers should be furnished with relevant data concerning infection rates for various groups in society, particularly for adolescents, and be provided with pertinent details concerning the current condition in the medical fight against AIDS. DiClemente and Beausoliel (1992) recommend that teachers try to make the classroom environment comfortable, and that enough time be set aside for classes in order to ensure the proper coverage of the lesson material. Teachers should be clear, and their message non-threatening, in order to facilitate their students' understanding and acceptance of the information. Most importantly however, teachers are urged to teach in a pro-active style, and to encourage classroom discussions, while leaving any of their own biases or inhibitions behind. Implicit in this recommendation is that teachers should not be embarrassed to discuss sexual issues with adolescents. They should recognize that students will, in all likelihood, pose potentially embarrassing questions, and possibly provide rather personal glimpses of their private matters. Teachers should also be prepared to appropriately deal with queries concerning homosexuality and drug use since scare tactics,

contempt and/or indifference are counterproductive (DiClemente 1989).

What this literature review clearly reveals, is that anything less than committed enthusiasm for health education, and particularly for AIDS education, is detrimental to the learning environment. Yet, as I will show, many of the teachers involved in this study did not display this absolute committment to health and AIDS education. While some teachers approached the AIDS curriculum with a great sense of enthusiasm, others taught the AIDS education lessons primarily because they had to. In the remainder of the thesis, I will describe the range of approaches that the teachers brought to their teaching, and discuss the concerns behind these approaches. But first, I consider the curriculum itself.

CHAPTER TWO

The AIDS Curiculum

> We decided to be pro-active rather than to react to the Ministry of Education's mandate to implement an AIDS Education Curriculum. We wrote ours in the Spring of 1987 when it was only to be mandated in the Fall, and to this day, Boards of Education across Ontario come to us and ask "Do you mind if we use your curriculum as a guide for ours?"
>
> Curriculum Writing Committee Chair

Introduction

AIDS education was mandated in Ontario by the Ministry of Education in May of 1987. The Ministry also made available a document titled "Education About AIDS" which was sponsored in conjunction with the Ministry of Health. The document provided scientific facts about HIV and AIDS. In that same year, a committee was struck by the Board of Education for the district that my study involved. The purpose of the committee was to put together an AIDS curriculum that discussed HIV infection, symptom identification, treatment, and life impact

in an age-appropriate manner for young adolescents. This chapter will provide an examination of the process by which the AIDS Education curriculum was created.

The Writing Committee

The curriculum writing committee was first struck in the spring of 1987 because of the impending Ministry Of Education directive on AIDS education slated to become mandatory in the fall of the same year. The committee consisted of nine individuals: four major writers, one board of education consultant, one coordinator/editor, and three medical experts who provided consultative services to ensure accuracy. The coordinator/editor of the curriculum committee had been a member of the Ministry of Education's team that had co-written the "Education About AIDS" document (with the Ministry of Health). He was therefore aware of the Ministry of Education's decision to mandate AIDS education. Rather than waiting until the directive was issued, the Board decided to take a proactive approach and bring a committee together to begin its work. Each of the committee members volunteered their services, and all but the medical experts were Middle School Physical and Health Education teachers employed by the Board of Education.

The teachers who became involved in this effort had

each expressed a direct and personal interest in being a part of the writing committee. According to the curriculum coordinator, the participants shared a common dedication to quality health education, and it was this committment that drew them together. The teachers were aware that as Physical and Health educators, they had the necessary background in teaching strategies and classroom management, but they did not possess the necessary medical background to pull the curriculum together. For this reason, Dr. S. Landis, an infectious diseases specialist and Assistant Professor of Medicine at McMaster University Medical Centre was asked to act as consultant. Dr. Landis provided the committee with additional information concerning HIV infection which was used in conjunction with the "Education About AIDS" document, and acted as reviewer to ensure medical accuracy. Further consultation and medical expertise was provided by Cindy Ripton, a public health nurse with the regions's Department of Health Services (from the Sexually Transmitted Disease Program) and by Ellen Souter, a community educator in the Family Planning Program, also with the region's Department of Health Services. The contributions of these three consultants proved to be invaluable. According to the committee's coordinator, their efforts kept the writers on-track and focused, allowing the committee to concentrate on writing to their student audience, and relieved them of any concern

regarding the scientific accuracy of their curriculum's content.

The writing of the curriculum was a collaborative effort. Normally the procedure for curriculum development in this board involves individuals assuming responsibility for specific sections or chapters of the curriculum. Rarely do curriculum writing committees meet as committees. The writers simply submit their work. It is then up to coordinators and editors to conjoin the fragmented chapters into a cohesive whole. However, the AIDS curriculum writing committee preferred an alternate approach. Members felt that in order to put together a smooth, continuous and complete curriculum that would meet the requirements of their young students, particularly in such an important and sensitive subject area, the writers should work together. The committee's writers and coordinator/editor sequestered themselves in a centrally-located secondary school for eight days in May of 1987 to write collaboratively and without interruption. Finishing touches were completed during the summer months, making the document one of Ontario's first completed AIDS education curriculums. That fall, all of the board of education's middle school physical and health education teachers were invited to attend a half-day instructional course. At the inservicing, committee members discussed the content of the curriculum, and provided insights about how the lessons might best be

presented. The curriculum that teachers are currently using remains unchanged from the original draft produced in 1987, although there have been calls for a more up-to-date version.

The Curriculum

The AIDS curriculum that the committee ultimately produced consists of fifty-eight pages, and is part of the senior (grade eight only) middle school health education curriculum which runs one hundred and eighty-eight pages in its entirety. Lessons 14, 15 and 16 of the health education curriculum deal specifically with HIV and AIDS. Since these lessons are carefully integrated with the rest of the health education curriculum, it is important to look at the whole document. The curriculum covers the following lessons and suggests following time allotments.

Brainstorming (50 minutes)
Making A Choice (100 minutes)
Understanding Sexual Functions (125 minutes)
Stages of Physical Intimacy (150 minutes)
Facts of Life--Birth Control (350 minutes)
Communicable Diseases (50 minutes)
Sexually Transmitted Diseases (50 minutes)
AIDS--Related Problems (100 minutes)
AIDS--Case Studies (100 minutes)

In total, 1075 minutes of the school year is devoted to health education, 200 minutes of which belong specifically to lessons about HIV and AIDS. Depending upon the length of class periods (periods are usually 40 or 50 minutes each), a minimum of four or five health classes are necessary to cover all of the HIV/AIDS information included in the curriculum.

As a prologue to the actual health lessons, the writing committee included two teacher directive sheets to be noted before beginning instruction. The first concerns the importance of "Climate Setting", and it urges teachers to spend time developing and maintaining and atmosphere of trust and acceptance. The point is made clear with reference to Aspey (1977); "the higher the levels of understanding, genuineness, respect and warmth a teacher gives to students, the more students will learn". Also included on this sheet is a brief description of the role of the teacher in climate setting. It encourages the teacher to provide comfortable seating, lighting, temperature and ventilation, to accept each student as a person of worth and due respect, to build relationships of mutual trust and helpfulness, and to refrain from inducing competitiveness. Teachers are further urged to exercise "taste, discretion and sensitivity in dealing with specific topics on the area of sexuality education...(and) should introduce these topics carefully and deal with them in the context of a well planned total program". The second

directive sheet concerns the option of sending home a parent/guardian letter.

The curriculum begins with Lesson One focusing on the topic of Brainstorming. Ideally, teachers will introduce the unit by helping their students develop decision-making techniques. These techniques are intended to be utilized later in the program when the students will be faced with important issues concerning choices and their emerging sexuality. Fifty minutes of classtime is recommended for this lesson since two work sheets entitled "The Power of Choice" and "Take Action" are to be completed during in-class small group activity. Lesson Two is an extension of Lesson One, and focuses on similar problem-solving skills and the development of the understanding that all decisions have consequences. At least two fifty minute classes are recommended for this lesson, and worksheets to be completed include "I Am Nobody", "Decisions! Decisions!", "Confused and Used", "Win a Genie", and "My Problem-Solving Style".

Lesson Three begins the section of the curriculum that leads more specifically to classes concerning human sexuality. Seventy-five minutes of classtime is recommended here, and the curriculum states that the time should be devoted primarily to a review of the male and female reproductive systems (students were originally taught this section in Grade Seven). Pre and post lesson tests are included, along with a student worksheet

on the female menstrual cycle. Lesson Four is devoted to the development of communication skills. Students learn how they might express their thoughts, feelings and emotions with peers, parents and others. Fifty minutes is required to cover the materials for this class. Lessons Five, Six, Seven and Eight cover two hundred and fifty minutes of the health curriculum, and address issues surrounding human sexuality. Areas discussed include understanding the stages of physical intimacy, how to set limits for personal sexual involvment, developing an understanding of the concept of abstinence, understanding conception and contraception, and understanding various methods of birth control (including abstinence).

Lessons Nine, Ten, and Eleven require one hundred and fifty minutes of class time in order for the students to apply their decision-making skills to issues concerning their own sexuality. Abstinence is stressed, as is understanding the consequences associated with sexual activity. Students work individually and/or in groups on projects including poster creation, work sheets, and brainstorming for poor reasons to have sexual intercourse. Class discussions focus upon the possible risks associated with being sexually active. These lessons lead into class time that deals specifically with sexually transmitted diseases such as gonorrhea, chlamydia and herpes. Lessons Twelve and Thirteen have students discuss how such sexually transmitted diseases are spread. The curriculum

also suggests that time should be allowed for whole class and/or small group discussions concerning the signs, symptoms, and consequences of these illnesses.

The final portion of the curriculum deals specifically with HIV and AIDS. Lessons Fourteen, Fifteen and Sixteen require at least two hundred minutes of class time in order to cover the material fully, and students can be provided the opportunity to work individually, as well as in groups for these lessons. The lessons provide a comprehensive review of HIV and AIDS-related facts. Each chapter details the objective of the lesson and includes well-organized lesson plans intended to facilitate the classroom effort, and a series of fact sheets for students to read and complete. Also available is a list of videos available through the Board of Education's library services. The curriculum outlines a number of interactive strategies the teachers may choose to employ in their classrooms, complete with scenarios for role plays and suggestions for group work.

Lesson Fourteen begins the section with a pre-test on AIDS. "AIDS - Facts or Fallacies" is a twelve item quiz that presents statements to which students circle true, false, or undecided to reflect their belief regarding each. Two of the statements included are "A positive antibody test for the AIDS virus means that the person has AIDS" and "The AIDS virus can be spread through casual contact, such as touching or being

near a person with AIDS". The idea here is to determine how much knowledge the students may already possess, and hopefully give the teacher some sense of how to best address the upcoming lessons. Student fact sheets about HIV and AIDS are to be distributed following the pre-test. A definition and brief history about AIDS is presented as Fact Sheet A, and Fact Sheets B through E(ii) provide information concerning HIV and AIDS and the immune system, modes of transmission, facts and myths, signs and symptoms, and treatment.

Lesson Fifteen requires that the students apply their problem-solving skills to AIDS-related situations. For example, students are asked to discover the best solutions for "Cindy and Jim" who are wondering if they should be having sex after learning about AIDS, for "Karen" who is afraid to be around her friend who has AIDS, and for "Mark" who wants to know the best way to protect himself from getting AIDS. The class may be divided into small groups or students may work individually to solve these assigned problems. Upon completion, the students are asked to present their solutions to the class and their findings are discussed by everyone. A second assignment has students pretending they are the writers of a newpaper advice column providing advice for others. For example, "Afraid Alice" is having sex with her boyfriend (only) and wants to know what her chances are of getting AIDS, and "Worried Wilma" had sex with a high-risk partner and wants

to have an AIDS test but doesn't want anyone to know. Students' advice is to be discussed by the class upon completion of the worksheet.

Lesson Sixteen wraps up the health curriculum with work on case studies and AIDS. Examples of these case studies include "Peer Pressure and AIDS" where "Danny and Kathy" deal with sexual pressure and with importance of communication about the pressure they are feeling, and "My Brother has AIDS", where "Betty" tries to be a supportive and loving sister to "Michael" whose lover and roomate has deserted him. Students may be divided into small groups and given specific cases to investigate, and final presentations of their findings may be made to the class. A second option here is for students to become involved in role-playing rather than the conventional sit down, pencil and paper approach. Lesson Sixteen supplies fifteen student worksheets for this class alone, and teachers are encouraged to allow for ample time in order to complete this section in an unhurried manner. The unit closes with a post-test to determine how well the students were able to absorb the HIV and AIDS-related material.

A final aspect of the curriculum that needs to be addressed is the discussion that the writers included concerning the intended message for the Grade Eight student. They stressed that the major objectives of the curriculum are

for the student to develop a positive self worth, a sense of responsibility for choices made, an appreciation for the value of abstinence, an appreciation for the consequences associated with sexual activity, and for an appreciation of the importance of communication, especially concerning sexual matters. Students are expected to be able to take each lesson and, once grasped and accepted, apply its message to the next until the unit becomes its intended cohesive whole.

Skills that should be developed during this process included responsible decision-making, the fostering of positive and effective communication abilities, the development of comfortable and responsible limits for sexual involvement, the ability to recognize the symptoms of pregnancy and of sexually transmitted diseases, and importantly, to be able to locate community-based agencies for assistance and/or support regarding sexuality issues. Students are not expected to memorize each and every detail of the scientific data nor memorize each relevant statistic. Rather, they are encouraged to learn how to protect themselves, and to recognize when and how they might best find help for themselves should the need arise.

Students are however, expected to gain some specific knowledge from the health program. Information presented is intended to assist their ability to recognize the choices and responsibilities associated with sexual activity. Abstinence

is repeatedly offered as a positive, if not preferable option. In particular, students are expected to come away from these classes with a clear understanding of human sexual functions and of the stages of physical intimacy. They should be aware that disease can be spread through sexual contact, be knowledgable about selected sexually transmitted diseases, and know how their transmission can be prevented. As well, students should acquire an understanding of the various birth control methods.

The teachers who wrote this curriculum recognized that they were including a tremendous amount of detailed and scientific information for such young minds to grasp, especially for such a short and intense period of study. Although it was important for them that the students learn and remember as many of the specifics as possible, they were realistic in their expectations concerning just how much information these thirteen and/or fourteen year-olds would take away with them. So they recognized that the way in which the material was presented was almost as important as the material itself.

The natural progression of the presentation and ordering of information was done in order to facilitate the students' ability to think through the information, become comfortable with its concepts, and then add it to the next lesson and so on. Beginning the unit with classes on

brainstorming was intended to encourage the adolescents to think for themselves, and to recognize that there may be a number of potential solutions to one particular problem. Once problem-solving skills are in place, students should be better equipped to make reasonable and rational decisions. This ability was determined as critical for the students' future health and well-being, particularly in the age of AIDS. The same rationale is true for the classes concerning the development of communication skills. An inability to adequately communicate one's thoughts and needs leaves the adolescent, the document suggests, vulnerable to the pressures and desires of others. Self-worth and confidence can grow from positive experiences with decision-making and communication, and it is in the best interest of the student that such confidences be given an opportunity to take root.

This was the background that the curriculum writers felt it was necessary for students to have before they dealt with the specific health and sex education lessons compiled by the committee and presented by the classroom teacher. Possessing an enhanced ability to think clearly and for themselves, the committee felt, allows the students to refresh their memories concerning biological specifics, as well as to accept new information. It also places them in a better position to accept the responsibility to make the critical decisions they must inevitably face.

It is clear that the curriculum was put together with great care and attention to detail. But one cannot assume that the curriculum, as a document, represents in any way how AIDS education is covered in the classroom. In Chapter Four I analyze teachers' actual handling of the AIDS curriculum. How do the teachers take the curriculum issued by the Board and present it to their students? But first I look at the kinds of concerns that the AIDS curriculum raises for teachers.

CHAPTER THREE

Teachers' Concerns About The AIDS Curriculum

> I think we have a pretty good bunch of teachers working for our Board. Some definitely enjoy teaching phy. ed. more though. I myself am a health educator. I think a big problem is that a lot of people get into teaching this because they want to coach and be involved in athletics. They really aren't interested in teaching health. They just have to, because its all part of the same course.
> -Male Health and Physical Education Teacher

Introduction

In this chapter, I will examine some of the concerns facing middle school physical and health education teachers who teach AIDS education classes. Although each of the teachers who participated in this study work from an identical grade eight health education curriculum, their thoughts, feelings and concerns surrounding teaching about AIDS to young adolescents, and about teaching in general, were different. I begin by looking at how teachers felt about having to cover

the AIDS curriculum. This is central because it bears on the more specific concerns they had. The teachers can be roughly categorized into one of three groups: those who were "enthusiastically committed", those who were "unenthusiastically committed" and those who were "uncommitted" to teaching about AIDS. For the "enthusiastically committed", the concerns tended to be practical ones such as how to most effectively reach their students. For those who were "unenthusiastically committed" or "uncommitted", the concerns were more fundamental and tended to be rooted in value conflicts.

The literature previously reviewed concerning AIDS education for adolescents stresses that in order for teachers to be effective, they must present information in a clear and comprehensive manner. They must also encourage frank discussion periods. Students should be given opportunities to ask questions, to discuss their concerns with their teacher and their peers, and to become comfortable with the information they have been presented. However, the literature largely overlooks the fact that an AIDS curriculum, as well as the demands made on teachers to teach it, raise all sorts of problematic issues for educators. They do not come to the classroom with a uniform perspective; they are individuals with their own values and codes of conduct as well as their own thoughts and feelings about the AIDS epidemic, and their

role as teacher. This chapter will provide an examination of their perspectives.

Approach to the AIDS Curriculum

In order to understand the teachers' perspectives about presenting the AIDS curriculum, one needs to understand how this responsibility gets assigned to teachers, and how they feel about this duty. Physical and health education are treated as two parts of one whole course, and anyone who teaches "phys. ed" must also cover health education, including AIDS. Among the teachers I talked to (six male and six female), all were teaching their subject of choice (in other words they were not really math teachers who got bounced down to the gym) and they stated that they were relatively satisfied with their current assignments.

> It's great, I love teaching phys. ed. and health.
>
> Teaching gym and health is the best! I enjoy coaching these kids in extra-curricular leagues, and I don't even mind having to come in early and stay late with them for their team practices.
>
> I wouldn't want to be doing anything else.
>
> Yea, it's o.k. I sure wouldn't want to be trapped in a classroom all day.
>
> I like it.

However, they differed in their views on having to cover the sexual education part of the health curriculum,

particularly the AIDS lessons. Some were enthusiastic about it, and were totally committed to doing an effective job. They saw it as appropriate, and saw themselves as well-positioned; a natural extension of their less formal role as "coach", and often "confidante".

> I'm more a health educator than a physical educator. I mean I do both, and I enjoy them, but I prefer health and I'm committed to health education.
>
> I'm really happy with my job. The kids are great and I like being able to teach them about all of this.

Others were far less comfortable with it, and they were not entirely sure they wanted to handle the subject of AIDS for students in grade eight. One comment offered by a male teacher was made in reference to his own lack of interest in covering the material:

> Oh, I don't know. I do it as a part of my job.

A second comment spoke specifically to this teacher's dilemma as it related to the appropriateness of AIDS education and values:

> Some kids need it, others can wait. Some don't even know what "erection" means.

Finally, there were those who treated health education, and particularly AIDS education as a "necessary

evil" attached to their jobs. These teachers were the uncommitted, and they were far more likely to be among those who argued that AIDS education did not belong in the grade eight health curriulum.

> These kids don't need to be learning about all of this right now. I tell them "your only responsibility in life right now is to be a good student". They're too young to deal with AIDS and all the other diseases out there.

The three categories that these twelve teachers fall into then, are "the enthusiastically committed", "the unenthusiastically committed" and "the uncommitted". Each of these groups with be reviewed separately, and their concerns, attitudes and perspectives will be examined in detail.

THE ENTHUSIASTICALLY COMMITTED

The concerns of the "enthusiastically committed" can be summarized with the phrase: All students must be taught about AIDS, but all students are not alike. Some are more mature than others, and have already begun to experiment with their sexuality. Others are less interested, or have less ability to understand the more complicated social issues at hand. The job of the teacher, as these "enthusiastic" ones see it, is to make each lesson as clear and understandable as possible. They must review and repeat, discuss and illuminate

in order to educate **all** students. This can be difficult enough with the most civilized of subjects, and it is certainly particularly challenging when the topic at hand is "sex". Therefore one of the most important concerns for these teachers is the problem of reaching **everyone** in the room.

> Not everyone understands what I'm talking about. Some are embarrassed, or shy, and get all red in the face when we start this section.
>
> I get a lot of giggling. But I tell them everything anyway.

These teachers are keenly aware that some of their students are not comfortable discussing sexual issues, yet that others are clearly more mature than the majority of the class. It is for these more mature students that these teachers are most concerned:

> I know some are already having sex. I need to reach those ones especially. For others, they hear it anyway. That way they'll know it when they need it.

A second concern for these teachers is reaching those students who are less able to understand the complicated issues that surround the subject of AIDS. Often, students who are deemed "Special Learning Disability (SLD)" or "General Learning Disability (GLD)" are put into the mainstream classes (including physical education and health) for non-core (mathematics and english) subjects. This is also true for students who are "English as a Second Language (ESL)". The

"enthusiastic" teachers said they take special time, and make a more concerted effort to work with these students.

> I try to help the GLD, SLD and ESL kids as best I can. I work with them at their seats or ask their sponsor teacher to go over their fact-sheets with them.

Another issue for the "enthusiastic" teachers was that not all students enjoyed health classes, and in fact, many found them boring.

> They just don't like health classes. They're bored and would rather be in gym. I have to work really hard to teach those kinds of kids.

The problem with these types of classes was that the teachers felt they were presenting particularly important information to a group not all that interested in health education. They were in a position to recognize this, since they saw students in both environments; the gym and the health classroom. The students' partiality for physical education classes was frustrating since the teachers were so committed to making sure all of their students learned about the dangers of AIDS. It was this frustration that fueled one teacher's desire to rally for support, and approach the Ontario Ministry of Education to have the physical and health education curriculum divided into two courses (Ontario is the only province in Canada that still presents physical and health education as one course). His argument was that if students

knew they had to take physical education **and** health education as two separate courses, they would be more attentive, and subsequently receive a better education in both subject areas. As well, teachers could decide which subject they themselves preferred, and they could put their heart and soul into that chosen area.

> Coaches could coach, and health educators such as myself could spend better time on the critical issues, including AIDS, instead of rushing through everything.

These teachers were also concerned about the lack of time they had to cover all of the AIDS-related materials. The AIDS lessons fall at the very end of the curriculum. Consequently, it is the last subject to be dealt with in the health classroom, and often little time remains to adequately cover the material that is included. Students are expected to digest the material quickly, a task that can be particularly problematic when the weather in June calls thirteen year-olds to the baseball diamond. Somehow, health work-sheets become less of a priority when the sun shines. To rectify this problem, two of the teachers have rearranged the order of their health lessons in order to deal with AIDS at the beginning of the school year.

> We decided to do AIDS first this year. Last year we ran out of time. It was June and we were rushing through everything to get it all done. AIDS is too important to do that anymore.

As well, these teachers were concerned about the timing of the presentation of AIDS lessons. They argued that waiting to teach about AIDS until grade eight was waiting too long, and subsequently it placed some of their students at risk. They were aware that some students were already sexually active by the time they reached their senior year of middle school, and waiting for grade eight before introducing information about AIDS meant that those students were probably not fully aware of the dangers of unprotected sex when they became sexually active. As such, they asserted that their students needed the information earlier.

> My only complaint is that AIDS should be taught earlier in grades 3, 4, 5 and 6. Grade 8 is too late for them. It's the time of big peer pressure so they don't have enough time to understand all of this before the pressure forces them into sex.

The major point this teacher made was one that suggested students needed time to become comfortable with the issues that may be raised in the AIDS classroom, particularly those that deal with how adolescents might protect themselves from HIV and AIDS. The underlying argument was that learning about condoms the day before (or after) a condom was needed, leaves little if any time to become comfortable with the idea. For these teachers, providing students with adqeuate time to talk and think was critical.

These teachers also asserted that the curriculum was

rather tame and that it did not fully address the needs of their students. The major message in the curriculum was one that stressed sexual abstinence for young people, and in the minds of these particular teachers, such a message was absurd because it taught the students nothing. They believed that young people were, or would be sexually active, and for the curriculum not to deal with this reality was both frustrating and a waste of time. In their opinion, the curriculum glossed over some of the real issues, including how young people were affected by AIDS, and it did not actively teach them how they might try to protect themselves from AIDS. They believed it was important, as AIDS educators, to supplement the lessons in order for their students to "really get it".

> I've brought people with AIDS into the school to talk with these kids, and tell them, I mean really tell them, about life with AIDS. They listen you know, when someone is standing in front of them and saying "I have HIV. Don't you get it".
>
> I bring in a video from home called 'AIDS in America' with Magic Johnson and other celebrities. I figure these kids are so into basketball and always want to know about Magic's disease anyway that they probably get more out of watching him than to just sit and do work-sheets.

These teachers believed that the curriculum fell short in the details it provided for its adolescent audience. One teacher complained that the vocabulary used in the curriculum masked the seriousness of AIDS by hiding behind terminology

that was difficult to understand. She felt that students were not getting the real message because "everything is written so medically and the kids don't understand". These teachers found it was important to deal with sexual issues both openly and directly if their students were to learn anything from the health classes.

> I give them a really straightforward approach. (the male teacher) is a lot more shy than I am. He gets kind of embarrassed when the kids get graphic. I just sit down and tell them everything. It effects me more than it does the guys. So I'm really straightforward with the girls and say "hey, you don't know where your boyfriend has been, like when you broke up last term. Use a condom, o.k.?"

> I have the girls put a condom on a wooden penis. They need to learn how to do it too I tell them, so I leave it for the end of a class and hand them each a condom just before they leave, they open it up, take it out, roll it on the penis and leave. Some are embarrassed, some laugh.

> We started these lunch-hour sessions called "Everything you wanted yo Know About Sex But Were Afraid to Ask". We've had over seventy kids show up and ask whatever they need to ask. Afterwards, I have kids come up to me and say "sir, when are we gonna have another one?" They really want to talk about all of this.

A final concern for these teachers was related to how the information was to be presented to their grade eight students. Since most the of data was outlined in detailed fact-sheets and work-sheets, it was clear that the bulk of the information was to be presented to seated students, and was for them to work on individually. According to the

"enthusiastic" teachers, that type of presentation was boring to students, and did little to encourage them to discuss the issues surrounding HIV and AIDS with their peers.

> There is just too much 'pencil and paper' in this curriculum. They need to have more group activities and be able to get up and move around. They also need more visuals, more videos to get and keep their attention.

For the "enthusiastic" teachers, getting, and keeping their students attention meant they had a better chance at educating them about AIDS. That education was their ultimate goal.

THE UNENTHUSIASTICALLY COMMITTED

A second group of teachers have been classified as the "unenthusiastically committed". Although they do present the AIDS lessons, they do so primarily because they "have to" in order to fulfill their professional duties as health and physical education teachers. One of the most pressing concerns for them was their belief that they should not be made solely responsible for teaching these young adolescents about AIDS. Some of the teachers argued that parents should be the primary educators, and that school lessons might act as back-up. Others suggested that parents might be involved in a support role, and that community-based AIDS educators might come into

the classroom to present the lessons. Under those circumstances, the classroom teacher would act as the primary information officer, and support would be provided by the home and community. One teacher suggested that his female health and physical education staffmate would be a more effective AIDS teacher than he, as might a community-based educator.

> Maybe someone who teaches this (AIDS) all the time would be even better than me, or for sure (his female staffmate) because she's more open and comfortable about talking to them about sex.

This group of teachers felt that they were being made responsible for educating the grade eight students about AIDS without support from external sources. It was not that they necessarily felt overwhelmed by the responsibility, rather, that it was more appropriate to have parents or others involved.

> I don't really mind doing these classes, but I think that it would make more sense if their parents would at least do follow-ups.

> I'm not overwhelmed by the responsibility of teaching this. It's o.k. I encourage them to take their notes and work-sheets and stimulate conversation at home.

A second and related concern for these teachers was the belief that asking for assistance from an external source such as an AIDS education specialist, might make them appear as though they were incompetent, or at least unwilling to fulfill their assigned duties.

> It would be great to get someone else in here to cover this, or at least to get help with it. Other staff would probably complain that I'm not doing my job though.
>
> I wouldn't want to ask for help. It just wouldn't look right.
>
> I'd rather just do it myself and get it over with. Why make waves?

It was interesting to note that most of these teachers believed that the request for assistance would be negatively construed by others, while the previous group of teachers gave little thought to how their supplemental actions might be interpreted. There were however, two teachers in this group who were willing to privately exchange class assignments in order to make the classroom experience more enjoyable for each other.

> We trade off these AIDS lessons. Since we do co-ed health, I do other stuff and she does all of AIDS. She's better at it than I am.

The "unenthusiastically committed" teachers had a number of the same concerns as the teachers who were "enthusiastic" about their roles. However, their concerns were more closely related to how they might facilitate an expedient coverage of the material rather than whether all students fully understood the lessons. As such, students' ability to comprehend the material was not as critical an

issue as was their level of maturity, since immature students often giggled their way through classes. Their questions and/or behaviours disrupted the lesson flow and teachers had to stop and deal with students' comments rather than gliding through the lessons uninterrupted. Similarly, students who acted out in class were a concern, not so much because of their lack of attentiveness, rather, because their behaviors caused teachers to spend more time struggling to get through the AIDS materials then they wished.

> It's hard to deal with all of them at the same time. Some are still so immature they can't handle it.
>
> I just want to get through it.

However, sometimes those students who were less than perfectly behaved provided their teachers with a welcome excuse to focus on something other than AIDS for a while.

When these particular teachers discussed the appropriateness of AIDS education classes for students in grade eight, most of them felt students were probably at a good age to begin learning about AIDS. They argued that since the majority of their students were not sexually active, it made no sense to introduce these issues any earlier since it may have confused or alarmed them. In their minds, the timing was adequate to prepare them for their futures. Those students who were more, or less mature than the majority would

simply have to "go with the flow".

> I think grade eight is a good time to start. They are already interested in boys and such, but most aren't getting into sex yet.
>
> A lot of these kids don't even have their period. I think talking about sex and intercourse, you know the detailed stuff, any earlier would scare them, and you have to talk about sex to talk about AIDS.
>
> Oh this is early enough. Why give them answers to questions they haven't even thought of?

Although some of these teachers felt that the responsibility of teaching about AIDS might belong more appropriately to parents or to expert AIDS educators, they had no particular concerns about the content of the curriculum. In their opinion, students were well able to understand the message in the material. The terminology, reported as occasionally "kinda medical" was easily translated, and some teachers provided their students with the street slang equivalent to stave off confusion.

> The AIDS section is really well-written. The language is a little scientific so I usually use slang terms to be sure the kids know what I'm talking about. But I always go in and warn (the principal) first in case we get any parents phoning because I used the word "boner" instead of erection. You know some kids don't even know what the word erection means.
>
> Its a good program and I heard that Boards all around Ontario are asking for copies of our program because it's well put together.

The teachers expressed positive feelings about the fact-sheets and work-sheets that were included in the curriculum. They felt the sheets were helpful, not only because they provided clear and comprehensive outlines of all of the pertinent information, but also because students' activities were well-planned. The teachers also made a number of positive remarks about the videos that were available for students' viewing.

> The work sheets are great. They keep them plenty busy and I don't really have to add much.
>
> I always order in the films. I find the kids get something to watch, they have someone else talking at them for a change.
>
> I think the way the curriculum is laid out is really good for us. We have everything we need right in the book and all we have to do is go through it.

The only complaint made about the curriculum by these teachers was directed against its less than up-to-date statistics. Since the curriulum remains unchanged from 1987, the figures provided regarding infection rates are no longer correct. A number of the teachers reported that they felt somewhat unprepared for questions concerning current trends, and suggested that an update would be welcomed. They suggested that these "new numbers" might be something they could obtain from the "health people" at the Board.

> The stats are outdated. Every once in a while I get a question about how many people have AIDS and I know that the numbers here are old, so I tell them these figures but that these were from 1987 and there are a lot more people sick than that.
>
> I think we should get some new statistics. I know the number of AIDS cases are higher than this, but I don't know exactly.

All in all, the most pressing concern for these teachers was how they might go about the business of presenting the AIDS-related lessons without becoming too deeply entrenched in the material. Since they felt that someone else should have the primary responsibility for educating the students about AIDS, they did not have any desire to spend more time on this section than necessary. They were committed to presenting the lessons, and they did not suggest they would neglect to present the classes, however, it was their stated goal to get through the lessons as quickly as possible since these classes were "just another part of my job".

THE UNCOMMITTED

The third and final group of teachers have been categorized as "the uncommitted". Although there were a number of similarities between these teachers' behaviours, and those who fell into the "unenthusiastically committed" group, there

were a number of differences. These teachers' concerns had more to do with fundamental objections to teaching about AIDS. As an example, they contended that the educational system as a whole was overburdened by the responsibility for the general health and well-being of students. Their argument was that today's parents are not completely fulfilling their duties as the nurturers, caregivers, and the moral educators of their own children. According to these teachers, parents often wait for the school system to "do everything" instead of teaching their children themselves about appropriate behaviours, sexual concerns, and morals.

> What I want to know is where are the parents? Discipline is non-existant in general. It's always the teacher's fault first and people often believe the kids before the adults. Parents aren't doing their job. They don't take the responsibility for their kids. Don't spend time with them, don't teach them anything. They leave everything up to school.
>
> The only pressure I feel is that we are supposed to do everything. We're supposed to stop kids from taking drugs, getting pregnant, not drinking, not smoking, not getting AIDS...when the hell are we supposed to teach the kids everything that's in the curriculum? Ask Johnny to read and he says...the... book...is...blue.
>
> The reason we have to teach this is because kids are having sex so young today. Why? They're not ready yet. Parents should be more involved and teach their kids when they're little about morals. Then they might wait until they're older to have sex.

The point they made was not that they felt incompetant

or overwhelmed by the subject of AIDS. Rather, they believed that teachers should not **have** to teach about sex and AIDS to such young people, particularly without the concommitant involvement of parents. Some saw a few of their students becoming sexually active when, in their opinion, they should have been more concerned with having fun and doing well in school. They believed students should not have been dealing with these very "grown-up" issues for which they were ill prepared. Such premature involvement in sexual activity was expressed by these teachers as a moral issue, and morality was a fundamental concern.

These teachers did not state that they disliked those students who they believed were sexually active. However, there was some sense of judgement, or at the very least, concern, about these sexually involved young teens. The teachers made it clear that they did not condone such behaviours at age thirteen, and also, that they held the students' parents at least partially responsible for the activities of their children. One comment summarized this concern:

> I know of at least three or four (students) in my class who are already involved in sex. They are just way too young to be doing that already. Why don't their parents care enough to look after them properly?

This group of teachers questioned the appropriateness

of teaching about AIDS to all students in grade eight. Although they recognized that some students were sexually active, they believed that the majority were not, and that exposing everyone to AIDS-related materials, and to graphic discussions about sex not necessary. According to these educators, HIV and AIDS classes could, and should wait for a few years.

> Well, I have to (teach about AIDS). I'd rather not because I think it could wait, but I teach it anyway.
>
> It (AIDS curriculum) belongs in high school.

The issue for these teachers was not that the information intended for presentation was difficult to follow or to understand, rather, that adolescents at this particular age (should) have no need for such pointed and direct sexually-oriented lessons. In the teachers' minds, students had enough to concern themselves with, and these more mature lessons were simply overload. As well, they believed that the content of the curriculum was excessive in its detail, particularly with those lessons surrounding sexual issues and AIDS. They claimed that most of their students were not ready for such specificity, and exposing them to concerns about sex and AIDS and condoms did little other than raise their fears about sex.

> I think it's all too much. These kids don't even understand about intimacy yet or what having a

> relationship ia all about. It (AIDS lessons) confuses them.
>
> Why should we teach everyone about AIDS when it's only a handful who need to know right now?
>
> I don't dwell on it for the guys. They are more interested in being in the gym. But I do spend a lot of time stressing morals and ethics. Morals and ethics. I talk about the seriousness of it all. Like the "Are You Ready?" sheet (about pregnancy, raising children and the financial stresses on young parents). Mostly I try to stress the morals and ethics, and the abstinence thing. You know...keep your pecker in your pants".

It appears that for these teachers, presenting lessons about HIV and AIDS was burdensome. The point they made was not that students in grade eight were unable to understand the terminology or the lesson material, rather, that in their minds, students had no need to know such details, particularly at this premature juncture. Although they did not suggest that they would shirk their professonal responsibilies and delete or avoid these particular lessons in the grade eight health curriculum, their attitudes concerning the presentation of the material intimated they were less than dedicated to the task. As well, their observable behaviours while presenting the AIDS-related material spoke volumes about their concerns.

It should also be noted that two of these "uncommitted" teachers made reference to students' racial group membership.

> I've noticed that the black girls I have always seem to know more about sex than the rest of the

> class. Either they're already doing it, or they talk about it a lot with their friends or at home. I think they must be more open about sex in black families.

> These (boys) don't speak english yet, but don't worry, they know what's going on in here. All I say is "sex, sex, condom, you know" and they get it.

Although the teachers did not make overtly negative remarks about the students' racial group memberships, it appeared that for them, race was an issue. Whether or not the concern was rooted in stereotypical perceptions or in some degree of miscommunication, these two teachers (in particular) dealt a little differently with the students of colour than they did with the caucasion students in the class. Occasionally, answers were more blunt, and questions of them were more detailed and direct. However, for the most part, the manner with which they handled the entire class remained fairly constant from one group to the next.

In comparison with the other two groups of teachers, these teachers had few concerns about the students' levels of maturity, or about their comprehension abilities. Their goal was simply to "get through it", and as such, each class and each pupil received relatively the same amount of attention and effort. Students who displayed behavioural problems were allowed to carry on somewhat longer than they might have in the gym perhaps, but teachers usually dealt with the outbursts

efficiently before carrying on. Time allotment was not an issue for them either. They felt that the lessons had been more than adequately organized, and in fact, any "left over" time was a bonus. Students (and teachers) were rewarded with an extra period in the gym.

Discussion

Clearly, teachers have a number of differing perspectives concerning teaching about AIDS. Their perspectives vary depending upon their own feelings and beliefs about sex and AIDS education for young adolescents. How then, are teachers to reconcile any tensions they might feel between the fulfilment of their professional responsibilities to impart AIDS-related information to their young adolescent students, and their moral concerns, personal feelings, and opinions about the appropriateness of teaching about sex and AIDS to tweleve, thirteen or fourteen-year-olds? They are, after all, mere mortals who entered the teaching profession presumably to enlighten and inform today's youth and tommorrow's promise. However, does it go without saying that once the decision has been made to "teach" one is absolutely bound to carry-out the determinations of those from higher-up? Perhaps. It may well be the case that teachers wield less power in the curriculum content realm than they may

desire, but it is also the case that it is "the teacher" who stands at the front of the room. And it is this teachers who interprets and subsequently presents "the curriculum".

CHAPTER FOUR

In The Classroom

Introduction

The curriculum supplied to teachers by the Board of Education may begin as a one hundred and eighty-eight page fixed and factual document, but it quickly becomes transformed when translated and presented by each unique individual charged with its dissemination. The concerns that teachers have about the AIDS curriculum and their mandate to teach it, raise obvious questions about what actually happens in the classroom. How do teachers cover the AIDS education lessons? How do their teaching techniques and styles of presentation reflect their attitudes about AIDS, about the appropriateness of AIDS education at this level, and about their role as teacher. Although it was taken into account that each teacher has his or her own unique and personal style of presentation in the health classroom, there were a number of behavioural similarities found that were specifically related to teaching about AIDS. These are the issues addressed in this chapter.

The chapter is based on the observation that the teachers brought varying degrees of enthusiasm to the task of

teaching about AIDS. There were those who were committed to providing their students with a comprehensive AIDS educational programme. These teachers encouraged discussions in their classrooms, fostered warm and comfortable environments within which to ask questions, and strove to provide their students with clear and straightforward answers. They had little difficulty discussing sex and HIV with their students. For them, the central issue was to provide a good and solid education about AIDS. There were teachers who were somewhat less enthusiastic. They understood and accepted the need for AIDS education. They tended to accept as well that in their capacities as health educators and coaches, they were uniquely situated to deliver the message. However, their approach was a reserved and halting one, characterized by reticence and a need to maintain full control over the classroom situation. Last, there were teachers who given a choice, would have preferred not to teach the AIDS curriculum at all. These teachers expended most of their energies avoiding discussions and student inquiries. The central issue for these teachers was to fulfil, even if only minimally, their professional duties as health and physical educators in a way that allowed them to say thay had covered the AIDS material. In order to cope with tensions they felt between what they believed was appropriate, and their professional teaching responsibilities, their AIDS-lesson classroom demeanor was often reserved, and

their behaviour hurried and unrelaxed. The chapter deals separately with each of these groups. It is important to note again that, according to the literature, the effectiveness of any educational program, and AIDS education more specifically, depends on the quality and the amount of interaction between students and teachers. This makes an examination of classroom behaviours and teaching strategies particularly relevant.

THE ENTHUSIASTICALLY COMMITTED

Teaching about AIDS, even for the most enthusiastic teacher is never an easy task. The analysis in Chapter Three shows that the AIDS curriculum raises a wide range of issues for the teachers having to do with everything from their own attitudes about AIDS to how they define their role as teacher. In addition, teachers can never completely predict how the students will react and what will happen in the classroom once the topic of AIDS is introduced. However, there are those educators who are so committed to teaching adolescents about the danger of AIDS (as well as other sexually transmitted diseases) that they put their concerns and reservations aside and jump in with both feet. Among the teachers I observed and interviewed, there were two individuals (one female, one male) who fell into this category. For these teachers, a major concern was to get the students interested and involved. Not

only did they cover the material provided by the Board of Education in its entirety, they went beyond the supplied materials and supplemented AIDS lessons with visitors, films and/or externally-procurred AIDS-related information.

The male teacher was a self-proclaimed committed health educator. His strong sense of connection with, and responsibility to his students was evident in his repeated references to "his" kids. He went to great lengths to teach "his kids" everything he could about AIDS. He began the section with Board-supplied materials that include a pre-test, fact sheets, work sheets, videos and a knowledge quiz. Once these materials were completed/viewed, he brought in speakers to impress upon the students the reality of AIDS in individuals' lives. One of the speakers was a person living with AIDS. Other visitors included speakers from the AIDS-educational community (Hamilton AIDS Network) as well as those who deal specifically with sexuality issues for teens. Nurses from the Department of Public Health came into the grade eight classrooms to educate students about the warning signs of syphilis and gonorrhea, as well as to inform them where pregnant teens might turn for support and counselling.

In explaining his rationale for going beyond the materials supplied in the curriculum package, this teacher stressed that simply following the prescribed AIDS curriculum was not enough.

> It's important for them to know as much as possible. Kids in this age group get bored with all the pencil and paper. There is too much pencil and paper and the kids need to hear it for real, and see it to make it real. I think we need more film and more real people to make it hit home. Otherwise, they don't believe.

There were a variety of ways in which this teacher tried to create the proper learning environment for his students, including those who might have been less interested or embarrassed to participate. He used direct eye contact when speaking with students, he called each addressed student by name, and asked questions throughout each lesson to keep the students engaged. His classroom behaviour demonstrated a positive attitude towards the subject. As he talked, he moved about the room, often working with individual students at their desks. He also had the students participate in the lesson by having them read aloud various sections from the overhead or fact sheet. In other words, he encouraged the students to become involved in their own education.

The female teacher who shared this enthusiasm behaved very much the same way, yet there were some subtle gender-related differences in her behaviour. While the male teacher was active, strong, "coachlike", and almost forceful in his classroom demeanor, the female teacher sat more quietly, often poised on the top of an empty student desk at the front of the

row. Her voice was clear and assured as she addressed her class and as she directed students to take turns reading aloud, however, she took more time learning about her students' opinions and/or feelings. She spent more time than he asking the students questions, and she encouraged them to make comments or offer their own observations while she guided them through the material. She would pepper her lessons with remarks directed at specific students in the room such as "'Billy', why don't you tell us about how you would handle it if 'Sara' wanted you to have sex without a condom". Her material presentations were more conversation-like, and a "lets talk about this" attitude prevailed.

> I have to talk about this to the class. They won't learn properly if I don't teach properly, and I have to do this right. AIDS is real and I know some are already having sex, so if I don't (teach them about AIDS)...who will?

Her goal was to impart the information about AIDS to all of her students, as directly and comprehensibly as possible. While there were some students who were less mature than others, in discussing the issues surrounding sexual activity and AIDS, she still attempted to include them in an academic manner, asking them questions about the more sterile and specifically scientific data. These students might be asked "what are the helper T cells?" or "what happens to the helper Ts when a person has HIV?". Questions that were more

social in nature, and in a sense more "dangerous", such as those that concern students' levels of sexual involvement, she left to those who were more bold, or more obviously interested, and in immediate need of the preventative message in the lesson. Some of the questions she asked these students were "do you know where to get condoms?" and "do you know how to use one? Would you use one?" She also attempted to answer as many of the students' questions as she could during each class, and she was very careful to discourage those who were less than enthusiastic from riduculing their classmates for participating.

Whatever the differences in their personal styles, a common problem the teachers had to deal with was the varying levels of maturity of their students. Some students giggled their way through the lessons, unable to cope with the detailed discussions of penises and vaginas, and of anal and oral sex. Others in the same class asked pointed questions about the safety of condoms and where they might purchase appropriate lubricants. Both teachers attempted to meet the needs of all of their students, to answer questions and clarify confusion whenever possible. However, those students who were the "loudest" and demanded the most attention, often got it. Those more quiet or embarrassed, although not badgered to participate, were in fact almost left to fend for themselves, coping with the onslaught of information as best

they could. As the female teacher reported;

> Its better to give too much information than not enough. Nobody ever dies of embarrassment, but they do if they don't know about AIDS.

Another common problem they faced in adopting an entirely open and honest approach to the material were demands on the students' part for the same honesty from their teachers about their sex lives. Some students interpreted the sexually explicit nature of the discussion as an invitation to pry into their teachers' personal lives.

> Hey sir! Before you were married and were out having sex, did you use a condom?
>
> Miss ...., have you had multiple partners? Its dangerous you know, you can get cancer.
>
> Do you know about the female condom? Ever used one?

For both teachers, fielding comments like these became commonplace. Often, their replies to such remarks were quick and sharp retorts; "thats none of your business" and "we're here to talk about your sex life, not mine".

It was also the case that students who had already begun to experiment with their own sexuality provided glimpses of their "adventures" for their teacher and classmates. These two teachers handled these unanticipated moments with grace, and they rarely became embarrassed. When one student began to provide the intimate details about her Saturday night date,

her teacher intervened with "it all sounds pretty interesting, but this is neither the place nor time to get into your personal life". She did not ignore the reality of her student's sexual activity, but neither did she encourage any further inappropriate information.

The apparent ease with which each of these educators dealt with the subject matter as well as the potential problems that came up in the classroom was directly linked to their skills as teachers. The male teacher was a seasoned professional with over fifteen years in the classroom. He was so comfortable in his role as an educator, that it was virtually impossible not to be at ease in his room. The female teacher, although relatively "new", made up for her lack of experience with unbridled enthusiasm. Both had excellent rapport with their students. It is important to note that even for these educators, not every lesson went off without difficulties. Dealing with young adolescents can be trying at the best of times, and dealing with teens and sex education simultaneously can be particularly stressful. Yet, even when problems arose in these classrooms, both the male and the female teacher managed to "keep their heads" and re-route off-track discussions to more appropriate territory. Beligerent students were asked to leave the class, and potentially embarrassing situations were often smoothed-over by their teachers' light-heartedness. Both of these teachers

were clearly committed to providing their students with the best education about AIDS as possible.

THE UNENTHUSIASTICALLY COMMITTED

Another five among the twelve teachers observed could be characterized as committed to providing a comprehensive AIDS education for their students, yet somewhat less enthusiastically than the two previously reviewed. They understood the responsibility of AIDS education as falling quite naturally to them, not only because they were the schools' health and physical educators, but also because they acted as "coach". In their minds, the additional time they spent with students on the basketball court led to more familiar interpersonal relationships. It follows that intimate topics such as sex and AIDS be assigned to those teachers who already relate less formally with the student body. As such, these five teachers accepted their role as AIDS educators. However, it is also fair to say that they were not entirely comfortable with the role. Although they recognized that their students did need to learn about AIDS, they contended that perhaps the responsibility might belong more appropriately to parents or even to experts from the Department of Public Health who regularly work with adolescents and their emerging sexuality. For most, this

reticence translated into an "it's a part of my job" approach to the classroom. They were committed to covering the AIDS curriculum but in an extremely controlled way.

The five teachers who approached the subject of AIDS with only moderate enthusiasm employed a number of teaching strategies that helped to ensure coverage of the material. But it was done in such a way that it discouraged any detailed teacher or student involvement. This is not to say that these teachers purposely avoided certain lessons or hand-outs, rather, it was the way in which they discussed the AIDS-related material with their adolescent students that discouraged involvement. For example, teachers often spoke in monotone voices, moving through the details on the fact sheets, at times too quickly for the students to absorb. Some behaved as though they were preoccupied or concerned with other issues, and they acted as though students should not disturb them with any long-winded questions that might require detailed answers. At times, students were given little opportunity to ask questions or to make observations of their own. The message they sent to their students indicated they were not really interested in delving any deeper into the material than necessary. In response, their students occasionally seemed bored and disinterested: in these cases there was little in-class participation and considerable chatting. These classes on AIDS often followed a fairly

predictable schedule; the introduction of the topic of the day, the handing out of photo-copied fact-sheets or work-sheets, the teachers' use of the overhead projector to review and summarize the seat material, and a quick "any questions?" as the end-of-period bell rang.

The teachers were technically fulfilling their duty to cover the Board-supplied material. But students in these classes were rarely provided the opportunity to really get involved with the subject material through role playing or group work. Ironically, one common strategy these teachers used to limit class discussions was to present too much information. The students received so many fact-sheets and work-sheets, that they were overwhelmed, and had to struggle to read through the material once before the class ended. There was rarely time left over to discuss issues the students may have wished to raise. However, on the few occasions that questions were asked, some of these teachers avoided answering by deferring to me. They took advantage of my presence as researcher and supposed "AIDS expert", and avoided becoming involved in the material by suggesting "perhaps Mrs. Cook might be able to answer that question".

Another strategy was to encourage the students to rush through the material using a "boy we've got a lot to cover today so let's get going" approach. While still standing out in the hallway students were directed to "hurry and get in

there and get organized". Before students were even seated, fact-sheets and work-sheets made their way around the room while students were further encouraged to "get going with this material". Page one was reviewed, page two, page three, and page four followed, until time ran out and students were left to scramble to their next class, stuffing the fact-sheets into their binders as they went. As well, the "kinda medical" terminology contained in the curriculum occasionally presented other difficulties for the students because they were not provided regular opportunities to request clarification.

Students received so much "paper" over so little time, that they expended most of their energies attempting to get organized. They checked, and double checked to ensure they had all of the fact-sheets and work-sheets, and in the correct order. This was necessary since they had to be able to prepare for their unit quiz on AIDS. In the end, the bulk of their attention was focused on the paper, and on preparing for "the quiz". Not on how, why or when AIDS may impact their lives. In adopting this strategy, the teachers put the emphasis on the written materials and on getting through them. The message was that any discussion or questions were secondary or supplemental to the main task at hand.

Another strategy involved allowing the students to take up valuable class time with chattiness or recalcitrant behaviour. These teachers attended to the troublesome "out of

line" student, and expended precious time trying to deal with their antics. For example, one (boys') group I observed spent a considerable amount of time arguing over who was sitting where, and why, and two of the students ended up in a tussle over who got to the chair first. Their (male) teacher gave the entire class a "lecture" about their recent lack of appropriate and mature behaviour. The AIDS lesson was subsequently hurried-through. Another situation I observed was an eraser fight (pieces of eraser thrown through the air at one another). Their (female) teacher stopped the lesson in order to deal with her students' behaviour, and she never returned to where she left off. In these classes, what inevitably happened was those students who **were** paying attention lost interest. Any momentum or classroom enthusiasm evaporated. After dealing with the behviour issues, the goal of the teacher became "finishing up" the lesson rather than "getting in to it".

Finally, a fourth strategy employed by one of the teachers involved a seeming lack of preparedness for the class. Handouts were not organized, the scheduled lesson plan was not reviewed, and students were given a make-shift, "quickie" lesson. The left-over class time was filled by students being told; "find something else to work on for today and we'll pick up from here next time".

All but the fourth approach assured that the scheduled

lessons were completed as presented in the curriculum. Students received the data sheets, were shown the Board-supplied videos, and given the final quiz to test their factual knowledge. However, it is important to note that the ultimate grade scored on a factual information-type quiz does not determine whether or not a student internalizes the information about AIDS. It does not guarantee that the student will be encouraged to behave appropriately when deciding whether or not to become sexually active, nor does it assist them to be better equipped against HIV and AIDS and to utilize proper methods of protection when the time comes. The strategies employed by these teachers did not allow for discussion. Students were hurried through mounds of material, not encouraged to ask questions and they had little classtime opportunity to get dialogues going with their peers.

It appears to be the case that for these teachers, the main goal was to disseminate the information, but to do it in such a manner that discussion periods were limited. The control and the containment of material were the most pressing issues for these teachers, for without them, students might have been able to raise any number of concerns these teachers preferred simply not to discuss. Whether it was through the barrage of materials, the "let's hurry up" approach, the excessive attention paid to the behaviourally handicapped or through an apparent lack of preparedness, these five teachers

managed to move through the AIDS-related lessons without getting excessively hung up on the "details".

THE UNCOMMITTED

The final portion of this chapter is devoted to an examination of the teaching strategies employed by teachers who would clearly rather not teach about AIDS at all. Their reservations about this aspect of the curriculum were much less equivocal than those teachers discussed earlier. These teachers were firm in their beliefs that the lessons were premature, and that students in grade eight should be spending more time concerning themselves with their studies and with just being "kids" than worrying about sex and AIDS. Their resistance was rooted not so much in embarrassment, or in the absence of current data about AIDS. Nor did it have anything to do with concerns about time restrictions or with the sometimes confusing "medical" terminology contained in the curriculum. Rather, the problem for these teachers was their belief that graphic sex and AIDS education for young adolescents was inappropriate.

> I don't think these kids need to hear all that. Besides, there's enough sex on t.v. they already see anyway.
>
> A lot of my kids don't even have their period yet. Whenever I start anything about them maturing or puberty or whatever they get embarrassed and giggle.

They're not ready, I don't believe.

Although none of the five reported that they felt uncomfortable with the AIDS-related material, or that they felt overwhelmed by the responsibility of teaching about AIDS, their classroom behaviours indicated they clearly had some difficulties with their role as information officers. Like the resistant teachers discussed earlier, these teachers were bound by the Board to teach these AIDS lessons to their grade eight students. But they faced a far greater tension in trying to reconcile what they **had** to do and what they believed was **appropriate** or **right**. These particular teachers did not believe their young students should concern themselves with such "grown up" issues at the tender age of thirteen.

In order to fulfill their professional responsibilites, yet still be true to their own convictions, these teachers used a variety of "avoidance" strategies when presenting the AIDS-educational material. The first and most dominant strategy was the "physical avoidance" method. One teacher spent the duration of a class with his back to his students while he busily scribbled notes on the front blackboard. Students' raised hands were not acknowledged since they could not be seen, and students soon became discouraged with their teacher's lack of attentiveness and dropped their hands. Few questions were asked or answered,

and the majority of verbalizations during this class were sarcastic or "smart-alecky" comments made by the less-involved students in the room.

Another example of this strategy involved a teacher who focused all of her attention on the over-head projector. Students who raised their hands to ask questions were often "put off";

> If you'll just wait a minute until I get all of this up here, and then I'll answer your question.

These teachers spent a significant amount of time moving around the room and busying themselves with one task or another. Examples of their behaviour include digging through the curriculum binder as if searching for something lost or misplaced, standing at the back of the room while repeatedly directing students to "hurry up and get the note copied", and sitting behind their desk, head down and apparently concentrating on other concerns. Essentially, these teachers made themselves interactionally unavailable to their students. By avoiding eye contact as well as by putting a physical distance between themselves and everyone else, these teachers managed to disengage themselves as persons from their classes, and from the message inherent in the material. Even though they presented the fact-sheets and showed the videos, they seemed to be wanting to communicate to their students that

they do not adhere to what they feel are the implicit moral messages in the curriculum about the acceptability of premarital sex, particularly at this age. They disclaimed subtly in their non-verbal behaviors, as well as more explicitly in their occasional comments. Most students opted to not bother asking questions since getting the attention of their teachers was often difficult. However, when questions did get through these "barriers" (usually through sheer perserverance on the part of the student), teachers' responses were often curt and to-the-point:

> **YES**...What **IS** it 'David'?
>
> What now? Don't you have everything or weren't you listening to my instructions?
>
> I already told the class we'd take up questions later. Just get back to your notes for today.
>
> That answer is right on the page in front of you.

A second strategy employed by these teachers was the "no talking/quiet time" method. One lesson began with students lined up in the hallway waiting to enter the classroom. Their teacher greeted them with this instruction;

> Today we're watching a film about AIDS...we're all ready to go so get to your seats quickly and we'll get started.

The students entered a dark classroom with the lights off, the drapes drawn, and the television ready to go. The film had previously been placed in the video cassette recorder

and the teacher needed only to press "play". She did, and the film and lesson began. A few students attempted to ask questions during the film, however they were instructed to "wait until the end". Since time ran out before the film ended and students had to scramble to make it to their next class, there was no opportunity for questions or a discussion.

In another class, students were met at the door with a stack of fact-sheets, and instructed to get seated and read through them "quickly and quietly". As they sat silently reading, their teacher wrote "QUIZ ON AIDS NEXT WEDNESDAY" on the front blackboard, thereby providing them with the impetus to complete their assigned task. Since the idea was for students to have "quiet time" to read, the class did not benefit from a question and answer period. What was most interesting about this "quiet time" strategy was that teachers were attempting to convince students they had to be quiet in order to learn. What was really happening, was that the teachers wanted the quiet time so they would not have to become involved and answer too many questions. It usually worked.

The third and particularly effective avoidance strategy used by one teacher was the "diversionary" method. The students and their teacher spent the first ten or fifteen minutes of the class discussing the intramural volleyball league, and it was only after that subject had exhausted

itself that attention was turned to the scheduled AIDS lesson. Students were informed "the movie isn't in" and instead were provided with a brief runthrough of pre-prepared over-head transparencies. Each student was handed a piece of foolscap paper and instucted to "take notes". One transparency after another flew across the over-head screen, accompanied by the teacher's "everyone got this?". Without waiting for students to reply, he went from one sheet to the next until he got to the bottom of his pile. Little discussion about AIDS took place, and in fact, the teacher was direct about his feelings concerning AIDS education for thirteen year olds when he offered this comment;

> You guys shouldn't be worrying about sex or diseases like AIDS anyway. The only responsibilities you should have are to be a good student, and study, and be a kid.

On one other occasion, the students were allowed to spend the first half of their health period playing pick-up basketball in the gym. Their teacher suggested they "work off some of their tensions from the day" with physical activity, before "getting down to some serious stuff". Once the students finally sat down for the lesson on AIDS, their teacher turned to me and said "They're all yours, ask them anything you want". I learned more than they did during that class.

Even though these teachers did their best to encourage

students to read through the material "quietly", or watch the film "quietly", or wait to answer questions "later" (perhaps even after a game of "pick-up"), there were some students who were determined to get their answers. Teachers' reponses were usually short and direct:

> I think you'll find your answer right on that first page.
>
> Yes, that's correct.

Students with their hands up in a quiet reading room usually had their questions answered privately. The teacher would see the hand raised, go to the student's desk and whisper the appropriate response. However, even this attention was limited. On one occasion, too many hands starting springing up in the air, and the teacher asked students to "read through everthing first and we'll talk about it all later".

Discussion

The research previously reviewed in Chapter Three clearly outlines the importance of teachers' dedication to AIDS education for adolescents. Experts in the field of adolescent study call for teachers to be forthright and direct in the AIDS education classroom, that they be willing to spend time discussing the issues at hand, and that they foster a

warm environment for teacher-student communication. Students must feel free to ask whatever questions they have, and be assured they will not be ridiculed by "heckler" classmates. As well, teachers should assist students to become comfortable discussing HIV and AIDS with their peers. Combining all of these characteristics help to ensure the effectiveness of an AIDS educational program.

However, these ideal classroom situations are difficult to create. Teaching about sex and AIDS is not a simple and straightforward task. Each educator takes a slightly different approach, and has more or less difficulty reconciling the tensions they may feel about the appropriateness of the material. The degree of dedication to deliver the HIV/AIDS lessons makes a tremendous impact upon how an educator approaches his/her class. There are teachers who are totally committed to the task at hand, those who recognize and accept their role and the need for these classes, as well as those who would clearly rather have someone else teach about AIDS. As well, they each have their own strategies to help get the job done.

The "enthusiastically committed" teachers came the closest to creating an ideal classroom environment. They discussed the issues with their students, asked them questions, and provided the encouragement for students to participate. Most importantly, they tried to make their

students understand the real facts about AIDS and how they might protect themselves. However, these classes were not without occasional difficulties. Some behavioural problems arose as well as those to do with the different levels of interest, and maturity of the students. Yet it was in their consistant and determined attempts to try to find a balance, or an appropriate compromise to educate **everyone**, that their dedication to their role as an AIDS educator became most apparent.

The "unenthusiastically committed" had more difficulty with the issues at hand, and they used a variety of teaching strategies to assist them in their efforts to get through the material as quickly and painlessly as possible. Although they recognized that they were well placed to present this information as health educators, they still felt somewhat uncomfortable with the role. They expended a considerable amount of effort attempting to control the flow of information, both to and from students.

The "uncommitted" had the greatest difficulties teaching about AIDS. Their belief that sex and AIDS education lessons were inappropriate for students in grade eight, impacted their presentation styles and teaching strategies, enabling them to circumvent the intention of the AIDS curriculum, even though technically they were covering the material. Teachers who taught with the lights off and the

curtains drawn made it virtually impossible for students to become involved in in-depth classroom discussions, and students often went away from the lessons with unanswered questions for "next time". The most critical issue however, was that because students did not become involved with the material, there was a sense that AIDS exists somewhere "out there", and that it was someone else's problem.

CHAPTER FIVE

Key Issues, Contributions and Future Considerations

The Key Issues

Teaching AIDS education classes to young adolescents is neither easy nor straightforward. As chapters three and four demonstrate, educators must be prepared to discuss any number of issues that concern human sexuality, and in order to teach the AIDS education lessons effectively, educators must also be conscious of the varying requirements of their pupils.

Although all of the middle school health and physical education teachers in this Board of Education work from the same health curriculum, and as such, share the same course outlines, they do not share the same preceptions about their roles as AIDS educators, nor do they share presentation styles. And although there are a number of similarities among all of the teachers who participated in this study, not the least of which is their professionalism and their dedication to it, there were a number of notable differences that have become the focus of this thesis. A point worth discussing

here, is that although a considerable amount of attention has been paid to the **overt behaviours** of the teachers, it is not only the observable teaching styles that are of concern. The symbolic interactionist perspective asserts that although conspicuous behaviours are certainly important to note while conducting a sociological study, it is also the **covert** issues at play that are of considerable significance. It is through these observable behaviours, that I, with a symbolic interactionist perspective, have attempted to recognize the attitudes, perceptions and convictions of the participating teachers.

Most (although not all) of the teachers who participated in this study received a half-day in-servicing at the time of the curriculum's introduction. Members of the writing committee were on hand to present the new curriculum, as well as to offer strategical suggestions and support, and all Board-employed health and physical education teachers were encouraged to incorporate the new curriculum into their schedules as soon as possible. While some teachers enthusiastically jumped in with both feet, others felt less than eager to disseminate such graphic materials to their young students. The observable, and varied presentations of the AIDS-educational materials, as well as the personal interviews with the participating teachers, provided me with insight concerning their committment to teaching adolescents

about AIDS.

Those educators who approached the AIDS lessons with committed enthusiasm had warm and inviting classrooms where students were encouraged to ask questions, participate in group-oriented assignments, and share their views, knowledge and confusions with their teacher and classmates. Speakers (such as people living with AIDS) were periodically invited to share their experiences, and these teachers often brought in supplemental materials (such as celebrity videos about HIV and AIDS) for the benefit of their students. Ridicule was prohibited, and students who chose to be disruptive were asked to leave and not return until they had undergone an "attitude adjustment".

It was not difficult to see that these teachers were both committed to their professions generally, as well as to being effective AIDS educators. Since I had the opportunity to observe them not only in the AIDS classroom, but also in the gym for physical education, it became clear that they were dedicated to adequate coverage of both subject areas. Interviews with these teachers yielded a significant amount of insight about the challenges involved in teaching sexually-active (or soon-to-be) adolescents, as well as about specific issues concerning teaching AIDS education classes.

The teachers who approached the AIDS lessons with "unenthusiastic commitment" presented the material in a more

conventional manner. Students' activities were usually well-planned and kept directional, and most of the students' efforts were restricted to picking up fact sheets, reviewing overhead notes, and completeing a unit quiz. These teachers spent more time presenting the Board-supplied materials than they did in discussion periods with their students, and usually the AIDS curriculum was covered in its entirety. Supplemental materials and/or outside speakers were not considered to be necessary. Interviews with these teachers were fruitful and interesting, and our conversations were often focused upon their concerns about the appropriateness of AIDS education for thirteen year-olds. They were, nevertheless, committed to fulfilling their professional duties as designated AIDS educators.

Finally, there were those teachers who were clearly "uncommitted" to teaching about AIDS. Usually, in these classrooms, the Board-supplied AIDS-educational materials were covered quickly and without ceremony, and efforts were often made to present the information in a condensed version. Fact-sheets and work-sheets were circulated, some videos were presented, and any discussion was usually limited to brief question and answer exchanges. Students were not encouraged to become involved with the material because these teachers were primarily interested in getting through the AIDS lessons with expedience.

What was most significant about the interviews with these teachers was their obvious concern about presenting information that, in their minds, was "too much, too soon". They were very concerned about offering graphic answers to questions that, according to them, students had not even thought of yet.

Whether the teachers presented the AIDS-related materials with enthusiasm or not, they each demonstrated their professionalism by their very participation in this study. Not only did they allow me access to their classrooms, they also provided me with a wealth of information during our interviews. Virtually every question I asked was forthrightly answered, and I consider myself fortunate to have been allowed these glimpses of their thoughts as well as their efforts.

The Literature and the Real Classroom

The AIDS educational literature that was reviewed in chapter one, provided a number of clear guidelines for teaching about AIDS in the adolescent classroom. Although a solid curriculum containing accurate facts about AIDS and adolescents is important, teachers must also be able to spend time discussing the realities of AIDS with their adolescent students. Young people must be given the opportunity to become comfortable with the information at hand, and to make

plans for future behaviours; plans that they can realistically live with and implement, particularly when the sexual moment arrives. The literature also recommends that the importance of condom use be stressed, and that students be allowed to have their questions and concerns about condom use, as well as those about intimacy and so on, answered in a non-judgemental and supportive way. The literature recommends, therefore, that teachers be comfortable with the subject matter at hand so that they are able to talk with their young students in a forthright and comprehensive manner.

The teachers who participated in this study fulfilled some, but not all of these proposed requirements. Those two teachers who were "enthusiastically committed" came the closest to this suggested "ideal". They provided ample time for students to discuss their concerns and to have their questions answered. These teachers encouraged students to become involved with the material, and they stressed the importance of condom use. They also made AIDS real for their students when invited guests came to talk about life with HIV. Most importantly, students were provided with a warm and supportive environment within which to learn about safer sex.

The "unenthusiastically committed" fulfilled only some of the literature's requirements. Comprehensive AIDS educational lessons were presented, and students were sometimes given the opportunity to ask questions in a non-

threatening environment. Videos and fact sheets were also used to help illuminate the issues at hand, and students were encouraged to attend to the material since a unit quiz closed the section. However, students in these classrooms were not provided extended periods of time to discuss concerns with their teachers or their peers, or to become actively involved in the material through role plays or group work.

The "uncommitted" fulfilled few of the suggested requirements. They presented most of the Board-supplied AIDS educational materials, and they usually provided students with the impetus to pay attention in class. However, one concern particularly notable in these classrooms was the lack of exchange between teacher and student for either questions or comments. Drawn curtains or misplaced lesson plans were not condusive to an optimal learning environment. A second concern was related to the expedience with which the teachers presented the materials. The literature clearly recommends time, and plenty of it, be provided for students who are just beginning to learn about how they might protect themselves from HIV and AIDS.

There were a number of explanantions for the strategical shortcomings, not only for those "uncommitted" teachers, but also for those "unenthusiastic" and "enthusiastic" teachers as well. Explanations range from the simple shortfall of adequate time in the health classroom, to

the positions the teachers held about the appropriateness and morality of AIDS education for thirteen year-olds, to the level of personal comfort these teachers felt while discussing graphic sexual situations with young adolescents.

It must be noted that these concerns are not confined to these particular health classrooms. Research in the field of the sociology of education recognizes such dilemmas, and such concerns are identified by Neutens (1992) as the "moral smog" of sexual education.

> While progress in human sexuality education has occurred, that progress has been challenged by an emerging "moral smog". That moral smog - or state of moral confusion - can detract from the effectiveness of human sexuality education, particularly if school health personnel are ill-prepared to deal with the matter (1992:74).

Neutens further suggests that educators need not suffer from such dilemmas, and he offers them advice on how teachers might go about clarifing the issues for themselves. Of his twelve recommendations, these are the most relevant for this thesis:

* Educate yourself. Learn what sources or influences drive your communities' opinion about human sexuality education and examine their backgrounds, motivations, and intentions. Read newspapers and magazines for trends as well as professional journals.
* Support a balanced, comprehensive program that reflects a pluralistic society, rather than a singular philosophy.
* Examine events around you, such as homophobic messages, puritanical postures, or advertisements that make sexuality external such as the way you dress, rather than internal such as the way you

feel.

* Teach from a base that supports individual freedom and personal dignity.
* Acquire the skills necessary to conduct human sexuality education within a restructured school system.
* Support parents and family by involving them in your program (1992:74-75).

Ellis, Bruess, Jones, and Laing (1992) also recommend that teachers take the initiative to become responsible and competent in the health classroom. Their guidelines include planning lessons which "reflect the abilities, needs, interests, development levels and cultural backgrounds of students", "incorporate topics introduced by students", "utilize affective skill-building techniques to help students apply health knowledge to their daily lives", "involve parents in the teaching/learning process" and "adapt existing health education curricular models to community and student needs and interests" (1992:77). The message inherent here, is that educators must be encouraged to take reponsibility for the comprehensive educations of their students, as well as for their own concerns and/or limitations. They also recommend that teachers be encouraged to educate themselves further when designated teaching assignments are less than straightforward.

Sociological Contributions of the Thesis

The study of AIDS education is still in its relative

infancy. Up until the late 1980's, AIDS was regarded by many as "the gay man's disease", and/or one that effects intravenous drug users. It is only of recent times that AIDS has been recognized as a plight that effects all people, regardless of age or gender, cultural group membership or sexual orientation. As such, education about AIDS has essentially only begun. Further, the examination of its processes, successes, and shortcomings is a fresh, compelling, and vital field.

This thesis has outlined the existing literature's recommendations for effective AIDS education for adolescents. It has also provided an examination of the methods, strategies, attitudes and perceptions of twelve individuals who are on the "front line"; educators who present AIDS lessons to grade eight students in middle school. With a symbolic interactionists's eye, my classroom observations and personal interviews with teachers have yielded a significant amount of information about the more pressing concerns these teachers have about their roles as AIDS educators. As well, this study has provided a glimpse into the AIDS classroom: one that recognizes a curriculum is only the starting point, and that curriculae do not provide all of the answers for students. Teachers, complete with their feelings, perceptions, comfort levels and committment to AIDS education, are the interpretors from which students learn and understand.

Individuals who are interested in this thesis and in this field of study will hopefully recognize that meaning, particularly meaning gleaned through, and from AIDS education classes, does not concretely exist on the pages of a curriculum or in any other way separate from the participating individuals. Rather, meaning and understanding come only from, and to, the individuals who are participating in the effort. Therefore, interested readers might recognize that all AIDS education teachers have unique and differing perceptions about their role as AIDS educators, that these perceptions lead to varied presentations of AIDS educational materials, and perhaps, that impacting the field of AIDS education might be better achieved through the recognition and inclusion of the study of educator's perceptions.

Future Considerations

My original intention for this thesis was to look generally at AIDS education in middle school, and examine both the perspectives of the teachers as well as those belonging to the students. However, after I began talking to the teachers, I decided that focusing on the teachers alone would be a significant research project of its own. That effort became this Master of Arts thesis.

As such, my intentions for future study are to

continue with research on AIDS education for adolescents. My focus will shift however, and will concentrate instead on the students' perspective in the AIDS education classroom.

Appendix A

Deanna L. Behnke-Cook
****
****

Attention: Mr.*******
Associate Director Of Education
******* Board of Education

1992 11 23

Dear Mr. *******;

I am a graduate student at McMaster University pursuing a Master of Arts degree in Sociology. For my M.A. thesis, I am examining the issue of HIV/AIDS education as it pertains to students in middle school. Part of the thesis will deal with the development of the HIV/AIDS curriculum. However, I am also interested in looking at how the issue of AIDS is handled in the health education classroom.

With your permission, I would like to sit in on some health classes while the subject of AIDS is being discussed. I would be there only as an observer and have no intentions of participating in any way in the discussions. I am strictly interested in how the existing curriculum is delivered, and would seek the permission of each individual teacher to ensure that my presence would not be problematic.

I want to stress that all of my research will be performed in the most unobtrusive manner possible and with utmost professionalism. As well, I can guarantee that no ***** Board of Education staff, student, family, teacher and/or school will be identified through my research or in my thesis. All of my notes will be kept absolutely confidential and any information that can lead to identification will be excluded from the thesis.

To date, I have had the opportunity to speak with Principal ***** at ***** school and Principal ***** at ***** school regarding my study. Both have found my topic interesting and are willing to have me in their schools.

I would be happy to meet with you to answer any questions you might have about my proposed research. I look forward to speaking with you soon.

Sincerely,

Deanna L. Behnke-Cook

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