Common Threads: From Canada to South Africa Combatting HIV/AIDS Together

The Common Threads: From Canada to South Africa Combatting HIV/AIDS Together project resource package consists of high quality "classroom-ready" lesson resources for Ontario secondary school teachers. These materials help develop awareness in Ontario's high school students of the global impact of their choices and actions, and help them make responsible choices for the sake of our collective future. The lesson resources are complete and "ready to use", designed using specific Ontario Ministry of Education curriculum expectations. They utilize multimedia elements but are available in various formats to provide maximum flexibility.

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From Canada to South Africa
Combatting HIV/AIDS Together

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Expectations

Civics
Grade 10, Open
CHV2O

Informed citizenship

ICV.05 – demonstrate an understanding of citizenship within a global context;
IC5.01 – analyse contemporary crises or issues of international significance (e.g., health and welfare, disasters, human rights, economic development, environmental quality) in the context of the global community;
IC5.02 – summarize the rights and responsibilities of citizenship within the global context, as based on an analysis of the United Nations' Universal Declaration of Human Rights (1948) and Convention on the Rights of the Child (1989);
IC5.03 – research and summarize civic actions of individuals and non-governmental organizations that have made a difference in global affairs (e.g., Cardinal Paul-Emile Léger, Nelson Mandela, Mother Teresa, Craig Kielburger, David Suzuki, Jean Vanier, Red Cross, Frontier College, Doctors Without Borders, YWCA/YMCA);
IC5.04 – compare the contributions of individuals, as explored in the student summaries, to arrive at a definition of the term "global citizen;"
IC5.05 – examine and describe methods of electing governments in other countries (e.g., France, Israel, South Africa, Ireland).

Purposeful citizenship

PCV.01 – examine beliefs and values underlying democratic citizenship, and explain how these beliefs and values guide citizens' actions;
PCV.03 – demonstrate an understanding of the challenges of governing communities or societies in which diverse value systems, multiple perspectives, and differing civic purposes coexist;
PCV.04 – demonstrate an understanding of a citizen's role in responding to non-democratic movements (e.g., supremacist and racist organizations, fascism, and communism) through personal and group actions (e.g., actions of the Righteous Among the Nations during the Holocaust, Medgar Evers, Emily Murphy).
PC1.01 – describe fundamental beliefs and values associated with democratic citizenship (e.g., rule of law, human dignity, freedom of worship, respect for rights of others, work for common good, sense of responsibility for others, freedom of expression);
PC1.02 – explain, based on an analysis of cases in local, provincial, national, and global contexts, how democratic beliefs and values are reflected in citizen actions;
PC3.01 – describe and assess the contributions that citizens and citizens' groups make to the civic purposes of their communities;
PC3.05 – describe ways citizens can be involved in responding to issues in which contrasting value systems, multiple perspectives, and differing civic purposes coexist, and determine their own sense of responsibility in relation to these opportunities for involvement.

Introduction to anthropology, psychology, and sociology
Grade 11, University/College preparation
HSP3M

Self and others

SOV.01 – describe some differences and similarities in the approaches taken by anthropology, psychology, and sociology to the concept of self in relation to others;
SOV.02 – demonstrate an understanding of the social forces that influence and shape behaviour as described by anthropologists, psychologists, and sociologists;
SO2.01 – identify and assess the major influences that contribute to an individual's personal and social development (e.g., heredity, environment, race, gender);
SO2.02 – analyse the role of the mass media in influencing individual and group behaviour;
SO2.03 – explain why behaviour varies depending on context and on the individuals involved (e.g., at work, within a family, in sports, in a crowd, in a large city or small town).
SO3.01 – explain the role of socialization in the development of the individual;
SO3.02 – identify the primary and secondary agents of socialization (e.g., family, school, peers, media, work) and evaluate their influence;
SO3.04 – evaluate the role of cultural influences in socialization (e.g., as they affect gender expectations).

Social structures and institutions

SSV.01 – identify social institutions common to many different cultures;
SSV.02 – compare how selected social institutions function in a variety of cultures;
SS1.02 – describe some of the social institutions of at least three diverse cultures (e.g., First Nations communities in Canada, Masai communities in Africa, Tamil communities in Asia);
SS1.03 – demonstrate an understanding of the ways in which social institutions change over time, from the perspective of at least one of anthropology, psychology, and sociology;
SS3.02 – analyse the psychological and sociological impact of changes in education on individuals, groups, and communities (e.g., democratization of education, gender balance in higher education, the home as school and office).

Social organization

ORV.02 – analyse the psychological impact of group cohesion and group conflict on individuals, groups, and communities;
ORV.03 – describe the characteristics of bureaucratic organizations;
OR1.02 – describe the different types of groups that form to serve collective needs (e.g., study groups, self-help groups, political groups, cults, youth subcultures);
OR2.03 – demonstrate an understanding of discrimination and exclusion in social relationships, from the perspectives of anthropology, psychology, and sociology;
OR2.04 – analyse examples of social or institutional practices in earlier historical periods that formed the basis for social relationships involving discrimination or exclusion in contemporary society (e.g., apartheid, segregation, ghettoization, ostracism, gender discrimination);
OR3.01 – identify examples of bureaucratic organizations (e.g., the military, non-governmental organizations), and describe their characteristics (e.g., cooperative, authoritarian).

Healthy active living education
Grade 11, Open
PPL3O

Healthy living

HLV.01 – demonstrate an understanding of sexual and reproductive health;
HLV.02 – demonstrate, in a variety of settings, the knowledge and skills that reduce risk to personal safety;
HLV.03 – describe the influence of mental health on overall well-being;
HL1.01 – describe factors (e.g., environmental, hormonal, nutritional) affecting reproductive health in males and females;
HL1.03 – demonstrate the skills needed to sustain honest, respectful, and responsible relationships;
HL1.04 – describe sources of information on and services related to sexual and reproductive health;
HL1.05 – assess reproductive and sexual health care information and services;
HL2.02 – demonstrate an understanding of the causes of relationship violence;
HL2.03 – identify and analyse the indicators of violence in interpersonal relationships, as well as appropriate intervention strategies;
HL2.04 – assess solutions and strategies for preventing and eliminating relationship violence;
HL2.05 – analyse the leading causes of injury and injury-associated deaths among adolescents (e.g., unwise risk taking, alcohol and drug abuse, life stresses);
HL2.06 – demonstrate an ability to minimize the risks of injury for adolescents;
HL2.07 – assess strategies for reducing injuries and injury-associated deaths among adolescents (e.g., personal and legal action, educational programs designed to reduce the risk of death from motor vehicle accidents);
HL3.01 – describe the characteristics of an emotionally healthy person (e.g., positive self-concept, ability to manage stress effectively, ability to work productively);
HL3.03 – analyse the factors (e.g., environmental, genetic) that influence the mental health of individuals and lead to the prevalence of mental health problems in the community.

Living skills

LSV.01 – use decision-making and goal-setting skills to promote healthy active living;
LS1.01 – describe their understanding of what constitutes healthy active living (e.g., a lifestyle that stresses the importance of exercise and healthy eating);
LS1.04 – explain the advantages, disadvantages, and possible consequences of risk-taking behaviour;
LS1.05 – describe how to determine whether a risk is worth taking or not.

Health for life
Grade 11, Open
PPZ3O

Determinants of health

DHV.01 – analyse the role of individual responsibility in enhancing personal health;
DHV.02 – analyse the social factors that influence personal health;
DH1.01 – describe the interrelationship of physical, social, and mental health in enhancing personal health;
DH1.03 – analyse how various lifestyle choices (e.g., decisions pertaining to nutrition, physical activity, and smoking) affect health;
DH1.04 – evaluate the factors (e.g., personal responsibility, the influence of peers, culture, and the media) that influence personal choices with regard to health-related products and services;
DH1.05 – explain how stress and one's ability to cope with stress affect personal health;
DH2.01 – describe how family, peers, and community influence personal health;
DH2.02 – analyse the social factors that influence personal health (e.g., employment, education, socio-economic status, isolation, rural and urban settings, access to health and recreational services);
DH2.03 – describe the influence of culture on health (e.g., foods eaten, methods of treating illness, gender roles).

Community health

CHV.01 – analyse the value of health information and health-promoting products and services;
CHV.02 – analyse how the environment influences the health of the community;
CH1.04 – analyse the cost and accessibility of health care services;
CH1.05 – evaluate the effectiveness of school and community health services (e.g., public health units, community agencies, mental health facilities) for themselves and others;
CH1.06 – evaluate the effectiveness of the methods and means used to communicate health information and ideas (e.g., the Internet, print media, research journals);
CH2.02 – describe environmental influences on health on the local, national, and global levels (e.g., pollution, industrial activity, weather);
CH2.03 – describe the impact of specific health problems (e.g., malnutrition, skin cancer, lung cancer, cholera, typhoid) on personal health and the health of others;
CH2.04 – analyse the impact of public health policies and government regulations on environmental health and community health (e.g., water treatment, waste disposal management, immunization program);
CH3.01 – explain the factors that contribute to the strengthening of the immune system (e.g., proper nutrition, physical exercise);
CH3.02 – explain methods used to prevent the transmission of communicable diseases (e.g., abstinence from practices that may lead to contamination, avoidance of drugs);
CH3.03 – evaluate the effectiveness of different types of treatment for the most common communicable diseases (e.g., hepatitis B, tuberculosis, STDs, HIV/AIDS);
CH3.06 – demonstrate an awareness of the contributions that individuals can make to the health of others (e.g., by giving blood, by consenting to be an organ donor, by participating in an anti-smoking campaign);

CH3.07 – analyse how research and medical advances influence the prevention and control of health problems.

Canadian and world issues: A geographic analysis
Grade 12, University preparation
CGW4U

Geographic foundations: Space and systems

SSV.02 – analyse the causes and effects of economic disparities around the world;
SSV.03 – demonstrate an understanding of the cultural, economic, and political aspirations of selected groups and the effects of their actions on local, national, and global issues;
SS1.05 – identify ways in which countries and regions of the world are becoming increasingly interdependent;
SS1.07 – identify similarities and differences in the economic and political aspirations of selected regional or cultural groups within different countries;
SS1.09 – demonstrate an understanding of the roles and status of men and women in different parts of the world;
SS2.02 – analyse the changing spatial distribution of political systems (e.g., democracy, socialism, communism, military dictatorship) around the world;
SS3.02 – select and compare statistical indicators of quality of life (e.g., those relating to population, culture, resources, technology, military expenditure, literacy, medical care) for a variety of developed and developing countries in different parts of the world.

Human-environment interactions

HEV.01 – analyse selected global trends and evaluate their effects on people and environments at the local, national, and global level;
HEV.02 – analyse geographic issues that arise from the impact of human activities on the environment in different regions of the world;
HE1.02 – describe selected world demographic trends and explain the factors influencing them.

Global connections

GCV.01 – demonstrate an understanding of the interdependence of countries in the global economy;
GCV.02 – analyse instances of international cooperation and conflict and identify factors that contribute to each;
GCV.03 – identify the contributions made by a variety of individuals, organizations, and institutions to sustainable development strategies for the developing world, and evaluate their economic, environmental, and social impacts;
GC1.02 – demonstrate an understanding of how scarcities and inequities in the distribution of resources (e.g., water scarcity, unequal land distribution, confiscation of land) contribute to uprisings and conflicts;

GC1.03 – describe the structure, membership, and activities of an international economic alliance in Africa or Asia (e.g., Organization of African States, Association of Southeast Asian Nations);
GC1.05 – identify individuals who have made significant contributions to addressing global issues (e.g., Nelson Mandela and human rights; Gro Harlem Bruntland, former Prime Minister of Norway, and sustainable development; Jody Williams, Nobel Peace Prize winner, and land mine treaty negotiations) and evaluate their impacts;
GC2.01 – analyse the economic and environmental consequences for selected countries of colonialism in the past and economic colonialism in the present;
GC2.03 – analyse the evolving global geopolitical role of a selected region or country (e.g., European Union, Russia, Asia Pacific nations) and evaluate how its actions contribute to cooperation or conflict;
GC3.01 – demonstrate an understanding of how quality of life and employment prospects are related to the global economy;
GC3.04 – evaluate factors (e.g., physical geography, growing of cash crops, foreign monetary assistance) that may compound problems of hunger and poverty in a selected country;
GC3.05 – demonstrate an understanding of how the work of the United Nations and other organizations on poverty, disease, and the environment is directly related to their own lives.

Understanding and managing change

UC1.01 – explain how economic and cultural considerations (e.g., the need for resources or workers, cultural or religious beliefs about child bearing) influence a country's population policies (e.g., China's one child policy);
UC2.03 – evaluate the role played by non-governmental organizations and local community initiatives in different parts of the world (e.g., the Grameen Bank in Bangladesh) in promoting sustainable development and resource management.

Challenge and change in society
Grade 12, University/College preparation
HSB4M

Social change

CHV.02 – describe key features of major theories from anthropology, psychology, and sociology that focus on change;
CH2.03 – demonstrate an understanding of how social change is influenced by poverty and affluence (e.g., consequences of unequal access to personal computers or higher education).

Social challenges

SC1.03 – demonstrate an understanding of the ethical issues related to health-care provision (e.g., the blood supply system, organ donation, medical research);
SC2.01 – explain the relationship between prejudice and discrimination, and assess the impact of both on ideas of self-worth;

SC3.02 – analyse, from a Canadian perspective, the social structures that support, and those that weaken, global inequalities (e.g., literacy, poverty, new technologies).

Coded expectations, food and nutrition sciences
Grade 12, University/College preparation
HFA4M

Self and others

SOV.01 – identify the social, psychological, economic, emotional, cultural, religious, and physical factors that affect food choices;
SOV.02 – summarize food-related issues that arise throughout the life cycle;
SO1.03 – describe economic factors that have an impact on the food choices of individuals and families;
SO1.04 – identify the ways in which physical factors influence food choices (e.g., geographical location, regional growing seasons, availability of food markets, home storage capacity);
SO2.01 – identify the factors that affect personal food choices throughout the life cycle (e.g., age, health, school and/or work schedules, lifestyle, level of physical activity, lactation, special dietary needs).

Personal and social responsibilities

PRV.02 – determine the relationship among nutrition, lifestyle, health, and disease;
PR2.01 – identify the social conditions that contribute to the incidence of illness and disease (e.g., improper nutrition, the pressure of daily living, stress);
PR2.02 – explain the relationship among lifestyle, food choices, and nutrition-related illnesses and diseases (e.g., cardiovascular disease, anorexia nervosa, tooth decay, osteoporosis).

Diversity, interdependence, and global connections

GCV.02 – identify the economic, political, and environmental factors that affect food production and supply throughout the world;
GCV.03 – identify the factors that are critical to achieving and maintaining food security and eliminating hunger;
GC2.01 – describe the effects of various economic factors on food production and supply (e.g., standards of living, poverty, personal and family incomes, employment and unemployment);
GC2.03 – demonstrate an understanding of the effects of different environmental factors and issues on the production and supply of food items (e.g., energy and resources required to produce various foods; use of pesticides, fertilizers, food additives, and irradiation);
GC2.06 – identify current food crises (e.g., contamination, crop failures), the factors causing each of them (e.g., production increases, unfavourable global weather changes), and their impact on the availability and cost of food;
GC3.01 – investigate the extent of hunger in the world today and present the results of their investigation;

GC3.03 – summarize the causes of food insecurity (e.g., an emphasis on cash-cropping and large-scale food production, globalization, urbanization, continued feminization of poverty);
GC3.04 – identify economic and social policies that influence food security (e.g., debt restructuring, the operations of the World Bank);
GC3.05 – describe the social and cultural traditions that account for inequality among peoples of the world (e.g., gender issues, distribution of wealth, failure to support small business);
GC3.06 – identify the ways in which the local community is responding to hunger and food security (e.g., with food banks, community gardens).

Individuals and families in a diverse society
Grade 12, University/College preparation
HHS4M

Self and others

SOV.01 – analyse theories and research on the subject of individual development, and summarize their findings;
SOV.02 – analyse theories and research on the subject of the development of and the psychological tasks connected with intimate relationships, and summarize their findings;
SOV.03 – analyse theories and research on the subject of parent–child relationships and their role in individual and family development, and summarize their findings;
SO1.01 – describe the development of individuals at different stages of life, drawing on a variety of developmental theories (e.g., Erikson's, Gilligan's, Kohlberg's, Levinson's, Piaget's, Sheehy's);
SO1.02 – analyse several viewpoints on similarities and differences in male and female development and on the impact of those differences on the roles individuals play (e.g., Levinson's, Buss's);
SO1.03 – evaluate emerging research and theories (e.g., brain research, evolutionary psychology, feminist theories, theories on aging) explaining the developmental tasks of individuals at various stages of life.
SO2.01 – demonstrate an understanding of the role of intimate relationships in the lives of individuals and families, considering the similarities and differences for males and females, and traditional and non-traditional relationships.

Personal and social responsibilities

PRV.02 – explain decisions and behaviours related to role expectations in intimate relationships;
PRV.03 – analyse decisions and behaviours related to parental and care-giver role expectations, including the division of responsibilities for childrearing and socialization;
PR2.03 – identify factors that are detrimental to maintaining satisfying relationships (e.g., infidelity, financial difficulties) and explain strategies for communicating and negotiating to maintain satisfying relationships;
PR3.03 – analyse the division of responsibility for childrearing and socialization, and the interaction of care-givers (e.g., mother, father, siblings, non-custodial parent, grandparents, child-care workers).

Diversity, interdependence, and global connections

GCV.01 – explain the historical and ethnocultural origins of contemporary individual lifestyles, socialization patterns, and family roles;
GCV.02 – analyse changes that have occurred in family structure and function throughout the history of the family;
GCV.03 – analyse socialization patterns and the roles of children and parents in various historical periods and ethnocultural contexts;
GC1.01 – describe the diversity in personal and family roles of individuals in various cultures and historical periods;
GC1.02 – analyse male and female roles in various societies and historical periods, taking into consideration societal norms and ideals, individuals' perceptions of roles, and actual behaviours;
GC1.03 – analyse changes in labour-force participation, taking into consideration male and female participation rates, child labour, retirement, and the impact of work on socialization;
GC2.01 – explain changing family forms and functions in various societies throughout history, and describe contemporary family forms;
GC2.03 – analyse the historical and ethnocultural factors affecting variations in mate-selection, marriage customs, and marital roles;
GC3.01 – describe patterns and practices in childbearing in various cultures and historical periods (e.g., reasons for having or not having children, age and marital status of parents, family size and spacing of children, adoption, foster care);
GC3.02 – analyse the roles of children in the family and society in various cultures and historical periods, taking into consideration expectations for pace of development, rites of passage, participation in education or labour, and the nature of parent–child relationships;
GC3.03 – identify cultural, historical, and religious variations in parental roles, childrearing practices, and the role of the extended family and society in childrearing.

Social challenges and social structures

SCV.02 – analyse current issues and trends affecting the dynamics of intimate relationships, and speculate on future directions for individuals and families;
SCV.03 – analyse current issues and trends affecting childrearing and socialization, and speculate on the changing role of children;
SCV.04 – demonstrate an understanding of the cycle of violence and the consequences of abuse and violence in interpersonal and family relationships;
SC1.01 – describe current perceptions, opinions, and demographic trends relating to the life patterns of individuals (e.g., life expectancy, educational attainment, labour-force participation, income), and speculate on the significance of these trends for individual development;
SC1.02 – explain the impact on individual development and decision making of social changes and challenges (e.g., AIDS, emerging communication technologies, the increase in non-family households, cultural diversity) and life events (e.g., illness, infertility, disability, unemployment, death, divorce);
SC2.01 – describe current perceptions, opinions, and demographic trends relating to intimate relationships, and speculate on the significance of these trends for individual and family development;
SC2.02 – analyse current issues relating to intimate relationships (e.g., cohabitation, delayed marriage, divorce, interracial marriage);

SC2.03 – identify the role of various social institutions (e.g., family, law, religion, economy, government) with respect to intimate relationships (e.g., definition of spouse, rights and obligations of spouses, social support);
SC2.04 – demonstrate an understanding of the cycle of violence in intimate relationships and of strategies for avoiding and responding to violence in relationships;
SC3.01 – describe current perceptions, opinions, and demographic trends relating to childbearing and childrearing (e.g., birth rate, age at childbearing, number of children, age at leaving home), and speculate on the significance of these trends for parent–child relationships;
SC3.04 – identify the role that different types of social institutions and systems (e.g., school, media, peer group, medicine, religion) have in the rearing and socialization of children;
SC3.07 – summarize the impact of economic and political instability (including war) and migration on child development and socialization.

Issues in human growth and development
Grade 12, University/College preparation
HHG4M

Human development

HDV.01 – demonstrate an understanding of established theories of bonding and attachment;
HDV.03 – demonstrate an understanding of the consequences of environmental deprivation during early childhood;
HDV.04 – analyse changes in human development throughout the life cycle, including early childhood, adolescence, mid-life, and aging;
HD1.01 – analyse and evaluate factors that contribute to the emotional and physical well-being of a newborn (e.g., nurturing, breast-feeding, security, trust);
HD1.04 – demonstrate an understanding of what constitutes an effective relationship of caregiver and child by applying attachment and bonding theories in a real-life setting;
HD2.01 – explain the relationship between maternal health and well-being and brain development in the child from the neonatal period to age three;
HD2.02 – demonstrate an understanding of the concept of "environmental deprivation" (e.g., lack of visual stimulation, limited exposure to language, minimal physical contact);
HD2.05 – investigate the long-term effects of inadequate nurturing and environmental deprivation (e.g., behavioural problems, criminal behaviour), and summarize their findings;
HD3.03 – describe the physical, intellectual, psychological, social, and emotional changes that take place during adolescence and throughout the remaining stages in the life cycle (e.g., development of identity, capacity for abstract thinking, awareness of aging).

Socialization and human development

SHV.01 – demonstrate an understanding of the critical role that a family plays in the socialization of its members;
SHV.02 – investigate and interpret the contributions that schools make to the socialization of individuals across the life span;
SHV.03 – identify and evaluate the various ways in which the media can be seen as agents of socialization;

SH1.01 – explain how the current social issues and personal challenges that families face (e.g., divorce, unemployment, poverty, dual/single income, stress) affect the socialization of family members;
SH1.04 – identify the various school and community programs and projects designed to assist parents in creating positive home environments that foster optimum human development (e.g., family resource centres; parenting centres; Healthy Babies, Healthy Children Program; family-life education programs);
SH2.01 – describe the diverse ways in which aspects of the school environment (e.g., teachers, volunteers, peer relationships, play, curriculum, adult-education programs, and extracurricular activities) contribute to the socialization of individuals at various stages of the life cycle;
SH2.02 – identify through research and critical analysis the social issues that schools face in educating individuals across the life span (e.g., safety, defiance of authority), and evaluate strategies for dealing with these issues.

Self and others

SOV.01 – demonstrate an understanding of the critical nurturing and teaching roles of parents and care-givers;
SOV.02 – analyse the many relationships that are a part of human development;
SO1.01 – demonstrate an understanding of how parents and care-givers can play a key role in ensuring that children are healthy, secure, and confident (e.g., by nurturing, having a positive attitude, demonstrating empathy);
SO2.03 – identify the issues that affect the ways in which children relate in a family (e.g., being a single child; a sibling; or an older, middle, or younger child).

Diversity, interdependence, and global connections

GCV.01 – demonstrate an understanding of the diverse influences that shape human growth and development;
GCV.02 – explain why social challenges need to be understood within an integrated framework;
GC1.05 – describe how cultural and religious differences affect the roles and responsibilities of parents, children, and others (e.g., of parents as authority figures; of couples in arranged marriages; of men and women in families and in society);
GC1.07 – compare child-rearing practices in various contexts (e.g., on a kibbutz, in a nuclear family);
GC2.02 – describe emerging initiatives promoting shared responsibility between parents and society (e.g., developing caring communities, extending maternity/parental leave, encouraging family-friendly workplaces), and evaluate their effectiveness;
GC2.03 – demonstrate an understanding of the effects that various economic, political, and social factors (e.g., poor nutrition, low birth weight, illiteracy, technological change) can have on human development;
GC2.04 – identify and evaluate ways to prevent these factors from negatively affecting human growth and development;
GC2.06 – identify various human-development initiatives that will assist countries in preparing themselves to meet new global challenges (e.g., as outlined by Keating and Hertzman, and by McCain and Mustard).

Parenting and human development
Grade 12, Workplace preparation
HPD4E

Stages of family life

FLV.01 – demonstrate an understanding of the stages and transitions in the family life cycle;
FLV.02 – compare the changing needs of individuals and families throughout life;
FL1.02 – demonstrate an understanding of the variations in family form (e.g., nuclear, common-law, lone-parent, blended families) that exist at various stages of the family life cycle (e.g., families with young children, adolescent children, and adult children);
FL1.03 – identify the patterns that occur in human development (e.g., dependence on parents, growing autonomy, independence, dependence on adult children) and in family development (e.g., beginning family, expanding family, contracting family);
FL1.04 – explain the adjustments parents and children make as they move from one stage to the next, and when an adult child returns to live at home (e.g., giving up personal space and certain freedoms, revising rules);
FL2.01 – identify how the needs of individuals and families are met at various stages of the life cycle;
FL2.03 – describe the role of the community in meeting individual and family needs during childhood and adolescence, on the basis of practical experience in a community setting.

Human development: Self and others

HDV.01 – demonstrate an understanding of the link between healthy prenatal and infant development and long-term growth and development;
HD1.01 – identify and describe strategies for promoting healthy pregnancies and optimum birth weights in first and subsequent pregnancies (e.g., prenatal health care and nutrition; abstinence from smoking, alcohol, and drugs; breast-feeding);
HD1.02 – demonstrate an understanding of the challenges and long-term costs associated with health problems in infancy that might be prevented with proper prenatal and postnatal care (e.g., low birth weights, delays in early physical development).

Personal and social responsibilities

PRV.02 – demonstrate an understanding of how the parental responsibility for the nutritional well-being of children and adolescents is best fulfilled;
PR2.02 – explain the impact of inadequate nutrition on student learning, growth, and development (e.g., diminished concentration).

Social structures and social challenges

SCV.01 – analyse the challenges of balancing work and family;
SCV.02 – demonstrate an understanding of the role and functions of schooling in our society and in relation to family life;

SCV.03 – evaluate the influence that the media have on parents, children, and adolescents;
SCV.04 – explain the role of social-service organizations in supporting children and families when problems arise;
SC1.03 – demonstrate an understanding of the effects on children and their families of parents' working full-time, part-time, or not at all;
SC2.03 – compare the role of parents, teachers, youth workers, and children in formal and informal education (e.g., mentoring, monitoring, modelling), on the basis of observations made in school and community settings;
SC3.03 – analyse how families can adapt to focus on the positive uses of media (e.g., by keeping abreast of current events through a discussion of daily news stories, by watching educational programming together);
SC4.01 – demonstrate an understanding of individual and family concerns (e.g., violence, poverty, family breakdown, addiction, death of a family member) that are addressed by agencies in society;
SC4.02 – identify the support and care options available to parents and siblings when a family member has a physical exceptionality or is affected by a disease or illness;
SC4.03 – explain the role and function of family counselling (e.g., short-term and crisis counselling, grief counselling, relationship counselling);
SC4.04 – identify job opportunities in the social-service sector that involve helping families.

Philosophy: Questions and theories
Grade 12, University preparation
HZT4U

Ethics

ET1.01 – identify the main questions of ethics (e.g., What are good and evil? What is the good life? What is virtue? Why be moral? What obligations do people have to one another?);
ET1.03 – use critical and logical thinking skills to defend their own ideas about ethical issues (e.g., the nature of the good life) and to anticipate counter-arguments to their ideas;
ET1.04 – demonstrate how the moral problems and dilemmas that occur in everyday contexts (e.g., in medicine, business, law, the media) can be effectively analysed using a variety of different philosophical theories (e.g., virtue ethics, social-contract theory).

Social and political philosophy

PP1.01 – demonstrate an understanding of the main questions of social and political philosophy (e.g., What are the just limits of state authority? Do people have a right to equal treatment? Should individual citizens be free to do what they want? What are an individual's rights and responsibilities?);
PP1.03 – use critical and logical thinking skills to develop and defend their own ideas about some of the major questions of social and political philosophy, and to anticipate counter-arguments to them;
PP1.04 – analyse how theories of social and political philosophy (e.g., libertarianism, egalitarianism) are adopted and realized in contemporary political policy making (e.g., concerning the distribution of wealth), and how the adoption of a particular theory makes a difference to political and social practices;

PP1.05 – demonstrate an understanding of how particular philosophical theories (e.g., of rights, citizenship, duties) have influenced the development of subjects such as political science, economics, or law.

Biology
Grade 12, University preparation
SBI4U

Understanding basic concepts

PD3.01 – analyse Canadian investments in human resources and agricultural technology in a developing country (e.g., investigate Canadian International Development Agency [CIDA]-funded projects in a developing country);
PD3.02 – describe examples of stable food-production technologies that nourish a dense and expanding population;
PD3.03 – outline the advances in medical care and technology that have contributed to an increase in life expectancy, and relate these developments to demographic issues.

Canadian and international law,
Grade 12, University preparation
CLN4U

Heritage

HTV.01 – demonstrate an understanding of the historical and philosophical origins of law and their connection and relevance to contemporary society;
HTV.03 – demonstrate an understanding of the relationship between law and societal values;
HTV.04 – assess the influence of individual and collective action on the evolution of law;
HT2.05 – analyse contemporary legal situations that raise the question of the conflict between what may be legally correct but is generally viewed as unjust;
HT3.02 – analyse how society uses law to express its values;
HT3.03 – identify and analyse contemporary events and issues that demonstrate a possible conflict between the law and societal values;
HT4.01 – evaluate the influence of individual citizens who have fought to change the law (e.g., Dr. Henry Morgentaler, Nelson Mandela, Sue Rodriguez);
HT4.02 – assess the role of collective action in changing the law in democracies (e.g., lobby and pressure groups, voting at the polls, citizen petitions).

Rights and freedoms

RFV.01 – demonstrate an understanding of the historical development of human rights legislation in Canada;
RFV.05 – analyse the conflicts between rights and freedoms and between minority and majority rights in a democratic society and describe the methods available to resolve these conflicts;
RF2.03 – explain the role of the courts in determining law-making jurisdiction.

Regulation and dispute resolution

RDV.01 – demonstrate an understanding of the role of governments, the courts, and individual and collective action in protecting the environment;
RDV.05 – demonstrate an understanding of the complexity of making, interpreting, and enforcing law on a global scale;
RD3.03 – identify global issues that may be governed by international law (e.g., human rights, jurisdictional disputes, refugees and asylum, collective security, trade agreements);
RD3.04 – explain the role and jurisdiction of the agencies responsible for defining, regulating, and enforcing international law (e.g., the United Nations, the World Health Organization, war crimes tribunals, the International Monetary Fund, Interpol);
RD4.04 – evaluate the effectiveness of international treaties for the protection of human rights (e.g., the Universal Declaration of Human Rights, the Declaration of the Rights of the Child);
RD5.02 – compare methods of resolving conflicts by peaceful means (e.g., international diplomacy, sanctions, arbitration, mediation);
RD5.03 – identify domestic laws (e.g., the Nuremberg Laws, laws on apartheid) that conflict with the principles of international law and explain how they violate those principles;
RD5.04 – evaluate the difficulties and effectiveness of international intervention in conflicts between nations.

Canadian and world politics
Grade 12, University preparation
CPW4U

Participation in the international community

ICV.01 – explain the rights and responsibilities of individual citizens, groups, and states in the international community;
ICV.02 – describe the main ways in which sovereign states and non-state participants cooperate and deal with international conflicts;
ICV.03 – evaluate the role of Canada and Canadians in the international community;
ICV.04 – describe the structure and function of international intergovernmental and non-governmental organizations;
ICV.05 – evaluate the role and operation of the international human rights protection system;
IC1.01 – evaluate the extent to which the rights and responsibilities of states in the international community are parallel to the rights and responsibilities of citizens in democratic national communities;
IC1.02 – describe the rights and obligations of international groups (e.g., the International Monetary Fund, transnational corporations, environmental lobby groups);
IC1.03 – describe the actions of particular individuals who have influenced global affairs (e.g., Nelson Mandela, Lester Pearson, Eleanor Roosevelt, Dag Hammarskjold, Mikhail Gorbachev, John Humphrey);
IC2.04 – identify the causes and consequences of non-governmental international conflict and violence (e.g., terrorism, tribalism, organized crime);
IC3.02 – explain the types of commitments made by Canada to other nations or to international or extranational organizations (e.g., membership in the Commonwealth of Nations, la Francophonie, or the North American Treaty Organization; participation in the United Nations and in peacekeeping missions);

IC3.03 – evaluate the extent to which key agreements and treaties signed by Canada (e.g., NAFTA, agreements relating to the testing of nuclear weapons over Canada) contribute to the well-being of Canadians and the world in general;
IC3.05 – explain the role of federal and provincial government agencies (e.g., Canada's Departments of Foreign Affairs and International Trade, the Canadian International Development Agency) in formulating and implementing Canada's foreign policy;
IC4.01 – explain the origins, functions, and objectives of selected international non-governmental organizations (e.g., the International Committee of the Red Cross, Amnesty International, the International Olympic Committee);
IC4.02 – explain the origins, functions, and objectives of international cooperation organizations (e.g., the United Nations, Asia-Pacific Economic Cooperation, the World Health Organization);
IC4.03 – evaluate the effectiveness of selected international organizations (e.g., the Organization of Petroleum Exporting Countries, the Non-Aligned Conference, the Arab League) in meeting their stated objectives;
IC4.04 – analyse the need for new international organizations as a result of globalization and the advent of new technologies (e.g., organizations for regulating extra-governmental firms, controlling drug trafficking, regulating activities in outer space);
IC5.01 – identify the most important international human rights documents (e.g., the Universal Declaration of Human Rights; the United Nations Covenant on Social, Economic, and Cultural Rights; the Geneva Conventions) and assess their significance;
IC5.02 – describe the role of agencies responsible for ensuring the upholding of human rights (e.g., the Human Rights Commission, the Commission on the Status of Women);
IC5.03 – explain the role of state and non-state participants in international controversies about certain rights.

Power, influence, and the resolution of differences

POV.01 – describe factors that make states powerful and factors that make states weak;
PO1.02 – evaluate the accuracy and usefulness of classifying states (e.g., as developing countries; Western countries; non-aligned countries; major, medium, or small powers) when describing relationships among states;
PO1.03 – analyse the rise and development of non-governmental organizations (NGOs) and corporations as world powers (e.g., Red Cross/Crescent; oil cartels; multinational corporations such as Nike, Shell, and Microsoft);
PO2.04 – explain the relationship between changes in information, telecommunications, and military technologies and changes in international, political, and economic relations (e.g., the American military development of the Internet, military and commercial uses of satellite telecommunications, the spread of industrial espionage);
PO3.05 – evaluate the nature and quality of Canada's influence within selected world and regional organizations (e.g., the United Nations, the International Olympic Committee, the Organization of American States).

Values, beliefs, and ideologies

VBV.03 – demonstrate an understanding of the many similarities and differences in the aspirations, expectations, and life conditions among the peoples of the developed and the developing nations;

VB2.02 – determine the origins and effects of nationalist armed conflicts (e.g., the Balkan wars, wars in Central Africa, apartheid in South Africa) and of rivalries rooted in ethnocentrism (e.g., between India and Pakistan, between Israel and Arab nations, between the diverse peoples of Indonesia);
VB2.03 – describe the peaceful legal means used to adjudicate conflicts between governments (e.g., Canadian federal-provincial conferences, the International World Court) and explain their relationship to values, beliefs, and ideologies;
VB2.04 – explain the key arguments for and against the processes of "globalization" in economics, politics, and culture, as well as their relationship to values, beliefs, and ideologies;
VB3.01 – describe the main economic, political, and social characteristics of developed and developing countries;
VB3.02 – compare key elements of selected theories concerning the nature of effective development (e.g., global industrialization, sustainable national development);
VB3.03 – analyse the main differences between the social beliefs and ideologies in developed and developing countries (e.g., individual and community property ownership, private and public capitalism, inter-party democracy and intra-party democracy);
VB3.04 – demonstrate an understanding of the commonality of human aspirations for a better, more secure life.

World geography: Human patterns and interactions
Grade 12, University preparation
CGU4U

Geographic foundations: Space and systems

SSV.03 – explain the influence of social, political, cultural, and economic factors on human environments and activities;
SS3.04 – assess the influence of different cultures on their local area (e.g., cultural centres, food, celebrations, customs).

Global connections

Overall expectations

GCV.01 – analyse the impact of culture on settlement patterns and human activities;
GCV.03 – evaluate the effects of the information revolution, technological progress, and global trade on world regions;
GC1.01 – explain how cultural characteristics (e.g., religion, language, ethnicity) act as linking factors within and between regions;
GC1.02 – explain the role of international organizations (e.g., United Nations, World Bank, World Health Organization, Red Cross, Amnesty International) in fostering contact between world peoples;
GC2.01 – analyse examples of the influence of culture on human activities (e.g., pilgrimages, tourism);
GC2.02 – analyse examples of social phenomena that contribute to cultural and economic convergence (e.g., widespread use of English in business, ethnic quarters in large cities, cultural associations and centres), peace, and good international relations;

GC2.03 – explain how people in different countries can work together to solve international problems (e.g., the Land Mine Treaty campaign);
GC2.04 – assess the impact of technological change in a region of the world;
GC3.01 – analyse selected settlement patterns around the world to show how they have been influenced by cultural factors (e.g., inheritance systems, land settlement systems);
GC3.02 – compare economic opportunities for men, women, and children in selected regions or countries (e.g., Canada, North Africa, Scandinavia, Japan);
GC3.04 – explain the role played by culture and economics in selected incidents of conflict or cooperation.

Understanding and managing change

UCV.02 – demonstrate an understanding of regional economic disparities and factors affecting them;
UCV.03 – assess the effectiveness of measures to alleviate regional economic disparities and conflict.
UC2.07 – explain how international aid has brought about change in disadvantaged countries;
UC3.02 – evaluate the political, economic, and social impacts of a selected development project on the ability of people to control their land and lifestyles;
UC3.03 – produce a case study of regional planning in a developing country aimed at reducing regional disparities and improving economic and social well-being.

Methods of geographic inquiry

GI3.02 – conduct an independent inquiry on a political, economic, cultural, or social issue related to a region or nation in Africa, Asia, or Oceania, using key concepts and methods presented in the course;
GI3.04 – forecast future trends relating to a selected issue in human geography (e.g., rural-to-urban migration in Asia).

Coded expectations, world geography: Urban patterns and interactions,
Grade 12, College preparation
CGU4C

Geographic foundations: Space and systems

SS2.05 – compare urban service systems in a North American city to those in a South Asian or African city;
SS3.03 – analyse the distributions of selected characteristics of an urban area (e.g., land use, ethnic groups, population structure) and explain the reasons for the observed patterns.

Human-environment interactions

HEV.02 – explain how humans modify the environment for urban needs;
HE1.02 – explain how urban places (e.g., Amsterdam, Hong Kong, Tokyo) are made distinctive by human activities that alter physical features.

Global connections

GC1.01 – demonstrate an understanding of how culture and economics influence the development of settlements;
GC1.02 – identify examples of cultural, political, and economic factors that contribute to cooperation or conflict in urban regions;
GC3.04 – compare economic opportunities for men, women, and children in selected urban regions (e.g., Cairo, Calcutta, Beijing).

Understanding and managing change

UC1.05 – demonstrate an understanding of how assistance programs (e.g., development, disaster relief) can have both positive and negative impacts on urban areas;
UC2.03 – propose ways to manage change in meaningful, efficient, and sustainable ways for people in selected urban areas in Africa, Asia, or Oceania.

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 1 – Day 1

Apartheid: The concept and ideology of racism

Apartheid: The concept and ideology of racism

Historical background
Impact of apartheid on health
Impact of apartheid on education

Estimated time required: 1 class; 75 minutes

Overall expectations

By the end of this session, students will be able to:
- Develop an understanding of apartheid as a unique and systematic concept and ideology of institutionalized racism.
- Develop an understanding and appreciation of the linkage between apartheid and economic exploitation.
- Develop an understanding and appreciation of the linkage between apartheid and impoverishment, marginalization, poverty, poor education and health.
- Develop an understanding and appreciation of the linkage between apartheid and the denial of human rights.

Enduring (key) learning

Students will understand the concept and nature of narrow nationalist ideology and its oppressive and repressive impact on the lives of people. Students will appreciate and understand the preconditions for resistance to oppression, and the struggle for freedom and democracy. Students will understand and appreciate the challenges of transition to democratic governance.

Prior learning

- Teacher and students will have examined and discussed the democratic rights enjoyed by Canadian citizens and residents under the *Canadian Charter of Rights and Freedoms*–(BLM 1-1)
- Teacher and students will have examined and discussed the *Universal Declaration of Human Rights*, adopted and proclaimed by the United Nations General Assembly on 10 December 1948 (BLM 1-2).
- Teacher and students will have examined and discussed the apartheid legislation in South Africa (BLM 1-3).

Getting ready

1. The teacher will duplicate and distribute copies of:
    a. BLM 1-4 A, historical background and BLM 1-4 B, worksheet
    b. BLM 1-5 A, impact of apartheid on health and BLM 1-5 B, worksheet.
    c. BLM 1-6 A, impact of apartheid on education and BLM 1-6 B, worksheet.

2. The teacher will duplicate, prepare and distribute as per simulation copies of:
    a. BLM 1-7 B, race classification cards; BLM 1-8, identity document; and, BLM 1-9, rights and privileges.

Resources

1. The History of Apartheid in South Africa
   www-cs-students.stanford.edu/~cale/cs201/apartheid.hist.html
2. Modern History Sourcebook: A. L. Geyer: The Case for apartheid, 1953
   www.fordham.edu/halsall/mod/1953geyer.html
3. HUMAN RIGHTS: Historical images of apartheid in South Africa,
   www.un.org/av/photo/subjects/apartheid.htm
4. History of South Africa – South African Government Information
   www.info.gov.za/aboutsa/history.htm

Teaching/learning strategy

Reading materials and worksheets – 25-30 minutes – BLM 1-4 – 1-6

1. The teacher should divide the class into groups of three to four students and provide each student with the Legacy of apartheid South Africa and accompanying worksheets (BLM 1-4 – 1-6).
    a. Have the students read the worksheet questions and respond with short answers derived from the text.
    b. Allow students about 25-35 minutes to complete their work.
    c. Follow this process with the apartheid simulation exercise described below.

Apartheid simulation – 25-30 minutes – BLM 1-7 – 1-9

2. The teacher should not describe the intent of the simulation. Merely instruct students to follow your directions. As set out below:
    a. Roughly divide the physical space of your classroom into two parts – about 13% black homelands, and 87% white South Africa. There should be no sitting facilities in the black areas.
    b. Roughly divide your students class into four groups –Africans or 'Bantu' (70%), whites (15%), Indians (3%), coloureds (9%).
    c. Hand an identity card (BLM 1-8) to each student according to their race classification.
    d. Hand each black South African an Identity Document (BLM 1-8). Those who are employed may come into White South Africa to work. The unemployed must stay in the Homelands.
    e. Hand each South African a copy of their rights and privileges (BLM 1-9).

Discussion – 10-15 minutes

3. The teacher should allow for students to express their learning experiences following the two activities outlined above. Some topics for discussion may include:
    a. What are the challenges which face a new democratic South Africa given the legacies of the past?
    b. How does the legacy of the past impact on education?
    c. How does the legacy of the past impact on health?
    d. How does the legacy of poverty influence the spread and impact of HIV and AIDS?

R 4. Extensions

- Prepare a report or write an essay on "The challenges of freedom!" Describe and link the legacies of the past, the impact of the past on the present, and the possibilities for the future.

Additional Internet resources

- 10 Year Review www.10years.gov.za/review/index.html
- 10 Years of Freedom www.10years.gov.za/
- African National Congress (South Africa's Liberation Movement). . . . . www.anc.org.za/
- African Union . . . . . www.africa-union.org/
- ANC Youth League . . . . . www.anc.org.za/youth/
- Anglo-Boer War Museum . . . . . www.anglo-boer.co.za/index.html
- Apartheid Museum www.apartheidmuseum.org/supplements/issue1/index.html
- Apartheid . . . . . en.wikipedia.org/wiki/Apartheid
- Canada and the Fight Against Apartheid, CBC Archives (Voice) . . . . . archives.cbc.ca/IDD-1-71-703/conflict_war/apartheid/ (Excellent materials)
- Class and Colour in South Africa 1850~1950, Jack & Ray Simons www.liberation.org.za/docs/books/ccsa01.php
- Commonwealth Secretariat . . . . . www.thecommonwealth.org/HomePage.asp?NodeID=20593
- Constitution of the RSA. . . . . www.info.gov.za/documents/constitution/index.htm
- COSATU . . . . . www.cosatu.org.za/
- Department of Education, History Classroom. . . . . www.sahistory.org.za/pages/mainframe.htm
- German South West Africa . . . . . www.zum.de/whkmla/region/southafrica/germanswa.html
- Heritage of Slavery in South Africa . . . . . www.museums.org.za/iziko/slavery/
- History Classroom . . . . . www.sahistory.org.za/pages/mainframe.htm
- History of the Griqua Nation & Nomansland . . . . . www.tokencoins.com/griqua.html#001
- Imbizo . . . . . www.info.gov.za/issues/imbizo/index.html
- Imperialism and the Union in South Africa, Timothy Keegan www.sahistory.org.za/pages/chronology/turningpoints/bk3/chapter2.htm
- Independent Electoral Commission . . . . . www.elections.org.za/
- International Convention on the Suppression and Punishment of the Crime of Apartheid www.unhchr.ch/html/menu3/b/11.htm
- Mahatma Gandhi, 1869-1948 . . . . . www.anc.org.za/ancdocs/history/people/gandhi/
- National Party (NP) . . . . . www.natweb.co.za/
- NEDLAC . . . . . www.nedlac.org.za/
- NEPAD . . . . . www.nepad.org/
- Parliament . . www.parliament.gov.za/pls/portal/web_app.new_middle_column?p_page_name=HOME_PAGE

- Plaatje, Soloman Tshekisho (1876-1932) . . . . . www.anc.org.za/ancdocs/history/people/plaatje/plaatje.html
- President Mbeki . . . . . www.info.gov.za/gol/gcis_profile.jsp?id=509
- Reflections on the Challenges Confronting Post-apartheid South Africa by Bernard Makhosezwe Magubane . . . . . www.unesco.org/most/magu.htm#historical
- SADC. . . . . www.sadc.int/
- South Africa Yearbook, 2003/04, History www.gcis.gov.za/docs/publications/yearbook/2history.pdf
- South Africa: The Transition Continues faculty.cua.edu/fischer/ComparativeLaw2002/toombs/SouthAfrica.html
- South African Communist Party . . . . . www.sacp.org.za/
- South African History . . . . . www.sahistory.org.za/
- Sterkfountein Caves. . . . . www.sterkfontein-caves.co.za/
- The Boer War South Africa 1899-1902 . . . . . www.geocities.com/Athens/Acropolis/8141/boerwar.html
- The Dutch East India Company . . . . . www.sahistory.org.za/pages/specialprojects/voc/voc.htm
- The First Anglo Boer War www.sahistory.org.za/pages/specialprojects/anglo-boer-wars/anglo-boer-war1.htm
- The Freedom Charter . . . . . www.anc.org.za/ancdocs/history/charter.html
- The History of Apartheid . . . . . www-cs-students.stanford.edu/~cale/cs201/apartheid.hist.html
- The Mandela Page . . . . . www.anc.org.za/people/mandela/
- The Non-aligned Movement . . . . . www.nam.gov.za/
- The Struggle for Liberation in South Africa by Govan Mbeki . . . . . www.anc.org.za/books/liberation.html#struggle
- Thulamela . . . . . www.primeorigins.co.za/interactive_map/nprov/thulamela.htm
- Truth and Reconciliation Commission . . . . . www.doj.gov.za/trc/index.html
- Umkhonto We Size . . . . . www.anc.org.za/ancdocs/history/mk/
- United Democratic Front . . . . . www.anc.org.za/ancdocs/history/udf/
- World Heritage . . . . . whc.unesco.org/pg.cfm?CID=31&l=EN

Canadian Charter of Rights and Freedoms

Department of Justice Canada / Ministère de la Justice Canada

Abridged version

Schedule B

***Constitution Act*, 1982 (79)**

Enacted as Schedule B to the *Canada Act* 1982 (U.K.) 1982, c. 11,
which came into force on April 17, 1982

Part I

Canadian Charter of Rights and Freedoms

	Whereas Canada is founded upon principles that recognize the supremacy of God and the rule of law:
Rights and freedoms in Canada	**1**. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.
Fundamental freedoms	**2**. Everyone has the following fundamental freedoms: a) freedom of conscience and religion; b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication; c) freedom of peaceful assembly; and d) freedom of association.
Democratic rights of citizens	**3**. Every citizen of Canada has the right to vote in an election of members of the House of Commons or of a legislative assembly and to be qualified for membership therein.
Maximum duration of legislative bodies	**4**. (1) No House of Commons and no legislative assembly shall continue for longer than five years from the date fixed for the return of the writs of a general election of its members.
Continuation in special circumstances	(2) In time of real or apprehended war, invasion or insurrection, a House of Commons may be continued by Parliament and a legislative assembly may be continued by the legislature beyond five years if such continuation is not opposed by the votes of more than one-third of the members of the House of Commons or the legislative assembly, as the case may be.
Annual sitting of legislative bodies	**5**. There shall be a sitting of Parliament and of each legislature at least once every twelve months
Mobility of citizens	**6**. (1) Every citizen of Canada has the right to enter, remain in and leave Canada.
Rights to move and gain livelihood	(2) Every citizen of Canada and every person who has the status of a permanent resident of Canada has the right a) to move to and take up residence in any province; and b) to pursue the gaining of a livelihood in any province.

Limitation	(3) The rights specified in subsection (2) are subject to a) any laws or practices of general application in force in a province other than those that discriminate among persons primarily on the basis of province of present or previous residence; and b) any laws providing for reasonable residency requirements as a qualification for the receipt of publicly provided social services.
Affirmative action programs	**(4) Subsections (2) and (3) do not preclude any law, program or activity that has as its object the amelioration in a province of conditions of individuals in that province who are socially or economically disadvantaged if the rate of employment in that province is below the rate of employment in Canada.**
Life, liberty and security of person	**7**. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
Search or seizure	**8**. Everyone has the right to be secure against unreasonable search or seizure.
Detention or imprisonment	**9**. Everyone has the right not to be arbitrarily detained or imprisoned.
Arrest or detention	**10**. Everyone has the right on arrest or detention a) to be informed promptly of the reasons therefor; b) to retain and instruct counsel without delay and to be informed of that right; and c) to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful.
Proceedings in criminal and penal matters	**11**. Any person charged with an offence has the right a) to be informed without unreasonable delay of the specific offence; b) to be tried within a reasonable time; c) not to be compelled to be a witness in proceedings against that person in respect of the offence; d) to be presumed innocent until proven guilty according to law in a fair and public hearing by an independent and impartial tribunal; e) not to be denied reasonable bail without just cause; f) except in the case of an offence under military law tried before a military tribunal, to the benefit of trial by jury where the maximum punishment for the offence is imprisonment for five years or a more severe punishment; g) not to be found guilty on account of any act or omission unless, at the time of the act or omission, it constituted an offence under Canadian or international law or was criminal according to the general principles of law recognized by the community of nations; h) if finally acquitted of the offence, not to be tried for it again and, if finally found guilty and punished for the offence, not to be tried or punished for it again; and i) if found guilty of the offence and if the punishment for the offence has been varied between the time of commission and the time of sentencing, to the benefit of the lesser punishment.
Treatment or punishment	**12**. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.
Self-crimination	**13**. A witness who testifies in any proceedings has the right not to have any incriminating evidence so given used to incriminate that witness in any other proceedings, except in a prosecution for perjury or for the giving of contradictory evidence.
Interpreter	**14**. A party or witness in any proceedings who does not understand or speak the language in which the proceedings are conducted or who is deaf has the right to the assistance of an interpreter.
Equality before and under law and equal protection and benefit of law	**15**. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Affirmative action programs	(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
Official languages of Canada	**16**. (1) English and French are the official languages of Canada and have equality of status and equal rights and privileges as to their use in all institutions of the Parliament and government of Canada
Official languages of New Brunswick	(2) English and French are the official languages of New Brunswick and have equality of status and equal rights and privileges as to their use in all institutions of the legislature and government of New Brunswick.
Advancement of status and use	(3) Nothing in this Charter limits the authority of Parliament or a legislature to advance the equality of status or use of English and French.
English and French linguistic communities in New Brunswick	**16.1**. (1) The English linguistic community and the French linguistic community in New Brunswick have equality of status and equal rights and privileges, including the right to distinct educational institutions and such distinct cultural institutions as are necessary for the preservation and promotion of those communities.
Role of the legislature and government of New Brunswick	(2) The role of the legislature and government of New Brunswick to preserve and promote the status, rights and privileges referred to in subsection (1) is affirmed.
Proceedings of Parliament	**17**. (1) Everyone has the right to use English or French in any debates and other proceedings of Parliament.
Proceedings of New Brunswick legislature	(2) Everyone has the right to use English or French in any debates and other proceedings of the legislature of New Brunswick.
Parliamentary statutes and records	**18**. (1) The statutes, records and journals of Parliament shall be printed and published in English and French and both language versions are equally authoritative.
New Brunswick statutes and records	(2) The statutes, records and journals of the legislature of New Brunswick shall be printed and published in English and French and both language versions are equally authoritative.
Proceedings in courts established by Parliament	**19**. (1) Either English or French may be used by any person in, or in any pleading in or process issuing from, any court established by Parliament.
Proceedings in New Brunswick courts	(2) Either English or French may be used by any person in, or in any pleading in or process issuing from, any court of New Brunswick.
Communications by public with federal institutions	**20**. (1) Any member of the public in Canada has the right to communicate with, and to receive available services from, any head or central office of an institution of the Parliament or government of Canada in English or French, and has the same right with respect to any other office of any such institution where a) there is a significant demand for communications with and services from that office in such language; or b) due to the nature of the office, it is reasonable that communications with and services from that office be available in both English and French.
Communications by public with New Brunswick institutions	(2) Any member of the public in New Brunswick has the right to communicate with, and to receive available services from, any office of an institution of the legislature or government of New Brunswick in English or French.
Continuation of existing constitutional provisions	**21**. Nothing in sections 16 to 20 abrogates or derogates from any right, privilege or obligation with respect to the English and French languages, or either of them, that exists or is continued by virtue of any other provision of the Constitution of Canada.

Rights and privileges preserved	**22**. Nothing in sections 16 to 20 abrogates or derogates from any legal or customary right or privilege acquired or enjoyed either before or after the coming into force of this Charter with respect to any language that is not English or French.
Language of instruction	**23**. (1) Citizens of Canada a) whose first language learned and still understood is that of the English or French linguistic minority population of the province in which they reside, or b) who have received their primary school instruction in Canada in English or French and reside in a province where the language in which they received that instruction is the language of the English or French linguistic minority population of the province, have the right to have their children receive primary and secondary school instruction in that language in that province.
Continuity of language instruction	(2) Citizens of Canada of whom any child has received or is receiving primary or secondary school instruction in English or French in Canada, have the right to have all their children receive primary and secondary school instruction in the same language.
Application where numbers warrant	(3) The right of citizens of Canada under subsections (1) and (2) to have their children receive primary and secondary school instruction in the language of the English or French linguistic minority a) applies wherever in the province the number of children of citizens who have such a right is sufficient to warrant the provision to them out of public funds of minority language instruction; and b) includes, where the number of those children so warrants, the right to have them receive that instruction in minority language educational facilities provided out of public funds.
Enforcement of guaranteed rignts and freedoms	**24**. (1) Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.
Exclusion of evidence bringing administration of justice into disrepute	(2) Where, in proceedings under subsection (1), a court concludes that evidence was obtained in a manner that infringed or denied any rights or freedoms guaranteed by this Charter, the evidence shall be excluded if it is established that, having regard to all the circumstances, the admission of it in the proceedings would bring the administration of justice into disrepute.
Aboriginal rights and freedoms not affected by Charter	**25**. The guarantee in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada including a) any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and b) any rights or freedoms that now exist by way of land claims agreements or may be so acquired.
Other rights and freedoms not affected by Charter	**26**. The guarantee in this Charter of certain rights and freedoms shall not be construed as denying the existence of any other rights or freedoms that exist in Canada.
Multicultural heritage	**27**. This Charter shall be interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canadians.
Rights guaranteed equally to both sexes	**28**. Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons.
Rights respecting certain schools preserved	**29**. Nothing in this Charter abrogates or derogates from any rights or privileges guaranteed by or under the Constitution of Canada in respect of denominational, separate or dissentient schools.(93)
Application to territories and territorial authorities	**30**. A reference in this Charter to a Province or to the legislative assembly or legislature of a province shall be deemed to include a reference to the Yukon Territory and the Northwest Territories, or to the appropriate legislative authority thereof, as the case may be.

Legislative powers not extended	**31**. Nothing in this Charter extends the legislative powers of any body or authority.
Application of Charter	**32**. (1)This Charter applies a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.
Exception	(2) Notwithstanding subsection (1), section 15 shall not have effect until three years after this section comes into force.
Exception where express declaration	**33**. (1) Parliament or the legislature of a province may expressly declare in an Act of Parliament or of the legislature, as the case may be, that the Act or a provision thereof shall operate notwithstanding a provision included in section 2 or sections 7 to 15 of this Charter.
Operation of exception	(2) An Act or a provision of an Act in respect of which a declaration made under this section is in effect shall have such operation as it would have but for the provision of this Charter referred to in the declaration.
Five year limitation	(3) A declaration made under subsection (1) shall cease to have effect five years after it comes into force or on such earlier date as may be specified in the declaration.
Re-enactment	(4) Parliament or the legislature of a province may re-enact a declaration made under subsection (1).
Five year limitation	(5) Subsection (3) applies in respect of a re-enactment made under subsection (4).
Citation	**34**. This Part may be cited as the *Canadian Charter of Rights and Freedoms*

all human rights for all

FIFTIETH ANNIVERSARY OF THE UNIVERSAL DECLARATION OF HUMAN RIGHTS

1948 - 1998

Abridged version

Universal Declaration of Human Rights

Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948

On December 10, 1948 the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights the full text of which appears in the following pages. Following this historic act the Assembly called upon all Member countries to publicize the text of the Declaration and "to cause it to be disseminated, displayed, read and expounded principally in schools and other educational institutions, without distinction based on the political status of countries or territories."

PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, Therefore THE GENERAL ASSEMBLY proclaims THIS UNIVERSAL DECLARATION OF HUMAN RIGHTS

as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1.

All human beings are born free and equal in dignity and rights.They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3.

Everyone has the right to life, liberty and security of person.

Article 4.

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5.

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6.

Everyone has the right to recognition everywhere as a person before the law.

Article 7.

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8.

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9.

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10.

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11.

(1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

(2) No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12.

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13.

(1) Everyone has the right to freedom of movement and residence within the borders of each state.

2) Everyone has the right to leave any country, including his own, and to return to his country.

Article 14.

(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.

(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15.

(1) Everyone has the right to a nationality.

(2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16.

(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

(2) Marriage shall be entered into only with the free and full consent of the intending spouses.

(3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17.

(1) Everyone has the right to own property alone as well as in association with others.

(2) No one shall be arbitrarily deprived of his property.

Article 18.

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19.

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20.

(1) Everyone has the right to freedom of peaceful assembly and association.

(2) No one may be compelled to belong to an association.

Article 21.

(1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

(2) Everyone has the right of equal access to public service in his country.

(3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22.

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23.

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

(2) Everyone, without any discrimination, has the right to equal pay for equal work.

(3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

(4) Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24.

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25.

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26.

(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(3) Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27.

1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of

which he is the author.

Article 28.

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29.

(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.

(2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30.

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Apartheid legislation in South Africa

Starting in 1948, the Nationalist Government in South Africa enacted laws to define and enforce segregation.

What makes South Africa's apartheid era different to segregation and racial hatred that have occurred in other countries is the systematic way in which the National Party, which came into power in 1948, formalised it through the law. The main laws are described below.

***Prohibition of Mixed Marriages Act*, Act No 55 of 1949**

Prohibited marriages between white people and people of other races. Between 1946 and the enactment of this law, only 75 mixed marriages had been recorded, compared with some 28,000 white marriages.

***Immorality Amendment Act*, Act No 21 of 1950; amended in 1957 (Act 23)**

Prohibited adultery, attempted adultery or related immoral acts (extra-marital sex) between white and black people.

***Population Registration Act*, Act No 30 of 1950**

Led to the creation of a national register in which every person's race was recorded. A Race Classification Board took the final decision on what a person's race was in disputed cases.

***Group Areas Act*, Act No 41 of 1950**

Forced physical separation between races by creating different residential areas for different races. Led to forced removals of people living in "wrong" areas, for example Coloureds living in District Six in Cape Town.

***Suppression of Communism Act*, Act No 44 of 1950**

Outlawed communism and the Communist Party in South Africa. Communism was defined so broadly that it covered any call for radical change. Communists could be banned from participating in a political organisation and restricted to a particular area.

***Bantu Building Workers Act*, Act No 27 of 1951**

Allowed black people to be trained as artisans in the building trade, something previously reserved for whites only, but they had to work within an area designated for blacks. Made it a criminal offence for a black person to perform any skilled work in urban areas except in those sections designated for black occupation.

***Separate Representation of Voters Act*, Act No 46 of 1951**

Together with the 1956 amendment, this act led to the removal of Coloureds from the common voters' roll.

***Prevention of Illegal Squatting Act*, Act No 52 of 1951**

Gave the Minister of Native Affairs the power to remove blacks from public or privately owned land and to establishment resettlement camps to house these displaced people.

***Bantu Authorities Act*, Act No 68 of 1951**

Provided for the establishment of black homelands and regional authorities and, with the aim of creating greater self-government in the homelands, abolished the Native Representative Council.

***Natives Laws Amendment Act* of 1952**

Narrowed the definition of the category of blacks who had the right of permanent residence in towns. Section 10 limited this to those who'd been born in a town and had lived there continuously for not less than 15 years, or who had been employed there continuously for at least 15 years, or who had worked continuously for the same employer for at least 10 years.

***Natives (Abolition of Passes and Co-ordination of Documents) Act*, Act No 67 of 1952**

Commonly known as the Pass Laws, this ironically named act forced black people to carry identification with them at all times. A pass included a photograph, details of place of origin, employment record, tax payments, and encounters with the police. It was a criminal offence to be unable to produce a pass when required to do so by the police. No black person could leave a rural area for an urban one without a permit from the local authorities. On arrival in an urban area a permit to seek work had to be obtained within 72 hours.

Native Labour (Settlement of Disputes) Act of 1953

Prohibited strike action by blacks.

***Bantu Education Act*, Act No 47 of 1953**
Established a Black Education Department in the Department of Native Affairs which would compile a curriculum that suited the "nature and requirements of the black people". The author of the legislation, Dr Hendrik Verwoerd (then Minister of Native Affairs, later Prime Minister), stated that its aim was to prevent Africans receiving an education that would lead them to aspire to positions they wouldn't be allowed to hold in society. Instead Africans were to receive an education designed to provide them with skills to serve their own people in the homelands or to work in labouring jobs under whites.

***Reservation of Separate Amenities Act*, Act No 49 of 1953**
Forced segregation in all public amenities, public buildings, and public transport with the aim of eliminating contact between whites and other races. "Europeans Only" and "Non-Europeans Only" signs were put up. The act stated that facilities provided for different races need not be equal.

***Natives Resettlement Act*, Act No 19 of 1954**

***Group Areas Development Act*, Act No 69 of 1955**

***Natives (Prohibition of Interdicts) Act*, Act No 64 of 1956**
Denied black people the option of appealing to the courts against forced removals.

***Bantu Investment Corporation Act*, Act No 34 of 1959**
Provided for the creation of financial, commercial, and industrial schemes in areas designated for black people.

***Extension of University Education Act*, Act 45 of 1959**
Put an end to black students attending white universities (mainly the universities of Cape Town and Witwatersrand). Created separate tertiary institutions for whites, coloured, blacks, and Asians.

***Promotion of Bantu Self-Government Act*, Act No 46 of 1959**
Classified black people into eight ethnic groups. Each group had a Commissioner-General who was tasked to develop a homeland for each, which would be allowed to govern itself independently without white intervention.

***Coloured Persons Communal Reserves Act*, Act No 3 of 1961**

***Preservation of Coloured Areas Act*, Act No 31 of 1961**

***Urban Bantu Councils Act*, Act No 79 of 1961**
Created black councils in urban areas that were supposed to be tied to the authorities running the related ethnic homeland.

***Terrorism Act* of 1967**
Allowed for indefinite detention without trial and established BOSS, the Bureau of State Security, which was responsible for the internal security of South Africa.

***Bantu Homelands Citizens Act* of 1970**
Compelled all black people to become a citizen of the homeland that responded to their ethnic group, regardless of whether they'd ever lived there or not, and removed their South African citizenship.

Various segregation laws were passes before the Nationalist Party took complete power in 1948. Probably the most significant were The Natives Land Act, No 27 of 1913 and ***The Natives (Urban Areas) Act* of 1923**. The former made it illegal for blacks to purchase or lease land from whites except in reserves; this restricted black occupancy to less than eight per cent of South Africa's land. The latter laid the foundations for residential segregation in urban areas.

The legacy of apartheid South Africa

Historical background

We must remember the past, define the future, and challenge the present—wherever and however we can. It will take the rest of our lives even to begin. But then, what else have we to do?

— Jane O'Reilly, U.S. feminist and humorist. (1980).

A. The system of apartheid ("apartness" in Afrikaans) was a cornerstone of South African economic development and political policies from 1948 until 1994. South Africa's political and legal system classified people by race and accorded (or denied) specific rights to the identified "race" groups. After World War II, when many countries moved away from colonialism and racial laws, South Africa moved to preserve and increase discrimination. Apartheid ensured that the white minority government, dominated by the primarily Afrikaner National Party, maintained economic, military, and political power over the resources and population of South Africa.

B. Discrimination against the African, Asian, and mixed race populations has characterized the region's history since the arrival of Europeans on the continent of Africa. In the 17th and 18th centuries, Dutch, German, and French settlers (later known as "Boers" or "Afrikaners") established a colony in the Cape area, subjugating the indigenous population and importing other slave labour. Once the British took control of the Cape area in the early 19th century, they began competing with the Afrikaners for control over the economic and human resources of the region. In the following decades, the British and Afrikaners moved north and east, establishing colonies that gave little or no political rights to Asians, people of mixed race, and Africans.

C. In 1910, British and Afrikaner settlers agreed to unite the four previously independent states of Natal, Cape, Orange Free State, and the South African Republic (Transvaal) into the Union of South Africa. Racial discrimination became institutionalized at a national level. Legislation enacted by the all-white Parliament in 1913 and 1936 prohibited African land ownership in 86 percent of the country. "Native reserves" for Africans were set up in the remaining 14 percent of the land, although Africans comprised approximately three-fourths of the total population. Other restrictions limited where Africans could live and work in areas outside their "reserves."

Population statistics: The total population of South Africa in 1980 was 29 million			
African	**White**	**Coloured**	**Indian**
72.70 %	15.50 %	9.00 %	2.80 %
21 million	4.5 million	2.6 million	0.8 million

D. After the electoral victory in Parliament of the National Party in 1948, the party set the apartheid system in place. One of the principal foundations of that system was the *Population Registration Act*, passed by Parliament in 1950, which legally (and often arbitrarily) classified every person in South Africa as a member of the "white," "coloured" (mixed race), "Indian" (Asian), or "black" (African) "race" or ethnic group. The *Group Areas Act* of 1950, and its various amendments, defined separate areas that legally could be owned and occupied by white, African, mixed race, or Asian people in South Africa. Three years later, the *Reservation of Separate Amenities Act* of 1953 mandated the reservation of separate (but usually unequal) buildings, services, and conveniences for each racial group.

1985 had at least 1000 "chameleons"

Political staff

PARLIAMENT – More than 1000 people officially changed colour last year.

They were reclassified from one race group to another by the stroke of a Government pen.

Details of what is dubbed "the chameleon dance" were given in reply to Opposition questions in Parliament.

The Minister of Home Affairs, Mr Stoffel Botha, disclosed that during 1985:

- 702 coloured people turned white.
- 19 whites became coloured.
- One Indian became white.
- Three Chinese became white.
- 50 Indians became coloured.
- 43 coloureds became Indians.
- 21 Indians became Malay.
- 30 Malays went Indian.
- 249 blacks became coloured.
- 20 coloureds became black.
- Two blacks became "other Asians".
- One black was classified Griqua.
- 11 coloureds became Chinese.
- Three coloureds went Malay.
- One Chinese became coloured.
- Eight Malays became coloured.
- Three blacks were classed as Malay.
- No blacks became white and no whites became black.

The Star, 21 March 1986

Race classification: Apartheid laws segregated the population into four broad racial groupings. Some of these groups were further subdivided.	
White	Under the terms of this act, all residents of South Africa were to be classified as white, coloured, or native people. Indians, whom the HNP in 1948 had refused to recognize as permanent inhabitants of South Africa, were included under the category "Asian" in 1959. The act required that people be classified primarily on the basis of their **"community acceptability;"** later amendments placed greater stress on "appearance" in order to deal with the practice of light-colored blacks "passing" as whites.
Coloured	
Native	
Indians	

E. In order to enforce the *Group Areas Act* and sustain the "native reserves" or "homelands" system, the government forcibly relocated people, primarily Africans, Asians, and people of mixed race. The Surplus People Project estimates that between 1960 and 1983, about 3,522,900 people were forcibly relocated. Africans were sent to one of ten homelands, which were established according to official cultural and linguistic definitions, or forced to become citizens of their assigned homeland even if they lived in urban, "white" South Africa. By the late 1970s, some 53 percent of the total African population resided in the homelands, ten percent more than in 1950. The government also initiated policies to transform these reserved lands into politically autonomous African states. Four "independent" homelands, recognized as independent countries only by South Africa, and six "self-governing" homelands were created. Residents of the homelands were stripped of their South African citizenship.

The uprooting of millions
More than 3.5 million people have been forcibly moved in South Africa since 1960, most of them Africans. At least another 1.7 million people were still under threat of removal in 1984. Many people have been moved more than once and others live in fear of further enforced removal.

The legacy of apartheid South Africa

Historical background – worksheet

Section A

1. (a) What was "apartheid;" and (b) what did this system do?

a) _____

_____

b) _____

_____

_____

Section B

2. (a) Which groups of people were discriminated against; and, (b) which groups of people did the discriminating?

a) _____

_____

b) _____

_____

Section C

3. (a) Which groups were in power in South Africa, (b) what was institutionalized, (c) what did the 'all white' Parliament legislate, (d) what was the ratio of land ownership available to and prohited to Africans; and (e) what was the population ratio of Africans to whites?

a) _____

b) _____

c) _____

_____

d) _____

e) _____

_____

Section D

4. What do you think the main purpose was for racially classifying every South Africa?

Section E

5. What do you think "spatial" segregation means and how did the *Group Areas Act* make this possible?

6. What do you think the Surplus People Project was about – who was surplus and surplus to what?

Impact of apartheid on health

Section A
The apartheid policies of the South African government had a harmful effect on the health of the majority of South Africans. When the government created the homelands and forcibly relocated people to these and other rural places, it did so with little concern for the capacity of these areas to sustain a population or to develop an economic base. The government frequently did not provide adequate housing, water, sanitation, schools, hospitals, and other public services.

Section B
Most blacks were not allowed to live near their urban workplaces, and many endured long commutes on public transportation (some up to three hours one way) to the cities from their homes. For those who left their homes to work as contract labourers, their housing consisted of single-sex hostels in urban areas and near mining camps where they lived for approximately 11 months out of the year. Moreover, those Africans who remained in the homelands—mainly the elderly, women, and children—were forced to rely on income from migrant or commuter labour and pensions because there were few sources of employment there.

Workforce - migrants and commuters: 1980
According to the official statistics, of the estimated total African workforce of 5.4 million in 1980, one quarter (24.1 per cent) were migrant or contract workers. Another 13 percent were 'commuters' making a total of nearly 40 percent who were officially regarded as being resident outside the part of South Africa in which they worked more or less permanently. Just under half the African workforce (46 percent) was both working and recognised as permanently resident outside the bantustans.

Section C
The migration also caused a proliferation of "squatter" communities on the periphery of urban centres. Physical conditions in these overcrowded and ill-served townships and squatter communities, such as make-shift housing, lack of protected water, and the absence of sanitary facilities, threatened the health of residents and encouraged the spread of disease. In addition, police surveillance, and the lack of jobs, privacy, and designated and clean recreational sites created much mental and physical strain on the families living in these areas.

Infant mortality rates in various urban centres: 1970 - 1980					
Deaths per 1,000 live births					
City	**Year**	**White**	**Coloured**	**Indian**	**African**
Port Elizabeth	1970	-	-	-	330
Johannesburg	1970	20	-	-	95
Grahamstown	1970	-	-	-	188
Bloemfontein	1972	-	-	-	170
East London	1972	-	-	-	107
Cape Town	1973	-	-	-	63
Cape Town	1981	9.4	18.8	20.4	34.6
Pretoria	1980	10.08	53.48	11.98	53.13

Source: Government health reports: (see Note 74, Part II).

Section D
As an apartheid legacy, few people in townships and squatter areas have had access to safe and adequate water supplies. In some areas, outdoor water spigots serve large numbers of families. In 1989 it was found that in an area near Durban there was only one water spigot for an estimated 15,000 to 20,000 persons. Women and children, often traveling substantial distances, are required to collect water in containers ranging from bottles and cans to huge plastic jugs weighing 30 pounds or more.

Section E
Sewage disposal has been another problem. Some townships have pit latrines; others have portable toilets, but often in inadequate numbers. Many residents use open buckets within their homes. The lack of adequate sewage disposal, combined with heavy rains, hot temperatures, and accidental spilling of these buckets, obviously creates enormous health problems—in particular, infectious diarrhea, other gastrointestinal disorders, and worm infestations. Flies and rodents are omnipresent vectors. Other sanitation problems arise in the disposal of garbage. Many open areas near houses serve as garbage dumps.

Official mortality rates				
	African	**White**	**Coloured**	**Indian**
Life expectancy in years (1969-71)	55.1	68.4	52.5	61.6
Infant mortality per 1,000 live births (1974)	100-110	18.4	115.5	32.0

Section F

A household health survey conducted in 1994 of a nationally representative sample of 4,000 households in South Africa found that approximately two-thirds of the African population is affected by poor public health conditions: overcrowding; lack of electricity, clean water, or sanitation. Only 20 percent of African households reported having a water tap inside the home, compared to nearly 100 percent of white and Indian households. Sixteen percent of African households have no toilet of any kind. Nearly 60 percent of African households lack electricity.

Section G

Poverty in South Africa was and continues to be a primary cause of many health problems. It creates financial obstacles for persons seeking health care and affects their living conditions. It is therefore significant that close to two-thirds of all African households (more than three-quarters in rural areas) have monthly incomes below the minimum living level of R900 and nearly one-fourth have a monthly income below R300. In comparison, in 1994, nearly two-thirds of white households reported a monthly income of more than R2000. Combined with the lack of education about health, those who are most in need of public health services (for example, immunizations, prenatal care, tuberculosis testing and treatment) often do not receive medical care. Diseases such as tuberculosis, cholera, and measles, and widespread hunger and malnutrition are common among the economically deprived population groups. Many diseases that are preventable with good immunization programs, improved sanitation and water supply, and better nutrition, and that have been all but eliminated among the white population, continue to plague blacks in South Africa. The epidemiology of the HIV/AIDS epidemic also demonstrates the link between poverty, low status and vulnerability to infection.

The legacy of apartheid South Africa

Impact of apartheid on health – worksheet

Section A

1. How did the apartheid policies affect the African people living in the "homelands?"

Section B

2. How would the laws preventing black workers from living with their families close to their places of work have affected health, family life, and education?

Section C

3. What was the relationship between the treatment of black workers, 'squatters' and the infant mortality data?

Section D

4. What impact would the lack of and access to safe and adequate dinking water have on people?

Section E

5. What was the relationship between the proper treatment and disposal of sewage and mortality?

Section F

6. What was the relationship between race and the provision of basic public services?

Section G

7. (a) What was the relationship between the apartheid race laws and the creation of poverty and, (b) what is the relationship between poverty and diseases such as HIV/AIDS?

a)

b)

Impact of apartheid on education

Section A
The Bantu Education Act (No. 47) of 1953 legislated educational opportunities for different racial groups. Two of the architects of Bantu education, Dr. W.M. Eiselen and Dr. Hendrik F. Verwoerd, had studied in Germany and had adopted many elements of National Socialist (Nazi) philosophy. The concept of racial "purity," in particular, provided a rationalization for keeping black education inferior. Verwoerd, then Minister of Native Affairs, said black Africans "should be educated for their opportunities in life," and that there was no place for them "above the level of certain forms of labour." The government also tightened its control over religious high schools by eliminating almost all financial aid, forcing many churches to sell their schools to the government or close them entirely.

Section B
Christian National Education supported the NP program of apartheid by calling on educators to reinforce cultural separation and to rely on "mother-tongue" instruction in the first years of primary school. This philosophy also espoused the idea that a person's social responsibilities and political opportunities are defined, in large part, by that person's ethnic identity. The government also gave strong management control to the school boards, who were elected by the parents in each district.

Section C
Official attitudes toward African education were paternalistic, based on trusteeship and segregation. Black education was not supposed to drain government resources away from white education. The number of schools for blacks increased during the 1960s, but their curriculum was designed to prepare children for menial jobs. Per capita government spending on black education slipped to one-tenth of spending on whites in the 1970s. Black schools had inferior facilities, teachers, and textbooks.

Per capita expenditure on education – 1980-81				
Population groups	**African**	**White**	**Coloured**	**Indian**
Rands (5 rands = 1 CDN dollar)	R 150.0	R 1,200.0	R 260.0	R 520.0

Section D
The National Policy for *General Affairs Act* (No. 76) of 1984 provided some improvements in black education but maintained the overall separation called for by the Bantu education system. This act gave the minister of national education authority to determine general policy for curriculum, examinations, and certification qualifications in all institutions of formal and informal education. But responsibility for implementing these policies was divided among numerous government departments and offices, resulting in a bewildering array of educational authorities: For example, the Department of Education and Training was responsible for black education outside the homelands. Each of the three houses of parliament--for whites, coloureds, and Indians--had an education department for one racial group, and each of the ten homelands had its own education department. In addition, several other government departments managed specific aspects of education.

Section E

Education was compulsory for all racial groups, but at different ages, and the law was enforced differently. Whites were required to attend school between the ages of seven and 16. Black children were required to attend school from age seven until the equivalent of seventh grade or the age of 16, but this law was enforced only weakly, and not at all in areas where schools were unavailable. For Asians and coloured children, education was compulsory between the ages of seven and 15.

School children in secondary school – 1979			
Population groups	**African**	**White**	**Coloured**
	14.0%	37.0%	17.0%

Section F

The discrepancies in education among racial groups were glaring. Teacher pupil ratios in primary schools averaged 1:18 in white schools, 1:24 in Asian schools, 1:27 in coloured schools, and 1:39 in black schools. Moreover, whereas 96 percent of all teachers in white schools had teaching certificates, only 15 percent of teachers in black schools were certified. Secondary school pass rates for black pupils in the nation-wide, standardized highschool graduation exams were less than one-half the pass rate for whites.

Students in university				
Population groups	**African**	**White**	**Coloured**	**Indian**
Rands (5 rands = 1 CDN dollar)	10,500	160,000	12,000	16,000
Areas of study were restricted for non-white students. White students had a full range of courses and professions that they could undertake.				

As the government implemented the 1984 legislation, new violence flared up in response to the limited constitutional reforms that continued to exclude blacks (see Constitutional Change, ch. 4). Finally, the government began to signal its awareness that apartheid could not endure. By 1986 President P.W. Botha (1984-89) had stated that the concept of apartheid was "outdated," and behind-the-scenes negotiations had begun between government officials and imprisoned ANC leader Nelson Mandela. The gap between government spending on education for different racial groups slowly began to narrow, and penalties for defying apartheid rules in education began to ease.

The legacy of apartheid South Africa

Impact of apartheid on education – worksheet

Section A

1. What did the 'architects' of apartheid use as their model for 'apartheid education' for black South Africans?

Section B

2. What were the languages of economic and social power and how would 'mother-tongue' instruction affect one's ability to use the languages of power?

Section C

3. What did the 'architects' of apartheid use as their model for 'apartheid education' for black South Africans?

Section D

4. What do you think the purpose of apartheid education was?

Section E

5. Why do you think education was not compulsory for black students and is there a relationship between compulsory education and school enrolment?

Section F

6. Examine the teacher pupil ratios: (a) determine the relationship between teacher pupil ratios and to the quality of education received by students; (b) determine the relationship between teacher qualifications and the quality of education received by students; (c) determine the relationship between teacher pupil ratios and teacher qualifications to the secondary school pass rates; and, (d) determine the relationship between teacher pupil ratios, teacher qualifications, and secondary school pass rates to the number of students in university.

a)

b)

c)

d)

Apartheid simulation – Instructions

Premise

Spatial segregation

- Black South Africans were accorded 13% of the land area called homelands.
- White South Africans were accorded 87% of the land area.
- Indian South Africans lived in segregated areas within the 87% land area.
- Coloured South Africans lived in segregated areas within the 87% land area.

Freedom of movement

- Black South Africans employed in white South Africa can live in 'townships,' but are required to return to the homelands if they are unemployed.
- All black South Africans over the age of 16 must carry an identity document called a Pass Book. Failure to have this book in one's possession is punishable by jail and/or a fine.
- Other South Africans are not required to carry this type of document.

Democratic rights

- Blacks do not have the right to vote.
- Hospitals access is based on race classification.
- Membership of the Communist Party, African National Congress, and Pan African Congress is illegal.
- Sexual relations between races is a criminal act.
- Strikes by black workers is illegal
- Black students cannot undertake to study any field of their choice.
- Black students cannot attend white universities.
- South Africans can be detained indefinitely without trial.
- All black people compelled to become a citizen of the homeland that responded to their ethnic group, regardless of whether they'd ever lived there or not, and removed their South African citizenship.

Classroom simulation

1. Roughly divide the physical space of your classroom into two parts – about 13% black Homelands, and 87% white South Africa. There should be no sitting facilities in the black areas.
2. Roughly divide your students class into four groups –Africans or 'Bantu' (70%), whites (15%), Indians (3%), coloureds (9%).
3. Hand an identity card (BLM 1-7) to each student according to their race classification.
4. Hand each 'black' South African an identity document (BLM 1-8). Those who are employed may come into white South Africa to work. The unemployed must stay in the Homelands.
5. Hand each 'South African' a copy of their Rights and Privileges (BLM 1-9).

Discussion

- Allow students to discuss how they felt about this systematic form of racism.
- Probe students' understanding and appreciation of the social, economic, and political implications of and purposes served by the apartheid ideology.
- Solicit students' appreciation of the challenges the new democratic South Africa faces given the legacy of apartheid.

Race classification cards

ZULU BANTU	ZULU BANTU
XHOSA BANTU	XHOSA BANTU
SOTHO BANTU	SOTHO BANTU
TSWANA BANTU	TSWANA BANTU

EUROPEAN

EUROPEAN

EUROPEAN

EUROPEAN

EUROPEAN

EUROPEAN

EUROPEAN

EUROPEAN

ASIATIC

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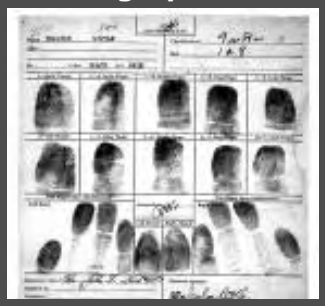
Pass laws – Identity Document

Identity Document

- Employers Name
- Tribal Group
- Homeland
- Place of Residence
- Unemployed

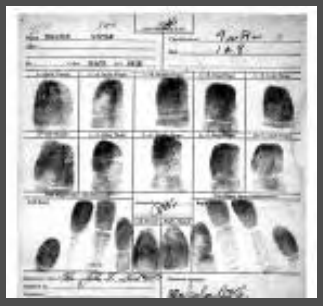
Fingerprints



Identity Document

- Employers Name
- Tribal Group
- Homeland
- Place of Residence
- Employed

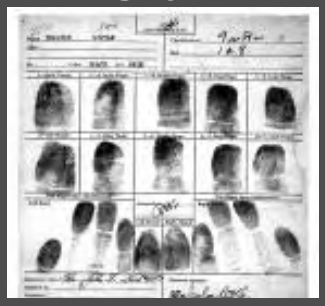
Fingerprints



Identity Document

- Employers Name
- Tribal Group
- Homeland
- Place of Residence
- Unemployed

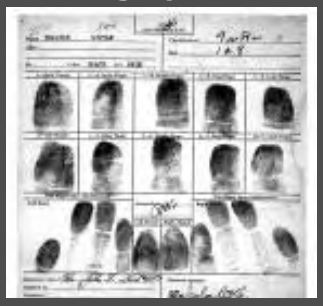
Fingerprints



Identity Document

- Employers Name
- Tribal Group
- Homeland
- Place of Residence
- Employed

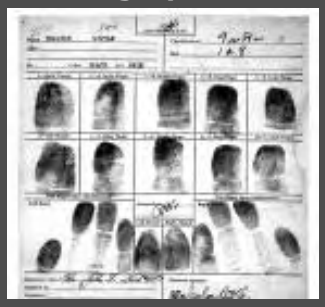
Fingerprints



Identity Document

- Employers Name
- Tribal Group
- Homeland
- Place of Residence
- Unemployed

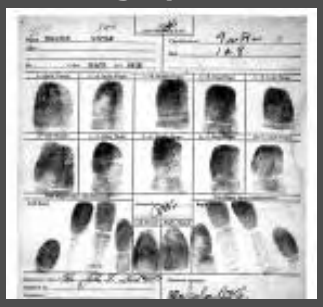
Fingerprints



Identity Document

- Employers Name
- Tribal Group
- Homeland
- Place of Residence
- Unemployed

Fingerprints



Rights and privileges

Racial do's and don'ts!	White	Black	Indian	Coloured
You can live anywhere in 'white' South Africa				
You may only live in the 'homelands' or designated nonwhite townships in white areas				
You have the right to vote for the national, provincial and municipal governments				
You must carry a Pass Book at all times – or face jail or a fine or both				Varies
You have the right to good schools, universities and the profession or career of your choice				
You have the right to excellent health care and facilities				
You may only be treated in black hospitals				
You may not be attended to by a 'white' ambulance even in an emergency				
You have the right to jobs reserved for whites				
You may only work at jobs designated for your race classification				
You have all the privileges of citizenship				
You have all the privileges of citizenship in your homeland but not in white South Africa				
You may not marry or have any sexual relations with a person of a race different to yours				
You can be detained (imprisoned) indefinitely without trial				
You may legally go on strike				
You may not join the Communist Party, African National Congress or Pan African Congress				

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 2 – Day 2

Preconceptions and the science of HIV/AIDS

Estimated time required: 75 minutes

Note to teacher: Many options for activities are included below. It is impossible to incorporate all into any one class session. Please choose those most appropriate for your students and their interpersonal dynamics.

Overall expectations

By the end of this session, students will be able to:
- describe key facts about HIV/AIDS including cause and treatment
- challenge their own preconceptions and societal myths about HIV/AIDS
- appreciate the scope of the HIV/AIDS epidemic globally.

Enduring (key) learning

Students will gain an appreciation for the scientific nature of HIV/AIDS. Students will also be made aware of their own vulnerability and by challenging their own preconceptions about HIV/AIDS with current facts and statistics, students will be ready to study the factors driving the disease.

Prior learning

- This lesson can stand alone or follow day 1 on the history of South Africa and apartheid.
- Students should be familiar with basic number skills (i.e. reading and interpreting data).

Getting ready

- Teacher should be familiar with HIV/AIDS background information (included and at listed web sites below).
- If doing activity BLM 2-5: The Spread of HIV/AIDS: A Simulation, a solution and glassware preparation is required. Instructions are provided.
- Duplicate (make transparencies) appropriate black line masters:
    - — BLM 2-1: HIV/AIDS – What do you already know?
    - — BLM 2-2: HIV/AIDS – How does the world perceive HIV/AIDS?
    - — BLM 2-3: HIV/AIDS – Basic terminology
    - — BLM 2-4: HIV/AIDS – The transmission equation (transparency)
    - — BLM 2-5: The spread of HIV – A simulation
    - — BLM 2-6: People tags
    - — BLM 2-7: HIV transmission game (an alternate simulation)
    - — BLM 2-8: Global summary of HIV/AIDS (UN Data)

Resources

- www.unaids.org (Joint United Nations Program on HIV/AIDS)
    - — Provides extensive and p-to-date information on HIV/AIDS across the globe.
    - — Information can be sorted by country/geographic region and includes current statistics, research, global/government responses, myths, treatment, and recent UN publications.

- www.cdc.gov/hiv/dhap.htm (Centre of Disease Control: National Centre for HIV, STD, and TB prevention)
    - — Provides accurate and extensive background information on the science and treatment of HIV/AIDS.
    - — Research relevant to HIV/AIDS (vaccines, new treatments, prevention) can also be found here.

Teaching/learning strategy

1. Distribute BLM 2-1: HIV/AIDS: What do you already know? (10 minutes)
    a. Have students complete this quietly on their own or it can be modified and used as a guide for brainstorming in a group.
    b. There are answers provided if you choose to discuss them here, but it may also be helpful to use the answers at the end of the session for students to assess their own learning. This may be a sensitive issue for some students (and teachers).

2. Refer to BLM 2-2: HIV/AIDS: How does the world perceive HIV/AIDS? No copies are required of this. (15 minutes).
    a. This activity will allow for small group discussions about students' perceptions about HIV/AIDS and will lead into the science of the disease.

3. Virus and infection lesson – HIV/AIDS basic science (30 minutes)

Distribute BLM 2-3: HIV/AIDS Basic terminology. Break down the acronyms to explain the nature of the virus and the disease (HIV/AIDS). For further information, see the Centre for Disease Control site (www.cdc.gov) listed under resources.

HIV – a virus		
H	Human	The virus requires a human host to reproduce.
I	Immunodeficiency	• The virus affects the human immune system (that system responsible for fighting disease). • The body cannot fight off other diseases if infected with HIV as strongly as an uninfected body.
V	Virus	• Viruses are a special class of life (there is debate as to whether they are living at all) that cannot reproduce without a host (for HIV, the host is a human body). • Once inside the human body, HIV attacks and takes over certain types of white blood cells in the immune system and uses them to make copies of itself. This destroys the white blood cells and weakens the host's immune system. • HIV is infectious but not contagious (it cannot be transmitted by casual contact like the common cold).
AIDS – a disease		
A	Acquired	• This means that the disease is **not** genetic and occurs because of some contact with the disease-causing agent (in this case, contact with another person infected with HIV).
I	Immuno	• This refers to the body's immune system (discussed above).
D	Deficiency	• The disease is characterized by a weakening of the body's immune system. • It makes the system "deficient."
S	Syndrome	• This is a word that refers to a collection of symptoms that collectively indicate/characterize a disease. For AIDS patients, this can be any number of infections or cancers. • A healthy immune system can usually fight off the many germs that we encounter every day – someone with a weakened immune system cannot fight them off as easily. • Because the immune system of an AIDS patient has been weakened, it is susceptible to many opportunistic infections – those infections that "take advantage" of the weakened immune system. Some of these infections are not usually seen in healthy individuals but can be fatal for those with AIDS. • Opportunistic infections can be treated to alleviate pain and suffering, but there is no cure for AIDS. • More information about opportunistic infections can be found at: www.aegis.com/topics/oi.

4. HIV infection equation (5-10 minutes)

Distribute (or prepare transparency) BLM 2-4: HIV/AIDS: The transmission equation. Discuss those conditions necessary for HIV transmission.

5. The spread of HIV – A simulation (20-30 minutes) (* an alternate activity called "HIV transmission game" is also provided at the end of this lesson).

Distribute BLM 2-5: The spread of HIV – A simulation.

- This is a good demonstration to show students how their own behaviours and relationships can put them at risk for HIV infection.
- Some chemical and glassware preparation is required and students must be able to move around to complete this activity.

Introduction

This is a hands-on activity that simulates the spread of HIV. Students are made aware of the rate at which HIV can spread within a population by exchanging "fluids" with each other during personal interactions.

- Round 1 simulates the spread of disease when fluid transfer occurs with each interaction.
- Round 2 simulates the spread of disease when fluid transfer depends on the behaviour of those involved. The activity can involve either or both of the rounds.

Materials

1. paper cups or small test tubes – requires 1/student (if you choose to do both rounds of the activity, you will need 2 test tubes or cups for each student)
2. tray (for cups) or test tube holder for test tubes
3. enough plastic pipettes for the class (1/student; more if you do round 2 of the activity)
4. 10 ML of 0.1 M NaOH (0.4 g of NaOH dissolved in water to make 100 mL of solution)
5. water
6. phenolphthalein solution in dropper bottles (every chemistry prep room has this)
7. If you choose to do round 2, copy and cut paper "behaviours" for each student (see attached)

Preparation before activity

1. Gather as many test tubes/cups as there are students.
2. One student will be the "carrier" of the virus. Do not tell this student or the class about the identity of the "carrier"). Fill one test tube/cup with 10 mL NaOH; fill the rest of the tubes/cup with water. Both solutions are clear and colourless so you should not be able to see a difference.
3. Arrange the test tubes/cups on the tray or holder (make a mental note about the location of the "carrier" test tube/cup).
4. Copy an appropriate number of student activity sheets.

Teacher instructions: round 1 – Everyone behaves the same

1. Distribute one test tube/cup and plastic pipette to each student (mentally make note of who picks up the "carrier" test tube/cup).
   Note: Be sure to choose students who are emotionally capable of being the "carrier."
2. Students must then circulate and participate in three different "interactions" with other students.
3. For each interaction, students must transfer some of their fluid to the other student and must receive some of the other students' fluid. Students keep track (on paper) of the people they interact with.
4. After three interactions, have students return to their seats.
5. The teacher will then add a few drops of the phenolphthalein indicator to every test tube/cup. Those infected with the virus will turn pink; those not infected will remain clear.
6. Have the students figure out who the original carrier was.

Teacher instructions: round 2 – Students are assigned different behaviours

1. This activity can be repeated exactly as above (with fresh samples) but students can be given one of several behaviour types (attached).
2. Before distributing their test tube/cup samples, give each student a behaviour type and encourage them to keep this behaviour throughout the activity.
3. Make sure you give the "infected" test tube/cup to someone with a behaviour that WILL pass it on. Compare the spread of the disease in round 1 to round 2.

Discussion questions

1. How many students had pink in their cups/test tubes at the end of the activity?
2. Calculate the percentage of students infected with the virus.
3. Draw (together) a representation showing the pyramiding effect of the spread of infection within the classroom.
4. Why does HIV spread so quickly? (If round 2 completed, compare numbers, percentages, and overall infection with round 1 and discuss any differences. What made the difference in infection rates in round 2?)

Clean up notes

Neutralize any cup or test tube containing NaOH with vinegar and rinse with plenty of water down the drain. Return all glassware to its original location. Neutralize any spills with vinegar and plenty of water.

Behaviours for round 2

Copy enough so each student receives one behaviour. Cut and distribute one behaviour/student.

✂----------

You have always been taught to **never** share your fluids with another person.
You will always say **no** and never share your fluids

✂----------

✂----------

You have always been taught to **never** share your fluids with another person.
You will always say **no** and never share your fluids

✂----------

✂----------

You have always been taught to **never** share your fluids with another person.
You will always say **no** and never share your fluids.

✂----------

✂----------

You have always been taught to **never** share your fluids with another person.
You will always say **no** and never share your fluids

✂----------

✂----------

You always try and pressure other people to share fluids with you.
When people say **no** to you, you keep trying and trying to get them to share fluids with you.

✂----------

✂----------

You always try and pressure other people to share fluids with you.
When people say **no** to you, you keep trying and trying to get them to share fluids with you.

✂----------

✂----------

You always try and pressure other people to share fluids with you.
When people say **no** to you, you keep trying and trying to get them to share fluids with you.

✂----------

✂----------

You always try and pressure other people to share fluids with you.
When people say **no** to you, you keep trying and trying to get them to share fluids with you.

✂----------

✂----------

Sometimes you use condoms when you trade fluids – sometimes you don't.

✂----------

✂----------

Sometimes you use condoms when you trade fluids – sometimes you don't.

✂----------

✂----------

Sometimes you use condoms when you trade fluids – sometimes you don't.

✂----------

6. Homework

Distribute BLM 2-8: Global summary of HIV/AIDS. Have students read and reflect/answer discussion questions. These questions deal with recent HIV/AIDS statistics from UNAIDS and contrast data from North America/Europe with Sub-Saharan Africa.

7. Other learning activities:

1. BLM 2-6: People tags – Looking at ourselves and others (Challenging assumptions) (15 minutes)
    - A quick activity for small groups that leads to a class discussion on preconceptions and judging others based on limited information.

2. BLM 2-7: HIV transmission game
    - A candy alternative to the simulation described above.

HIV/AIDS: What do you already know?

Adapted from: *Behind the Pandemic: Uncovering the Links Between Social Inequity and HIV/AIDS*

Name: _____

1. What does HIV stand for? _____

2. What does AIDS stand for? _____

3. How are HIV and AIDS related to each other?

   _____

   _____

   _____

4. How can people get AIDS? Think of as many ways as you can (you can write more than 4).

   -
   -
   -
   -

5. How does HIV harm the human body? _____

6. Is there a cure for AIDS? _____ If yes, what is it? _____

7. How many people have HIV/AIDS in the world right now? _____

8. In which region(s) of the world do most people living with HIV/AIDS live?

   _____

9. What are some things that can make a person more vulnerable to HIV infection?

   _____

Do you have any questions about HIV/AIDS that you would like to have answered? If yes, please write them below.

HIV/AIDS: What do you already know? (answers)

1. HIV = Human Immunodeficiency Virus

2. AIDS = Acquired Immuno Deficiency Syndrome

3. HIV is a virus that can cause the disease called AIDS. People infected with HIV are known to be HIV positive. Some HIV positive people will develop AIDS.

4. People can get the HIV virus from:
    a. Unprotected* sex with an infected individual (globally, this is the primary method of heterosexuals infection)
    b. Sharing needles with infected individuals
    c. From infected mother to child during pregnancy, birth, or breast-feeding
    d. From blood transfusions with infected blood (although this is rare in countries where blood screening tests are performed)
    e. There is no scientific evidence to suggest that HIV can be spread through other routes (i.e. mosquito bites, air, or water)

* This virus may be passed from one person to another when infected blood, semen, or vaginal secretions come in contact with an uninfected person's broken skin or mucous membranes (A mucous membrane is wet, thin tissue found in certain openings to the human body. These can include the mouth, eyes, nose, vagina, rectum, and opening of the penis.)

5. The Human Immunodeficiency Virus attacks cells of the human immune system (called T helper cells). These cells play a central role in the immune response and trigger other cells to help fight off infections. If the number of these T helper cells gets too low, the person will become vulnerable to the opportunistic infections and cancers that typify AIDS. People with AIDS often suffer infections of the lungs, intestinal tract, brain, eyes, and other organs, as well as debilitating weight loss, diarrhea, neurological conditions, and cancers such as Kaposi's sarcoma and certain types of lymphomas.

6. There is no known cure for AIDS. Anti-retroviral drugs are available to slow down HIV's ability to make new copies of itself inside the infected person. Opportunistic infections (those that result from the body's weakened immune system) can be treated but there is not cure for AIDS.

7. As of December 2004 (and according to the U.N.), there were 39.4 million people living with HIV (37.2 million adults, 17.6 million women, 2.2 million children under 15 years).
    Other important information
    a. In 2004, 3.1 million people died of HIV (510 000 were children under 15 years).
    b. In 2004, 4.9 million people were newly infected with HIV

8. The developing world has been significantly affected by HIV. 64% of all people living with HIV live in Sub-Saharan Africa (76% of ALL women with HIV live in Sub-Saharan Africa). Other areas of the world like Asia and the Caribbean are also showing high levels of infection.

9. Social and environmental determinants of general health including gender, income level, education level, social status.

HIV/AIDS: How does the world perceive HIV/AIDS?

1. Working individually and avoiding discussion, students are given two minutes to complete each sentence starter (can be written on the board or overhead). Encourage them to create as many sentences as possible with the sentence starters and to include their own opinions as well as those they believe are commonly held by society in general.

The world tells me that HIV/AIDS is.....

The world tells me that people who are living with HIV/AIDS are.....

2. Form small groups of 4-6 students. For each sentence stem, group members individually select their "best" sentence completions. Have the group record these of a piece of chart paper.

3. Each group places their collective statements on two separate walls. Invite students to walk through each others' ideas.

4. As a large group, discuss the questions below. Key ideas can be identified and recorded on the board/chart paper:

    - What do you notice about the kinds of statements and words that are used about HIV/AIDS? About people living with HIV/AIDS?
    - What kind of feelings and thoughts are behind these thoughts and words?
    - How might these underlying feelings and thoughts influence how people and society respond to the HIV/AIDS pandemic? How will they affect the way people living with HIV/AIDS are treated?

In your discussion, emphasize that:

- HIV/AIDS is one of the most devastating diseases that humankind has faced. It has serious implications for not only individuals and families, but for entire communities and for society on a large scale.
- The world has not experienced such a deadly disease since the Black Death killed one third of Europe's population in the 14th century.
- Unlike most diseases that tend to affect the very young and elderly, HIV/AIDS primarily affects people in their most productive years (15-45 years old).

HIV/AIDS – Basic terminology

HIV – a virus		
H		
I		
V		
AIDS – a disease		
A		
I		
D		
S		

HIV/AIDS: The transmission equation

HIV
Someone in the equation must be HIV +

+

Body fluid
With enough HIV virus (blood, semen, pre-semen, vagina fluid, breast milk)

+

Opening
to blood stream

+

Activity
that can move fluids between people (unprotected sex, sharing drug needles, dirty tattoo equipment, transfusions, breast feeding etc.)

→

Possibility of HIV infection

The spread of HIV – A simulation

Adapted from: *Ellen Averill, Access Excellence*

Name: _____

HIV is the virus that causes the disease known as AIDS. This hands-on activity will simulate the spread of a viral infection (in this case HIV) within your classroom population.

Materials

- 1 cup or small test tube/student (you will need two if you are doing both rounds of the activity)
- 1 pipette/student (2 if doing round 2)
- student worksheet
- pen or pencil

Instructions (round 1) – Everyone behaves the same

1. You will receive a cup/test tube containing a clear liquid and a plastic pipette.
2. Circulate through the class and participate in three (3) different interactions with people in your class.
    - An interaction involves:
        i. you pipetting a small amount of your fluid to the other person
        ii. you receiving a small amount of the other person's fluid
        iii. recording the name of the person you interact with in the space provided.
3. Continue interacting until you have met three different people.
4. Your teacher will now circulate and add indicator solution (phenolphthalein) to your fluid. If your fluid turns pink, you have been infected. If it remains clear, you are not infected. One of your classmates was originally (and secretly) infected with the virus.
5. Return your glassware/cups to their original location.

Instruction (round 2) – Different behaviours

Round 2 is exactly the same as round 1 except that you will have a certain behaviour to follow. Your teacher will distribute various behaviours throughout the class before the activity begins. You must follow this behaviour throughout the activity. Record your observations below.

My interactions:

Round 1: _____ _____ _____

Round 2: _____ _____ _____

Discussion questions

1. As a class, share your data and determine who the original carrier was in your class.

Carrier for round 1: _____

Carrier for round 2: _____

2. The numbers.
   a. How many people were infected by the end of the activity?

   Round 1: _____ Round 2: _____

   b. Express this number as a percentage of your class population.

   Round 1: _____ Round 2: _____

   c. In your own words, compare the levels of infection between rounds 1 and 2.

3. Why did HIV spread so quickly through the population?

4. If you completed round 2, what types of behaviour lead to HIV infection?

5. Describe ways to control the spread of HIV. How does your data from round 2 support these ideas?

People tags: Looking at ourselves and others to challenge assumptions

From PeaceCorp.gov *Challenging Assumptions and Promoting Cultural Awareness*

1. Prepare for the lesson by making one copy of the people tags for every four students. Cut off the fact cards and keep them for the second part of the activity.

2. Divide students into groups of four. Give each group a set of people cards (Uncle Fred, Aunt Jennifer, etc.) and object cards (dictionary, clock, etc.). Do not give out the fact cards yet.

3. Assign the task: You are doing your holiday shopping for Uncle Fred, who rides in a motorcycle gang; Aunt Jennifer, a librarian; Cousin George, a Navy recruit; and Great-Aunt Phyllis, a senior citizen. From the collection in front of you, which gifts would you choose for each?

4. After a few minutes, discuss the following.
   - Who gave Uncle Fred the leather jacket? Aunt Jennifer the coffee mug? Cousin George the tattoo? Great-Aunt Phyllis the rocking chair?
   - How did you decide who would get each gift?
   - How did the labels (i.e., "senior citizen," "librarian") influence your decisions?

5. Pass out the fact cards and comment that perhaps the students need more information before making their final gift choices.

6. Give students time to "reassign" gifts.

Debriefing

Use the following questions to guide discussion about getting to know people before making judgments.

1. How did it feel to try to choose gifts for people based on a single piece of information or label?

2. What happened when you were given more information? Who changed their gift ideas? Why?

3. What is the purpose of this activity? Can you give some examples of ways labels influence the way you think about other people or things?

4. What are some problems that can occur when we rely too much on labels?

5. What if you were asked to choose gifts for a member of this class whom you don't know well? What could you do that would help you choose the right gift?

6. How can we apply this activity to learning about HIV/AIDS and the people infected/affected by it?

Uncle Frederick **(motorcycle rider)**	**Aunt Mina** **(librarian)**	**Cousin Wei** **(Navy recruit)**	**Great Aunt Keesha** **(senior citizen)**
Fact card: Aunt Mina likes modern fashions – the leather look is "in"	**Fact card: Cousin Wei is looking forward to a career in the theatre after his Navy tour**	**Fact card: Uncle Frederick collects antique furniture**	**Fact card: Great Aunt Keesha has always been the rebellious and daring one of the family**
coffee mug 	**tattoo** 	**alarm clock** 	**computer disk** 
dictionary 	**rocking chair** 	**leather jacket** 	**theatre tickets** 

HIV transmission game (30 minutes)

Purpose: To increase awareness about the speed of transmission of HIV and other STDs. The effects of peer pressure are also illustrated.

Materials

Hershey's hugs and kisses
Hershey's almond kisses
Index cards
Pens/pencils
Small brown paper bag for each student

Preparation

- In each participant's bag (except one) place a mixture of approximately 10 to 12 Hugs & Kisses and one marked or unmarked index card. In one participant's bag put 10 to 12 Almond Kisses (instead of Hugs & Kisses) and an unmarked index card. Put a star (*) on the bottom of the bag with Almond Kisses.

- Mark the bottom corner of two index cards with a small "C." Place each card in a different bag with Hugs & Kisses.

- Mark two other index cards with a small "IC." Place each card in a different bag with Hugs & Kisses.

- Write on a fifth index card: Do not participate. When asked, tell anyone who wants to exchange candy, 'I do not want to exchange hugs and kisses.' Place the card in a bag with Hugs & Kisses and put an "A" on the bottom of the bag.

- Write on two separate index cards: Do not participate with anyone other than your partner. When asked, tell anyone (other than your partner) who wants to exchange candy, 'I do not want to exchange hugs and kisses with anyone other than my partner.' Place each card in a different bag with Hugs & Kisses and put an "M" on the bottom of each bag. Give these two bags to the two participants who are willing to sit in the front of room.

- Do not place any of the seven, marked cards in with the bag with Almond Kisses.

Procedure

1. Ask for two participants who are willing to be partners and to sit in the front of the room throughout the entire exercise. Give each of these two participants a bag marked with an "M."
2. Hand out the other bags to the remaining participants. Explain that each participant is receiving a bag with Hershey's Kisses and an index card. Ask each participant to pull the card out of his/her bag and follow the instructions on it (if there are any) and to keep secret any instructions on his/her card.
3. Tell the participants that they are to exchange candy and that they should write on their index cards the name of everyone with whom they exchange candy.
4. Give participants about five minutes to exchange candy and to write down names. Then, have everyone return to his/her seat.
5. Find out who got the most signatures.
6. Ask the one person whose bag has a star (*) on the bottom to stand up. Explain that this was the person who started out with Almond Kisses and that, for the purposes of this exercise, the Almond Kisses represent HIV infection.
7. Then, ask anyone who has an Almond Kiss in his or her bag to stand up. Explain that, because they exchanged Hugs & Kisses for Almond Kisses, they too are infected with HIV.
8. Ask everyone who is still seated to check their index cards for the name of anyone who is standing. Ask participants to stand up if they see the name of someone who is standing on their index cards. Continue to ask participants to stand until everyone except the three participants with the "M" and the "A" on the bottom of their bags are standing.
9. Ask the participants with "C" written on their cards to sit down. Explain that the "C" means they always used condoms or clean needles and protected themselves from HIV infection. They are not infected with HIV.
10. Ask the people with "IC" written on their cards to sit down. Then, ask them to stand right back up. Explain that these people used condoms and/or clean needles each time, but they used them incorrectly. They are infected with HIV.
11. Explain to the participants that this activity contains an error because someone might have received an Almond Kiss (HIV infection) and then given it away again. By contrast, you cannot give away HIV. Once you have it, you can share it with others; but, you can never get rid of it yourself.
12. Remind participants that this is a game. No one can become infected with HIV because he/she eats a particular kind of food nor by sharing or exchanging food.

Discussion questions:

1. Did anyone notice anyone who did not stand up? Introduce the "abstinent" participant and the "monogamous" partners. Ask them how they felt not playing. How did the others feel when these people refused to exchange candy with them?

2. Why is it difficult not to participate when everyone else is participating?

3. How did the person with the Almond Kisses (HIV infection) feel?

4. The one person whose bag had a star did not know he/she was "infected" with HIV. How could we have known ahead of time?

Global summary of HIV/AIDS (according to the United Nations) December 2004

R

Number of people living with HIV/AIDS in 2004	Total	39.4 million (35.9 - 44.3 million)
	Adults	37.2 million (33.8 - 41.7 million)
	Women	17.6 million (16.3 - 19.5 million)
	Children under 15 years	2.2 million (2.0 - 2.6 million)
People newly infected with HIV in 2004	Total	4.9 million (4.3 - 6.4 million)
	Adults	4.3 million (3.7 - 5.7 million)
	Children under 15 years	640 000 (570 000 - 750 000)
AIDS deaths in 2004	Total	3.1 million (2.8 - 3.5 million)
	Adults	2.6 million (2.3 - 2.9 million)
	Children under 15 years	510 000 (460 000 - 600 000)

Questions to consider:

1. Why are there numbers in brackets following the number given for each group?

2. For 2004:
   a. What percentage of total HIV/AIDS cases are adult women? _____
   b. What percentage of total HIV/AIDS cases are children? _____

3.
   a. How many people live in Canada? _____
   b. How does the population of Canada compare to:
      i. the number of HIV/AIDS cases in the world?

      ii. the number of AIDS deaths in 2004?

HIV/AIDS statistics – December 2004 (from UNAIDS)

North America, Western, and Central Europe

	Adults and children living with HIV	Number of women living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adults and child deaths due to AIDS
2004	1.6 million	420 000	64 000	0.4	23 000
2002	1.6 million	390 000	62 000	0.4	22 000

Sub-Saharan Africa

	Adults and children living with HIV	Number of women living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adults and child deaths due to AIDS
2004	25.4 million	13.3 million	3.1 million	7.4	2.3 million
2002	24.4 million	12.8 million	2.9 million	7.5	2.1 million

4. What does Sub-Saharan mean? Name four countries that are considered part of Sub-Saharan Africa.

5. In your own words, describe the overall (adult and children) HIV/AIDS infection levels for 2004 in Sub-Saharan Africa compared to those in North America/Western & Central Europe.

6.
   a. Calculate the percentage of HIV cases in North America/Western & Central Europe that are women. (You need the number of women cases and the total number of cases)
   b. Calculate the percentage of HIV cases in Sub-Saharan Africa that are women.
   c. Why do you think there are such big differences?

7.
   a. Calculate the total deaths due to AIDS as a percentage of total adults and children living with HIV:
      i. for North America/Western and Central Europe:
      ii. for Sub-Saharan Africa
   b. Is there a difference? If so, why do you think this difference exists?

HIV/AIDS statistics – December 2004 (from UNAIDS)

Solutions

1. The numbers in brackets represent the range of data in which the best estimate lies. Verifying HIV status is often difficult in some parts of the world so estimates must be made.

2. For 2004:
   a. What percentage of total HIV/AIDS cases are adult women? = 44.7%
   b. What percentage of total HIV/AIDS cases are children? 5.5%

3.
   a. How many people live in Canada? 30 000 000
   b. How does the population of Canada compare to:
      i. the number of HIV/AIDS cases in the world?
   - more people are living with HIV/AIDS than are living in Canada as an entire country!
      ii. the number of AIDS deaths in 2004?
   - the number of deaths from AIDS in 2004 is the equivalent to 10% (1/10th) of the Canadian population dying in one year!

4.
   - means those parts of Africa south of the Sahara desert
   - countries include: South Africa, Botswana, Zambia, Zimbabwe, Malawi, Mozambique, Lesotho - there are many!

5. Overall infection levels in Sub-Saharan Africa are much higher (7.4% of population) compared to 0.4% of population in N.A./Western and Central Europe.

6.
   a. North America/Western and Central Europe women = (420 000/1 600 000) x 100% = 26.3%
   b. Sub-Saharan Africa that are women = (13 300 000/25 400 000) x 100% = 52.4%
   c. Answers will vary depending on students' exposure – women's rights, sexual freedom, gender based violence, poverty, safe sex, community support, unemployment – many of these issues will be discussed in future lessons.

7.
   a) i. for North America/Western and Central Europe: (23 000/ 1 600 000) x 100% = 1.4%
      ii. for Sub-Saharan Africa: (2 300 000/25 400 000) x 100% = 9.1%
   b) Answers will vary: varying access to drugs, nutrition, proper care, early diagnosis etc.

Note: deaths reported here are just for 2004 and do not represent all of the deaths that will be experienced by the 25.4 million living with HIV/AIDS in Sub-Saharan Africa or the 1.6 million living with HIV/AIDS in North America/Western and Central Europe.

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 3 – Day 3

The impact of HIV/AIDS

Estimated time required: 1 class (75 minutes)

Overall expectations

By the end of this session, students will be able to:
- understand the inter-related issues of HIV/AIDS
- determine the impacts and effects of AIDS at various levels of interaction (individual, family, community, country, world)
- challenge their own preconceptions and societal myths about HIV/AIDS
- appreciate the scope of the HIV/AIDS epidemic globally.

Enduring (key) learning

Students will understand the impact and effects of HIV/AIDS through the investigation of various issues. The influence of one issue will be linked directly with many others. Most importantly, they will understand the importance of STIGMA in perpetuating all of the issues.

Prior learning

- Students have already studied some of the HIV/AIDS statistics in Canada and in other countries. Many of the terms will resurface and they will become more familiar with them.

Getting ready

- Duplicate or make overheads for BLM 3-1
- Duplicate copies of the case studies and cut apart BLM 3-2
- Duplicate or make overhead for BLM 3-3
- If groups are presenting or sharing information, markers and large sheets of paper may be used.

Teaching/learning strategy

1. The teacher will begin by encouraging the students to compare the words/concepts "Infected vs. Affected." (Infected refers to those individuals who are HIV+; affected refers to all of the other people who experience the devastation of HIV/AIDS but are not necessarily infected themselves).
    - Have the students reconsider the statistics from the previous day. Consider the following comparison:
      How many people does HIV/AIDS infect?
      How many people then, would this affect?

2. Use BLM 3-1 to begin a brief discussion on the ripple effect of HIV/AIDS.
    - Consider what happens when you throw a stone or an object in the water - the ripples start out from the centre and works outward. This is similar to our concepts of how people are infected and affected by HIV/AIDS.
    - Imagine that in this case, the "stone" being thrown into the water is an individual's infection with HIV.
    - Encourage students to think about how an individual's HIV infection influences those around him/her. Throughout the brief discussion, have them fill in the 'ripples.' For example, the inner ripples may be those people closest to the HIV+ individual (families and friends). The ripples farther away will represent those people farther removed, but still affected by the HIV+ individual. These may include (but students may highlight others): individuals, families, communities, countries, and the world.

3. Using case studies (BLM 3-2), students will consider the affects of HIV/AIDS in more depth.
    - Divide students into small groups of 2-4 students.
    - Give each group a case study. Allow them to read and discuss the case study.
    - Encourage students to consider the case study within the context of its placement on the 'ripple effect.'

4. As a large group, have the students share their case studies and their discussions. From the large group discussion, common additional discussion may evolve:
    - Many of the case study scenarios are connected or they have interconnected influences.
    - For the placement on the ripples, many may be placed in more than one area, thus emphasizing the ripple effect.
    - Emphasize that HIV infection can have huge impacts (the affects) on many people, not just for the infected individual.

5. To summarize learning, use a mind map or web diagram. You may have them develop their own or use BLM 3-3 A or 3-3 B. This may be done individually, in small groups or as a teacher-led class discussion. Note that leader words may be provided in the hand-out or by the students depending on level.

6. Homework and/or extensions
    - Write a story entitled: "A day in the life…."
        - Describe the daily rituals, chores, contacts, etc. of someone infected or affected with HIV/AIDS. You may consider: a young boy or girl whose parent has just died from AIDS, a health worker who distributes anti-retroviral drugs, a sex trade worker, a parent who works away from home, etc.

R

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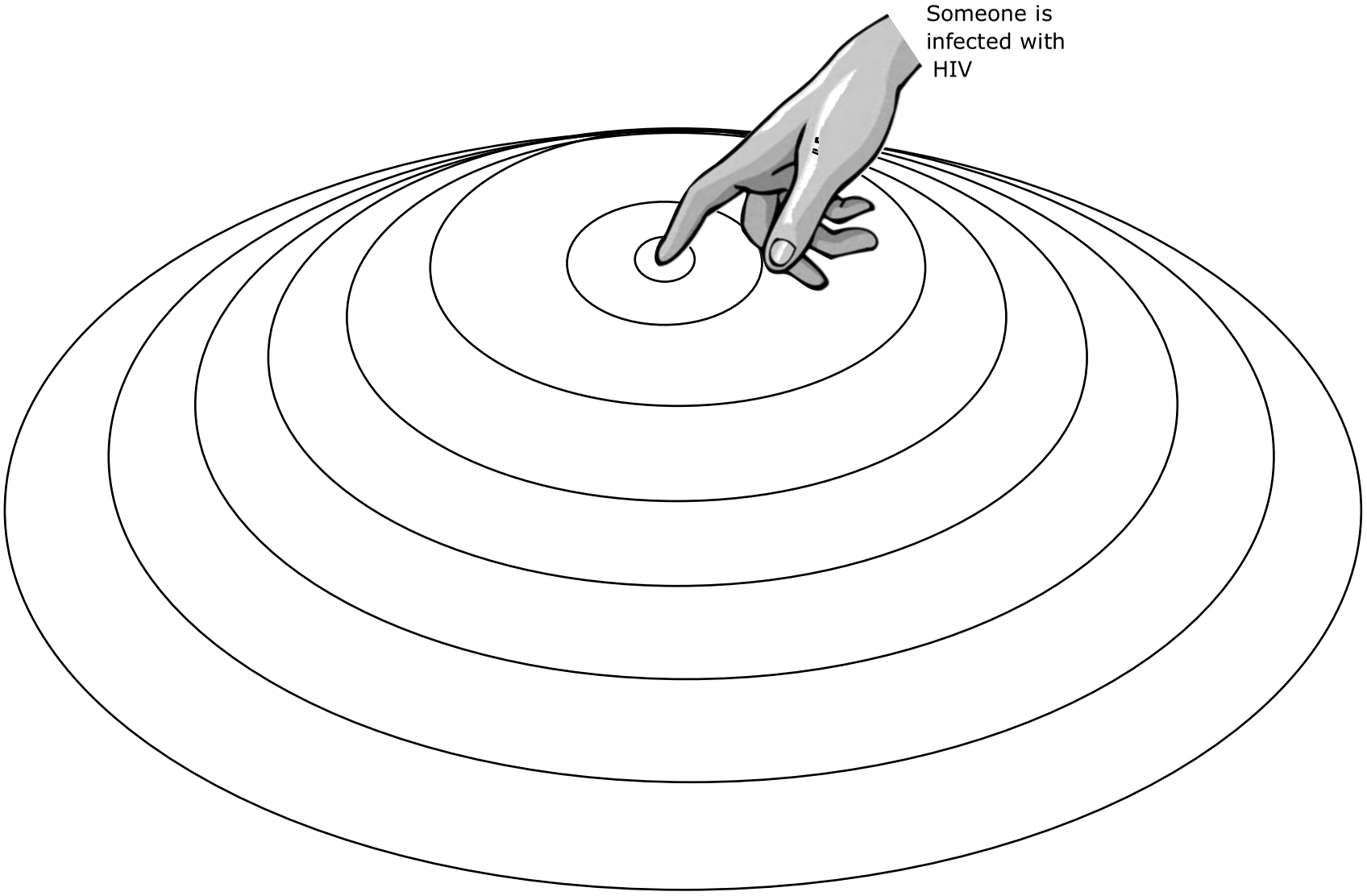
- Write a letter (parent, child, student, etc.) about "What I want out of life." Consider the impact of HIV/AIDS within the letter.

The ripple effect of AIDS

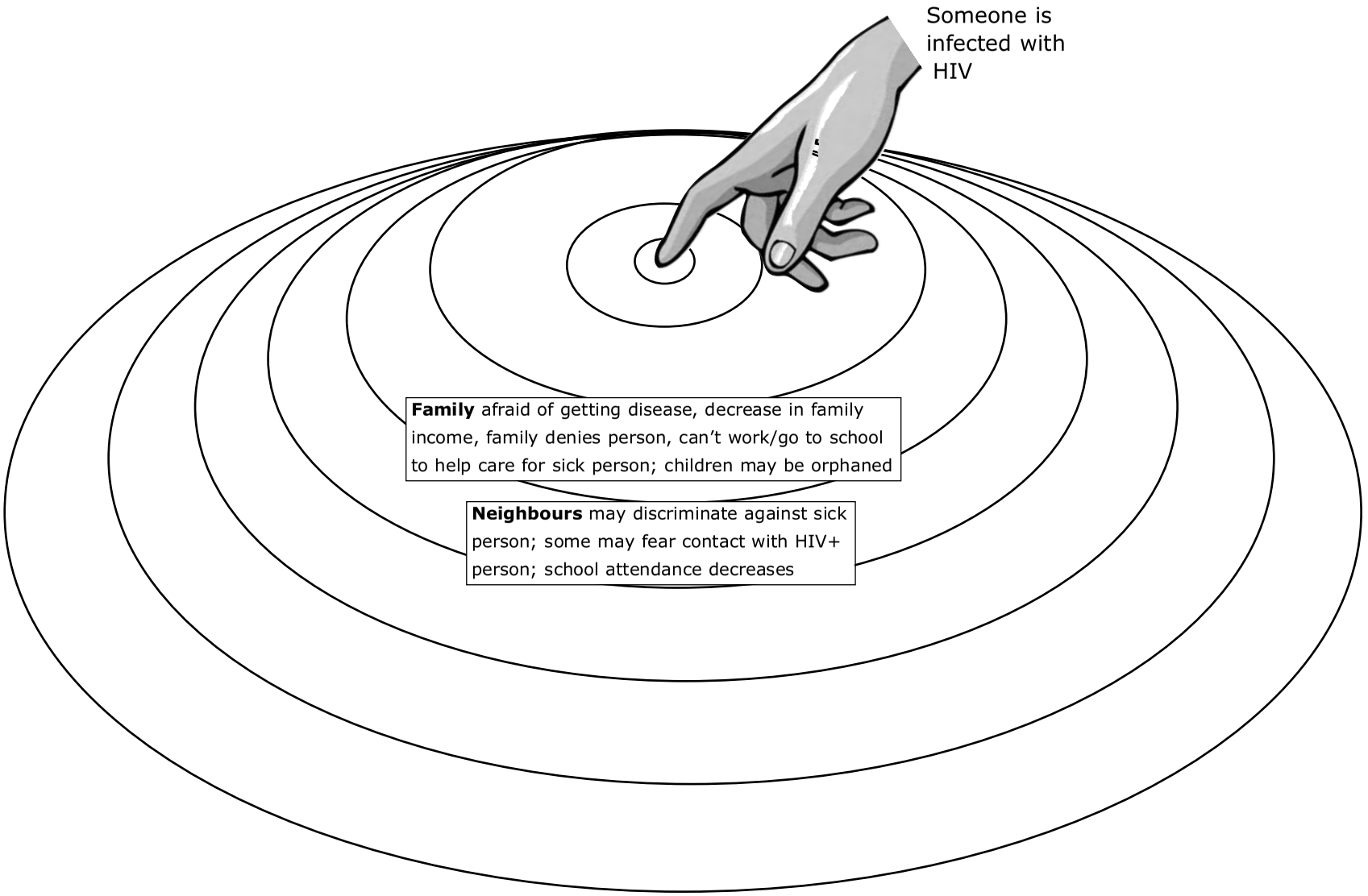
Consider the effects of HIV/AIDS infection from the individual **infected** to those **affected**. Use the ripples to record your ideas about how HIV/AIDS affects those around an infected individual (think small → big).



The ripple effect of AIDS

Consider the effects of HIV/AIDS infection from the individual **infected** to those **affected**. Use the ripples to record your ideas about how HIV/AIDS affects those around an infected individual (think small → big).

Some starting ideas are provided



Case studies

HIV/AIDS: Infected vs. Affected

Instructions: Cut out individual case studies and distribute one per student group

I am a goldmine worker in South Africa. To get a job and make money, I work several hours away from my wife and children, but then again, this is very common here. Because I am far away from my wife and kids, I live in a hostel with many other workers. I miss my wife and kids and it can get pretty lonely at times. Occasionally, I pay a prostitute for sex. Of course, I don't tell my wife this, but it is very common for men to expect their wives to be faithful.

I am only 16 years old and I am on my own. My family was too poor to keep me so I make money the best way I can. There are many lonely men around here who are working. They have families, but they live so far away. They are willing to pay me and in return I offer sex. It helps me pay for food and a place to stay. Sometimes, I make just enough to get a meal for the day. It doesn't sound like a glamourous life, but at least I have food. The messages say to use protection to prevent AIDS, but most of the men won't wear condoms.

As a teacher, it is very difficult. There is so much to do in a day. It is so important for students to do well so they can get jobs and make their lives better. But sometimes, students just don't show up for school for a few days. We suspect why it may be, but they won't tell us. Some kids are ashamed because someone in their family has AIDS. There is such a stigma. All we know is that children stop coming to school because a parent is sick. The child has to help to get food and water, to bring in money, to do household chores, to care for younger brothers and sisters, and to care for their sick parents. School becomes a low priority.

I am a member of the Treatment Action Campaign (TAC). We advocate for the rights of people living with HIV/AIDS. We demand that the government of South Africa should create a national treatment plan for those who are infected with HIV/AIDS so that everyone can afford the drugs they need.

I am a local representative for teachers in my region. A big problem for us is the number of children who do not come to school because their parent has AIDS. But, teachers are also getting AIDS too. We could help the teachers if they would only disclose their HIV status, but that is a lot to ask given the stigma and discrimination. One teacher lost her job after telling others that she was HIV+. We were able to get her job back, but it was so difficult for her to work with all of that stigma. The thing is that so many people are affected, but there is so much embarrassment and confusion too. For those that are able to tell us, we promise confidentiality. They need a lot of counselling too for personal and financial reasons. They too, will need to prepare for their funerals and for the stability of their children after they are gone.

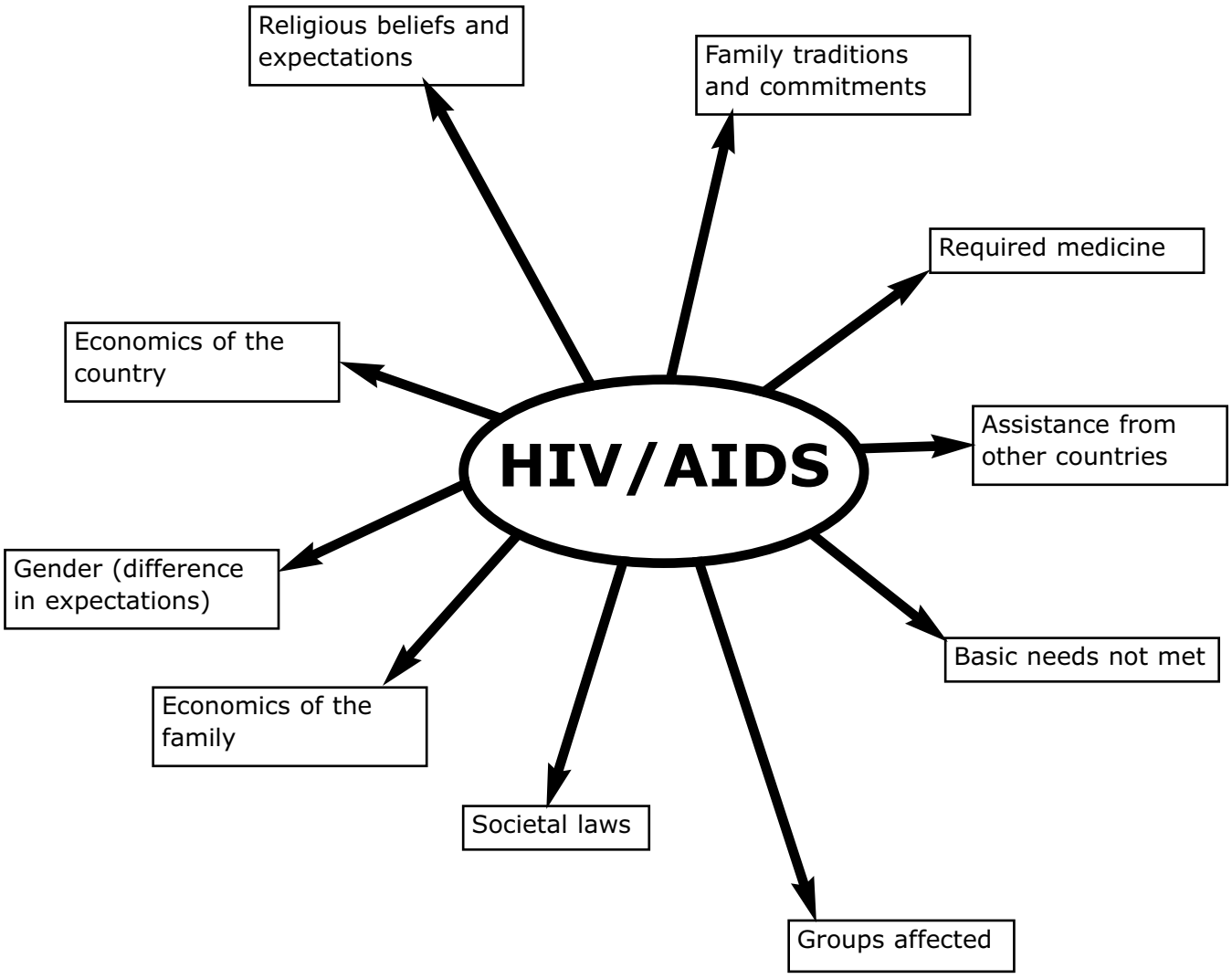
I am a grandma here, but I now have the extra responsibility of taking care of my grandchildren. Their mother and father have died of AIDS. It was very difficult to see my own child become so sick and waste away. She couldn't even provide food for her own kids. Of course, we rarely ever say it is AIDS, but we know. So, now I have her four children, the youngest who has AIDS himself. It is so difficult, but luckily I have help. Through a special program, I am able to talk with other grannies that are in a similar situation. The kids and I get counselling and some access to financial support.

I used to own a coffee house in Soweto, but there is no market for it. But now, I have a business that is booming. I sell caskets and organize funerals. Did you know that families spend about three times their total household monthly income on a funeral? That is more than they spend getting their hair cut, having a barbeque and shopping. More people have been to funerals in the past month than weddings! Of course, they don't advertise that they died of AIDS...but we know. That's why there are so many funerals.

I am a doctor doing HIV/AIDS research in South Africa. Many westerners are surprised by how advanced our medical system is when they visit. We have done much research into the epidemic of AIDS especially in the transmission from mother to child. We have made great strides, but there are many, many frustrations. Although we know what needs to be done, it is very costly. As well, our government sometimes resists and disagrees with our research. Their ideology has set us back in decreasing the epidemic. If only they would make it more of a public policy and make a clear statement about prevention, we could combat the disease so much better! Many healthcare professionals are fed up with the government's lack of progress in supplying nevirapine (which has proven to be effective and economical in reducing the transmission of the virus from mothers to their babies). Some doctors began applying to other organizations for money to pay for nevirapine and some doctors even used their own money to buy the drug! The government says that doctors are forbidden to provide the drug and can be fired if they do. Even though the High Court ordered the government to make nevirapine available to pregnant women to prevent the transmission of the AIDS virus to their babies, can you believe that the health ministry still refused to provide these drugs on a large scale (even though drug companies were providing them for free or very cheap)? That's why we publicly demonstrated to embarrass the government into acting. In 2003 TAC laid culpable homicide charges against the Health Minister and her colleague claiming that they were responsible for the deaths of 600 HIV-positive people/day in South Africa because they have no access to antiretroviral drugs.

AIDS in different families – The issues

Instructions: Develop a mind map or graphic organizer to show the areas, issues, situations and factors that are affected by HIV/AIDS.



Impact of AIDS

Instructions: Describe how HIV/AIDS impacts each factor listed below. You may have others you wish to include.

Factor	Impact of AIDS
Gender	
Roles of males and females	
Access to resources	
View of the 'sick' person or family	
Role(s) of extended family	
How the government views the issue	
How other countries view the issue	
Effects on different people within the family	

Impact of AIDS

Instructions: For each factor listed below, describe the issues associated with AIDS.

The following chart provides some suggested responses to BLM 3-3a and b (mind map and chart). Many of the answers are connected and/or overlap. There are also different ways in which students may explain and make the connections. This is to encourage further discussion and connections of factors.

Factor	Impact of AIDS
Gender (differences in expectations)	• More women are getting HIV/AIDS. • Women do not always have the choice whether to have sex or not and therefore may contract HIV/AIDS from the husband. • Men are often away from home for work and seek pay for sex (usually unprotected sex) and take this back to their wives. • Young girls often have to care for their sick parents and younger siblings and this prevents them from going to school. • Etc.
Roles of males and females	• It is an obligation of the wife to have sex with her husband and she cannot usually ask for the use of a condom as she may be accused of being unfaithful. • Men are expected to provide financially for their family—with the sickness of AIDS, they may lose this ability. • Women are to care for their family and provide the basic necessities, when they have sickness from AIDS, their responsibilities get put on other females in the family.
Access to resources	• Without access to medicine, there is not hope of overcoming AIDS. • When a parent has AIDS, the ability to get other resources (food, money, etc) is very difficult and often left to older (female) children. • When children are not able to go to school, their ability to get resources now and in the future is limited.
View of the 'sick' person or family	• The sick person is sometimes viewed as being possessed or demon-like, and therefore others stay away. • If it is known that the person has AIDS (as opposed to another disease), they and their community have a stigma and are shunned.
Role(s) of extended family	• Other members in the family might have to take on the role of caring for the children…this puts an added financial strain on them. • It is often the grandmothers who assume the new parenting role.

Factor	Impact of AIDS
How the government views the issue	• The government may choose to address the issue of AIDS or not…for instance, some governments have been slow to provide the drugs that may help. • The government in South Africa has made comments that continue the misperceptions and stigma associated with AIDS.
How other countries view the issue	• Other countries and other governments can provide funding to AIDS related projects. • Some programs that are provided come with strings attached, for instance, some funding is linked to abstinence education only.
Effects on different people within the family	• Other people in the family also feel the stigma if the disease is AIDS. • Other people in the family need to provide more for the family.
Groups affected	• Groups that have unprotected sex are vulnerable — Teenagers — Sex trade workers and their customers — Wives who cannot refuse sex or ask for condom use — Babies (as it may be passed from the mother)
Basic needs not met	• When a person has AIDS, they become unable to meet their basic needs and to help their family meet those needs (of food shelter and clothing). Often these responsibilities are transferred to young children in the family who have become orphaned.
Required medicine	• In developing countries, people cannot afford the medicine to help with the symptoms of HIV or to prevent the transmission from mother to baby, therefore, HIV is more likely to quickly develop into full blown AIDS. • Whether people are able to get the drugs or not depends on their income level and/or on the government programs to provide these drugs and how they are distributed to those that need it. • Canada has encouraged the use of non-generic drugs to decrease the costs and make these drugs more accessible to these countries.
Family traditions an commitments	• Women are expected to stay at home and care for the family and household while the men seek paid work away from home (families may only see each other a couple of times a year). • The man is considered the head of the household.
Religious beliefs and expectations	• It creates great stigma to have HIV/AIDS as it is connected to unfaithfulness. Often it is the woman who is accused of being unfaithful.

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 4 – Day 4

Factors driving the HIV/AIDS epidemic

Estimated time required: 1-2 classes of approximately 75 minutes

Note to teacher: Many options for activities are included below. It is impossible to incorporate all into any one class session. Please choose those most appropriate for your students and their interpersonal dynamics.

Overall expectations

By the end of this session, students will be able to:
- describe key factors driving the epidemic of HIV/AIDS
- identify groups that are most vulnerable to HIV/AIDS
- assess the impact of HIV/AIDS and how the needs are met of those infected and affected by the disease
- describe the factors that may escalate the incidences of HIV/AIDS and ultimately, initiatives that may reduce the number of people affected and infected by HIV/AIDS

Enduring (key) learning

Students will understand factors that contribute to the alarming statistics of HIV/AIDS. They will make connections to any previous lesson(s) and understand how contributing factors impact the disease. Finally, students will also gain an understanding about the ways in which HIV/AIDS affects one's ability to meet their own needs.

Prior learning

- This lesson can stand alone or follow lessons on the history of South Africa and apartheid and/or the logistics of infection of HIV/AIDS.
- Students should be aware of the terms: infected and affected.

Getting ready

- Teacher should be familiar with HIV/AIDS background information (included and as listed in websites below).
- Determine an appropriate method to group students.
- Gather and prepare group materials (i.e. markers, chart paper, board space).
- Duplicate (or make transparencies of) appropriate black line masters:
  - BLM 4-1: HIV/AIDS – Maslow's hierarchy of needs - Breaking the foundation of the pyramid
  - BLM 4-2: Scenario cards
  - BLM 4-3: The causes and effects of HIV/AIDS

Resources

- www.unaids.org (Joint United Nations Program on HIV/AIDS)
  - Provides extensive and up-to-date information on HIV/AIDS across the globe.
  - Information can be sorted by country/geographic region and includes current statistics, research, global/government responses, myths, treatment, and recent UN publications.

R Teaching/learning strategy

1. The teacher begins with a discussion encouraging the students to review the information from the previous day.
   - We have already learned of the devastating impact of AIDS for those infected. Additionally, we cannot underestimate the effects of all those affected. The teacher asks the questions:
     - "So, how did we get to this stage?"
     - "What are the factors driving the epidemic?"

2. Encourage students to consider Maslow's hierarchy of basic needs.
   - Student understanding of this may vary. BLM 4-1: Basic needs may be used to direct discussion and highlight the learning. It may also be used as a diagnostic analysis of what students already know.
   - Have students consider how having HIV/AIDS may affect one's ability to achieve those needs at various levels. At this point, the considerations may be very general in nature.

3. In order for students to consider some of the factors driving the HIV/AIDS epidemic/pandemic, they are going to consider different scenario cards (BLM 4-2, scenario cards).
   a. Divide the students into small groups of 3-4 people. Each group will receive a scenario card.
   b. Using their scenario card, the group should consider 'the factors driving the epidemic' in the specific situation presented. The group should record these factors on a piece of chart paper.
   c. When each group has considered its scenario card, have groups rotate so that each group receives a new scenario. The group should discuss the new scenario and add additional factors. Depending on time and number of students, this may be done 2-5 times. Note that some of the situations may be different while many others have similar or overlapping factors.
   d. Have students post their 'driving factors' on the board or wall.

Note: You may wish to encourage students to develop their own scenarios by investigating the situation through books, articles and the Internet.

4. As a class, design a large mind map to show the various factors students have identified.
    - Encourage students to see repeats in the responses by placing them together on the mind map.
    - Look for similarities in responses by grouping them close together.
    - Have students look at connections between different responses. For instance, poverty may be linked to lack of food.

Note: That there are many arrows or connections between factors.

The list below may provide some assistance in encouraging student responses.

Factors driving epidemic	Impacts of epidemic
• Cultural beliefs, practices, taboos • Gender • Migration • Poverty (household, national, international) • Political climate • Stigma, discrimination, marginalization • Decreased food security • Increased poverty/decreased economic productivity • Overburdened health care system • Weakened education • Reversal of human development process • Social costs	• Loss of productivity • Stigma • Weakened education • More orphans • Food insecurity • More household poverty • More burden on health care system • Less development for the country (economic)

5. When the web appears to be complete, ask students to consider how contributing factors that they listed relate to the impacts that were discussed the previous day. What are the connections between factors and impacts? (A spiral effect seems to continue). BLM 4-3, 'The Causes and Effects of AIDS' may be used to review the causes and effects of AIDS.

6. After the discussion of factors driving the epidemic, return to Maslow's hierarchy of needs. Encourage students to consider the following:
    - How can attaining the needs be different for those infected and those affected?
    - Compare the ways people attain their needs in a developed country like Canada versus a developing country like South Africa.

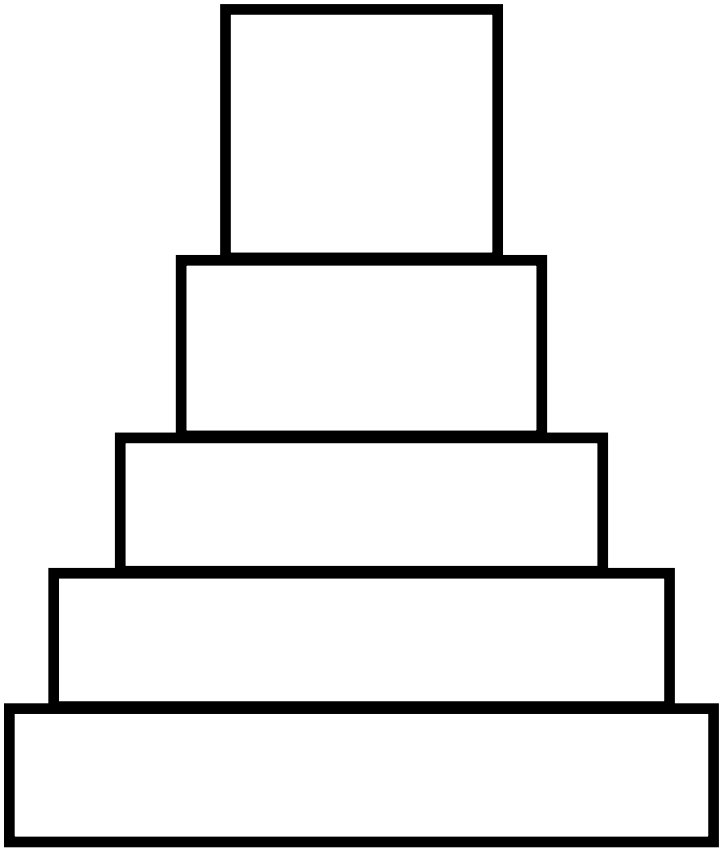
7. Homework
   Writing a letter home.
   Write a letter from the point of a medical professional, social worker, development worker, etc. working with people who are infected or affected by HIV/AIDS. Show how the hierarchy of needs may be compromised. In your letter home to Canada, draw on some comparisons between the situation in Canada and the situation in South Africa.

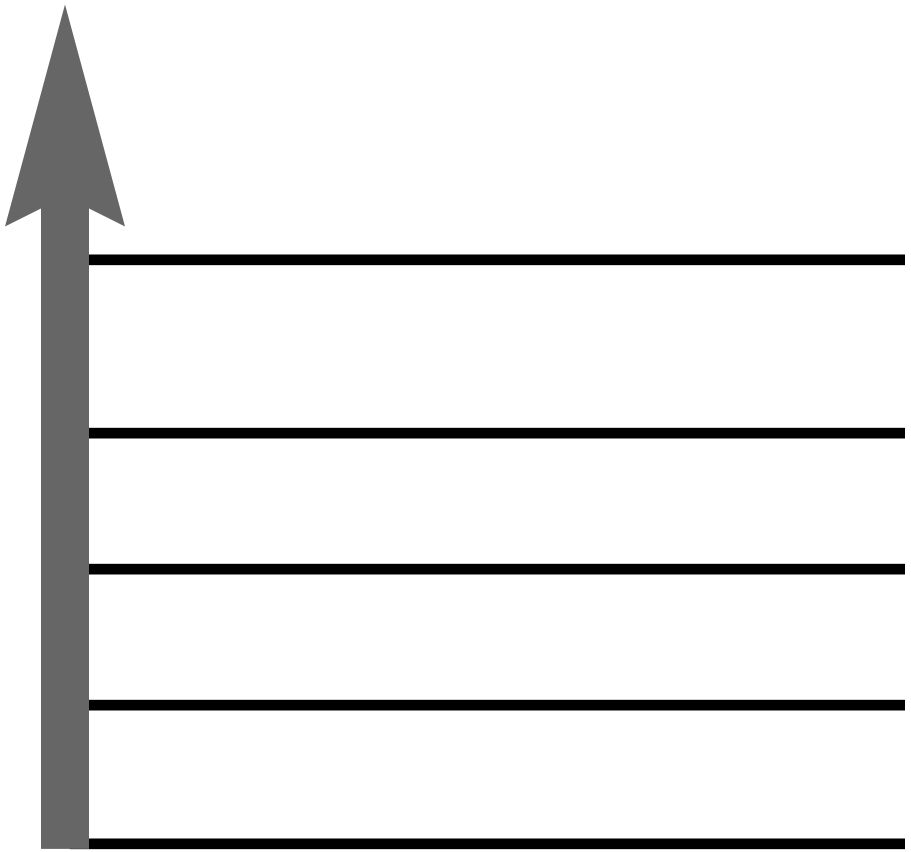
HIV/AIDS: Breaking the foundation of the pyramid

Name: _____

Instructions:

For each level of the pyramid, state the basic needs of individuals. On the right side of the arrow, describe how HIV/AIDS makes meeting these needs more difficult.



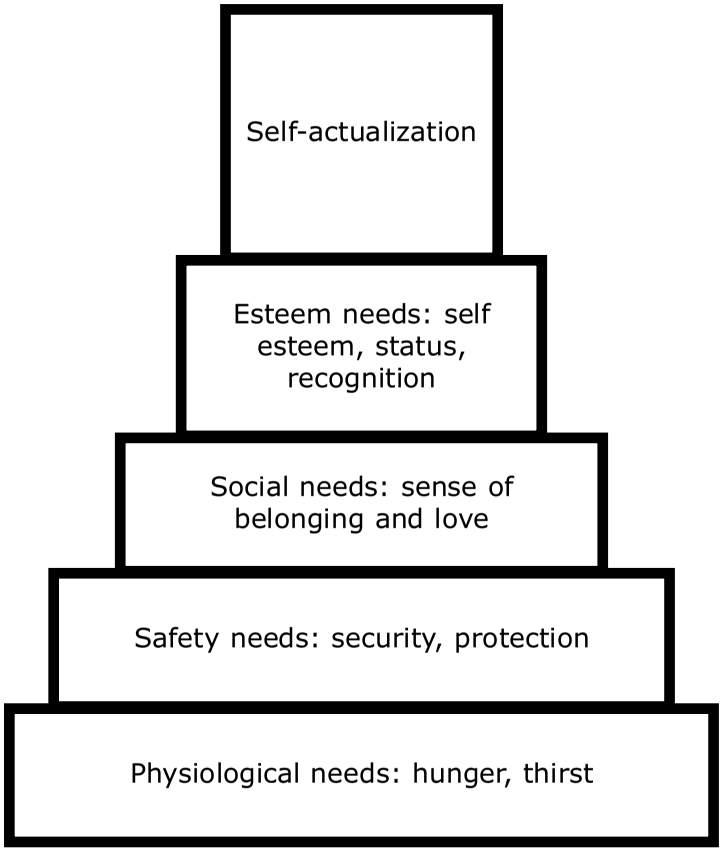


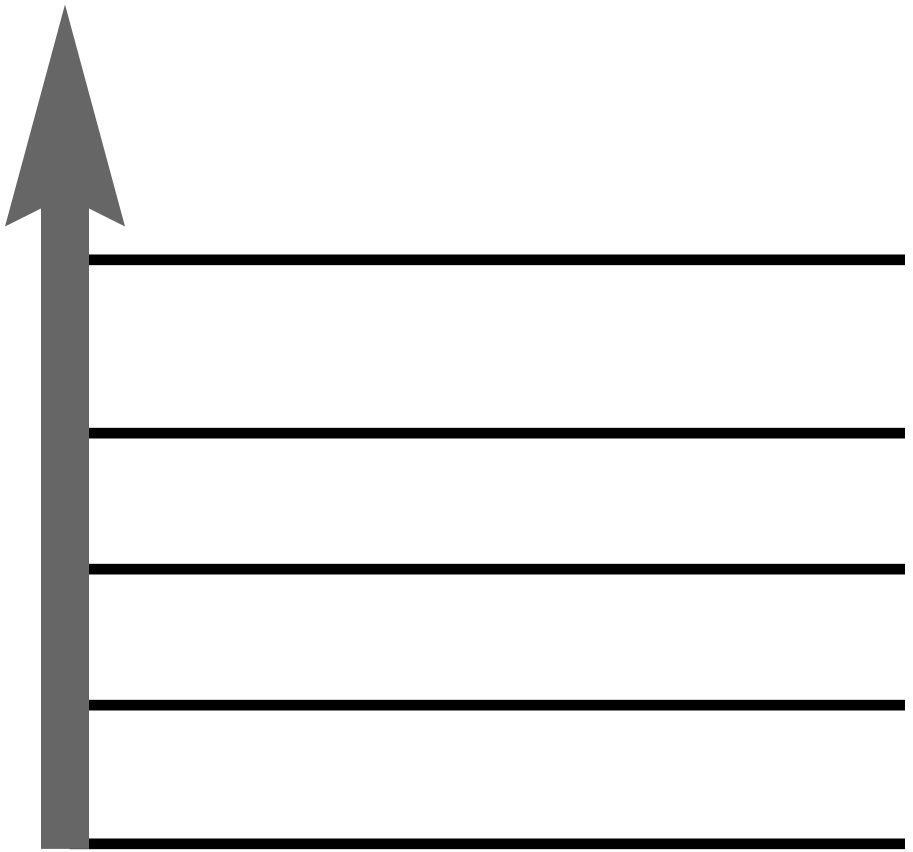
HIV/AIDS: Breaking the foundation of the pyramid

Name: _____

Instructions:

For each level of the pyramid, state the basic needs of individuals. On the right side of the arrow, describe how HIV/AIDS makes meeting these needs more difficult.





How does Mazlow's hierarchy work?

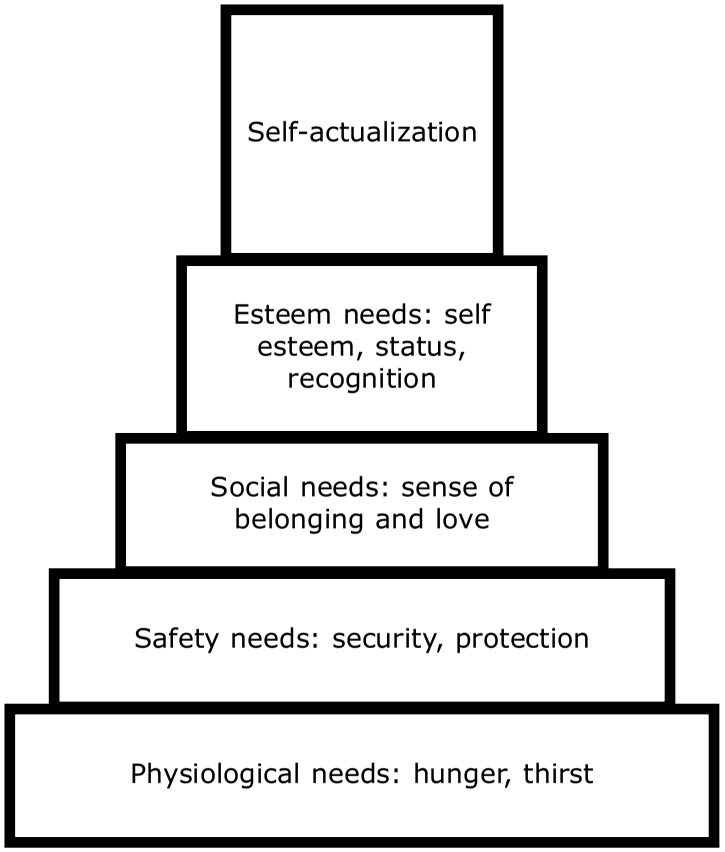
This is a theory linking a person's motivation to their needs. Starting at the bottom of the pyramid, it states that people will initially seek to satisfy basic needs like food and shelter. Once these needs are met, they no longer act as motivation and the individual's motivating forces move up the hierarchy of needs (i.e. If you had enough food to eat, searching for food is no longer going to be a motivation for your behaviour/actions. You will instead start to satisfy safety needs.)

HIV/AIDS: Breaking the foundation of the pyramid

Name: _____

Instructions:

For each level of the pyramid, state the basic needs of individuals. On the right side of the arrow, describe how HIV/AIDS makes meeting these needs more difficult.



The way people think about themselves is very much affected by the way the disease is harming their bodies and perceived by society; own sense of self may be redefined by the disease

Self-esteem will be lowered, status is lowered because of the way society views the disease, people only associate you with the disease rather than your accomplishments

There is stigma about being HIV+, people are not accepting about the disease, makes intimate relationships difficult, may feel left out/discriminated against

People lack energy from illness so find it hard to protect themselves or their families, hard to find work if ill, security threatened with little money

People feel ill/sick, makes it hard to find food or water

I have all the symptoms HIV, but I don't want to go and get tested. How would it help? After all, those drugs that are supposed to help are too expensive and we can't begin to pay the fees and still have food and pay the fees for our children's school. I have been faithful to my husband but I am not so sure he has for he works as a truck driver and is most often away from home to earn our family money. I know those truck stops have young sex workers who are eager to make what money they can. But I cannot refuse his sex when he is home or if I ask him to wear a condom, he will call me unfaithful and may even beat me.

I work as an aid worker within this region. It is unfortunate to see how little the government spends on health care and education. Providing adequate funding could really help to reverse the incredible spread of AIDS. But the country is between a rock and a hard place. It must pay back debt to other countries before spending money on its own social services. And the financial aid that comes in from other countries is often caught up in red tape and rules, i.e. AIDS funding needs to be linked to abstinence. This is not realistic for depth of the problem.

I am a fairly well-off business man—not the stereotypical infected AIDS person. But traveling within the country and sometimes outside, there are many temptations. Sometimes while on the road, I visit some upscale commercial sex workers. Many of the businesses encourage it and it is even considered quite prestigious to be offered women. I know my wife is faithful and she wouldn't ever think of having me wear a condom. If only she knew.

I just had a baby four days ago. I think I have AIDS given the symptoms we can always see in others. The clinic encouraged me to get a test during my pregnancy because they say I can save my baby from having AIDS. But, even if I did know, I could never afford the drugs for my baby. It is just better not to know. Besides, if they found out I did have AIDS, what would others say…that I have been unfaithful, that it was my fault, that my baby is poisoned? They would throw me out of my own home. Besides, I could never afford the formula and the stigma that goes with it if I were not to breastfeed.

I am a 12 year old girl and I may have AIDS. Many of my friends have experienced the same fate too. It is not uncommon to be raped or to be forced into selling yourself for money. It is a very painful and humiliating experience, but you just keep it inside. Men are looking for younger and younger women to have sex with (with or without their consent). It is believed that young virgins can cure men of their own HIV.

I moved to the city a few years ago because I had heard that there were jobs, but, the reality is there are no opportunities if you don't have an education. I never got my high school diploma because it was hard for my mom to pay the school fees. Anyway, now I may pay for a meal or a phone call home by having sex with a man. I suppose I could go home, but I would only be a burden on my family too. I can't possibly ask my customers to wear a condom because they would just find another girl. At least I get by—for now.

I am a grandmother, but I have become a mother instead to my four young grandchildren. My daughter became sick very quickly because of AIDS. Her husband couldn't take the stigma and left her before she even passed away. It is terrible to see your child die in front of your eyes. It is very difficult to care for her children because there are expenses I can't always afford. I do, however, go to a support group for grannies caring for their grandchildren. It helps a lot to talk to others in the same situation. The kids get to play with other kids, I get to talk to other grandmas in the same situation, and the best thing is we all get a balanced meal for that day.

I am a research doctor. Most westerners don't realize that our medical system is so advanced. Our doctors performed the first heart transplant in the world many years ago. Our researchers have done much research on HIV/AIDS, but one of our main problems is that the government has avoided addressing the real problem of AIDS. They could make a lot of headway in reserving the problem by stating how AIDS is contracted, but some of their statements have sent out mixed messages to the people of the country. This also gives a message to the western world that we are a backward country.

I am a nurse at a local health clinic. Many people come in with all of the symptoms of AIDS but refuse to get testing. I can't really blame them though because knowing whether you have AIDS or not doesn't make the medication easy to get. Plus, it brings a lot of discrimination in the community. We try to encourage condom use, but people have been told by some that condoms actually contain the AIDS virus. It's funny, the very thing that may help prevent the disease is thought to cause it.

HIV/AIDS: The causes and effects of HIV/AIDS

Name: _____

Instructions:

Using the chart, consider how AIDS affects the factor and, in turn, is affected by the factor.

How AIDS affects it...	Factor	How it affects AIDS
	Education	
	Health care system	
	Human rights	
	Poverty	
	Politics	
	Economy	
	Food and household security	

HIV/AIDS: The causes and effects of HIV/AIDS

Name: _____

Instructions:

Using the chart, consider how AIDS affects the factor and, in turn, is affected by the factor.

Some sample answers are provided below. Students will consider other unique suggestions.

How AIDS affects it...	Factor	How it affects AIDS
Higher student absenteeism due to illness, teachers ill with disease, students tired from helping with sick parents/siblings	**Education**	Education helping to bring information to children and adults about prevention/stigma/truth about HIV/AIDS/access to health care
Higher pressure on system for care, drug access, beds in hospitals, need more staff to care for sick (many have to be cared for in their homes)	**Health care system**	Providing drugs/treatment to HIV+ patients; providing support and care for sick people
Discrimination against those who are and those who may be HIV+, denial of employment/housing, violence	**Human rights**	Groups fighting for equality for HIV+ people; helping to bring issues about developing countries into the global public eye
Sick people cannot work as much so therefore cannot buy basic needs; as numbers of sick increase, work force decreases – industry suffers	**Poverty**	Forces people into different work situations to get money (i.e. sex work) just to eat; drugs cost money and the poor cannot often access them
Leaders are forced to acknowledge own opinions; leaders have to deal with personal topics in public; people are lobbying for fair treatment from government	**Politics**	Some leaders have denied the HIV/AIDS problem and have negatively affected the world's response to the epidemic
Disease high in working age adults – huge numbers of working people not working so economy affected negatively; pressure for health care money	**Economy**	Drug companies need to allow for cheap/free drugs to developing countries; the world is more interested in money than people dying
Being sick makes it difficult to find food/water and provide necessities for families	**Food and household security**	HIV/AIDS treatment requires good nutrition (hard to get in some places); orphans are looking after siblings and this increases their vulnerability to HIV

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 5 – Day 5

Our response to the HIV/AIDS crisis

Estimated time required: 1 class (75 minutes)

Overall expectations

By the end of this session, students will be able to:
- understand ways in which they can respond to the HIV/AIDS crisis
- form critical opinions about how the world is responding to the HIV/AIDS crisis

Enduring (key) learning

Students will view real-life footage showing the way HIV/AIDS infects and affects populations in South Africa. Students will learn about the various ways in which the world is (and is not) responding to the HIV/AIDS epidemic and will be encouraged to use their skills and talents in their own responses.

Prior learning

- This lesson should follow at least one of the other lessons in this package so that students have a sense of the global HIV/AIDS epidemic.
- Students should generally have an appreciation for the scope of the epidemic and the effects it is having on people, communities, countries and the world.

Getting ready

- Access a DVD player and television set.
- Make any copies of relevant articles/readings as chosen for the class (see Extension activities)

Resources

- OSSTF HIV/AIDS DVD

Teaching/learning strategy

1. View OSSTF DVD

2. Brainstorm
   Ask students:
   - How did your opinions and impressions about HIV/AIDS change with viewing the movie?
   - From what you now know, how can the world help to eradicate HIV/AIDS?
   - How can you/we help to ease the suffering of HIV/AIDS in the world?
   - Collect ideas and leave them in a visible place (use large cards, chart paper, board)

3. Why is education important in preventing further spread of HIV/AIDS?

4. "Spread the word not the virus" is a slogan used in the film. Create your own HIV/AIDS awareness slogan.

5. What was it that called Stephen Lewis to action?

6. Identify the contributing factors for the spread of HIV/AIDS in South Africa.

7. How is the legacy of apartheid in South Africa a complicating factor in the spread of HIV/AIDS?

8. Identify a class or individual project to respond to the HIV/AIDS epidemic.

   Some ideas for action:
   - Write a letter to the Prime Minister and demand that Canada recognize the severity of the HIV/AIDS crisis and continue support for affordable and accessible anti-retroviral treatment.
   - Plan a unique fundraising activity for your school and donate proceeds to the Stephen Lewis Foundation or other HIV/AIDS-related organization.
   - Write letters to multi-national pharmaceutical companies and ask for free availability of anti-retroviral therapy for developing countries.
   - Volunteer with a local or international HIV/AIDS service group.
   - Invite speakers to your class or school to talk about their experiences with HIV/AIDS.
   - Develop an awareness campaign on issues that affect young people and their vulnerability to HIV/AIDS.
   - Tell your family and friends what you have learned.
   - Plan a school-wide event for World AIDS Day (December 1st each year). www.unaids.org/en/events/world+aids+day+2004.asp
   - Create an artistic display (art, music, drama) to share your feelings and response to the HIV/AIDS crisis. Call your school to action!
   - Develop your own unique response to the crisis and share it with your class/school.

9. If Day 2 was completed, revisit the students' preconceptions and see how they have changed with this HIV/AIDS unit.

Homework

Exploring HIV/AIDS on the web

Now that you have had some exposure to HIV/AIDS and the many issues and challenges associated with this disease, it's time to see what IS being done. By the end of this activity, you will:

- know the basics about HIV/AIDS
- be up-to-date with current statistics about HIV around the world
- see what organizations are doing around the world to help stop the spread of HIV and to support those infected/affected by the epidemic
- see how you can help in your own school and community.

A. HIV/AIDS 101

Action: Go to www.unaids.org. Select "Resources" (at left), "Fast facts about AIDS."

1. What does HIV stand for? What does AIDS stand for?
2. How is HIV different from AIDS?
3. According to the Centre for Disease Control, how is AIDS defined?
4. What are the symptoms of HIV infection?

Action: Go to www.cdc.gov. Select "Diseases & Conditions," "HIV/AIDS," "Fact Sheet: HIV and its Transmission."

5. How is HIV transmitted?
6. List and refute three myths about the spread of HIV. (For example, some people believe that HIV can be spread by mosquito bites. It cannot be spread this way – why? And how does the disease present itself in the population that tells scientists that this is not a real route of transmission?)

Action: Return to www.unaids.org. Select "Resources," "Fast facts about AIDS," "Myths."

7. Discuss the risk of HIV infection associated with playing sports and through casual contact like shaking hands, using a public toilet, and sharing eating utensils.
8. Is AIDS a "homosexual and drug user" disease? Use data to support your answer.

Action: Go to www.biology.arizona.edu. Select "Immunology," "HIV and AIDS," HIV impacts."
*Note that the references given here (Nature and Science) represent some of the most prestigious science publications in the world.

9. When was AIDS first recognized as a disease?
10. Where did HIV originate? Describe how the virus was transmitted to humans.

Action: Return to www.unaids.org. Scroll to the bottom of the page and select the most recent AIDS Epidemic Update (under Publications). Choose the HTML format.

11. Under "Global Summary" you will find some up-to-date statistics about the HIV/AIDS epidemic. How many people are currently living with HIV/AIDS? (Just to get a sense of this number, remind yourself of the population of Canada). What percent of them are women? How many children are living with HIV/AIDS?
12. Why are the numbers presented here given as ranges?
13. Go back to the "Contents" of this update (use the back arrow). Choose "Introduction". What are some of the major themes of this update (the current issues facing the epidemic)? The headings will give you some good clues.
14. Go back to the "Contents" and select "Women and AIDS." Using the information here, summarize the major challenges facing women around the world that increase their vulnerability to HIV infection (again, titles will help you navigate through this page).
15. Go back to the "Contents" of this update, and select "Maps." Locate the map that summarizes total global HIV/AIDS infection (total number of people living with HIV/AIDS).
    a) What parts of the world are most affected?
    b) Go back to the "Contents" page and return to the "Introduction." Find the table on "Regional HIV and AIDS statistics." For the area(s) that you identified in 15a), what is the adult prevalence rate? How does this prevalence rate compare to the adult prevalence rate for North America?
    c) Knowing what you do now about HIV/AIDS and from some of the information you gathered in 14, why do you think these prevalence rates are so different?

Responses to the epidemic

Action: Go to www.stephenlewisfoundation.org. Select "Click logo to enter," "About us."

16. Read the "Why" section of this page. What is the Stephen Lewis Foundation responding to? (In their eyes, what are the pressing needs in Africa with respect to HIV/AIDS?)
17. Go back to their home page. Because of these needs, the Stephen Lewis Foundation has three main purposes. What are they? Look through the "Projects" section to see how the foundation is supporting people at the local level.
18. Who is Stephen Lewis?
19. Select "Share Ideas," "Youth Take Action." These are ways that students like you have been able to share their learning about the tragedy of the HIV/AIDS epidemic and have been able to raise money to help support organizations like the Stephen Lewis Foundation. Describe five events organized by youth to help support the foundation. Are these things that may be possible in your own school community?

Action: Go to www.un.org/millenniumgoals.

20. What are the Millennium Development Goals (MDG) – who proposed/supports them and what is their overall objective? What is their proposed date of adherence?
21. List the eight MDGs.
22. Notice that HIV/AIDS is included in this list of target areas. Click on goal #6. What are the components of this goal?

23. Select "Background" just under the main title of this page. Select the most recent "Millennium Development Goals: Progress Report." This chart provides an overview of regional progress towards meeting the MDGs. You may have to zoom in to view all of the details in this chart.
24. Spend some time examining this chart. It is organized by MDG and region. The colours are defined at the bottom of the chart. What noticeable area(s) of the world is/are missing from this chart? What do you think that is? (Refer to: unstats.un.org/unsd/mi/mi_worldmillennium_new.asp for some additional information on this.)
25. Use the progress chart to answer the following:

a) Which regions of the world seem to be showing the least progress towards the MDG?
b) Which goals seem to be proving the most difficult to meet?

Action: Go to www.tac.org.za. Select "About TAC."

26. What doest TAC stand for?
27. What does TAC do?
28. Do a quick web search for "Zackie Achmat." Who is he and why is his work so significant (now and in the past)?

Action: Go to www.lovelife.org.za.

29. Look at this site and through its "Youth" link. What is the purpose of this organization?
30. Go back to the LoveLife home page and select "Corporate," "About us," Now – what is the point of this organization? Who are they targeting and why?
31. What three components does this organization use? Do they seem to be making a difference? Explain.
32. Spend some time looking through this site (and listening if you have the computer capability). Look at the media programs and message they are conveying to youth. Why do you think this approach is working to fight HIV/AIDS in young people in South Africa?

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 6 – Day 6

Culminating activity
'Call to action'

Estimated time required: 75 minutes

Note to teacher: The options for activities are included below. These are offered as 'doable' activities intended to empower students as local, national and global citizens. Please pursue other ideas most appropriate for your students and their interpersonal dynamics.

Overall expectations

By the end of this session, students will be able to:
- describe and integrate the relationships between socio-economic, political and legacy issues and health—specifically HV/AIDS
- challenge their own preconceptions about their ability to influence change
- appreciate the role Canadians can play in providing leadership in combating HIV/AIDS through drug patent law changes and other proactive actions

Enduring (key) learning

Students will gain an appreciation for the more complex nature of diseases including the socio-economic, political and scientific nature of HIV/AIDS.

Students will become aware of their power as global citizens to understand problems and influence solutions.

Students will develop a greater sense of citizenship in general, and Canadian and global citizenship in particular.

Prior learning

- This lesson can stand alone or follow the previous five lessons

Getting ready

- Teacher should duplicate (make transparencies) appropriate black line masters:
  - BLM 6-1: HIV/AIDS – Impact of poverty on AIDS in Africa
  - BLM 6-2: HIV/AIDS – Avoiding global bio-apartheid
  - BLM 6-3: HIV/AIDS – Socio-cultural aspects of HIV/AIDS in South Africa
  - BLM 6-4: HIV/AIDS – Strict international patent laws hurt developing countries
  - BLM 6-5: The problem with patents
  - BLM 6-6: Implausible denial: Why the drug giants' arguments on patents don't stack up

R Teaching/learning strategy

1. The teacher should divide the class into groups. Ideally, the groups should be 3-5 students. Distribute multiple copies of the same article (5.1 through 5.6) to each group.
    a. In each group, students are to read the articles.
    b. Then, create a chart summarizing the previous and new information they have learned.

2. Bring the entire class together and allow each group to share with the rest of the class the most important information especially as it relates to new information they have learned about HIV/AIDS.

Final assignment

1 You have recently learned a lot about the pandemic of HIV/AIDS. You want to make a difference by letting others know about the issues as well. Choose one of the options below to turn your knowledge into action.
    a. Write a letter to the government of Canada (you may choose the political party). Describe the issues about HIV/AIDS and how the government can help make a difference with the situation. Consider what the government has already done and continues to do and what more could be done.

OR

    b. Develop a fundraising proposal to be carried out in your school. Consider how you would educate your possible contributors about the situation of HIV/AIDS. Also consider what is already being done by the government. Finally, discuss the kind of project to which you would donate your contributions.

2. The content for either choice should focus on and tie together:
    a. The historical, social, political, cultural and economic legacies which impact upon or retard development in general and more specifically on health and HIV/AIDS.
    b. The roles of and limitations (especially economic and capacity to deliver) of governments in stemming the tide of the pandemic.
    c. The role of multinational drug companies, the place of patents, generic drugs and manufacturers.
    d. The role of Canada and Canadians in playing a leading role in 'being global citizens."

Impact of poverty on AIDS in Africa

The following quote reveals a lot:

"Although there are numerous factors in the spread of HIV/AIDS, it is largely recognised as a disease of poverty, hitting hardest where people are marginalised and suffering economic hardship. IMF designed Structural Adjustment Programmes (SAPs), adopted by debtor countries as a condition of debt relief, are hurting, not working. By pushing poor people even deeper into poverty, SAPs may be increasing their vulnerability to HIV infection, and reinforcing conditions where the scourge of HIV/AIDS can flourish."

— Deadly Conditions? Examining the relationship between debt relief policies and HIV/AIDS, Medact and the World Development Movement, September 1999

Africa Action, an organization looking into political, economic and social justice for Africa has an article on the impacts of IMF and World Bank structural adjustments and its impacts on health in Africa, and is worth quoting at length:

"Health status is influenced by socioeconomic factors as well as by the state of health care delivery systems. The policies prescribed by the World Bank and IMF have increased poverty in African countries and mandated cutbacks in the health sector. Combined, this has caused a massive deterioration in the continent's health status.

"The health care systems inherited by most African states after the colonial era were unevenly weighted toward privileged elites and urban centers. In the 1960s and 1970s, substantial progress was made in improving the reach of health care services in many African countries. Most African governments increased spending on the health sector during this period. They endeavored to extend primary health care and to emphasize the development of a public health system to redress the inequalities of the colonial era. The World Health Organization (WHO) emphasized the importance of primary health care at the historic Alma Ata Conference in 1978. The Declaration of Alma Ata focused on a community-based approach to health care and resolved that comprehensive health care was a basic right and a responsibility of government.

"These efforts undertaken by African governments after independence were quite successful....

"While the progress across the African continent was uneven, it was significant, not only because of its positive effects on the health of African populations. It also illustrated a commitment by African leaders to the principle of building and developing their health care systems.

"With the economic crisis of the 1980s, much of Africa's economic and social progress over the previous two decades began to come undone. As African governments became clients of the World Bank and IMF, they forfeited control over their domestic spending priorities. The loan conditions of these institutions forced contraction in government spending on health and other social services....

"The relationship between poverty and ill-health is well established. The economic austerity policies attached to World Bank and IMF loans led to intensified poverty in many African countries in the 1980s and 1990s. This increased the vulnerability of African populations to the spread of diseases and to other health problems....

"The deepening poverty across the continent has created fertile ground for the spread of infectious diseases. Declining living conditions and reduced access to basic services have led to decreased health status. In Africa today, almost half of the population lacks access to safe water and adequate sanitation services. As immune systems have become weakened, the

susceptibility of Africa's people to infectious diseases has greatly increased....

"Even as government spending on health was cut back, the amounts being paid by African governments to foreign creditors continued to increase. By the 1990s, most African countries were spending more repaying foreign debts than on health or education for their people. Health care services in African countries disintegrated, while desperately needed resources were siphoned off by foreign creditors. It was estimated in 1997 that sub-Saharan African governments were transferring to Northern creditors four times what they were spending on the health of their people. In 1998, Senegal spent five times as much repaying foreign debts as on health. Across Africa, debt repayments compete directly with spending on Africa's health care services.

"The erosion of Africa's health care infrastructure has left many countries unable to cope with the impact of HIV/AIDS and other diseases. Efforts to address the health crisis have been undermined by the lack of available resources and the breakdown in health care delivery systems. The privatization of basic health care has further impeded the response to the health crisis....

"The World Bank has recommended several forms of privatization in the health sector.... Throughout Africa, the privatization of health care has reduced access to necessary services. The introduction of market principles into health care delivery has transformed health care from a public service to a private commodity. The outcome has been the denial of access to the poor, who cannot afford to pay for private care.... For example, ... user fees have actually succeeded in driving the poor away from health care [while] the promotion of insurance schemes as a means to defray the costs of private health care ... is inherently flawed in the African context. Less than 10% of Africa's labor force is employed in the formal job sector.

"Beyond the issue of affordability, private health care is also inappropriate in responding to Africa's particular health needs. When infectious diseases constitute the greatest challenge to health in Africa, public health services are essential. Private health care cannot make the necessary interventions at the community level. Private care is less effective at prevention, and is less able to cope with epidemic situations. Successfully responding to the spread of HIV/AIDS and other diseases in Africa requires strong public health care services.

"The privatization of health care in Africa has created a two-tier system which reinforces economic and social inequalities. As health care has become an expensive privilege, the poor have been unable to pay for essential services. The result has been reduced access and increased rates of illness and mortality. Despite these devastating consequences, the World Bank and IMF have continued to push for the privatization of public health services."

— *Ann-Louise Colgan, Hazardous to Health: The World Bank and IMF in Africa*, Africa Action, April 18, 2002

The article also comments on recent increases in funds to tackle HIV/AIDS and other problems and concludes that because some underlying causes and issues are not addressed, these steps may not have much effective impact:

"The World Bank has also increased its funding for health, and for HIV/AIDS programs in particular. While the shift in focus towards prioritizing social development and poverty eradication is welcome, fundamental problems remain. New lending for health and education can achieve little when the debt burden of most African countries is already unsustainable. Debt cancellation should be the first step in enabling African countries to tackle their social development challenges. Additional resources to support health and education programs should be conceived as public investment, not new loans. The new spin on the World Bank and IMF priorities

fails to change the basic agenda and operations of these institutions. Indeed, it appears to be largely an exercise in public relations. The conditions attached to World Bank and IMF loans still reflect the same orientation prescribed over the past two decades. The recent moves towards promoting poverty reduction have actually permitted these institutions to increase the scope of their loan conditions to include social sector reforms and governance aspects. This allows an even greater intrusion into the domestic policies of African countries. It is highly inappropriate that external creditors should have such control over the priorities of African governments. And it is disingenuous for such creditors to proclaim concern with poverty reduction when they continue to drain desperately needed resources from the poorest countries....

"The free market fundamentalism of the World Bank and IMF has had a disastrous impact on Africa's health. The all-out pursuit of market-led growth has undermined health and health care in African countries. It has forced governments to sacrifice social needs to meet macroeconomic goals.

"This approach to development is fundamentally flawed. The failure to prioritize public health denies its significance in promoting long-term economic growth. As the WHO Commission on Macroeconomics and Health recently concluded, health is more than an outcome of development, it is a crucial means to achieving development."

— *Ann-Louise Colgan, Hazardous to Health: The World Bank and IMF in Africa*, Africa Action, April 18, 2002

www.globalissues.org/Geopolitics/Africa/AIDS.asp#ImpactofPovertyonAIDSinAfrica

Avoiding global bio-apartheid

by Peter Stoett
Toronto Star
Oct. 23, 2005. 01:00 AM

We need to avoid a pandemic scenario where the wealthy foot bill to cordon off the infected.

It is a scenario with variations reproduced in countless science fiction novels and films: A world bifurcated according to immunization. Those with the proper vaccines or genetic codes live, insecurely, in protected areas; those without are doomed to die in the forbidden lands.

Such a dystopian image may be less fictional, however, if the international community does not establish clear ethical guidelines in its response to pandemics. Of course, many would argue that the mixed approach to HIV/AIDS already belies such a discriminatory response to killer diseases.

Add to this the so-called "neglected diseases," such as malaria and yellow fever, affecting mainly states also struggling to deal with the AIDS pandemic, land and forest degradation, and civil or international military conflict, and it is obvious we are not sharing the burden of global health, but making squalid contributions while hoping to be minimally affected.

However, the striking emergence of the H5N1 virus, or avian influenza, is again raising the question of just how separated the world may become by biosecurity concerns.

When George W. Bush offered his characteristically militaristic foray into disease control earlier this month (he asked Congress to allow him to "bring in the troops" to quarantine affected areas), it was surely a harbinger of what could come: entire communities, perhaps even countries, quarantined through military force, to protect the rest of us. No one gets in or out; or so the idea goes.

Beyond the impossibility of such a step (consider, for example, the task of putting an effective quarantine around China), the ethics demand discussion.

While we should not panic over H5N1, it does have the potential to jump the species barrier and spread like wildfire.

Who will be most visibly affected — or, rather, infected — if a major human-to-human outbreak occurs?

Even at this stage, when the main modes of transmission are migratory birds, we can glimpse the future: The poor, many of them engaged in the poultry industries of Asia, eastern Europe, and northern Africa, are going to be hurt first. While it is an easily defensible truism that disadvantaged persons should receive extra protection during episodes of severe health crises, it is equally clear this is rarely the case. Two tragic events this summer, famine in Niger and Hurricane Katrina along the Gulf Coast, have demonstrated the disproportionate impact such disasters have among the least advantaged members of society.

With a pandemic there will be strong and virtually undeniable calls for strict quarantines of impoverished areas, and international agencies will scramble to provide vaccines (this could take up to six months) to adjoining areas.

Disease containment will become a military exercise and perhaps a permanent feature of international politics.

Sadly, this may be inevitable; our collective record on AIDS suggests we can't overcome political and economic obstacles to provide a greater public good.

But we can start working now toward establishing a new global ethic, articulated through multilateral institutions such as the World Health

Organization, that accepts the harsh realities of the need for quarantine but rejects the option of letting entire communities go to waste.

We can reward, not punish, farmers who report H5N1 and other virulent strains; we can better equip the WHO with the ability to intervene as early as possible, assisting poor and rich alike; we can continue, as Canada is doing, to contribute to the development of vaccines and the science of epidemiology; we can contribute more to disease surveillance .

Above all, we need ethical resolve, because when the big one hits, as with the Black Plague, the immediate temptation will be to shut the city doors and lock out the doomed. This won't work this time around, and we can do better. We need to avoid the bio-apartheid scenario, where the infected are cordoned into what are essentially large-scale concentration camps, while the wealthy pay for oppressive measures to keep them there.

We may be on the verge of a major humanitarian disaster that will reveal in the starkest terms possible the differences between rich and poor, both between North and South, East and West, and within each.

The time for dialogue is now.

Socio-cultural aspects of HIV/AIDS in South Africa

South Africa has the largest number of people living with HIV/AIDS in the world, and the fastest growing epidemic. The reasons for this are complex; nevertheless, certain socio-cultural factors have been identified as responsible for the rapid spread of the disease. These include the following:

- gender inequality and male dominance
- violence and sexual violence
- political transition and the legacy of apartheid
- stigma and discrimination
- poverty
- commercialisation of sex
- lack of knowledge and misconceptions about HIV/AIDS
- cultural beliefs and practices.

Gender inequality and male dominance

South African culture is generally male-dominated, with women accorded a lower status than men. Men are socialised to believe that women are inferior and should be under their control; women are socialised to over-respect men and act submissively towards them. The resulting unequal power relation between the sexes, particularly when negotiating sexual encounters, increases women's vulnerability to HIV infection and accelerates the epidemic.

Women's inferior status affords them little or no power to protect themselves by insisting on condom use or refusing sex.

Many women also lack economic power and feel they cannot risk losing their partners, and thus their source of financial support, by denying them sex or deciding to leave an abusive relationship.

Entrenched ideas about suitably "masculine" or "feminine" behaviour enforce gender inequality and sexual double standards, and lead to unsafe sexual practices. Abstinence and monogamy are often seen as unnatural for men, who try to prove themselves "manly" by frequent sexual encounters, and often the aggressive initiation of these.

Examples of other prevalent ideas which result in sexually unsafe behaviour include the following: sex on demand is part of the marriage "deal;" sexual violence is a sign of passion and affection; men have natural sexual urges that cannot be controlled in face of women's powerful attractions; sex is necessary to maintain health and gender identity.

These views serve to justify men's sexual behaviour to some extent: men are given license to be sexually adventurous and aggressive, without taking responsibility for their actions.

Women's respectability is derived from traditional roles of wife, home-maker and mother. Childbearing and satisfying her husband, sexually and otherwise, are key expectations for a wife - even if she is aware that her husband is unfaithful. Refusing a husband sex can result in rejection and violence.

The low status accorded to a woman without a male partner may be an additional reason making women less likely to leave an abusive relationship. Too much knowledge about sex in women is seen as a sign of immorality, thus insisting on condom use may make women appear distastefully well-informed. Married women who request safer sex may be suspected of having extra-marital affairs or of accusing their husbands of being unfaithful.

Physical and sexual violence

Violence against women is a major problem in South Africa, and is linked to its male-dominated culture. Men often use violence in an attempt to maintain their status in society and prove that they are "real men" by keeping women under their control. Physically abusive

relationships limit women's ability to negotiate safer sex: many men still do not want to use condoms, and some become violent if women insist on protected sex. Women may not even raise the issue of safer sex for fear of a violent response.

One result of apartheid-era violence by the state and the armed resistance movement is that violence came to be seen as a familiar, acceptable way of solving conflicts and wielding power. In addition to heterosexual relationships, violence pervades a wide range of social relations, including same-gender sexual relationships such as those between male prisoners.

South Africa, where a woman has about a one in three chance of being raped in her lifetime, has the highest sexual violence statistics in the world – with obvious implications for the spread of HIV/AIDS. The genital injuries that result from forced sex increase the likelihood of HIV infection; when virgins and children are raped, the trauma is more severe, and risk of infection even higher.

In cases of gang rape, exposure to multiple assailants further increases risk of transmission. Increasing numbers of rapes of female children may represent men's attempts to seek sexual relations with young girls to avoid HIV infection or because of the belief that sex with a virgin will cure AIDS.

Women with a history of being sexually abused are more likely to risk unsafe sex, have multiple partners, and trade sex for money. Men who are violent to their partners are also more likely to have sexually transmitted infections (STIs). These factors combine to put women who suffer sexual violence at very high risk of contracting HIV/AIDS.

Political transition and the legacy of apartheid

The early years of the HIV/AIDS epidemic in South Africa coincided with the end of the apartheid era, a period of complex political transition and societal instability. Leadership was distracted by the then more immediate concerns of the struggle towards democracy, with the result that crucial time was lost in the fight against AIDS.

Elements of the apartheid regime - such as migrant labour, the homelands system, the Group Areas Act and forced removals - contributed to the widespread poverty, gender inequality, social instability and unsafe sexual practices that now continue to influence the spread of HIV/AIDS.

The migrant labour system has been particularly important as a vehicle for HIV transmission. Labourers were prevented from settling where they worked in the urban areas, but maintained links with their families in rural parts, and moved between the two. This to-and-fro migration has been a major factor in the spread of HIV and other STIs (which, in turn, increase the risk of HIV infection). Migrant labour patterns persist because of uneven development and employment opportunities, both within the country and in neighbouring African states.

People separated for long periods tend to seek sex outside their stable relationships, which, in the single-sex hostels accommodating migrant labourers, has often been in the form of unsafe male-to-male sex, and making use of the sex-work industry that developed in the vicinity. Men frequently become HIV-infected at their place of work, and then carry the infection back home and pass it on to their wives and unborn children.

Another form of migration occurred when the former revolutionary cadres, such as umKhonto weSizwe, returned from the north of South Africa's borders in 1994 and were incorporated into the national defence force. Their return, from areas of high HIV prevalence, contributed to the rapid growth of the epidemic. Refugees from neighbouring African states also entered the country, often bringing new strains of the

virus with them.

Stigma and discrimination

The stigma attached to HIV seriously hinders prevention efforts, and makes HIV-positive people wary to seek care and support for fear of discrimination. People who are infected may also be reluctant to adopt behaviour that might signal their HIV-positive status to others. For example, a married HIV-positive man may not use a condom to have sex with his wife; an HIV-positive mother may continue to breastfeed her baby. Many people might not want to get tested for fear of their community finding out.

Homosexuality is also stigmatised in South Africa. There is still significant denial of the existence of homosexuality in the black community and a history of poor government interventions focused on gay people. The violence often suffered by young homosexuals as a result of social stigma may cause them to hide their sexuality and not access information that could help protect them against HIV infection.

Poverty

High levels of unemployment and an inadequate welfare system have lead to widespread poverty, which renders people more vulnerable to contracting HIV because of the following factors:

- The daily struggle for survival overrides any concerns people living in poverty might have about contracting HIV.
- Strategies adopted by people made desperate by poverty, such as migration in search of work and "survival" sex-work, are particularly conducive to the spread of HIV/AIDS.
- People living in deprived communities where death through violence or disease is commonplace tend to become fatalistic: the incentive to protect oneself against infection is low when HIV is only one of many threats to health and life. Poverty may also breed low levels of respect for self and others, and thus a lack of incentive to value and protect lives.
- Poverty is generally associated with low levels of formal education and literacy. Knowledge about HIV and how to prevent it, as well as access to information sources such as schools or clinics, is subsequently low in poor communities.

Ironically, socio-economic development and poverty relief can, in fact, sometimes drive the epidemic. This is particularly the case when development is linked to labour migration, rapid urbanisation, and cultural modernisation – all of which occur to a significant extent in South Africa. Thus, although poverty contributes to the spread of HIV/AIDS, alleviating poverty can do likewise. For example, improved infrastructure such as new transport routes and improved access are seen as positive developmental goals. However, this often results in a larger migrant population, and facilitates the spread of AIDS to previously inaccessible parts of the country.

Commercialisation of sex

A prominent aspect of South African culture that undoubtedly contributes to the HIV/AIDS epidemic is that sexuality is frequently seen as a resource that can be used to gain economic benefits.

The country has seen the rapid development of a relatively affluent black middle class with a desire for material goods, and a sexual culture that associates sex with gifts. Men gain social prestige by showing off material possessions and being associated with several women.

Young women are often persuaded to have sex with "sugar daddies" – older, wealthier men – in exchange for money or gifts. Some girls enter the sex industry for similar reasons. Young women infected with HIV by sugar daddies then infect younger men, who in turn infect other young women and in time become HIV-positive older men themselves – and so the cycle con-

tinues. Older men also infect older women, usually their wives. Both younger and older women give birth to children, some of whom will be HIV-positive.

Lack of knowledge and misconceptions about HIV/AIDS

It appears that the majority of South Africans have heard about AIDS, and have a fairly good level of knowledge of the basic facts i.e. that the disease is spread sexually, and that condoms reduce risk. Nevertheless, there are still many people, especially those with low levels of formal education and who lack access to accurate, relevant information on HIV/AIDS and sexuality, who are unaware of the risks.

Women in particular have high rates of illiteracy, and many girls do not complete basic education. Also, women may be unaware of risks because their time is taken up with tending the home, and they have limited links with the outside world.

Added to this is the problem that dangerous myths and misconceptions about HIV/AIDS abound. These include believing that the virus can be contracted by sharing food, that infected people can be recognised by their symptoms, and, perhaps the most notorious of all, the belief that sex with a virgin can cure the disease. Beliefs such as this give people a false sense of their level of risk, and contribute to confusion about how HIV is transmitted.

People who do possess some knowledge about HIV often do not protect themselves because they lack the skills, support or incentives to adopt safe behaviours. High levels of awareness among the youth, a population group particularly vulnerable and significant as regards the spread of HIV/AIDS, have not led, in many cases, to sufficient behavioural change. Young people may lack the skills to negotiate abstinence or condom use, or be fearful or embarrassed to talk with their partner about sex. Lack of open discussion and guidance about sexuality is often lacking in the home, and many young people pick up misinformation from their peers instead.

Cultural norms and practices

Certain prevalent cultural norms and practices related to sexuality contribute to the risk of HIV infection, for example:

- Negative attitudes towards condoms, as well as difficulties negotiating and following through with their use. Men in southern Africa regularly do not want to use condoms, because of beliefs such that "flesh to flesh" sex is equated with masculinity and is necessary for male health. Condoms also have strong associations of unfaithfulness, lack of trust and love, and disease.
- Certain sexual practices, such as dry sex (where the vagina is expected to be small and dry), and unprotected anal sex, carry a high risk of HIV because they cause abrasions to the lining of the vagina or anus.
- In cultures where virginity is a condition for marriage, girls may protect their virginity by engaging in unprotected anal sex.
- The importance of fertility in African communities may hinder the practice of safer sex. Young women under pressure to prove their fertility prior to marriage may try to fall pregnant, and therefore do not use condoms or abstain from sex. Fathering many children is also seen as a sign of virile masculinity.
- Polygamy is practised in some parts of southern Africa. Even where traditional polygamy is no longer the norm, men tend to have more sexual partners than women and to use the services of sex workers. This is condoned by the widespread belief that males are biologically programmed to need sex with more than one woman.

Urbanisation and migrant labour expose people to a variety of new cultural influences, with the result that traditional and modern values often co-exist. Certain traditional values that could serve to protect people from HIV infection, such as abstinence from sex before marriage, are being eroded by cultural modernisation.

Strict international patent laws hurt developing countries

Amy Kapczynski, *YaleGlobal*,
Dec. 16, 2002

Last year, at a conference about health and human rights, a representative from a pharmaceutical company told the audience a joke. It was about the now infamous lawsuit that 39 pharmaceutical companies brought against the South African government. The lawsuit was intended to stop the government from making cheaper medicines available in their country - and in the context of the HIV/AIDS pandemic, it generated global outrage. After three years of obstructing the implementation of the South African law, the companies were forced to abandon the lawsuit, which had become a PR nightmare. Here's the joke: "People ask me," the representative said, "how we could have been so stupid as to sue Nelson Mandela. I tell them: We had to. Mother Theresa was already dead."

Perhaps not a terribly funny joke, but it usefully highlights a seismic shift in global public awareness and opinion that happened recently. In 1998, when the 39 companies filed their suit, it seemed to them a perfectly good idea to sue Nelson Mandela to stop him from encroaching upon their patents. Even Al Gore supported the lawsuit, traveling to South Africa to threaten the government with trade sanctions if they did not revoke the law. Three years later, that same lawsuit came to be seen akin to an assault upon a saint. How did this happen, and what have we learned from it? What was the South African lawsuit about, and what does it tell us about globalization?

Understanding the lawsuit requires a bit of background. Patents are temporary monopolies granted by governments. They give the inventor a right to exclude everyone else from producing, selling, or distributing a product in that country. Monopolies are generally viewed as a bad thing, because they create what economists call "deadweight losses." So why are governments granting them? The theory is that the higher prices that patents allow companies to charge provide incentives to develop and commercialize new products. The dirty secret about patents, as a law school professor of mine once put it, is that no one knows how strong patents have to be to serve this purpose. For example, are twenty years of patent protection necessary to provide sufficient incentives for research? Or is ten years sufficient? Under international rules, patents must now be granted for a minimum of twenty years - although until recently, patents were often much shorter, even in the U.S.

Here is another dirty secret: Patents cannot generate innovation where there is no market. Even with patents, it is not profitable for companies to produce drugs for diseases that primarily affect the poor. So, for example, only 13 out of the 1393 new drugs approved between 1975 and 1999 were for tropical diseases, which is to say, diseases that primarily affect poorer regions of the world. This suggests that the patent system is a raw deal for developing countries - because it gives them monopoly prices without giving them innovation. It also suggests a need for substantial public funds for drug development for neglected diseases.

Cut to South Africa in 1998: Approximately one in five adults is living with HIV/AIDS. Since 1996, the world has known that "cocktails" of antiretroviral drugs save lives. They are not a cure for AIDS, but here they have turned it into an almost chronic disease, akin to diabetes. The rate of AIDS deaths in the U.S. was plummeting, but in South Africa, no one except the exceedingly rich could afford the drugs. In the U.S., taxpayers subsidize the cost of the drugs, which cost around $15,000 per year. In South Africa, making treatment universally available at such prices would have bankrupted the government. But it was not the drugs themselves that were expensive - it was the patents. Where there are no patents on these drugs, as

is the case in India, for example, you can buy equivalent versions of those $15,000 drugs for $200. India does not currently grant patents for products (pharmaceutical or otherwise), although they soon will have to, according to an agreement which all WTO members must sign and adhere to, known as the "TRIPs" - Trade-Related Aspects of Intellectual Property - agreement.

The South African government was in a bind. South Africa has a strong patent system - the legacy of apartheid, but also the result of pressure from countries like the United States. Affordable drugs existed, but not for them. So, in 1998, they did what any responsible government would do: They passed a law that would give them the power to bring drug prices down. The law would have allowed them to "parallel import" cheaper medicines - that is, to take advantage of the fact that patented drugs are sold at different prices in different countries. Parallel importing is what busloads of senior US citizens do when they go to Canada to fill their prescriptions - buying the same brand-name drugs in a country where they are less expensive. And it's completely legal under the TRIPs agreement.

The South African law might also have given the government the power to use generic drugs, harnessing the power of competition to drive prices down. The TRIPs agreement allows governments to override patents and allow generic production, through a strategy known as "compulsory licensing." Governments can use compulsory licensing whenever they choose, as long as they follow certain procedures (which include first negotiating with the patent-holder and allowing appeal of the government's decision). In an emergency, or where the product is for public non-commercial use, a government can issue a compulsory license without even consulting the patent-holder.

A Bolshevik notion? Piracy? Only if you consider the US Congress to be communists and pirates. During the anthrax crisis last year, Congress threatened to use compulsory licensing to obtain the antibiotic Cipro more cheaply and quickly from generic manufacturers. Bayer, who holds the patent on Cipro, immediately offered to dramatically lower its prices and increase production.

Faced with a potential public health crisis, Congress recognized what many other countries have been arguing all along: that patents are not "rights" but rather privileges - and that they do not come before the rights to health and life. But that is not how they - or the drug industry - approached the issue when it came to South Africa. The possibility that South Africa - a tiny percentage of the world's drug market - might start using generic drugs was treated as a colossal threat to the interests of the U.S. pharmaceutical industry. It did not matter that the United States had signed the TRIPs agreement in 1994, recognizing that developing country governments have the ability to do just what the U.S. would later do with Cipro. And it didn't matter that literally millions of lives were at stake. According to Charlene Barshefsky, the US Trade Representative at the time: "We all missed it.... I didn't appreciate at all the extent to which our interpretation of South Africa's international property obligations were draconian."

Activists around the world realized it, and mobilized against the lawsuit with slogans like "Patient Rights Over Patent Rights," and "Stop Medical Apartheid." In March, 2001, when the case finally reached the courtroom, the drug companies, fearing the public relations backlash, withdrew their suit.

Riding on the momentum of this win, and with the example of Cipro now in hand, developing countries successfully secured affirmation at the WTO Ministerial meeting in Doha in November, 2001, that they have the right to parallel import and issue compulsory licenses, and that the TRIPs agreement should be "interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all."

The problem with patents

OXFAM

www.oxfam.org.uk/what_we_do/issues/health/implausible_denial.htm

While people in rich countries enjoy the benefits of ever-improving drug treatments, in poor countries 30,000 people die every day because effective medicines are too expensive or simply not available. Now World Trade Organisation rules on patents, which are set to come into force in 2005, could make the situation even worse.

Patents give companies the exclusive rights to make, use and sell the patented product for a given number of years. New WTO rules on patents and copyright (Trade Related Aspects of Intellectual Property Rights or TRIPs) will give pharmaceutical companies patent protection on all their new drugs for at least 20 years.

Trans-national drug companies helped to set up, and will benefit directly from, TRIPs. The companies hold more than 90 percent of drug patents and, thanks to these patents, are able to charge high prices for their drugs and prevent the sale of cheaper versions (called generics). In a nutshell, patents keep medicine prices high so poor people can't afford them.

Drug companies argue that the protection of patents enables them to recoup the costs of the research and development that went into their production. This is true but it's rich country markets that generate super profits for the drug companies—poor people should not pay the penalty for protecting those markets.

Until recently, cheaper copies of life-saving medicines (generics) have been produced by some companies, many of which are based in poor countries. These have offered poor people an affordable alternative to expensive brand-name medicines. The new patent rules threaten this practice because drug companies will be able to use TRIPs to rigidly to enforce their patents in poor as well as rich countries. A recent, much publicised deal by the World Trade Organisation on TRIPs and access to medicines does little to help poor people access affordable medicines when they are sick.

Oxfam is calling for the World Trade Organisation to reform TRIPs so that poor country governments have the unambiguous right to obtain the cheapest possible life-saving medicines, without facing the threats of legal challenges or trade sanctions. Oxfam is also calling on the pharmaceutical industry, including GlaxoSmithKline and Pfizer, to support reforms to TRIPs, not to block developing countries from getting access to affordable generics medicines, and to set realistic prices for their medicines so that people who need them in poor countries can afford them.

Together with poor country governments and organisations such as Medicins sans Frontieres, Voluntary Services Overseas and the Treatment Action Campaign we have achieved real change—both in the rules that govern patents and in the attitudes of companies. However, there is still some way to go and we still need your support.

Dodgy deals

The following is a potted history of patents and access to medicines at the World Trade Organisation

Back in 2001, 142 countries at the WTO summit in Doha, confirmed that governments should be free to take action to protect public health even if this means overriding the patent rights that big drug companies have on their medicines.

Thanks to this landmark agreement - the Doha Declaration on TRIPs and Public Health- poor country governments have the right to ask local companies to produce low cost versions of life saving medicines (called generics) if the drugs produced by the big pharmaceutical companies prove too expensive. (See "The problem with patents.")

This was great news but for the majority of poor countries there was a important catch. While a government could ask companies in their own country to produce cheap generic medicines where the patented equivalent proved too expensive or was in limited supply, it was still illegal under WTO rules for other countries to export cheap generic drugs to them. This means the vast majority of poor countries, which don't have the capacity to develop and produce drugs in-country, will not be able to get access to affordable medicines. This should have been a purely technical matter and trade ministers committed themselves to find an early solution. However, thanks to a stubborn US government acting under the influence of a powerful drug company lobby, the talks were stuck in deadlock for months.

In September 2003, ahead of another WTO Meeting in Cancun, Mexico, and with developing countries under immense pressure to adopt a deal, the WTO finally reached an agreement.

This agreement, though trumpeted as a 'historic' breakthrough by the WTO - is seriously flawed and does little to address the problems of access to affordable medicines faced by millions of sick people across the developing world. Developing countries successfully stopped the US and the pharmaceutical lobby from excluding many important diseases of the third world from the deal, which is an important achievement. However, no matter how desperate the health need, a poor country without the capacity to produce a needed drug - which is virtually all of them - will have to ask another government to suspend the relevant patent and license a local company to produce and export it.

Few countries, if any, will be prepared to help other countries in this way, as it would provoke retaliation by the US, which fiercely defends the commercial interests of the drug companies. What is more, the agreement is wrapped in so much red tape and uncertainty that in practice it will be very difficult to use.

The bottom line is that many poor countries will still have to pay the high price for patented medicines or most probably, without. The World Trade Organisation has failed to live up to the Doha pledge to put people's health before profits.

The campaign to cut the cost of vital medicines has achieved some great successes, but it's clearly not over yet. Despite its flaws, Oxfam will now fight to ensure that developing countries can and do use this deal, so that poor people, where ever they live, can access affordable medicine when they are sick, whatever their illness, as intended by the Doha Declaration

Campaign successes

Oxfam's Cut the Cost campaign was launched in February 2001, to draw attention to a worldwide crisis in the making. Much premature death and disability associated with infectious diseases could be avoided if poor people had affordable medicines.

Global patent rules put the price of new, more effective medicines beyond the reach of poor people. Patents allow wealthy drug companies to charge high prices, and prevent the sale of cheaper versions of these medicines (generics).

Oxfam joined with Médecins sans Frontières, VSO, Treatment Action Campaign, and other partners to cut the cost of vital medicines. Oxfam's campaign called for reform of global patent rules, and challenged drug giant GlaxoSmithKline (GSK) to take the lead within the pharmaceutical industry to promote poor people's access to medicines.

Together with 38 other multinational companies, GSK had brought legal action against the South African government, which was seeking the right to import cheaper medicines. Just two months after Oxfam launched its campaign, and following an international outcry, the South African court case was dropped - a victory for a global campaigning coalition.

Later in 2001, 32,000 people in 163 countries signed a petition calling on the World Trade Organisation (WTO) to change its patent rules when it met in Doha. Together with others we ensured that the issue of access to medicines dominated the meeting. The final deal - the Doha Declaration - reaffirmed that public health is more important than patents. This was an important step forward in making medicines affordable for developing countries.

What's more, the combination of mounting public pressure and competition from cheap generic medicines from India has prompted the big drug companies to lower the price of HIV/AIDS medicines in some poor countries. As a result, countries such as Uganda have been able to increase treatment rates for people with HIV/AIDS by as much as 200 percent!

In addition, in March 2005, due to the growing public concern, a group of European investors, together worth £600 bn, took the unusual step of issuing a statement on how drug companies should respond to the health crisis in the developing world. This included urging the drug companies to allow developing countries greater scope to override patents, and to set drug prices in different countries that take into account what people can afford.

Growing international concern also prompted the UK government to set up an Independent Commission to look into the health and development problems thrown up by WTO patent rules.

Oxfam's "Cut the Cost" campaign has helped prove that companies, politicians, and officials do listen when enough people express their concern. Those people, who took time to sign the petition, or to write to GSK, have achieved real change - both in the rules that govern patents and in the attitudes of companies.

Implausible denial:

Why the drug giants' arguments on patents don't stack up

Oxfam's Cut the Cost Campaign was launched in February 2001. It is a response to the global health crisis where 11 million people die needlessly each year from infectious diseases. The campaign seeks to make more life-saving medicines available to poor people in developing countries. While there are many factors involved, our campaign focuses on the need to change the WTO patent rules, and the strategies of the pharmaceutical giants, both of which combine to put life-saving medicines beyond the reach of the poor. In response to Oxfam's basic demand that patent protection should take into account national economic and health circumstances, a number of counter arguments have been put forward by the major pharmaceutical companies, including:

- The advantages to the industry of enforcing a global and uniform system of patent rights.
- The risk that any diminution of the minimum 20-year patent terms imposed under the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPs) would undermine incentives for research and development (R&D), to the detriment of developing countries.
- The claim that the industry is already – via Public Private Partnerships (P3s) and voluntary donation schemes - doing what it can to address the public health needs of developing countries.

This paper sets out these core arguments and explains why Oxfam believes they are, at best, unconvincing.

Argument 1:

Given that the pharmaceutical industry operates in a global market, a uniform global patent system and pricing policy are needed to protect the value of companies' intellectual property world-wide. Without a uniform patent system providing 20 year protection, the industry would lack incentives for undertaking research into major diseases.

Oxfam's view: Patents do play an important role in generating incentives for R&D. However, the super-profits which patents generate are concentrated in industrialised countries, which have a greater capacity to absorb the higher prices associated with patenting. Developing country economies are too small and purchasing power too limited to absorb higher prices. Applying stringent patent protection in developing countries will not generate more revenue for companies, but it will significantly limit poor peoples' access to vital medicines.

The pharmaceutical industry is amongst the most profitable in the world. The United States dominates the global pharmaceutical market, alone accounting for 40 percent of sales in the world's top ten markets. Developed countries as a whole – North America, Europe and Japan – account for roughly 80 percent of global sales. The incentives provided by these markets have led leading pharmaceutical companies consistently to enjoy above-average price/earnings ratios, reflecting the perception of investors that they will continue to deliver above-average earnings and dividends growth.

The incentives offered by developing countries, on the other hand, are extremely limited, because of the small market potential they offer – the whole of Sub Saharan Africa, for example, accounts for under $1 billion US (of a $343 billion US industry) in annual global sales, and South Asia little more. The application of more stringent patent protection will not increase the capacity of governments or individuals – who buy 80 percent of medicines from their own pockets – in developing countries to buy medicines and thus increase incentives.

Argument 2:

Strong patent protection will not damage public health in developing countries if it is accompanied by P3s that provide heavily discounted and/or donated drugs, and if the industry develops 'tiered pricing' policies.

Oxfam's view: P3s may be part of the solution, but are inadequate in isolation. They are ad hoc and reversible, frequently conditional, and provide no guarantee that the best attainable prices are achieved.

Public Private Partnerships may be useful…

P3s, in which companies participate in efforts to increase access to medicines, have an important contribution to make. P3s have played a striking role in preventative health – most notably in vaccinations – but should not be seen as an alternative to efforts by governments to adopt systematic policies on pricing and patenting, and to reform international patent rules, particularly with a view to promoting market-based solutions to affordability through generic competition.

…but can have significant weaknesses…

P3s often bear little relation to the scale of the problem they are set up to address. Despite considerable publicity surrounding it, even the co-ordinated efforts of the five companies participating in the UNAIDS Accelerating Access Initiative fail to offer solutions that are commensurate with the problem. For example, in Uganda it is estimated that the program will reach between 20,000 and 50,000 people at best, while the number of HIV positive Ugandans is 1.4 million. There is also a danger that in concentrating on negotiating private initiatives, public health bodies – both national and multilateral – fail to evaluate whether such initiatives are in fact a sustainable alternative to generic competition in bringing down and sustaining low prices.

…and are not an alternative to systematic cheap medicine policies…

Despite significant and ever-growing company offers of substantial price cuts, such offers are an ad hoc disease-specific approach to the problem rather than a systematic solution to the issue of price. Oxfam is concerned that they leave developing countries reliant on the charity of companies, that they are reversible and their scope is under the control of the companies, which is a particular concern if the main motivation is merely PR management of a topical media issue.

As evidenced by the recent price cuts offered by the Indian firm Cipla on generic HIV/AIDS drugs which undercut multinational companies' offers, and Merck's further price cuts in the face of global campaigning, P3s such as the Accelerating Access Initiative provide no guarantee that prices will be set at or below generic levels. Unless companies are more transparent in their costing and pricing, their claims that they are selling at or below cost cannot be corroborated.

Argument 3:

Differing periods of patent protection or substantial price cuts in poor countries would result in rich countries' pharmaceutical markets being flooded with cheap generics or parallel imports, seriously undermining the industry's profitability.

Oxfam's view:
The risk of low-price generics or parallel imports of patented products leaking from developing to developed countries is overstated (indeed, the US market has been able to sustain substantially higher prices than most countries around the world, including its immediate neighbours Mexico and Canada). Given that these threats appear in practice to be manageable, it is perfectly possible to have a differentiated patent regime and/or pricing policies tailored to the differing health and economic circumstances of individual countries.

The evidence shows that parallel importing is in practice manageable…

Existing restrictions on parallel importing – the importation into a more expensive market of a branded product from a market in which it is sold more cheaply - allow prices of patent-protected products to vary substantially amongst developed countries. In the US, for example, (according to a November 1999 *USA Today* investigation), prices of the top 10 best-selling drugs were around 40% higher than in Canada and around 20% higher than in the UK, a situation which can persist because of the US prohibition on parallel importing (other than for personal use). It would obviously be even more difficult to import products into the US from countries that are further afield. In the European Union, parallel importing is permitted, but only from other member states (and therefore not from developing countries).

With ingenuity – e.g. distinctive labelling, perhaps modifying the appearance of the product, careful monitoring of distribution, vigorous customs enforcement etc – it is clear that leakage of low-price products back from developing countries to high-price developed markets could be minimised. Indeed, the fact that a number of global pharmaceutical companies already offer significant discounts on HIV/AIDS medicines in Africa clearly implies that they believe it possible to manage the threat of parallel imports back into Europe or the US. This is particularly true given that discounted medicines are distributed to the public health system and not to private traders. Contraceptive medicines have for some time been sold at significantly lower prices in developing than developed countries, without major re-export to industrialised markets.

…and patent terms do not need to be the same everywhere (or enforced uniformly)

A valid patent in one country rules out the importation of generics into that market. Historically it has been possible to operate a system in which countries balance IP protection and social and economic needs of their citizens without undermining patent protection regimes in other markets. Generic medicines produced, for example in India, are unable to enter markets in which patented versions of the same product are available. However, there is nothing to stop a company acting responsibly by issuing a voluntary license or waiving patent protection, as shown by the recent decision by Bristol-Myers Squibb to waive patent rights on the HIV/AIDS drug Zerit in South Africa.

Furthermore, prior to TRIPs many countries (e.g. India) provided only for process patents thus allowing local manufacturers to develop equivalents using alternative processes. This system did not significantly deter innovation into new medicines for northern markets, and offered a means for governments in poor countries to provide cheaper medicines and support local firms.

Given the role that generic competition plays in public health in developing countries and the need for patent reward to be commensurate with the social benefits it provides, Oxfam sees no convincing reason in practice for patent terms to be the same everywhere.

Argument 4:

Without effective patent protection there would be no research and development (R&D) into 'Third World' diseases.

Oxfam's view:
There is chronic under-resourcing of R&D into tropical diseases due to the limited market potential offered by the poor countries in which these diseases are most prevalent. Strong patent protection will not materially increase either the market potential in these disease areas, or the incentive for R&D (as it is profits, not patents per se, which are the incentive for R&D). There are better ways of ensuring the necessary R&D. Meanwhile, strong patent protection in rich countries is enough incentive to

yield results on medicines common to rich and poor countries.

Very little R&D is spent on diseases of developing countries…

According to the latest figures from the WHO, only 0.2% of all health-related research is spent on acute respiratory infections (such as pneumonia), diarrhoea and tuberculosis – ailments which account for 18% of the global disease burden. Some analysts argue that research into drug resistant tuberculosis, for example, is ten years away from bearing fruit, because of the concentration of the disease in poor countries. Malaria, which accounts for 3% of the global disease burden – 10% in Sub-Saharan Africa – accounts for only about 0.1% of research funds. Most of the estimated $26 billion US spent on R&D by US firms in 2000, by contrast, was directed at products for 'rich country diseases' - cancer and diseases of the cardiovascular, central nervous, endocrine and metabolic systems.

…because the potential market is simply not big enough…

The lack of R&D into diseases of poverty is a function of the limited market potential offered by the people and countries in which these diseases are most prevalent. In 2000, for example, Latin America – often heralded as offering important markets – accounted for only 4% of total global pharmaceutical sales and Sub-Saharan Africa probably well under 1%. In 1997 per capita sales for pharmaceutical products in the UK was $233 US per person, for the US it was $319 US. In Bangladesh per capita total health expenditure – including staffing and infrastructure, as well as drugs – was $13 US per person. The figure for Uganda was $14 US. Statistics for Sub-Saharan Africa clearly illustrate the problem. The combined GNP of the 20 biggest Sub-Saharan African economies was $271 billion US in 1999 ($577 US per head), compared with $1,338 billion US ($22,640 US per head) in the UK, which itself accounts for just 4% of the world pharmaceutical market. According to the 2000 World Health Report, in most of these 20 countries total health expenditure is less than 5% of national income. Even if all 20 of them spent 10% of their GNP on health and 20% of that on pharmaceuticals, the market would still be less than 2% of the world total, and a breakthrough drug with the potential to capture 5% of the entire Sub-Saharan African drugs market would produce sales of just $270 million US per year. By contrast, Viagra - Pfizer's drug for erectile dysfunction - had worldwide sales last year of $1.3 billion US. In fact, Pfizer had eight products with sales of more than $1 billion US, including three with sales of more than $3 billion US and one – the cholesterol reducing agent Lipitor – with sales of more than $5 billion US.

…and stronger patent protection would not materially change the picture because it is profits, not patents per se, which are the incentive for R&D…

Patents create the ability to charge high prices for drugs, but sustaining the high price of medicines does not create or enhance the capacity of people – or their governments – to buy them.

...nor would extending patent protection to developing country governments do much to stimulate local R&D and innovation

When it comes to pharmaceutical products developing countries tend to be net importers of technology as most lack the industrial or research base to take advantage of patent protection. For these countries the main constraint on innovation is low levels of development. The TRIPs agreement will restrict the scope such countries have for copying and technology transfer, while simultaneously raising the cost of protected technologies and products owned by others.

There are other ways of ensuring the necessary R&D, though…

Significant innovation such as the Green Revolution, the Human Genome project and the Internet, have been premised on public funding, co-operation and information-sharing rather than patenting, illustrating that there may be more subtle and effective ways of securing R&D into tropical diseases. These include substantially increased publicly funded research. Incentives to the private sector could include targeted tax relief in developed countries for R&D into tropical diseases; differential tax treatment of profits on sales made in different parts of the world; and purchase funds that guarantee an eventual market or prize funds for cures for particular diseases. Medicines developed with significant public funding should go onto the market with limited, if any, patent protection to ensure that returns to companies are not excessive, thereby maximising the benefits to the poor.

…and strong patent protection in rich countries is a sufficient incentive for R&D into diseases that occur in developed and developing countries, such as HIV/AIDS…

Patents in developed countries are a sufficient incentive for R&D into drugs for diseases which are common to developing and developed countries. The absence of blanket, global intellectual property protection such as that now offered under TRIPs did not prevent the development of numerous anti-retrovirals, antibiotics, cancer drugs etc.

…and, anyway, the problem for many people is not that the medicines do not exist, but that they are too expensive

For millions of people per year in developing countries, the problem is not that drugs to save their lives do not exist, but that they cannot afford them. Public health improvements could be made in certain therapy areas even if nothing more was ever spent on R&D, although treatment for drug resistant strains of diseases are needed.

Argument 5:

Companies, like individuals, have the right to protect their property – including intellectual property – against theft, which is why they are seeking protection through the WTO.

Oxfam's view:
Governments have to balance different and sometimes competing rights of citizens. Attempts by governments to defend the right to health care by flexible patent enforcement are under threat by company bullying, even when such flexibility is apparently consistent with the TRIPs agreement. Companies should respect the spirit and letter of the legal limitations on their patent rights. Where they fail to do so, and insist on a rigid approach to patent enforcement at the expense of poor people's health, they are discovering that they risk public condemnation.

A patent is a contract between governments and private actors through which the government agrees to intervene in the market to allow patent-holders to keep prices artificially high, thereby generating profit margins high enough to act as an incentive for future R&D and to reward the risks involved in investment. For governments to award such rights they should strike a balance between social benefits the product offers and the need for incentives. Patents should be defined by what national laws and international agreements say, rather than by what multinational companies would like. Developing country governments are right to carefully assess the scope and duration of the patent protection they offer in order to ensure that the costs do not outweigh the benefits. The "right" to intellectual property has to be balanced – and particularly in developing countries with acute health needs – with the obligations held by governments to meet other rights of their citizens – such as those to health and education. In the case of diseases such as

HIV/AIDS where medicines prolong lives, the right to life must surely trump the right to intellectual property.

Under TRIPs, patent laws can contain public health safeguards such as compulsory licensing provisions. Companies must respect these and abstain from manoeuvres – such as taking legal action or advocating trade sanctions – aimed at frustrating efforts by governments such as those of Brazil and South Africa to make use of such safeguards.

Furthermore, although patents confer on companies the right to enforce market exclusivity, they do not impose on them the obligation to do so. A responsible management will take account of all relevant factors – immediate profit implications, damage to its reputation, risk of consumer boycotts and government displeasure etc. – in deciding how vigorously to enforce intellectual property rights in any given situation.

Argument 6:

The global pharmaceutical industry is not a charity and it's not a national health service. As in any industry, profits and returns to investment in research and development matter. It takes $500 million US to bring a new drug to market, and the rewards for innovation have to be sufficient to justify the risks involved. A 20-year patent term is justified by the cost and risk associated with R&D into new drugs.

Oxfam's view:
Oxfam fully accepts the need for profits and returns to investment in R&D. We believe, however, that the industry is not as risky – and R&D not as costly – as is often claimed. The industry's claim that it costs $500 million US to bring a new drug to market is misleading, and the significant contribution of public funding is often glossed over. In addition, Oxfam recognises as legitimate the question raised by many government and public health groups as to whether the full 20 years of patent protection is necessary, even in rich markets, especially given the significant decline in average drug development times from which the industry has benefited in recent years. Oxfam's position is that patents are important, but it is not very important for patents to be long, and not at all important for patents to be long everywhere.

The industry is not as risky as claimed:
Despite claims that the industry is particularly risky, examples of significant drug companies facing financial difficulties are extremely rare. The pharmaceutical industry is, in fact, amongst the most profitable in the world. Leading pharmaceutical companies consistently enjoy above-average price/earnings ratios, reflecting the perception of investors that they will continue to deliver above-average earnings and dividends growth. Drug companies do spend heavily on R&D, but they typically spend twice as much on sales and marketing, and production costs are so low relative to the prices they charge that profit margins of 25 to 30% are typical. In 2000, Pfizer's production costs were 17% of sales, R&D 15%, and selling and other costs 39%, leaving a profit margin of 30%. GlaxoSmithKline's production costs were 21% of sales, R&D 14%, other costs 37%, and the profit margin 28%.

Headline 'cost per new drug' figures can be misleading:
Most frequently-cited figures for the average cost of discovering and bringing to the market a new drug – e.g., the $500 million US estimate used by the industry's US lobbying organisation PhRMA – are essentially tweaked and updated versions of DiMasi et al's 1991 estimate of $231 million US at 1987 prices. The following are good reasons to treat such high figures with caution:

- Definitions of 'R&D' and 'new drug.' Significant amounts of R&D are typically incurred in conducting trials which are not necessary for regulatory approval, but which are aimed at bolstering a product's marketing claims. And most studies look only at the number of 'new entities' launched (i.e., drugs

with a new active ingredient) and ignore the much larger number of approvals for new formulations, combinations etc. In both cases, the effect is to inflate the 'R&D cost per new drug.'

- High discount rate. Virtually all studies inflate R&D expenditure to reflect the time between the money being spent and the product being launched. Discount rates used, however, to capitalise R&D in this way typically reflect not just price inflation or interest forgone between the time the money is spent and the date a product is launched, but also the 'opportunity cost' of the expenditure (i.e., what the money might have earned had it been productively invested elsewhere). The result is – via compounding – very substantially to inflate the 'cost per new drug.' The DiMasi study used a 9% real annual discount rate, with the result that the opportunity cost component was more than half of the final $231 million US figure. Other studies have used discount rates of up to 14%.
- Dangers of extrapolation. The R&D cost per drug will be very sensitive to small changes in development and approval times and to success rates in R&D. Extrapolating from historic data risks substantially overestimating likely future costs. In particular, development and approval times have fallen significantly in recent years (e.g., since the early 1990s, average US clinical development times have fallen by more than two years and approval times by 18 months). Moreover, many industry experts expect new technologies (notably genomics) to cut substantially the R&D failure rate. Lehman Brothers, for example, has postulated a fall of more than 25% in the cost per new drug between 1996 and 2005.
- Tax-deductibility of R&D. The headline figures used by PhRMA etc. ignore the tax-deductibility of R&D. Applying a marginal corporation tax rate of, say, 35% to a pre-tax cost figure of $500 million US gives a post-tax cost of $325 million US.

Much R&D is publicly funde

The US National Institutes of Health (NIH) has estimated that in 1995 the contribution of private industry to overall US health R&D was just 52% and the NIH alone accounted for 30%. The private industry percentage has probably fallen since - the NIH's 2000 budget was $17.8 billion US (compared with the US drugs industry's domestic R&D expenditure of $22.4 billion US estimated by PhRMA) and has jumped a further 14% to $20.3 billion US this year.

Some specific examples of the contribution of US public funding of R&D:

- A 1998 investigation by the *Boston Globe* concluded that 45 of 50 top-selling drugs approved in the US between 1992-97 had received government funding at some stage of development.
- A May 2000 report of the Congressional Joint Economic Committee found that seven of the 21 most important drugs introduced in the US between 1965 and 1992 (including tamoxifen, AZT/zidovudine, Taxol, Prozac and Capoten) were developed with the help of federal funds
- The National Cancer Institute (NCI) – one of the institutes of the NIH – has played a significant role in the discovery and development of cancer drugs. Nader & Love ('Federally Funded Pharmaceutical Inventions', 1993) reported that of 37 cancer drugs approved since 1955, 34 had received US government support during development. A later study showed that 50 of 77 cancer drugs on the US market as at January 1, 1996 had been sponsored by the NCI.
- There has also been substantial federal involvement in the development of AIDS drugs. For example, AZT was originally synthesised in 1964 by the Michigan Cancer Foundation under an NCI grant and - although GlaxoSmithKline eventually secured the anti-HIV use patent - the award of this patent was hotly disputed by the NIH, which claimed an involvement in discovering AZT's anti-HIV utility. Videx (ddI) was discovered by the NIH and licensed to BMS. And NIH

involvement – much of it via the National Institute of Allergy and Infectious Diseases (NIAID) - was also important in the development of 3TC, Invirase, Ziagen, Zerit and Viramune, amongst others.

The 20-year patent protection offered under TRIPs is arbitrary and could be reduced without prejudice to R&D. Because of 'discounting', R&D investment decisions depend heavily on projected revenues in the early years after launch….

In making R&D investment decisions a company will compare the present values of estimated future income and expenditure by applying a discount rate. The earlier revenue comes on stream, the more valuable it is in accounting terms. Conversely, the later revenue comes on stream, the less valuable it is, since it is more heavily discounted. In the pharmaceutical industry, R&D costs are relatively immediate and predictable, but revenues lie in the speculative future. The discount rate applied to them to calculate their present value will reflect not just time value but also the risk that the drug candidate fails in R&D or flops on the market. Thus a typical discount rate applied to any proposal to research and develop a drug would be around 25%.

What are the implications of applying such a discount rate in the context of the debate on patents? Firstly, it suggests that, while patent terms must exceed the five years needed for R&D to have any purpose, it is not very important for patents to be as long as 20 years. Estimated revenues in the early years after launch are far more important in R&D allocation decisions than revenues in later years. It follows that cutting patents to 15 years globally (which would get closer to the average level of effective protection offered in the 1980s) would have few adverse effects on R&D decisions, since the discounted value of revenue in the final five years will be small.

For developing countries, the advantage of shorter patent periods is earlier access to inexpensive generic medicines and an earlier fall in the price of branded products as a result of competition. And as argued earlier in this paper, the small size of developing-country markets means that even having little or no patent protection would barely reduce the overall R&D incentive in the case of a global disease. It would, however, greatly reduce the period during which people in poor countries were forced to pay high prices for their medicines.

Conclusion

Oxfam believes a strong and profitable pharmaceutical industry is important to advances in human welfare. But the combination of unfair WTO patent rules and ruthless corporate strategies to maximise profit are contributing to the global health crisis where hundreds of millions of poor people suffer the misery of chronic ill-health and early death.

So far, the counter-arguments of the pharmaceutical giants have been weak. The major companies know they face a serious crisis in their public relations and yet they appear unable to respond currently to the scale of the challenge facing them. Oxfam hopes that soon, one or two companies in the industry will learn from forward-looking companies in other sectors, such as oil, and start to provide leadership towards a profitable but also more responsible business strategy to respond to the global health crisis.

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 1

Rubric

R "The challenges of freedom!" Report/essay

Describe and link the legacies of the past, the impact of the past on the present, and the possibilities for the future.

Category	Level 4	Level 3	Level 2	Level 1
Knowledge/Understanding • General information and ideas • Recognizes present situation	• Provides thorough, specific and accurate info about apartheid in South Africa	• Provides considerable and accurate info about apartheid in South Africa	• Provides some specifics and some accuracy about apartheid in South Africa	• Provides information with limited accuracy about apartheid in South Africa
Thinking/Inquiry • Focused to the challenge of freedom • Analysis presents possibilities for the future	• Reports thoroughly the on the topic • Effectively uses the past and present to form thoughts about the future in South Africa	• Reports focuses on the topic with considerable effectiveness • Uses the past and present to form thoughts about the future in South Africa with considerable effectiveness	• Reports shows some focus the on the topic • Uses the past and present to form thoughts about the future in South Africa with some effectiveness	• Reports focuses on the topic with limited success • Uses the past and present to form thoughts about the future in South Africa with limited effectiveness
Communication • Organization / flow	• Organization and flow produces a clear and highly concise report	• Organization and flow produces a considerably clear and concise report	• Organization and flow produces a somewhat clear and is concise to some extend	• Organization and flow produces report that has limited clarity
Application • Applies to South Africa within the context of Canada and the rest of the world	• Report recognizes South Africa's situation in relation to the rest of the world with a high degree of effectiveness	• Report recognizes South Africa's situation in relation to the rest of the world with a considerable degree of effectiveness	• Report recognizes South Africa's situation in relation to the rest of the world with some degree of effectiveness	• Report recognizes South Africa's situation in relation to the rest of the world with limited effectivness

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 2

Rubric

R "Global summary of HIV/AIDS" — Reflection/discussion questions

Complete BLM 2-8 Global summary of HIV/AIDS

Category	Level 4	Level 3	Level 2	Level 1
Knowledge/Understanding • Answers are complete • Uses info learned from the lesson to in answers	• Provides thorough, specific and accurate info for the calculations and reflections	• Provides considerably specific and accurate info for the calculations and reflections	• Provides some specifics and some accuracy for the calculations and reflections	• Provides limited specifics and accuracy for the calculations and reflections
Thinking/Inquiry • Completes calculations	• Calculations are complete and make conclusions with a high degree of effectiveness	• Calculations are mostly complete and make conclusions with considerable effectiveness	• Calculations are somewhat complete and make conclusions with some effectiveness	• Calculations are often incomplete and make conclusions with limited effectiveness
Communication • Wording and clarity	• Wording for answers is always clear and concise	• Wording for answers is usually clear and concise	• Wording for answers is sometimes clear and concise	• Wording is limited in clarity
Application • Uses results of statistics to compare Canada with South Africa	• Thoroughly compares and draws on similarities between Canada and South Africa	• Compares and draws on similarities between Canada and South Africa with considerable effectiveness	• Compares and draws on similarities between Canada and South Africa with some effectiveness	• Compares and draws on similarities between Canada and South Africa with limited effectiveness

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 3

Rubric

R "A day in the life..."

Story: Describe the daily rituals, chores, contacts, etc. of someone infected or affected with HIV/AIDS. You may consider: a young boy or girl whose parent has just died from AIDS, a health worker who distributes anti-retroviral drugs, a sex trade worker, a parent who works away from home, etc.

OR

Write a letter (parent, child, student, etc.) about "What I want out of life." Consider the impact of HIV/AIDS within the letter.

Category	Level 4	Level 3	Level 2	Level 1
Knowledge/Understanding • General information and ideas	• Provides thorough, specific and accurate info about HIV/AIDS in South Africa	• Provides considerable and accurate info about HIV/AIDS in South Africa	• Provides some specifics and some accuracy about HIV/AIDS in South Africa	• Provides information with limited accuracy about HIV/AIDS in South Africa
Thinking/Inquiry • Connects the various levels (ripple effect) affected by HIV/AIDS	• Story or letter thorough shows the ripple effect of HIV/AIDS	• Story or letter shows the ripple effect of HIV/AIDS with considerable effectiveness	• Story or letter shows the ripple effect of HIV/AIDS with some effectiveness	• Story or letter shows few of the levels of the ripple effect of HIV/AIDS
Communication • Organization / flow • Establishes a character	• Organization and flow produces a clear and highly concise story or letter • The story or letter follows the character through with a high degree of effectiveness	• Organization and flow produces a considerably clear and concise story or letter • The story or letter follows the character through with considerable effectiveness	• Organization and flow produces a story or letter that is somewhat clear • The story or letter follows the character through with some effectiveness	• Organization and flow produces a story or letter with limited clarity • The story or letter follows the character through with limited effectiveness
Application • Recognizes the real life situation of an individual within his/her environment	• Provides thorough and specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides some specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides few specific examples representative of members in South African society infected and/or affected with HIV/AIDS

Common Threads:
From Canada to South Africa
Combatting HIV/AIDS Together

Lesson 4

Rubric

R "Factors driving the HIV/AIDS epidemic"

Write a letter from the view point of a medical professional, social worker or development worker, etc. working with people who are infected or affected by HIV/AIDS. Show how the hierarchy of needs may be compromised. In your letter home to Canada, draw on some comparisons between the situation in Canada and the situation in South Africa.

Category	Level 4	Level 3	Level 2	Level 1
Knowledge/Understanding • General information and ideas	• Provides thorough, specific and accurate info about common situations of people infected and affected by HIV/AIDS	• Provides considerable and accurate info about common situations of people infected and affected by HIV/AIDS	• Provides some specifics and some accuracy about common situations of people infected and affected by HIV/AIDS	• Provides information with limited accuracy about common situations of people infected and affected by HIV/AIDS
Thinking/Inquiry • Connects the hierarchy of needs to those living with HIV/AIDS South Africa and Canada	• Letter thoroughly shows hierarchy of needs of those infected and affected	• Letter shows the hierarchy of needs of those infected and affected with considerable effectiveness	• Letter shows the hierarchy of needs of those infected and affected with some effectiveness	• Letter shows few of the hierarchy of needs of those infected and affected of HIV/AIDS
Communication • Organization / flow • Establishes a perspective (view point)	• Organization and flow produces a clear and highly concise letter • Letter follows the perspective through with a high degree of effectiveness	• Organization and flow produces a considerably clear and concise letter • Letter follows the perspective through with considerable effectiveness	• Organization and flow produces letter that is somewhat clear • Letter follows the perspective through with some effectiveness	• Organization and flow produces letter with limited clarity • Letter follows the perspective through with limited effectiveness
Application • Recognizes the real life situation of an individual within his/her environment	• Provides thorough and specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides some specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides few specific examples representative of members in South African society infected and/or affected with HIV/AIDS

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Lesson 6

Rubric

R Culminating activity – 'Call to action'

Write a letter to the government of Canada (you may choose the political party). Describe the issues about HIV/AIDS and how the government can help make a difference with the situation. Consider what the government has already done and continues to do and what more could be done.
OR
Develop a fundraising proposal to develop in your school. Consider how you would educate your possible contributors about the situation of HIV/AIDS. Also consider what is already being done by the government. Finally, discuss the kind of program to which you would make your contributions.

Category	Level 4	Level 3	Level 2	Level 1
Knowledge/Understanding • General information and ideas	• Provides thorough, specific and accurate info HIV/AIDS in Africa	• Provides considerable and accurate info about HIV/AIDS in Africa	• Provides some specifics and some accuracy about HIV/AIDS in Africa	• Provides information with limited accuracy about HIV/AIDS in Africa
Thinking/Inquiry • Consideration of role of drug companies in dealing with the pandemic	• The assignment conveys the role of the drug companies in dealing with the pandemic with a high degree of effectiveness	• The assignment conveys the role of the drug companies in dealing with the pandemic with considerable effectiveness	• The assignment conveys the role of the drug companies in dealing with the pandemic with some effectiveness	• The assignment conveys the role of the drug companies in dealing with the pandemic with limited effectiveness
Communication • Organization / flow	• Organization and flow produces a clear and highly concise letter or proposal	• Organization and flow produces a considerably clear and concise letter or proposal	• Organization and flow produces letter or proposal that is somewhat clear	• Organization and flow produces letter or proposal with limited clarity
Application • Recognizes the role of individuals and Canadian community in addressing the issue	• Provides thorough and specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides some specific examples representative of members in South African society infected and/or affected with HIV/AIDS	• Provides few specific examples representative of members in South African society infected and/or affected with HIV/AIDS

Glossary

Glossary

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS):
AIDS is a medical diagnosis given by a medical doctor to someone in a more progressed stage of HIV disease. The doctor may give a diagnosis of AIDS when someone is HIV positive and has an opportunistic infection.

ACUTE INFECTION:
An infection causing disease with a sudden onset, severity and (often) short course. As related to HIV infection: Once the virus enters the body, HIV infects a large number of CD4+ T cells and replicates rapidly. During this acute or primary phase of infection, the blood contains many viral particles that spread throughout the body, seeding themselves in various organs, particularly the lymphoid tissues.

AFFECTED COMMUNITY:
This includes HIV-positive people, persons living with AIDS and other individuals, including their families, friends and advocates, directly impacted by HIV infection and its physical, psychological and sociological ramifications.

ANTIVIRAL:
A substance or process that destroys a virus or suppresses its replication.

ANTI-RETROVIRAL DRUGS (ARV):
Medications that are used to treat HIV. These medications prevent the HIV from making new copies of itself, which allows the immune system to get stronger by making more white blood cells.

APARTHEID:
An official policy of racial segregation formerly practiced in the Republic of South Africa, involving political, legal, and economic discrimination against nonwhites. (1948-1991)

ASYMPTOMATIC:
Without symptoms, usually used to describe a person who has a positive reaction to one of several tests for HIV antibodies, but who shows no clinical symptoms of the disease.

AZT:
The first anti-retroviral drug available to treat HIV.

BACTERICIDAL:
Capable of killing bacteria.

BACTERIUM:
A microscopic organism composed of a single cell. Many bacteria can cause disease in humans.

BODY FLUIDS:
Any fluid in the human body, such as blood, urine, saliva, sputum (spit), tears, semen, mother's milk or vaginal secretions. Only blood, semen, mother's milk and vaginal secretions have been linked directly to the transmission of the HIV virus.

CHILD MORTALITY RATE:
The number of children out of 1000 born in a given area who will die before they turn five years old.

CONTAGIOUS DISEASE:
Any infectious disease capable of being transmitted by casual contact from one person to another. Casual contact can be defined as normal day-to-day contact between people at home, school, work, or in the community. HIV is not contagious.

DIAGNOSIS:
The determination of the presence of a specific disease or infection, usually accomplished by evaluating clinical symptoms and laboratory tests.

DISCRIMINATION:
The policy or practice of treating one person or group of people unfairly over another according to factors unrelated to their ability or potential.

END-STAGE DISEASE:
Final period or phase in the course of a disease that leads to a person's death.

EPIDEMIC:
An outbreak of infectious disease affecting a large portion of the population of a region.

EPIDEMIOLOGY:
The branch of medical science that deals with the incidence, distribution and control of a disease in a population.

ETIOLOGY:
The study or theory of the factors that cause disease.

HIV DISEASE:
Symptoms and conditions associated with HIV infection characterized by a gradual deterioration of immune function. During the course of infection, crucial immune cells called CD4+ T cells are disabled and killed, and their numbers progressively decline. CD4+ T cells play a crucial role in the immune response, signaling other cells in the immune system to perform their special functions.

HOST:
A plant or animal harboring another organism.

HYPOTHESIS:
A tentative statement or supposition that may then be tested through research.

IMMUNE DEFICIENCY:
A breakdown or inability of certain parts of the immune system to function, thus making a person susceptible to certain diseases that they would not ordinarily develop.

IMMUNE RESPONSE:
The activity of the immune system against foreign substances.

IMMUNE SYSTEM:
The complex functions of the body that recognize foreign agents or substances, neutralize them and recall the response later when confronted with the same challenge.

IMMUNITY:
A natural or acquired resistance to a specific disease. Immunity may be partial or complete, long lasting or temporary.

IMMUNOSUPPRESSION:
A state of the body in which the immune system is damaged and does not perform its normal functions. Immunosuppression may be induced by drugs or result from certain disease processes, such as HIV infection.

IMMUNOTHERAPY:
Treatment aimed at reconstituting an impaired immune system.

INCIDENCE:
The number of new cases occurring in a given population over a certain period of time.

INCUBATION PERIOD:
The time interval between the initial exposure to infection and appearance of the first symptom or sign of disease.

INFECTION:
The state or condition in which the body (or part of the body) is invaded by an infectious agent (e.g., a bacterium, fungus or virus), which multiplies and produces an injurious effect (active infection).

INFECTIOUS:
Capable of being transmitted by infection, with or without actual contact.

LATENCY:
The period when an organism (i.e., a virus or a bacterium) is in the body and not producing any ill effects.

OPPORTUNISTIC INFECTION:
An illness caused by an organism that usually does not cause disease in a person with a normal immune system. People with advanced HIV infection suffer opportunistic infections of the lungs, brain, eyes and other organs.

PANDEMIC:
A disease prevalent throughout an entire country, continent or the whole world.

PATHOGEN:
Any disease-producing microorganism or material.

SEGREGATION:
The policy or practice of separating people of different races, classes, or ethnic groups, as in schools, housing, and public or commercial facilities, especially as a form of discrimination.

SEXUALLY TRANSMITTED DISEASE (STD):
STDs are infectious diseases spread from person-to-person through direct body contact or contact with infected body fluids. The term is used to describe any disease acquired primarily through sexual contact.

STIGMA:
Marked by shame or disgrace. To characterize or brand as disgraceful or ignominious.

SUSCEPTIBLE:
Vulnerable or predisposed to a disease.

SYMPTOMS:
Any perceptible, subjective change in the body or its functions that indicates disease or phases of disease, as reported by the patient.

TRANSMISSION:
In the context of HIV disease: HIV is spread most commonly by sexual contact with an infected partner. The virus can enter the body through the mucosal lining of the vagina, vulva, penis, rectum or, very rarely, the mouth during sex. The likelihood of transmission is increased by factors that may damage these linings, especially other sexually transmitted diseases that cause ulcers or inflammation.

HIV also is spread through contact with infected blood, most often by the sharing of drug needles or syringes contaminated with minute quantities of blood containing the virus.

Children can contract HIV from their infected mothers either during pregnancy, birth, or via breastfeeding.

Current research indicates that the AIDS virus may be 100 to 1000 times more contagious during the first two months of infection, when routine AIDS tests are unable to tell whether people are infected.

VIRUS:
Organism composed mainly of nucleic acid within a protein coat. They can be seen only with an electron microscope. During the stage of their life cycle when they are free and infectious, viruses do not carry out the usual functions of living cells, such as respiration and growth.

When they enter a living plant, animal or bacterial cell, they make use of the host cell's chemical energy and protein and nucleic acid-synthesizing ability to replicate themselves.

After viral components are made by the infected host cell, virus particles are released and the host cell is often dissolved.

Some viruses do not kill cells but transform them into a cancerous state; some cause illness and then seem to disappear, while remaining latent and later causing another, sometimes much more

severe, form of disease. Viruses, known to cause cancer in animals, are suspected of causing cancer in humans. Viruses also cause measles, mumps, yellow fever, poliomyelitis, influenza and the common cold. Some viral infections can be treated with drugs.

Resources

1. HIV and You – Glossary of HIV/AIDS Related Terms
   http://www.hivpositive.com

2. Legal Definitions
   http://www.legal-definition.com

3. Answers.Com
   http:/www.answers.com

4. Behind The Pandemic
   http://www.usc-canada.org/web-edkit.pdf

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Website resources

Behind the Pandemic - Uncovering the Links Between Social Inequality and the HIV/AIDS Pandemic

www.usc-canada.org/pandemic_en.asp

This kit is organized into three sections designed to increase awareness of HIV as a social and international development issue. It contains instructions for leading activities and background notes for educators. High school students are provided with basic background information on transmission, history and the current state of the global HIV pandemic.

Participation in a simulation will allow students to experience the challenge HIV poses for individuals, communities and nations.

Analysis of case studies explores integrated, positive and innovative approaches to slow the progress of the pandemic and encourages students to get involved in initiatives to respond to the global HIV/AIDS pandemic.

Canadian International Development Agency - CIDA Global Classroom Initiative

www.acdi-cida-gc.ca/index.htm

Comprehensive resource for researching Canadian global initiatives. Teacher Zone and Youth Zone provide school based education resources and activities for use in the classroom, designed to raise student awareness of basic human rights and connect Canadian students to the global community. Students can familiarize themselves with volunteer, internship and employment opportunities in developing countries.

HIV/AIDS in Africa - grades 9 to 12

Global Trek appropriate for grades 3 and 7.

This site also provides other useful links.

Canadian HIV/AIDS Information Centre, Canadian Public Health Association of Canada - Change the World Campaign

www.campaign.cpha.ca/indexe.htm

National, independent and not for profit with international links to public health, CPHA promotes universal and equitable access to the basic conditions necessary to achieve health for all Canadians. The Change The World Campaign targets male and female youth ages 15 to 24. The focus is the promotion of behavioural change with a dual focus of prevention and stigma / discrimination. Free posters and materials in both French and English may be ordered.

Canadian Council for International Co-operation - Make Poverty History

www.makepovertyhistory.ca

This site contains a short commercial starring Sara McLachlan, Bryan Adams and other Canadian celebrities who are calling for more and better aid, trade justice, cancelling the debt and ending child poverty in Canada. The site also provides articles, a photo gallery and an opportunity for students to email the Prime Minister and their MP calling them to action.

UNAIDS - Basic Facts About the HIV/AIDS Epidemic and Its Impact - Questions and Answers

www.unaids.org

From the home page type questions and answers into the simple search box. Select #4 - Questions and answers Basic Facts About the HIV/AIDS Epidemic and Its Impact.

Nelson Mandela Children's Fund Canada

www.mandela-children.ca

The Nelson Mandela Fund Canada is a partner in the OSSTF Common Threads From Canada to South Africa project. The NMF Canada goals are to assist disadvantaged children and youth in South Africa, assist and provide financial aid to children and youth in South Africa and to educate and inform the public about social and economic challenges facing children and youth in South Africa. This site contains the text of Nelson Mandela's, "I am Prepared to Die," statement from the dock at the opening of the defence case in the Rivonia Trial.

The Stephen Lewis Foundation

www.stephenlewisfoundation.org

The threefold purpose of the Stephen Lewis Foundation is to:

- provide care at community level to women who are dying, so that their last days are free from humility and indignity;
- assist orphans and other HIV/AIDS-affected children, in every possible way, from the provision of food to the payment of school fees;
- support associations of people living with HIV/AIDS so that they can educate themselves and share information with the broader community on prevention, treatment, care and the elimination of stigma.

This site contains information on upcoming events, fundraising ideas, a newsletter and the CBC interview with Stephen Lewis.

Teresa Group

www.teresagroup.ca/index.html

The Teresa Group provides practical assistance and emotional support as well as leadership through example, education and innovation. The Teresa Group works in association with the HIV/Aids Comprehensive Care Team at the Toronto Hospital for Sick Children and other community agencies. This website offers links to other Canadian organizations, general HIV/AIDS information for children and families living with HIV/AIDS, games, resources and an excellent "Lets Talk" site.

United Nations Educational Scientific and Cultural Organization (UNESCO) Reducing HIV/AIDS Vulnerability Among Students in the School Setting

www.unesco.org

This manual is designed for those who will be training teachers on how to teach about HIV/AIDS in the classroom. The manual is formatted for flexibility, and trainers are encouraged to omit or modify sections of the material as appropriate for differing social, cultural or religious contexts.

The methods recommended in this manual focus on "life skills" techniques, and learner-centred activities, in which students themselves play an active role. Lecturing is kept to a minimum. The life skills emphasized include not only the aquisition of knowledge of HIV/AIDS and sexually transmitted infections (STIs) but learning to manage personal stress, family issues, drug abuse and other risk factors.

***To access this site from the UNESCO home page type the title into the search engine.**

The Communication Initiative

www.comminit.com/drum_beat.html

Weekly electronic publication exploring initiatives, ideas and trends in communication for development. The Communication Initiative focuses on a variety of topics including HIV/AIDS, children, health, adolescents, girls, and sustainable growth.

Interagency Coalition on AIDS and Development (ICAD)

www.icad-cisd.com

The ICAD's mission is to lessen the spread and impact of HIV/AIDS in resource poor communities and countries by providing leadership and actively contributing to the Canadian and international response. ICAD is a network of 155 Canadian international development non-governmental (NGOs), AIDS service organizations and individuals who are concerned about global HIV/AIDS issues.

Canadian AIDS Society (CAS)

www.cdnaids.ca

Canadian AIDS Society is a national coalition of 123 community based AIDS organizations across Canada, dedicated to strengthening the response to HIV/AIDS across all sectors of society and to enriching the lives of people and communities living with HIV/AIDS.

CAS seeks to accomplish their mission through promoting education and awareness, mobilizing communities, advocating at the federal public policy level and providing information and resources.

United Nations Development Fund for Women (UNIFEM)

www.genderandaids.org

Unifem, with support from UNAIDS is a comprehensive gender and HIV/AIDS portal that provides up to date resources on the gender dimensions of the HIV/AIDS epidemic. The site aims to promote understanding, knowledge sharing and action on HIV/AIDS as a gender and human rights issue.

Eldis Gateway to Development Information

www.eldis.org

This comprehensive site offers comprehensive information on a variety of topics ranging from HIV/AIDS to trade policy, the World Bank and the International Monetary Fund (IMF). Eldis supports the documentation, exchange and use of evidence-based development knowledge and communicates this knowledge effectively through a range of services using the internet as the medium for delivery.

Eldis offers quick access to major websites related to subject type.

Canadian AIDS Treatment Information Exchange (CATIE)

www.catie.ca

CATIE provides treatment information not only for people living with the virus but also for their families, care providers, AIDS Service Organizations and Health Care Intermediaries. It does so through a comprehensive website, three electronic mailing lists, various print publications and a bilingual, toll-free phone service.

By providing the latest and most complete information available, CATIE staff enable people with HIV/AIDS to become actively involved in developing strategies to optimize their health care. The slogan Making a Difference Through Information is a credo we live by.

Education International

www.ei-ie.org/aids/en/index.htm

Teacher Unions in South Africa have launched an innovative programme seeking to save teachers' lives through peer education, HIV testing and counselling, plus antiretroviral (ARV) treatment for those who need it.

The pilot project, "Prevention, Care and Treatment Access for South African Educators," (PCTA) will train 7,500 peer educators and provide ARV treatment to 2,300 teachers and their spouses in Eastern Cape, Kwa-Zulu Natal and Mpumalanga provinces.

UNICEF – Unite for Children. Unite Against AIDS

www.unicef.org/uniteforchildren

UNITE FOR CHILDREN – UNITE AGAINST AIDS is a global Campaign to alert the world to the fact that children are missing from the global AIDS agenda. It provides a platform for urgent and sustained programs, advocacy and fundraising to limit the impact of HIV/AIDS on children and help halt the spread of the disease. Policymakers and the global public must become aware that AIDS not only affect adults, but is having a devastating affect on children throughout the world.

Convened by UNICEF, the campaign will provide a child-focused framework for country-level programs around four urgent imperatives that can make a real difference in the lives and life chances of children affected by HIV/AIDS. The “Four Ps” are:

- Prevent mother-to-child HIV transmission
- Provide paediatric treatment
- Prevent infection among adolescents and young people
- Protect and support children affected by HIV/AIDS

AfroAIDSinfo

www.afroaidsinfo.org

Your knowledge hub in the fight against HIV/AIDS - Promoting thought leaders among researchers, health professionals, policy makers, educators and the public. Information on this portal is derived from scientific research with a southern African focus.

Canadian Foundation for AIDS Research (CANFAR)

www.canfar.ca

CANFAR, the Canadian Foundation for AIDS Research, is the national charitable foundation whose goal is to raise awareness in order to generate funds for research into all aspects of HIV infection and AIDS.

CANFAR is the only organization operating in Canada for the sole purpose of privately funding research on AIDS and HIV infection in numerous areas including: fundamental and applied research, education and prevention, psychosocial initiatives, care and community research.

The AIDS Consortium

www.aidsconsortium.org.za

The AIDS Consortium was established by Prof. Edwin Cameron (today a distinguished Judge of the Supreme Court) and other HIV specialists and academics, as a project at the Centre for Applied Legal Studies at the University of the Witwatersrand in 1992. Its objective was to promote a non-discriminatory response to HIV/AIDS epidemic based on people's basic human rights as enshrined in the Constitution. The founding document was the HIV/AIDS Charter, which set out the basic human rights of people living with HIV/AIDS.

South African Democratic Teachers' Union

www.sadtu.org.za

SADTU is a union of organising teachers - irrespective of race, creed, or gender - nationally throughout South Africa. The union believes that teaching – more than any other profession influences who we are and also influences the societies we live in. The union believes that taking up the aims to balance the professional and trades union aspects of members lives is in the long term interests of members and society at large. It ranks amongst the largest unions affiliated to the Congress of South African Trades Unions (COSATU); and is also a member of the Education International, an international trades union coordinating body organising workers in the educational sector with over 23 million members.

Treatment Action Campaign (TAC)

www.tac.org.za

The Treatment Action Campaign (TAC) was launched on 10 December 1998, International Human Rights Day. Its main objective is to campaign for greater access to HIV treatment for all South Africans, by raising public awareness and understanding about issues surrounding the availability, affordability and use of HIV treatments.

XVI International AIDS Conference

www.aids2006.org

AIDS 2006 is the conference for everyone involved in combatting the HIV/AIDS epidemic -- researchers, healthcare workers, civil society, governments, UN organisations, activists, donors, industry, the media, and people living with HIV/AIDS.

As the world's largest, most comprehensive HIV/AIDS conference, AIDS 2006 is an unparalleled opportunity to expand public awareness of HIV/AIDS, share knowledge and learn from others in the field, and chart a course for a stronger, more effective global response to the pandemic.

The Conference theme is Time to Deliver, reminding us of past and present commitments for action on HIV/AIDS and demanding accountability for those promises at every level of the response.

Artists International Direct Support

www.artistsandkidsforaids.com

Twenty-five artists from around the world agreed to participate in the creation of the International Portfolio and have donated one hundred hand-made limited edition prints to the project. Once received by the organization, the production and creation of portfolio sets began. This portfolio was not only to raise funds for the children affected by HIV/AIDS, but also to raise the awareness of the pandemic through exhibitions and sales of the portfolios.

Common Threads

www.commonthreads.ca

Common Threads is the name of the OSSTF International Solidarity Program. In collaboration with an international partner, the Common Threads team travels overseas and conducts reasearch on a criticlal current topic. Upon returning, the team designs comprehensive "classroom ready" lesson plans in accordance with the Ontario Ministry of Education curriculum. Each project includes a program video, CD-ROM and supporting assessment rubrics. Course expectations are also included in the material, making it easier to select the appropriate courses.

Materials from the first two Common Threads projects can be found on the website.

They are called *Globalization, Sweatshops and the Clothes We Wear* and *From Canada to South Africa: Combatting HIV/AIDS together*.