Addressing the Susceptibility of Youth to HIV Infection

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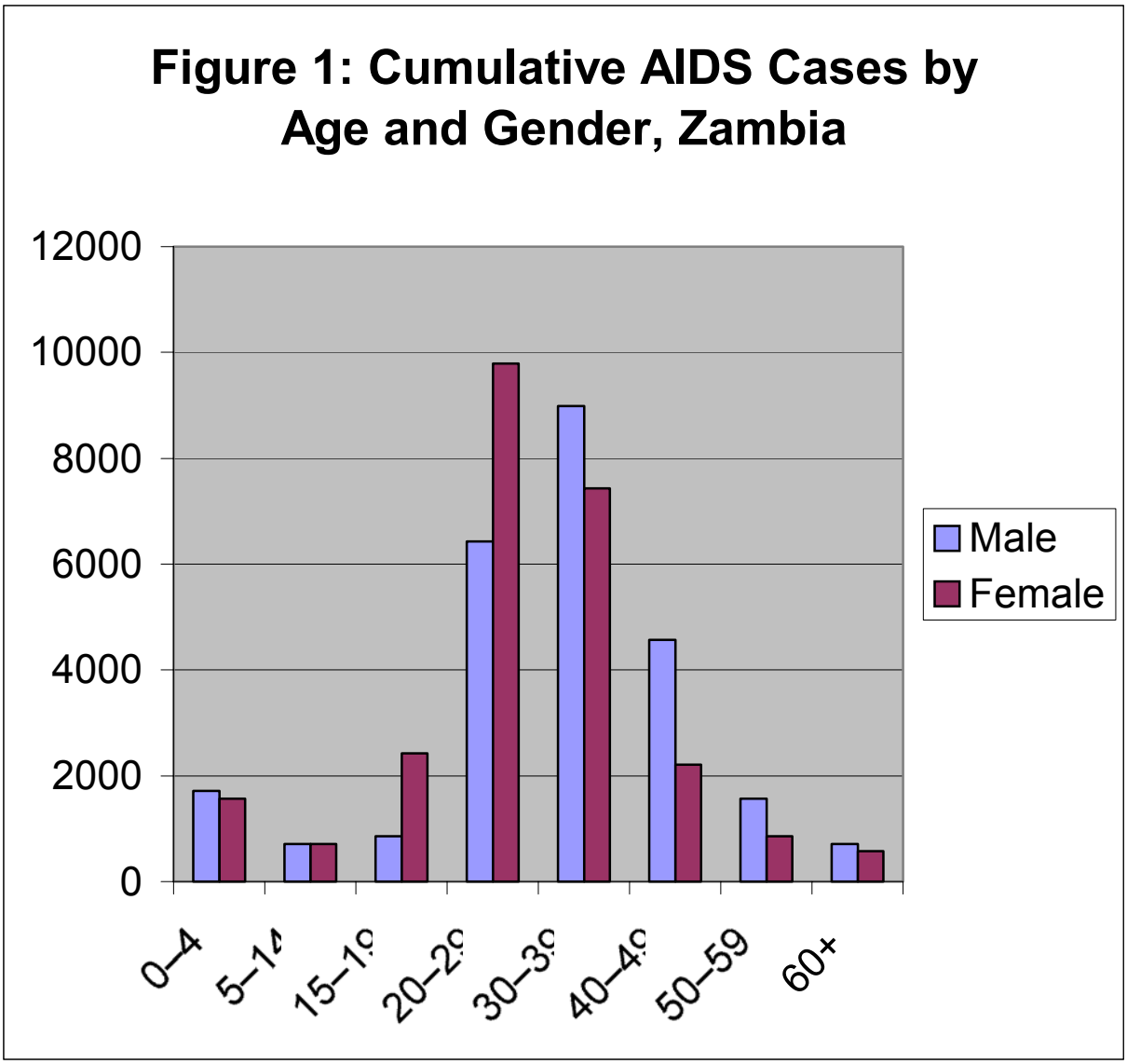
We have a twofold task this afternoon: to deepen our understanding of just how susceptible young people are to the risk of HIV infection, and as we do so to identify actions we could take in our home countries to reduce that susceptibility.

The AIDS Generation

Some months ago, in what amounts to a severe judgement on modern society, a major publication referred to today's young people as "the AIDS generation" (Kiragu, 2001, p.1). The young are people who have never known a world without AIDS. They are people who are themselves extremely susceptible to HIV infection, with a significant number of them having already progressed to full-blown AIDS. With some 12 million young people being infected with the disease, almost one-third of those currently living with HIV/AIDS are aged 15–24 (UNAIDS, 2001a). In some countries it seems possible that more than a third of the 15 year-olds will die of AIDS-related illnesses in the coming years. For countries with high rates of infection the prognosis is even worse. In Zimbabwe, it can be expected that half the 15-year old boys born in 1997 will die of AIDS before they reach the age of 50 (UNAIDS, 2001a, pp. 23–24), while in the absence of treatment 90 percent of Botswana girls and 88 percent of the boys who were aged 15 in the year 2000 are likely to die of the disease. In Zambia, even if HIV risk drops by 50 percent by the year 2015, more than half the boys now aged 15, and approximately the same proportion of girls, will die of AIDS (Kiragu, 2001, p. 56).

Bleak as these statistics are, they do not tell the whole grim story. The susceptibility of young people to HIV infection is characterised by remarkable gender differences. From age 15 onwards, AIDS cases and infection rates rise very steeply for girls. There is also a sharp rise for boys, but the increase is much less than for girls (Figure 1). In very many parts of the world, this leads to HIV prevalence among young women aged 15–24 being several times higher than among males belonging to the same age group. Thus, in India the estimated prevalence rate for 15–24 year-old girls is 0.4 to 0.8 percent, whereas for boys it is 0.1 to 0.6 percent. In Kenya, the infection rate for young women ranges from 11.1 to 15.0 percent and for young men from 4.3 to 8.5 percent. Brazil, on the other hand, shows a different pattern, with prevalence rates for young men (0.6 to 0.8 percent) being higher than those for young women (0.2 to 0.3 percent) (UNAIDS, 2000, Annex 2). The differences that have been observed show the importance of customising responses to the situations within a country or region.



While certain principles may apply across many parts of the world, such as that young females tend to be at greater risk of HIV infection than young males, countries need to be aware of the their own specific situations and take steps accordingly.

A second feature of young people's susceptibility to HIV infection is that a great deal of the infection occurs during the years of schooling or very shortly thereafter. Figure 1 shows the cumulative AIDS cases for Zambia up to the end of 1999. These are cases of full-blown AIDS, a condition that does not develop until several years after the primary infection with HIV. The relatively high levels of AIDS below age 5 are due, for the greater part, to parent-to-child transmission. The majority of children infected in this way will die before their fifth birthday, though a small proportion may survive on into their school years and even into late adolescence and young adulthood. The occurrence of AIDS between ages 5 and 14 is minimal, though it does occur and seems set to become an ever greater problem. Projections from South Africa show that among 5–9 year-olds deaths from AIDS now equal and will soon surpass deaths

from all other causes combined, while in about another decade this will also be the case among 10–14 year-olds (ABT Associates, 2001).

We must also remember that, if AIDS is manifesting itself at an increasing rate among those aged 15–24, the long period that elapses between the initial infection with HIV and the appearance of clinical AIDS means that HIV must have been contracted at a very young age, when the individual was in primary or lower secondary school. This very sombre fact points to the importance of strategies that address the knowledge and behaviour needs of children while they are still young. Waiting until they are older is leaving it too late.

The Silent Epidemic

More than nine-tenths of those who are HIV positive are not aware that they are infected, and the proportion is higher in the most seriously affected countries. This may even be more true of youth than of adults, because of simplistic assumptions about youth being a time of generally good health.

When HIV first enters the human system, flu-like symptoms may manifest themselves for a brief period, but these quickly subside. Thereafter the infected individual looks and feels no different from others, though all the time the immune system is gradually succumbing to the onslaught of the virus. This asymptomatic period accounts for about 80 percent of the time between the initial infection and eventual death from AIDS (World Bank, 1997, p. 19). For the greater part, the disease is invisible at this stage and can be detected only by relatively sophisticated and often unavailable HIV tests. For many years, the young person may be carrying the virus, with the immune system steadily losing its ability to protect the body against a variety of illnesses. Throughout this period there is also capacity to transmit the infection to others, but the infected person is not aware that they constitute such a threat. The potential to transmit infection is highest when viral loads in the blood are high, a condition that occurs on two occasions—in the period shortly after initial infection and in the period when full-blown AIDS has developed. Since new HIV infections are occurring at very high rates among young people, it follows that young people may form a special highly infectious group, with enhanced potential to spread the disease among themselves and to others, without their being aware that they might be doing so.

A second reason why we refer to the silent, invisible epidemic is because of the reaction of society. Fourteen years ago, Jonathan Mann, the esteemed director of the Global Programme on AIDS, said that we were dealing with three epidemics:

1. The silent epidemic of HIV that, for the greater part, is spread by that most basic of human activities, sex.
2. The second epidemic of the illness of AIDS, which is still devastatingly incurable.
3. The third epidemic of the adverse social reaction to persons infected with or affected by the disease (Walrond, 2000, p.59).

While there has been some improvement over the years, the social reaction to HIV/AIDS still tends to be very adverse. Countries deny that they have a problem of AIDS. Communities do not want to hear about the disease in their midst. Families and

individuals go to great lengths to attribute a sickness or death to any cause other than AIDS.

In addition, through an intolerable violation of their basic human rights, persons with AIDS and those in their immediate families frequently experience stigmatisation and discrimination. They are alleged to have brought the problem on themselves through their immoral behaviour and hence are regarded as being culpable and blameworthy. Some have been abandoned by their families. Others have lost jobs. Others are ostracised by communities. Some have even faced physical violence which, in a notorious South African case, eventuated in murder.

Testing and Health Services

Given the silence inherent in the epidemic and the climate of silence, denial and discrimination that society creates, there is little incentive for young people to seek to know their HIV status or to come out into the open about it. They seem to be caught whichever way they turn. They receive little real encouragement to go for counselling and testing. Often these services are not available. Where they are, young people may fear to make use of them, lest they be seen doing so, thereby tacitly admitting that they have some sort of problem. In a related vein, in their anxiety and embarrassment about sex, they are reluctant to present themselves for medical attention when they experience sexually-related problems. They fear they will be proffered judgemental, moralising advice and they cannot be certain that the testing and necessary drugs will be available.

These considerations draw attention to two key components that should be integral to every HIV prevention strategy that targets young people:

1. adequately resourced health services to which young people can have recourse at times and in a manner that they do not perceive as constituting a threat. The services provided, the personnel providing them, and the circumstances under which provision is made should be friendly to young people who may present themselves for attention; and
2. more widely available voluntary testing and counselling services, with great attention to the need for counselling that will provide emotional support to an anxious young person, and for absolute confidentiality, not merely in regard to the test results but also in the circumstances and set-up of the testing facilities.

Both of these are areas where policy-makers, through their interest and action, could contribute to substantial control and reduction of HIV transmission.

Responding to a Dangerous Lack of Knowledge

The physical, psychological and emotional changes that are intrinsic to the development of young people contribute in special and virtually unavoidable ways to their vulnerability to HIV infection. These range from the delicate, thin, easily lacerated membranes in the immature genital tract of a girl, through lack of experience and assurance on the part of both boys and girls, to an almost compulsive urge to experiment, take risks, and show oneself as an adult. It is not easy to address these factors. But other factors that contribute to adolescent and youth vulnerability can be addressed.

One of these is ignorance. Even though most young people allege that they know something about AIDS, many show themselves ignorant in ways that could be lethal for them. For instance, in several countries, including those with high prevalence rates, a significant proportion of youth do not know any way of protecting themselves against HIV/AIDS. This has been found to be the case for 51 percent of girls and 35 percent of boys, aged 15–19, in Tanzania; in Bolivia, the percentages were 33 percent for girls and 26 percent for boys, while in Bangladesh the figures stood at the extraordinarily high level of 96 percent for girls and 88 percent for boys (UNICEF, 2000, p. 6). Another aspect of this potentially fatal lack of knowledge is the large number of young people who believe that HIV infection will show in the appearances. In Vietnam, 50 percent of girls aged 15–19 do not know that a person with HIV may look healthy. In Nepal, 80 percent of girls of this age do not know that a person who looks healthy can be infected with HIV and can transmit it to others. More than half the girls in South Africa and Lesotho, where the prevalence levels are particularly high, are also in danger of being deceived by the healthy appearance of a partner into thinking that he could not be infected with HIV (UNICEF, 2000, p. 7).

This ignorance extends to various areas of sexual activity. In Caribbean countries, where sexual activity begins at a young age, many young people seem to be well informed on HIV transmission, with almost all of them knowing that the virus is spread through sexual intercourse. According to their understanding, however, intercourse refers exclusively to vaginal penetration. They do not know that oral and anal intercourse and any other way of sharing bodily sexual fluids also constitute high-risk activities.[1]

A characteristic feature of youth is a sense of invulnerability, the "it won't happen to me" syndrome. Young people apply this to sexual encounters as readily as they do to fast driving or turning to drugs for stimulation. Outside of Africa, Haiti's HIV prevalence of 5.2 percent is the highest in the world. Yet in Haiti 63 percent of sexually active girls, those aged 15–19, believe that they are not at risk of contracting the disease (UNICEF, 2000, p. 7).

A final area where the knowledge and sexual practices of youth may lead to disaster arises from the trust they show in each other when they enter into a relationship. Establishing a relationship is a wonderful and very beautiful thing. In fact it is so valuable and marvellous that it needs to be safeguarded. A major safeguard is to abstain from sexual intercourse (whatever its form) until marriage, but where this is not done to use a condom or other barrier that will prevent HIV transmission. Frequently, young people are reluctant to follow this latter course of action, feeling it betrays a lack of trust in their partner. And in several instances, they may stop using condoms after some weeks or months of a relationship, protesting that there is no longer any need, that they are faithful to each other. What they often do not know is whether that fidelity is absolute, and also what the sexual history of the partner was before they came together.

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[1] Statement from peer educator, addressing secondary and tertiary level students in Trinidad, March 2002.

These illustrations and situations show that ignorance about HIV risks is very widespread, especially in the early years of sexual activity. Much more needs to be done to ensure that young people are provided with accurate information and to keep them alert to the risks they might encounter. As UNICEF rightly says, "the overwhelming message is that information about AIDS and its deadly danger is not getting out or is not being absorbed" (UNICEF, 2000, p. 6). There is urgent need for sustained information and education campaigns that will put correct information before young people, in a way that will speak to them, and that will help them make these messages their own.

Unfortunately, adult attitudes to providing youth with information are often ambivalent. Many adults do not speak about sexual matters with their children. Many do not want such matters to be discussed in schools. Many believe, quite wrongly, that information and education about sex will lead to sexual experimentation and promote immoral behaviour. They are afraid to let the young people know about sexual matters, but they are quick to react negatively should any mishap, such as HIV infection, occur.

Policy-makers must take the lead in responding to both the information needs of young people and the anxieties expressed by older generations. They must be fearless in promoting information, education and communication campaigns. At the same time, they must remain sensitive to cultural, traditional and religious concerns and ensure that the messages that are propagated accord with the best values from these. In this regard, it should help policy-makers to know that HIV/AIDS information and education programmes do not lead to increased sexual activity. Quite the contrary, they have been found to contribute to delaying the onset of sexual activity, reducing the number of sexual partners, and lessening unwanted pregnancies and STDs (UNAIDS. 1997, p.5).

Capitalising on Peer Influence

Very many young people feel compelled to behave in ways that will be approved by their colleagues and peers. They are very sensitive to the opinions of their peers and are reluctant to deviate from peer norms. This happens as much in the sexual as in other areas of their lives. This heavy influence of peers and of the group has negative and positive aspects. Negatively, some may engage in sexual practices, including those that risk transmitting HIV, because their peers do the same and this seems to be expected of them. Thus, in Kenya, male adolescents whose friends were sexually active were found to be seven times more likely to be sexually active themselves (Kiragu, 2001, p. 22). Positively, significant peers can influence their colleagues to desist from sexual activity or to take the measures needed to protect themselves against HIV transmission.

The strength of peer influence is such that every effort should be made to make full use of it for the purposes of HIV prevention. Education and communication programmes directed towards HIV prevention amongst young people are more likely to succeed if they involve the participation of young people themselves, or of those close to them in age. This participation should embrace two aspects. First, young people themselves should have a large say in the content of what is to be presented.

Nobody knows their needs, aspirations and concerns better than they. Second, they should play an important role in the actual presentation of material. Young people listen to one another and can speak a language that strikes an immediate chord with their age-mates. Involving young people in programme development and presentation recognises the powerful socialising influence that the youth have over each other and seeks to win over to its side the potency of peer pressure. Because the messages are not coming from outsiders but from contemporaries or peers themselves they are more readily assimilated into the peer culture and norms.

Examples of the good that can be achieved in this way come from Uganda and Zambia. In both countries, young people run, write and edit newspapers—"written by young people for young people". With the aim of educating the youth about HIV/AIDS, as well as sexual health and reproductive issues, these publications speak to young people in ways that few teachers or parents could. In both countries also, pro-life "youth alive" organisations reach out to young people to influence positive attitudes and behaviour change, through educating and sharing with their peers on HIV/AIDS and other issues related to health and life. It is significant that the two countries where these initiatives are in full swing, Uganda and Zambia, are also countries that show significant decline in HIV prevalence among those aged 15–19, particularly among girls.

Most countries are rich in their experience of youth activities and initiatives. Many of these are worthy of more support than they currently receive. Many others could also be initiated. What is needed is to challenge young people to play a greater role in the planning, design, implementation, monitoring and evaluation of programmes that will enhance the ability of their peers to adopt sexual behaviour that will protect them from HIV infection. And having challenged them in this way, the action must be followed through by facilitating their access to the necessary resources and, equally important, by giving them their head and allowing them to proceed in ways they think fit.

Addressing the Context in Which HIV Transmission Occurs

More than a century ago, Louis Pasteur, the father of bacteriology, put it that "the microbe is nothing, the terrain is everything".[2] HIV transmission does not depend solely on sexual or drug-using behaviour. As with any other infectious disease, it is also greatly influenced by the 'terrain', the social and economic context. Aspects of that context that are relevant to the susceptibility of youth to HIV infection include gender dimensions, poverty, and the standards that society sets for itself. A comprehensive approach to the prevention of HIV among youth must address each one of these.

Gender Aspects: Evidence from virtually every country shows that in the area of sexual relationships women enjoy less power than men. Decisions about when, where and how to have sex rest more with men than women. A Zambian study confirmed that less than 25 percent of women believe that a married woman can refuse to have sex with her husband, while only 11 percent thought they could ask their husband to

[2] Quoted in Stillwaggon, 2000.

use a condom (Commonwealth Secretariat, June 2001). This subordination of women puts them at considerable HIV risk. Thus, a study by the National AIDS Research Institute in India found that 14 percent of married women in Pune who reported no history of sexual contact outside their marriages tested positive for HIV (Shreedharr, 1995). Even more striking, participants at the International AIDS Conference held in Durban in July 2000 heard delegates from Africa stating that the most risky behaviour an African woman could engage in was to get married.

The unequal relationships that women experience in their marriages are mirrored at an early stage in the unequal relationships that girls experience in sexual encounters. The most obvious aspect of this is seen in what UNAIDS calls age-mixing, young women having sexual relationships with older men (UNAIDS, 2000, p. 48). This very common behaviour pattern is almost tailor-made to spread HIV infection, transmitting it from the older, more sexually experienced man, to the young female who in turn passes it on to her young male sexual partners. In Trinidad and Tobago, nearly 30 percent of teenage girls said that they had sex with older men; as a result, HIV prevalence is five times higher in girls than in teenage boys (Commonwealth Secretariat, June 2001). There is also evidence that fear of HIV is leading older men to seek out young girls as partners, in the belief that they are less likely to be infected. Every such practice puts girls and young women at great risk. The outcomes are seen in the rapid acceleration of infection rates in girls from age 15 onwards, reaching their peak, in some countries, around age 25, whereas the increase among men does not take off to the same extent until around their mid-twenties.

Because of their lower social and economic status, many women and young girls cannot negotiate sexual encounters, experience great need to maintain relationships with a sexual partner, and may be required— by financial circumstances, by their families, or by their partners— to engage in commercial sex activities. Worldwide the outcome is that the proportion of women and girls who have become infected with HIV is increasing and now stands at more than 47 percent.

Other social circumstances, such as domestic abuse, coercive sex, rape, and child abuse also increase the HIV risks of women and young girls. Many countries are concerned about the sexual harassment of schoolgirls by their teachers and of young female employees by their superior officers. Clearly there is need in these areas for vigorous action, for campaigns to discourage older men from seeking out young girls for sex, for the elimination of sex between learners and teachers, and for ensuring that schools and educational institutions are safe environments, physically and sexually, for all learners, but especially for girls and young women.

Addressing gender inequalities is integral to addressing the susceptibility of young people to HIV infection. Programmes and interventions must target two audiences: women and girls on the one hand, in order to provide them with the social, economic and negotiating skills that will empower them to minimise their risk of HIV infection; men and boys on the other hand, so that they become more responsible in their sexual behaviour and learn to “honour their masculinity by actively caring for their partner’s and their children’s health” (UNAIDS, 2001b).

The attention to men and boys is of the greatest importance. In many respects, AIDS is a man's disease, though women bear the brunt of the impacts (and will soon account for more than half of all HIV and AIDS cases). The disease was first observed in men. It has been transmitted worldwide by men. It is being kept going by men. Society finds it convenient to blame female prostitutes for the transmission of the disease, but overlooks the fact that almost every infected prostitute picked up the infection from an HIV positive man. Lenient social, cultural and economic arrangements in society allow men a great deal of sexual licence, and many cultures encourage or even demand high-risk sexual behaviour from boys and young men. Responding to these cultural norms and expectations places many boys and young men at high risk of HIV infection. At times, it also places them in intolerable psychological positions where they feel obliged, against their better judgement, to experiment, take risks, and demean at one and the same time the women they abuse and themselves as abusers. Programmes that address gender inequalities must address these situations also, and seek to replace the false sexually-macho image of manhood with one that can find its expression and fulfilment in a more respecting and caring attitude for young women and girls. They also need to create space where boys and young men can speak about sexuality and the concerns it raises for them, and reveal the insecurity that this area of life occasions for so many of them.

Poverty Aspects: HIV/AIDS is not a disease of the poor, but being poor facilitates the transmission of HIV and its more rapid development into full-blown AIDS. The disease also makes the poor poorer. HIV/AIDS is no different from any other infectious disease in this two-way interaction with poverty. "There is an established literature in public health and a century of clinical practice demonstrating that persons with nutritional deficiencies, with parasitic diseases, whose general health is poor, who have little access to health services, or who are otherwise economically disadvantaged, have greater susceptibility to infectious diseases, whether they are transmitted sexually, by food, water, air, or other means" (Stillwaggon, 2000). Although not formally caused by poverty, HIV/AIDS has rapidly become a disease of poverty, and the indications are that it is likely to become more and more concentrated in the poorer segments of populations (Vandemoortele & Delamonica, 2000).

Job opportunities, livelihoods and recreational outlets are important aspects of the poverty situation for young people. Where job opportunities and prospects for sustainable livelihoods exist, young people feel they have a future to look forward to and protect. Evidence is beginning to emerge of a developing association between lower rates of infection and the economic security that higher levels of education make more readily attainable. Thus in one area of South Africa, infection rates among the employed have been found to be 26 percent lower than among the unemployed (Williams, Campbell, & McPhail, 1999). But where job and livelihood prospects are absent, young people tend to lack hope for the future and see no reason for protecting themselves against a disease that will not affect them with palpable sickness for several years. By that time, many of them aver, they will have died already from hunger and hopelessness: "for some young people, the immediate conditions of daily life are so adverse that they outweigh concerns about contracting HIV/AIDS" (Kiragu, 2001, p.54).

A Zambia youth activist put this simply but forcibly in a presentation to the International AIDS Conference in Durban in July 2000:

> Regarding youth life styles, nearly 70 percent of youth (16–20 years old) are out of school, 70–75 percent are unemployed, 80 percent live in high density compounds and are poor, and there is virtually no "healthy" recreation or entertainment available. Youth live for the moment. They experiment, explore, and seek immediate gratification. They want to make money now and for girls sex is a means for making money. Boys want girls to flock around them, to look appealing to girls, and they want sex. ….Regarding the aspirations of youth in Zambia, many say they have nothing to look forward to and no hope for the future. Education is no guarantee of a good job, money, or a secure future. …. Youth in Zambia do not feel at risk for HIV infection. Unplanned pregnancies are much more worrisome to girls than STDs or HIV, claiming that they could not live with the embarrassment of becoming pregnant, but if they had an STD or HIV no one would know. By and large, youth view STDs as treatable, but, without a positive attitude towards the future, they don't worry about the lack of treatability of HIV (Hachonda, Serlemitsos & Bharath, 2000).

Recent anecdotal evidence from Zambia, where the school enrolment rates have been declining steadily, tells of parents who do not want to send their children to school partly because they do not see the school as leading to any employment prospects, and partly because of AIDS-related fatalism. "Why send children to school," they ask, "when in a few years they will die from this disease? Better to profit from their labour now than to have them wasting their time and our limited resources in school."

In this context, it is notable that in a common action statement for dealing with the HIV/AIDS epidemic in Malawi, the Government and faith communities in that country have expressed their commitment to the integration of vocational training into community youth programmes and also to providing behavioural education along with recreational and sporting activities for youth (Malawi, 2001). The importance of recreational and sport opportunities comes out in a South African report which suggests persons affiliated with churches and sports clubs may be at lower risk of HIV infection (ABT Associates, 2001).

Poverty reduction strategies are the concern of the majority of developing countries today. Job creation and the development of livelihood opportunities are integral to these strategies. They are also integral to the strategies for the prevention of HIV transmission among youth. As was well said by the youth activist from Zambia, unless there is a future to look forward to, young people will not be concerned with staving off HIV infection. That future is intimately connected with employment and livelihood prospects, and its current protection is also connected with recreational provisions and with answers to the difficult question "what are they doing when they are doing nothing?" It is to areas such as these that policy-makers could well turn much of their attention if they wish to take action that will reduce the susceptibility of youth to HIV infection.

The Standards of Society: Young people are not given sufficient help by society in their efforts at HIV prevention. Neither are they given sufficient credit for their efforts. Double standards for sexual and other behaviour prevail for men and women, for old and young. Men and boys tend to have more sexual partners than women and girls. Males are expected to be knowledgeable about sexual matters, whereas females

who show knowledge or interest in sexual issues may be regarded as immoral or promiscuous. Communication on sexual matters for boys and men may consist in little more than boastful accounts of 'conquests', whereas women and girls discuss issues more sensitively and intimately between themselves and within their families. For the greater part, virginity is highly prized in a girl, whereas in some cultures it is viewed with suspicion and concern in a boy.

As they strive to adapt themselves to the gender norms that their culture prescribes for their biological sex, young people experience difficulties with these ambivalent attitudes of society. Their difficulties are increased when they see older people behaving and living in ways they would condemn in the young. Many societies create an almost impossible task for young people, expecting them to behave in certain ways but confronting them with social norms, expectations and role models that point in a very different direction. The models placed incessantly before the young through advertisements, in the media, and through the entertainment industry glorify the physical aspects of sex, but say little about the arduous task of building enduring human relationships that support and are supported by sexual practice. "While young people obtain a great deal of information about reproductive health from entertainment programmes in the mass media, many of these programmes have the effect of promoting attitudes and behaviour and portraying sex in ways that encourage risk-taking" (Kiragu, 2001, p. 36).

In this turbulent environment, many young people often face another difficulty. They do not have the trust or confidence of their elders or society. These think the worst of them and have low or minimal faith in their ability to use their sexuality responsibly or to protect themselves against HIV infection. This comes out very strongly whenever the question of abstinence is raised. Young people feel badly that so many adults seem to think that sexual abstinence is beyond their reach and that youth and abstinence are almost incompatible terms. Because adults do not challenge them more constructively and positively, young people adjust their standards to the lower expectations that are being formulated for them, and so the adult prophecy becomes in many instances self-fulfilling: young people are not abstinent because we older people do not think they can be. One can sense a similar defeatist attitude coming through some reports from UNAIDS.[3]

Young people can do better than we expect of them, but they will not be able to do so unless adult society expresses more faith in them and presents them with higher challenges. It is time that we turned our backs on defeatist attitudes and became more positive, trusting and confident in our approach. Here is an area where policy-makers can give the lead. In doing so, not only will they win youth over to their side, but they will contribute strikingly to turning back the tide of HIV prevention.

Reaching Young People through the Mass Media and Entertainment

Although we have noted that the mass media and entertainment industries may pose some problems for young people in the type of sexual image they may portray, we should also recognise the power of these channels of communication to reach and

[3] This appears strongly on pages 55–57 of the UNAIDS *Report on the Global HIV/AIDS Epidemic, June 2000*

influence large numbers. If properly researched, designed and delivered, media and entertainment presentations can address topical issues in ways that speak very directly to adolescents and young adults. Properly used they can be powerful channels for the communication of correct information and the development of healthy attitudes. In this way they can have a significant role in influencing young people to adopt behaviour patterns that will protect them against HIV infection. A significantly important feature of this approach is its ability to reach large numbers on their own ground, including those who are not participating in any formal educational programme.

A very successful example of this approach comes from South Africa where an NGO called Soul City makes comprehensive use of the mass media in a conscious effort to induce behaviour change. Soul City produces highly respected and thoroughly professional television, radio and print presentations. These focus on a combination of education and entertainment —"edutainment"—through drama, comedy, puppets, song, community theatre, television, radio and magazines. In an effort to reach as many young people as possible, the TV programmes are screened at prime viewing time. In addition to HIV/AIDS, Soul City's messages extend to other social issues, such as violence against women, alcohol and drug abuse, disabilities, and mother and child issues. Independent evaluations have shown that Soul City programmes reach a very wide and diverse audience of young people, that they are succeeding in breaking down the wall of silence that surrounds HIV/AIDS in South Africa, improving information, and promoting greater sexual and social responsibility. A further evaluation, published earlier this year, also reported that the programmes were promoting delay in sexual activity, reduction in the number of sexual partners, and greater willingness to use condoms.

The success of the Soul City programme has led several neighbouring countries to adopt its products in suitably localised forms. A similar venture has been undertaken in Kenya where *Heart and Soul*, a soap opera covering such themes as promiscuity, poverty reduction and human rights, was scheduled to begin radio and television broadcasting as well as street theatre performances earlier this year.

These and similar multimedia campaigns suggest promising areas for consideration by policymakers who are concerned about moving forward the HIV prevention agenda. They are an efficient and effective way of reaching and influencing a large number of young people. One of their strengths is that such a high proportion of young people can have access at least to radio broadcasts. However it should be noted that investigations have shown that these multimedia campaigns do not address successfully every aspect of HIV prevention. But if combined with face-to-face communication, such as peer education in small groups, they can be very effective (Kiragu, 2001, p. 37).

Education

The Importance of the Education Sector

In late April 2002 the World Bank published a new report: *Education and HIV/AIDS. A Window of Hope*. Referring to the document, the Executive Director of UNAIDS, Dr. Peter Piot, wrote: "This welcome new book argues convincingly that we must adopt cross-sectoral strategies for fighting HIV/AIDS, ones that take full advantage of the benefits of education and help to create healthy, cohesive societies".[4]

There are several reasons why the World Bank can quite rightly refer to education as the window of hope in relation to HIV/AIDS:

1. Education, and above all school education, has been shown to work in reducing HIV prevalence rates among young people. Uganda and Zambia have both experienced dramatic declines in the infection rates of the sub-group of 15–19 year-old girls with secondary school education, and in Zambia it has been found that a girl who has dropped out of school is three times more likely to be HIV infected than an age-mate who remained in school (Fylkesnes *et al*., 2001). The precise mechanisms by which education contributes to this change are not yet clearly understood, but they may lie in a combination of enhanced ability to use information, the package of habits and dispositions that learners accumulate throughout their schooldays, the way school education opens one up to future prospects, and the increased opportunities it provides for economic independence (a factor which works against the HIV-facilitating environment of poverty, and more specifically helps in directing young women away from reliance on commercial sex) (Coombe & Kelly, 2001).
2. Currently there is no known cure for HIV or AIDS. Although work on the development of a vaccine is proceeding, none is yet available and the likelihood seems to be that ten years or more will pass before a universally available, affordable and easily applied vaccine comes on to the market. Drugs that hold HIV in abeyance are available, but even with the substantial price reductions that have been effected in the past year, their cost remains very high, their administration requires a well-developed health infrastructure of the kind that several countries do not have, and there are growing concerns about the development of HIV strains that are resistant to the drugs currently in use. In this set of circumstances, the only remaining recourse is education. Every prevention effort, the majority of coping strategies, much of the activity directed towards the mitigation of impacts, and virtually every programme designed to outwit and get ahead of HIV/AIDS, depends on education.
3. Formal school education reaches the majority of young people in a country. Further it reaches them at an early age when they are in their most formative years. Therefore it has the potential to transmit significantly important HIV prevention and other AIDS-related messages to young people when they are in their most receptive developmental stage.
4. School education is among the most powerful tools for transforming the poverty and gender inequality environment in which HIV/AIDS flourishes. It is

[4] *Education and HIV/AIDS. A Window of Hope*. Executive Summary, April 2002 (back cover). Washington, D.C.: World Bank

universally acknowledged that growth out of poverty and growth in education are almost synonymous. Likewise, the education of both boys and girls contributes significantly to the transformation of societies into ones where there is less acceptance of gender inequality and female disempowerment.

5. Girls who remain longer in school tend to commence sexual activity at a later age, are more likely to require male partners to use condoms, and marry at a later age (World Bank, 2002). Each of these factors contributes to the reduction of HIV infection.

Making Education More Potent Against HIV/AIDS

But education, especially school education, can play an even more crucial role in preventing HIV infection. Already it is doing well, but it can do even better. Policymakers who wish to capitalise on the contribution that education can make to reducing the susceptibility of youth to HIV infection should address themselves to the following issues:

Expand access and improve the quality of provision: Education in the sense of schooling can do nothing to reduce the transmission and impact of HIV/AIDS for children who, for whatever reason, are denied access to school. Neither can it promote the knowledge, understanding and attitudes that are fundamental to the reduction of HIV transmission if the quality is so poor that real and meaningful learning achievement does not occur.

Hence the AIDS epidemic underscores the crucial importance of attaining the International Millennium Development Education-For-All (EFA) Goals. These are to ensure (i) that by 2015 every child can access and complete free and compulsory basic education of good quality, and (ii) the elimination by 2005 of gender disparities in primary and secondary education. "(F)ull speed ahead on EFA goals is vital. … (A) general basic education—and not merely instruction on prevention—is among the strongest weapons against the HIV/AIDS epidemic. …(A)n urgent, strategic, and education-centred response … is of the utmost importance" (World Bank, 2002, p. 6).

It is also important to take steps that will enable children, especially girls, continue into the secondary level. What is gained at this level appears to make a crucial difference to the protection of oneself and one's potential partner against HIV infection. Expanded access to secondary education also provides a surer route out of poverty, at both individual and national levels, and through this mechanism provides a surer defence against HIV transmission.

Mainstream HIV/AIDS into every aspect of education: The potential of HIV/AIDS to devastate the lives of individuals, the economies of countries, and education systems themselves, is too great for the disease and its consequences to be merely bolted on as some additional consideration within the programmes of already over-worked education ministries, departments and institutions. This is the most devastating disease that humanity has ever confronted. Responding to it is not an optional extra, but must become an integral and accountable part of concerns and programmes at all levels, from the office of the Minister down to the humblest village school.

Accentuating the importance of this mainstreaming is the fact that HIV/AIDS places the entire education system and every institution under profound threat. An education system that does not mainstream HIV/AIDS into every facet of its operations runs the risk of being overwhelmed by the epidemic and the variety of its impacts. It can become so weakened by the epidemic (through the loss of educators, impairment of quality, numerous negative effects on learners, educators and managers, and constraints on resources) that its ability to provide both general education and HIV/AIDS education could be greatly reduced. In the absence of mainstreaming, the one system that has the potential to provide crucial HIV protection to society could find that it was unable to do so because it was itself besieged by a network of interrelated, institutionally debilitating, and complex AIDS-related problems.

A practical aspect of this mainstreaming is to ensure that education policies, procedures and regulations are reformulated to take account of HIV/AIDS. It will also be necessary to incorporate HIV/AIDS issues into every aspect of an education ministry's strategic planning process. In severely affected countries, mainstreaming HIV/AIDS will also necessitate dedicated structural arrangements, involving full-time staff possessing considerable authority and backed up with adequate human, financial and material resources, that will maintain the momentum for progress in everything that relates to the interaction between the disease and the education sector.

Establish programmes and activities that run along a continuum from prevention to care, within the education sector and all its institutions: At the sectoral level, provision must be made for programmes that respond to the needs of employees. If the system is to function, all categories of education staff must know about the disease and how to protect themselves against it. This calls for programmes that address HIV/AIDS in the workplace. At the institutional level, there is need for specific programmes that teach about HIV/AIDS and such related areas as reproductive health (see below).

Moreover, although our concern today is primarily with reducing the susceptibility of youth to HIV infection, we cannot overlook the dimensions of care and the management and mitigation of impacts. Aspects that are of particular relevance to the education sector include responding to the needs of the exponentially increasing number of orphans, catering for learners, educators and education employees who are HIV infected or whose condition has progressed to AIDS, reaching out to and providing support for infected persons in communities, especially those who are relatives of school personnel, and establishing schools as multipurpose welfare and development centres within affected communities.

Engage creatively with others: In the past the cardinal error was made of treating HIV/AIDS as being primarily a health problem. To treat it as being primarily a problem for education would be to repeat and compound the error. HIV/AIDS is wider than any sector, but touches the entire range of development and human welfare interests. Responding to it likewise demands the widespread participation and interaction of players from various areas of the public sector, as well as the involvement of the numerous organs of civil society. The walls of territoriality that

government ministries create for themselves and that the government sector sometimes uses to effect the marginalisation of NGOs, faith-based communities, community-based organisations, business coalitions, and other partners, must be broken down. It is paramount that in the struggle with HIV/AIDS the education sector manifest the fullest cooperation, sharing of resources and facilities, and collaboration in programme design, implementation and evaluation with these and other potential partners. The problem of AIDS is too large for the sector or any of its partners to deal with on their own. But working together they can succeed in bringing it to heel.

HIV Prevention Education in Schools

Within the context of the provision of a general education of good quality, schools can contribute significantly to HIV prevention by what they teach in the areas of HIV/AIDS, reproductive health, sex education, life skills, and skills-based health education. The future of children and young people is in the hands of schools and educators. In a very generous spirit, these apply themselves industriously to ensuring that their charges learn and understand a wide range of subjects. The AIDS pandemic requires that they extend these subjects to include the many dimensions needed for a response to the disease. Failing this, they will have the disappointment and trauma of seeing much of their hard work going to waste, as learners whom they could have equipped with protective knowledge, skills, and attitudes that would have eventuated in sexually responsible behaviour become HIV infected and eventually succumb to the disease.

Ideally, the content of what is taught in schools should extend to the following areas:

- Sexuality and relationships, leading to a good understanding of what sexuality means, its role in relationships, and the norms for a healthy sexuality.
- Manifesting respect and regard for others in a spirit of equality and power-sharing between girls and boys that extends to all areas of life.
- Knowledge and understanding of HIV/AIDS, the modes of transmission, what infection does within the human body and how it progresses, and popular myths and errors relating to the disease.
- A core set of psycho-social life-skills for the promotion of the health and well-being of learners. These should include decision-making, interpersonal relationships, self-awareness, stress and anxiety management, coping with pressures, how to negotiate contentious situations, assertiveness, and attitudes of self-esteem and self-confidence.
- Knowledge and understanding of how to protect and manage one's reproductive health.
- The role and value of abstinence, the development of positive attitudes towards this, and the skills that enable one to abstain from sexual activity.
- The meaning of protected sex, the role it plays in preventing HIV infection, the skills that are implied, and how to access and use condoms and other supplies.
- The desirability of voluntary counselling and testing, and the importance of early presentation of potential STDs to the appropriate health services.
- The meaning of a healthy lifestyle, its role in making an individual less susceptible to HIV infection, and its role in promoting the quality of life and extending the survival years of an individual who is HIV infected.

It is necessary to make some observations about this comprehensive programme. The ultimate objective is behaviour that will not put an individual or any partner at risk of HIV infection. For many young people, this will involve helping them to maintain behaviour patterns that are already appropriate, whether these involve abstinence or some other method of self-protection. For others, it will involve motivating them to change to behaviour that does not put them at risk of infection and providing them with the attitudes, information and skills that will support them in making this change.

Second, it is necessary to begin at the proper beginning, that is, in an understanding of sexuality and relationships. Educators should not hesitate to affirm that sexuality is a beautiful, good, extremely powerful energy, experienced in every cell of our being as a mighty urge to overcome our incompleteness and to find fulfilment in a strong and abiding relationship with another. Having sex, or genitality, is a very important aspect of this larger reality of sexuality, but it is no more than an aspect. It does not exhaust the full notion of sexuality which can work powerfully and constructively even in the absence of the particularised, physical, short-lived bodily encounter with another that constitutes 'having sex'. In practical terms this means that it would be a mistake to focus on protection messages, whether these relate to abstinence, condom use, delaying sexual debut or whatever, prior to establishing a good understanding of the meaning of sexuality and relationships.

Third, learners should be introduced to this comprehensive package while they are still very young, some would say from the day they commence school. While it may be necessary to begin at a later age for those who are already in the school system, HIV/AIDS-related forms of education should start as early as possible with younger children, and certainly well before they enter the period of puberty. But whatever is presented to children must be appropriate to their age and grade. It would be foolhardy and counterproductive to expose young children to matters that were beyond their comprehension and experience.

A further issue is the need to remain sensitive to traditional, cultural and religious values. The concerns of parents should also be taken into account. As stated already, the overwhelming weight of evidence is that this form of education does not lead to increased sexual activity, but on the contrary can lead to later and less sex. But parents, and many educators themselves, need to be convinced of that.

Finally, the importance of emphasising a healthy life-style should be noted. Conditions of poverty facilitate HIV transmission partly because the body's defence mechanisms are already run down through malnutrition, the legacy of other illnesses, a heavy burden of parasites (especially from malaria), and vitamin and trace element deficiency. When HIV succeeds in gaining admission to such an impoverished body its task is greatly facilitated because the defence system is already low. The individual can become infected in circumstances where a better nourished and healthier individual would be able to ward off the infection. Maintaining a healthy life-style is in itself a substantial step in the direction of preventing HIV infection. It is also a significant step in the direction of slowing down the progression of HIV to clinical AIDS. All other things being equal, infected persons who maintain a healthy life style

are likely to enjoy more years of life than infected persons who do not take balanced nourishing meals, who smoke, take alcohol or use drugs, and who do not take adequate exercise and rest. This is an important message that educators can always communicate, without fear of giving any offence to parents. It could also be a life-saving message, since it might contribute to keeping an infected person alive until a vaccine applicable to infected persons becomes available.

The Tasks of the Policymaker in Education's Fight with HIV/AIDS

The tasks that confront policymakers in relation to harnessing the potential of education for reducing HIV infection among the young can be summarised as follows:

1. Ensure that the education sector is on track to meet the globally agreed Education-For-All goals.
2. Promote every initiative that seeks to extend educational opportunities for girls.
3. Advocate strongly for the mainstreaming of HIV/AIDS within the education sector, so that the sector can continue to function in a society with AIDS and so that it may respond creatively to the AIDS-related needs of that society, and monitor that all this is being done.
4. Support initiatives from within the education sector for a broad, holistic approach to HIV/AIDS education for all learners, and show this support concretely by advocacy and facilitation of the funding that this implies in terms of training educators, developing and producing materials, and evaluating progress.
5. Advocate for and promote constructive engagement between education ministries and civil society in the jointly conceived and executed development of the education sector and enhancement of its role in preventing HIV, providing care and support for those infected or affected, and managing the impacts of the disease.
6. Mobilise resources for the holistic development of the education sector in general and for its HIV/AIDS directed activities in particular.

Strategies for Reducing the Susceptibility of Youth to HIV Infection

The pages above have outlined a number of strategies that would contribute to reducing the susceptibility of young people to HIV infection. In the order of appearance these were:

1. The development of more universally available and more youth friendly HIV testing and health services.
2. The promotion of information, education and communication campaigns that will respond to the needs of youth for better, accurate and more comprehensive information.
3. The greater involvement of young people in programmes directed towards HIV/AIDS information, understanding and protection.
4. Unremitting attention to changing the contextual factors that facilitate the transmission of HIV, with specific attention to (i) promoting gender equity and female empowerment, but without overlooking the paramount role that men

and boys must play in the combat with HIV/AIDS, (ii) poverty reduction, above all through the creation of employment opportunities for youth and the provision of recreational facilities, and (iii) being more forthright in challenging certain norms and practices in society and in presenting high ideals to youth.

5. Providing extensive support for efforts to bring HIV/AIDS messages to young people through the mass media and entertainment industries.
6. Harnessing the potential of the education sector to prevent HIV infection among the young.

Three final points need to be made. The first is the need for everybody to speak with one voice. The sexual transmission of HIV occurs through behaviour that takes place in very private circumstances. It is also behaviour that gives physical expression to what is probably the deepest and most powerful of human instincts. Advocacy to modify, shape or change that behaviour may be effective if the content of the messages is consistently the same, but is likely to be ignored if conflicting messages are received. If one group advocates condom use while another group decries this as immoral, or if one group advocates abstinence while another group denigrates this as impossible, the effect will be to leave individuals not knowing what they should do. And in such circumstances they will continue to practice in the way they always did. On the other hand, Senegal and Uganda agreed to sink differences. This they did by approving a common menu of approaches from which every group could choose whatever best fitted in with its philosophy and ideology, and agreeing to stay silent about approaches that caused some offence. This allowed government, civil society, traditional leaders, and faith organisations to convey non-conflicting messages. In several counties people have become so confused about AIDS, where it originated, what causes it, how it can be prevented, that they have ceased to hear the messages that are being conveyed. They are crying out in their suffering for clarity and unanimity from their leaders. Policymakers and all those in leadership roles have a bounden duty to ensure that they are answered appropriately.

The second point is the importance of advocacy at all levels. “The critical factor for a renewed and effective strategy for preventive education is the massive, unfailing and unrelenting support of political authorities at the highest national level” (UNESCO, 2001, p.12). Lower levels will direct their advocacy efforts to the policymaker. The policymaker, especially if elected, must direct advocacy efforts to the general public as well as to lower level administrators and implementers. There is need to keep HIV/AIDS always on the agenda and indeed close to the top of the agenda. There is need to maintain a focus on youth. There is need to deny entry to AIDS fatigue. There is need for complete transparency about the extent of the disease in society, with no denial, no attempt to tone down disturbing statistics. There is need to proclaim progress and successes. There is need to reach out in understanding and sympathy to severely affected communities, families and individuals. There is need to encourage people to be open about their HIV status and to encourage the dynamic participation of people living with HIV/AIDS in every effort at prevention, care and impact management. Advocacy at all times and on every occasion is crucial in the struggle with HIV/AIDS.

The final point is the crucial importance of leadership. The theme of the Africa Development Forum held in Addis Ababa in December 2000 was "AIDS: The Greatest Leadership Challenge." The Forum recognized that responding to HIV/AIDS requires even more commitment, vision and leadership than fighting a war of independence. The examples of Thailand, Senegal and Uganda show the potential of committed national leadership for rolling back the AIDS epidemic. That leadership function is not concentrated solely in the Head of State but is widely diffused throughout government and society. It is shared extensively by the policymakers who have been elected by the people. It is the responsibility of these policymakers to provide the leadership that is needed for overcoming AIDS, particularly in relation to its propensity to infect youth. It is their responsibility to demonstrate the dynamic, sustained, publicly manifested, resource-backed and action-backed leadership that will stem HIV/AIDS, that will reduce the susceptibility of youth to HIV infection, and that will contribute to ushering in a world free of AIDS.

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