PATHWAYS TO ACTION

HIV/AIDS PREVENTION, CHILDREN AND YOUNG PEOPLE IN SOUTH AFRICA

A Literature Review

CADRE
CENTRE FOR AIDS DEVELOPMENT, RESEARCH AND EVALUATION

Save the Children

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HIV/AIDS PREVENTION, CHILDREN AND YOUNG PEOPLE IN SOUTH AFRICA
A Literature Review

Developed for Save the Children by the
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Note

This document represents a companion document to *PATHWAYS TO ACTION: HIV/AIDS Children and Young people in South Africa – A Bibliography*. This report and the companion bibliography are available in Acrobat Reader format on the Cadre website (www.cadre.org.za). Research in this area is ongoing and suggestions of more recent relevant studies would be welcomed.

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ACRONYMS AND TERMINOLOGY USED

ANC	Antenatal clinic
ASO	HIV/AIDS service organisation
CBO	Community-based organisation
DOE	Department of Education
DOH	Department of Health
HPS	Health Promoting Schools
KABP	Knowledge, attitudes, beliefs and practices
NGO	Non-governmental organisation
PHC	Primary health care
PLHA	People living with HIV/AIDS
SCF	Save the Children Fund
SRH	Sexual and Reproductive Health
STI	Sexually transmitted infection
UNAIDS	United Nations AIDS Organisation
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing
WHO	World Health Organisation

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NOTE ON TERMINOLOGY: CHILDREN, YOUNG PEOPLE AND YOUTH

There is no generally accepted definition of childhood and youth. Notions of childhood and youth are to a large extent cultural constructions,[1] and the defining characteristics of childhood and youth are not necessarily bound by particular age categories. Generally accepted indicators of childhood and youth such as age, financial dependency, responsibility and blameworthiness, and emotional need for primary caregivers vary considerably across cultures and contexts.

It is often suggested that the world of childhood and youth needs to be described from the perspective of the special duties and obligations which a society adopts towards their wellbeing, and from the perspective of what it expects from them in turn. This is set against the more general duties, obligations and expectations which a society adopts towards its adult members.

Given the complexities of defining childhood and youth, and following the recommendations of Save the Children, we have chosen to talk of young people rather than youth, recognising that full financial and emotional independence is often not gained until the middle to late 20s in South Africa, and wanting to place an emphasis on maturational dimensions which are conveyed by the term young people, but not necessarily by the term youth. We have also situated our concept of what it means to be a young person within the context of HIV/AIDS, and 'youngness' refers to a maturational state which is found in those members of society who are engaged in the initial process of orienting themselves in feeling, thought (including values) and behaviour to sex and relationships in the HIV/AIDS context. Here again we run into difficulty, because throughout ones lifespan, development in these areas continues, meaning that there is constant maturation. Thus we need to revert to some kind of normative framework. This was finally determined to include people 25 years of age or younger. The focus of this report, however, is oriented more towards the teenage and formative years around early sexuality.

The normative framework for *children* used in this report is to define them as prepubescent young people, recognising however, that the law defines a child as someone who has not attained legal majority, ie. 18 years of age. Eleven to 12 years is the age at which most young people enter puberty, and reference to children in this report, unless otherwise stated, refers to young people under the age of 12 years. When the term *young people* is used on its own it generally refers to people 25 years of age or younger, including children.

Magqabasini village, near Flagstaff in the Eastern Cape province. Pic: Greg Marinovich (Beyond Awareness Campaign)

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1. Aries, 1973

SECTION ONE: INTRODUCTION AND OVERVIEW

There appears to be a pervasive belief in South African society, that young people have not responded to HIV/AIDS. This report is an attempt to take stock of what has happened in respect of the response to HIV/AIDS by children and young people in South Africa, as well as the societal response to the needs of young people.

There is no national behavioural surveillance system in South Africa and there have been no comprehensive attempts at drawing conclusions from the many KABP (knowledge, attitudes, beliefs and practices) studies that have been conducted in many different contexts throughout South Africa since the late 1980s. The consequence is that it has been virtually impossible to make informed judgements about behavioural and social responses to HIV/AIDS.

We have a less than satisfactory understanding of the extent of HIV prevalence amongst young people and equally, we have insufficient closely evidenced understanding of the response of young people to HIV/AIDS. Furthermore, although there is ample evidence of numerous attempts to promote HIV prevention and mitigation of the impact of HIV/AIDS, the scope, models and impact of such interventions have not been adequately documented or understood. In this context we are not in a position to talk definitively about the cumulative effect of intervention programmes. Nor are we able to evaluate impacts of specific programmes. Whilst in this report we do discuss some of the difficulties associated with evaluating specific programmes, our emphasis is more on understanding the conceptual underpinnings of programmes. We have looked at approaches to intervention and attempted to understand predominant trends of intervention programmes and contemporary programme development needs.

Whilst in this report we do discuss some of the difficulties associated with evaluating specific programmes, our emphasis is more on understanding the conceptual underpinnings of programmes. We have looked at approaches to intervention and attempted to understand predominant trends of intervention programmes and contemporary programme development needs.

Throughout this review, the position is adopted that prevention and care are related. An adequate support and care framework depends on establishment of a sound prevention framework. It should be understood that there is a continuum of activities that move from prevention through to care and support. For example promotion of prevention may lead to greater understanding of how infection occurs and lessens anxiety about infection in the presence of HIV positive people, thus lessening the chance of hurtful avoidance and social stigmatisation. Conversely, perceptions that there is an adequate care system in place may increase the likelihood of people taking the step of finding out their HIV status, which in turn promotes prevention. It also leads to perceptions that HIV infection can be managed effectively over a long period of time.

It is time to modernise our conceptual frameworks with regard to the wide range of behaviours and practices that are appropriate in responding to the epidemic. We need to understand that what is appropriate and useful as a response to HIV/AIDS extends beyond the realm of sexual behaviour, and we should not assume that sexual behaviour is the single lens through which we must understand and measure forward progress. There are many complex and significant behaviours and practices in the prevention-care continuum, and efforts need to be oriented towards identifying, measuring, and indeed, celebrating these. These range from, for example, wearing a red ribbon, to using a condom, to undergoing voluntary counselling and testing, to being supportive of people living with HIV/AIDS. Each of these activities contributes, directly or indirectly, to both prevention and care. Wearing a red ribbon expresses proactive personal and social concern which operates within the prevention-care continuum. Condom use signifies internalisation of risk. Voluntary counselling

and testing contributes to earlier detection of HIV which is promotive of care and also of prevention. Less directly, but significant nonetheless, being supportive of a person living with HIV/AIDS may contribute to disclosure of HIV status and a more positive social environment for people wanting to know their status. This is obviously good for prevention.

Another important general stance taken in this review is that behaviour change should not be simplistically thought of in terms of measures of individual dispositions and responses, although this has largely been the emphasis of much prevention research. In this review we have carefully avoided reducing the concept of behaviour to 'something that people do', and have attempted to draw attention to the multiple factors which need to be taken into account in understanding the responses of young people to HIV/AIDS. Many of these factors operate in the background of awareness and through social influences and conventions which people adopt without ever thinking about them. This means the concept of prevention is understood as needing to target not only individuals and their immediate social environments, but also contextual factors that the environmental affords by way of support for behaviour change.

In this review we have carefully avoided reducing the concept of behaviour to 'something that people do', and have attempted to draw attention to the multiple factors which need to be taken into account in understanding the responses of young people to HIV/AIDS.

It is also important to understand the limitations of the concept of 'change' embedded in the notion of 'behaviour change'. The concept implies a requirement of a shift from practicing the 'wrong' behaviour (unsafe sex), to practicing the 'right' behaviour (safer sex). This was an appropriate conceptual framework in the early stages of the epidemic, where safer sexual practices were uncommon, and there was a need to re-orient existing practices. However, in an advanced epidemic the situation is quite different. Many individuals enter their sexual lives practicing safer sex, or adopting strategies that are appropriate to HIV prevention. Such individuals do not need to be persuaded to change these practices, nor is it appropriate to measure their behaviours and practices in terms of the concept of 'change'. In this instance, models of endorsement of new social norms around safer sex, or support for maintenance of behaviour changes also need to be emphasised.

To return to the review, the specific aims and objectives are to:

- comprehensively review the current state of knowledge about the response of children and young people in South Africa to HIV/AIDS, and to develop an understanding of what we know in this area.
- develop an understanding of the gaps in what we know and how our knowledge base needs to be improved.
- develop an overview of the programmes which have been developed for assisting children and young people to deal with the risks of HIV infection and positive responses to the challenges of living in an advanced HIV/AIDS epidemic.
- develop a conceptual framework for understanding preventive behaviour, care, support and social mobilisation, taking into account key features of the South African context.

The review looks at the limits of our understanding of how young people have been affected by HIV/AIDS and about how they have responded to it. Following this, the programmes which have been developed to assist young people in responding to HIV/AIDS are discussed in broad terms with a view to understanding the main methodologies and emphases. Gaps and problems

associated with this ‘response framework’ are reviewed and suggestions are made about how the response could and should be developed.

In brief, and at the broadest level, this review has led to the conclusion that whereas there has been significant and broad-based recognition of the seriousness of the HIV/AIDS epidemic, and whereas there is a rapidly developing appreciation of the need to respond to HIV/AIDS, there is now a pressing need to endorse and focus on social mobilisation at all levels. Although responses to date have been, in many respects, less than adequate, there is a global awareness of HIV/AIDS and an understanding of the need to respond. This report suggests that there has been an underestimation of the achievements to date.

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It might have been expected that the mobilisation of awareness as well as parallel support services would have significantly limited impact, but it is of no surprise that the support programmes that have been developed have not been sufficiently prioritised, nor have they penetrated deeply into community life. In the light of this, it is clear that there is a need to develop a second wave of response which needs to work at the level of civil society, and in local and district contexts.

There is increasing evidence that widespread concern is leading to a growing wave of attempts at local level to find ways of responding to the threat of HIV/AIDS. Even in some of the remotest areas of the country one can find community leaders, cultural groups, or service clubs which have tried in different ways to do something about HIV/AIDS. But these nascent attempts are mostly unsupported, are seldom directly funded, and are often not strategically developed or sustained, and they are also sometimes at odds with the needs of the broader society. It is important therefore, that campaigns are coordinated to take into account the development of the society’s capacities to respond to the epidemic. It is important not to offer solutions which the society is unable to deliver, without simultaneously advocating and creating a context for such delivery. Further, communication activities do not go very far in addressing the many underlying structural, organisational, capacity and developmental problems which need to be addressed in creating effective local level responses to the epidemic. In general, it appears that there has been an over-reliance on high budget communication activities at the expense of systematically developing a second tier response.

The conclusions of this report suggest that the response to HIV/AIDS has progressed through an important first stage, and that further progress faces a formidable development challenge which entails finding ways of supporting communities in developing their responses to HIV/AIDS. Amongst the challenges to be faced in this second wave are the challenges of developing and expanding services aimed at supporting prevention, care and support efforts. The main orientation in this review is to focus on the challenges that need to be faced, and on the need to develop models for mobilisation that allow for sustained HIV/AIDS response.

It should be pointed out that this review is situated in a broader programme being conducted on behalf of Save the Children. Simultaneous to the development of this review and partly informing it, another process has been underway. This has been an exploratory, action-research process involving the further development of the ideas presented in this report through implementation in two different settings. The first of these is a social mobilisation

project aimed at developing a framework for response to HIV/AIDS in a group of remote rural villages in the Eastern Cape, with a special emphasis on issues relating to young people. The second involves mobilisation of response amongst visually impaired young people in an institutionalised peri-urban setting. Each of these projects has faced different challenges which have allowed us to test and further develop some of the ideas presented in this report. The outcomes of these two projects are presented in a separate report: *'Making HIV/AIDS our problem: The development challenge'*.

Key points made in this review

- Intervention activities can be conceptualised at three different levels:
  - programmes targeted directly at young people including mass media campaigns, lifeskills programmes and peer education programmes;
  - programmes aimed at developing access to services for young people in the interest of HIV prevention and care and developing the orientation of services to the needs of young people;
  - activities addressing conditions affecting youth exposure to risk at legislative, policy and rights levels with a view to providing a social base of support for interventions.
- There have been few attempts at taking stock of programmes for young people and while there is a broad range of programmes being conducted, there is little co-ordination of efforts.
- In appraising prevention response it is important to take stock of what has already been achieved, and to consider what types of efforts have been more and less successful, and towards what ends. It is time to move beyond the widely held perception that young people are not responding to the need for HIV prevention, and to take stock of the ways in which they have responded whilst at the same time noting the areas where there has been relatively less progress.
- There needs to be recognition of areas in which appropriate attitudinal and preventive responses have taken place, and that these should be endorsed and promoted as social norms.
- There needs to be recognition that some areas of prevention have been overlooked or not sufficiently targeted, for example: delaying sexual debut, age differentials between partners in early sexual experiences, the need to treat sexually transmitted infections, protecting siblings from sexual exploitation, reduction of sexual frequency and secondary abstinence.
- There is need to recognise that young South Africans have not responded uniformly to HIV prevention and greater attention needs to be paid to sections of the population of young people who have not been targeted or reached by current initiatives.
- There is need for HIV/AIDS awareness programmes to place a greater focus on children, and for there to be a more developmentally sensitive approach to sexual education.
- Mass media campaigns have to a large extent achieved what mass media campaigns are capable of achieving – increased awareness and social concern about HIV/AIDS. Translation of this response into social action requires

support for a second wave of interventions which should be prioritised. This requires interventions that are targeted at the contexts where prevention behaviours are exercised – within interpersonal relationships, family relationships and at community level and this requires a social mobilisation and community development emphasis.

- There is a need to move away from event-based approaches towards more sustained activities. Understanding or knowledge must be tied to possibilities for action and accompanied by preparation in the development of appropriate skills for action, rather than being disembedded and abstract.
- The emphasis to date has been largely focused on individual behaviour, and relatively little attention has been given to the interpersonal, community and environmental supports necessary for enabling and supporting appropriate behaviours and practices. These include the development of lifeskills; development of youth norms around HIV prevention; enrichment of young people's recreational and cultural environments; development of services appropriate to adolescents; and development of the regulatory environments which endorse social commitment to the needs and rights of young people.
- There is a need to recognize and address the gender disparities in sexual activites, especially the gendered and cultural aspects of sexual negotiation. These need to be targeted at a social as well as an individual level, and should be couched in the broader framework of legal and human rights.
- There is a need to adopt models of intervention which emphasise maintenance of specific behavioural decisions and which focuses on individual, cultural and social elements which support decisions to avoid risk, including value systems and rights and legal frameworks.
- There is a need to recognise that contextual factors play a significant role in determining response to the epidemic, including socioeconomic, gender, education, age, locality, resource and HIV/AIDS related service delivery factors.
- Response needs to be consolidated at local level and district level, through the development of practical models for social mobilisation in different areas of prevention, care and support that can easily be applied by organisations working within communities. Appropriate behaviours and practices can only be sustained if they are systematically supported and reinforced at individual, interpersonal, community and environmental levels. In particular it is important to support approaches which orient existing services and resources to the specific needs of young people.
- There is a need for programmes and interventions to be developed to a much greater extent on the basis of sound research and evaluation.
- There is a need to understand the relative costs of different kinds of interventions, measured against the types of achievements which they might be expected to deliver.

SECTION TWO: METHODOLOGY OF REVIEW

The following steps were taken in developing this review

- An extensive electronic search of international and national electronic databases was conducted to identify relevant research published in journals and books, as well as in the extensive 'grey' literature – much of which is not documented on the standard electronic search engines and published data bases of HIV/AIDS literature. The latter includes commissioned programme evaluations and baseline studies, as well as studies undertaken at Masters and PhD level in South African tertiary institutions. The quantity of literature collected in this way ran into over 1 000 references. This included research conducted in South Africa, but also key studies done in other contexts, which have a bearing on behaviour change methodologies and conceptual frameworks for HIV prevention, care and support. The scope of the search included theoretical and conceptual perspectives.

- The review was supplemented with an understanding of key intervention programmes. Information was sought, through electronic media, conference presentations and the work of key South African organisations involved in HIV/AIDS. An effort was made to identify and classify the principal methodologies being employed in promoting prevention amongst young South Africans.

- The next task was to select material that specifically applied to young people and HIV prevention in the Southern African context. This proved to be a challenging task. Firstly, much literature relating to other areas of the world is relevant to South Africa and literature sources referring to other countries could not automatically be discarded. Secondly, a good deal of the literature around HIV/AIDS, children and young people concerns issues to do with children's care, support, and rights. Because social orientation in these areas has a direct bearing on how children and young people are educated to respond to HIV/AIDS and how the society protects them, it was also important to review developments in this area. Thirdly, there is an extensive body of literature on child and youth development which needed to be included as it has a bearing on HIV/AIDS. Fourthly, there is an extensive area of 'grey' literature covering recommendations and concepts for programme development, policies relating to work with children and young people, and case studies on the impact of HIV/AIDS on children and young people, which needed to be perused to gain an impression of current opinion.

- Analysis of literature and programmes yielded: findings of South African studies and trends over time; an understanding of the research methods and indicators used in studying preventive behaviour in South Africa; an overview of approaches to behaviour change, including *foci* and targeted impact areas; an appreciation of overlooked areas of prevention; some understanding of the impact of existing programmes based on available evidence; identification of key elements of successful programmes; description of the psychological, and societal transformation processes involved in the shift towards HIV/STD prevention; and identification of areas requiring further investigation.

- In addition to analysis of the above areas, the implications of the findings of the review for policy makers and programme designers were explored.

SECTION THREE: LIMITS TO UNDERSTANDING

HIV surveillance amongst young South Africans

According to the 1996 census 31% (12.7 million) South Africans were between the ages of 10 and 25.[2] Considering that the peak period of HIV infection falls between 18 and 25,[3] the need to institute effective HIV prevention programmes in young people is seen as a priority.

Most South African HIV prevention programmes reference the national antenatal statistics as a starting point for justifying the urgency and relevance of their activities. For the most part however, this data tends to be presented with little critical analysis and is quite often utilised to infer that South African young people have not responded significantly to the epidemic. These assertions are disturbing because running parallel to the antenatal data are many studies that demonstrate high levels of AIDS awareness as well as extensive orientation towards preventive practices including condom use, abstinence and partner reduction.[4] Over and above these findings, antenatal prevalence data over the last three years points to important declines in HIV and syphilis levels amongst young people. As Figure 1 shows, amongst women under 20, HIV prevalence declined from 21% in 1998, to 16.5% in 1999, and to 16.1% in 2000. Similarly, in figure two overleaf, syphilis levels amongst under 20s declined from 7.9% in 1998, to 5.4% in 1999 and to 3.9% in 2000. Similar declines also occurred in other age groups.

Running parallel to the antenatal data are many studies that demonstrate high levels of AIDS awareness as well as extensive orientation towards preventive practices including condom use, abstinence and partner reduction.

Figure 1: HIV prevalence trends among antenatal clinic attendees in South Africa, 1998-2000

AGE GROUP	Est HIV+ (95%CI) 1998	Est HIV+ (95%CI) 1999	Est HIV+ (95%CI) 2000
<20	21.0 (18.4-23.8)	16.5 (14.9-18.1)	16.1 (14.5-17.7)
20-24	26.1 (24.1-28.1)	25.6 (24.0-27.3)	29.1 (27.4-30.8)
25-29	26.9 (24.7-29.0)	26.4 (24.6-28.3)	30.6 (28.8-32.4)
30-34	19.1 (17.1-21.1)	21.7 (19.1-23.8)	23.3 (21.5-25.1)
35-39	13.4 (11.2-15.6)	16.2 (14.1-18.3)	15.8 (13.9-17.7)
40-44*	10.5 (6.8-14.1)	12.0 (8.5- 15.6)	10.2 (6.9- 13.3)
45-49*	10.2 (0.4-20.0)	7.5 (-0.77-15.9)	13.1 (2.09-24.0)

Source: National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa 2000, Department of Health, South Africa

The data suggests that pregnant teenagers in 2000 have a lower HIV and syphilis risk profile than pregnant teenagers in the preceding two years. Over and above the trends in safer sexual practices we have mentioned, factors contributing to this reduction are likely to include the widespread application of syndromic management protocols for dealing with sexually transmitted infections, and widespread distribution of male condoms.

2. Statistics South Africa, 1996
3. National Population Unit, 2000
4. See Section 4, page 19

Figure 2: Syphilis prevalence amongst antenatal clinic attendees in South Africa, 1998-2000

AGE GROUP	Est RPR+ (95%CI) 1998		Est RPR+ (95%CI) 1999		Est RPR+ (95%CI) 2000	
<20	7.9	(6.6-9.2)	5.4	(4.2-6.5)	3.9	(3.2-4.7)
20-24	11.4	(10.0-12.8)	9.5	(8.3-10.7)	4.9	(4.2-5.6)
25-29	13.1	(11.5-14.7)	8.9	(7.7-10.1)	5.4	(4.5-6.2)
30-34	9.9	(8.4-11.6)	10.2	(8.2-12.2)	4.5	(3.5-5.5)
35-39	9.7	(7.4-11.9)	7.9	(6.0-9.7)	4.4	(3.2-5.5)
40-44*	10.8	(7.1-14.5)	5.5	(3.0-8.1)	3.7	(1.7-5.7)
45-49*	10.5	(8.3-20.2)	2.8	(2.6-8.1)	1.7	(-1.6-4.9)

*Source: National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa 2000, Department of Health, South Africa. * Wider CI's relate to the small number of participants in the study.*

Biomedical data suggests that sampling in antenatal studies may be compromised by reduced levels of fertility amongst HIV positive women. It must be noted that safer sexual practices, and condom use in particular, also affect the reliability of antenatal sampling. For example, women who have adopted various safer sex strategies including secondary abstinence and condom use are far less likely to become pregnant and are therefore less likely to be represented in the national antenatal sample. Importantly, this latter group are likely to have far lower levels of HIV prevalence than their pregnant peers, and this affects the generalisability of the antenatal prevalence findings. In the absence of behavioural surveillance data, we need to be circumspect about antenatal data. In particular, in an advanced epidemic such as that in South Africa, it is vital to consider available behavioural data when modelling prevalence and infection trends amongst the general population. It is worth pointing out that estimates of AIDS mortality do not provide any insight into contemporary HIV preventive practices.

Women who have adopted various safer sex strategies including secondary abstinence and condom use are far less likely to become pregnant and are therefore less likely to be represented in the national antenatal sample. Importantly, this latter group are likely to have far lower levels of HIV prevalence than their pregnant peers.

In this review it is stated that through comparison between early behavioural studies and more recent ones, there is good reason to believe that there has been a notable improvement in safer sexual practices amongst young people in

Anti-AIDS club condom distribution programme, Orange Farm, Gauteng. Pic: Cedric Nunn (Beyond Awareness Campaign)

South Africa – particularly condom use. This is supported by recent condom distribution data. For example, in 2000, some 274 million free condoms were distributed by the Department of Health and a further 16 million condoms were distributed through commercial and social marketing efforts.[5] Whilst it is not clear what proportion of these condoms were readily available when needed, or what the levels of consistent use were, it is clear that such high levels of distribution are a further measure supporting understanding that of important national trends in reduced risk of HIV infection.

With a view to developing a more detailed understanding then, there is an urgent need to supplement antenatal data with other types of data – for example annual population-based behavioural surveys, as well as gathering of HIV prevalence data using other types of sampling – for example, population-based sampling. Over and above providing a more accurate picture of prevalence, such information would assist in streamlining prevention interventions towards more appropriate, cost-effective and impactful models.

It is important to point out that in the case of younger children we have a poor understanding of HIV prevalence. There is also little data on the related impacts of HIV/AIDS on children and young people – for example, numbers of families with one or more parents infected and numbers of children currently orphaned. There is neither an adequate surveillance system for monitoring these trends, nor a system in place for keeping a tally of children and young people in distress because of HIV/AIDS. Perhaps of greater concern, is that there does not appear to be a strong likelihood that such systems will be in place at a national level in the foreseeable future. It would be worthwhile therefore, to aggressively pursue fast-track systems of monitoring that can be applied at local level, and that can be used to frame planning and evaluation of grassroots activities and support.

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National behavioural surveillance

There is currently no national behavioural surveillance system in place[6] in South Africa, although there are developments in this area.[7] There is no national health survey of children and young people and remarkably little data is available on aspects of the response to HIV/AIDS amongst children. There have been very few national level behavioural studies and most studies are highly context specific. With the exception of the Demographic and Health Survey,[8] and a recent loveLife survey[9] there has been little population-based research on behavioural responses to HIV/AIDS. It should also be noted that the two studies cited do not focus specifically on HIV/AIDS, and the DHS survey contains limited data about young people. These reports have also only been made available in summary form, and are thus of little value to social scientists who may wish to analyse trends in more detail, or deduce a baseline understanding of behavioural trends.

Clearly there is a need for systematic development of further data on a national scale, and there is also need for consolidation and closer analysis of the studies that do exist. There have been a number of useful site-specific research studies[10]

5. Interviews, Department of Health, and Society for Family Health, South Africa, October, 2001
6. UNAIDS, 2000a
7. South African Behavioural Risks, Sero-status, and Mass Media Impact Survey, by an HSRC-led Consortium
8. DHS, 1998
9. loveLife, 2001
10. See Section 4, page 19

and these could usefully be integrated to reach an approximation of a national picture. However, there are methodological problems associated with doing this.[11] For example, much research has been conducted on a once-off basis, often for academic purposes, and sometimes attached to particular interventions in the form of evaluations. As such, these studies are usually limited to particular settings with very little work covering multiple sites, and little integrative or meta-analytic work which attempts to understand trends across studies. The piecemeal character of existing research specifically focused on children and young people has not been conducive to accrual of understanding in the field.

Theory development

Most of the social research on response to HIV/AIDS conducted in South African consists of KABP studies conducted amongst discrete groups of youth,[12] usually in educational settings (schools and universities), or in the context of health service utilisation. Most of this research is descriptive in nature, with results usually described in terms of percentages of groups of people thinking, feeling or acting in certain ways in relation to issues of HIV prevention. There is very little substantive theoretical work oriented towards understanding HIV/AIDS in a South African context.

With regard to intervention models there has also been little theoretical development, although some national campaigns, notably loveLife[13] and Soul City,[14] have articulated particular frameworks for intervention. However, these are not rigorously theorised.

There is little research critically analysing the efficacy of specific theoretical models, and little South African research which develops our understanding of the relationship between the two broad frameworks for understanding behaviour change which are commonly used – that is, intentional (decision-making) models and environmental models. This is also an international trend.[15]

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Most South African research and evaluation studies do not adopt a specific theoretical orientation and there appears to have been little contribution to understanding the social response to HIV/AIDS by South African researchers, beyond identification of some of the trends of response relating to, for example, gender dynamics or cultural particularities. Many of the KABP studies draw on a wide range of health behaviour models, but are limited by a lack of critical analysis.

Intervention research

There have been no comprehensive attempts to understand the reach and impacts of governmental, private sector, non-governmental organisation, faith-based and other institutional and community-based responses to HIV/AIDS. In the case of workplaces and smaller communications campaigns, evaluations are often commissioned internally, and seldom brought into the public domain. This makes it difficult to know just how much is going on, who is doing what,

11. ibid
12. For details of these studies see 'Knowledge, attitudes, beliefs and practices' in the bibliographic review of studies focusing on children and young people.
13. loveLife (www.kff.org; www.lovelife.org.za)
14. Soul City (www.soulcity.org.za)
15. Macintyre, 1999

which segments of the population are being covered, which issues and foci are being focused on, and what is not receiving attention.

There has been little research around concepts and models of prevention and little accrual of understanding of what works, for whom, and under what circumstances. There is little evidence of up-scaling of prevention models on the basis of research evidence.

Research projects on interventions are usually once-off, *ad hoc* initiatives driven by researcher interests and availability of respondents. Frequently funded by external sources, some of these studies show scant evidence of being developed with a view to feeding the results back into programme development. Funded research projects are often not connected to ongoing intervention programmes, although they do tend to contain general intervention recommendations. With regard to the efficacy of interventions there have been less than ten controlled design intervention trials in South Africa,[16] and whilst formative evaluation programmes have been spoken of as a priority[17] they remain uncommon. There have been some evaluations of interventions,[18] but there is little evidence of evaluation research in the case of most smaller programmes. There has been very little research into South African school-based HIV prevention projects outside of the Western Cape.

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Soul City has an extensive research component, loveLife is developing a research framework and a number of smaller programmes, notably Stepping Stones,[19] are being thoroughly researched. Shorter-term interventions, such as the Beyond Awareness Campaign of the Department of Health, which was completed in 2000, have tended to rely on process evaluation and qualitative analyses.

Very little is known descriptively, or in terms of evaluative research, of national sectoral interventions such as the South African National AIDS Council (SANAC), or initiatives such as Business Against AIDS, although these have been in existence for a number of years.

It is uncommon to find rigorous research-based programme development towards sustained, cost-effective interventions.

It appears that most intervention programmes, particularly at community level, are conceived without reference to research. Community mobilisation in the form of AIDS awareness campaigns, World AIDS Day activities, event-oriented interventions, and activities such as door-to-door campaigns are largely conducted on the basis of common sense thinking with little reference to previous experience or evaluation, and are usually not evaluated. It must be noted that event-based activities are costly, often intentionally serving the purpose of 'being seen to be doing something', and it is questionable whether they lead to sustained activity.

There has been little research, with one notable exception,[20] clarifying the nature of risk behaviour amongst young people. There has also been little research on factors which reduce risk behaviour or conditions associated with risk prevention – for example factors which predispose some individuals to be earlier adopters

16. Campbell, 1999; Mathews, 2000
17. Campbell & Macphail, 1999
18. See 'Evaluation of interventions' in the accompanying bibliographic review of studies focusing on children and young people.
19. These programmes are discussed later in this review.
20. Flisher, 1993

of prevention behaviour than others. There is also very little clarity on factors which promote maintenance of appropriate behaviours and practices.

Youth group, Johannesburg, Gauteng. Cedric Nunn (Beyond Awareness Campaign)

Finally, there has been an emphasis on the concept of behaviour change to the exclusion of understanding the need to endorse and support emotional, cognitive and behavioural frameworks which are already latent within youth culture, and which don't need to change as such. The common-sense appeal of behaviour change concepts to the exclusion of acknowledging a range of existing appropriate practices, as well as adoption of appropriate practices at the onset of sexual life, has constrained the development of wider and more appropriate interpretive frameworks.

Social dynamics

There is a troubling lack of accrual of understanding of the psychological, cultural and sociological dynamics driving the epidemic.

There is little work in the relevant areas of enculturation and socialisation, cognitive and emotional development, the development of sexuality and sexual relationships, the impact of rapid social change, and the impact of mass media communication. Perhaps, most notably, there appears to be little literature which considers changing intervention needs across the human lifespan; that is, along a maturational continuum. For example, there is a dearth of research on vulnerability to risk in the transition from primary to secondary schools in spite of this being a well-recognised period of vulnerability. There has been very little research which studies peer groups and social networks which in other contexts have also been shown to have an important mediating influence on prevention.[21]

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International models of human development and behaviour change in childhood and adolescence have prevailed – and we must wonder how neatly they fit into the South African context where economic, cultural and social heterogeneity characterises the society. There has also been little contribution to understanding the significance of the linguistic heterogeneity that exists in the country in relation to HIV/AIDS communication.

Overall, the theoretical frameworks for understanding behaviour change, even when social and cultural issues are explored, tend towards treating the

21. Low Beer et al, 2000

individual as the unit of analysis, rather than the social or environmental milieu.[22] Community level dynamics relating to concepts such as social capital[25] and social cohesion have largely been overlooked.[23]

Environmental and service delivery factors

There has been remarkably little research on social mobilisation, integration of services, health and education service delivery, and other crucial issues which impact on HIV/AIDS prevention and care efforts. This point was amply made in 1999,[24] and it appears that a few years later the position has not changed. Also, little attention has been paid to environmental factors such as access to media, mobility amongst young people, communication networks and socioeconomic factors driving the epidemic amongst young people.

Whilst there have been policy oriented studies of the integration of primary health services, models of community-based HIV/AIDS care and support, and counselling,[25] much of the social science research has focused on specific behavioural outcomes, rather than on data gathering about social support and intervention.

Little attention has been given to the many social environmental conditions that are vital to understanding the individual and social response to HIV/AIDS such as confidential and consistent availability of condoms, access to voluntary counselling and testing facilities, or perceptions and practices of health care workers.

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Research priorities

There appears to have been little agreement about research priorities or appropriate indicators for conducting longitudinal and cross-contextual research, or for measuring progress of interventions.

There have been no significant South African attempts to establish common criteria for monitoring of socio-behavioural responses to the epidemic, although a number of relevant international guidelines exist.[26] Research studies tend to use diverse indicators, even with regard to basic units of analysis such as condom use, whilst broader population characteristics and contextual factors are not described in standard ways. This makes composite meta-analytic studies virtually impossible.

Research projects tend to focus on specific outcomes such as condom use, or specific sexual practices, without paying sufficient attention to the significant steps and psychosocial processes which lead to such outcomes. There is thus little understanding of what has been achieved in terms of creating or sustaining contexts for lower risk behaviours and practices.

A number of authors have produced reviews of research which generally suggest foci and priorities for future research. There has been some writing on research priorities in developing countries including a particular focus on Africa[27] that

22. Kelly & Parker, 2001b
23. Kawachi & Berkman, 2000
24. Campbell and MacPhail,1999
25. Schneider, 2000; Russell & Schneider, 2001; Richter, 1999
26. UNAIDS, 2000a, 2000b; FHI & Impact, 2000

has suggested the need to use qualitative methodologies, formative evaluation models (with an emphasis on programme development rather than outcome evaluation), and appropriate development indicators to understand community level dynamics relating to such concepts as social capital and social cohesion. Other work[28] has set out priorities for research in youth prevention based on an analysis of research conducted in seven countries. In particular this work identifies a need to focus on youth sexual cultures using qualitative methods.

It would be of benefit for there to be some discussion amongst the community of social scientists and programme developers working disparately in this field to identify research priorities given programme development and evaluation needs. Part of the problem is that there is no general registry of ongoing and completed research, nor of prevention, care or support interventions and programmes. Much of the information that does exist lies scattered about on a wide range of websites, in small publications, evaluation reports, subject specific journals, and theses. There is no substantive South African resource where one can expect to find up to date information about what research programmes are in place, what research data is available and where one can obtain access to research resources. The internet could readily be exploited in this regard.

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For these reasons, amongst possible others, there has been little concerted attempt to prioritise social science research in HIV/AIDS, and social scientists have also been slow to respond to the epidemic. Developments such as the 2001 AIDS in Context Conference[29] at the University of Witwatersrand, and the establishment of journals such as the African Journal of AIDS Research[30] are encouraging developments, as is the formation of a number of research and intervention oriented units focusing on social research and prevention in the HIV/AIDS field.[31]

Much more could be said about the above issues, and further comment is offered in the course of this document, particularly relating to areas which we need to know more about, including suggestions about how this might be done. Having examined some of the shortcomings of the social research environment in South Africa, we now turn to trends emerging from existing research.

27. Campbell & MacPhail, 1999
28. Dowsett & Aggleton, 1999
29. 2001 AIDS in Context Conference at the University of Witwatersrand
30. http://www.cadre.org.za
31. Centre for the Study of AIDS, University of Pretoria; Centre for the Study of AIDS in Society, University of Cape Town; Cultural and Media Studies Unit, University of Natal, Durban; HIVAN, University of Natal Durban; Centre for AIDS Development, Research and Evaluation (Cadre)

SECTION FOUR: WHAT WE KNOW ABOUT YOUNG PEOPLE'S RESPONSES TO AIDS

Introduction

The knowledge, attitudes, beliefs and practices (KABP) approach to studying HIV risk and prevention behaviour is widely employed internationally,[32] and this is certainly also the case in South Africa.

It should be said that KABP is a particular version of the more general KAP (knowledge, attitudes and practices) concept. Another version of the basic model is KAPB (knowledge, attitudes, perceptions and behaviours). In our view KABP is a preferred framework for analysis as the notion of belief allows the inclusion of culturally grounded understanding including culturally specific understandings of the body, illness and sexuality, which may be important mediators of HIV/AIDS response.

KABP refers to four important elements of response, but how these elements combine to produce desired outcomes is a matter of great conjecture. Later in this document there is some discussion about models of behaviour change and it is suggested that the 30 or more models which have been developed, mainly by North American behavioural scientists, have made only a limited contribution to the understanding of behaviour change. These approaches tend to create artificial distinctions which then become the subject of endless permutations and quantitative analysis, as if by analysing the relationships of these elements further and further we might come to a truer picture and theory of behaviour change. But this may reflect a denuded model of the person, which lacks elements which are essential to understanding behaviour. In addition to KABP we need to consider the contradictions and unconscious elements which motivate behaviour, and especially sexual behaviour. We need to consider closely, how the service environment and our experiences of being cared for matters, and shapes how we respond to others and look after ourselves. We need to take into account the framework of individual aspirations and hopes, and the sense of belonging or alienation that shapes our relations with others. We need to consider how ideology, gender, race and class, shape our understanding of our place in society. However, unfortunately much of our understanding of response to HIV/AIDS does not take these important psychosocial and contextual factors into account.

We need to take into account the framework of individual aspirations and hopes, and the sense of belonging or alienation that shapes our relations with others. We need to consider how ideology, gender, race and class, shape our understanding of our place in society.

The bibliographic companion document to this review contains numerous references to studies conducted in other countries in Africa, but for the purposes of the review we have focused on those conducted in South Africa – numbering close to 100 studies. A full analysis of this data would be a massive undertaking, but would possibly yield interesting findings about changes in trends over time and differences across contexts. Unfortunately there have been few repeat studies and comparative analyses of unrelated studies. This would be a problematic undertaking since the indicators and scales of measurement in different studies are rarely comparable and sampling methodologies are often not reported, thus limiting potentials for interpretation. But a meta-analysis of changes across time on some of the more comparable data, such as age of sexual debut would possibly yield interesting information.

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32. UNAIDS, 1999.

Some general trends in the research are:

- very few studies focusing specifically on children and young adolescents and on maturational or developmental factors associated with HIV prevention;
- relatively few studies examining KABP in relation to care and support;
- widespread emphasis on studying 'knowledge'.

Further to this, much of the research looks at outcomes – for instance the narrow outcome of actual condom use, but without looking at the wider constituent elements of this outcome, for example, KABP around acquiring condoms, having a condom in one's possession, negotiating condom use and maintaining condom use behaviour. Preventive behaviour and the adoption of new behavioural practices does not happen in an all-or-nothing way and we need to understand the many shifts and reorientations that are associated with the final outcome.

HIV/AIDS knowledge amongst children and young people

Studies show that, for the most part, young people are well informed on the most important facts about HIV prevention and some populations (particularly university students) have been so since the early 1990s. Certainly, in the latter half of the decade, most studies have shown high levels of understanding of the main methods of transmission and risk prevention. It is therefore questionable that understanding of the finer points of transmission, where relatively poor understanding prevails, is really critical to the development of risk avoidance behaviours.

The following summarises findings of key studies[33] in broad terms:

- There is a high level of knowledge about the causes of AIDS and its prevention, with many recent studies across a range of contexts, reporting high levels of correct knowledge in excess of 80% correct responses. Some studies conducted in the early 1990s show lower levels of knowledge of HIV/AIDS and significant misperceptions, but by the mid 1990s many studies found knowledge levels on the basic facts were achieving scores of 70% correct and above, though with some gaps in understanding. By the late 1990s there was improved knowledge in areas such as vertical transmission and the relationship between HIV and AIDS.
- Respondents living in informal housing and rural areas consistently lag behind their economically advantaged and urban counterparts in exposure to AIDS information and knowledge. Higher levels of education also have a positive relationship to HIV/AIDS knowledge. Younger children are significantly less informed than their older counterparts.
- Young people in poor and rural communities have far less access to a wide range of sources of information on HIV/AIDS than urban and economically advantaged counterparts.
- Most young people obtain information about HIV/AIDS from the mass media, most notably radio and television. However, most people learn about sex from their friends.

There is a high level of knowledge about the causes of AIDS and its prevention, with many recent studies across a range of contexts, reporting high levels of correct knowledge.

33. Bekskinska & Stadler, 2000; Coughlan et al, 1996; du Plessis et al, 1993; Elkonin, 1993; Everatt & Orkin, 1993; Frame, 1991; Friedland et al, 1991; Goliath, 1995; Govender et al 1992; Kaya & Kau, 1994; Kelly, 2000; Kelly, 2001; Martindale, 1990; Mathews et al, 1996; Naidoo, 1994; NPPHCN, 1996; Peltzer et al, 1998; Richter, 1996; Rutenburg et al, 2001; Strebel & Perkel, 1991; van Wijk, 1994; Varga, 2000

Amatole, Eastern Cape. Pic: Kevin Kelly (Cadre)

- Knowledge of efficacy of condoms for HIV prevention is high.
- Gaps in knowledge are mostly in knowledge areas where infection risks are not clear-cut or are contingent on other factors. For instance, there is uncertainty about the issue of HIV transmission through oral sex and kissing. There is also some confusion about transmission channels of air, saliva, skin, insect bites and sharing eating utensils; but misperceptions about other issues such as infection through donating blood have decreased significantly over time.
- Awareness of risk is often not matched by a realisation that HIV infection and risk of transmission may be present without the infected person being symptomatic, although this awareness appears to have improved. Awareness in this area seems to be education level dependent and incorrect perceptions seem to be more strongly present in rural environments. This is an important area for communication campaigns to concentrate on as it seems that the lack of visible illness is one of the main reasons that people have struggled to appreciate the realities of infection. It must be taken into account that HIV/AIDS is unique amongst other infections in the sense of being invisible for a long time. This 'credibility' problem needs to be addressed directly by greater emphasis on understanding the illness process. A number of studies suggest that knowledge of the symptoms of HIV/AIDS is one of the areas where there is least understanding and where there has been least communication. There is also some disbelief about whether AIDS is curable, but most studies conducted after the early 1990s reflect such views only for the minority of people, sometimes only a small minority. Related to this is a common assumption that people with HIV have a particular 'look', and being thin is felt by some young people to be associated with HIV infection. There is fairly widespread evidence, that many young people (but not a majority) tend to believe that a healthy looking person is unlikely to be HIV infected.

Awareness of risk is often not matched by a realisation that HIV infection and risk of transmission may be present without the infected person being symptomatic, although this awareness appears to have improved.

- Young people are not well informed about mother-to-child-transmission and the risks associated with breast feeding. However, very few studies have looked at these knowledge areas.
- Younger adolescents in primary schools tend to be significantly less informed in almost all areas of HIV/AIDS knowledge than their older, high school counterparts.

- On unprompted questions about knowledge of prevention methods, by far the most widely recalled prevention method is the condom, followed by faithfulness to partners, limitation of number of partners and abstinence. Alternative sexual practices are seldom mentioned as prevention methods, although this may be misleading as responses which reflect this choice ('kissing and cuddling only') tend to be thought of as abstinence.

- Whilst the seriousness of the HIV/AIDS problem is widely acknowledged by young people, and the vulnerability of young people to HIV infection is recognised, we should note the responses of young people when they are asked to assess their own risk of infection. A number of studies show that whilst they understand AIDS as a fatal sexually transmitted condition with no cure, percentages of respondents who perceive themselves to be personally at risk of being infected, are far lower. For example, a study of attitudes amongst 12 to 17 year olds[34] showed that at least 70% identified AIDS as one of the five greatest concerns for young people today. Ratings for perceptions of HIV/AIDS as a serious problem dropped from 74% to 37% when reference was made to individual perception of self-risk amongst sexually experienced youth.

- Interpretation of risk tends to be informed by subjective and social beliefs about who constitutes a high risk partner and these characterisations are informed by prevailing social stereotypes, with 'outsiders from other areas' identified as being most likely to be infected. This has even been found to be true in high prevalence areas. It has also been found that close and intimate relationships are perceived as low risk environments, with an underestimation of the risks of infection as a consequence of the partner's previous sexual history.

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The concept of knowledge, as measured in many of these studies, may be more about recognising ideas than having a useful understanding of issues. It is telling that in studies that have both open-ended questions and closed-ended knowledge questions, there is a marked difference in 'knowledge' between the two. Whereas respondents are able to recognise statements as true or not true, this knowledge is not readily generated through recall. Furthermore, misconceptions arise when respondents provide answers to open-ended questions. This raises the issue of what we mean by 'knowledge'. When studies do probe intimate decision-making processes such as issues around how partners make decisions about risk, emotional, cultural and social factors which underlie abstract knowledge emerge as influencing decision-making. This suggests that the education process needs to go beyond provision of abstract messages or decontextualised, textbook knowledge, and should rather engage with young people's capacities to assess risk and to understand the influence of emotions on risk assessment. Also important is self-knowledge about how to assess and deal with a situation that is new, and where one might be feeling insecure, or where one feels powerless and lacking in self-efficacy. In short, what many studies have called knowledge is not necessarily the right kind of knowledge.

It is suggested later in this review that the type of interventions that have predominated in the HIV/AIDS prevention field, namely mass media, have delivered what they are capable of delivering. But this is not the kind of knowledge that necessarily empowers new action. So whilst 'knowledge' levels

34. loveLife, 2000

are high, it is true to say this only using a limited concept of knowledge. Many authors have spoken about the gap between knowledge and practice (KAP-gap). Our contention is that this is real only in a limited sense, and this so-called gap reflects the limited range of knowledge that has been imparted, rather than an implicit failure of knowledge to empower action. It is suggested that AIDS interventions need to move more decisively beyond the mass media approaches into more interactive styles of communication that foster interpretation of information within local contexts, and which involve mobilisation of social contexts to the point where new forms of empowering understanding can be developed.

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Attitudes

An attitude is a predisposition towards responding to ideas and situations in particular ways. Studies on attitudes have mainly examined attitudes towards HIV/AIDS prevention methods (mainly condom use), attitudes towards people living with HIV/AIDS and attitudes to HIV disclosure. Some studies have examined attitudes to abstinence, whilst others have sought to examine sexual negotiation and gender-related perceptions. Many of the studies included in the bibliographic review do not cover attitudes towards PLHAs, although some do.[35] Key findings include:

- Studies widely report that condoms are understood to diminish sexual pleasure and are inconvenient to use. Attitudes of young people to condom use reveal male-female differences. Sexually experienced boys feel strongly that sex is better without a condom and whilst girls tend to agree with this their attitudes towards condoms are far more positive. A few studies show that young women are better disposed to condoms than their male counterparts. It must be noted that such negative attitudes to condoms do not necessarily correspond with failure to accept pragmatic benefits of using a condom during sex.
- Condoms tend to be associated with conflict in relationships and discussion about condom use in relationships raises questions of mistrust. However, condom use does not need to be discussed in every sexual act, nor on a continuing basis once a couple has agreed to use condoms. Attitudinal factors and issues of mistrust thus relate mainly to the introduction of condoms into sexual practice.
- There are mixed research results relating to attitudes towards PLHAs ranging from high self-reported positive attitudes to high levels of prejudice and ostracisation. PLHAs tend to report high levels of negative attitudes, which do not coincide with self-reported attitudes of young people. One way of accounting for this is that even isolated incidents can impact strongly on PLHAs and seemingly small incidents such as someone hesitating to drink from the same cup, or someone using rubber gloves unnecessarily, can be hurtful and rejecting.
- Attitudes to disclosure amongst HIV infected people, and the discomfort which young people initially feel in responding to PLHAs is negatively mediated by the perception that HIV/AIDS is necessarily a fatal condition. In one study[36] it was found that young people initially feel a great deal of hesitation in responding to someone who has HIV/AIDS, but this effect is

35. loveLife, 2001a; Kelly, 2000; Killewo & Wall, 1997; Kushlick & Rapholo, 1999; loveLife, 2001; Richter 1993/94/95/96
36. Kelly, 2001

mitigated by contact as people begin to realise that one can have a 'normal' relationship with that person.

- Children's attitudes towards PLHAs are more negative than attitudes of older counterparts.
- Attitudes towards voluntary testing and counselling appear to be mediated by perceptions that AIDS is a fatal condition, leading to the perception that there is 'no point in being tested'. Although this has only been examined in a few studies, it seems that it is important to expand information on the potential to extend life through managing HIV infection.
- Positive attitudes are revealed in answers to questions related to caring for people living with HIV/AIDS. However, studies also show that a majority of young people report not having someone in the family who is HIV infected or who has AIDS.

It is important in understanding attitudes, to distinguish between private experience and public experience. A person may, for example, individually feel tolerant and accepting towards PLHAs, but not express this sentiment publicly, and privately held attitudes may be overridden by public sentiment. Young people may, for example, feel compassion towards people with HIV/AIDS, but fail to express this in public. This is a complex issue which suggests a need for public adoption and endorsement of positive responses, for example, by establishing agreement within community groups that PLHAs should be supported and that discriminatory behaviour should be censured. The intervention emphasis needs to be addressed at developing a public language of tolerance and positive orientation, because it is at this level, more than at the level of the individual that there appears to be a problem. The development of a public language contributes to normativity of appropriate attitudes, and is fostered not only by words and concepts, but also by more subtle approaches such as, for example, wearing a red ribbon.

It is important in understanding attitudes, to distinguish between private experience and public experience. A person may, for example individually feel tolerant and accepting towards PLHAs, but not express this sentiment publicly, and privately held attitudes may be over-ridden by public sentiment.

Beliefs and perceptions about HIV/AIDS

HIV/AIDS beliefs refer to the background assumptions which inform acquisition of knowledge, and which often are based on complex systems of understanding about the body, health and illness. Beliefs are difficult to change because they are often not based on explicit thinking processes, and like attitudes may rest on forms of social representation that are subscribed to by virtue of being part of a social group. As such, beliefs belong as much to the social environment as they do to individuals. Beliefs are often present below the level of conscious thinking and may undermine attempts to build actions on the basis of good knowledge. They may also undermine creation of positive and constructive attitudes.

Findings of South African research studies[37] concerning beliefs include:

- Under-inclusive thinking (not seeing oneself as personally vulnerable) by projecting risk of HIV/AIDS onto outsiders. This is a very common aspect of young peoples' response to HIV/AIDS and shows, most notably, in the belief that one is only likely to contract HIV if one has sex with someone from outside of one's own community, or with different 'types' of people. This leads to an underestimation of the risk of becoming infected closer to home.

37. Gouws, 2000; Kelly, 2000; Kelly & Parker 2001; Ntlabati & Kelly, 2001; le Clerc-Madlala,2001; Varga,1996/97/2000;

This is also connected to a tendency to believe that one is unlikely to become infected in a loving relationship.

- Over-inclusive thinking (over estimating of risk of infection), by for example, feeling at risk of infection through eating from a utensil which an HIV positive person has used. Children are much more likely to have these beliefs.
- Belief that the risk of infection diminishes over time in the context of a relationship.
- Belief that if one were likely to become infected one would be infected already.
- Belief in myths. In this regard there is little quantitative evidence of the existence of a belief amongst young people that myths such as having sex with a virgin will cure AIDS, although some qualitative studies have reported this phenomenon. This may or may not be an isolated phenomenon, but because of its possible consequences, it should be properly assessed. Some beliefs about AIDS are found across many contexts, much like urban myths – for example, the belief that virus injected fruit is being deliberately circulated – yet these seem not to be seriously subscribed to, sometimes not even by those who circulate them.[38] Concern about such issues is possibly an expression of young people's uncertainty about how to engage with apparently pervasive sexual risk.
- The belief that AIDS can be caused by witchcraft is low amongst rural youth. No data is available for urban youth.

There is little quantitative evidence of the existence of a belief amongst young people that myths such as having sex with a virgin will cure AIDS, although some qualitative studies have reported this phenomenon.

Like attitudes, beliefs may be culturally grounded, but they are more cognitive (thought based) than attitudes, which are more feeling based. Thus beliefs can be targeted more effectively through mass media.

Practices relating to HIV/AIDS

The concept of practice relates to a broad range of activities relating to HIV risk and prevention, as well as care and support. Practices are also taken to refer to constituent behaviours which make up targeted behaviours of prevention programmes. For example the practice of using a condom involves many smaller scale processes, such as condom acquisition, talking to a partner about condom use, and the practicalities of using a condom. Many of the studies which have looked at practices have tended to consider only outcomes, for example, condom use, without due consideration to the constituent parts. Comparison of studies in this area is particularly difficult because of the wide variety of different ways that indicators (for example, condom use) are measured, and because of the different ways in which questionnaires break down facets of risk exposure and behaviour.

Specific areas of prevention practice and risk reduction

Many survey studies reviewed do not contain much detail is this area, but a number of studies have looked in greater depth at aspects of prevention practice:[39]

38. Joffe, 1999; Kelly, 2000, 2001; Richter & Swart-Kruger 1993-96; loveLife, 2001a
39. Jewkes et al 2001; Wood et al, 1998, 2000; Varga & Makubalo, 1997, loveLife 2001a

Magqabasini village, near Flagstaff in the Eastern Cape province. Pic: Greg Marinovich (Beyond Awareness Campaign)

Sexual debut

- There is a high degree of variation across contexts relating to age of first sexual intercourse experience.
- Boys tend to start to experiment with sex earlier, but take longer to become involved in steady relationships.
- The majority of studies describe the median sexual debut age at 15-16 for boys and 16-17 for girls. However, median age does not reflect that in some communities it is not uncommon for up to 25% of young people to have had at least one sexual experience at or below the age of 13 years. Thirteen year olds are typically in grades 6 and 7 and thus the focus of AIDS education, if it is to reach young people when they are beginning to experiment with sex, should start in senior primary school.
- Rural sites have significantly lower sexual debut ages and poorer young people are significantly more likely to have sex at a young age.
- Age of first sexual intercourse appears to have decreased dramatically over the last 20 years, by about three years.
- There are blurred boundaries between childhood sexual games and sexual intercourse in some rural areas in particular, so that many young people have early sexual experiences without taking a clear decision to become sexually involved.
- The concept of virginity does not have a strong meaning for boys and girls, although in some areas, and particularly in KwaZulu-Natal, there is an

There are blurred boundaries between childhood sexual games and sexual intercourse in some rural areas in particular, so that many young people have early sexual experiences without taking a clear decision to become sexually involved.

increasing cultural interest in the concept of virginity in response to HIV/AIDS,[40] and by way of responding culturally to the need to curb the epidemic.

- Boys tend to report early sexual experimentation as sexual intercourse, whilst girls tend not to consider early sex as actual sexual intercourse. There is a need for studies to examine young people's definitions and understandings of sexual intercourse.

- High age differentials are reported between girls and their older partners in early sexual experiences, with one study reporting that 23% of respondents had sex with someone five or more years older at sexual debut. This phenomenon appears to be more prevalent in poorer communities and is reflected in the following comment: "The girls that sleep with older guys... it's a class distinction thing, the *cheaper* your school, the older the guys you sleep with".

Sexual consent and coercion[41]

- There is strong evidence that first sexual intercourse for girls is often coerced, with a number of studies reporting experiences of coercion or manipulation ('not your choice') in first sexual intercourse. The percentage of cases in which this is reported is in most instances between 30-40%.

- Decisions to engage in sex for the first time are largely influenced by the male partner.

- There are high levels of ambivalence about sexual activity amongst sexually active adolescent girls. Young women aged 15 to 30 years are significantly less likely than their male counterparts to respond positively to the question: 'Do you like sex?'. In one study that examined this question, only 59% of females who have had sex before responded 'yes' to this question as opposed to 85% of males. A number of studies report young girls having sex merely to please their partners.

There are high levels of ambivalence about sexual activity amongst sexually active adolescent girls. Young women aged 15 to 30 years are significantly less likely than their male counterparts to respond positively to the question: 'Do you like sex?'.

- There is ample and strong evidence that gender-related oppression and bullying in sexual relationships are commonplace as are coercive and non-dialogical approaches to sexual relations. Young women are frequently subject to threat of violence and rape both by partners and strangers.

- Young boys feel some pressure to be engaged in sexual relationships with sexual activity often being thought of as a source of peer-group esteem.

- Material incentives play an important role in sexual decision-making, even in non-commercial sexual exchanges. In a loveLife survey, 43% of respondents who were sexually experienced reported that they knew of some young people their age (range 12-17) who have had sex for money, and 16% reported that they themselves have had sex for money, drinks, food or other gifts.

Levels of sexual activity.[42]

40. leClerc-Madlala, 2001; Scorgi, 2001
41. Jewkes et al 2001; Wood et al, 1998, 2000; Varga & Makubalo, 1997, loveLife 2001a
42. Gouws, 2000; Kelly, 2000, 2001; Kelly & Parker 2001; Richter, 1993-96; Williams et al, 2000; Beksinska & Stadler, 2000; Buga et al, 1996a, 1996b; Boxford, 2001; CASE, 2001; Fisher et al, 1993; Rutenburg et al, 2001

- Whilst about 50% of young people (estimated across research studies) under the age of 16 have had a sexual intercourse experience, the assumption that young people are regularly sexually active from an early age is not true. Young people are generally not frequently or regularly sexually active. There is largely irregular and opportunistic sexual activity within the first few years of being sexually active.
- Frequency of sexual activity in adolescence increases with age.
- There is a strong correlation between socioeconomic status and sexual activity amongst early adolescents, with greater levels of sexual activity amongst the less economically advantaged.

Condom acquisition and use

It has already been suggested that the promotion of condoms has had significant impact, and that condom use is widespread and often consistent. However, in some quarters there is the persistent conviction that condom use has not appreciably changed. For example, the viewpoint that "Despite considerable public education efforts over the past five years, condom use amongst sexually active teenagers remains at around 10%",[43] is regularly featured in loveLife communications without reference to any supporting research. The net effect of this viewpoint, particularly given its widespread prominence, has been to distort public understanding of youth response to HIV/AIDS. This claim is considerably at odds with the wide range of research studies we have reviewed – all of which illustrate a more promising picture in relation to condom use amongst young people.[44] In section two we have made reference to the large number of condoms distributed annually in South Africa, and the findings presented below support the notion of fairly widespread uptake of this prevention method.

It has already been suggested that the promotion of condoms has had significant impact, and that condom use is widespread and often consistent. However, in some quarters there is the persistent conviction that condom use has not appreciably changed.

- The most nationally representative survey on condom use was the Demographic Health Survey conducted in 1998 with a sample of 854 15 to 19 year olds. Of these 19.5% reported using a condom in the last sexual act with any partner, and 21.2% with a non-spouse partner.
- Consistent condom use amongst young people ranges from relatively low rates in rural areas (20-30%) to considerably higher levels (as high as 70-80%) in some urban settings.
- Communities of young people vary considerably in respect of regularity of condom use. Whereas in one community a high percentage may have used a condom before, a low percentage will have used a condom in the last sex act. In another community the gap between having ever used a condom and having used a condom in the last sexual act is less marked. The gap between 'ever' and 'last time' reflects consistency of use and rural respondents seem to use condoms less consistently. This may be related to supply and access problems, and there is evidence of this in a number of rural communities covered in the reviewed studies. The South African Health Review 2000[45] shows high levels of availability of condoms in all provinces (fixed clinic waiting rooms, 87%; rural clinics, 85%). However, studies reviewed show that in some communities there are problems related to

43. loveLife 2001, p.12
44. DHS, 1998; Buga et al, 1996; Kelly, 2000, 2001; Kelly & Parker, 2001; Beksinka & Stadler, 2000; Peltzer, 2000; Williams et al, 2000
45. van Rensburg et al, 2000

lack of confidential, non-judgemental access to condoms. This is an important factor that considerably limits condom access by young people. Also, contrary to the above review, there are many rural areas of the country where condoms are unavailable.

- Rates of young people never having used a condom vary substantially, ranging from 60% in remote rural areas to only 14% amongst privileged urban youth.
- It seems that the biggest challenge in promoting condom use is maintaining condom use in long-term and established relationships.
- Condom use positively correlates with education levels.
- Condom use is associated more strongly with pregnancy prevention than with HIV/AIDS and STD prevention in some studies.
- There is a complex and unclear relationship between motivations for using condoms given that condoms are a contraceptive and an HIV barrier method. There has been little promotion of the dual protective value of condom use.

There is some evidence suggesting adoption of secondary abstinence as a response to risks associated with sex. Secondary abstinence refers to the decision to abstain from sex following previous sexual activity or sexual debut. Various factors associated with this include HIV prevention, pregnancy prevention, STD prevention and avoidance of sexual violence or coercion.

Abstention[46]

- There has been very little research on abstention trends.
- There is some evidence suggesting adoption of secondary abstinence as a response to risks associated with sex. Secondary abstinence refers to the decision to abstain from sex following previous sexual activity or sexual debut. Various factors associated with this include HIV prevention, pregnancy prevention, STD prevention and avoidance of sexual violence or coercion. Justifications for secondary abstinence also include, but are not necessarily always related to, religious convictions. Nineteen percent of a

Magqabasini village, Eastern Cape. Pic: Greg Marinovich (Beyond Awareness Campaign)

46. Varga, 2000; Scorgi, 2000; le Clerc Madlala, 2001; Kelly & Parker, 2001

random sample of tertiary institution females reported having had sex before, but not in the past year. Findings in five other sites were not as high, but this suggests that secondary abstinence is a prevention option that may find more support than is often assumed, and is worth promoting more actively. Reasons given for abstinence in this site included: "Yes, I'm scared of AIDS so I decided to chill and not have sex for a while"; "I tried having sex once but later got scared to do it because of AIDS"; and "I became sexually inactive because of (concern about) AIDS."

- As noted earlier, abstinence has generally not been given particular emphasis in HIV/AIDS intervention programmes and campaigns. Abstinence remains the one sure way of HIV/AIDS prevention, yet promotion of condom use as the primary means of prevention presents an expectation of sexual activity amongst adolescents and young people as a whole. This may overlook the potential adoption of abstinence messages especially for young people who are receiving HIV/AIDS messages but are not yet involved in sexual activity.

Abstinence remains the one sure way of HIV/AIDS prevention, yet promotion of condom use as the primary means of prevention presents an expectation of sexual activity amongst adolescents and youth as a whole.

- There has been little research on courtship practices and we have not found research that has examined whether the period between establishing a courtship and having sexual intercourse has changed as a response to HIV/AIDS.

Alternative sexual practices

- There is very little research on whether young people are adopting alternative means of sexual expression apart from penetrative sex. Alternatives include oral sex, masturbation, mutual masturbation, and 'thigh sex'.
- There is no research on practices relating to sex during menstruation and very little to go on in understanding the prevalence of anal sex amongst young people.

HIV counselling and testing[47]

- HIV counselling and testing is not widely available, nor widely promoted. A recent survey of primary healthcare services across South Africa[48] shows that HIV testing is available at only six out of every ten fixed clinics. However, research studies from rural areas suggest that access to voluntary counselling and testing services is poor and research also suggests that in many cases counselling services are less than adequate. One study from a deep rural area suggests that negative and critical attitudes on the part of clinic staff, and concerns about confidentiality, mean that even where services are available the context is not conducive to helping a young person through the sensitive process of finding out his/her HIV status.
- There appears to have been little promotion of voluntary counselling and testing as a prevention option. It seems that the perception that AIDS is a death sentence and that there are few supportive services available has led to the perception that there is little value in knowing one's HIV status.

47. Richter et al, 2000; Kelly 2001; Russel & Schneider, 2001
48. van Rensburg et al, 2000

Amatole, Eastern Cape. Mary van der Riet (University of Pietermaritzburg)

Personal involvement[49]

- There are high levels of reported interest in becoming involved with HIV/AIDS response initiatives (more than 50% in each of six communities across South Africa). However, there are significantly lower levels of awareness of how to meaningfully become involved, and the steps one might take to become involved.

The need to understand contexts of risk

It is important to appreciate that young people as a group are not homogenous. Responses on many of the above indicators vary across contexts, sometimes to a remarkable degree, and prevention planning needs to take into account how young people differ and what their specific needs are in relation to HIV.

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Whereas in the adult epidemic the vectors of transmission are quite well known, amongst young people this is not the case. Migrancy, long-distance trucking and commercial sex work, are for instance, accepted as exposing adults to risk. Also socially mobile and economically active adults and their partners, are often spoken about as being most at risk.

With young people we cannot assume similar patterns. From what we have gleaned from the scattered pieces of research, it would seem that less educated and rural young people, and especially girls, are behaviourally speaking most exposed to risk, and are least equipped to manage their risk exposure. In almost every area of response, education and socioeconomic environment appear to distinguish those who are adopting risk prevention practices and those who are not. Wealthy and more educated young people who have good social support, and a positive sense of their futures, tend to have sex later, have partners who are closer in age to themselves, tend to use condoms more, are more active in making decisions about their sexual and reproductive health, and have better access to information and better access to services.

It is clear that economically disadvantaged young people living in rural areas need to be targeted more actively, and in ways which address their particular challenges. Much more is said about the response framework following, but

49. Gouws, 2000; Kelly, 2000, 2001; Kelly & Parker, 2001

whatever forms of intervention are put in place, they need to be crafted according to an understanding of contextual circumstances, and need to include an understanding of risk profiles, available communication channels, social support networks, and so on. The 'one size fits all' approach to prevention has arguably delivered what it is capable of delivering – a fairly good base of knowledge. We need to understand the population of young people and their different needs so that they can be supported and assisted and so that prevention attempts can be endorsed and appropriately built upon. This requires contextual analysis.

For example, if we show that teens who talked with their mothers about condoms before their first sexual encounter are three times more likely to use condoms than teens who did not do this,[50] it does not necessarily mean that the discussion was the most relevant influence on their behaviour. The dialogue may itself be a product of some more basic mediator of response. Consider, for example, that the mothers of the teens who did not have such dialogue are mostly working mothers, and that this reflects an entirely different social context, family structure, relation to authority, and level of independence of the teenager. Each of these factors may influence the likelihood of condom use, and we must be cautious about attributing causal significance to observed associations between phenomena. Because two things occur together does not mean that the one leads to the other, but rather, they may both instead be a result of some more primary cause or mediating phenomenon. In other words, it is better to understand *how* behaviours happen, and under what circumstances they happen. This will allow us to be better positioned to talk about what makes a difference with respect to shifts in behaviours and adoption of specific practices.

Following the disciplinary framework of social epidemiology,[51] the socio-environmental factors which need to be understood as determinants of particular health outcomes, may lie 'upstream' of what is apparent as problematic behaviour. Behavioural outcomes may result from determinants which are not immediately apparent in the current environment, and we need to look to the factors which cause them, so to speak, upstream. The upstream search may reveal important determinants which at first glance may have seemed unconnected to the targeted problem, or traces of historical influences which are no longer readily evident within the present context, but which work through the social arrangements they have created.

Description of the factors which have been associated with HIV prevention behaviour include poverty, education, locality, mobility, gender, criminal justice issues, levels of service delivery, social capital and legal regulatory frameworks. What tends to be lacking is an understanding of how these factors are associated with low uptake of prevention behaviours, that is, how they are contributory factors to the spread of the AIDS epidemic.

Description of the factors which have been associated with HIV prevention behaviour include poverty, education, locality, mobility, gender, criminal justice issues, levels of service delivery, social capital and legal regulatory frameworks.[52] What tends to be lacking is an understanding of *how* these factors are associated with low uptake of prevention behaviours, that is, *how* they are contributory factors to the spread of the AIDS epidemic. The chain of causation is often remote – for example, from *apartheid* to breakdown of family structures through migrancy, to deterioration of cultures of regulation of youth sexuality, to decrease in age of first intercourse in particular environments. But we must understand the mediating influences, or the chains of association between these phenomena. Unfortunately much public debate about HIV/AIDS is conducted without this middle ground of explanation being filled in, and because of this explanatory hiatus, a false tension is created between the general need for social development,

50. Solar-Tuttle, 2000

51. Berkman & Kawachi, 2000

52. Dowsett & Aggleton, 1999; Donovan & Ross, 2000; Kelly & Parker, 2001; Ntlabati et al, 2001; Jewkes, ; Campbell & MacPhail,1999 ; Williams et al, 2000.

and the need for more direct avenues of intervention, such as obtaining condoms to be used during sex. The key point in this discussion is that behavioural outcomes are not necessarily remediable through behavioural intervention alone, and that background contextual factors may need to be addressed before sustained behavioural change is achieved. With this in mind we turn to examine what has been done to assist young people in the face of HIV/AIDS.

SECTION FIVE: COMMUNICATION CAMPAIGNS

A wide range of communication campaigns have been conducted in South Africa to raise awareness about AIDS and to bring about HIV preventive practices amongst young people.[53] The range of campaigns is multifaceted and rapidly developing and includes localised, event-based campaigns to wideranging and costly multimedia campaigns including:

- programmes *targeting children and young people*, including mass media campaigns, lifeskills programmes and peer education programmes;
- programmes which are aimed at *improving access by youth to services*, and developing the orientation of services to the needs of youth;
- *attempts to regulate conditions affecting youth exposure to risk* at legislative, policy and rights levels to provide a social base of support to interventions.

It should be noted that although specific programmes are reviewed it is not intended that this be seen as an evaluation of programmes. Instead we have provided an overview of the range of responses, with the aim of getting a sense of directions and emphases.

Programmes targeting young people

Mass media communication campaigns

Mass media communication campaigns have been employed as a mechanism for conveying both basic and complex information about HIV/AIDS in South Africa since the late 1980s. The early initiatives of the *apartheid* government – which comprised advertising delineated along racial lines – were widely discredited. The early 1990s saw the introduction of a 'yellow hand' icon associated with AIDS, with messaging largely driven by a combination of basic information and imperatives towards partner reduction, condom use and the like. In the post-*apartheid* government, communications activities included the introduction of the red ribbon logo, wider promotion of the AIDS helpline on billboards and posters, and orientation of messaging to incorporate both prevention and care aspects. However, during this period, considerable political weight and funding was also put behind the development of the AIDS play Sarafina II. The play was widely discredited, and was abandoned soon after its inception. Government HIV/AIDS communication was subsequently refocused and this led to the development of the Beyond Awareness Campaign which was conducted by various consortia between 1997 and 2000, as well as further consortium led activities scheduled to run from 2001 to 2003.

Running parallel to these developments was the introduction of the Soul City television and radio series which first flighted in 1994; campaigns of the National Progressive Primary Health Care Network (NPPHCN); activities of the Society for Family Health, which promoted condom use and low cost, socially marketed, condom brands; and the introduction of the loveLife campaign which began mass media communication activities in 1999. Alongside such campaigns there has been a wide range of communication activities that have been less rigorous

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53. Dickson-Tetteh & Ladha, 2000

consistent and systematic in their delivery. These include various advocacy activities – for example, the government initiated 'partnership against AIDS', and advocacy activities of government departments amongst other organisations.

Provincial governments, non-governmental organisations, community-based and sectoral organisations have also been widely involved in HIV/AIDS communication campaigns, largely located in lower cost event-based communication, but extending into outdoor, print and radio advertising. There is a distinct focus on various AIDS related days, condom week, and other short-duration activities at this level.

It is important to create a distinction between these purposive campaigns and HIV/AIDS communication that takes place in the news media (including broadcast and print media) which further frame understanding of the epidemic, but which do not operate from a rigorous purposive foundation.

An entry point for understanding the influence and impacts of purposive campaigns is to assess how target groups have received information about HIV/AIDS, and then to assess recall of specific campaigns or campaign elements. A number of surveys[54] indicate that mass media, and particularly radio has been the source of information from which the South African public have been most exposed to HIV/AIDS programmes. This is closely followed by television, which is relevant for targeting both urban and rural audiences. It is important to note however, that information disseminated via mass media channels is limited. These include:

A number of surveys indicate that mass media, and particularly radio has been the source of information from which the South African public have been most exposed to HIV/AIDS programmes. It is important to note however, that information disseminated via mass media channels has distinct limitations.

- unidirectional delivery;
- the capacity to deliver only simplified key messages in discrete areas of information;
- the need to ensure that information and messages are intelligible to specific audiences;
- the need to address linguistic variations countrywide;
- the need for repetition of information to facilitate recall;
- the need to use a variety of mediums to reinforce information;
- the need to address the heterogeneity of target audiences;
- the need to meet costs of accessing mass media channels including outdoor, print and broadcast media;
- the need to assess impacts and cost-benefits of interventions.

Communications approaches

National HIV/AIDS communications interventions have included both single media and multimedia approaches including:

- Television advertising, for example, the Beyond Awareness Campaign's promotion of the AIDS Helpline, Soul City's promotion of HIV/AIDS issues; and the Society for Family Health's condom advertisements.

54. loveLife 2000, Kelly 2000; Soul City 2000a, 2000b; Markdata 2000

Students at University of Natal, Pietermaritzburg, KwaZulu-Natal. Pic: Greg Marinovich (Beyond Awareness Campaign)

- Radio advertising, which has been widely utilised in national and provincial government campaigns, as well as in various non-governmental campaigns.
- Print advertising in newspapers and magazines utilised by various campaigns.
- Outdoor advertising, including billboards and signage and extending to mobile media such as commuter taxis, buses and trains. Various campaigns including the Beyond Awareness Campaign, provincial government campaigns and the loveLife campaign have been prominent in this area.
- Television and radio programming, primarily oriented within an entertainment education framework. The most prominent example in this regard are Soul City and Soul Buddyz which have utilised drama formats. Use has also been made of interactive formats such as loveLife's Scamto series, and documentary programming, such as the Beyond Awareness Campaign's Living Openly project.
- Print supplements, typically involving the insertion of magazine format publications into national newspapers for dissemination. Soul City and loveLife have utilised this approach.
- Small media approaches, including leaflets, posters, booklets and branded utility items, with the widest use being by the Beyond Awareness Campaign. This was incorporated the development of a national AIDS Action Office – a clearinghouse facility which allowed organisations and individuals to order free HIV/AIDS materials.
- Helplines, which allow for complex personalised interaction and discourse between target audiences and trained counsellors. This includes the expansion and promotion of the national tollfree AIDS Helpline through the Beyond Awareness Campaign, the development of a women's support line by Soul City, and loveLife's Thetha Junction youth helpline.
- Community-based interactive approaches: for example, the development of the AIDS Memorial Quilt and AIDS Mural projects by the Beyond Awareness Campaign, and the event-based approaches to sports and healthy living promotion by loveLife.

- Support systems and infrastructure, for example the loveLife Y-centres and a national adolescent friendly clinic initiative, which works with public sector clinics.

A further common element of most campaigns is that of *branding* – an orientation which lends itself to sustained campaigns, and which allows target audiences to identify the sources of information. Branding is widely utilised in advertising to reinforce consumer orientation towards particular products, which in turn supports sales. Consumer brands are often oriented towards emotive rather than objective responses, and this allows for branding nuances to develop over time. For example, the Coca Cola brand has been reinforced over many decades, but is nuanced each year by new slogans and advertising campaigns that both reinforce existing markets, and facilitate market growth. Motor vehicle branding is oriented towards concepts such as quality and style and allows different companies to use brand appeal to sell vehicles with virtually identical features to brand nuanced sectors of the consumer market.

The value of branding of HIV/AIDS campaigns has not been widely explored, nor sufficiently theorised, but does have value in setting campaigns and target audiences apart, and has potential to support social mobilisation. Soul City is as much a brand as it is a television and radio series, and the Soul City logo is utilised across other mediums as well. The loveLife campaign is purposively brand oriented, with the brand being intended to convey a particular 'youth lifestyle'. The Beyond Awareness Campaign adopted an approach to branding that was less oriented towards branding the campaign and more oriented towards creating an association between the red ribbon icon and HIV/AIDS. This latter approach was specifically to allow for other initiatives to benefit from a generic *red ribbon* brand. This approach allowed individuals to wear red ribbon badges and red ribbon branded utility items without necessarily associating themselves with a particular campaign, but rather with the notion of supporting HIV/AIDS in some way.

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Extending beyond campaign branding has been the extensive use of advocacy approaches towards affirming particular campaigns or elements thereof. Typically this has included events, launches, press conferences, press releases, public relations and other mechanisms for advancing the interests of campaigns more broadly. Whilst there are obvious benefits to these approaches, their orientation is often towards uncritically promoting campaign successes, and towards promoting particular initiatives as more relevant and significant than others. Whilst this is the stuff of public relations, in the context of a broad-based epidemic that is led on several fronts, it is important to be cautious about skewing public understanding of the complex dynamics of the epidemic as a whole.

Strategies, models and theories

By and large, mass media communications campaigns have been strategy-based, with strategies incorporating a series of basic assumptions related to communications approaches and media to be utilised to bring about specific changes. Whilst strategy-based approaches allow for viable communications campaigns, without theoretical development and model building, overall impacts will be limited. The value of theory is that it allows for explicit interrogation of the ways that target audiences receive and respond to information, and is specifically useful in understanding how particular impacts

might be achieved. There is a need to be rigorous in understanding particular campaigns within the context of other campaigns, and also to develop sufficient understanding of the location of campaigns within the context of the epidemic as a whole. Various sections of this review point to extensive and complex gaps in our understanding of the epidemic, as well as issues related to understanding the contexts of young people's responses to HIV/AIDS that have not been addressed. Achieving a more rigorous approach requires some development of theoretical frameworks that would enrich the impacts and cost-benefits of communications approaches. Some of the national mass media campaigns do make use of explicit theoretical frameworks. The Beyond Awareness Campaign, for example, articulated implicit communications frameworks in a manual entitled *Communicating beyond awareness*,[55] whilst Soul City has drawn extensively on the Johns Hopkins University's Center for Communications Programs *steps to behaviour change* model[56] and loveLife makes reference to a range of implicit assumptions regarding the nature and contexts of youth communication.

Evaluation of campaigns

Over the past decade there has been a greater orientation towards evaluation of national-level communication campaign activities. This has not extended to provincial and local campaigns. The evaluation of national mass media campaigns has largely been driven by the need to demonstrate to funding bodies and the public at large, the benefits of sustained multimillion rand investments in communications activities. Such evaluations are typically developed and funded internally within campaigns, and are oriented towards internal assumptions, strategies, models and theories. External research agencies or consultants are generally contracted to work in partnership with internal research structures in the development, management and interpretation of research activities and findings.

The evaluation of national mass media campaigns has largely been driven by the need to demonstrate to funding bodies and the public at large, the benefits of sustained multimillion rand investments in communications activities.

The limitation of such evaluations is that they tend to be programme specific and do not lend themselves towards understanding the broader HIV/AIDS communication milieu. They often do not sufficiently recognise the impacts of parallel communications activities and do not necessarily explore the specific information needs of target audiences. Recent mass media campaigns can be summarised as follows:

The Beyond Awareness Campaign was a multimedia and multi-activity HIV/AIDS campaign of the Department of Health targeting youth in the 15 to 30 year age group. The objectives included:

- intensifying communication of key messages around HIV/AIDS;
- promotion of the red ribbon;
- development and promotion of the national tollfree AIDS Helpline;
- development and dissemination of small media communications resources that support action around HIV/AIDS;
- promotion of social action through targeted projects including the AIDS memorial quilt, communications activities in tertiary institutions and

55. Parker et al, 1998
56. Piotrow et al, 1997; Singhal and Rogers, 1999, 2001

promotion of social action in the news media;

- development of behavioural research to provide insight into youth response to HIV/AIDS.

The campaign was managed by two consortia via two separate contracts over a three year period. Although elements of the Beyond Awareness Campaign involved mass media communication, for the most part activities centred around the development of a range of generic communications products including, for example, the development of a set of eleven thematic leaflets which were made available in all eleven languages, thematic posters, development of guidelines, policy and protocol documents, utility items and the like, which are all functional to local level communication activities. Similarly, development of the AIDS memorial quilt and mural projects provided models for local level interactive activities.

The fixed time period of the contracts, and the developmental nature of the campaign did not lend itself to impact evaluation and elements were thus evaluated utilising descriptive and process evaluation approaches. These were insufficient for understanding the impact of the campaign and the lack of rigorous evaluation limits perpetuation of key campaign elements that may have been effective.

The sporadic and uneven nature of government HIV/AIDS campaigns needs to be looked at critically. The short-term nature of tendered contracts, combined with the trend towards diverse consortia implementing contracts works against the need for consistent ongoing strategies, models and theoretical frameworks. Additionally, there have been considerable delays in contracting of further campaigns by government and in 2001 there was a nine month gap between the completion of the Beyond Awareness Campaign and the contracting of subsequent activities.

The sporadic and uneven nature of government HIV/AIDS campaigns needs to be looked at critically. The short-term nature of tendered contracts, combined with the trend towards diverse consortia implementing contracts works against the need for consistent ongoing strategies, models and theoretical frameworks.

Soul City is a sophisticated entertainment-education[57] project which was initiated in the early 1990s. Although not specifically targeting young people, Soul City does reach into younger age groups. The project has a clearly articulated health communication philosophy and has adopted the five pillars of health promotion outlined in the Ottawa Charter,[58] which involve: building healthy public policies; creating supportive environments (safe, stimulating, satisfying and enjoyable) for change; developing personal skills; strengthening community actions; reorienting health services; and the creation of a supportive environment for change.

Soul City is not an HIV/AIDS specific intervention, but rather, deals with a wide range of health issues including HIV/AIDS but extending to, for example, children's health, reproductive health, alcohol abuse, hypertension, crime, abuse of women, amongst other themes. It is to be expected therefore, that Soul City would only make discrete impacts in the area of HIV/AIDS.

Soul City is broadcast annually over a three month period on television (13 episodes), on radio (60 episodes) and is supported by a range of booklets on social development and health which are distributed throughout the year. Content is developed through formative research processes and evaluations are conducted on a regular basis.

57. Soul City, 2000a, 2000b
58. WHO,1986

The behaviour change methodology of Soul City has a particular slant which relies quite heavily on constructive, pro-social role modelling (providing models of positive and socially oriented attitudes and actions), and modelling of problem solving and coping strategies. This is usually presented in settings which are intended to be real and familiar to the intended audiences. Soul City seeks to follow an entertaining and non-didactic model and attempts to prompt its audience into reflecting on their own attitudes and behaviour, with a strong emphasis on the aspect of choice.

Evaluations of Soul City[59] released to date have not definitively proven a causal link between the intervention and specific HIV/AIDS-related behaviour changes, although they do show that Soul City has been an important source of information and inspiration, and that it has been a thought provoking and valued stimulus for pro-social problem solving at a number of levels. The evaluations do not deeply explore the relevance of parallel non-Soul City interventions, nor do they adequately explore longer term behavioural outcomes. There is also little exploration of the contexts within which viewing, listening and reading occur, or of the relationships between programming and enabling environments.

Soul City recognises that part of the function of mass media is to create a supportive environment in which individuals and organisations on the ground can more easily conduct their education and counselling work. There is some evidence that Soul City influences the broader environment by influencing people in particular leadership roles – for example, Soul City messages are amplified through reaching teachers and nurses, to the extent that it influences their practices and enhances the potential for service delivery in the related sectors.

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Soul City was also more recently involved in the development of **Soul Buddyz**, a television and radio series which targets children in the 8 to 12 year age group. The programme content incorporates similar diverse foci including, for example, HIV/AIDS, children's rights, sexuality, accidents, disability, road safety and bullying. Evaluations of the series are underway.

loveLife is a high budget communications activity primarily aimed at 12 to 17 year olds and is oriented towards the development of healthy lifestyles incorporating pregnancy reduction, and prevention of HIV/AIDS and other STIs. The initiative has a number of components including awareness and education through conventional advertising (primarily outdoor advertising), as well as utilising television and radio programming. Outreach activities include the development of youth centres, a helpline, and the promotion of sports, debating and other activities. loveLife has produced a summary of evaluations conducted on its first year of operation[60] and is presently designing further evaluations. loveLife has also conducted its own youth survey[61] aspects of which are discussed in the KABP section of this review.

Some aspects of the loveLife campaign have been widely perceived as contentious – particularly the high profile outdoor media campaign that has incorporated messages that various experts have suggested are confusing and not readily

59. Soul City, 2000a, 2000b; Case 1996

60. loveLife, 2001b

61. loveLife, 2001a

decipherable.[62] loveLife's 2001 evaluation[63] of the billboards skirted the issue of decipherability, examining instead aspects of recognition of the billboards. The study examined, for example, prompted recognition by respondents at (66.5%), the notion that the billboards were 'about real life' (58.3%) and whether the billboards had 'caused them to think' (27.2%). Such data does not provide much information on the relevance of the billboards within the broader campaign. If the purpose of the billboards is to encourage discussion (as is implicit in loveLife's broader aims and objectives), or to promote a ''lifestyle brand' then it is necessary to specifically evaluate this aspect.

With regard to the evaluation of other communication components, the summary of evaluations shows mainly descriptive analysis of *awareness* aspects – for example reach of programming, or appeal or recognition of particular elements of the campaign – as opposed to more deeply unpacking the relationship of the campaign to its stated objectives. It is thus difficult to draw conclusions about behavioural impacts without further research. However, this limitation may also be a product of the fact that the campaign is in an early phase of operation and impact analysis may indeed be premature.

Evaluating impacts

In evaluating campaigns, recall of messages and recognition of materials are often used as measures of success. However, these approaches do not contribute sufficiently to understanding campaign impacts. This is all the more complex when the communication activity takes the form of a television drama series, or relies on interpretation of messages when the centre of the campaign is promotion of a particular lifestyle or coherent set of behaviours.

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The evaluation literature has endorsed theory-led evaluations which make sense of how communications come to have an effect on behaviour. However, there is a bewildering array of theoretical models of behaviour change and communication[64] practice, which leads to the question 'Which theory is appropriate?'. Although there are many similarities between the theoretical models, they generally involve different understandings of how action and communication interrelate. At an international HIV/AIDS conference[65] there was little evidence presented to suggest that communications models are converging and one of the more prominent researchers in the field ended his presentation with the question 'Is it time for a new theory?'.[66] The finding that theoretical developments to date have proven unsatisfactory is hopefully an encouragement to researchers working in the area of mass media communication in South Africa. It is quite apparent that a great deal has happened in a short period of time, and there is fertile ground for theoretical development.

It might be said that mass media and communication campaigns can effectively work at the level of impacting on individual orientations to behaviour and at the level of cultural understanding – that is, in the domain of what is shared as understanding and meaning between people. At both of these levels the power of mass media might work to provide new information, and new dispositions

62. Internet discussion on Marketing Web, 2001
63. loveLife, 2001b
64. Airhenbuwa, 2000; Piotrow et al, 1997; www.communit.com
65. AIDS Impact Conference, Brighton, July 2001
66. Fishbein, 2001

to act. The former is delivered at the level of cognition or thought, whilst the latter impacts upon the normative social framework or value system that defines what is desirable and acceptable and what is culturally unacceptable. This is an important level to address, because when normative social frameworks are created, these tend to pre-empt the need to establish frameworks for action in the context of individual behaviours. For example, a study[67] that reviewed negotiation of condom use amongst youth in various sentinel sites found that the site where there was the highest level of condom use (a private school) had a relatively low level of discussion of condom use between partners. In this context it is normative to use condoms – that is, it is expected that people would use condoms – and therefore condom use doesn't need to be a subject of specific discussion preceding sexual intercourse. This demonstrates how normative expectations may create paths of action at a precognitive level, ie. the way we act before we come to explicitly think about our actions. Social norms create frameworks and socially accepted rules for action which we subscribe to before we come to think about what we do.

National mass media campaigns have to some extent tried to impact on social norms. For example, the Beyond Awareness Campaign promoted a set of shared values associated with the symbol of the red ribbon. The campaign attempted to endorse an orientation towards care and shared concern in relation to HIV/AIDS, using the red ribbon as a positive rallying symbol. loveLife and Soul City,[68] also aspire to shift the normative frameworks for behavioural response, and seek to promote particular lifestyle values as well as to develop an orientation towards the value of acquiring particular understanding and skills as a foundation for dealing with difficult predicaments. loveLife has sought to promote a culture of openness and shared decision making (talk about it!) and Soul City has focused on developing a culture of reflective problem solving. In the case of Soul City, mass media provides a background to a more fundamental and transformative set of activities around problem solving and skills development.

AIDS mural, ML Sultan Technikon, Durban, KwaZulu-Natal. Pic: Greg Marinovich (Beyond Awareness Campaign)

67. Kelly & Parker, 2001
68. Usdin et al, 2001

Appropriateness and cost effectiveness

Communications campaigns utilising mass media are extremely costly and it is complex to develop criteria that might convey an understanding of their specific cost-effectiveness. None of the mass media communication interventions outlined above make open reference to their overall budgets, nor do they attempt to contextualise interventions and impacts in relation to cost. It is appreciated that internationally there are few resources to draw upon when attempting cost-benefit analysis, and the complexity of communications campaigns does not readily allow for clear analysis. In fact, the multitude of parallel mechanisms that contribute to individual cognitive processes, practices and behaviours related to HIV/AIDS, make it difficult to understand the weighting and relevance of mass media interventions per se. Internally oriented evaluations are an obvious first step in understanding communications impacts, but data gathering needs to be extended to the development of research studies that examine impacts from an independent standpoint. Independent national surveys incorporating generic and specific communications questions would be useful. Smaller scale qualitative studies should also be promoted, and the development of such research by students at post-graduate level is worth encouraging.

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With regard to the appropriateness of content of mass media communication campaigns, there has been no definitive study of message content at a national level. A survey[69] amongst 15 to 30 year olds in six sentinel sites across the country showed that messages promoting the use of condoms have been most prominently communicated to youth. Messages about being faithful to one partner or abstaining from sex were not nearly as prominent. Areas needing further focus include, for example, STI treatment, HIV testing, delaying sexual debut, protecting siblings from sexual exploitation, addressing age differentials between sex partners, endorsement of secondary abstinence and other preventive strategies. It is not clear however, how such needs might penetrate into the planning phases of mass media campaigns. Current national communications campaigns are not particularly well oriented towards understanding grassroots information needs, partly because data is not rigorously accessed, and partly because there are limits to the breadth and complexity of information that can be conveyed through mass media channels.

Interactive approaches such as helplines allow for more complex and specialised information to be conveyed, and analyses of call content would be useful towards understanding gaps and shaping key messages at national level. Although a number of campaigns incorporate helplines, few appear to be rigorously collating or analysing call trends.

Finally, there is a need to understand more closely, the HIV/AIDS communication environment as it pertains to children and young people – in particular the weighting of the impacts of mass communication interventions within the context of general interpersonal communication about HIV/AIDS amongst children and young people. This would provide insight into the overall relevance of such campaigns, and would also contribute to improvements in appropriateness and cost efficiency.

69. Kelly, 2000

Getting into details: Shifting response

In considering the promotion of reproductive health, there is a need to consider promotion of condoms for wider purposes. There has been very little emphasis in South African campaigns on the dual protection aspects of condom use, yet several international studies have found that the likelihood of using condoms for disease prevention is reduced when the female partner employs a contraceptive method other than condoms.[70] This lends some support to the idea of promoting condom use as a primary method of birth control, amongst young people in particular.

One South African research study suggests that the manner of introduction of injectable contraception in a rural context [71] had a profound effect on the regulatory culture of early adolescent sexuality, and created a poor context for use of condoms for HIV and STI prevention. It might be argued that the motivation behind the need to avoid pregnancy can be harnessed if the dual protective properties of male and female condoms are promoted, and condoms are promoted as both a primary means of birth control and HIV and STI prevention, amongst adolescents. This may entail a higher risk of pregnancy.[72] However, this is slightly offset in the South African context by the availability of abortion on demand and, in the case of known condom failure, availability of emergency contraception for some.

There are complexities involved in use of the condom as a dual protection method which need to be further looked at. For instance, the possible failure to use the condom as a barrier method when fertility is perceived to be low or non-existent, for example during menstruation or pregnancy. Research is needed to examine the effectiveness of using condoms as a dual protection approach versus using different methods (including, for example, hormonal contraceptives) to achieve dual protection. The point is that public health debate, research and interventions need to enter more fully into the complexities of these issues, now that the need for dual protection has become an issue of social concern.

Youth development and lifeskills programmes

The advertising messages, broadcast programming, newspaper and outdoor communication which are featured in mass media campaigns, go some way towards providing young people with perspectives which assist them in adopting and maintaining HIV preventive behaviours. But there are many personal and interpersonal reasons why young people may have a less than satisfactory response to persuasive messages. They may, for instance, lack skills of self-assertion, or be overcome by strong feelings of needing approval, or lack a sense that their own needs and thoughts are important. For these issues to be addressed, efforts need to focus on personal development and mass media communication does not lend itself to bringing this about. A more intensive, intimate and personal register of address is required if changes are to happen in the nooks and crannies of individual lives, where intentions and decisions erode, and where communication is constrained.

There is a rapidly developing culture of youth development initiatives in South Africa based around promotion of lifeskills which involve small group and peer

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70. Lord, 2001
71. Ntlabati et al, 2001
72. Lord, 2001

group exploration and learning. This is happening because of a recognition that new skills are necessary for young people to respond positively in oppressive and undermining circumstances – for example, against the current of gender power relations. It is well recognised that young people need to learn particular lifeskills to assist them to:

- feel positive about and responsible for their sexuality and reproductive health;
- be aware of and counteract the gender dynamics which are part of their social inheritance and which impact on their sexual interactions;
- be able to understand and communicate their needs effectively;
- be able to assert and express themselves amongst other people; and
- stand by their rights as citizens and young people.

It has been suggested that mass media campaigns are of value as an introduction to the more fundamental work of bringing response 'down to the ground' – into relationships, communities and organisations. If mass media casts seed for further development, lifeskills activities are part and parcel of the germinating, rooting and growing process. Worldwide, health promotion in schools was refocused with the emergence of the AIDS epidemic in the mid-1980s.[73] Children and young people in these contexts were seen as a relatively easy group to target with HIV/AIDS prevention messages. The idea that the school could be the principal community-based organisation countering HIV/AIDS persists in recent literature.

It has been suggested that mass media campaigns are of value as an introduction to the more fundamental work of bringing response 'down to the ground' – into relationships, communities and organisations. If mass media casts seed for further development, lifeskills activities are part and parcel of the germinating, rooting and growing process.

There is a need, to some extent, to think critically about the lifeskills movement, and it is appropriate to wonder what it says about a society where the responsibility of equipping young people to live more creatively, healthily and positively, is placed in the hands of agencies external to families, and somewhat apart from cultural and religious frames of reference. Perhaps in many years time we will wonder how the responsibility of educating young people about sexuality, relationships and decision making was shifted from primary care givers, families and communities, and became the technical concerns of social scientists, health workers and educators. But it has become, quite literally, an issue of life and death that this be led by formalised approaches in some way. Clearly communities, families and the like have not, to any significant extent, provided the necessary frameworks for effective responses to HIV/AIDS, and perhaps the necessary background of hope, self-esteem and social role-modelling to create self-efficacy. Self-efficacy refers to the sense of feeling that one has the creativity, confidence and skills to manage one's life within a context of trying circumstances.

In South Africa, a national project committee for HIV/AIDS and lifeskills was established by the Department of Health in conjunction with the Department of Education and in 2000, an integrated plan that included six components was drawn up to implement an HIV/AIDS programme. However, there appears to have been a very halting approach to institutionalised lifeskills education within schools. A lifeskills and HIV/AIDS teacher training project conducted in 1997/8 with over 6000 teachers in five provinces, has had relatively little impact on delivery of lifeskills education in the classroom. This is a result of a lack of integration of the training activity with structures and planning frameworks within the Department of Education.[74]

73. Coombe, 2000

74. Unreleased DOE report on the implementation of lifeskills training in the provinces, 2001. Personal communication, provincial manager.

There is no national audit of HIV/AIDS education in schools or school health services available in the public domain, and it is quite unclear at this stage what is being done, where, and by which agencies. Research conducted in twelve schools and six communities across South Africa in 1999 and 2001[75] showed that education on HIV/AIDS was conducted erratically and that in these contexts lifeskills education is skeletal at best – even in places where there has been extensive training of teachers to teach in this area. It appears that there have been significant difficulties involved in implementing lifeskills education in schools. These include: problems of prioritising lifeskills programmes, which are perceived to be a teacher intensive activity in an environment where there is much pressure to improve school performance; no follow-through on the mandate to provide lifeskills education; no follow-up training of teachers; little promotion of the value of the concept of teaching lifeskills amongst teachers; and perceptions that it is a soft teaching option which is not highly esteemed amongst teachers. Unfortunately there is little data available on national impacts of lifeskills programming.

This is not to say that the resources for lifeskills teaching do not exist. Detailed materials have been developed for use in schools,[76] including teacher and parent guidelines. These materials are tailored to all grade levels and have been carefully developed and teachers have been trained to use them – but clearly training does not in and of itself ensure delivery of services. Instead, what is required is a systematic programme of encouragement, monitoring and follow-up.[77]

Concerning the latter, there needs to be greater recognition on the part of trainers in the field that the implementation of a lifeskills programme is a demanding task that will necessarily draw on human resources within schools that are already pressed to meet other commitments. Unfortunately, difficulties associated with implementing comprehensive approaches have not led to a focus on a *short form* approach oriented specifically towards HIV/AIDS. In this instance it may be important to focus on the particular problem of HIV/AIDS given that there is an urgent need to fast-track response. This could perhaps allow for a longer track towards implementing the fuller lifeskills curriculum.

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Running parallel to school-based initiatives, a number of organisations involved in HIV/AIDS prevention have initiated a range of activities broadly grouped around the idea of youth development, which in various ways have set out to teach young people lifeskills. These tend however, not to be implemented on a large scale. Most prominent of these programmes is the Stepping Stones programme and the work of DramAidE, both of which have specific foci on HIV/AIDS, but which also focus on gender issues and communication skills more generally.

The **Stepping Stones** behavioural intervention was developed in 1995, and has received strong international acclaim. It has been used throughout sub-Saharan Africa, and has been translated into a number of languages. The approach was developed in Uganda,[78] and is based on a social learning theory model. It focuses on preventing HIV infection through trans–forming gender relations and through lifeskills learning. Self-efficacy and empowerment in a number of specific areas are seen as goals. The model incorporates behavioural rehearsal

75. Kelly & Parker, 2001; Kelly, 2001
76. Department of Health lifeskills education materials and teacher and parents guidelines
77. Hubley, 1996
78. ACTIONAID Strategies for Hope.(http://www.stratshope.org)

and modelling, and uses role-play as a major tool. The approach has been specifically adapted for South Africa,[79] with additional material included on gender, gender violence and reproductive health.

School pupils, Eastern Cape. Kevin Kelly (Cadre)

The Stepping Stones manual addresses HIV issues within the context of broader sexual and reproductive health concerns and sets out 14 practical steps (involving 14 three hour sessions), which present ways of developing communication and relationship skills in community contexts, for promoting health at this level. The manual is designed to be used in its entirety, rather than as a set of separate modules, and is designed to be run with peer groups, but incorporating members of the broader community at the beginning and end. Sessions focus on different content areas. There are plans for this programme to be developed further through a large scale controlled trial intervention,[80] and appropriate evaluation tools have also been developed.

Key features of Stepping Stones include:

- a focus on all sections of the community, rather than specifically high risk groups;
- a focus on ‘axes of difference’ in communities, especially gender and age;
- use of participatory methods which are enjoyable and empowering;
- recognition of the needs and priorities of participants as its starting point, and all work beginning with participants’ own experiences and contexts;
- recognition of the idea that the best solutions are generated by people themselves rather than suggested from the outside;
- design that enables the exploration and negotiation necessary for communities to address and change social norms.

The series of workshops seek to:

- increase knowledge of sexual and reproductive health problems including HIV;
- change attitudes towards condom use and encourage condom use;
- change attitudes towards people with AIDS;

79. Jewkes & Cornwall,1998
80. Jewkes et al, 2000

- change HIV risk perceptions;
- transform gender relations and reduce gender-based violence;
- enhance understanding of the impact of behaviour on others;
- improve communication in relationships;
- provide assertiveness skills; and
- discuss ideas of loss, grief and dying.

DramAidE is another initiative in the area of lifeskills development. The organisation has been in existence since the early 1990s and is currently based at the University of Zululand and Natal (Durban). The organisation has pioneered a culturally sensitive approach to lifeskills and HIV/AIDS education, building on the participatory learning methods of Paulo Freire and the drama and theatre techniques of Augusto Boal.

A strong emphasis is placed on understanding the lives and circumstances of learners through encouraging them to express themselves creatively through drama, theatre, song, dance and the visual arts.

Role-play, experiential exercises and learning games are a feature of most lifeskills oriented programmes. Such methods involve the use of simulation to engage people directly in close to life experiences, allowing for opportunities to identify and explore problems and to find creative solutions to them. DramAidE has developed a large repertoire of such methods – games, exercises, group facilitation methods – which have been tried and tested with a large range of youth participants in multiple contexts.

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Drama has played a prominent part in South African AIDS education, as has puppetry through the early efforts of African Research and Education Puppetry Programme. Drama has proved to be a useful feature for creating a lively, entertaining, engaging, context in which to explore AIDS issues. Role-play and participatory drama methodologies allow people to enter into understanding issues in ways that are personal and localised and these methods translate abstract issues into the language of experience.

DramAidE school interventions involve a multidimensional approach aimed at targeting and engaging with teachers, learners and the community; exploring solutions to gender, relationship and sexual health problems, promoting development of responses to HIV/AIDS on the part of schools, and conscientising parents about the need to be concerned about AIDS.

This organisation clearly has significant experience in the field, and an understanding of the difficulties involved in presenting lifeskills in under resourced environments in culturally sensitive ways. Particularly noteworthy is the development of lifeskills education approaches in primary schools in KwaZulu-Natal.[81]

A common thread is the creation of an appealing and fun environment, which involves young people in dialogue about issues of importance to them. DramAidE has also conducted a number of campaigns to promote mobilisation around HIV/AIDS and gender issues in tertiary institutions. Training guidelines have

81. Mlungwana, 2001

been developed for this work,[82] and DramAidE has undertaken to train groups of young people in tertiary institutions and youth oriented organisations throughout the country, to become facilitators using these methods.

DramAidE has had a number of its interventions evaluated and there is good empirical evidence that, in the short term at least, the methodology significantly contributed to preventive behaviour amongst young people.[83]

A third youth-oriented development programme is **President's Award** – a large scale life orientation and skills development programme, which has grown exponentially in South Africa and is currently being implemented in other parts of the continent. It has not hitherto dealt specifically with HIV/AIDS, but is now orienting more directly around AIDS issues especially in its young offenders programme, but also in its general youth development programme.

Participants progress through a four stage process towards achievement of three levels of attainment (Bronze, Silver, Gold), each of which involves fulfilment of criteria-led tasks in the following areas: community service, learning of a new skill, learning of a new recreation activity, and completion of an outdoors expedition. What is perhaps most notable about this programme is that it is largely facilitated by volunteers led by a small national team. It provides lifeskills learning opportunities both for volunteers and young participants.

There are many other programmes at different stages of development, including: 'I have hope' peer group project (Old Mutual); Metro Life; Abasha Phezulu (Society for Family Health); 'Better Life Options' (Young Mens Christian Association); Khulisa; Planned Parenthood Association sexual and reproductive health training programmes; and 'Child-to-Child'. Of particular note are programmes of Scripture Union and Youth for Christ, which are extensively involved in an impressive range of youth development activities, both in school and out of school. Approaches of both these organisations stand out for their endorsement of abstinence in relation to HIV prevention. The issue of delay of sexual onset and sexual abstention does not feature prominently in any of the other training programmes reviewed, and it is worth reflecting on American experience in relation to this: "The most effective prevention messages are those which help provide skills to be used interpersonally regarding refusal, delay, and negotiation."[84] They are both also strongly oriented towards the needs of children at different stages of development. In addition to these there are programmes run by organisations such as the Family and Marriage Association of South Africa and faith-based organisations. There are also a range of youth empowerment organisations and youth leadership training initiatives, not specifically oriented around HIV/AIDS, but which are concerned with assisting young people to engage socially from a position of self-confidence and self-respect. Schools, sport and cultural groups, community service organisations, and a range of other community groupings have attempted to promote youth development in response to HIV/AIDS. However, we were not able to locate documents which provide insight into the extent and scope of these various interventions although an audit has been commissioned by the National Youth Commission to assess these aspects.

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82. Botha & Dalrymple, 1998; Botha & Dalrymple, 2000
83. Harvey, 2000
84. Solar Tuttle, 2000

Youth skills development programme, Johannesburg, Gauteng. Henner Frankenfeld. (Beyond Awareness Campaign)

Within the ambit of HIV/AIDS prevention initiatives, a number of training materials have been produced to accompany training programmes.[85] Of note is the Stepping Stones manual and training materials for sexual and reproductive health communication and relationship skills.[86] DramAidE have produced a video and training programme[87] for guiding peer education workers in lifeskills training specifically relating to gender. The National Progressive Primary Health Care Network has produced a series of pamphlets called 'Let's teach about AIDS'. Soul City and Planned Parenthood Association of South Africa[88] have produced training packages for lifeskills training. Soul City and loveLife have both produced and mass distributed booklets on effective parenting.

The lifeskills movement is closely allied to the peer-education movement and lifeskills are usually taught in a group context between, and often by, peers. The peer-education movement is premised on the understanding that peers are more likely to be able to understand and engage with each other in talking about sexual and reproductive health issues than with authority figures and health workers who often represent different social and class values.[89] Peer group programmes are by definition facilitated by same age peers, and may also be gender specific. For young females in particular, there appears to be a well recognised value in discussing intimate matters with same sex peers. However, there does not appear to have been much progress in developing such programmes in South Africa to date, and perhaps it could be more generally said that the role of male and female same sex peer support groups appears not to have been sufficiently prioritised in health promotion.

The peer education model has been quite widely deployed in the workplace and there is some sound evidence that it has met with success. However, both deployment and success of peer-to-peer youth programmes are not as well established. Child-to-Child is a methodology which is being incorporated as

85. Department of Health, 1999
86. Jewkes and Cornwall, 1998
87. Botha & Dalrymple, 2000
88. PPASA Adolescent Health Training Pack; Soul City Adolescent Health Training Pack
89. Solar-Tuttle, 2001

part of a health programme run from Hlabisa hospital in KwaZulu-Natal to build a successful relationship with surrounding schools and their communities and is based on the general methodology promoted worldwide by the Child-to-Child Trust. Child-to-Child activities have also been undertaken by the Gauteng Department of Education since 1999. The programme is conceived as fostering outcomes-based education, inclusive education in schools, and promoting children's rights. The methodology involves a six step approach and aims to involve parents in the school. But it seems that the dynamics of doing this have created a number of complications around teachers and parents not finding mutual ground and there have also been difficulties in inter-sectoral collaboration between health and education.

Lifeskills: A summary of observations

- The challenge of responding to HIV/AIDS has led to a perception of the need for lifeskills training for young people and has contributed to the growth of youth development initiatives.
- There are significant infrastructural and human capacity difficulties in implementing comprehensive lifeskills programmes within schools, and progress has been slow. HIV/AIDS-education has been delivered in an erratic way by a wide range of organizations and intermittently by health services.
- There is a great deal of creative thinking and innovation going on in South Africa in the field of lifeskills learning and youth development and a wealth of 'home-grown' materials and programmes are available.
- There is little data on the numbers of young people being reached through lifeskills and youth development programmes, and there is insufficient understanding of the scope and focus of activities.

Case study: The struggles of a young people's AIDS club

The following account represents a problematic situation which has now been remedied through the enthusiasm and persistence of those involved. As a case, it nonetheless shows up certain problems in developing and sustaining fledgeling HIV/AIDS response activities.

The 'AIDS Awareness Club' is a peer-oriented project based in an historically disadvantaged tertiary institution in South Africa.[90] When first visited by researchers in 1999, it was a well established project with a good track record of achievements over a period of a few years. It was characterised by high levels of enthusiasm amongst the students, a strong sense of group identity and cohesion, and an active membership. This picture of hope and optimism seemed a model of what can be achieved when the energy, time, pro-social orientation, and enthusiasm of young people is harnessed. It was therefore surprising, when visited a year later, that the group was largely dispirited and inactive. The club had become a shadow of its former self. What happened? The activities of this club have included, amongst others:

- running campus awareness campaigns amongst staff and students on the campus;

90. Exact site locality confidential.

- counselling fellow students about sexual health matters and HIV/AIDS;
- directly distributing condoms to staff and students;
- assisting students to make decisions about HIV testing;
- promoting discussion about the introduction of rapid HIV testing;
- conducting HIV/AIDS education in local communities and schools;
- running an abstinence week on campus;
- making AIDS memorial quilt panels;
- promoting the rights of HIV positive people;
- assisting in HIV/AIDS policy development;
- raising funds for education equipment and materials; and
- support for, and sharing of materials and skills with community organisations trying to mobilise around HIV/AIDS.

Over the past few years more than 500 students per year had applied to be members of this club. A selection process involving individual interviews was conducted to identify a total of 50 student members in any one year. The members covered a range of faculties and years of study. The programme was promoted as a work-study programme where students learned practical skills, including interpersonal and management skills in a working environment. The students earned a certificate for successfully participating in the activities of the club and were of the view that their involvement would enhance their employment prospects. The staff at the health centre, where the club was physically located, had put much effort into training and supporting activities.

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The breakdown of the functioning of the club was basically a result of lack of funding. It seems that this was in turn a result of lack of recognition of the value of the club within the institutional environment, and a product of a generally resource constrained situation. The institution funded the campus health centre which in turn funded the AIDS Awareness Club. There were also environmental and drug abuse clubs run from the centre, and these had suffered funding problems. In the light of funding constraints, students hoped to raise funds themselves but were told that they had to do this through the institution's central fund-raising channels. This involved a slow, bureaucratic process which effectively constrained further club activities.

The provincial Department of Health was approached and invited the club to submit a funding proposal, but there too the process proved to be less than efficient when the club was visited in 2000. The students were pessimistic about the possibility of doing any meaningful work for the rest of the year. Club members had no money for transport and could only visit schools within walking distance. As a result there was very little activity by mid-year, in spite of there being operational plans and the necessary time and skills available. Members were pessimistic about earning certificates of performance and the whole project lacked energy and dynamism because of this. Some private funding was raised for the purchase of education equipment and materials and there was some interest shown by outside bodies for supporting what was obviously a very promising and cost-effective initiative. The Beyond Awareness Campaign supported activities of this club through a tertiary

institutions mobilisation initiative, but this was on a short-term basis.

The factors which enhanced the original success of this initiative were:

- integration of HIV/AIDS activism with learning of lifeskills;
- motivation for involvement because of enhancement of employability through having been involved;
- a youth friendly *modus operandi;*
- a creative approach;
- provision of a permanent venue;
- a team approach;
- a committed mentor;
- clearly defined roles and objectives, and assistance in developing these;
- a sense of being part of a broader, important social movement; and
- a sense of being of assistance to the community.

The factors which compromised the club were:

- lack of institutional prioritisation of HIV/AIDS;
- lack of recognition of the work being done within the club by institutional management;
- prevention of the independent fund-raising of the club;
- funding bureaucracy; and
- lack of mechanisms in the society as a whole to identify success stories, support them and model other initiatives on them.

It can be concluded that the students and health centre staff were way ahead of their institution in understanding the need for responding to the HIV/AIDS crisis and had pioneered effective models for doing this. In this case at least, all the successful ingredients were in place, but sustained support was lacking. Mobilisation for this needed to occur at a higher level and there needed to be recognition of the value of this kind of initiative.

It is a tragedy that a society desperate for solutions did not have the infrastructure to recognise and support them. There is an urgent need to identify successful projects and to provide ongoing support for initiatives and for youth activities that are both personally enriching and socially valuable. It would seem important to identify successful projects and to focus on them as models of best practice which can be emulated elsewhere. Through analysis of these, one might develop an understanding of sustainable models of practice that are fuelled by the energy, resourcefulness, and wish to contribute to the response to HIV/AIDS that is increasingly evident amongst young people.

It can be concluded that the students and health centre staff were way ahead of their institution in understanding the need for responding to the HIV/AIDS crisis and had pioneered effective models for doing this.

Developing the service environment for young people

Primary health care

"In rural South Africa, the provision of adolescent health services in a youth friendly environment does not necessarily require major structural or infra structural developments, or a large injection of resources. Rather, it is possible to make significant progress by making use of under-utilised buildings/spaces and efficient use of existing health sector resources." [91]

If there is a single factor that hinders effective response to HIV/AIDS in South Africa, it is the lack of an adequate supportive service environment. Such an environment begins with the provision of health promotion education and lifeskills training services and extends to other appropriate services.

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In the discussion of lifeskills training programmes it was suggested that apart from the use of comprehensive lifeskills training programmes in specific youth development programmes, there is a need to advocate for implementation of proposed and partly initiated lifeskills activities in schools. Some of the more comprehensive models developed outside of the formal educational settings might serve as pathfinders or models for programmes in schools. The same may be said of other models of sexual and reproductive health services which have been developed as alternatives to government health services, for example, in tertiary institutions.[92]

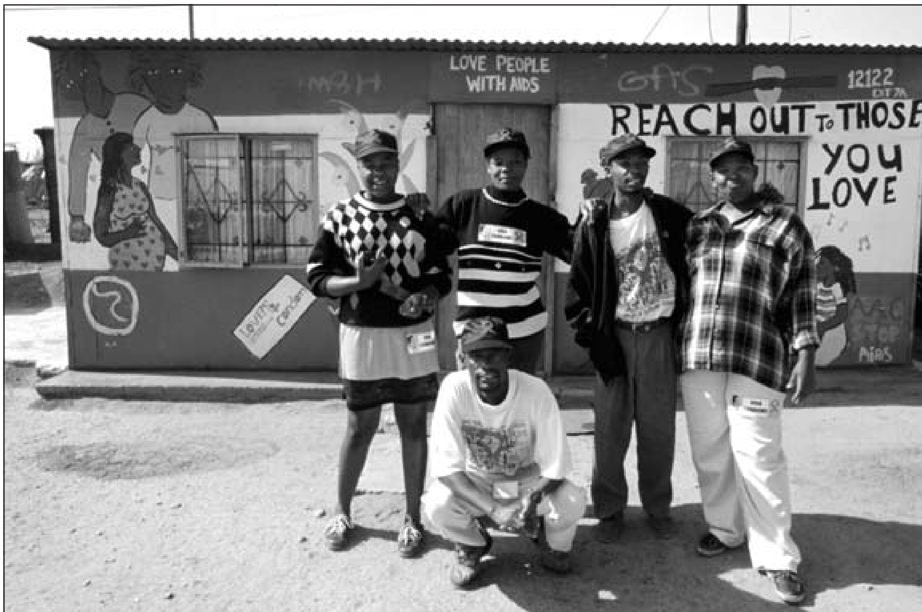
Another example is loveLife's Y-Centres, which offer sexual and reproductive health services to youth directly. Rather than setting up an alternative health system, these centres are likely to have most impact as models of high quality practice. Y-Centres are located in selected under-resourced communities, and are intended as models for providing adolescent sexual health education, counselling and care in non-clinical settings. They are however, capital, resource and personnel intensive and as highly capitalised models they are not workable for the provision of sexual and reproductive health services for young people in the country as a whole.

The Reproductive Health Research Unit, which forms part of the loveLife consortium has introduced a National Adolescent Friendly Clinic Initiative (NAFCI)[93] which appears to hold promise for development of the public sector adolescent reproductive health environment. NAFCI is a health service quality improvement accreditation programme which aims to improve the quality of adolescent health services within existing public sector primary health care clinics. The programme endorses objectives which include:

- improving accessibility and acceptability of health care services for adolescents;
- establishing national standards and criteria for adolescent health care;
- building capacity of health care providers to improve delivery of adolescent friendly services.

The approach is specifically designed to strengthen the public sector's ability to respond appropriately to adolescent health needs, and is currently being piloted

91. Stadler et al, 1999
92. Chetty, 2000
93. Dickson-Tetteh et al



Youth club in Orange Farm, Gauteng. Pic: Cedric Nunn (Beyond Awareness Campaign)

in ten government clinics in South Africa. This initiative hopes to develop the capacity of clinics following a four phase plan, featuring four levels of accreditation, and four stages of implementation. The programme also identifies characteristics of adolescent-friendly health care providers who: treat adolescents with dignity and respect; are friendly and have non-judgemental attitudes; maintain privacy and confidentiality; promote free and informed choice; have the knowledge and skills to manage common adolescent health problems. Specific standards of service are also outlined, as are standards for management, training and the physical environment of the clinic. In the context of an urgent need to respond to the epidemic however, it is problematic that such initiatives may take several years to move to scale.

There are also many factors that prevent development of effective responses at the basic level of availability of health resources. The tools for effective response are often not available – for example, condoms, HIV testing resources, counselling and health information materials.[94] Development of such capacities needs more than simple provision or supportive training.

There are also many factors that prevent development of effective responses at the basic level of availability of health resources. The tools for effective response are often not available – for example, condoms, HIV testing resources, counselling and health information materials.

The development challenges of implementing models of adolescent sexual and reproductive health has been researched in a three site intervention of an adolescent sexual and reproductive health programme.[95] One of the conclusions of this research was that the model needs to be sufficiently flexible to be able to adapt to different dynamics in each locality. Models need to have the capacity to solve the problems which particular localities pose.

Perhaps in engaging existing health, education and welfare service providers it is important to pay attention to structural transformation issues which impinge upon and give shape to the local service environment.[96] In a remote rural area of the Eastern Cape it has been shown that health development is contingent upon the service delivery framework which is established within the health, welfare and education sectors of local government. When these are poorly developed, the continuum of intervention and care from basic awareness building to health behaviour improvement and care of people with AIDS-related

94. Kelly, 2001
95. Stadler et al, 1999
96. ibid

conditions can break down at many points. It is also important within systems of care to develop the functional integration of services (health, education, welfare).

A review of African functional integration[97] initiatives shows some of the following emphases: closer working together of services, which includes setting up of referral linkages between service providers; providing two or more services together; adding new services to primary health care services; integrating health care with community, family or development activities; and integrated training for comprehensive primary health care services.[98] The opportunity to engage in structural transformation of service delivery systems lies at district level. It is at this level that development and integration of HIV/AIDS response services need to be coordinated, consolidated and developed.

Research in the Northern Province outlines requirements for the development of adolescent reproductive health services.[99] These include:

- building on the capacities of managers, supervisors and those who provide services directly;
- involving youth, community members and the local media at the outset;
- integrating new adolescent services into existing health services to ensure continuity of access to resources as well as access to appropriate back up and referral systems;
- identifying at least one health care professional who will take primary responsibility for establishing and maintaining the service and ensuring continuity;
- providing ongoing appropriate in-service training and support;
- complementing health education and outreach activities with improved health services;
- utilising and supporting peer group counselling, condom distribution, participatory design of health promotion media, and health committees;
- building on community institutions which have been demonstrably adolescent oriented;
- using local languages and showing respect for local cultural practices and meanings;
- recognising diversity within communities;
- ensuring careful screening, training and support when community-based counselling, referral and distribution systems are developed;
- ensuring community, local health worker, supervisory and management support to encourage teachers involved in life skills training;
- sustained monitoring and feedback.

Developments at the level of service delivery also require development of the relationships between health service providers and health service users. This requires active engagement of different parties in health provision and begins

97. Schierhout & Fonn, 1999
98. Stadler et al, 1999
99. Ibid

with mobilising different sectors of the community which have latent potentials for contributing to such promotion. What community members can meaningfully contribute varies greatly and includes: particular skills, for example, event organising experience; understanding of particular issues, for example, the experience of PLHAs in dealing with stigmatisation; social influence; material resources; spare time; contacts with outside authorities; and so on. It may not always easily happen that the potential contributions of communities are effectively harnessed around particular issues, such as HIV/AIDS. One research study in six diverse communities found that awareness of the need to respond to the problem of HIV/AIDS, did not readily translate into action, because of a lack of models for meaningful engagement and practical opportunities to contribute.[100] It seems critically important that models of community mobilisation around HIV/AIDS be developed.

A follow-up project to this review is the development of HIV/AIDS mobilisation projects in a group of deep rural villages and also in schools for disabled youth. Each project has been conceptualised in such a way as to explore the dynamics of mobilisation and the problematic issues involved.

There is an extensive body of literature which endorses the value of participation in health development initiatives, one of the most pervasive themes of which is the difficulty involved in building relationships between project initiators and community members. Perhaps most importantly, and this was found in development of an adolescent friendly health initiative in the Northern Province,[101] involvement of multiple community participants and agencies meant that strategies and approaches frequently needed to change in response to unanticipated demands and needs. Also, individual personalities, interpersonal and structural tensions within communities and institutions, and other vagaries of communal life, have a bearing on programme development. New systems cannot be developed without taking these into account, and without attending to them.

It is often pointed out that the concept of community may be a problem. "Many of the problems often arise from a misunderstanding and naïve conception of 'community'."[102] Communities are not necessarily coherent entities and the people who participate in community building initiatives are usually not disinterested role-players, but often represent particular interests and standpoints, including political positions. This means that development of services is not something that can be separated from social development in a more general sense, and it is often said that success depends on recognising the schisms within communities, the power dynamics at play in participatory processes, and the personal and interpersonal needs and aspirations which come to have a bearing on programme development.

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School-based health services

Currently the national departments of Health and Education are engaged in a process of developing national policy guidelines for health services in schools. Pending this development, there is little clarity about what can be expected in terms of minimal health services, including health promotion for school

100. Kelly & Parker, 2001
101. Stadler et al, 1999
102. Ibid, page 37

children. In this context, the Department of Health has promoted the adoption of a Health Promoting Schools (HPS) concept and has encouraged its provincial managers to provide support to schools which adopt the HPS model. It has also produced draft policy guidelines on health promoting schools. [103]

There has been no national audit of schools adopting this model but in the Western Cape especially, and certainly in some of the other provinces, a small number of schools have adopted the concept. As yet, a national framework for endorsing and promoting the concept is not yet in place, and the national Department of Education has not explicitly endorsed the concept, believing that the current policy framework for health in education is inclusive of the main concepts of HPS. The Medical Research Council has developed guidelines for evaluating health promoting schools which are also useful as a tool in developing HPS. Currently HPS programmes rely on *ad hoc* funding and do not yet have a countrywide institutional support base.[104] The Department of Health draft policy guidelines on HPS call for the establishment of a national interdepartmental committee for health promoting schools, and a National HPS Forum/Network. Unfortunately, there is no national non-governmental organisation devoted specifically to the promotion of HPS, although the Children's Institute at the University of Cape Town and the Education Department at the University of the Western Cape have particular interests in promoting the concept.

It is noted elsewhere in this report that it took a national non-governmental initiative to mobilise resources, research, a framework and a programme for development of an adolescent friendly clinic initiative, and the same may need to be the case with HPS, although – as is the case in relation to adolescent friendly clinics – this can only be done with close collaboration of government departments involved in school health. However, in this instance, a somewhat different problem pertains than in the adolescent clinic case, and this involves the overlapping domains of interest of Health and Education Departments. School health is a shared concern but this concept has clearly been led from the health side. Department of Health policy guidelines on HPS recognise the problem that school health services are not formally or organisationally located within Department of Education structures, creating a need for intersectoral structures that facilitate appropriate collaboration between government departments to provide comprehensive support services to schools/sites.

HPS appears to be a promising concept, but there has been no substantive evaluation of its success. The concept relies on systematic, stage-wise analysis of school health indicators by the school, including the learners, parents and teachers, using particular criteria and methods of analysis. There is no common template for action and each health promoting school is seen as growing according to its particular resources, circumstances and needs, engaging learners, parents and teachers in the development process. Focus areas might include sanitation, nutrition, the improvement of school health services, the creation of a safe environment, development of the school policy framework, building of interpersonal skills, development of relationships between students, staff and parents, and improvement of the physical environment of the school. The broad-ranging analysis of school health status which initiates the implementation of the health promoting process breaks down 'school health' into its many component parts, which makes the task of improving health a matter of many manageable small steps.

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103. Department of Health, 2000

104. Swart, nd

Very little is known about sustainability, and until a national framework of development and support is set in place, it will not be clear how the concept could relate to the lifeskills training initiative of the Department of Education.

The model is clearly in an early stage of development and it will need a supportive network and much effort to locate it in schools, which are faced also with the daunting and equally important task of improving school performance.

Telephone help-lines

There are a number of other kinds of resources for supporting positive response to HIV/AIDS amongst young people in South Africa, and perhaps most notable amongst these are telephone helplines.

A number of South African HIV/AIDS and related programmes offer telephone helpline services. These include the Department of Health's AIDS Helpline; Soul City's women's helpline; and loveLife's Ithetha Junction. All of these tollfree helplines offer information and basic counselling support. Ithetha Junction is especially oriented to the needs of young people.

Helplines provide a vital interactive element and are often the simplest course of action that can be taken in addressing questions, obtaining access to resources, obtaining counselling support, and obtaining referral to local services.

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The scale of services offered bears mention. The national AIDS Helpline, for example, is supported by a staff of 60 who between them are able to provide information in all eleven official languages to over 30 000 callers each month. These helplines provide a vital point of access to information and must be considered a significant national resource in the response to HIV/AIDS.

Helplines provide important opportunities for research including ready access to trends in relation to caller concerns – for example predominance of calls around transmission, testing, prevention or care issues. Myths and contemporary concerns can also be tracked on a regular basis. Calls can be analysed to obtain a sense of the types of questions and knowledge that is sought and this is a potentially valuable second generation surveillance system.

Rights supporting prevention

It is important in understanding behavioural responses to HIV/AIDS to appreciate the influence of social norms and expectations on individual behaviour. Amongst such influences are rights charters, laws and policies. It is necessary to take stock of what social frameworks exist for supporting behavioural response of young people to HIV/AIDS.

There exist a number of international frameworks, policies and guidelines relating to the rights and interests of children and young people in the HIV/AIDS context. In South Africa there are also a number of discussion papers developed by the South African Law Commission which are oriented towards legal and human rights regulations to support the national response to HIV/AIDS. [105]

The United Nations Convention on the Rights of the Child stipulates that every child has the right to: [106]

105. http://wwwserver.law.wits.ac.za/salc/discussn/discussn.html

106. Sloth-Nielsen, 1995

AIDS Helpline , Johannesburg, Gauteng. Pic: Warren Parker (Cadre)

- information and open communication on health issues, including sexuality and relationships;
- receive training in basic survival skills and lifeskills;
- time and opportunities to question and discuss values, ethics and morals;
- time and opportunities to be able to freely seek information and express their ideas.

The Nineteenth Session of the UN Committee on the Rights of the Child (*Children's rights and HIV/AIDS,* October 1998) recommended that:

- HIV/AIDS programmes should be children's rights-centred.
- States, programmes and agencies of the United Nations system, and NGOs should be encouraged to adopt a children's rights-centred approach to HIV/AIDS;
- States should incorporate the rights of the child in their national HIV/AIDS policies and programmes, and include national HIV/AIDS programme structures in mechanisms responsible for monitoring and coordinating children's rights.

The South African resource manual, *HIV/AIDS and the Law* (1997), identifies legislation and regulations which provide protection for children's rights threatened by HIV/AIDS, including the rights of children to appropriate and effective education. [107] Other specific rights stipulated include:

- The right to sexuality education: The Children's Charter of South Africa states that a child should have access to information that will contribute to his/her physical and emotional wellbeing. In terms of the Charter a child has a right to be appropriately educated about sexuality and AIDS. All children therefore have a right to sexuality education.
- Testing of children and confidentiality of results: The Child Care Act protects the rights of children, including their medical treatment. At the age of 14, a child can legally consent to an HIV test and he/she has the right to keep the results private.

107. AIDS Law Project and Lawyers for Human Rights, 1997

- The right to contraception and reproductive health: The Constitution provides that all children have the right to health, including the right to protect and control their reproductive health.

The South African Law Commission's Consultative Paper on Children Infected and Affected by HIV/AIDS (1998) specifies that: [108]

- All schools should implement universal precautions to eliminate the risk of transmission of blood-borne pathogens, including HIV, in the school environment.
- HIV/AIDS education programmes should be implemented at all institutions for learners, educators and other staff.

National policy on HIV/AIDS for learners, students and educators[109]

In 1999, reflecting the Law Commission recommendations, and following consultations between the Department of Education and the Education Labour Relations Council, the Department of Education distributed HIV/AIDS policy and guidelines for learners and educators in its institutions. The following items relate specifically to the conditions for creation of a positive response to HIV/AIDS:

- Infection control measures must be universally applied to ensure safe institutional environments.
- Learners must receive education about HIV/AIDS and abstinence in the context of lifeskills education as part of an integrated curriculum.
- Educational institutions must ensure that learners acquire age- and context-appropriate knowledge and skills to enable them to behave in ways that will protect them from infection.
- Educators need more knowledge of, and skills to deal with, HIV/AIDS and should be trained to give guidance on HIV/AIDS.

The national and provincial Departments of Education are HPS appears to be a promising concept, but there has been no substantive evaluation of its success. The concept relies on systematic, stage-wise analysis of school health indicators by the school, including the learners, parents and teachers, using particular criteria and methods of analysis. Responsible for implementing this policy. Every Education Department is required to designate an HIV/AIDS Programme Manager, as well as a working group to communicate policy to all staff, to implement, monitor and evaluate the Department of Education's HIV/AIDS programme, and to advise management regarding programme implementation and progress. The principal is responsible for implementation of the policy at school. School governing bodies are expected to take reasonable measures to supplement government allocations for health and safety equipment.

The legal and human rights frameworks provide a powerful foundation for advocacy for HIV/AIDS prevention in schools and the rights and obligations referred to potentially allow claims to be made against the responsible duty bearers, in the event of their lack of attainment. Schools and the education

The legal and human rights frameworks provide a powerful foundation for advocacy for HIV/AIDS prevention in schools and the rights and obligations referred to potentially allow claims to be made against the responsible duty bearers, in the event of their lack of attainment.

108. The SA Law Commission project on HIV/AIDS was driven by the Commission itself, under the Department of Justice. Its recommendations were incorporated in the Minister of Education's policy on HIV/AIDS, learners and educators.
109. Republic of South Africa, 1999

system as a whole could be held accountable for the failure to provide adequate training to teachers, to develop sustainable prevention programmes and to equip learners with appropriate knowledge and skills. The legal frameworks and the expectations provided by them have not been brought to bear by learners or parents, and the abject failure of certain schools to prioritise AIDS education, is open to legal challenge.

In addition to the above regulatory framework, legal frameworks exist for protecting children against sexual exploitation. These are currently in a state of transformation and legislation is being finalised. The effect of this is to make regulations pertaining to adolescent sexuality more appropriate to the South African context.

Early or precocious sexual activity has been widely reported as an important predictor of sexual health risk and has been associated with higher levels of teenage pregnancy, higher levels of STDs, and greater risk of HIV infection. It has also been suggested that delay in the age of sexual initiation has been an important factor leading to reduction of HIV infection in Uganda. However, although abstention has been featured in communication campaigns in South Africa, it has lagged far behind promotion of condom use as an intervention.[110] Whereas this emphasis on condom use is appropriate for those who are sexually active it is unlikely to be of much support to those who are sexually active early with partners significantly older than themselves. In relationships where there are high age differentials between partners, there is unlikely to be the capacity by the younger, usually female partner, to engage in negotiations leading to condom use, if necessary. Delay in sexual onset in such contexts may be the only workable means to avoid HIV risk and this requires the development and support of social norms and proscriptions around very early sexual activity. This in turn requires endorsement of a normative and legal framework and in many countries, including South Africa, there are laws established to protect young people from sexual exploitation, and relating to the age of consent.[111] These have not hitherto been invoked and hardly discussed in South African HIV/AIDS prevention efforts. There does not appear to be significant social awareness that much adolescent sexuality is technically illegal to the point of being considered statutory rape.[112] The manipulation or coercion of children and young people by those older than them to engage in sexual acts has not been treated as a human rights violation or as a transgression of the law. Technically the current legislation holds that sex with someone under the age of 16 is classified as statutory rape. However, a recent discussion document of the South African Law Commission on the Child Offences Act recommends that this law be amended. This involves the recognition that consensual sexual acts between children under the age of 16 are increasingly common worldwide and also in South Africa. The Law Commission's Substantive Discussion Paper on Sexual Offences therefore recommends that a new statutory offence replace the current section 14 of the Child Offences Act and recommends the enactment of a statutory provision called 'child molestation'. The proposed change is a reformulation of the statutory rape provision contained in section 14 of the 1957 Sexual Offences Act which prohibits sexual acts with and between children under the age of 16.[113] Rather than create a blanket prohibition of sexual acts

Delay in sexual onset in such contexts may be the only workable means to avoid HIV risk and this requires the development and support of social norms and proscriptions around very early sexual activity. This in turn requires endorsement of a normative and legal framework

110. Kelly & Parker, 2001
111. www.avert.org/aofconsent.htm
112. See section 4
113. wwwserver.law.wits.ac.za/salc/

Amotole, Eastern Cape. Pic: Kevin Kelly (Cadre)

with children below 16 years of age, the provision specifically provides for a two year age difference as a defining age gap for non-consensuality, when one of the respondents is younger than 16 years.

The proposed new clauses deem child molestation to have occurred in the case of:

- any person who intentionally commits a sexual act with a child, at least two years younger than him or her;
- any person who commits any act with the intent to invite or persuade a child, at least two years younger than him or her, or who allows any person to commit a sexual act with that child;
- consent by a child to any sexual act, which shall not be a defence to a charge under this section.

Furthermore, the Law Commission proposes that the sexual penetration of any child below the age of 12 years should constitute rape.

Whereas there is little appreciation amongst the South African public of the illegality of many sexual acts in terms of the 1957 Criminal Offences Act, the legislation, being more in keeping with contemporary mores, will offer a tool for the establishment of a new framework for consensuality and also a psychological armament for young people. This is especially true of young girls who are vulnerable to sexual coercion,[113] or those who are in sexual relationships with older people without particularly wanting these relationships, and from which they wish to extricate themselves. Endorsement of such a law by communities and by young people themselves, may go a long way to creating a new normative framework around sexual initiation and proscription of high age differentials in early sexual experiences.

This is especially true of young girls who are vulnerable to sexual coercion, or those who are in sexual relationships with older people without particularly wanting these relationships, and from which they wish to extricate themselves.

Whereas laws relating to prohibition of early sexual relationships with large age differentials are extremely difficult to enforce, they may nonetheless serve to create new norms around sexual initiation, and age differentials in particular, if appropriately promoted. Given the social and normative aspect of sexual

113. Wood & Jewkes, 1997; Varga 1997

behaviour, and the apparent breakdown of social regulatory mechanisms around early sexuality that seem to have accommodated this change,[114] this kind of intervention must be seen as an important element of a societal response to HIV/AIDS.

Other than the above, there are a number of other rights and policy frameworks which have a bearing on prevention and care issues. These include laws relating to sexual abuse, rape, and access to antiretroviral therapy which have not been covered above as they are less directly concerned with behavioural prevention.

114. Ntlabati et al, 2001

SECTION SIX: AN HIV/AIDS RESPONSE FRAMEWORK FOR CHILDREN AND YOUNG PEOPLE

In this section a number of features of the HIV/AIDS prevention framework that cut across four types of intervention (mass media, lifeskills, services, regulation) are presented. Also included is a fifth, largely overlooked area, namely community mobilisation. It is suggested that if we summate all of the programmes described above and the many, generally smaller programmes not explicitly mentioned, South African youth are in general exposed to a multifaceted and extensive array of interventions working simultaneously, at a number of levels.

Whilst it would seem appropriate for HIV/AIDS to maintain a high communication intensity, this review leads unequivocally to the conclusion that it is not at this level that the South African AIDS response falls short. It is rather at the level of the more direct and localised interventions that the prevention efforts should now focus – that is, at the level of lifeskills education, the development of services oriented to young people, the improvement of service delivery, and operationalisation of regulatory and rights frameworks.

Whereas we have gone some way to establishing that the so-called gap between awareness and behaviour might not be as severe as it is often claimed to be, it should be pointed out that the idea of a gap might be premised upon a problematic understanding of the notion of awareness. Abstract awareness that works only at the level of understanding the general risk of HIV is surely not expected to have a central impact at the interfaces where courses of action are determined. For instance, can behavioural shifts based on personal choice cannot be expected in the face of gender power imbalances, interpersonal pressure and lack of social support for intentional behaviour.

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Mass media campaigns need to be followed through at this more local and personal level, but as has been pointed out, there are significant problems in making progress at this level. The following is a description of some of the issues that make the net product less than it might be, and which need to be addressed to shift prevention programming downwards into localised domains.

Summary of problems of the existing HIV/AIDS response framework

The existing response framework is characterised by a number of problems including:

- emphasis on message-based campaigns, often with little attempt to understand the underlying difficulties in implementing targeted behaviours;
- emphasis on event-based rather than development-oriented programmes;
- poor conceptualisation and development of interventions directed at maintenance of preventive behaviour;
- under-emphasis of important and specific HIV prevention directions;
- lack of research on effectiveness of programmes and lack of satisfactory development of indicators for monitoring and evaluation utilising a second generation surveillance system;

- poor co-ordination of interventions;
- poor mobilisation of individuals and formations concerned with young people including parents, teachers, churches and formations of young people themselves;
- poor implementation of lifeskills education and health promotion in schools;
- poor development of integrated services for youth;
- lack of appropriate indicators and measures for evaluating programmes;
- failure to sustain or move to scale with interventions that have demonstrably worked.

The need to move from awareness activities to intervention programmes

Event-based interventions refer to AIDS awareness activities which culminate in an event or series of events over a limited time period. Such 'situated' interventions are contrasted with ongoing, developmental intervention programmes, which are more strategic and step-wise in orientation.

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The national Department of Health has regularly issued directives for World AIDS Day, Condom Week, and Candlelight Memorial Day to be used for development of community AIDS awareness and support events across the country. Equally, there has been extensive application of concepts such as the Department's AIDS train, or loveLife's Love Train – both of which are oriented towards irregular and short term presence at train stations along selected routes. There is also an annual 'celebration' of the government's partnership against AIDS 'birthday'. These short-duration interventions involve often complex preparatory organisation, and are costly undertakings in themselves.

Although the scope and extent of such activities has not been researched, AIDS awareness events are commonplace in most South African towns and cities. Frequently accompanied by political speech-making, marches, entertainment and cultural events, such activities have been used to inform people about the existence of HIV/AIDS and to familiarise the public with condoms.

There have been few research attempts to understand what this level of activity ultimately means for the HIV/AIDS epidemic and the evaluations that do exist are limited to reflecting on the immediate or short-term effects. Perhaps such events have played an important role in 'breaking the ice', in which case the biggest value would have been derived in the early days of the epidemic. They may have given the problem of HIV/AIDS local expression in contexts where there have been few other responses to the epidemic.

There may also be other beneficial spin-offs. For instance, news coverage of HIV/AIDS is typically higher on special days such as World AIDS Day. To a large extent, this has been the general motivation for promoting AIDS related days. However, what needs to be assessed is whether similar news coverage could be generated through simpler and less costly activities such as press releases or media briefings. Perhaps this approach would orient the contents of news reports more towards marking progress to date, and less towards the often misplaced statements of politicians addressing these events, or descriptions of the accompanying cultural activities.

An important issue to consider is whether events represent a way for

organisations and communities to deal with the perceived need to 'be seen to be doing something about AIDS' rather than actually committing their efforts and resources to a more fundamental orientation around AIDS. If an organisation's involvement in an HIV/AIDS campaign leads to engagement with HIV/AIDS issues, the adoption of an AIDS policy and plan, and ultimate commitment of resources to managing AIDS, then the initial activity can be seen as fruitful. However it is not clear how often this has been the case.

In essence, event-based campaigns are of limited value in the long term, unless they are part of systematic programmes of action. Furthermore, the ratio of costs to benefits of events may be found to be wasteful and inappropriate at this stage of the epidemic.

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There is much evidence that in some sectors of society, and particularly in large corporations, prevention programmes are becoming institutionalised. In relation to young people, a recent summary of responses of tertiary institutions to HIV/AIDS,[115] shows that many have developed and adopted policies which drive their response to HIV/AIDS. This has not occurred in schools however, and most schools are without a plan, policy, infrastructure, or service delivery networks in relation to HIV/AIDS.

There is little evidence of the upscaling of successful small-scale projects in South Africa and there are a number of possible reasons for this. Small AIDS service organisations often rely on volunteers, and are often only funded for particular activities. Funding of the research and development process for upscaling is not easy to obtain. Longer term developmental tasks may be put aside in favour of more visibly deliverable tasks and small organisations seldom have the organisational leadership and capacity to grow into larger organisations which can offer programmes on a more ambitious and sustained scale. Also, in small organisations it seems that there is often a lack of understanding of the psychological and social requirements of an adequate intervention framework, accompanied by little appreciation of the current state of intervention efforts and responses. The unavailability of models for sustained community mobilisation is problematic.

Another reason for the failure of interventions to grow to scale lies in a lack of a conceptual framework for developing responses. The Department of Health has a comprehensive HIV/AIDS plan, yet little consideration has been given to promoting the elements of the plan, nor to breaking down the components into areas of focus and models of intervention that can be applied either within government, or by other organisations. An understanding of the communications implications of the plan are singularly lacking. At a community level, as has already been pointed out, although there is a high degree of interest in becoming involved in HIV/AIDS related activities and a potentially large volunteer force, there remains a need to develop models for community mobilisation to guide how this might take place.

The need to localise interventions

Models for community based response to HIV/AIDS are needed. Fragmented and insubstantial local projects need to be re-oriented towards standardised models of intervention and co-ordinated in a centralised way. District health offices may be suitable bases for such activities, but the relative merits of co-

115. Chetty, 2000

ordinating local initiatives through such offices, as opposed to non-governmental community AIDS fora, needs to be explored. In the Eastern Cape, under the umbrella of the EQUITY Project, district health offices have formed HAST (HIV, AIDS, STD, TB) committees to co-ordinate local efforts. A wide spectrum of representatives typically attend these meetings, ranging from PLHA groups, hospice groups, police and prisons, educational institutions, and faith-based organisations. There has not to date been an evaluation of the successes and difficulties associated with organising response at a district level on this basis, but there is evidence[116] that some such projects have come to play a critical role in mobilising development activities, ensuring optimal use of resources in under-resourced environments and instituting innovative ideas.

Organising HIV/AIDS activities at the district and community level has multiple advantages. These include relevance to local conditions; tailoring of information to specific needs; increase in innovation with successful initiatives having the potential to be developed into models; and a greater range of people getting involved on a more permanent basis. Thought needs to be given to the orientation towards, and involvement of young people at this level.

To successfully achieve the goal of organising district and community level responses, there needs to be collation of the tools, models, and frameworks for action that have been developed nationally and internationally. It would be a waste of effort to have to reinvent models that have already been successfully developed elsewhere. But there needs to be a resource base for the dissemination and further development of such models. For example, the model for health promoting schools needs to be made available, but to date no organisation has taken it on as a responsibility to develop the national implementation of such a programme. It is clear that the exigencies of other development needs in education and health make the successful roll-out of this model an inevitably slow process. Given however, that the foundation work on the model is done, an NGO taking on the sustained development of health promoting schools as its mandate would accelerate the process.

To successfully achieve the goal of organising district and community level responses, there needs to be collation of the tools, models, and frameworks for action that have been developed nationally and internationally. It would be a waste of effort to have to reinvent models that have already been successfully developed elsewhere. But there needs to be a resource base for the dissemination and further development of such models.

Another benefit of local level organisation is that it creates a co-operative framework wherein functional integration of prevention services can occur, and the continuum of prevention and care can be developed. It also allows for various sectors of the community to become involved, including, for example, organisations of young people. Integration of services can be guided at a policy and macro-level, but the practicality of doing this is necessarily a matter of local development. So too the problem of co-operation of health and education services can ultimately only be worked out in the context of an understanding of the particular difficulties faced by health and education workers, and in a context where practical arrangements can be negotiated.

The need to develop and support behaviour change maintenance frameworks

Any sustained behavioural repertoire requires some form of commitment, implicit or explicit, to bind the person to a course of action. This serves to sustain behaviour patterns when motivation wanes, or when other circumstances mitigate against maintenance of a behaviour. It is one thing to implement a new behavioural repertoire once, or perhaps a few times, but behavioural

116. Kelly & Senekal, 2001

repertoires that are not bound in place by something more permanent than the vagaries of an intention (often a product of a particular time and place), are not likely to be sustained. This applies whether one is talking about losing weight, using condoms, or abstaining from sex. Fundamental to behaviour change is the need to create social frameworks which assist people to bind themselves to courses of action. Value systems, interpersonal commitments, public commitments, and ritualistic forms of social-binding such as induction into a community group, serve to achieve the end of transforming behaviour and establishing a relatively stable framework for maintaining the adopted behavioural repertoire.

Fundamental to behaviour change is the need to create social frameworks which assist people to bind themselves to courses of action.

Models for encouraging groups of people to adopt their own preferred response to the epidemic through acts of social commitment, need to form the cornerstone of community movements around HIV/AIDS behavioural response. Development of an HIV/AIDS response 'mission' by a group of young men to, for example, consistently use condoms would certainly be a supportive framework. The concept of 'pledging', which has been part of a number of American youth development initiatives, is not prominent in South Africa. These approaches essentially utilise methods of community building which have long been around. They recognise that action and intention are social in character and that it is often through acknowledging the expectations or receiving the endorsement of others that we are able to initiate and maintain regular and recognisable patterns of behaviour. Purposeful generation of community normative expectations followed by formal community adoption, may go a long way to promoting prevention behaviour.

The rights and legal regulations relating to the requirements that the educational system provide adequate HIV/AIDS education, and the regulatory aspects of the law relating to child sexual exploitation, were discussed above. These are essentially similar mechanisms – social frameworks for behaviour which create pre-commitments to action around which social pressure (advocacy) and if necessary, legally binding social pressure, can be raised to promote adoption of socially agreed upon expectations.

AIDS Memoriol quilt pledge panels. Cedric Nunn (Beyond Awareness Campaign)

The need to understand compound effects

There is little recognition of the compound and accruing effect of the many campaigns which are conducted for young people. The compound effects of different awareness campaigns, exposure to small media items, and other interventions are not readily predictable, but it has been suggested that the net effect of this coverage may be more extensive than the effect of any particular campaign.[117] The media and communications environment around HIV/AIDS includes high proportions of content in the news media as well as other information channels. Parallel events in separate content domains may also affect responses to HIV/AIDS. This includes political views, perceptions of the government, racism and its public mediation, and developments in changing gendered perceptions, which are all likely to contribute to the response of young people.

It is often suggested that the metaphors and imagination around the social representation of HIV/AIDS has a critical influence in developing responses to the epidemic. [118] Research in other countries has shown that the tacit influence of imagery can actually have a negative effect but in actual fact little is known about the use of negative imagery and fear. The highly emotive and often tragic images and alarmist language of HIV/AIDS that sometimes appear in the news media may on the one hand capture interest and concern, but they may also serve to distance people from HIV/AIDS.

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In a recent study it was found[119] that when young people were asked to recall anything that had influenced them to be concerned about HIV/AIDS, they had brought up a wide range of examples including: being emotionally touched by sad HIV/AIDS stories; sudden realisation of the human meaning of HIV/AIDS statistics; personal experiences of a pregnancy scare; informal conversations; and the involvement of significant others in HIV/AIDS prevention activities. It is therefore important to consider the entire 'mediating' environment in which the responses of young people to HIV/AIDS are formed. It is important to identify what types of influences are synergistic (lead to an acceleration of impact when paired together that is greater than the sum of their parts), and what influences undermine each other. There is a need to understand how such cumulative effects might be worked into theoretical and strategic frameworks of intervention.

Developmentally specific programmes

A developmental perspective involves recognising that the enculturating influences on a developing young person change. In terms of enculturating influences, the child in his/her first three years of life will, in many circumstances, only be exposed to primary care-givers. The school going age child is increasingly exposed to peer influences, usually from same sex peers, and later within a mixed sex peer-group context.

The child may be highly exposed to mass media in pre-school years, but an interest in the wider world including extra-familial interests generally develops progressively through the late primary school years and continues to develop through high school and post-school. High school and tertiary education, employment (or unemployment), travel and life experiences, all add to the developmental context. The point is that these contexts need to be thought

117. Parker et al, 2001
118. Sontag, 1989

about as socialisation contexts, where the developing young person is formed, and campaigns need to incorporate an understanding of life-phases. At a very simple level, this may mean that peer group work is more and less important, around particular issues, at certain stages; or it may mean that same sex lifeskills work is more appropriate at specific stages. The fact is, we know very little about these issues.

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There can be no doubt that in South African society HIV/AIDS campaigns have placed sex in the public domain in an unprecedented way. Much more research and thinking needs to go into understanding how public discourse of sex should be managed. Sexuality and culture are closely intertwined and the management of sexuality within cultural confines has much to do with the ways members of societies think of their bodies, manage their feelings, and interact with the bodies of others.

There is more to prevention than targeting high risk behaviours

The applicability of 'behaviour change' approaches to HIV/AIDS was established in the early years of the epidemic when at risk groups were relatively well defined and where risk could be attached to particular sexual relationships and risk behaviours – for example, the epidemic amongst gay men in the United States, or groups such as truckers, sex workers and injecting drug users. In the case of such target groups the main patterns of transmission were fairly easy to determine and success depended on the adoption of particular behaviours. However, advanced epidemics pose new challenges, beyond the simple promotion of particular prevention behaviours:

- Target audiences are larger and more diverse. Those who are at risk and especially the relationships and behaviours through which the virus might be transmitted can no longer be readily isolated or targeted.
- The concept of 'change' is not always appropriate in advanced epidemics. Not all young people need to change their behaviours, and certainly not all are exposed to the same degrees of risk. There are some who are not yet sexually active, some who have decided to abstain from sex, some who use condoms consistently, and some who are in mutually faithful relationships. However, whilst they do not need to change their behaviours, their practices nonetheless need to be understood, supported and endorsed. Thus, intervention for these individuals needs to be about maintaining and endorsing their practices rather than changing their behaviour.
- It is worth extending thinking about HIV prevention beyond the realm of sexual practice. For example, regularly wearing a red ribbon, may considerably influence other aspects of an individual's response to HIV/AIDS, but it does not involve 'change' of behaviour so much as the creation of new practices. Similarly promotion of male participation in community AIDS initiatives may lead to a greater involvement of men in sexual health promotion, and ultimately to the reduction of risk. Behaviour change models which try to persuade people to use condoms or not to discriminate against people with HIV/AIDS, may fail to address the need to create 'contexts' of change, and endorsement of community norms and expectations which are conducive to the desired behavioural outcomes.
- Finally, given that individual behaviours always depend upon practical and material conditions, behaviour change models need to be supported and

sustained by changes at a structural level where such conditions are determined. For example, amongst a target population of irregular condom users the problem may lie not in the minds of individuals, so much as in the lack of availability of condoms, or in the way in which condoms are dispensed. Change at this level would need to proceed through the channelling of appropriate resources in the health system, and training of condom distributors, which in turn depends upon organisational factors far removed from the minds of the potential condom user. Again, whilst behaviour change models aim to directly achieve desired outcomes, they need at the outset to take into account and to address what may seem to be apparently remote determinants of the desired outcomes.

Pathways to action: Models for development of response to HIV/AIDS

There are a wide range of models for understanding how behaviour change takes place and for promoting change.[119] These have been extensively reviewed and there is a rich literature on the subject. It falls beyond the scope of this review to discuss the debates that have fuelled the development of theories of health behaviour change, but a number of general points need to be made before discussing some of the issues that stand out as having relevance for HIV/AIDS prevention practice amongst young people in South Africa.

Many of the models which dominated the first decade of social science research into AIDS are premised on the assumption that individual reason is a necessary element in the chain of events leading to behavioural outcomes. Common to many of these models is the assumption that an individual's decision whether or not to engage in preventative behaviour is based upon the perception of the risks and of the advantages and disadvantages that the individual may derive from a protective act, which is seen to constitute a motivation to act. Most of the models are, in different ways, cognitively based and premised on a belief that information is a necessary motivation for behaviour change. However, we do not necessarily make cognitive risk assessments when we make HIV risk reduction decisions. In the throes of an unexpected sexual encounter, one's health beliefs, expectations and motivations may have little effect in determining outcome.

Our motivations may lie as much in our emotions as in our thoughts, and these are not always readily understandable. We cannot "assume that health protection is the most important thing for an individual and is therefore the motivation structuring one's behaviour".[120] Many of the models of behaviour change tend to downplay the other motivations which drive risk behaviour. "Although other behavioural motivations, such as the fear of being alone or the influence of peer group behaviour, are explored, their role is interpreted in terms of the rationale of health protection".[121]

Also, these models tend to downplay the social and cultural character of behaviour. Our reasons for acting may lie outside of ourselves, in our histories and cultures, when we follow pathways of action which are laid down by convention and which we unquestioningly follow. Further our health and risk behaviour may be determined by material necessities which drive us, although we do not necessarily choose or like them. A young destitute girl exchanging

119. Airhihenbuwa, 2000; Piotrow et al, 1997; UNAIDS,1999; *http://www.comminit.com/change_theories.html*

120. Bajos, 1997, p.228.

121. Bajos *et al*, 1997, pp.25-6

sex for money or other incentives might be a case in point.

The wide range of interventions described in this report represent a diverse set of inputs. Whilst there have been some attempts to combine these elements into a coherent model[122] there has been no substantive attempt to develop models for South African conditions, which include a well developed media and communications environment and a largely underdeveloped local infrastructure.

We need to understand the severe limitations of theoretical frameworks that make assumptions about an individual's capacity to choose particular paths of action – not only for the cognitive reasons outlined above, but because supportive infrastructure, resources and social systems are not in place. For example, condom use is contingent on the discrete and non-judgemental access to condoms in the local environment; voluntary counselling and testing depends on the availability of appropriately trained counsellors and HIV testing resources. Equally, many young people are infected with HIV through circumstances outside their immediate choice or control, for example, in sexual encounters with older partners, through coercive sex, sexual exploitation and abuse by adults, and rape. These concerns are less likely to be emphasised in theories developed in less problematic contexts. The power of the behavioural and social sciences has not been brought to bear and there has been little progress in thinking about the relationships between human motivation, social organisation, cultural transformation and development.

We need to understand the severe limitations of theoretical frameworks that make assumptions about an individual's capacity to choose particular paths of action – not only for the cognitive reasons outlined above, but because supportive infrastructure, resources and social systems are not in place.

In the course of this review many points have been made about how the HIV/AIDS response framework needs to be developed. These are consolidated into the following suggestions about essential constituents of what might be thought of as a necessary second wave of HIV/AIDS prevention planning for children and young people in the South African context and include the need for:

- a life-span developmental model which takes into account the changing influences and socialisation patterns in a young person's life from infancy to adulthood;
- an age appropriate approach in terms of intervention focus (message and medium), which considers key socialisation influences in the young person's life;
- an approach located within a framework for sustained youth development work rather than event-based interventions;
- an approach that is not message based, but is instead oriented towards sustained activities. Understanding or knowledge must be tied to possibilities of action and accompanied by preparation in the development of appropriate skills for action, rather than disembedded and abstract;
- an approach that targets highest risk groups, but at the same time works at the level of creating normative social frameworks to guide people into not needing to negotiate every risk avoidance act anew, so that prevention behaviour ultimately becomes a matter of regular cultural practice;
- an approach which recognises that the broader context of sexual behaviour is important, especially the gender and cultural aspects of sexual negotiation which need to be targeted at a social as well as an individual level;

122. Soul City thoughts on behaviour change: http://www.comminit.com/power_point/change_theories/sld031.htm

- an approach that recognises young people as living within an HIV-positive world and as capable of understanding the challenges of HIV/AIDS. This requires approaches that endorse existing behaviours, practices and responses. Specifically, targeted behaviours and practices must be understood broadly and extend beyond the sexual realm. These might incorporate wearing a red ribbon, providing assistance to local level HIV/AIDS activities, or speaking up for a person or family who are affected by HIV/AIDS;
- an approach that is promotive as well as preventive – that is, which positively brands risk avoidance behaviour and constructs a positive culture around culturally constructive and attractive images of behaviour;
- an approach that is oriented towards maintenance of specific behavioural decisions and which focuses on individual, cultural and social elements which support decisions to avoid risk, including value systems and rights and legal frameworks;
- an approach which proactively addresses contextual obstacles to maintenance of behaviour change through mobilising a supportive framework in education, health, family and recreational fields;
- an approach that includes development of a framework for mobilisation integration of existing individual, community and social resources (e.g. district health and education management);
- an approach that involves children and young people in formulating courses of action and decision making;
- an approach that orients existing services and resources to the specific needs of young people;
- an approach that recognises the heterogeneity of young people and addresses them as members of communities of risk rather than as being uniformly at risk, and that develops targeted programmes accordingly;
- an approach that is built from research and analysis, that draws lessons from evaluation of interventions, and that is respectful of the different lived experiences of health programme developers, young people and children.

In conclusion, it should be said that as an extension of this review, the above ideas are being applied in a practical context, in two social mobilisation projects involving young people in remote rural areas and visually disabled young people. The focus has moved in these projects from the above 'conceptual tools' into potentially sustainable localised responses. This is a response to the need to develop tools and models for community mobilisation. It is also an attempt to understand the challenges of implementing contextual and developmentally oriented HIV/AIDS responses, building on the foundation of what has already been achieved through the collective impact of various multifaceted interventions.

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