THE BANGLADESH OBSERVER

04 2002

AIDS education and mass

Population Times Report

IN June 2001 member states at the United Nations General Assembly Special Session on AIDS agreed to "ensure that by 2005, at least 90% of young men and women aged 15 to 24 have access to the information and education necessary to develop the life skills required to reduce their vulnerability to HIV infection". One way to achieve this goal, at least in theory, is through a country's education system-especially if programmes reach students at an early age, before some begin to drop out of school. At the International AIDS Conference in Durban in 2000, the "Prevention Works" Symposium recommended that HIV/AIDS education begin early, focusing on children as young as five years old.

Nevertheless, there is considerable disagreement over HIV/AIDS education-including what to teach, at what age, in what setting, by whom, and to what end. Political pressures often keep sex education-and thus HIV/AIDS education-out of the classroom. Sensitivities about sexuality and young people's behaviour often obstruct AIDS education even where there is a strong national commitment to address the AIDS crisis. In spite of such obstacles, some school programmes appear to have made gains, although evidence from programme evaluation is sparse.

Comprehensive evaluations have examined the impact of HIV education programmes worldwide. In Canada and the US researchers found that one-third of the 28 programmes they reviewed delayed the age at sexual initiation among students participating. A more recent analysis that reviewed school-based education programmes in Namibia, Nigeria, South Africa, and Zimbabwe found that some of the programmes helped delay sexual initiation, decreased number of partners, and increased contraceptive use. For example, in Namibia a cirriculum that emphasized abstinence and safer sex practices helped some female students delay the start of sexual activity but did not increase abstinence or condom use overall. In Brazil students participating in a school-based AIDS education programme reported having fewer sex partners than students in schools without AIDS programme.

Important components of AIDS education programmes for youth include addressing peer pressure and norms that encourage risky behaviour. Changing young people's risk-taking behaviour requires going beyond providing information to helping young people acquire the ability to refuse sex and to negotiate with sex partners.

In Thailand a comprehensive education programme for young people included problem-solving exercises, role playing, and analysis of "triggers" for unsafe-sexual behaviour (such as alcohol use). This programme helped to achieve a 50% decline in new HIV cases, and the incidence of STIs among young men in the programme was one-seventh of that among a control group without AIDS education.

Researchers have identified key elements of HIV/AIDS education programmes, largely from US-based studies. Programmes are more likely to be successful by:

o Focusing on reducing specific risky, sexual behaviours;

o Using theoretical approaches to behaviour change that have proved successful as a basis for programme development;

o Having a clear message about sexual activity and condom use and continuously reinforcing this message;

o Providing accurate basic information about the risks of adolescent sexual activity and about methods of avoiding intercourse or using condoms against HIV infection;

o Dealing with peer pressure and other social pressures on young people to be sexually active;

o Providing modeling and practice of communication, negotiation, and refusal skills;

o Using a variety of teaching methods that involve the participants and help personalize information;

o Using teaching methods and materials appropriate to students' age, sexual experience, and culture;

o Selecting as teachers people who believe in the programme and then training them to be effective.

More evaluation is needed of developing-country AIDS education for youth in school and out of school.

HIV/AIDS education programmes should be age-appropriate-that is, programmes for younger adolescents should focus on avoiding or delaying sex, while those for older adolescents should include discussion of condoms and other contraceptives in addition to urging abstinence. Of course, education cannot help young people who cannot avoid or delay sex, even they want to-for example, young women trafficked into prostitution or raped in refugee camps.

Peer education. Many strategies for youth now make peer education a key approach. Perhaps the most important goal of peer education is to establish standards for acceptable behaviour. When youth play a role in developing social and group norms that protect against HIV infection, they serve as positive role models for behaviour change.

Most young people find trained peer educators credible because they communicate well with other youth and set believable examples of behaviour. Peers also can help other young people acquire such skills as sexually negotiation and assertiveness.

For peer education programmes to be effective, training of the peer educators is essential-including follow-up sessions that reinforce knowledge, beliefs, and skills.

"To give sex education to adolescents is to prevent early births, unwanted pregnancies, STIs, and AIDS," says this poster from Cameroon. "If only I'd had good information!" this young woman reflects, while her classmates laugh at her on their way to school.

Training not only should ensure that peer educators know how to teach about HIV/AIDS but also that they are able to see things from the perspective of the young people they are trying to reach.

A wide variety of peer AIDS-education programmes in developing countries reach young people, including in Indonesia, Kenya, Peru and Zambia. While evidence from evaluation is slight, peer education programmes have been found to reduce the incidence of STIs including HIV, change risky behaviour, and improve health, including among the peer educators themselves. In a US peer education programme among youth, for example, condom use increased from 45% to 55% among participants surveyed. In Peru, in the absence of the Es Salud peer project, youth condom use in the project area would have been 39% less.

Peer education is sometimes assumed to be inexpensive, since it relies on volunteers. Costs can run high, however, to train, support, equip, and supervise peer educators. High turnover among peer educators requires continuous recruitment and training of replacements. Also, peer programmes usually need professionals to provide guidance and support. While a growing consensus holds that peer educators should be compensated in some way, experience cautions against overcompensation to avoid distancing peer educators from their audience.

Mass media communication

The mass media-especially television and radio-reach large numbers of young people around the world and have enormous influence. In a 23-country study among 12-year-old school children whose homes had electricity, over 90% watched an average of three hours of television per day. In virtually all developing countries most women ages 15 to 19 have regular access to television and radio. While young people obtain a great deal of information about reproductive health from entertainment programmes in the mass media, many of these programmes have the effect of promoting unsafe attitudes and behaviour and portraying sex in ways that encourage risk-taking.

Increasingly, reproductive health groups are working with the mass media and entertainment industries to develop accurate and healthy presentations of sexual topics and to raise media literacy among young people. A 1999 review in Europe found that the mass media promoted open and frank discussion about responsible sexuality. Messages encouraged healthful sexuality and did not stress fear or shame. In the US the Media Project honors members of the entertainment industry who incorporate accurate and honest portrayals of sexuality into their programmes. In South Africa a programme by Soul City helps young people understand that television and radio programmes do not always reflect reality and that viewers should think critically about what they see and hear.

Because mass media entertainment is so popular, it can reach many young people with positive health information. In Uganda, for instance, the Safer Sex or AIDS Campaign, which encouraged young people to make responsible decisions about HIV/AIDS, reached 92% of its intended audience. In Zimbabwe a similar communication campaign reached 97% of youth surveyed. In Botswana Tsa Banana, a mass media campaign to improve adolescent reproductive health, reached about 70% of adolescents.

Mass media can be an efficient way to reach and influence young people. For example, in Kenya a call-in radio programme for youth cost just three US cents per young person reached. The cost of getting one young person to take action to improve reproductive health-for example, visiting a health clinic-was 12 cents.