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**FOCUS on Young Adults
Partner Dialogues 2001**

Dialogue on HIV/AIDS and Youth

Thursday, May 24, 2001
Washington, D.C.

Meeting Report

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Contents

I.	Introduction and Background	3
II.	Meeting Highlights	3
	A. Introductory remarks	3
	B. Update on the youth dimension of the epidemic.....	3
	C. Youth vulnerability to HIV/AIDS.....	4
	D. Program responses: prevention	6
	E. Program responses: mitigation.....	8
	F. Future directions	9
	Annexes	11
	1. Meeting Agenda	12
	2. Participants	13
	3. Presentations	16

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Acknowledgments

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I. INTRODUCTION AND BACKGROUND

On May 24, 2001, the FOCUS on Young Adults Program hosted a half-day dialogue in Washington to examine youth and the HIV/AIDS epidemic. A total of 33 participants attended the meeting, including 4 from FOCUS, 11 from USAID, and 18 from partner organizations.

The objectives of the dialogue were to:

1. Update participants on the youth dimension of the epidemic and the underlying factors that make youth especially vulnerable to HIV/AIDS.
2. Analyze regional differences in the epidemic's impact on youth and subgroups of the youth population that are at high risk of infection.
3. Examine the evidence on which interventions and programs are effective in preventing HIV transmission among youth and in helping youth cope with the impact of the epidemic.
4. Look at how to incorporate what we have learned to ensure that future HIV/AIDS programming takes into account the special needs of youth.
5. Consider strategies for bringing programs to scale, given limited resources.

II. MEETING HIGHLIGHTS

A. Introductory remarks

FOCUS Director Sharon Epstein noted that the dialogue is the third in a series of four meetings that the FOCUS program is holding on key topics related to young adult reproductive health (YARH). HIV/AIDS is a fundamental part of YARH interventions, and FOCUS has integrated HIV/AIDS into many of its documents and activities. For further information, see the FOCUS website, www.pathfind.org/focus.htm.

B. Update on the youth dimension of the epidemic

Karen Stanecki of the U.S. Bureau of the Census presented the latest information on the epidemic's impact on young people (her slides are attached). She pointed out that most of the statistics broken out by age come from sub-Saharan Africa, where 70 percent of people with HIV/AIDS live. In other regions, the epidemic is concentrated among intravenous drug users, men who have sex with men, and sex workers. There is very little information by age for those groups.

The nature of the HIV/AIDS epidemic is that in its early stages, everyone is vulnerable. As the epidemic matures, the people most at risk are those just beginning their sexual behavior—youth. Thus, programs must make youth a priority.

Most of what we know about HIV prevalence in youth comes from community-based studies in Africa. For youth, the pattern of infection in sub-Saharan Africa essentially has remained unchanged over the last decade. Young women almost universally have much higher levels of infection than their male counterparts of the same age. Prevalence in males peaks at older ages, and almost never peaks at as high a level as for young females. This pattern is found in both urban and rural areas.

HIV prevalence estimates derived from surveys of women at prenatal care clinics accurately represent overall levels of adult infection. However, such estimates typically understate youth female prevalence and overstate youth male prevalence.

A recent multicenter study attempted to explain why infection rates in West Africa are lower than in Eastern and Southern Africa. The study found the same pattern of higher youth female prevalence in all regions and concluded that there were no big differences in sexual behavior or in rates of sexually transmitted infection. However, the study did find significant differences in the age pattern of sexual partnerships. In Eastern and Southern Africa, young women were more likely to have male partners who were significantly older. Based on this and other studies, we now believe the following pattern of sexual activity is driving the epidemic: (1) Young girls are getting infected before marriage by partnerships with older infected men. (2) These young women in turn infect their spouses. (3) Their spouses in turn infect younger women.

We are just beginning to see deaths from infections that occurred in the early 1990s. Massive mortality in the 20- to 24-year age-group is yet to come. These deaths will have a huge impact on population structures and society. The numbers of AIDS orphans, already large, will increase enormously.

Issues raised during the subsequent dialogue:

What we know about regions other than sub-Saharan Africa. Elsewhere, intravenous drug users and men having sex with men are the main risk groups. Some generalized epidemics exist in Asia, including Thailand, Burma and Cambodia. To the extent that drug users and men having sex with men are youth, there will be a youth impact. However, we know little about the age structures of these groups, other than anecdotally.

The role of age at marriage. We don't know whether age at marriage is a significant factor either in driving the epidemic or in slowing it in countries such as Uganda, where infection rates among youth have dropped.

C. Youth vulnerability to HIV/AIDS

Karusa Kiragu, of the Center for Communication Programs at Johns Hopkins University, described six categories of factors that make youth vulnerable to HIV infection:

Biology. A number of biological factors predispose young women to infection.

Cognitive and emotional development. Many young people do not have the cognitive maturity to rationally protect themselves. Youth tend to underestimate the risk to themselves. Furthermore, many youth are embarrassed to use condoms or don't know how to use them properly.

Lack of information and access. What youth know about HIV/AIDS is very superficial. Many still do not know even one way to protect themselves against infection—even in places where HIV infection levels are high.

Cultural norms and social expectations. A number of these predispose youth to infection, including early marriage, gender-based violence, and particularly sex-related traditions that create risks (e.g., female genital cutting and dry sex). Furthermore, in many cultures, young men do not feel responsible for the consequences of their sexual behavior and therefore do not protect themselves.

Poverty. Family context and family income are important. Economic necessity may supersede young people's desire to protect themselves, thus leading to the phenomenon of exchange of sex for money or goods, and thus some level of sexual dependence.

Discrimination and cultural intolerance. Youth in many cultures have few rights to talk or to participate. They do not get the reproductive health care they need. Society looks at youth as a problem to be solved rather than as equal partners.

Issues raised during the subsequent dialogue:

Youth attitudes toward condoms. Youth in many countries have doubts and concerns about the efficacy and safety of condoms. In many countries, youth don't know or don't believe that condoms prevent HIV and pregnancy. Adults—even many of those who staff organizations dedicated to preventing HIV/AIDS—often compound such attitudes. This suggests that young people do not live in isolation and that educating adults and policy makers is critical. We must also remember that reluctance about using condoms may also be related to underlying factors, such as a young woman's fear that using condoms may provoke violence from a sexual partner, or that she will appear sexually promiscuous if she asks her partner to use a condom.

Addressing the generation gap. A huge gap between the parents' world and children's world exists in many African countries. Parents don't know what to say to their children about many things, including sexuality. This must be kept in mind when designing programs that have as their goal increasing adult-youth communication.

The rights of youth versus the rights of parents. Talk of youth rights is often countered with talk of parental rights. Studies show that around the world the majority of kids don't talk to their parents about sex. At the same time, we know that parents would be happy if someone else talked to their children about sexuality in a responsible way.

D. Program responses: prevention

Carl Kendall of Tulane University described what we know about the effectiveness of programs to prevent HIV infection in young people.

Kendall noted that we cannot treat youth as a homogenous group. The many pathways from child to adult make it difficult to address the variegated youth population. Many things influence the behaviors associated with HIV transmission, and they operate at many different levels. We do not yet have the tools to understand fully how these factors play out. We know that each factor, by itself, has only weak to moderate effects. Thus, programs and policies targeting multiple factors will probably be more effective in influencing behaviors.

A recent FOCUS review of YARH program effectiveness drew mainly on 40 relatively well-designed studies that use control or comparison groups (for more detail on this review, see the report of the March 2001 *FOCUS Dialogue on Research and Evaluation*, available on the FOCUS website). Overall conclusions from this review include:

- Only a small proportion of interventions have a strong impact-evaluation component. Most of the evidence available is on changes in knowledge and attitudes. We still know very little about the impact of programs on behavior.
- Much of the evidence from rigorous studies is for small-scale programs implemented over short periods of time.
- Programs appear to be more effective at influencing knowledge and attitudes than behaviors.
- Although not all ARH programs have been effective, most models or approaches have been effective in one or another study.
- Multicomponent programs that target multiple risk and protective factors appear to be more effective than more narrowly focused programs.

Twenty years into the epidemic, there should exist a great deal of solid evidence to stand on for developing interventions. But there is a need for still more good studies, especially in relation to adolescents.

Another recent review (Merson et al., 2000) of HIV prevention programs found that targeted condom promotion efforts are effective and that voluntary counseling and testing approaches work, particularly in high-prevalence areas. This review uncovered only two studies targeted toward youth. Other research and action agenda include those of the US Agency for International Development (USAID), the National Academy of Sciences (its 1996 report, *Preventing and Mitigating AIDS in sub-Saharan Africa*), the National Institutes of Health, and the HIV Prevention Trials Network (another program of the National Institutes of Health).

Although we know how to build a relatively expensive, high-quality program that works, we still need to know more about designing programs that will reach large numbers of young people at a reasonable price. Most likely, there is a need for comprehensive

programs for targeted populations. We know that youth centers and clinics are not successful in attracting large numbers of young people for reproductive health services. We know we have to use both mass communication and interpersonal communication channels. We must adopt a harm-reduction mentality and think about positive approaches to youth sex and sexuality. We know some kids will have sex, even if we tell them not to, just as we know that talking about sex does not cause kids to go out and have more of it.

Issues raised during the subsequent dialogue:

Strengthening relationships between service organizations of different types. We need to make stronger linkages between programs of different types. Hotlines, for example, should strengthen their informal arrangements with and referrals to service sites.

Substance abuse and its link to sexual risk-taking. High levels of alcohol use and abuse complicate addressing sexual behaviors. There may be reasonable actions to address such abuse, however. For example, sex workers hang out in many places where people drink beer. That suggests a possible intervention. Moreover, we need to differentiate abuse from use. Many people drink alcoholic beverages when socializing. Therefore many interventions help youth practice negotiating sex and condom use even while slightly inebriated.

Appropriate use of mass media. Programs should use mass media, when appropriate, given a local context and program objectives. Use of mass media makes sense in cities, where many young people watch TV and where we are trying to change social norms. In rural areas, it is less appropriate because some places do not even have access to radio.

Targeting in-school versus out-of-school youth. Out-of-school youth are generally thought to be at higher risk of infection and have less access to information and resources. In some countries, more than four of every five teenage girls does not attend school. Elsewhere, however, the majority of teens are in school. We have proven curricula that can increase knowledge and positively influence behaviors. Successful school programs are run professionally and take time to train teachers and to gain the support of school administrators.

Stigma and discrimination. Efforts to address stigma are widespread, but not well-evaluated. Some ongoing studies are taking a rigorous look at the impact of such programs.

Unintended results of targeting youth. Done well, targeting of youth, like targeting of truck drivers and sex workers, can happen without creating an additional onus or backlash.

Targeted versus general approaches. In general, those working in the HIV/AIDS field see HIV as a health and medical problem. Those working with youth see the problems of

youth (including risky sexual behavior) as social problems that should be addressed through broader interventions. The need to wed these two approaches is recognized by field program staff, but it is necessary to understand better why and how interventions work. The population and their needs should drive the multipronged solutions, with cleverly designed programs then making an impact.

E. Program responses: mitigation

Ann McCauley of the Horizons Project discussed some of the issues related to mitigating the effects of the epidemic on youth.

Youth and voluntary counseling and testing. Horizons-sponsored research in Uganda and Kenya shows that 20 percent of the young people who come in for counseling are not sexually active. They come for information. Another finding is that parental consent issues are very important. In Uganda, no parental consent is needed for counseling and testing. In Kenya, parents must consent for counseling and testing for youth under 16. Such a policy presents a real barrier.

Access to treatment. Adolescents—especially unmarried adolescents—won't likely seek treatment. To do so, they would have to admit that they are sexually active. U.S. data show that adolescents have much more difficulty disclosing their HIV status and staying on a strict medicine-taking regimen.

Stigma. Because of stigma, many youth don't seek care. A Horizons-sponsored program in Thai schools addresses stigma. The program shows that stigma is more complicated than we thought. On one hand, youth are willing to take care of an HIV-infected family member; on the other, most want to keep the family member's HIV-positive status secret. Stigma and discrimination have their gradations.

Social stability. We must focus more on long-run problems related to AIDS and adolescents. Families hit by AIDS use up savings, take kids out of school; and decrease all members' food intake. The impact on adolescents is extremely negative. They may care for a dying parent or parents for years in a fragile, poorly functioning household. If both parents are dead, youth are more likely to leave school, leading to a serious loss of human resources for the country. The number of teachers who die is almost as great as the number of teachers who finish their teacher training. As the crisis spreads across society, the number of adults able to run the country declines. Private sector growth is inhibited when social capital is destroyed and production lost. Ultimately, societal institutions also weaken.

Programs for orphans. Laelia Gilborn of the Horizons Project described a Horizons-sponsored study in Uganda of a program for AIDS-affected children. The study examines two interventions: (1) the first promotes succession planning for children living with HIV-infected parents (preparation of wills, naming and preparing of guardians, creating "memory books"); (2) the second provides more typical orphan support (access to education and health care) to children who have lost both parents and are living with

guardians. A preliminary impact analysis shows that the orphan support program has a significant impact on a range of variables, including school performance, levels of happiness, and health. The succession planning program has spurred more community members to get tested for HIV; improved the preparation and commitment of guardians (of whom 50 percent are aunts and uncles; 30 percent are grandmothers; and the rest are siblings and other more distant relatives); encouraged more parents to disclose their HIV status to spouses and children; and encouraged more parents to appoint and talk to a future guardian. Anecdotally, there is evidence that property-grabbing has decreased.

Issues raised during the subsequent dialogue:

Garnering support for mitigation programs. HIV/AIDS has moved beyond a public health problem to become a large-scale development problem. If we want to increase USAID funding for mitigation, we need an intensive advocacy campaign by groups outside of USAID. The message must be that the agency's vertical funding structures do not allow it to address these problems in the most cost-effective way. Another strategy is to highlight the link between prevention and mitigation and to stress that we can enhance both by linking them. First, we must show that multisectoral efforts have direct and measurable impact on health outcomes. Many people believe this, but we need the good research to prove this assertion.

F. Future directions

The final session of the dialogue looked at priorities for action in a resource-poor context. The following recommendations emerged:

Do more to target youth. The data are clear about the need to target youth. Now, we need to do further analysis to determine where we can reach large numbers of adolescents at a reasonable cost. No single answer exists. Thus, we must look at the context of each situation and at the massive cohort where we get the biggest "bang" for the buck. In addition, we need to look at local resources.

Start early. The earlier we can put resources into fighting the epidemic the better. One place to begin is to persuade political leaders to make available the resources to fight the epidemic.

Give adults a role. Resources should be targeted at parents to help their children. Even if mothers can't do for themselves, they can try to do better for their children. Parents themselves don't have the information they need to help their children. When they get it, they feel more comfortable. Not only the parents but also the extended family and other adults need to be connected to children.

Emphasize the private sector. We should work with governments to set policies and standards but not to structure clinics. The informal and formal private sector should be used more for counseling, information and services.

Educate international organizations on the importance of youth . We must ensure that stakeholders understand the dynamic of the epidemic and how youth fit into it. We must convince them that prevention among youth is key and that they must advocate for the inclusion of youth in their national plans.

Build on efforts in youth development. We should help existing youth-serving organizations (e.g., Scouts) that already address broad youth development to incorporate a focus on HIV/AIDS. At the same time, we must resolve the tension between our lack of resources and the apparent need for multicomponent programs. Moreover, we still do not know what combination of youth development activities is ideal for reducing risky behaviors.

Link HIV prevention to a broader social movement. Social movements such as religions can give young people positive messages about delaying sex. We can link HIV prevention to such an advocacy movement, thus encouraging youth to have a vision for the future.

Educate leaders. We must work with leadership, both in developing country governments and within international donor agencies. We also need to increase the focus on youth among those working on HIV/AIDS. The emphasis on targeted interventions has perhaps contributed to a particular focus on youth. We need to make the point with policy makers that HIV is an entry point for working with youth. Youth have broad needs that require broad investments, and making these investments will address issues of social stability.

Annexes

Annex 1: Agenda

FOCUS on Young Adults Partner Dialogues 2001

Dialogue on HIV/AIDS and Young Adult Reproductive Health

- 8:30 - 9:00 *Coffee and Sign-in*
- 9:00 – 9:10 *Welcome and introductions* Sharon Epstein, FOCUS Director
- 9:10 – 9:30 *Update on The Youth Dimension of the Epidemic* . Karen Stanecki, Census Bureau.
- 9:30 – 10:00 *Youth Vulnerability to HIV/AIDS*. Karusa Kiragu, JHU, Center for Communications Programs.
- 10:00 – 12:30 *Program Responses*
- 10:00 – 11:15 *Effectiveness of prevention programs*. Carl Kendall, Tulane University
- 11:15 – 11:30 *Coffee break*
- 11:30 – 12:30 *Effectiveness of programs to mitigate the impact of the epidemic on youth*. Ann McCauley and Laelia Gilborn, HORIZONS project
- 12:30 – 2:00 *Working lunch: Future directions*

Annex 2: List of Participants
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*Dialogue on HIV/AIDS &
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Annex 3: *Presentations*
(attached)

Presentations:

Karen Stanecki, U.S. Census Bureau. "FOCUS Dialogue on HIV/AIDS and Youth: Update on the Youth Dimension of the Epidemic."

Karusa Kiragu, Johns Hopkins University, Center for Communication Programs. "HIV/AIDS: Why Youth are Especially Vulnerable."

Carl Kendall, Tulane University. "HIV/AIDS and Youth: Effectiveness of Prevention Programs."

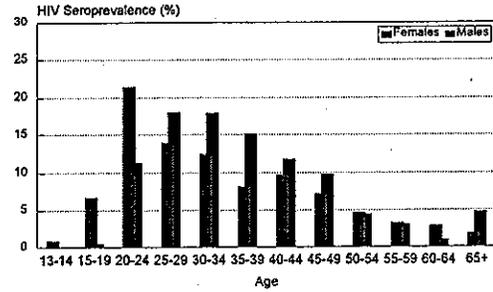
Laelia Gilborn, Horizons Project. "Impact of HIV/AIDS on Youth in Uganda: Findings from programs for children affected by AIDS."

FOCUS Dialogue on HIV/AIDS and Youth

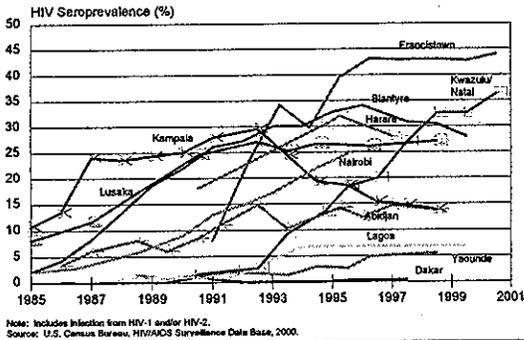
Karen A. Stanecki

U.S. Census Bureau
Population Division
International Programs Center

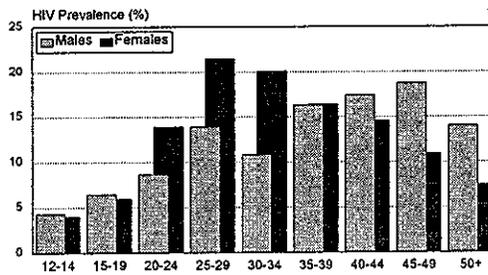
HIV Seroprevalence of Adult Population
Masaka, Uganda by Age and Sex: 1989-90



HIV Seroprevalence for Pregnant Women
Selected Urban Areas of Africa: 1985-2000

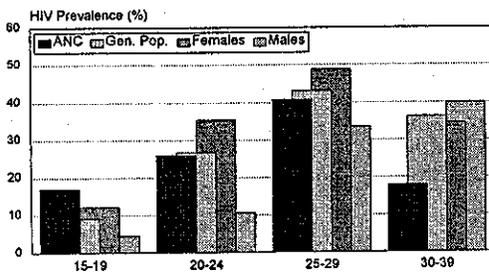


HIV Prevalence by Age and Sex
Rwanda, 1997



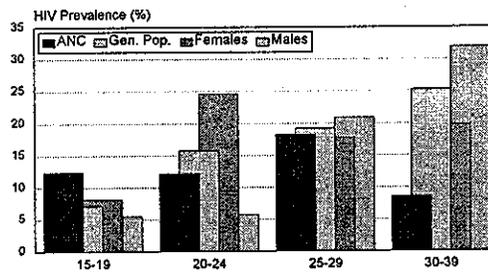
Republic of Rwanda, Ministry of Health

HIV Prevalence for Pregnant Women, 1996 and General
Population by Sex, 1995-96
Zambia, Urban



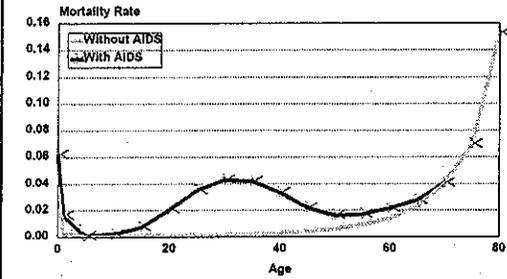
Fykenes

HIV Prevalence for Pregnant Women, 1996 and General
Population by Sex, 1995-96
Zambia, Rural



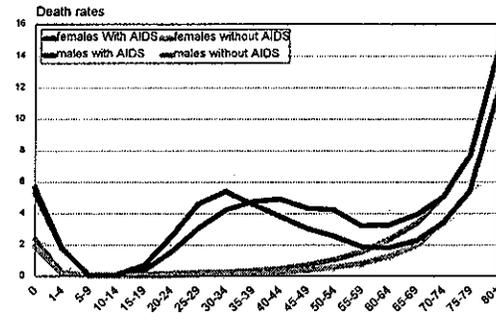
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Illustrative Impact of HIV on Age-Specific Mortality Rates at Approximately 20% Adult Prevalence



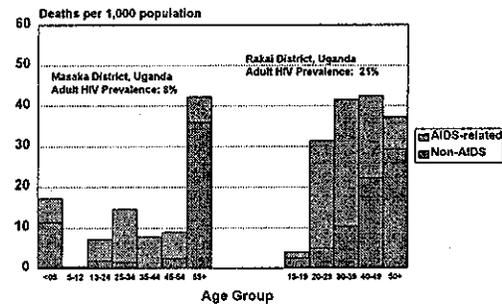
Source: International Programs Center, U.S. Census Bureau.

Estimated mortality, with and without AIDS, by sex, South Africa 2020

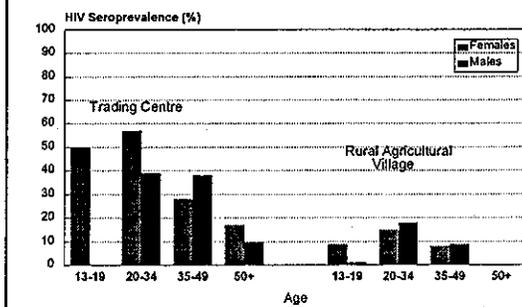


Source: U.S. Census Bureau, International Data Base and unpublished tables.

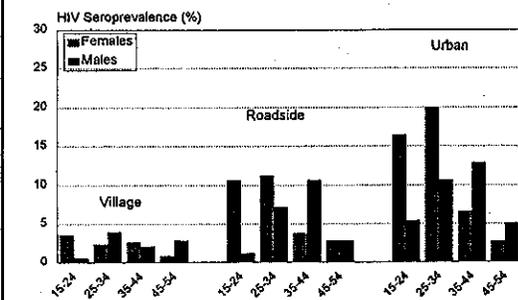
Empirical Evidence of AIDS Impact on Mortality



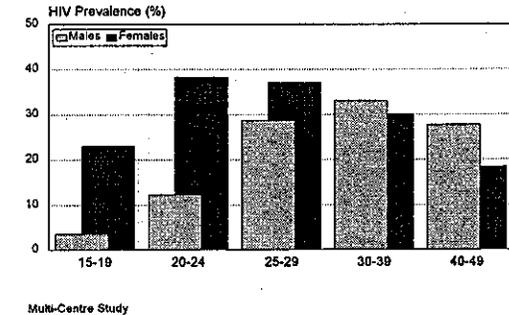
HIV Seroprevalence for Rakai District by Age, Sex, and Residence: 1990

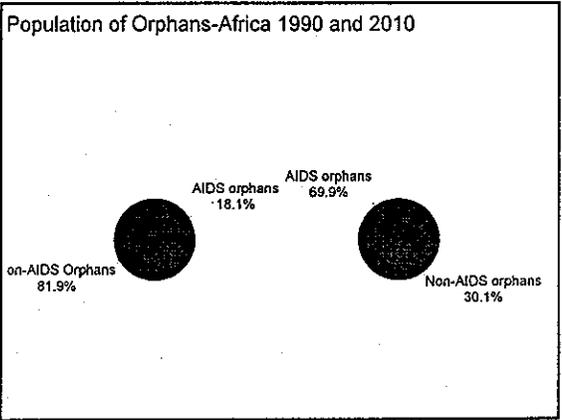
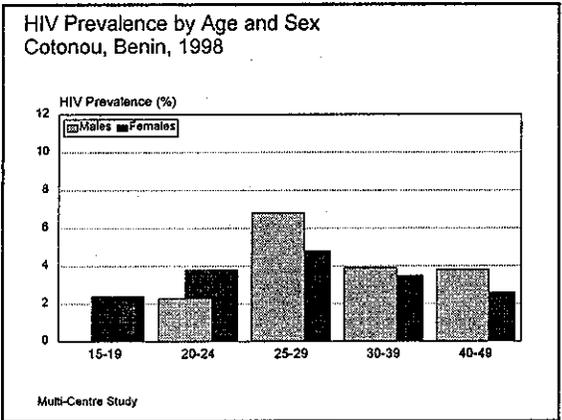
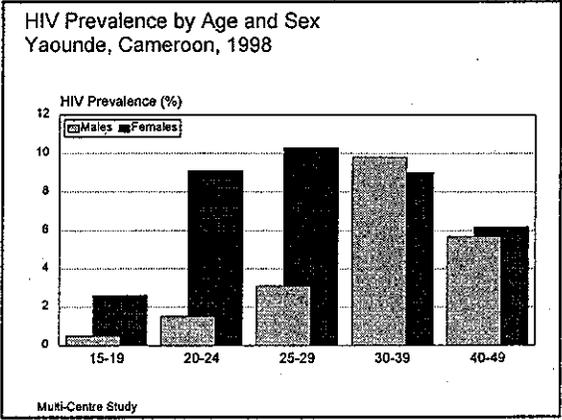
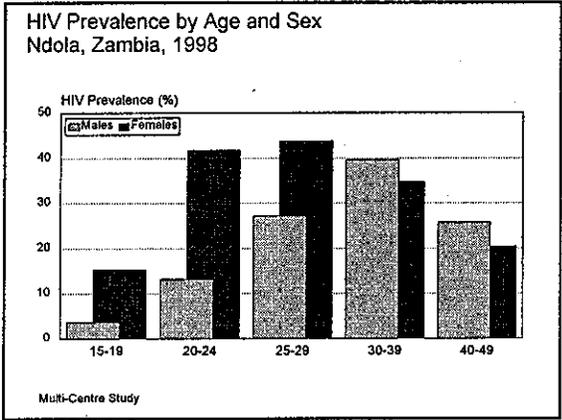


HIV Seroprevalence for Mwanza, Tanzania by Age, Sex, and Residence: 1990-1991



HIV Prevalence by Age and Sex Kisumu, Kenya, 1998





HIV/AIDS Why Youth are Especially Vulnerable

Karungari (Karusa) Kiragu
Johns Hopkins University
Center for Communication Programs
at the
FOCUS On Young Adults
Partner Dialogue Series
May 24, 2001

Training

Why Young People are Vulnerable

- Biological factors
- Cognitive and emotional development
- Lack of information and access
- Cultural norms and social expectations
- Poverty and economic dependence
- Social powerlessness

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Biological Factors

- Greater surface area in female exposed to virus
- Higher concentration of HIV in sperm
- Immature cervix less resilient to HIV
- Hormonal changes thin mucus plug
- Reduced vaginal secretion
- Less likely to recognize and treat STDs

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Cognitive and Emotional Development

- Analytical and decision-making ability
- Sense of invincibility
- Anxiety, embarrassment and denial
- Vulnerability to peer opinion

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Older People are More Vulnerable to HIV/AIDS

Relative Risk

Adult Health Picture Vocabulary Test

— Males — Females — Total

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Respondents 15 years and above. Source: Halpern et al. 2000 (533). Controlling for age, physical appearance and mother's education

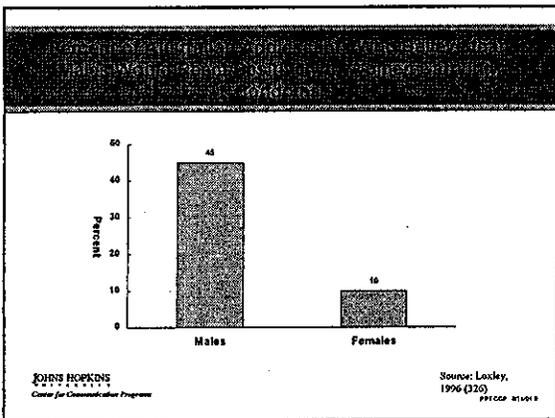
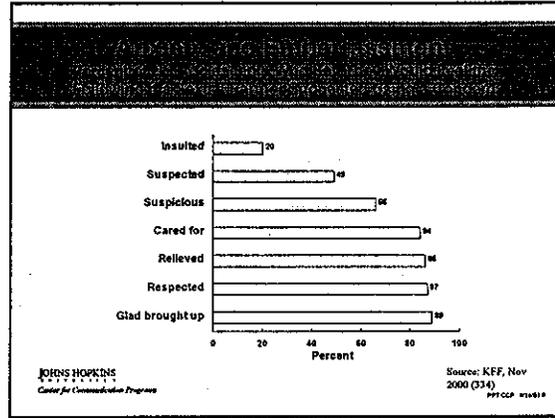
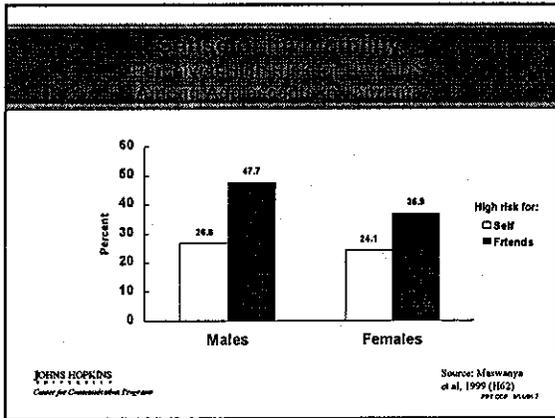
Sense of Invincibility

"AIDS is spreading because of the prostitutes." (Male, age 13-16, South Africa)

"I suppose all those drug users...And other crazy people.....And gays. I guess you've got to be careful yourself"
Males, age 15, Finland

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SA: Mael-Phill & Campbell, 2001 (531)
Finland: Pösoonen & Kontula, 1999 (1899)

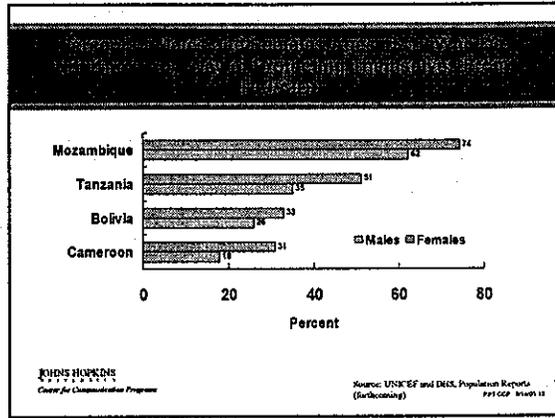


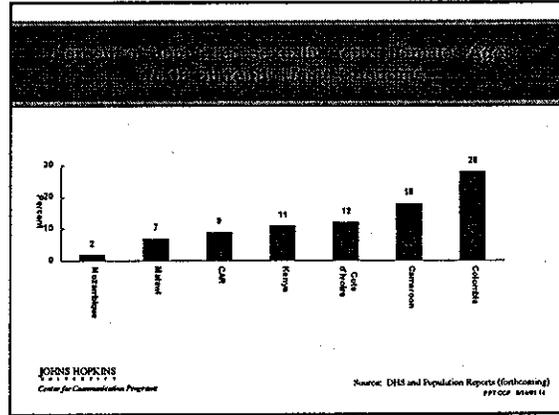
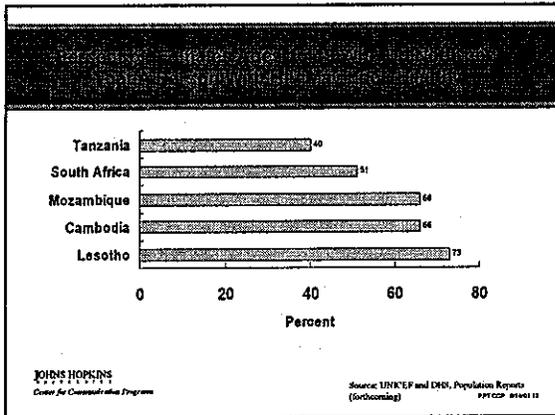
Guys were asking me why I could not have sex with such a nice girl. They say I was stupid
(Male 13-16, South Africa)

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McNeil and Campbell, 2002 (331)
PPTCCP 014920

- Many young people uninformed
- Girls less knowledgeable than boys
- Lack of condom use

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PPTCCP 014921

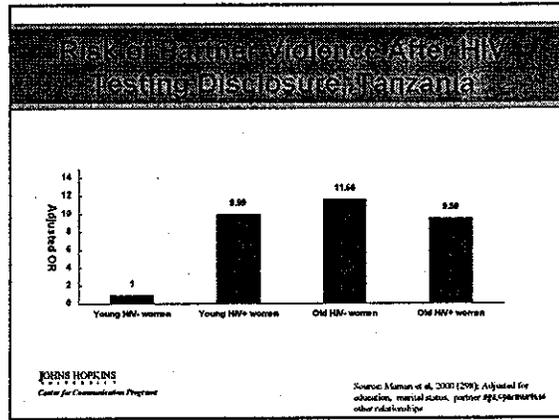




Cultural Norms and Traditions

- Sexual double-standards
"Tie up your chickens" in Nicaragua
Isoka, the ultimate compliment in S. Africa
Good girls dont
- Power Dynamics and Gender-based violence
- Martial and sex-related traditions
- Lack of male accountability

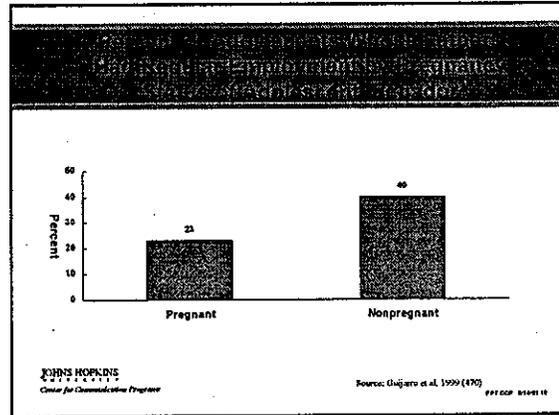
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PPT COP 81481 15



Transactional Sexual Relationships

- Parental income
- Transactional sexual relationships
- Migration to seek jobs

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**Limited rights
and
Limited say**

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PP1GGP 0140110

**“The seepage of HIV infection into
younger groups signals a failure to
respect, protect and fulfil their
human rights.”**

UNAIDS, April 2000

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Source: UNAIDS Technical Update,
2000, (11)

PP1GGP 0140120

HIV/AIDS and Youth:
Effectiveness of Prevention Programs
FOCUS Partner Dialogue

Carl Kendall, PhD
Tulane University
May 24, 2001

Why an interest in young adults?

- Demographic and social reproduction
- 1.75 billion youth
- 85% in developing countries
- 15 million teenage births
- 1/2 of new HIV infections
- In some areas 1 in 5 girls <19 HIV+
- Youth are flexible and developing lifetime habits

The Adolescent Context

- Need to understand biological/psychological development
 - Uneven development – by age and outcome
 - Different sexual identities
 - Mood swings/inconsistencies
 - Self-consciousness/weak ego
 - Self-definition through others
 - Fragile interpersonal relationships/distrust
 - Separation: need to break with parental/other authority

The Adolescent Context

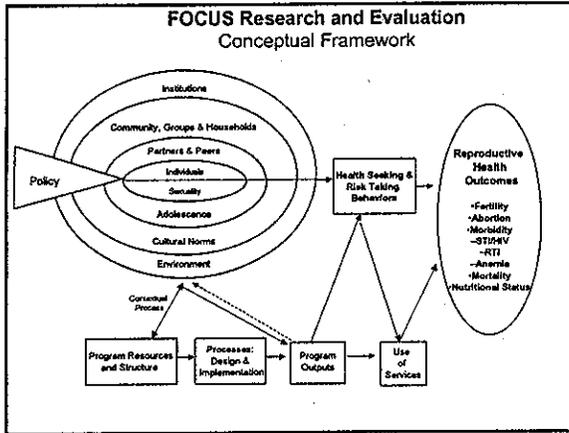
- Need to understand social development
 - Structures that put youth at risk
 - Family: risks/support
 - Significance of fathers
 - Friendship networks
 - Interplay between development and friendship networks
 - Social isolation
 - Institutions that support/discourage
 - Media and the global construction of adolescence

The Adolescent Context

- Need to characterize sexuality
 - "Regional" characteristics
 - Africa characterized as:
 - The only almost purely heterosexual epidemic in the world
 - It is driven by a "Sexual Culture" which is driven by fertility rather than fear of mortality
 - Driven by male "sexual needs"
 - Resists condom use
 - Resists alternative sex
 - Encourages multipartnerism, especially polygyny

Today's Presentation

- Part 1 ARH: What do we know with confidence about ARH programs?
- Part 2 HIV Prevention: What do we know with confidence about HIV prevention programs?
- Other Agendas
- Areas of agreement/discordance



What do we know about the factors that influence adolescent/young adult sexual and contraceptive behaviors?

Evidence from U.S. (especially Kirby, 2000)

- Adolescents are influenced by a myriad of factors operating at different levels (individual, family, peer, school, community, society)
- The various factors have small-to-moderate (as opposed to large) statistical effects
- Programs and policies targeting multiple factors will probably be more effective in affecting behaviors, although this approach likely to be more costly
- Adolescents are not a homogenous population (e.g., gender, sexual activity, in-school status, labor force participation); programs and policies must target different sub-populations of youth with appropriate interventions

Risk and Protective Factors for Adverse RH Outcomes

Community Level	School Level	Family Level	Individual Level
<ul style="list-style-type: none"> Economic status Facilities or organizations Violence Social norms Peer attitudes & behaviors Media 	<ul style="list-style-type: none"> School type, size Infrastructure S/T Ratio Student SES Peer attitude & behaviors Teacher attitudes & behaviors Prog. quality 	<ul style="list-style-type: none"> Family structure Economic status Sibling behaviors Parental attitudes Parental behaviors 	<ul style="list-style-type: none"> Biological Gender Marital status Race or ethnicity Religion or religiosity School attendance Work KAPSI "Connectedness" Self-efficacy Locus of control Partner charact. Non-sexual risk behaviors

What do we know about the relative effectiveness of different types of programs on adolescent/young adult sexual and contraceptive behaviors?

Evidence considered:

- "Level 1" studies
- "Levels 2 & 3" studies to supplement evidence – but cautionary note

Categories of ARH Programs

- Supportive environment
- Reproductive health knowledge, skills and behaviors
- Utilization of services

ARH Programs: Goals, Strategies and Types

Goals	Strategies	Program Setting/Types
<ul style="list-style-type: none"> Create a supportive environment (community/institutions) Positively influence knowledge, attitudes, perceptions, skills and behavior (individual/interpersonal) Increase use of services and programs 	<ul style="list-style-type: none"> Advocacy Change social norms Change policy & regulatory environment Influence opportunity structure for youth Information Counseling and mentoring Skills development Communication Promote safe and healthy behaviors Child development 	<ul style="list-style-type: none"> Community Based: <ul style="list-style-type: none"> Community mobilization Youth serving orgs. (YSO) Livelihood programs Mass Media-Based: <ul style="list-style-type: none"> Community Mobilization BCC School-Based: <ul style="list-style-type: none"> SRH Educ./PLE Life-skills Educ. Peer promotion Mass Media-Based: <ul style="list-style-type: none"> BCC Social Marketing Community-Based: <ul style="list-style-type: none"> YSO Peer promotion Parental programs Youth develop. Workplace-Based: <ul style="list-style-type: none"> Educ./Life-skills Peer promotion Health Facility-Based: <ul style="list-style-type: none"> Youth friendly service Service provider training Peer outreach Links with other institutions or programs Mass Media-Based: <ul style="list-style-type: none"> Social marketing Community-Based: <ul style="list-style-type: none"> YSO Youth centers Peer promotion

Summary of Available 'Level 1' Evaluation Studies by Goal and Setting

GOAL AND SETTING	POCERS Studies	Other Studies
Goal 1: Create a Supportive Environment: Agency and Character Social Norms: Policy Development and Implementation	0	0
Goal 2: Increase Knowledge, Attitudes, Skills, and Behavior		
School Based	2	20
<ul style="list-style-type: none"> • HIV/AIDS Education (2) • General Reproductive Health Education (7) • Broadening Education (1) • Integrated School and Clinic Program (2) 		
Mass Media Based	1	5
<ul style="list-style-type: none"> • Media Only (1) • Media with Social Marketing (1) 		
Community Based	1	1
<ul style="list-style-type: none"> • Youth Development (1) • Peer Education (1) 		
Workplace Based	1	1
<ul style="list-style-type: none"> • Cambodia Chemical Workers • Thai Army Recruits 		
Goal 3: Increase Service Utilization		
Health Facility Based	4	1
<ul style="list-style-type: none"> • Youth Friendly Services (2) • Youth Clubs (1) • Integrated School and Clinic Program (1) 		
Mass Media Based	0	0
<ul style="list-style-type: none"> • Community Based • Outreach - Youth Development (1) 		
Total Unique Studies	9	28

Creating a Safe and Supportive Environment: Types of Interventions

- Policy Dialogue, Formulation and Implementation
- Influencing the Social Context: Social Norms and Cultural Practices
- Fostering Understanding Between Young People and Adults

Influencing the Social Context, Norms and Culture: Evidence

- Media campaigns promoting positive image of girls who use condoms-
 - changed attitudes, increased condom use at first sex (Paraguay)
- Social action community intervention
 - decreased community resistance to ARH and increased participants knowledge of formal services (Bangladesh-BRAC)
- Condom promotion program
 - 10 fold decline in STD incidence in military conscripts and change in norms and behaviors in brothels (Thailand)
- Work with traditional leaders to advocate alternatives to FGM
 - reached over 1,000 girls and obtained support of traditional leaders (Kenya)

Fostering Understanding Between Young People and Adults: Evidence

- Sensitization of teachers to needs of young people promoted more open dialogue (Thailand-Lifenet)
- Training of health workers and teachers resulted in students increased comfort discussing RH issues with teachers (Brazil)
- Participatory learning approaches sensitize clinic staff to better advocate for youth needs, resulting in broader array of programmatic responses (Zambia)

Conclusions:

- More attention needs to be paid to measuring the impact of policy interventions on making the environment more enabling & supportive for youth, as well as the subsequent impact of such changes on youth behaviors and RH outcomes
- Interventions addressing changing social norms and fostering communication and understanding have not been widespread, but some have demonstrated impact on youth behaviors

Improving Knowledge, Attitudes, Skills, and Behaviors

- School-based programs appear to be effective at influencing SRH knowledge and attitudes. However, the extent to which they influence long-term behaviors is less certain.
- Further OR needed to identify the key elements of effective school-based programs in developing countries.
- Considerable evidence that mass media programs influence adolescent knowledge and attitudes. Less evidence on sexual and contraceptive behavior impacts

Improving Knowledge, Attitudes, Skills, and Behaviors (con't)

- Youth development approaches appear promising, but more rigorous evaluation in multiple settings is needed.
- Peer promotion approaches appear promising, but a number of key questions require further investigation.
- Limited evidence on workplace-based programs indicates potential for reaching out-of-school youth.

Increasing Service Utilization

- There does not appear to be a "magic bullet" to increasing the use of clinic-based services by unmarried adolescents.
- "Youth friendly service" initiatives appear to be better when combined with other "outreach" strategies in order to attract youth to clinic-based services.
- The available evidence does not suggest that youth centers increase the use of RH services by adolescents.

Increasing Service Utilization (con't)

- Mass media and social marketing approaches have high potential "reach" but there is no evidence of increases in the use of clinic-based health services by youth in connection with such programs.
- Community outreach approaches implemented in connection with multi-component strategies may have the greatest potential for increasing use of health services.

Evidence on Program Effectiveness: General Conclusions

- Only a small proportion of ARH interventions have an impact evaluation component
- Much of Level 1 evidence is for small-scale programs implemented over short periods of time
- Programs appear to be more effective at influencing knowledge and attitudes than behaviors.

Evidence on Program Effectiveness: General Conclusions (con't)

- Although not all ARH programs have been effective, most models or approaches have been effective in one or another study.
- Multiple component programs that target multiple risk and protective factors appear to be more effective than more narrowly focused programs.

Evidence of prevention efforts for HIV

- Review Sources:
 - Choi and Coates (AIDS 1994)
 - Merson, Dayton and O'Reilly (AIDS 2000)
 - USAID
 - NIH

Evidence from Merson et al.

- Prevention efforts:
 - Targeted condom promotion
 - Sex workers and clients
 - Truck drivers
 - Factory workers
 - "Total" institutions - the army
 - VCT (but not in low seroprevalence)
 - STD treatment (sometimes)
- Found only two studies targeted to youth

Recommendations

- Community-directed programs showed mixed success
- Three high risk groups relatively unstudied:
 - MSM
 - Youth
 - IDUs
- In youth, out-of-school important

Recommendations

- Need to combine STD treatment and condom promotion
- Need to explore policy interventions, such as removing import tax on condoms
- Need to evaluate social marketing
- Need to understand the role of mass media

Recommendations

- "Government" efforts have been significant for national programs in Thailand, Uganda, Senegal (scaling up)
- Role of alcohol
- Sexual networks and mixing patterns
- Concurrent sexual partnerships
- Decision-making about sex

Recommendations

- Effect of ART on risk-taking behavior
- Prevention behaviors in HIV+
- Interventions need to be selected based on incidence and prevalence, on the one hand and behavioral context, on the other

Other Agendas

- The USAID trinity (1987):
 - Distribution of condoms
 - Behavior change communication
 - Improving the diagnosis and treatment of STDs
- Discrimination and stigma
- Focusing on the impacts of the epidemic in education, agriculture, on orphans, families and villages
- Empowerment

Other Agendas

- USAID Universal framework of indicators
 - Add productivity and security of vulnerable populations
 - Community ownership of responses
 - Resource losses addressed
 - Stigmatization

Other Agendas: NAS

- Studies linking incidence with behavioral and demographic variables
- Research on sexual networks
- Research on more reliable ways of collecting information on sexual behavior
- Research in sexual initiation and formation of sexual norms and attitudes
- Research on the frequency of specific sexual practices

Other Agendas: NAS

- Research on coercive sex
- Research on the dual role of condoms
- Research on local knowledge of stds and responses to them
- Research on acceptance of and behavioral responses to HIV vaccination

Preventing and Mitigating AIDS in sub-Saharan Africa: Research and Data Priorities for the Social and Behavioral Sciences 1996

Other Agendas: NIAID

- Focus on women, heterosexual epidemic
- Preventing perinatal transmission
- Behavior change: "We basically flooded the Royal Thai Army with AIDS prevention messages..."
- STDs

Other Agendas: HPTN

- Perinatal transmission
- Microbicides
- Sexual behavior
- STD control
- Antiretroviral therapies
- Injection drug use

General Conclusions

- Experience of other programs
 - Understanding context
 - Targeting behaviors
 - Targeting audiences
 - Problem of channel vs. message
 - Power of multiple sources
 - Legitimacy and authority
 - Attention to natural pathways of change

Lessons learned and Contradictions

- Targetted programs vs. comprehensive programs
- Service-based programs have low coverage
- Mass media appears both strong and weak
- New potential pathways of transmission

Risk pools overlap

- Out-of-school youth
- Orphans are adolescents
- New targets: youth involved with drugs
- New targets: teen pregnancy
- New targets: socially isolated youth
- New targets: homeless youth

Behavioral Goals overlap

- "Harm reduction"
- Pregnancy prevention
- Condom use
- STD treatment

Impact of HIV/AIDS on Youth in Uganda:

Findings from programs for children affected by AIDS

- Research Partners:** Makerere University,
Department of Sociology
Population Council,
Horizons Project
- Implementing Partner:** PLAN International/Uganda
- Researchers:** Laella Gilborn (PC)
Rebecca Nyonyintono (MU)

Problem Statement

- Children orphaned by HIV/AIDS are vulnerable in almost all aspects of their lives.
- The set-backs start *before* their parents' death.
- Parents and children worry about the children's uncertain future.
- Few programs reach AIDS-affected children (or their families) until after parental death.

Succession Planning

Targets HIV positive parents, their children and future guardians.

- Appointing of future guardians
- Counseling and disclosure
- Memory books
- Will-writing and legal training
- Community sensitization
- IGAs, training, seed money

Orphan Support

Targets orphaned children and guardians.

- Education and health assistance
- Vocational training, seed money
- AIDS and FP Education
- Community Sensitization
- Orphan Counseling
- Training and Support for Guardians

Study Objectives

- Impact of Orphan Support on child well-being.
- Acceptability of Succession Planning.
- Impact of Succession Planning on child well-being.
- Impact of SP on adult well-being and guardian capacity to care for orphans.

Study Design

Site	Baseline	Intervention(s)	Follow-up	Observations
Control	O1		O2	O3
Expt 1	O1	OS	O2	O3
Expt 2	O1	OS + SP	O2	O3

Three arms (2 experimental, 1 control) in each of 2 rural districts: Luwero and Tororo Districts.

BASELINE FINDINGS

1999

Baseline Sample

- HIV Positive Parents (353)
- Children of HIV+ Parents (495)
- Standby Guardians (99)
- Orphans (233)
- Active Guardians (227)

728 Children

679 Adults

Total = 1407

Profile of the Families

- Parent Households
 - ┆ 70% widowed
 - ┆ 40% have foster children
- Standby Guardians Households
 - ┆ 11% widowed
 - ┆ 51% have foster children
- Current Guardian Households
 - ┆ 25% widowed
 - ┆ 46% have foster children,
in addition to the child enrolled in the study

Health and Nutrition

- Health and nutritional well-being are comparable among affected and orphaned children, but hunger is a widespread problem.
- Half of younger children do not eat lunch on school days (*n=442*).
- One third of older children say they do not get enough to eat (*n=286*).

Education

- School enrollment rates are at 88-92% and are comparable for males and females.
- Enrollment is highest among older orphans.
- Adult illness takes a toll on schooling, especially for older children (*n=181*).
 - ┆ 26.0% say their attendance declined and
 - ┆ 27.6% say their grades declined.

Education

- Older children explain this as follows:
 - ┆ I stay at home to care for a sick parent.
 - ┆ I stay at home to do chores.
 - ┆ I am unmotivated, worried, sad.
 - ┆ No money for school supplies.
 - ┆ Absences affect grades.

Material Wellbeing

- More than a quarter of older children state that their parent's illness was followed by increased poverty in the family.
- Measured by the possession of basic necessities, orphans are actually better off than their peers living with HIV positive parents.

Material Wellbeing

- Property grabbing further undermines economic stability for children affected by AIDS.
- Widows (29%) and orphans (21%) are far more vulnerable to property grabbing than are widowers (7%).

Psychosocial Issues

- Being in school, being with other children, and recreation are critical in maintaining psychosocial wellbeing for all children.
- Honest discussion about parental illness and planning for the future are very important to older children.

Psychosocial Issues

- Although only 43% of parents had done so, most older children felt parents should tell their children about being HIV positive.
 - So children can know the truth.
 - So children can learn how to avoid AIDS.
 - So children can prepare mentally.
 - So children can prepare practically.
 - So a guardian can be arranged.

Psychosocial Issues

- Although most parents think it would be a good idea, they find it difficult to discuss.
- But, 91.3% of parents who have had such discussions feel that it was a good idea.

HIV/AIDS Knowledge

- Most older children believe that they will be able to avoid becoming infected with HIV.
- But knowledge of and sources of information about AIDS prevention is limited.

HIV/AIDS Knowledge

AIDS Prevention Methods Identified by Older Children

■ Abstinence	56.6%
■ Condoms	40.2%
■ Avoid sharing sharps	26.6%
■ Monogamy	19.2%
■ Unable to name a method	10.2%

HIV/AIDS Knowledge

Sources of information about HIV/AIDS transmission and prevention:

■ Parents	42.8%
■ Teachers	40.6%
■ Friends	9.1%
■ Aunts/Uncles	7.7%

Planning for the Future

- The vast majority of HIV-positive parents (91.5%) express worries about their children's future wellbeing.
- Top concerns are education, food/clothes/survival, property grabbing, guardian (lack of), shelter.

Planning for the Future

- About half (51.7%) of parents have arranged for a guardian.
- Fewer than half have told their children about being HIV positive.
- Only 10.1% of parents have prepared a will.

Planning for the Future

- Among parents who had not appointed a guardian, the following reasons were given:
 - There is no one able or willing.
 - I have not thought about it, am still well.
 - I do not want to reveal my HIV status (♀).
 - The person I have in mind died, is sick, or is HIV positive.

Planning for the Future

- Of those we reached, more than 50% of standby guardians say they are somewhat or very unprepared.
- Half (48%) doubt their ability to feed the children enough, and only 30% think they would be able to send the children to school.

Youth Living with Guardians

- Feelings of sadness and loneliness continue to affect children who have lost parents.
- But among older orphans, 60% are "happy" and 16.2% "relieved" to be in the foster household.
- Measures of child well-being reveal few pronounced differences between orphans and non-orphans.

Youth Living with Guardians

- Still, guardians have many worries:
 - Money to send children to school
 - Money to feed, clothe, house children
 - Own old age, ill health, physical limitations (30% in poor health)
 - Child's ill health
 - Feeling overwhelmed with responsibility

Youth Living with Guardians

- Many guardians are infected with HIV/AIDS.
 - Many HIV parents are also guardians themselves.
 - Parents who have *not* arranged for a guardian explain that the appropriate person is sick, old, HIV-positive or "likely to die before I do."
 - Of the 51 guardians who had been tested for HIV, one-third report that they are HIV-positive.

PRELIMINARY IMPACT ANALYSIS

2000

Orphan Support Program

- *All (100%) of younger orphans are enrolled in school (vs. 94%). Over half say their attendance and performance in school have improved (vs. 10%) since in foster HH.**
- *Orphans who receive school assistance are significantly happier than those who do not.**

Orphan Support Program

- *They eat more frequent meals and are significantly happier and healthier than others orphans the same age.**
- *The guardians feel more prepared for their responsibilities and report significantly fewer worries about them.**

Succession Planning Program

- *More community members are getting tested for HIV as a response to the introduction of succession planning.*
- *IGAs have succeeded in enabling parents to send their children back to school and in bringing the parents, children and standby guardians closer.*

Succession Planning Program

- *Standby guardians feel significantly more prepared and committed to care for the orphans.*
- *Parents are at first wary of memory books, disclosure and will-writing, but come to see these as positive steps.*

Succession Planning Program

- *Parents are significantly more likely to appoint and talk to a future guardian.**
- *More parents in SP have disclosed their HIV status to spouses and children.*