

Dying to learn:



Christian Aid/Fabienne Fosseze

Young people, HIV and the churches

A Christian Aid report
by Mary Garvey

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
PLHAs	People Living with HIV and AIDS
STIs	Sexually Transmitted Infections
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
WCC	World Council of Churches

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The author: Mary Garvey wrote this report as senior policy officer, HIV, in Christian Aid's Global Advocacy and Policy Division. She is now director of international programmes at the Catholic Institute for International Relations.

Publisher's note: Christian Aid is the official relief and development agency of 40 British and Irish Church denominations. It works where the need is greatest, regardless of race or religion, in more than 50 countries worldwide.

Christian Aid links directly with poor communities through local organisations whose programmes aim to enable self-sufficiency. It also seeks to address the root causes of poverty and spend around ten per cent of its income on development education and related campaigning at home.

Preface by the Archbishop of Cape Town

The challenge of the HIV and AIDS pandemic touches the church both in the heart of our faith and in the body of our community. It is also a challenge to the church's mind as to what we believe and who we understand ourselves to be.

In rising to this challenge, we do well to remember that Jesus Christ, whose body the church is, was in the context of his society, a young man. The church, if true to her Lord, is therefore forever young. Jesus bore the marks of his self-giving love on his body. They are the marks of his suffering and his death. We call these 'stigmata', the 'signs' that mark him as our Saviour.

In southern Africa, nearly 80 per cent of young people claim allegiance to the church. The church is made up people who, like Jesus, are full of life, energy and passion, in love with life. But we fall short in our efforts to guide and support them in their desire to express and experience love. Love and sex, which are the very essence of creation and God's gift to all his creatures, are shrouded in guilt, ignorance and taboo.

At the very point in their lives when God has given them all the physical means to love, our young people are, at times, abandoned by parents, society and the church and left to learn by themselves the life skills which sexual relationships require. In a world beset by the devastating HIV pandemic, we are leaving our young people, the flower of our church and our society, to wither and die through ignorance, the absence of open, honest and compassionate sharing of vital information, our embarrassed silence and resistance to reality.

Our young people, who make up the majority of those infected, bear the marks of suffering too. They suffer the devastating impact of 'stigma' the signs that mark our silence, our complicity, our lack of compassion and dishonesty.

But none of this need be. Death need not be the final word. The truth will set us free if we allow God's spirit of truth to work in and through us. *Dying to learn* provides us with a very important measure of the truth we need to help the church to be an agent – a way of truth and life in the fight against HIV.

The church is indebted to Christian Aid for providing essential information on sexual health and HIV education for young people. Christian Aid's commitment to partnership with the church is made all the more pertinent as together we seek to empower young people in their life choices with the honest, supportive and compassionate help they need in order to live their lives safely and wholly and be a generation free from AIDS.

+ Njongonkulu Ndungane
Archbishop of Cape Town
June 2003

Executive summary

Forty-two million people worldwide are now living with HIV and AIDS (UNAIDS, 2002a). Every day another 8000 die, and 13000 are infected.

Ninety five per cent of new infections and deaths are in developing countries, over half in Africa.

More than half of those newly infected are young people, aged between 15 and 24 (UNAIDS, 2002b). Young people are particularly vulnerable to HIV. Many young people do not know how to protect themselves from HIV. Half of teenage girls in sub-Saharan Africa do not know that a healthy-looking person can be living with HIV (UNAIDS, 2001).

The churches responded quickly to the crisis, using extensive and well-established networks, providing care to the sick on a vast scale. However they have become less involved in prevention work. In addition to the discomfort experienced by many in talking about sex, the churches have been concerned that sexual health and HIV education¹ may lead to promiscuity² amongst young people.

Examining the evidence of links between sexual health and HIV education and promiscuity

Anecdotal evidence has been used to both support and refute the link between sexual health and HIV education and promiscuity. An evidence-based approach to decision-making is critical because of the scale of the HIV problem. Decisions made about sexual health and HIV education are key to the health and well being of young people. In this document evidence of academic research is examined. Academic studies that examine the impact of sexual health and HIV programmes on the age of sexual debut of young people, and on levels of sexual activity are considered. Other important findings are also noted. Only academic studies that have used widely accepted research techniques have been included.

Conclusions

The evidence from research is that sexual health and HIV education, including related life-skills education

- does not hasten sexual debut
- does not increase the number of sexual partners

Hence sex and HIV education does not promote promiscuity amongst young people.

This evidence alone would be sufficient to promote sexual health and HIV education. However, there are other important findings, critical at a time when the HIV epidemic is affecting young people so severely.

Good quality sexual health and HIV education

- reduces levels of pregnancy and STIs, including HIV
- reduces stigma and discrimination against people living with HIV and AIDS.

In addition

- Condoms, used correctly and consistently, are effective in preventing HIV infection among young people who are sexually active
- There is, as yet, insufficient academic evidence to conclude that abstinence-only programmes are beneficial in delaying sexual debut.

If sexual health programmes for children are to have maximum impact, they should begin before the sexual activity begins and sexual behaviour patterns start to form

¹ *Sexual health and HIV education* is understood to mean frank, open, supportive education that promotes abstinence as the best way to prevent HIV, faithfulness, and safer sex practices including information about and access to condoms, and provides young people with the skills they need to communicate about sex, say 'no', or negotiate safer sex.

² *Promiscuity* is understood to mean earlier sexual debut and increase in sexual activity and number of sexual partners.

Recommendations

It is the responsibility of everyone to respond to this crisis. The churches are in a powerful position because of their extensive networks and influence at all levels of society. They are responding to the crisis, particularly in caring for the sick.

Talking about sex is hard. Yet it is critical that the churches, and others in contact with young people, engage with them on issues of sex and HIV, and that they support others in their efforts to do so.

In particular, this requires an acceptance of two realities:

- that, according to all available data, in the majority of countries, the majority of young people are sexually active from a very young age and therefore at risk of being infected with HIV.
- that good quality sexual health and HIV education will not increase promiscuity; on the contrary, it will promote safer behaviour, and reduce HIV, other STIs and teenage pregnancy.

In order to address these realities, there needs to be active support of and advocacy for sexual health and HIV education:

- that is open, frank and supportive, promoting abstinence, faithfulness and safer sex
- that ensures that young people have all the information and skills they need before they become sexually active and sexual behaviour patterns start to form
- that fosters development of the life skills young people need, including skills to challenge adverse gender norms in relationships, communicate about sex, say 'no', and negotiate safer sex
- that includes ensuring that the young people who are sexually active have access to condoms, in order to protect themselves from HIV, and not spread it to others
- that takes into account the reality of young people's lives, and is sensitive to issues of gender, culture, and the economic and social pressures that young people experience, as well as non-judgmental and supportive of young people already infected
- that utilises church networks to reach to out-of-school young people, child-headed households and other vulnerable children, and educate them about sexual health and HIV.

1. Introduction

Forty-two million people worldwide are now living with HIV and AIDS (UNAIDS, 2002a). Every day, another 13,000 people become infected and more than half of these are young people, aged between 15 and 24 (UNAIDS, 2002b).

Ninety-five per cent of these new infections and deaths are in developing countries, over half in Africa (see Box 1). Most people who become infected do not have adequate information about HIV in order to protect themselves from infection.

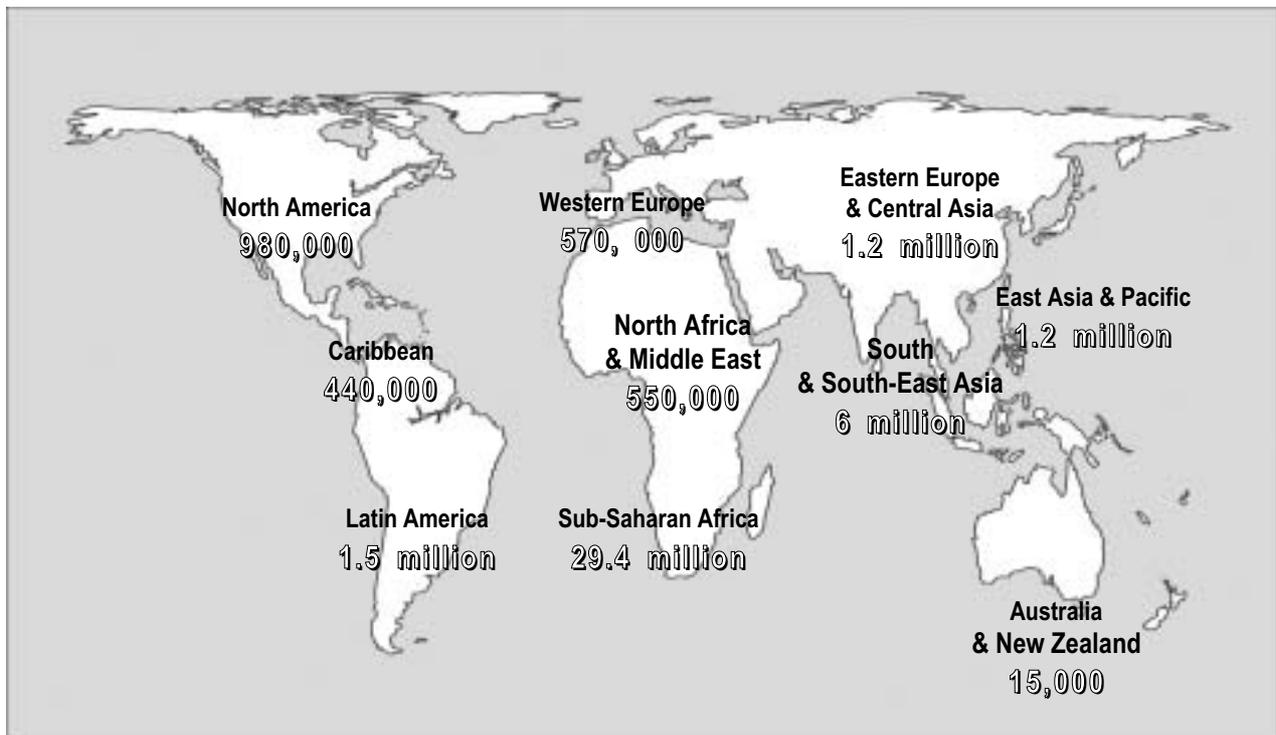
HIV is a major problem in our world, the worst pandemic mankind has experienced, and we are only in the first phase of it. In many countries, the churches have responded quickly to the crisis, leading the way in caring for those affected by HIV, the sick and the dying. However there has been a reluctance to speak openly and frankly about HIV and sex, particularly among young people, fearing that this may lead to promiscuity. At a time when HIV is leading to the deaths of 8,000 people every day, such reluctance has led to criticism of the churches, a criticism which many churches now accept as valid. This report explores one of the causes of this reluctance, the assumption of a link between sexual health and HIV education and an increase in promiscuity among young people. Anecdotal evidence of the link is often used. Here the focus is on the evidence provided by academic studies using accepted research techniques. The evidence shows that sexual health and HIV education do not promote promiscuity. Conversely, good quality sexual health and HIV education can lead to safer sexual practices amongst young people, lower rates of HIV and other sexually transmitted diseases (STIs), reduced teenage pregnancies, and more positive attitudes towards people living with HIV and AIDS (PLHAs).

'The churches are living with HIV/AIDS. God's children are dying of AIDS. As people of faith we have done much, and yet there is much we have avoided. We confess our silence. We confess that sometimes our works and deeds have been harmful and have denied the dignity of each person. We preach the good news "that all may have life", and yet we fear that we have contributed to death.'

World Council of Churches, (2001)

Box 1

Adults and children estimated to be living with HIV/AIDS, end 2002



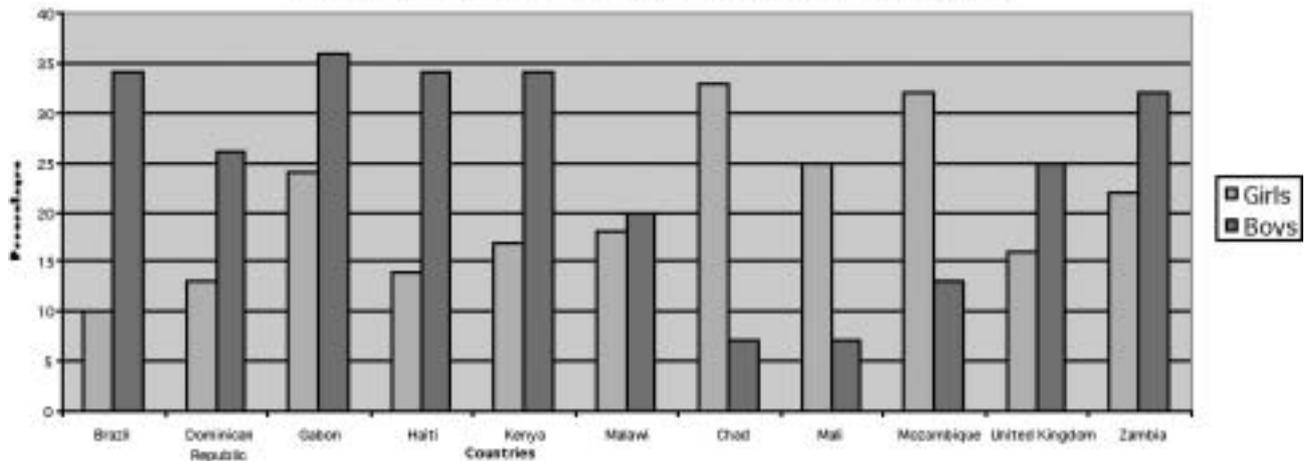
Source: UNAIDS, AIDS Epidemic Update, December 2002

2. HIV and young people

Twelve million young people between the ages of 15 and 24 are living with HIV and AIDS. More than half of all new infections are now of young people, with over 6,000 becoming infected every day (UNAIDS, 2002b). These figures show that young people are particularly vulnerable to HIV.

The statistics for HIV infection amongst young people support what young people are saying about their sexual activity, that many have sex before they turn fifteen. In Brazil 10 per cent of girls and 34 per cent of boys are sexually active before they reach 15. In Mozambique, 32 per cent of girls and 13 per cent of boys are sexually active before the age of 15. The statistics show marked gender differences in the ages at which girls and boys become sexually active in different countries, indicating that the start of sexual activity is influenced by local norms (see Table 1).

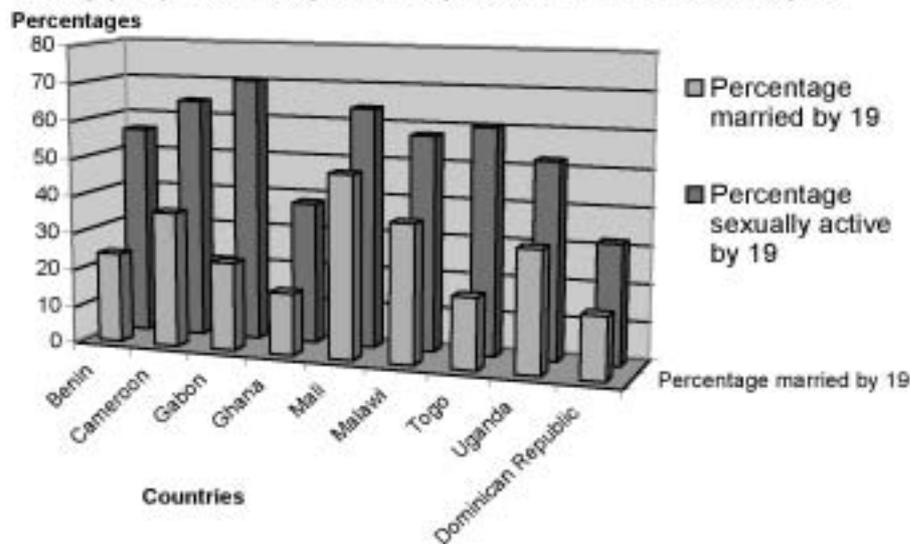
Table 1
Percentage of young people who are sexually active before 15



Source: UNAIDS, Young People and HIV/AIDS: Opportunity in Crisis, 2002

Table 2 indicates that many young people do have sex before marriage. In some cultures early sex and sex before and outside marriage is supported. In Jamaica, only 16 per cent of all women of reproductive age are legally married (McFarlane, 1999)

Table 2
Young people sexually active by 19 and those married by 19



Source: Measure Demographic and Health Surveys (DHS), 1998-2001

Not all young people *choose* to become sexually active. Some are physically forced to become sexually active; some are pressured or cajoled by teachers, family members or peers; some have sex in return for much-needed money or gifts from 'sugar daddies'. For girls, forced sex can lead to damage of the genital tract, significantly increasing the risk of HIV and other STIs. A study of abuse of girls in schools in Zimbabwe, Malawi and Ghana found that sexual abuse of girls by male pupils and teachers is accepted as an inevitable part of much school life and a reflection of gender violence and inequality in the wider society (Leach, 2001).

A study amongst 584 primary school children in Tanzania, found that 68 per cent of girls were sexually active and, of these, 47 per cent reported forced sex. For 31 per cent, their first sexual experience was forced³. In addition, forty-six percent of those sexually active reported having sex with adults, including teachers and relatives (Matasha et al, 1998).

The vast majority of young people do not know how HIV is transmitted or how to protect themselves from the infection. In India only 37 per cent of young people have ever heard of HIV or AIDS, only 33 per cent in Bangladesh (UNAIDS, 2002b). In Mozambique, 74 per cent of girls and 62 per cent of boys aged 15-19 are unaware of any way to protect themselves from HIV (UNAIDS, 2001). In Somalia only 28 per cent of girls have heard of AIDS and only one per cent know how to protect themselves (UNAIDS, 2002b). Throughout sub-Saharan Africa, where girls receive less education than boys, only half of teenage girls realise that a healthy-looking person can be living with HIV (UNAIDS, 2001).

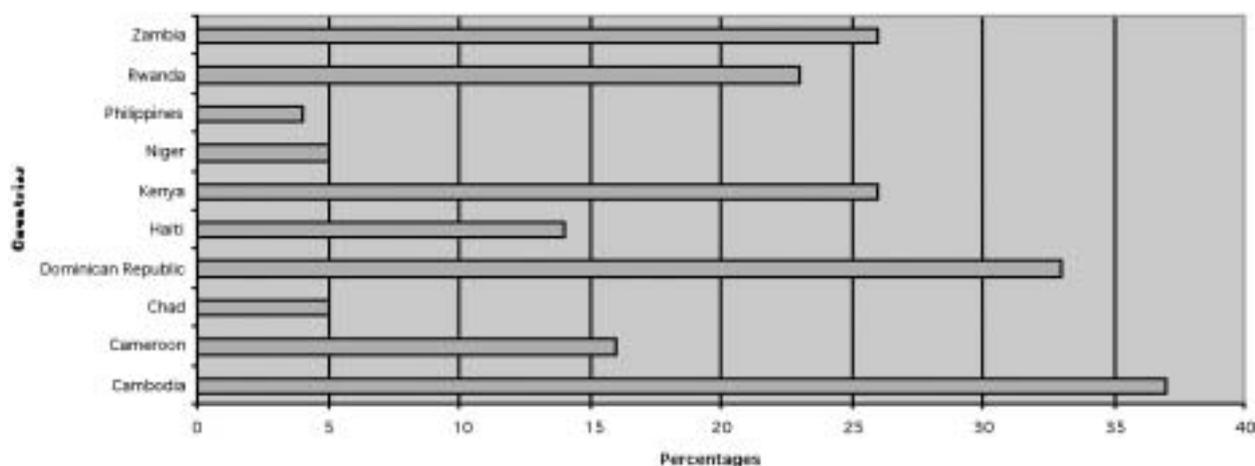


Christian Aid/karen Ward

Christian Aid partner Christian Council of Ghana, educates young children about HIV. Kofi Bekoe is talking about what it means to be living with HIV

So there is an urgent need to educate young people about sex and HIV. They are having sex. Many are having sex from their early teens. They urgently need the knowledge and the skills to protect themselves from HIV and other STIs.

Table 3
Percentages of Young Women aged 15-24 who have sufficient information to protect themselves from HIV



Source: *Young People and HIV/AIDS: Opportunity in Crisis*, UNAIDS, 2002

³ The range of ages of primary and secondary school children in many countries may vary widely because children may start school late, repeat years due to poor performance and drop out and return because of inability to pay fees and costs, or pregnancy in the case of girls.

3. HIV and the churches

Some Christian churches, particularly in Africa, responded quickly to the HIV epidemic, leading the way in providing care to those who are sick and dying. Using their resources as well as their extensive and well-established networks, they have mobilised communities to provide spiritual and practical support on a massive scale. For example, the Catholic Church organisations provide 25 per cent of all HIV care services globally (Holy See, 2001). However churches have become less involved in HIV prevention, even though prevention can potentially save lives and prevent suffering.

Issues of sex and sexuality are central to the work of HIV prevention. In families, schools, and communities, dealing with such issues is never easy or straightforward. The churches now recognise that the difficulties they have experienced in dealing with issues of sex and sexuality have weakened their response in relation to prevention of HIV. They also recognise that silence, contradictory and punitive messages, or messages that undermine those of HIV professionals contribute to confusion, stigma and discrimination.

'We confess our silence. We confess that sometimes our words and deeds have been harmful and have denied the dignity of each person' (World Council of Churches, 2001).

The churches have a long tradition of caring for the sick, but fewer skills, and fewer human and other resources to support HIV prevention work. Some churches are now adapting to the new situation. The Church of the Province of Southern Africa has drawn up and obtained funding for an ambitious strategy across six countries in Southern Africa. The programme will train, inform and educate church leaders to provide HIV education, particularly for young people. (see box 5).

Yet, as the HIV pandemic spreads, a further 6,000 young people are infected each day. The reality is that large numbers of young people, sexually active from a very young age, are not receiving adequate sexual health and HIV education, do not have knowledge or skills to protect themselves from HIV, and are therefore becoming infected and dying.

It is estimated that one third of the world's population is Christian. In sub-Saharan Africa, over half the population belongs to the Christian community. In many parts of the world, the Christian churches have tremendous influence and power at many levels within society, with political leaders, educators and their congregations, particularly among young people. The churches have well-established networks through which the young people can be reached and these networks become even more important in countries where high proportions of young people do not go to school. Churches are rooted in communities, and so are well placed to work with and support and lobby traditional, local and national leadership in preventing HIV among young people.

'Today, churches are being obliged to acknowledge that we have – however unwittingly – contributed both actively and passively to the spread of the virus. Our difficulty in addressing issues of sex and sexuality has often made it painful for us to engage, in any honest and realistic way, with issues of sex education and HIV prevention'

World Council of Churches, (2001)

'You have the leaders (the bishops) saying one thing and you know the reality'

Canon Gibson Simpambo, Port Elizabeth, South Africa

'Religious leaders are negative on the facts delivered and on ages to be taught about AIDS'

Head teacher, Kisumu, Kenya

'We have to change – we are in crisis. I have seen so many of my friends and relatives and their children die. It is not enough to preach morals. We must help young people to be safe from this virus and if that means condoms, so be it'

**Member of clergy, Swaziland
M.M.**

4. Sexual health and HIV education and promiscuity – is there a connection?

All available data shows that young people have sex and that many have sex from a very early age. Generally, it is easier to influence young people's behaviour before behaviour patterns are established. Sexual health and HIV education need to be taught before young people become sexually active ie before their early teens.

For the majority of people, talking about sex is not easy, and particularly when talking with very young people. In addition to the discomfort experienced by many, there is also the concern that sexual health and HIV education may lead to promiscuity, and this concern can be a barrier to open, frank sexual health and HIV education for young people. However young people are having sex and are not receiving the education they need.

So the apparent dilemma is that if young people receive sexual health and HIV education they may become promiscuous and if they don't they may become infected with HIV.

Christian Aid and HIV

'HIV has become one of the most serious development challenges of our time. There is a pressing need for a broad, holistic and flexible response to halt its spread and control its impact.'

'Christian AID identifies HIV prevention for young people as one of its top priorities and will support faith-based organization and other partners who are working with and for young people.'

HIV strategy, Christian Aid, 2003

But evidence given to support the link between sex education and promiscuity is anecdotal. Here we will examine evidence of academic research that has used accepted research techniques.

4.1 Defining the problem

Different people can understand the terms 'sexual health and HIV education', 'abstinence', 'delaying sexual debut', 'young people', 'life skills' and 'promiscuity' in different ways. Hence the definitions used for the purposes of this report are described below.

Sexual health and HIV education does not have a fixed syllabus. The content varies according to the cultural, social and economic context. The quality of delivery also varies. However, research and evaluation has generally been conducted with projects that provide full, frank and supportive sex and HIV education, promoting a full range of safe sex strategies - abstinence, faithfulness and safer sex practices, including condom use and fostering the development of relevant life skills, such as communication and negotiation. The education aims to be gender sensitive, begin before young people are sexually active and to be sustained over a period of time. Such an understanding of sexual health and HIV education is appropriate for this report, as it is these kinds of programmes that give rise to more concern about promiscuity. The UNAIDS recommendations on the contents of good HIV/AIDS education programmes are contained in Box 2.

'Abstinence' is used to describe the current sexual behaviour of a person, ie not currently sexually active with others. It can be used in reference to a person who has been sexually active, as well as a person who has no sexual experience. Abstinence can be promoted and prolonged, regardless of a person's previous sexually behaviour.

Frequently in research and in this report, the term **'delaying sexual debut'** is used. It means delaying the first sexual experience for as long as possible, or alternatively, prolonging abstinence for young people who are not already sexually experienced. All good sexual health and HIV education programmes for young people promote 'delay of sexual debut' and 'abstinence' as the most effective ways to prevent HIV and other STIs whilst, at the same time, accepting the reality that the majority of young people in most countries will be sexually active before they marry.

The UN defines 'youth' as those between 15 and 24 inclusive and UN agencies appear to use the terms 'youth' and **'young people'** interchangeably (UN, 2002). Much of the statistical data available relates to young people, aged 15-24. However many children are sexually active before they reach 15. So, for the purposes of this report, the term 'young people' is used to include such children. Whilst it is not possible to be specific, this age may be as young as ten.

Box 2

Essential elements of effective AIDS education programmes

Effective AIDS education programmes

Effective AIDS education programmes fulfil all the following functions:

- Focus on life skills – particularly relating to decision-making, negotiation, and communication – with the joint aim of delaying first sexual intercourse and encouraging protected sex.
- Concentrate on personalising risk through appropriate role playing and discussions.
- Discuss clearly the possible result of unprotected sex – and in equally clear terms the ways to avoid such an outcome.
- Incorporate gender sensitivity in sexual decision making, for both boys and girls.
- Explain where to turn for help and support among peers, school staff and outside facilities.
- Stress that skills useful for self-protection from HIV also help build self-confidence and avoid unwanted pregnancy, sexual abuse and the abuse of drugs, including tobacco and alcohol.
- Reinforce norms and peer group support for saying 'no', practising and sustaining safer behaviour and resisting unsafe behaviour, both at school and in the community.
- Provide sufficient time for classroom work and interactive teaching methods such as role play and group discussions.

In addition

- Primary and secondary school students need to be taught to analyse and respond to social norms. Social norms are formed by the media, by young people's peers, and by society at large. These norms in turn influence behaviour. Students should learn to decode and analyse these norms and understand which ones act in a potentially harmful direction and which ones protect their health and well-being.
- There must be good training for both the teachers themselves and peer educators.
- Programmes for children should begin at the earliest possible age, and certainly before the onset of sexual activity.

Adapted from: *Learning and Teaching about AIDS in Schools*, UNAIDS, Geneva, 1997

The term 'young people' groups together girls and boys. Yet there are many gender differences, eg cultural roles and perceptions, access to education and resources, legal rights. Some of these differences are considered in section 7.1.

In the context of sexual health and HIV education, '**life skills**' are those skills that young people need to develop in order to communicate about sex, to say 'no', and to negotiate safer sex practices. Though the problems of forced sex and incest must be dealt with in the adult population, young people can be taught skills that will help them deal with potentially harmful situations.

The definition of '**promiscuous**' behaviour is influenced by culture, society and religion. For the purposes of this report, an increase in 'promiscuity' includes lowering of the age of sexual debut and an increase in sexual activity and the number of sexual partners.

5. Considering the evidence

There is much anecdotal evidence of the impact of sex and HIV education on the sexual behaviour of young people. There have also been studies of a range of different impacts of sex and HIV education on the sexual behaviour of young people. These include reported age of sexual debut, safer sex

practices, teenage pregnancy rates and levels of STIs. As the focus here is the possible link between sexual health and HIV education and promiscuity we will first consider two questions:

- **Does education about sex and HIV have an impact on the timing of sexual debut?**
- **Does education about sex and HIV have an impact on sexual activity and the number of sexual partners that young people have?**

Other impacts of sexual health and HIV education will also be considered.

Only studies obtained by using generally accepted research methods and inclusion criteria have been included. These techniques include:

- Experimental design: The use of intervention and comparison study groups to compare changes in sexual behaviour between groups that did and did not receive the sexual health education
- Longitudinal studies: The comparison of baseline with follow-up data – to quantify the levels of change in sexual behaviour and to determine causality
- Representative sample: An acceptably large sample group – so that conclusions can reasonably be drawn
- Validity: Follow-up over a period of time – ensuring that actual, rather than intended, changes in behaviour are measured

When criteria are only just met eg short follow-up period or smaller sample group, this has been noted.

6. Review of the evidence

6.1 The impact of sexual health and HIV education on sexual debut

In 1997, UNAIDS commissioned a comprehensive review of all literature on the impact of HIV and sexual health education on the sexual behaviour of young people (Gruseit et al, 1997). Following an extensive search for relevant studies, the reviewers found 68 reports that met their criteria. These studies varied widely in factors such as size, country of origin, duration of study, date of study, etc. The type of study also varied. Some were intervention studies, some controlled, some cross-sectional studies, and some national and international comparisons.

Of the 52 studies that evaluated specific interventions, 27 reported that HIV and sexual health education neither increased nor decreased sexual activity. Twenty-two reported delayed sexual debut and/or reduced numbers of sexual partners or reduced unplanned pregnancy and STI rates. Only three studies found increases of sexual behaviour associated with sexual health education. One study found that pregnancy decreased but did not investigate whether this was because of reduced sexual activity or increased safer sex. Further details of this review are found in Box 3 on p12.

In 2001, a later review of studies of a wide range of programmes aimed at reducing teenage pregnancy was conducted (Kirby, 2001). Only those programmes employing rigorous research methods were included in the review. The author also noted:

‘...a large body of evaluation shows clearly that sex and HIV education programmes included in this review do not increase sexual activity – they do not hasten the onset of sex, increase the frequency of sex, nor increase the number of sexual partners. To the contrary, some sex and HIV education programmes delay the onset of sex, reduce the frequency of sex, or reduce the number of sexual partners.’ (Kirby, 2001; p5)

Table 4
Table showing impact of sexual health and HIV education on young people who had not had their sexual debut when the intervention started

Author (year)	Site	N	Mean age	Percentage already sexually active	Results Impact on those <i>not</i> sexually active at start of intervention
Klepp et al (1997)	Tanzania	814	13.6	51% of boys and 10% of girls	After one year, 93% in intervention group remained abstinent, compared to 83% in comparison group
Eggleton et al (2000)	Jamaica	945	12.1	34%	After nine months, 76.7% of intervention group remained abstinent, compared to 77.5% in comparison group
Stanton et al (1998)	Namibia	515	17	48%	After one year, 17% in intervention group remained abstinent compared to 9% in comparison group

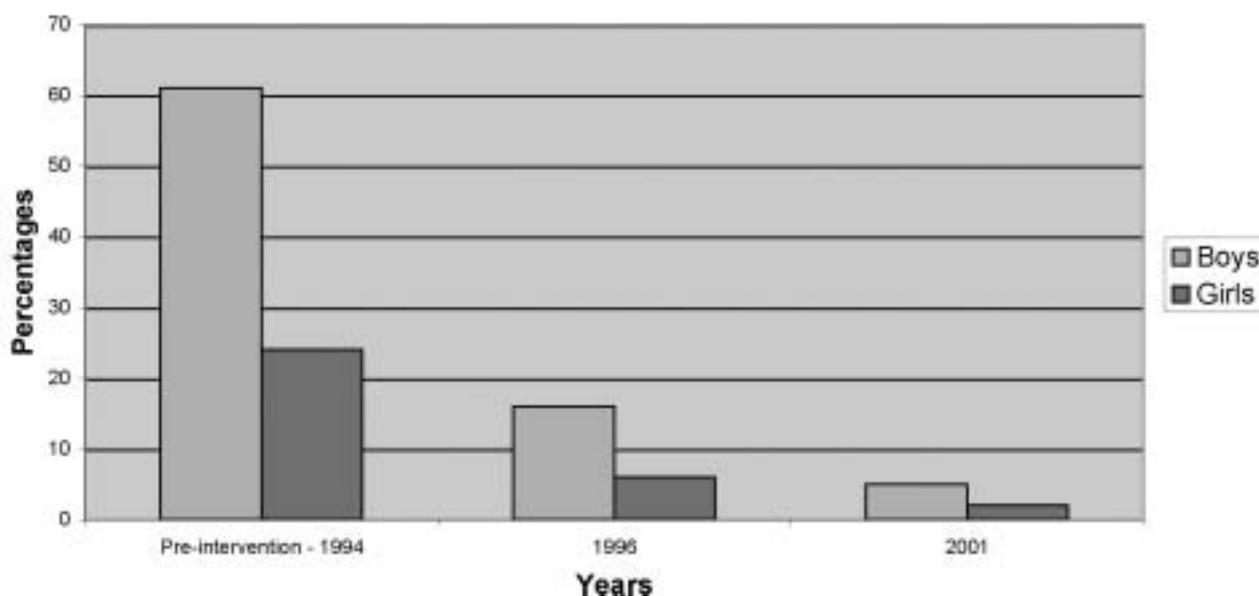
N = number of young people in study

These studies focus mainly on developed countries. In developing countries, there is a scarcity of studies that meet accepted research standards, because these countries have less access to resources. Table 4, on p10, summarises the results of three longitudinal studies in developing countries. Their findings are consistent with those of larger studies: that sexual health and HIV education either has no significant impact on, or delays, sexual debut.

In a recent three-year intervention amongst primary school students in Tanzania, of those not sexually active when the programme began, 63 per cent became sexually active during the intervention, compared to 69 per cent in the comparison group. (LSHTM/AMREF/NIMR, 2003). The benefits of the intervention were greater for boys than girls.

In a study amongst primary school children in the Katakwi/Soroti area of Uganda, 43 per cent of 287 young people (mean age 14) were sexually active in 1994. Following an AIDS prevention programme over a number of years in the primary schools, only 3.5 per cent of 400 young people (mean age 13.9) were sexually active in 2001 (Ngatia, 2001).

Table 5
Percentages of young people who were sexually active during a primary school AIDS- prevention project in Uganda, 1994-2001



Source: Ngatia et al, 2001

Sex and HIV education does not hasten sexual debut. On the contrary, sex and HIV education has little impact on, and often delays, sexual debut.

Box 3

Summary of findings of a review of research on the impact of HIV and sexual health education on the sexual behaviour of young people

Summary of findings of UNAIDS review

The impact of HIV and sexual Health Education on the sexual behaviour of Youth (Grunseit et al, 1997)

UNAIDS reviewed 53 studies that evaluated different interventions. There were four types of studies reviewed, controlled intervention studies, intervention studies, cross-sectional surveys and international or national intervention studies. Evaluations included impact on sexual debut, sexual activity, number of partners, pregnancy rates and safer sex practices. The findings for each in relation to sexual debut and sexual activity are as follows:

Controlled intervention studies

(Participants assigned randomly to intervention group or to control group that did not receive intervention, and then the two groups compared)

Fifteen studies compared the impact of sexual health education on groups that received the education against those who did not. Of these studies, six reported no relation between sexual health education and sexual activity and three reported delayed sexual debut. Others reported reduced sexual activity or a decrease in the number of sexual partners. The conclusion was that 14 of the 15 interventions did not indicate that sexual health education led to earlier sexual initiation or increased sexual activity. The exception was an abstinence-only programme that led to greater sexual activity (touching) but not to increased coital activity.

Intervention studies

(No comparison control group used)

Of the 38 studies, 14 showed reductions in sexual activity and pregnancies, 21 showed no impact on sexual activity and one found a reported increase in the number of homosexual partners. This could possibly be a consequence of greater willingness to report such activity as a result of the education.

Cross-sectional surveys

(Use of surveys to determine whether participants had received sexual health education and then subsequent sexual behaviour compared)

Of nine cross-sectional surveys of those who had received sexual health education, eight found no relation between sexual health education and levels of sexual activity. The ninth found an association between sexual health education and earlier sexual debut at 15 and 16 years of age, but not at 17 or 18 years of age. This study also noted other stronger effects on sexual debut, such as parental education and ethnicity and concluded that it is unlikely that sexual health education will have a substantial detrimental impact on sexual behaviour (Marsiglio and Mott, 1986).

International or national comparison studies

(Large studies that also take account of local context)

These studies consider the impact of sexual health education on sexual activities and indicators such as pregnancy, taking into account other influences such as local policies and services and culture. The conclusion was that 'sexual health education either does not have an adverse effect on unprotected sex and adolescent pregnancy or may promote appropriate choices around sexual health'. One study used a 37-country comparison and concluded 'Countries that address young people's sexual health in a frank, open, and supportive manner experienced fewer of the negative consequences of sexual activity, yet did not see greater sexual involvement' (Jones et al, 1995, p. 61).

The review concluded that there was little evidence to support the contention that sexual health and HIV education promote promiscuity.

6.2 The impact on sexual activity and numbers of sexual partners

The UNAIDS review found that 27 of the 53 studies reported no impact on sexual activity, neither the number of sexual partners nor the frequency of sex. Of the others, 22 reported a reduction in the number of sexual partners, reduced sexual activity or delayed sexual debut. Hence the conclusion of the UNAIDS review was that sexual health and HIV education do not promote an increase in the number of sexual partners or in sexual activity.

Researchers in developing countries have reached similar conclusions. These are summarised in Table 6.

Author (year)	Location	N	Mean age	Percentage sexually active	Result
Alpasca et al (1995)	Philippines	805	14	11%	No statistically significant change
Antunes et al (1997)	Brazil	304	19	87%	Males – no change Females – less risky sex with secondary partners
Fawole et al (1999)	Nigeria	450	17	36%	In intervention group, mean number of sexual partners fell from 1.51 to 1.06. In control group, mean increased from 1.3 to 1.39
Ngatia et al (2001)	Uganda	287	14	43% pre-intervention in 1994 4% in 2001	Average number of partners of sexually active primary students fell from 2.2 in 1994 to 1.5 in 2001

N = number of young people in study

Hence the evidence is that sexual health and HIV education do not increase sexual activity or the number of sexual partners.

Sexual health and HIV education does not increase sexual activity or the number of sexual partners. On the contrary, sexual health and HIV education has little impact on, and sometimes reduces, sexual activity and number of sexual partners.

6.3 Other impacts of sexual health and HIV education

6.3.1 The impact on sexual norms of young people

Academic research has also considered the impact of sexual health and HIV education on the sexual norms of young people, ie changes in their personal values and standards.

In the Philippines, an AIDS education programme significantly increased the proportion of students (mean age 14) who agreed that young people should delay sex until they become adults or until they got married (Aplasca et al, 1995). In Tanzania, students who were part of an HIV education programme reported stricter attitudes towards having sexual intercourse than students who did not follow the programme (Klepp et al, 1997)

A controlled intervention in Namibia resulted in significantly fewer girls (but not boys) intending to take alcohol, in order to avoid risky behaviour. Similarly, an STD/HIV/AIDS programme using peer educators in Nepalese schools resulted in a reduction of drug use from 37 per cent to 25 per cent and concluded that such peer education influenced students 'to behave in safer ways'. (Timsina, 2002).

Sexual health and HIV education can have a positive impact on the sexual norms of young people, so that they are less accepting of risky sexual behaviour in themselves and others.

6.3.2 The impact on teenage pregnancy and STIs, including HIV

In addition to promoting abstinence, faithfulness and safer sex, those concerned with sexual health and HIV education also seek to reduce unwanted teenage pregnancies and levels of STIs, including HIV.

Changes in levels of teenage pregnancy and STIs, including HIV, are commonly used indicators to assess changes in sexual activity. They are proxy indicators because occurrence will depend on whether or not safer sex practices have been used.

Studies to measure the impact of sexual health and HIV education on teenage pregnancy and STIs, including HIV, require long-term, sustained follow-up, including biological testing. Over the period of such a study, young people are exposed to a variety of influences on their sexual behaviour, including peers, media, and family hence it is difficult to isolate and measure the impact of an education programme. Nevertheless, some evidence is available.

In Uganda, following a study of a school health and intervention programme over seven years in twenty-seven schools, school drop-out because of pregnancy fell from an average of three per year at the start of the programme in 1994 to none in 70 per cent of the schools in 2001 (Ngatia et al, 2001).

As noted earlier, (Jones et al, 1985), a 37-country comparison of patterns of teenage pregnancy noted that those countries that address young people's sexual health in a frank open, and supportive manner experienced fewer negative consequences of sexual activity, yet did not see greater sexual activity.

A review of over 250 studies concluded that sexual health and HIV education can reduce teenage pregnancy and STIs and that the success of such programmes depends on the weight given to consideration of the socio-economic environments of the young people e.g. community disadvantage, family structure and economic disadvantage, family and peer attitudes and behaviour, availability of resources and services (Kirby, 2001). Also important in such programmes is the weight given to helping young people to develop skills and confidence, so that they can say 'no' or negotiate safer sex in their particular contexts.



Christian Aid partner, GAPA Bahia in Brazil, runs centres where young people can come to discuss sexual health problems with peers and obtain condoms

Christian Aid/Christina Parsons

Some sexual health and HIV education has little impact on the sexual behaviour of young people, while some delays sexual debut and reduces the number of sexual partners. The quality of the education is all-important in ensuring some impact on sexual behaviour, including safer sex practices, and this will, in turn, reduce teenage pregnancies, STIs and HIV. Kirby strongly recommends the adoption of programmes that have been proved to work (Kirby, 2001). UNAIDS provides guidelines for the qualities of good programmes (see Box 2).

Sexual health and HIV education can reduce levels of pregnancy and STIs, including HIV. However the impact will depend on the extent to which the education is frank, open and supportive, taking account of the realities of the lives of young people, and developing the necessary life skills to communicate about and negotiate about sex.

6.3.3 The impact on attitudes towards people living with HIV and AIDS

In a study among young people in South Africa, after an AIDS education intervention, 41 per cent of students said they would accept someone with HIV into their class, compared to 17 per cent before the intervention (Kuhn et al., 1994). In Nigeria, 79 per cent of students who had received HIV education said that they could touch and care for someone living with AIDS, compared to 14 per cent in the control group (Fawole et al, 1999). Studies amongst young people on an AIDS prevention programme in Philippines noted 'increasing compassion towards those with AIDS' (Alpaca, 1995, p.S11).

Rejection of people with HIV and AIDS among young people is generated from a fear of being infected. When they know more about how HIV is transmitted, the risk diminishes, and students express compassion and acceptance.



Christian Aid/Kate Splevins

Lindiwe Zaca from Imbali, South Africa found he was HIV positive five years ago. He has been stigmatised and rejected by his family

Sexual health and AIDS education reduces stigma and discrimination of those living with HIV and AIDS.

7. Other important conclusions

7.1 The importance of gender considerations in sexual health and HIV education

Physiological differences contribute to girls being more vulnerable to HIV than boys. Girls receive less education than boys and so have less access to information about HIV. Girls will be expected to stay home from school when a relative needs care, to perform household tasks, or when there is not enough money for school fees for all the children. Orphaned girls are more likely to be withdrawn from school than their brothers.

In many societies, girls have less power in negotiations about sex and are less likely to be able to say 'no', whilst boys have 'macho' role models, encouraging early sexual activity. Gender-based violence in homes and at school accounts for some HIV infection.

Sexual health and HIV education needs to take account of the real pressures that boys and girls are under. Young people need to learn how to analyse social norms, so that they can identify influences that are potentially harmful, and resist them. Education needs to be designed so that it is gender sensitive for both boys and girls.

7.2 The impact of abstinence-only programmes on the sexual behaviour of young people

The content of sexual health and HIV education programmes vary. However the majority of programmes promote abstinence as the preferred option, whilst accepting that, for most young people, abstinence will not be the preferred option. Abstinence-only programmes, whilst also varying in content, are generally understood to be the ones that strongly promote abstinence until marriage as the only option, and therefore give less priority to developing knowledge and skills required for safer sex amongst young people.

There has been very little rigorous study of the impact of abstinence-only programmes. The comprehensive UNAIDS review, discussed above, found that, of 53 studies that met its criteria for inclusion, only five were abstinence-only programmes (Grunseit et al, 1997). Of the 53 studies included, only three provided some evidence of increased sexual activity, and one of these was an abstinence-only programme.⁴

In 2001, an extensive review of sexual health education programmes found 74 studies that met the review criteria, only three of which were abstinence-only programmes. The review concluded that these abstinence-only programmes did not have a significant effect either on the initiation of sex or on sexual activity. However the author notes that, though conclusions cannot be drawn from just three studies, the 'early results are not encouraging' (Kirby, 2001, p88).

In 2002, Kirby undertook a further review of ten abstinence-only programmes that did meet generally accepted standards of good research. Again he found that there is too little evidence to reach conclusions.

'There do not currently exist any abstinence-only programs with strong evidence that they either delay sex or reduce teen pregnancy. However, this does not mean that abstinence-only programs are not effective, nor does it mean that they are effective. It simply means that given the great diversity of abstinence-only programs combined with very few rigorous studies of their impact, there is simply too little evidence to know whether abstinence-only programs delay the initiation of sex. That is, "the jury is still out".' (Kirby, 2002, p6).

However, a longitudinal controlled intervention study is currently underway in the US and due to be published in 2005. This will provide evidence of the impact of these programmes on the sexual activity of young people.⁵

Amongst sexual health and HIV educators, there is wide agreement that abstinence is the best choice for young people. However, many young people do not choose to abstain until marriage. These young people are at risk of HIV and other STIs. They need to know, and have the right to knowledge about safer sex. They also need to develop skills to protect themselves from HIV and other STIs. Grunseit questions the validity of programmes that do not recognise the diversity of young people's sexual behaviour and possibly alienates those that do not choose abstinence.

⁴In evaluating an abstinence-only programme, Christopher & Roosa (1990) found an increase in non-coital sexual activity e.g. breast touching, though levels of coital activity remained stable.

⁵ Evaluation of Abstinence Education Programs Funded under Title V, Section 510, <http://aspe.hhs.gov/hsp/abstinence02/execsum.htm>

'A programme that precludes the discussion of prophylactic measures so as to not undermine the abstinence message misses the opportunity to educate students who will become sexually active in the future' (Grunseit et al, 1997, p19).

There is, as yet, insufficient academic evidence to conclude that abstinence-only programmes do, or do not, delay sexual debut.

7.3 Condoms and young people

As stated earlier, with very few exceptions, research to date has been on programmes that adopt an open, frank approach to sexual health and HIV education, promoting abstinence, faithfulness and safer sex, including clear information about and access to condoms. Because such education does not increase promiscuity, it is therefore implicit that information about, and provision of condoms for young people who are sexually active will not promote promiscuity.

In 2000, WHO undertook an extensive review of all available scientific studies and concluded that when used *consistently* and *correctly*, condoms significantly reduce the risk of HIV and other STIs (WHO, 2000). Young people are having sex at a young age. The WHO conclusions underline the importance of giving young people frank, accurate information on how to use condoms properly, as well as youth-friendly access to condoms.



Christian Aid/Michael Griever

Children learning how to use condoms in Ghana

Female condoms are becoming more easily available in some countries. These too, when used correctly and consistently, can prevent HIV. Importantly, they give more power to girls in negotiations about safer sex.

Young people have a right to information that could protect their lives, and the lives of others, from HIV. Sero-discordant couples have support in accessing condoms to protect the lives of their partners.⁶ Sexually active young people have more frequent changes of sexual partners and are less likely to know their HIV status. They also have the right to access condoms, male and female, to protect their lives and the lives of others from HIV.

Extensive academic research concludes that:

- **sex education that includes the promotion of condoms does not lead to promiscuity among young people**
- **condoms, when used correctly and consistently, are effective in preventing HIV infection.**

⁶ Couples are sero-discordant when the status of one partner is HIV-positive, and the other HIV-negative (or unknown).

7.4 The importance of other influences on the sexual behaviour of young people

Young people will learn about sex from a wide range of sources, including peers, media, parents, teachers, family members, and sexual partners. Research in Uganda found that peers were the primary source of information on sex and sexuality. Research in the UK also found that the majority of young people gained their sexual knowledge from friends but that they would have liked to have learnt more in school. The UK study concluded that 'those for whom school is the main source of information about sexual matters are no more likely to have had intercourse before the age of 16 than those citing other main sources' (Wellings, 1995, p. 417). The issue is not whether young people learn about sex, but what they learn and from whom.



Christian Aid/Judith Esorbano

There are also many influences on young people's sexual behaviour, including culture, gender norms, and religion.

Factors identified include levels of parental income and unemployment; school performance; educational opportunities; ethnic origins; church attendance; history of sexual abuse; models of sexual behaviour and sexual risk-taking; peer sexual behaviour; peer substance abuse and community attitudes towards pregnancy. But because there are so many factors, which may have different levels of importance at different times, it is not possible to make accurate estimates of comparative impact.

In Jamaica, Eggleston observed that socio-economic and cultural factors encourage early sexuality and parenthood among young people, thus competing with sexual health and HIV education programmes promoting the delay of sexual activity (Eggleston, 2000). In Tanzania, of 68 per cent of primary school girls who were sexually active, 44 per cent had had sex with teachers, relatives and other adults. In addition, 52 per cent had had sex in return for either gifts or money (Matasha et al., 1998). Sex education needs to take account of these very real influences and pressures young people are subject to, ensure that young people understand their rights, and equip them with the skills they need to communicate, to say 'no' or negotiate about sex.

Sexual health and HIV education must equip youth with the knowledge and skills they need to recognise, analyse, and respond to the wide range of influences and pressures they are subject to, when making and communicating their decisions about saying 'no'

7.5 When to start sexual health, HIV and life skills education

Research amongst 515 young Namibians (mean age 17) showed that a HIV-prevention programme delayed sexual debut for some who were sexually inexperienced (Stanton, 1998). Seventeen per cent remained inexperienced one year later, compared to nine per cent in the control group. However the intervention had no significant impact on those who were already sexually active and, at 17 years, half the intervention group was already sexually active. Hence an intervention at a younger age would almost certainly have had a greater impact on these young people.

In Uganda, where the intervention took place in primary school classes with a mean age of 14, there was much greater impact, as was seen from the table 5.

It is widely agreed that it is easier to influence behaviour before patterns have been established and the same is true for the sexual behaviour of young people. It is important to reach young people before they become sexually active. By the early teens young people need to have received the necessary knowledge and learnt the relevant skills that will protect them from HIV. Hence age-appropriate sexual health and HIV education needs to take place in primary schools. Delaying education puts young people at risk of HIV.

Another argument for starting sexual health and HIV education in primary school is the high dropout rates before secondary school in many countries, particularly amongst girls (see 7.6 below).

All experience to date has proved that HIV and health promotion programmes for children should begin at the earliest possible age and certainly before the onset of sexual activity.’ (UNAIDS, 1997, p7).

7.6 Out-of-school young people

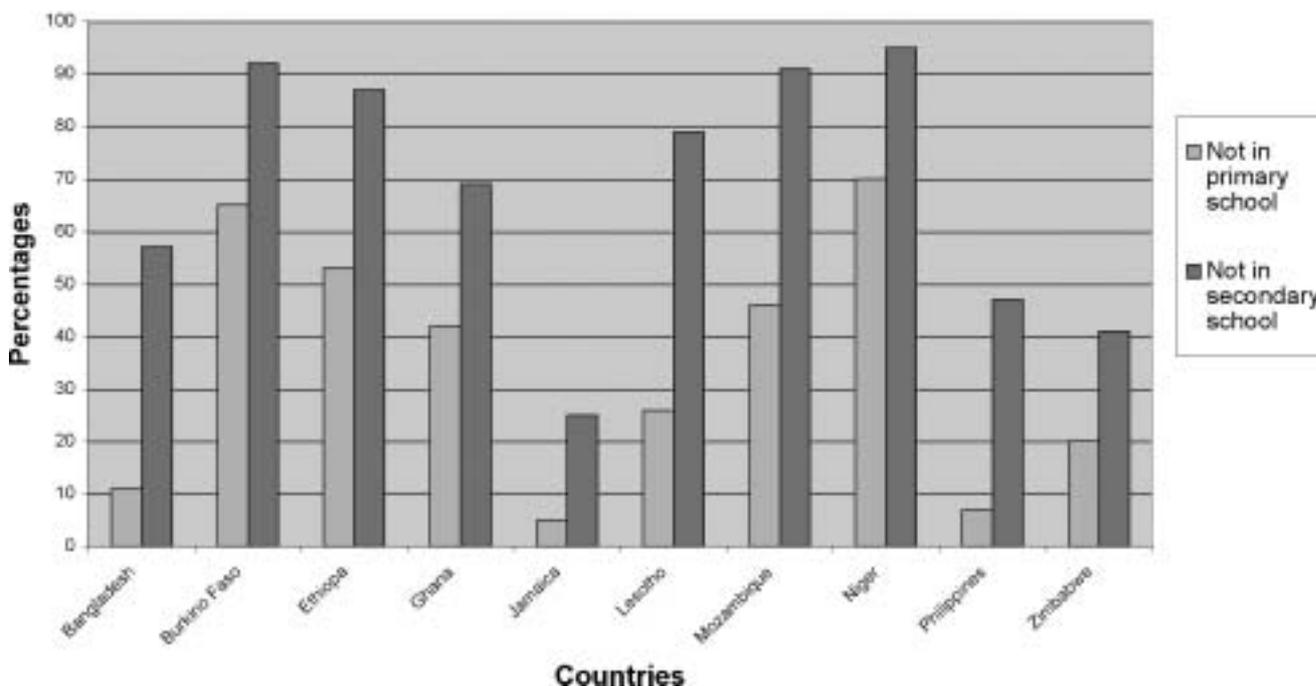
The majority of the HIV-prevention programmes reviewed have taken place in primary or secondary schools. Yet in many countries, children stop attending at an early age, or do not go to school at all (Table 7). Because of the impact of AIDS on households, it is more difficult for families to pay school fees, and children, particularly girls, are required to stay home to carry out household tasks and care for sick relatives. In addition, there are now 13.2 million AIDS orphans and this figure is predicted to rise to over 25 million by 2010 (TvT Associates, 2002). Some of these will struggle in child-headed households or fend for themselves on the streets. The evidence is also that out-of-school young people are more vulnerable to HIV. They become sexually active at an earlier age and have more sexual partners. Their main source of learning about sex is their peers and most out-of-school young people will learn little about HIV.



Christian Aid/Fabienne Fosseze

Aminata Tapily, preparing millet for transportation in Kintaba, Mali. She does not go to school where she would learn about HIV, because she is needed on the family farm

**Table 7
Percentages of young people not enrolled in primary and secondary school**



Source: UNESCO, 2003

In many countries, out-of-school young people do go to church and/or can be reached through the church networks. The churches are in a position to provide on-going open, frank, supportive sexual health and HIV education to out-of-school young people that will protect them from HIV and a considerable number of churches are already providing such education.

Out-of-school young people are more vulnerable to HIV than those in school, and so need to be reached through other networks, and provided with good quality sexual

7.7 The cost effectiveness of sexual health and HIV education programmes

Cost effectiveness is not the only consideration when making decisions about sexual health and HIV education programmes, or in other HIV interventions. However, given the size of the pandemic and limited resources available, it is an important consideration. Analysis shows that prevention programmes are effective. They are also cost-effective, when compared with costs of anti-retroviral drugs to prolong life, or home-based care (Marseille et al, 2002, Creese et al, 2002). Youth education programmes, particularly those involving peer educators, are highly cost-effective in terms of life years saved by the intervention. Other cost-effective prevention interventions are treatment of STIs, voluntary counselling and testing, and provision of condoms.

Youth sexual health and HIV education, particularly peer youth education, is highly cost-effective.

8. Limitations of the evidence

There is considerable consensus amongst researchers that there is a need for more research on the effectiveness of different sexual health and HIV education programmes on sexual behaviour of young people.

As already discussed, there are many influences on the sexual behaviour of young people other than those provided by sex and HIV education. Whilst other influences cannot be isolated or eliminated, random controlled trials, that compare intervention groups with control groups under similar conditions, go some way to minimising their significance on the broad conclusions of research findings.

Much of the research that exists has been conducted in more developed countries, though more is now being undertaken in less developed countries. Evidence from research in less developed countries, where the HIV epidemic is more acute, has been heavily drawn on in this report. However, it should be noted that, to date, the findings from more developed and less developed countries are very similar in terms of the impact on sexual debut and numbers of sexual partners.

It has also been noted that there are variations in the content of sex and HIV education. There are, of course, also variations in the quality and style of delivery of such education. In spite of all these variations, the findings are broadly conclusive. They are also consistent with studies on the impact of programmes to educate young people about alcohol, tobacco and other drugs, and the risks. There is no evidence that these programmes increase use of alcohol, tobacco or other drugs among young people. Good programmes, particularly those using peer education, can reduce the use of alcohol, tobacco and other drugs. However social reinforcement, social norms and developmental behaviour models can have more impact than awareness programmes alone (Rundall et al, 1988).

Some research on the impact of sexual health and HIV education has relied on self-reported behavioural change; other research has considered indicators of changes in sexual behaviour such as changes in rates of teenage pregnancy and incidence of HIV and other STIs. Young people may not report accurately about their sexual behaviour. There are gender differences, influenced by social norms. More girls may be afraid that they may be punished or that the information may not be treated confidentially. More boys may over-report on sexual activity in order to appear 'macho'. However, in

most studies techniques are used to ensure the accuracy of the data, eg follow-up questions, asking peers general questions about their friends' sexual activity. More recent research, in primary schools in Tanzania, is comparing evidence from self-reported behaviour change with indicators of that change, such as levels of pregnancy, STIs and HIV (LSHTM/AMREF/NIMR, 2003). Early indications are that whilst sexual health and HIV education do result in reported delay of sexual debut and reduction in the number of sexual partners, there is not a corresponding reduction in levels of STIs and teenage pregnancy. Reasons may be the length and size of the intervention, and that such interventions need to be supported by others, targeting religious leaders, traditional healers, out of school youth, etc.

9. Conclusions and implications

Conclusions of academic research on the impact of sexual health and HIV education on the sexual behaviour of young people are described in Box 4. They show that sexual health and HIV education do not promote promiscuity amongst young people. Good quality education can prolong abstinence and reduce numbers of sexual partners, as well as teenage pregnancy and levels of STIs and HIV. It will also reduce stigma and discrimination against people living with HIV and AIDS.

So sexual health and HIV education should not be dismissed on the grounds that it will make young people promiscuous. On the contrary, failure to provide education puts young people at great risk.

There is not sufficient evidence to say that abstinence-only programmes do, or do not, have an impact on the sexual behaviour of young people.⁷ However, they generally place less emphasis on developing the knowledge and skills that young people need to say 'no' and practise safer sex, and can alienate those who are sexually active or have been infected with HIV.

It is widely agreed that the most effective way for young people to prevent HIV is to abstain from sex. Yet the reality is that young people are having sex and many are sexually active before the age of 15. Many have not heard about HIV and do not have enough information to protect themselves. At a time when 12 million young people are already infected with HIV, and 8,000 more people are being infected each day, we all have a responsibility to pursue every possible means to prevent the further spread of the virus. The failure to provide sexual health and HIV education is placing young people, and their partners, at risk of HIV. Good quality sexual health and HIV education must be a priority for all who have contact with young people.

There are numerous initiatives being taken by groups at different levels, many led by the churches. Box 5 describes an initiative that is being taken by the Church of the Province of Southern Africa in response to the crisis.

⁷ Abstinence-only programmes are those that strongly promote abstinence until marriage as the only option.

Box 4
Conclusions

What the evidence shows

The evidence from research is that sexual health and HIV education,* including related life-skills education

- does not hasten sexual debut
- does not increase the number of sexual partners

Hence sex and HIV education does not promote promiscuity** amongst young people.

Sex and HIV education also:

- has either little impact on, or delays, sexual debut
- has either little impact on, or reduces, sexual activity and the number of sexual partners.

This evidence alone would be sufficient to promote sexual health and HIV education.

However, there are other important findings, critical at a time when the HIV epidemic is affecting young people so severely.

Good quality sexual health and HIV education

- reduces levels of pregnancy and STIs, including HIV
- reduces stigma and discrimination against people living with HIV and AIDS.

In addition

- Condoms, used correctly and consistently, are effective in preventing HIV infection among young people who are sexually active
- There is, as yet, insufficient academic evidence to conclude that abstinence-only programmes are beneficial in delaying sexual debut
- If sexual health promotion programmes for children are to have maximum impact, they should begin before the sexual activity begins and sexual behaviour patterns start to form

**Sexual health and HIV education* is understood to mean frank, open, supportive education that promotes abstinence as the best way to prevent HIV, faithfulness, and safer sex practices including information about and access to condoms, and provides young people with the skills they need to communicate about sex, say 'no', or negotiate safer sex.

***Promiscuity* is understood to mean earlier sexual debut and increase in sexual activity and number of sexual partners.

Box 5

The Church of the Province of Southern Africa

The Church of the Province of Southern Africa

In August 2001, the All African Anglican Conference on HIV/AIDS, representing 33 African nations, met in South Africa to plan a co-coordinated response to the crisis. They agreed a vision for Africa.

'We, the Anglican Communion across Africa, pledge ourselves to the promise that future generations will be born and live in a world free from AIDS.'

In order to achieve the vision, the Church of Province of Southern Africa, comprising of the churches in Angola, Lesotho, Mozambique, Namibia, South Africa and Swaziland, undertook a participatory strategic planning process involving representatives from all levels within the churches across all 23 dioceses.

The Church of the Province of Southern Africa now has a detailed strategic plan to achieve its vision. The strengthening of leadership and prevention of HIV amongst youth are amongst the priorities of the plan as demonstrated by the following extracts.

'Church leaders will have the skills and confidence to train, inform and educate communities, particularly young people, openly, truthfully and appropriately about HIV prevention, gender, reproductive and sexual health and life skills.'

'Leadership will be established at every level that has a solid understanding of the issues surrounding HIV, and the confidence and skills to implement the programme.'

Amongst its activities, the programme will

- *'develop age-appropriate, culturally sensitive materials for comprehensive HIV, reproductive and sexual health and life skills education in churches.'*
- *'conduct training in 23 dioceses on how to carry out education for HIV prevention, particularly for young people.'*

'Adults and youth will form committees on sexuality education and HIV prevention.'

To ensure the plan is fully implemented, the Church of the Province of Southern Africa has entered into partnership with a number of funding bodies, including Christian Aid and DFID. They now have access to financial, technical and moral support so as to ensure their vision – future generations born and living in a world free from AIDS, becomes a reality.

Adapted from: Church of the Province of Southern Africa Ministries (2002), Archbishop Ndungane of Cape Town/Christian Aid (2003)

10. Recommendations

Young people are our 'window of hope'. But unless they receive education about sex and HIV, many millions more of them will die. It is the responsibility of everyone to respond to this crisis. The churches are in a powerful position because of their extensive networks and influence at all levels of society. They are responding to this global crisis, particularly in caring for the sick.

But, there are weaknesses in the response to HIV and AIDS, particularly in the area of prevention. Talking about sex is hard. Yet it is critical that the churches, and others in contact with young people, engage with them on issues of sex and HIV, and that they support others in their efforts to do so.

In particular, this requires an acceptance of two realities:

- that, according to all available data, in the majority of countries, the majority of young people are sexually active from a very young age and therefore at risk of being infected with HIV.
- that good quality sexual health and HIV education will not increase promiscuity; on the contrary, it will promote safer behaviour, and reduce HIV, other STIs and teenage pregnancy.

In order to address these realities, there needs to be active support of and advocacy for sexual health and HIV education

- that is open, frank and supportive, promoting abstinence, faithfulness and safer sex.
- that ensures that young people have all the information and skills they need before they become sexually active and sexual behaviour patterns start to form.
- that fosters development of the life skills young people need, including skills to challenge adverse gender norms in relationships, communicate about sex, say 'no', and negotiate safer sex.
- that includes ensuring that the young people who are sexually active have access to condoms, in order to protect themselves from HIV, and not spread it to others.
- that takes into account the reality of young people's lives, and is sensitive to issues of gender, culture, and the economic and social pressures that young people experience, as well as non-judgmental and supportive of young people already infected.
- that utilises church networks to reach to out-of-school young people, child-headed households and other vulnerable children, and educate them about sexual health and HIV.

'We are all living with AIDS. As the body of Christ, confronted by a disaster unprecedented in human history, we share the pain of all who suffer as a result of AIDS. Faced by this, we hear God's call to be transformed.'

Archbishop Ndungane, Capetown, South Africa

Through its fourteen member churches, the Christian Council of Ghana is actively involved in age-appropriate sex and HIV education for young people from the age of six. Recognising that younger children are a key target group, CCG provides training for 6-14 year olds in schools that helps them to communicate effectively and openly on issues related to sex. Sex and HIV education continues for 15-25 year olds through the use of peer educators.

Christian Council of Ghana, Accra, Ghana

'HIV is a sexually transmitted infection... There is a critical need for our people to be 'comfortable' and 'factual' in their conversation about sexuality and human sexual behaviour.'

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