SOCIETY OF PUBLIC HEALTH

and

YOUTH SUPPORT

"THE PREVENTION OF HIV/AIDS IN YOUNG PEOPLE"

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at

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EPIDEMIOLOGY AND THE CURRENT POSITION

Dr. Nick Gill

Looking at the natural history of HIV in individuals, from innoculation, 30% have an acute sero-conversion illness. Then there is a long period of asyptomatic infection at the end of which a proportion will have persistent generalised lymphadenopathy then move on to severe HIV disease most of which manifests itself as AIDS. It is well known that early on, when people have HIV they are infectious, but now there are microbial grounds for believing they gradually become more infectious as they develop AIDS.

What proportion of those infected will develop AIDS? From data on a cohort of gay men in San Fransisco, a unique group where the time of infection is known, we find that very few develop AIDS after the first two years, but the graph rises steadily after three years until at ten years at least 50% have AIDS and another 35% have clear progressive evidence of the disease developing, so at least 85%-90% will eventually die of it. We do not yet know what percentage will have HIV but never go on to develop AIDS, perhaps only 1%, but these figures show HIV is one of the most virulent infections known, comparable with rabies, and much more likely to kill than Lassa fever.

What affects the rate of HIV infection?

1. Age. Younger people have a slower progression rate.

2. Gay men have a shorter progression rate. Kaposi's Sarcoma is predominantly in gay men, and is thought to be due to another infectious agent potentiated by HIV.

3. There is evidence fron Nairobi that HIV develops much more rapidly in women there than women in western countries.

4. Evidence from Jamaica that co-infection with another virus HTLVI, increases the rate of progression.

5. Some evidence from Switzerland shows that methadone treatment slows the progression of AIDS.

6. Zidovudene treatment at certain stages slows development.

7. There is debate about whether cytomegalavirus affects the rate of progress.

The rate of progress is NOT affected by:

1. Continual sexual exposure to HIV.

2. If a partner has AIDS it does not predict your incubation for AIDS; it seems to be an individual response to the virus.

3. There is no evidence a 'healthy lifestyle' delays progress

Survival of AIDS cases.

This has improved. In 1979/86 medium survival was less than 12 months, now it is two years, but very much still fatal.

Transmission.

1. Sexual contact is the major mode. In UK men and men worldwide, men and women.

2. Sharing needles by drug users. Second largest cause in UK and perhaps in Southern Europe.

3. Mother to infant transmission, Major problems in North American inner cities and Africa.

4. Contamination through blood and blood products.

Prevention.

1. Safe sex.

2. No sharing of needles.

3. Blood donor screening and heat treatment.

4. Education.

Surveillance.

We are able to get a worldwide pattern from doctors' case reports, voluntary HIV testing, prevalence monitoring programmes and ad hoc data. There is a rapid rise in infection in groups worldwide. 80-90% of prostitutes in Nairobi were infected by 1987, and there is a steady rise in pregnant women in Kampala. HIV is increasing dramatically amongst drug users in Bankok, there is a rapid rise in Burma, and now 10% of prostitutes in Bombay are infected. There are enormous differences in the impact of the epidemic in different regions, e.g. in pregnant women:

200-300 per thousand in Central and East Africa.

10 per thousand in New York and New Jersey.

.39 per thousand in Rome.

.4 per thousand in London etc.

Likewise there are enormous differences within the same countries and demographic differences between rates of infection in men, women, age groups, ethnic groups, though 35-44 year olds are most infected, also 15-24 year olds.

At the end of January 1991 there were 4,098 reported AIDS cases, and we can see a lot more cases from injectors. 23% of men and 45% of women are under 24. There is a small group of gay men who are still at behavioural risk, and acute hepatitis B. The marker for HIV in drug users went up last year. The group who contracted HIV through heterosexual contact is small but there is an upwards trend. Altogether there is a prediction of 13,000 cases being diagnosed by the end of 1990 (reporting can be slow).

Data on HIV infection acquired through heterosexual intercourse in England and Wales is available from a variety of sources. Relevant information is summarised in this update.

Confidential reports of AIDS cases.

Reporting of AIDS cases began in 1982. By the end of September 1990 219 cases (138 men, 81 women) had been reported in whom the source of infection was thought to be heterosexual intercourse. 27 of these had heterosexual intercourse with partners who had another major risk factor for HIV infection such as injecting drug use of male bisexuality. 170 had heterosexual intercourse abroad. The remaining 22 (11 men, 11 women) denied having sex abroad or knowing whether their heterosexual partner(s) had another risk factor for HIV. The proportion of AIDS cases thought to be due to heterosexual contact increased from 3.6% in 1988 or earlier, to 7.8% in 1989, and 9.8% in the first 9 months of 1990.

Laboratory reports of known HIV infections.

Of the adults in England and Wales known to be infected with HIV by the end of September 1990, 951 (including 464 women) contracted the virus through heterosexual intercourse; 138 had heterosexual partners who were found to have another major risk factor for HIV infection, 541 had heterosexual intercourse abroad, and 217 were reported as HIV infected heterosexuals with no further information. The remaining 55 (including 24 women) denied having sex abroad or knowing whether their heterosexual partner(s) had another risk factor for HIV. HIV reports thought to be due to heterosexual contact rose from 2.5% in 1986 or earlier, to 7.7% in 1987, 8.2% in 1988, 11.2% in 1989, and 15.3% in the first 9 months of 1990.

PHLS collaborative laboratory study of HIV tests.

Since late 1986 PHLS laboratories have been contributing to this study by collecting information on HIV tests conducted. In the first two years over 6,650 women, who had no risk for

HIV infection other than heterosexual intercourse with a number of partners, were tested for HIV for the first time and two were discovered to be infected. Between April 1989 and March 1990, however, 2,208 women in the same exposure category, five were found to be infected with HIV.

PHLS collaborative study of attenders at genitourinary medicine clinics.

In 1986 and 1987, in this voluntary survey of attenders at sexually transmitted disease clinics, the only women identified as infected were at extra risk through heterosexual intercourse with men who were either drug users or known to be infected. For the first time in 1988, despite falling participation in the survey, HIV infections were identified in three women who contracted the infection through sexual intercourse and who were unaware of the risk status of their male partner(s).

Other studies.

An example is the unlinked-anonymous survey of attenders at the sexually transmitted disease clinic of the Middlesex Hospital in London (Br Med J 1989; 298:419-22). In 1987 the prevelence of infection in heterosexual female attenders was 1% (4/412) compared with only 0.5% (2/395) in early 1986.

Data from other surveys of HIV infection in heterosexual groups was summarised on page 51 of the Cox report. In particular, two unlinked-anonymous serosurveys of pregnant women in central London revealed 13 (0.38%) infected women out of the 3,453 tested in 1987 and 1988. A further study using dried blood spots obtained from neonates showed a total of 12 positives amongst 24,548 tested in central London, 14 out of 42,334 in outer London and 2 in 47,633 outside London. (Lancet 1990 i:516-9).

The consistency of these findings from several independent data sources confirms that transmission of HIV through heterosexual intercourse is taking place in England and Wales at present.

The rate of increase of transmission of HIV by this mode remains uncertain, as does the time over which the increase will continue and the ultimate anonymous HIV prevalence monitoring programme, when available, will provide valuable information in this regard.

These facts and the continuing frequency of other sexually transmitted disease in young adult heterosexuals (Genitourinary Med 1989; 65:117-21) make it imperative that intensive efforts should be made to reduce HIV transmission through heterosexual intercourse.

In conclusion HIV is an unstable virus within countries and around the world, but prevention CAN work. There is a need for educators to understand the LOCAL epidemic and not judge it by others.

"NON-SEXUAL SPREAD OF HIV"

Jane Wilson

I have been asked to speak to you on the non-sexual spread of HIV and its implications for young people. Our project is located in a large housing estate on the outskirts of Edinburgh and as many of you know Edinburgh has been dubbed as the "AIDS Capital of Europe".

Before I outline how we are responding to this epidemic I would like to briefly present a few statistics so you can understand the magnitude of the problem in Lothian and also trends which seem to be emerging with regard to the spread of HIV.

You can see from U.K. HIV Antibody Prevalence rates (rates per 100,000 pop.) that Scotland comes fourth amongst the top six areas. However, when you compare the prevalence rates for Lothian Region you get a very different picture with Lothian Region far oustripping other regions. (See Fig.1)

Further, when we look at transmission categories we can see that unlike other areas the pool of infection exists among I.V. Drug Users who are young, mobile, sexually active men and women of childbearing age. (See Fig.2)

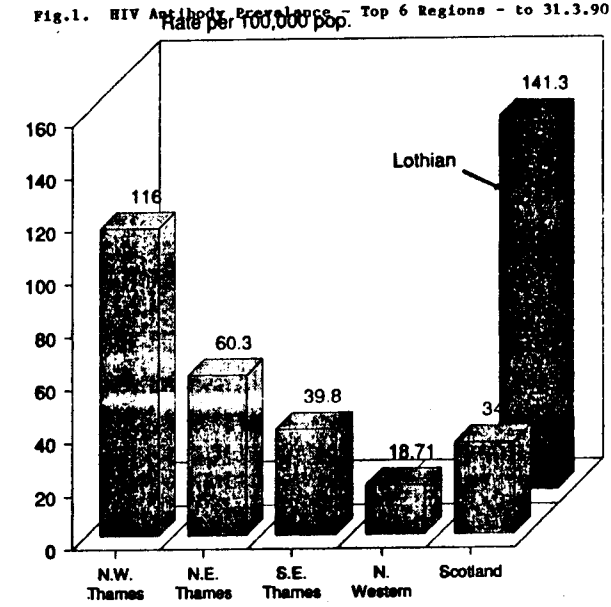
Edinburgh has:
- 1% of the U.K. Population
- 23% of all HIV positive women
- 50% of babies born to HIV positive women
- 30% of HIV positive drug users in the U.K.

By the end of 1992 AIDS will be the commonest cause of death among young men in Edinburgh, and by the late 1990's the commonest cause of death amongst young women.

As you can see, it is an unenviable position but we are fighting back not only to support and care for those already infected but to develop and apply strategies which will reduce spread of HIV amongst our young people.

The early 80's saw the first wave of HIV infection in homosexual men in Lothian. This was quickly followed by the second wave which was predominantly intravenous drugs users.

Fig.1. HIV Antibody Prevalence - Top 6 Regions - to 31.3.90



HIVPV

Fig.2. HIV Sero-Positivity Lothian March 31.90 (N=1053)

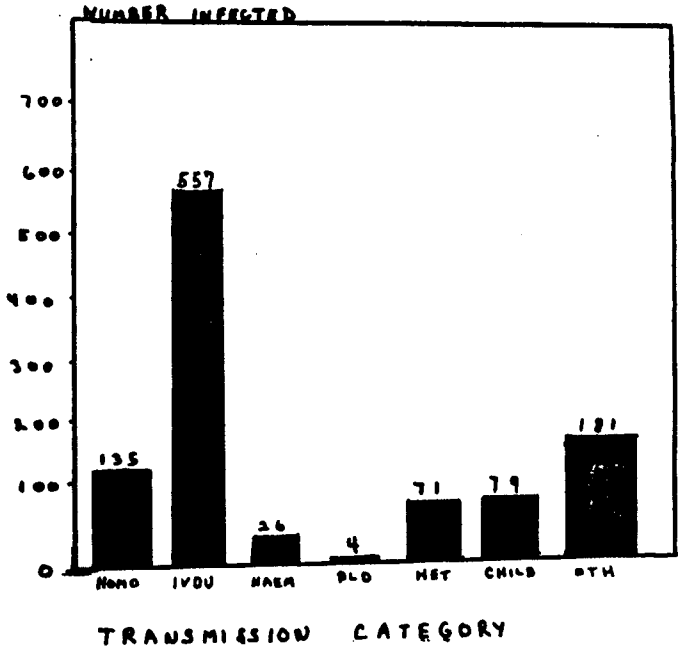


Fig 3

HIV - SCOTLAND

HETROSEXUAL SPREAD (BY QUARTER)

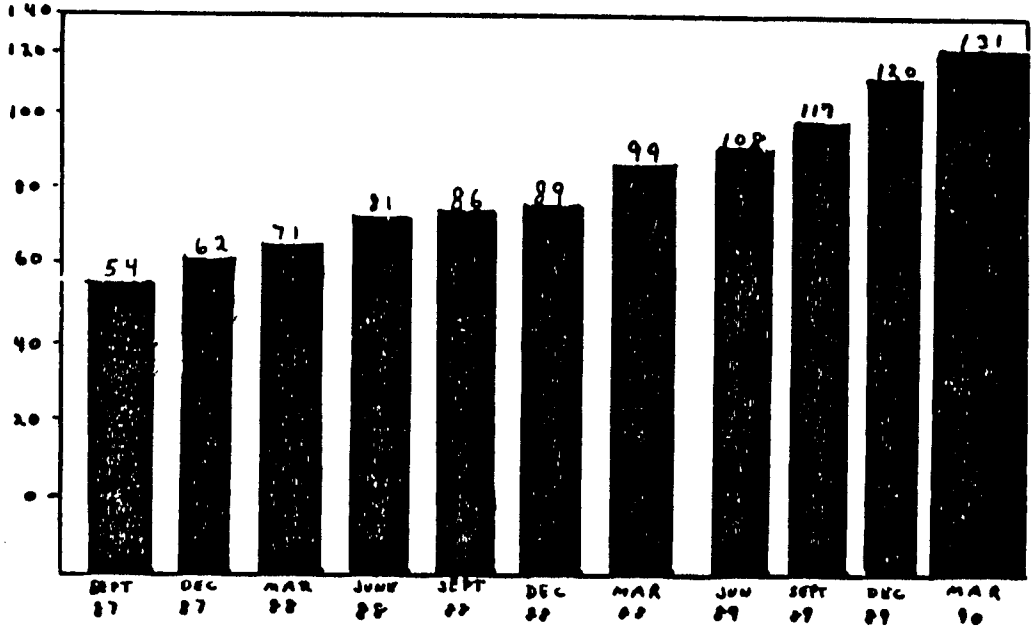
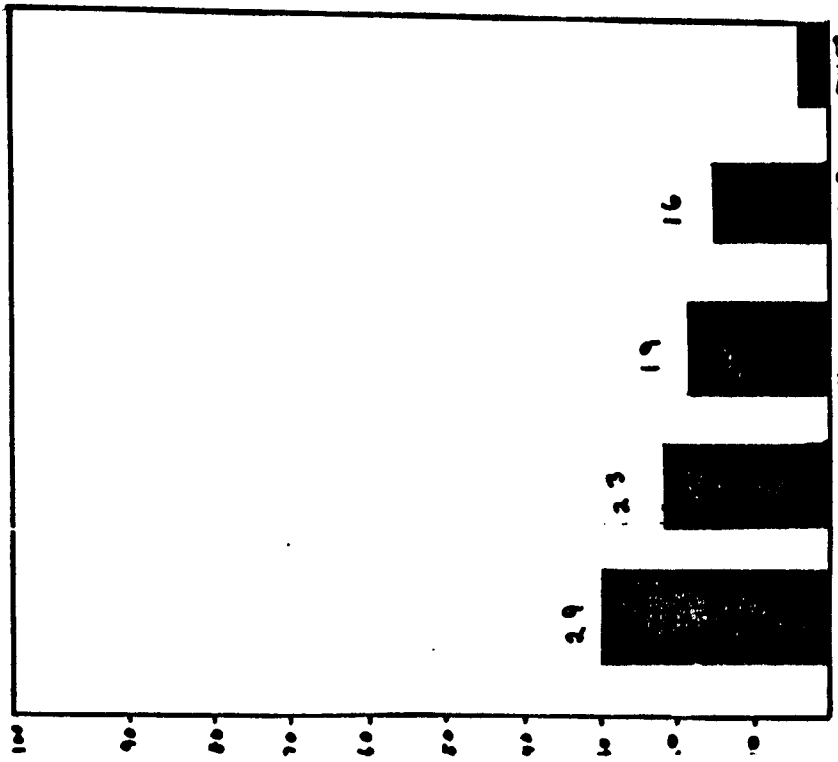


Fig 4

MARCH 89-90

N = 91



We have now entered the third wave which is heterosexual. This third wave has not yet been widely experienced in other parts of the U.K. For those still debating as to whether heterosexual spread is a myth we in Lothian can say it is not just a theoretical possibility but now a reality.

If we look at heterosexual spread by quarter from September 1987 to March 1990 you can see an increase of nearly threefold. (See Fig.3)

Also looking at reported positive tests for 1989-90 we find that while there has been a 27% decrease for those who contacted HIV via I.V.D.U. there was a 68% increase for those who contracted HIV via sexual contact. (See Fig.4)

We can draw two conclusions from this:

a) the situation for people using drugs is improving

b) there is real cause for concern about sexual spread

The discovery in 1985 of such high seroprevalence rates amongst Edinburgh's I.V.D.U.'s posed a major problem. This group were young, hidden, often anti-authoritarian, and did not readily avail themselves of existing services on a voluntary basis.

In line with the guidelines set out by the Advisory Council on the Misuse of Drugs, Lothian rapidly adopted a Harm Reduction Model which would not only shift the focus on managing drug problems but also to place halting the spread of HIV as a priority. Within the Harm Reduction model such options as needle exchanges, free condoms, safer sex/drug use counselling and Substitute Prescribing could be offered. This approach, by attracting users into services also allowed us to assess the scale of the problem and engage users on longer term task or moderating risky behaviour.

Harm minimisation is not about being totally safe without risk, rather it is the development of practices and policies which reduce the risk - make the activity less dangerous and by reducing the degree of danger it alters the probabilities. It is an attempt to reduce harm by shifting from high risk behaviours to safer behaviours. In assessing the risk for I.V.D.U.'s in Lothian a harm reduction approach could work along the following lines:

HARM REDUCTION

HIGH

Random needle sharing
Reduce amount of injecting and number of times sharing occurs
Cleaning equipment before using
Only using new sterile equipment
Move from injecting to alternative methods e.g. oral, smoking, sniffing
Reduction in amount used
Cessation of drug use

LOW

Over the past five years Edinburgh has expanded its services in line with a Harm Minimisation strategy. A needle exchange bus services a large housing estate and a number of fixed exchange sites are in operation offering clean injecting equipment, free condoms and support and advice to encourage lower risk behaviours. G.P.'s are increasingly offering clean injecting equipment to users. Many drug agencies have worked in co-operation with these approaches.

Substitute prescribing was introduced at the end of 1985. Initially, users who were HIV positive could be maintained on methadone dispensed at the City Hospital. Several G.P.s with large caseloads of drug users began prescribing oral substitutes to encourage a move away from injecting and a shift from illicit to licit drugs. The Community Drug Problem Service, a multidisciplinary team led by a Consultant Psychiatrist, offered consultation and back-up to all G.P.'s to support the management and prescribing for drug using patients as well as providing a direct service to users. Several outreach projects were initiated to draw out the hidden population and maximum contact with services. These workers could provide or channel users to agencies who could offer support and advice on broader issues affecting users such as housing, benefits, family and relationship problems along with health education on HIV and safer drug use and the counselling required to encourage and sustain behaviour change.

The heterosexual spread which we have recently entered will initially affect/infect women in drug using communities given the high rate of infection among young men in these areas.

Education and information alone on safer drug use and particularly safer sex practice will be insufficient to foster change. What we advise on safer sex practices can engender anxiety, conflict and resistance amongst this population of women.

The adoption of safer sex practices require major alterations in lifestyle, values and beliefs for these women. What we are offering would require a shift from:-

Existing in the moment	to	Active forward planning
Deep dependency needs	to	Independence
Internalised powerlessness	to	Response....ability
Socially learned and culturally reinforced sexual passivity	to	Sexually assertive behaviour
Selflessness	to	Self protection
Primacy of needs of others Submissions to sexual desires of men	to	Self regard
Importance of status and identity as "mother" in the community	to	Forfeit prospect of parenthood/childlessness

Workers need to be sensitive and resonant to the ways in which these women experience their reality. If we do not acknowledge and support women in working through these conflicts we can only expect to be met with resistance, avoidance or verbal passive compliance which does not translate into action. Issues which may appear as emotional or psychological in essence have social roots and will require a broadening of the goalposts to encompass the wider issues which impact on women's lives and restrict their choices.

We have a responsibility to our young people to take up the challenge and confront the dilemas posed by this epidemic. If we merely moralise or lecture about drug use and sexual behavour we will miss the opportunity to effectively intervene and have an impact on the outcome. This generation of young people should expect no less from us than a full committment to reassess our own prejudices and attitudes and to creatively and constructively build options and solutions which are consistent with their experiences.

"THE IMPACT OF H.I.V. INFECTION ON CONTRACEPTIVE PRACTICE"

Phyllis Mortimer SCMO

The title of this talk is a general one, but obviously in the context of this meeting I shall refer mainly to young people.

A decade ago when AIDS was identified as a clearly defined new disease our current young people were only five to ten years old, so their interest in the condition must have been minimal to say the least. An optimist at that time might have envisaged the future of the 90's as one in which the youngsters of mid teens to early twenties were well informed on all aspects of HIV infection and had exchanged the sexual freedom of the 60's to the enlightened self-interest of "safe sex". If this had occurred, I believe there would have been a marked effect on all aspects of family planning, both in it's use and uptake, and in consumer-lead demand for higher quality. In this paper I propose to discuss the reality as it appears in the setting of a busy family planning service in an Outer London Borough.

In the early days of the AIDS epidemic it was widely held that, within five years, everyone would know someone with acknowledged HIV infection or AIDS, and that this would be the greatest incentive for changing risky lifestyle practices. However, the gloomy early predictions for U.K. infection did not apparently occur and the "doubling-time" for notified cases of AIDS infection lengthened. It was a familiar story for Health Educators who, if the worst had occurred, would have been blamed for not controlling the epidemic; but who in the event, were blamed for causing "unnecessary" panic!

The reasons for this early change in HIV infection pattern are well documented. At that time the majority of patients came from the gay community: information was rapidly disseminated by the articulate members of this group who tend to have good communication networks: behaviour changed dramatically and safe sex practices introduced.

Sadly, such responsibility was not always shown by other high risk groups: for the drug user who needed high drugs "now" the warnings seemed irrelevant. For the considered low risk heterosexual it was still something which happened to "them" not "me".

We are now in a situation where estimates of 500,000 cases of AIDS worldwide are made with an anticipated 5-6 million infected people. In the U.S.A. the majority of infection is acquired during the ages of 15-19 and there is no reason to assume that the U.K. will not follow the same pattern.

It is not part of my brief to discuss the HIV education input or impact, but it is obvious that, by the time the youngsters appear at Youth Advisory Clinics, Family Planning Clinics or their GPs, for contraceptive advice their attitudes will have already been affected or determined by overt and hidden messages. The amount of school time that can, or will, be devoted to HIV issues will be determined by attitudes of Head teachers, staff, P.T.A's, and timetable pressures. Equally, the amount of home discussion is enormously variable - from an excessive preoccupation due to parental fears (which may easily cause frigidity or impotence in later life) to a complete indifference and inability to answer any of the youngster's questions. Their factual knowledge varies enormously and we cannot assume that anyone we see will have any conception of what HIV infection involves.

In a recent group discussion at a Youth Advisory Clinic the girls denied that they had ever had any information from any source except the media: this, of course, must be taken with a large dose of scepticism since an academic question might well have produced the same result. However, the media influences are potent: casual sex in television drama: the words and stimulation of pop music and attitudes in some teenage magazines may well be counter-productive when responsible "safe-sex" is what is needed to prevent the spread of the HIV virus. It was interesting and relevent to note that in our discussion the girls admitted that they would listen far more readily to someone of their own age who had practical experience in the HIV field than they would to their more mature teachers, nurses and doctors.

In all discussions about HIV infection we do, at our peril, deny the power of sexual urge. I regularly see adults who have been to Thailand and other high risk areas, who are well aware of the risks, but still unable to resist the sexual blandishments on offer. How much more difficult is it for young people to resist what they feel thay have discovered uniquely for the first time in history! If business men in Thailand can fail to use a condom despite presumed experience with such prophylactics, who can be surprised when the inexperienced abandon the attempt?

A major problem, of course, is still the attitudes of many girls and young women to sexual negotiations. Many fear that, either discussing safe sex will imply to their boyfriends that they have had numerous previous partners, or that the boy will react badly and leave them. Sadly for some youngsters the lack of a boyfriend appears far more serious than the risks of unprotected sex. The agony columns of teenage magazines are still full of confused letters of the "do I have to give in to him?" kind - many are from girls as young as 13 or 14.

A consideration of Abortion Statistics is helpful - and depressing. In a recent analysis of 1,000 pre abortion counsellings (1) these are a few of the relevent figures:-

	Girls under 16	Girls 16-19
Total (out of 1,000)	47	237
"Regular" relationships (2 months or more)	34	199 + 7 married
∴ Casual relationships or "one night stand"	13	31
Regular partner but using no contraception	27	106
Previous terminations	3	19
Previous children	0	34

It is obvious that the mechanism for catching HIV infection is exactly the same risk as for having an unwanted pregnancy: yet the numbers of women requesting termination continues to rise.

In detailed discussion with those requesting termination the lack of self esteem among the very young causes great concern. "He said he wouldn't use a condom, it would spoil his enjoyment" or "he said he'd take care of me, but I didn't see him put anything on", or "it was dark, so I don't know what happened", are all familiar sayings.

A new anxiety is also arising about the lack of knowledge, concern and responsibility of some young gay men. Uninvolved in the early publicity and networked information some of them are also taking unnecessary risks.

Doctors and nurses providing family planning services have a duty be aware of the possibility of HIV infection and be prepared to give the safest advice to those who are, or might be, infected. The idea that "it doesn't happen in my patch" or "there are 20 more girls waiting in the clinic so I haven't time" could lead to problems, if not actual tragedy.

A recent article on "Contraceptive use in HIV infected women (2) showed that the majority "wanted at least one child, and did not see HIV infection as being a contraindication to this". It is therefore very important that the medical staff can talk through the risks and that the patient really understands the currently estimated 25% of babies who will be affected. They should also understand the risks from breast feeding.

For the HIV positive woman who requests safe contraception it is particularly relevant that a combination of the most effective method combined with the maximum protection for her partner is chosen. The I.U.C.D. is definitely contraindicated: it is less reliable, has the risk of causing or exacerbating a pelvic infection, and may well cause heavier periods. The cap

has some followers who feel that any barrier method is effective, however this is not so, the vagina is unprotected and infection could be transmitted in this way.

The combined pill is likely to be the method of choice for most women,it is very effective, easy to take and usually reduces the menstrual loss. There are some concerns about possible effects on the auto-immune system but probably the greatest reservation is the patient's ability to remember to take the pill. Drug misusers may well have periods of poor memory and patients who have already developed early cerebral HIV infection will possibly have difficulty in compliance. These reservations apply even more to the Progesterone Only Pill except the immune system should not be affected. For many patients therefore the ideal may prove to be Depo Provera, especially as the majority of patients using this method become amenorrhoeic.

For cross infection protection, condoms should be used, ideally combined with a Non oxynol 9 spermicide, since this has some virucidal action.

Obviously, a policy if "condoms for all" is the ideal and these should be freely available. However, the economic burden is enormous and there are situations where more money spent on condoms could mean the closing of a Family Planning Clinic. GPs do not provide condoms and in areas where most Family Planning Clinics have been closed, free condoms then become unavailable to the young who may be most in need.

The premises in which family planning is offered should also be sensitive to the impact of HIV infection. Literature should be available and in positions where clients can help themselves without embarrassment. Since it is difficult to provide high profile advice without antagonising youngsters with an attitude of "DON'T": The literature impact should be friendly not aggressive.

All staff should be able to give quiet, tactful details about HIV counselling services in a totally non-judgemental way: remembering that most youngsters will only ask once. All nurses and doctors should have sufficient knowledge to give advice, if not actual councelling, and considerations of time for consultation and sound proofing of rooms is very relevant.

In practical terms all cross infection precautions which already existed for Hepatitis B will be effective against HIV infection. Autoclaves are a must, yet family planning and vaginal examinations are still caried out in situations where sterilization is primitive.

In an ideal future all the above considerations will have been met and the, entirely controllable, spread of HIV infection in the U.K. will have stopped. More designated Youth Advisory Clinics will help youngsters to mature sexually and responsibly. While not wishing to pre-empt the next speaker I would also commend the work of A.E.C.T. and it's programme of school visits especially it's new booklet "HIV - It's Your Choice" and to congratulate Eastenders for tackling the subject in the way that really get through to young people. That is - through the Soaps!

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HEALTH EDUCATION MATTERS - PREVENTING HIV/AIDS IN YOUNG PEOPLE

Veronica Payne

Young people have been widely identified as particularly at risk of HIV/AIDS. In this paper I will discuss the extent to which this is an accurate portrayal of young people's experiences. I will also consider the role of HIV/AIDS health education and factors which mediate the effectiveness of safer sex messages.

There are many sterotypes that exist about young people. These range from the archetypal teenage rebel who appears committed to destroying the very fabric of society through drugs, sex and, of course, rock and roll, or perhaps more recently acid house parties, to the model young person who studies hard and does good work in the community and indeed has a "heart of gold".

Clearly neither is a terribly accurate picture of young people or their experience. Similarly, such stereotypes do not consider the effect of highly gendered socialisation where young men are expected to break the rules in order to assert and test out their masculinity, whereas the same behaviour by young women is a sign of deviance and faulty socialisation.

Differential power relations that exist between men and women within a society which is structured on the privileging of heterosexuality and the dominance of the family unit are highly significant when considering the effect of safer sex messages

and the extent to which young women and men are able to negotiate safer behaviour. The existence of AIDS has presented us with the opportunity to critically examine these, and other, power relations. If we ignore this opportunity we do so at our peril.

Janet Holland et al (1991) suggest that:

> "The threat of death has made change imperative, but, for change to be effected, the processes through which sexuality is socially constructed must be identified."

It is the appearance of sex as natural rather than as socially constructed which is profoundly challenged by AIDS.

Clearly, the impact upon young people of HIV/AIDS is significant. Young people are at a time in their lives when they are beginning to be sexual with others for the first time. They are also at a point in their lives when they are uncertain about many things and are viewed neither as children nor as adults. Yet the message is to act responsibly - a message which many adults are unable to heed.

A distinction may be found in much health education material between "moralism" and "realism". The guidelines that accompany a DES video for use in schools with young people suggests that:

> "[...] teaching must focus on the positive benefits of responsible sexual behaviour and the virtues of abstinence and restraint."

Whilst it would be unwise to assume that all young people are sexually active, it is equally unwise to assume that young people will heed a message couched in prohibitive terms. Clift and Stears (1991) argue that the majority of health education materials prepared for use with young people aim not only to provide information about HIV/AIDS relating to transmission and safer behaviour and the necessary skills needed in order to negotiate such behaviour, much of this material is also underridden by a particular moral view. This is a view that seeks to priviledge the family unit and the dominant heterosexual paragdigm above all others. This is a view which marginalises and excludes those who do not subjugate themselves to this discourse.

Safer sex messages which solely focus on persuading young women to use condoms, or rather on persuading those young women to persuade their (male) partners to use condoms fails to appreciate the discursive structure within which such advice is given. It is vital to understand the social meanings that have been ascribed to condom use Holland et al (1991) suggest that:

> "[...] these meanings are illustrative of the gendered nature of responsibility and what is considered 'appropriate' beahviour in contraception and safer sex. These meanings cannot simply be swept away and replaced by public education."

Warwick et al (1988) state that lay health beliefs are a central factor in determining and mediating the effectiveness of health education interventions. Effective health education must take account of the social context of condom use within relationships structured by the practices of heterosexuality. Holland et al further suggest that:

> "Young women are not without the ability to choose and to act for themselves, but they are heavily socially constrained. Young men are much better placed socially to gain sexual pleasure for themselves. When a young woman insists on the use of a condom for her own safety, she is going against the construction of sexual intercourse as man's natural pleasure and woman's natural duty."

Thus it is within a critical analysis of these discursive practices that HIV/AIDS health education must be located if it is to begin to address the task with which it is charged. There are a range of different models of health education. It is suggested by Aggleton and Homans (1987) that:

> "These differentiate between the different goals that health educational intervention might have, as well as between the means by which these goals might be achieved."

Models of health education include those that focus on information giving, behaviour change, self-empowerment, community based responses and those which are more socially transformatory. It is suggested by Watney (1991) that health education initiatives can be categorised as either those based upon behaviour modification, which tend to be straightforward interventions; those based upon lifestyle modification which attempt to work at a more sophisticated level taking account of the importance of social and psychological factors as well as community identity; and thirdly, those based upon group cultural modification. These models are generally repressive techniques that supposedly prevent HIV transmission by punitive means.

I would suggest that effective HIV/AIDS health education must be located within a critical understanding of not only the factors which mediate individuals ability to effect behaviour change, but also within an understanding of the dynamics of oppression that exist in society which are focussed by HIV/AIDS.

HIV/AIDS health education that is specifically designed for young people needs to take account of the diversity of young people and to realistically consider their needs without resorting to promoting any moral framework. I would suggest that the central concern should be to prevent the further spread of HIV amongst young people and to enable young people to develop the necessary skills and abilities in order to make choices about the sexual behaviour that they engage in.

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WORKSHOP SUMMARY

1. What can they be told and when can we start?

Schools vary widely. Some teachers are extremely good at coping with the subject, but there is a need for us to disseminate knowledge to people who have doubts about educating the young in case we promote a prurient interest in sex. We can quote the good example of Holland in particular, and the general principle that where liberal sex education policies are pursued then the age of first sexual activity tends to rise, so these fears are seen to be unfounded. We also heard about some very good peer initiatives in Torbay, where they targeted young people, including seasonal workers, by using local discos where the DJ's were the educators.

2. Can we stay objective when talking to the young?

We discussed if we need it, what it is, and whether it is simply a non-judgemental approach. There was agreement that this is necessary in any dialogue with patients. As to giving an unbiased view, the reason for giving the BIASED view was on medical gounds. We give a highly medically orientated view on smoking based on the risks of that activity, why not AIDS? However objective our information, what we came up against was other factors that might militate against acceptance by the person/s we had been talking to - the attitude of parents, teachers, political influences, finance, ethnicity. We must be aware of differing backgrounds.

It was also felt very strongly we must create an environment in which young people feel comfortable, and where they would feel we were giving non-judgemental advice. We must be aware of misusing our power and dictating to them. But we also agreed that, for us who are parents, it is difficult to act objectively towards our own children!

3. How should we confront the denial of AIDS?

We looked at the level at which denial operates. First the general society view that denies sexuality, then personal denial, Young people find it very difficult to admit they are having sexual relations and putting themselves at risk. Denial is seen as counter to identification because people focus on at risk groups in a scape-goating "it can't happen to me" way. Also, teenagers feel they have their life ahead of them and there is denial of vulnerability, of the possibility of death, which is underscored by the fact that with AIDS there is no immediacy about becoming ill (like smoking), so they cannot relate to it as it is not visible. There is also the denial of risk in partners. A denial <u>they</u> may have been with others, or that <u>you</u> have, keeping up a delusion of fidelity. Denial has also been fuelled by the media's lack of balance - either AIDS is rampant or "here are the ways you won't get it". The taboo

on sex and drugs fuels denial too, and the lack of respect for people with HIV. Confronting the denials means getting people to identify with at-risk groups, and talking more openly about taboo subjects, treating teenagers as mature and individual. We agreed the booklet "Trading Fear for Facts" is one of the ways to confront them.

4. Are current Health Promotion/Education programmes useful, and to whom should they be targeted?

We heard about health promotions such as free condoms at acid house parties, but people felt they were frequently being blocked from going into schools, especially if safe sex or condoms are mentioned. They complained that school governors had the authority to sanction sex education, but there was a lack of government guidelines, and individual teachers were worried about offending them or the parents. We more or less agreed that over 14's were the target, but some are for talking to much younger, even junior school children. The problem we felt was, even if they got the information were they listening? You can't reach all children, and you can't target ethnic groups because they would not be allowed out to a promotion. There is general approval of the latest TV adverts, but we felt it would not change their lifestyles. On the other hand we didn't come to any conclusions as to what would.

5. Is the material used in Health Promotion/Education, adequate and available?

We looked at some positive and negative features. On the negative side the HEA comes off pretty badly. Often material is not availabe, often inappropriate. Everyone agreed the problem is that the sort of material we use for AIDS education dates very quickly - the style of the language, the attitudes of the people writing the material, fashion sketches etc. It all needs to be updated at very regular intervals so that young people can identify with the material. There is critisism for the lack of material dealing with feelings and emotions, from relationships to having HIV and facing illness and death. There is a lack of co-ordination with the resources as well, and it is hard to know what is available or how to get hold of it, and sometimes it was felt it went to the wrong professional. On the positive side the national AIDS Manual is thought to be helpful, but the most important resource is the teacher, more important than videos or material. But there is not enough guidance for teachers, and computer games and videos are an adjunct. Bringing in local broadcasters and people from the media can help more than using professional health educators.

Chairman:

Dr. D.M.L. Birch - Youth Support

Speakers:

Dr. Nick Gill	- Director CDSC, PHLS, Colindale
Jane Wilson	- Senior Clinical Psychologist Muir House Drug Project, Lothian Regional Council
Phyllis Mortimer	- SCMO For Adult Services Croydon
Veronica Payne	- HIV/AIDS Training and Development Officer, Bristol Polytechnic

6. Do we have to "shroud-wave"? - Equating sex with death?

The general answer is 'NO'. But there needed to be a sense of precaution, balancing being realistic and the risks. It was felt very important to adopt a positive view of sex, and that the media had largely been responsible for the sex/death image, with fear a central issue. The "It doesn't happen to us, it's not my problem" issue was discussed, and how to achieve the gradual move from guilt. It was felt the tombstone image alienated young people.