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CREATING CONTEXTS THAT SUPPORT YOUTH-LED HIV PREVENTION IN SCHOOLS

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Abstract

What contextual factors affect the success of HIV-prevention in schools? What are the most appropriate strategies for creating contexts that support the success of schools-based efforts to reduce HIV-transmission? This paper examines current research, policy and practice in youth HIV-prevention, pointing to gaps in understanding that hamper the design, implementation and evaluation of interventions. Firstly we outline the goals of peer education, the most popular youth HIV-prevention approach, pointing to contextual factors that impact on programme success. Secondly, we review research into contextual influences on programme outcomes, highlighting its fragmented and descriptive nature, and the need for comprehensive frameworks to pull together findings in ways that could better guide research and practice. Thirdly we examine the policy context within which youth HIV education is currently delivered, and some concrete examples of youth-oriented initiatives. Running throughout the discourses of researchers, policy-makers and programme designers is a shared belief in the value of community mobilisation (including the strategies of ‘participation’ and ‘partnerships’) for promoting contexts most likely to support health-enhancing behaviour change. Yet references to these strategies remain vague and unsystematic, with little formal attention to the types of social relationships that they should seek to build, and little acknowledgement of the complexities of implementing them. In conclusion, we point to the concepts of bonding, bridging and linking social capital as useful starting points for conceptualising the types of types of social relationships that effective ‘participation’ and ‘partnership’ strategies should aim to promote.

1. Introduction

What contextual factors impact on the success of HIV-prevention in schools? What are the most appropriate strategies for creating contexts that support the success of schools-based efforts to reduce HIV-transmission? Young people are worst affected by HIV/AIDS, and much energy is being put into interventions to reduce youth HIV-transmission. Increasingly attempts are being made to integrate interventions into schools-based curricula and activities. Such interventions have had very variable successes. However, our ability to learn generalisable lessons from these patchy outcomes is limited by the lack of comprehensive theoretical frameworks conceptualising the array of multi-level factors that prevent or hinder the likelihood of health-enhancing behaviour change (MacPhail and Campbell, 1999; Waldo and Coates, 2000). Historically, research has tended to focus on two levels of analysis. At the micro-level, studies have sought to explain and predict sexual behaviour and the possibility of behaviour change in terms of individual-level properties, such as HIV-related knowledge, attitudes and behavioural intentions. At the macro-level, efforts have been made to explain high levels of HIV amongst young people in terms of features of the wider social environment, e.g. gender and poverty. However, less research has focused on the processes intervening between micro- and macro-levels of analysis, particularly at the local community level. In this paper we argue that there is an urgent need for theoretical renewal in the field of HIV-prevention research, particularly in relation to identifying those community-level relationships that enable or restrain the possibility of programme success.

In this paper, a 'community' is defined as a group of people who live and/or work in a common geographical place. Whilst it is often argued that 'communities' are better defined as 'communities of interest' (e.g. the Christian community) than 'communities of place' (e.g. the residents of Summertown), for reasons related to pragmatism and resources, health-related community development projects usually focus their energies on geographically bounded spaces. For this reason, this is the definition preferred here. The concept of local community mobilisation plays a key role in HIV/AIDS management strategies world-wide,

encompassing strategies such as participatory peer education and multi-stakeholder partnerships (UN AIDS, 1999, 2001). Yet despite the popularity of such strategies, much remains to be learned about the types of social relationships that community mobilisation should be seeking to promote, the processes underlying the impact of local community mobilisation on sexual health, and factors that promote or hinder such mobilisation (Campbell, forthcoming). This undermines our ability to learn lessons from the proliferation of variously successful community mobilisation efforts in the HIV-prevention field.

Three approaches to HIV-prevention

Early HIV-prevention research focused overwhelmingly on the individual level of analysis, usually using KAB (knowledge-attitudes-behaviours) conceptual frameworks. These assume that HIV/AIDS-related knowledge and attitudes play an important role in shaping peoples' sexual behaviour. KAB-type frameworks underpinned the first generation of HIV-prevention interventions. These sought to increase knowledge and change attitudes through traditional didactic *information-based health education*. However, such approaches have had limited success in promoting behaviour change. It is now generally accepted that knowledge and attitudes are very weak determinants of behaviour (Joffe, 1996).

Against this background it was argued that programmes should seek to change not only knowledge and attitudes, but also to provide people with the behavioural skills needed for healthier behaviours, and to increase peoples' confidence in their ability to perform healthier behaviours. This led to the second series of HIV-prevention programmes, namely *self-empowerment approaches* (see Marks *et al.*, 1999 for a discussion of various health promotional approaches). These taught people behavioural skills such as how to put on condoms, and how to negotiate condom use with a reluctant partner. They also sought to develop peoples' confidence through strategies such as assertiveness training courses. Such approaches are said to have underpinned the success of HIV-prevention in organised, strong identity groups in more affluent countries (e.g. the gay community in San Francisco). However they have had less luck in less cohesive or organised groups – and in low income countries. In the latter contexts it is argued that whilst such programmes may motivate individuals to make decisions to engage in safe behaviour in the context of an intervention

workshop, social norms, constructed in conditions of poverty and gender inequalities, make it difficult for them to act on these decisions in real-life relationships

This insight has been associated with the growing popularity of a third series of HIV-prevention approaches. These target the peer group or community rather than the individual. *Peer education* is based on the assumption that peers are the most important influence on young peoples' sexual behaviour, and that they are most likely to change their behaviour if they see liked and trusted peers are changing theirs (Dube and Wilson, 1999; Ngugi *et al.*, 1996). Young people are trained in factual knowledge about HIV and participatory educational techniques (e.g. drama's, role plays). They are also given free supplies of condoms to distribute. Ideally, they are given full control of setting up and running peer educational meetings in formal and informal settings.

Conceptual underpinnings of peer and community level approaches

Whilst peer and community level approaches are extremely popular in the world of practice, our conceptual understandings of the mechanisms whereby they have their effects are in their infancy. Peer education has been referred to as a 'method in search of a theory' (Turner and Shepherd, 1999, p. 236). One reason for its patchy successes is the dearth of conceptual frameworks to inform the design and evaluation of programmes. Campbell (forthcoming) begins to point to some of the processes underlying successful peer education. Firstly peer education succeeds to the extent that it provides the contexts in which peers can collectively renegotiate their social identities, on the assumption that sexuality is shaped by peer norms as much as by individual decisions. Secondly peer education should empower young people in two ways. It should provide them with confidence and negotiation skills, as well as a sense of ownership of health information and health interventions (traditionally the province of medical experts). Such a sense of 'youth ownership' of the problem of HIV is regarded as a key dimension of the motivation young people would require to act on combating it. This combination of confidence, negotiating skills and ownership ideally contributes to a sense of increased self-efficacy amongst young people, which increased the likelihood that they will feel in control of their health. Equally importantly, peer education should empower youth through teaching them to think critically about obstacles to behaviour change. According to

Freire's (1973) concept of critical consciousness, participatory educational approaches have the greatest chance of succeeding if participants have a sound understanding of the social factors which stand in the way of behaviour change. This enables peers to collectively 'brainstorm' ways in which they might act to undermine the impact of such factors.

However, successful peer education programmes need to aim for more than the renegotiation of identities, and the development of empowered and critically conscious youth peer groups. They also need to contribute to the development of 'health-enabling community contexts' (Tawil *et al.*, 1995, p. 1299) that enable and support these processes. The task of conceptualising and promoting such contexts is currently the key challenge facing HIV-prevention researchers and activists. The remainder of this paper provides an overview of current research, policy and intervention thinking in this area, in order to point towards gaps in current thinking, and towards an expanded agenda for youth HIV-prevention research. In the paper's concluding section, it will be argued that the concept of social capital provides a tentative starting point for beginning to fill these gaps, although much work remains to be done in developing this concept.

Summertown case study

The question as to how best to define and promote the development of communities that enable peer educational success has been raised in a recent case study of a peer education programme led by young people in Summertown, a gold mining community near Johannesburg, where levels of youth HIV are high (Summertown is a pseudonym for our area of interest). A baseline study (MacPhail and Campbell, 2001), conducted before the peer education programme was initiated, highlighted how youth continued to engage in high risk sex, despite good knowledge about HIV/AIDS and how to prevent it. Focus groups suggested that the following factors contributed to the spread of HIV/AIDS: low levels of perceived risk; peer pressure for unprotected sex; limited availability of condoms in a context where clinic staff were often hostile to young people, especially women, seeking condoms; and economic factors which made transactional sex a survival option for some young women. All these factors were located within the context of gender norms which placed boys under pressure to have frequent unprotected sex, and which limited girls' power and sometimes

their willingness to insist on condom use. The authors concluded that traditional information-based sexual health education was unlikely to have any impact in the absence of efforts to promote health-enabling community contexts – to support the performance of safer sex by young people.

Following this baseline study, the researchers conducted a case study of a schools-based peer education and condom distribution programme (Campbell and MacPhail, 2002). This programme was part of a larger community-wide HIV prevention intervention in Summertown, including biomedical STI control, community-led peer education and condom distribution and multi-stakeholder project management (see Campbell, forthcoming, for a discussion of the larger study). The study identified various obstacles to the development of youth empowerment and critical thinking that the authors argued were essential preconditions for programme success.

At the level of programme delivery, the highly regulated nature of the school environment militated against the development of autonomous critical thinking by learners. Rigid teacher control of the programme undermined any sense of ‘youth ownership’ of its activities and goals. Youth had been schooled in a tradition of didactic teaching methods, which meant that neither peer educators nor their target groupings were familiar with the participatory and interactive methods that characterise the critical thinking underpinning successful peer education. Peer educators were more comfortable focusing on biomedical aspects of HIV/AIDS than the social aspects, further undermining the development of critical thinking skills. Youth peer education activities tended to be male-dominated, replicating the very gender dynamics the programme should ideally have challenged. Finally learner attitudes to the programme, within the context of the stigmatisation of HIV/AIDS, also greatly undermined programme efforts.

The study also focused on aspects of learners’ beyond school environments that undermined programme success. Limited opportunities for communication about sex with peers and sexual partners undermined the ease with which programme participants could transfer the lessons they had learned into their daily social and sexual lives. So did limited opportunities for communication with adults about sex, and parental denial of youth sexuality and of the dangers of the HIV/AIDS epidemic. Young people are less likely to take sexual risks when

they grow up amongst adults who feel comfortable talking about sex and relationships (Aggleton and Campbell, 2000). Adults generally offered poor role models of sexual relationships, with young people often having had little first hand contact with adults who related to their sexual partners in an egalitarian or co-operative way. Finally young peoples' lives were blighted by macro-social environments characterised by poverty, lack of educational opportunities and unemployment. These undermined their confidence and their sense of personal agency to take control of their lives in general, or their sexual health in particular.

The authors conclude that many of these problems cannot be addressed by schools-based programmes in a vacuum. Providing young people with HIV-related information and behavioural skills is not enough. Programmes also need to work towards creating social and community contexts that enable and support young people to act on this information and to put these behavioural skills into practice. Two forms of community mobilisation are increasingly seen as key strategies for creating health-enabling community contexts. The first is grassroots participation of target audience members in the design and implementation of programmes. However this is not enough. Often, those most vulnerable to HIV infection are also those with the least access to the political influence and material resources that may be necessary for them to achieve programme goals. Against this background, grassroots participation needs to be backed up with a second community mobilisation strategy, viz: the creation of 'partnerships' or 'alliances' between peer education networks and more powerful groupings, locally, nationally and internationally (Gillies, 1998). In the original project proposal, the Summertown HIV-prevention programme sought to address these problems through creating partnerships between peer educational groups and more powerful groupings from civil society and the public and private sectors. The peer education programme discussed above was to have been integrally linked to a wider multi-stakeholder HIV-prevention programme in Summertown that would draw peer educator representatives into such local partnerships. However, in practice, as discussed below, a variety of reasons hindered the effectiveness of the partnerships between Summertown stakeholders, with low levels of school peer educator participation in the stakeholder process being one of the project's disappointments.

Small-scale community projects are most likely to succeed if they are located within the context of supportive local and national government policies (Evans, 1996; Woolcock, 1998). As discussed below, the South African government has done important groundwork in laying down health, educational and social development policies that, if fully implemented, would provide invaluable support for schools-based peer education efforts (Harrison *et al.*, 2000). However, as was the case in Summertown, many obstacles stand in the way of the practical implementation of potentially excellent policies in the South African schools context.

It is against this background the Summertown experience suggests there is an urgent need for research which furthers our understandings of: (i) contextual influences on the success or failure of participatory peer educational programmes in schools; (ii) the types of partnerships needed to facilitate contexts that are supportive of schools-based peer education; (iii) factors which promote or hinder the development of such partnerships; and (iv) factors which promote or hinder the practical implementation of sound government policies in applied contexts within schools.

2. Empirical research on contextual influences on peer education

To what extent are these issues already addressed in the academic literature on youth peer education? A literature search used various combinations of the words ‘peer education’, ‘HIV/AIDS’, ‘partnerships’, ‘advocacy’ and ‘youth or young people’ drawing on (i) PubMed/ MEDLINE; (ii) the International Bibliography of the Social Sciences; and (iii) the abstracts from the 2002 international AIDS conference in Barcelona. Attention was confined to studies in sub-Saharan Africa, particularly South Africa. Numerous articles focused on contextual influences on programme success or failure. However, whilst reference was frequently made to the need to establish partnerships as a strategy for supporting schools-based programmes, this was usually made in passing. There was virtually no account of the types of partnerships that would be most appropriate, or of factors that would facilitate or hinder their development. Furthermore, whilst the importance of supportive school or government policy was alluded to in passing, not one paper focused explicitly on the role of policy in supporting peer education, or on obstacles to policy implementation within schools.

Below we categorise articles dealing with factors influencing programme success or failure to provide a flavour of the issues currently being researched.

Design of peer education programmes

Neglect of gender in youth HIV-prevention material

Several articles emphasised that youth-focused peer education materials were unlikely to have any impact because they did not specifically deal with gender. In a six-country study Mannathoko (2002) referred to the ‘wall of silence’ about the role of gender and sexuality in fuelling the epidemic, impeding meaningful discussion about HIV between parents and children, teachers and students, and boyfriends and girlfriends. Morrell, *et al.* (2001) in South Africa, and Schatz and Dzvimbo (2001) in Zimbabwe show how failure to take account of the irreducibly gendered nature of sexuality and sexual health undermine the likelihood that prevention messages will resonate with learners’ personal experiences of sex.

Lack of knowledge about factors affecting the effectiveness of peer education

There is a pressing need for documenting and sharing the positive and negative experiences of youth peer education programmes (James, 2002; Renkin and Pedro, 2002), with many arguing that lack of understanding of the reasons for programme successes and failures means that programmes often repeat the same mistakes. In a study throughout South Africa, Hlongwa (2002) highlight unresolved issues which hinder programme planners and designers: the benefits of unpaid volunteers or paid peer educators; in-school versus out-of-school peer educators; and factors affecting programme sustainability.

Management of schools programmes

Adult control of programmes

From Botswana, Leathlana, *et al.*, (2002) argue that the reason for the ineffectiveness of many youth-based programmes is that adults run them. Youth leadership is vital to facilitate young peoples’ sense of working towards a common goal. Young people are often more likely to understand and trust one another than adults, and are united by common cultural interests (e.g. music) which can be harnessed for peer educational goals (with the proviso that a degree of adult involvement is necessary for programme sustainability.)

Teacher training and confidence

Johnson, Vergnani and Chopra (2002) point to the importance of regular in-service training for South African teachers responsible for promoting HIV education, and the development of teachers' confidence to discuss sex with learners. A significant proportion of teachers who had received intensive HIV-education training continued to harbour myths (e.g. that only someone with full-blown AIDS could spread HIV). Many trained teachers continued to lack confidence about discussing AIDS and condoms with learners. Another South African study highlights poor teacher awareness of the Department of Education's HIV-prevention policies (Ayo-Yusuf, Naidoo and Chikte, 2001).

The role of institutional leadership in overcoming stigma and denial

Chetty (2002) traces how institutional denial and the stigmatisation of HIV/AIDS have hampered institutional responses in the educational field. He emphasises the role of strong leadership in changing the institutional climate in a way that promotes appropriate HIV-prevention.

The quality of the within-school environment

Johnson, Vergnani and Chopra (2002) point to the importance of active programme support and participation by school principals, the existence of a sound schools-based HIV/AIDS policy, and the availability and proper translation of appropriate programme materials. Moletsane, *et al.* (2002) compare how school cultures impact on the likelihood of peer educational success in two South African township schools with different organisational styles. The first school has a more democratic, undisciplined and youth participatory ethos (the 'social capital model'). The second is more concerned with rigid structure and efficient management (the 'school effectiveness model'). Whilst the social capital school was better able to disseminate HIV-prevention lessons about gender inequalities in ways that students could understand, the better-managed school provided the strongest long-term likelihood of institutionalising HIV-prevention programmes in sustainable ways.

Integration of peer education with other community strengthening efforts

A South African study focuses on the importance of integrating HIV-prevention efforts with programmes seeking to empower young people through life skills and self-esteem promotion, vocational training, art and music therapy and individual and community development through sport (Renkin and Pedro, 2002). In a study of higher educational institutions' responses to the epidemic, Chetty (2002) regrets that responses have too often been limited to the level of awareness raising. He points to the need for institutions to develop more integrated responses, combining awareness with community based care, workplace programmes and voluntary counselling and testing.

A Zambian study draws attention to the complex array of multi-level factors impacting on high risk sexual behaviours by young people (Magnani, *et al.*, 2002). Authors highlight the complex interaction of gender, peer influence and socio-demographic factors impacting on HIV transmission - making it unlikely that single interventions will change risk behaviour. In another Zambian study, Motsepe, *et al.* (2002) point out that young people are increasingly caring for people living with AIDS, and that their support and training should be part and parcel of integrated programmes in the HIV/AIDS field.

The need to involve People Living with AIDS in prevention efforts

Whilst stigmatisation and denial have historically made people reluctant to publicly disclose their HIV-positive status, and led others to treat them in an unsupportive and intolerant way, this situation is starting to shift slightly as HIV-positive people organise in a more assertive way, and the sheer extent of the epidemic makes it increasingly difficult to deny. A South African study argues for the vital importance of involving people with AIDS in the training of peer educators and in programme implementation (Nyawo and Xaba, 2002). Such involvement plays a key role in dispelling myths and stigma around HIV/AIDS, and also in motivating peer educators. Another South African study (Makhasi, 2002) reports on the need for the training and support of HIV-positive youth ambassadors to encourage: 'positive living' as a preventative tool, sexual behaviour change amongst peers, and lobbying around issues affecting youth living with AIDS. The success of such programmes is argued to depend heavily on the extent to which they are supported by government, private sector and donor agencies.

Wider contextual factors impacting on peer educational success

Environmental obstacles to HIV-prevention success

Several papers highlight how external factors limit programmes. In rural Tanzanian schools peer education efforts were hindered by economic pressures on pupils to engage in risky sex, the difficulties of organising regular peer education clubs and adult-free environments within schools, and low levels of literacy amongst youth peer educators. (Makokha, *et al.*, 2002) A study in several African countries focused on the role played by NGOs in promoting youth peer education (Kelly, *et al.*, 2002). The under-funding of NGO-linked peer education programmes was identified as a key barrier to success. Programmes lucky enough to receive some funding still battled in the face of unstable budgets, which limited sustainability, as did over-reliance on non-paid volunteers.

Partnerships and multi-sectoral responses

Whilst youth peer education researchers often refer to the importance of partnerships and multi-sectoral approaches, such references are made in passing with little discussion of the types of partnerships and multi-sectoral responses that are needed. However, some limited discussion of such factors does take place in papers about workplace peer education programmes aimed at adults. There is an urgent need for activists and researchers to start documenting information about the types of partnerships that are needed to supplement schools-based peer educational programmes. The adult-targeted peer educational literature provides a starting point for this challenge.

In their study of HIV prevention in a South African gold mining community, Ndhlovu *et al.* (2002) highlight the need for programmes to develop models of multi-sectoral programme support to ensure effective implementation and programme sustainability. Efforts may be hampered by inadequate attention to capacity building around financial and project management, or to the transfer of management power from programme researchers and funders to local NGO's. Esu-Williams *et al.* (2002) focus on how stigma and discrimination hinders electricity workers from accessing workplace HIV/AIDS services. Workers would be more likely to access these services if they were offered by NGOs. Yet NGOs often lack capacity in the areas of counselling, medical support and voluntary counselling and testing.

They argue for partnerships between workplaces and NGOs – with workplaces helping NGOs to develop capacity, and NGOs assisting workplaces by providing neutral and trusted services. Lovelace, *et al.* (2002) point to trade unions as the most appropriate partners with the private sector for ensuring that workers access services.

Need for development of youth advocacy

Articles on peer education generally focus narrowly on the goals of HIV-prevention and AIDS care, with little focus on the potential of peer education to serve as springboard for wider efforts to encourage youth advocacy to lobby government, corporate structures and international actors about broader issues relating to youth empowerment (a key component of peer education success). One notable exception here is a paper by Moodley (2002) who calls for the development of youth-specific advocacy frameworks for linking young people with powerful social actors and agencies beyond the boundaries of their local communities. Drawing on the experience of a number of African countries, he highlights the potential for mobilising famous African artists and musicians to play a role in the development and support of youth advocates.

Another exception was Schatz and Dzvimbo's (2001) Zimbabwean research, arguing not only for greater adolescent involvement in programme design, but also for the importance of locating HIV-prevention efforts within broader efforts to empower young people to make more positive lifestyle decisions in other spheres of life. Such programmes are most likely to succeed if they provide adolescents with channels to contribute to wider debates about public policy reform and gender inequality, and to participate in multi-dimensional partnerships aiming for wider social change.

This concludes our thumbnail overview of current academic debates about contextual influences on youth HIV-prevention programmes. Whilst various studies point to contextual factors which impact on programme success, they do this in a fragmentary way. There is an urgent need to pull together this range of insights into more comprehensive conceptual frameworks. These would serve as conceptual tools for the design and evaluation of youth peer education. They would also provide guiding frameworks for much-needed research into the types of community mobilisation – including partnerships and participation - most needed

to facilitate youth programmes, and into factors that facilitate or hinder the development of such partnerships and participation.

3. Youth-oriented HIV prevention policies, campaigns and interventions

Moving from research to policy and intervention, successful HIV prevention cannot be conducted in a vacuum. Efforts will be greatly enhanced if conducted within the contexts of government policies that are supportive of peer educational goals. The role of youth participation and community mobilisation is widely recognised in the formulation of policies and the design of interventions. However, there is seldom adequate recognition of the challenges facing community mobilisation efforts, or of the types of local community relationships and alliances best suited to support youth HIV-prevention goals. Much work remains to be done in formulating concrete guidelines for translating policy and intervention rhetoric into practice.

Policies

Current national efforts to promote HIV-prevention amongst young people fall, in part, within the context of the National Integrated Plan (NIP), an inter-sectoral national government plan for responding to HIV/AIDS. This plan pulls together the health, education and welfare sectors, although in practice the health department plays the largest role (Hickey, 2001). Three programmes advocated by the plan include: schools life skills programmes and voluntary counselling and testing programmes in public health facilities; and a community and home based care and support programme to be implemented at provincial level in selected sites. Life skills training is the entry point for efforts to prevent HIV-transmission amongst learners.

There are also individual efforts within the departments of education, health and social development. Within the *Department of Education*, for example, there is growing alarm about the impact that the HIV/AIDS epidemic will have on the educational sector. Uneca (2000) highlights 5 potential impacts: declining student enrolments, increased teacher mortality and attrition, greater productivity losses, declining funds for education (through the diversion of funds to Aids-related issues) and a reduction in the quality of education.

Two major policy initiatives have guided education department attempts to introduce HIV/AIDS education as a priority area for young people. These include Curriculum 2005, seeking to shift schools from the traditional didactic methods towards more youth-centred, participatory approaches to learning, within frameworks encouraging broad life competencies, and the Life Skills and HIV/AIDS Education Programme. The Department of Education set up a central group of life skills trainers throughout the country to develop a core curriculum for teacher training and classroom use. However, the impact of this initiative was limited, partly because its success was undermined by an overly prescriptive approach to dealing with HIV, and because insufficient attention was paid to the programme by most school principals (Dickson-Tetteh and Ladha, 2000).

In 2000, the new National Minister of Education, Kader Asmal, identified HIV/AIDS as a priority issue, arguing that the education system is experiencing its worse crisis ever through HIV/AIDS. He plans to create the post of director of HIV/AIDS within the education department and has called for more peer education programmes in schools (Asmal, 2002). Acknowledging that 'quick fix' solutions are inadequate, emphasis is being laid on the need for contextual interventions including initiatives to promote gender equity in schools, to promote conflict resolution, develop self-esteem, build a democratic school culture and secure schools against violence. Whilst applauding these policy prescriptions in principle, doubts have been expressed as to whether schools are equipped to deal with such complex solutions, given their difficulties in implementing the relatively simpler life skills approaches (Morrell, *et al.*, 2001). Poorly resourced schools may lack even pens and paper, let alone books and manuals to support teachers in curriculum implementation (Review Committee of Curriculum 2005, 2000).

Within the *Department of Health*, youth HIV prevention falls under the sub-directorate of Youth and Adolescent Health (within the Maternal, Child and Women's Health directorate). This group has, for example, set up a task team to formulate Policy Guidelines for Young Peoples' Health, emphasising the influence of the social environment on their behaviour, particularly the potentially negative impact of gender relations. Against this background, the Dept. Health has emphasised the importance of

providing a safe and supportive environment for young people, providing them with information about health risks, building health-related skills, offering counselling, and ensuring access to health services (Dickson-Tetteh and Ladha, 2000). One example of an initiative by the *Department of Social Development* is the 'National Strategic Framework for Children infected and affected by HIV/AIDS', which focuses on the effects of AIDS on children.

Media campaigns

Various government departments have been involved in facilitating various HIV-related media campaigns aimed at young people, including the Beyond Awareness Campaign, Soul City and LoveLife. Much money and energy have gone into developing and implementing these. Whilst campaign evaluations claim success in promoting behaviour change, controversy exists surrounding the validity and reliability of the methods used by evaluation researchers and of the effectiveness of the media as a behaviour change agent (Leclerc-Madlala, 2002). Whilst media campaigns undoubtedly have a role to play in increasing factual knowledge of health risks, the gap between knowledge and behaviour change is often wide. This is why so much emphasis is being placed on promoting youth participation in HIV-prevention campaigns, in the light of the insight that behaviour change is most likely to take place in collective peer contexts, and on the basis of active youth participation in health promotional efforts. To cite only one example, consistent with this growing emphasis on participation, in partnership with local and overseas funding agencies, the Department of Social Development is currently one of the major funders of a new component of the LoveLife programme, aimed at building a national youth service core of youth health education volunteers.

Interventions

There is a proliferation of large and small-scale HIV-prevention interventions aimed at young people in KwaZulu-Natal (KZN), our particular province of interest. These use various entry points, including life skills training in schools, drama, sports, gender and women's projects, church activities, leadership and advocacy drives, and reproductive health promotion efforts. These draw on various civil society, government and private sector players in partnerships and stand-alone programmes. Here we cite some examples of this work.

DramAide is an NGO which seeks to personalise the risk of HIV/AIDS through promoting youth participation in dance, poetry and drama. DramAide projects include 'Act-alive', which develops secondary school youth clubs and seeks to establish 'health promoting schools' as 'drivers' for developing local communities that are caring and supportive of people living with AIDS. 'Circle-time' focuses on life skills development amongst primary school children. 'Pro-teach' works with tertiary, secondary and primary school teachers, covering in-service life skill courses for teachers and pre-service courses education colleges.

An increasingly popular strategy is developing youth role models and leadership. Effective AIDS care is increasingly being emphasised as an important tool of HIV prevention. Seeing people with AIDS involved in life-enhancing and fulfilling activities, and being treated humanely, helps young people to confront their own denial and fears of infection, and seek out prevention information. One such project is run by the National Youth Commission, and is known as the Young Positive Living Ambassadors project, first piloted in KZN. Its main objective is to promote acceptance and care of young people living with HIV and AIDS, and to prevent further spread of HIV, through the notion of 'positive living'. The project has a rights-based approach and is underpinned by the belief that young people must own and drive programmes that are designed to meet their needs.

The YMCA has developed a well-respected peer education programme known as 'Better Life Options' (BLO), with good links to the Department of Health, locally, provincially and nationally. BLO seeks to change the behaviour of young people (in and out of school), building a healthy youth culture and providing family life education. It is underpinned by a peer education approach in schools, youth clubs and churches. The programme is youth-driven, including young local and regional co-ordinators. Despite significant successes, interviews with BLO staff also highlight the challenges that face them in their work. One of these is working with local churches, for example. Many young people have felt that programme goals are inconsistent with conservative patriarchal church structures, which deliver prescriptive messages that may be at variance with young peoples' everyday life contexts and relationships. Parental involvement has also been complicated. Many parents feel they are not good role models for the types of behaviours needed for enhanced sexual health, and are sometimes happy to leave this aspect of their children's education to others.

4. What types of relationships should community mobilisation strategies be seeking to promote?

The policies and interventions outlined above are consistent with Beeker et al.'s (1998) claim that the field of HIV-prevention has undergone a 'paradigm drift' away from its initial focus on individual behavioural factors, to include attention to the importance of strengthening communities to respond appropriately to the epidemic. In relation to youth, this 'drift' has been motivated by three insights. The first is the importance of promoting grassroots youth participation in HIV-prevention efforts. The second is the importance of linking HIV prevention efforts with other life skills or youth interest programmes. The third is the key role of 'partnership working' in programme funding, design and implementation. The problem of HIV/AIDS is too complex to be addressed by any single constituency, and particularly by constituencies such as youth, who traditionally have minimal access to political influence and economic power. The most effective response is one that is spearheaded by partnerships both within grassroots communities, and among grassroots collectivities and appropriate government agencies, civil society groupings – and where possible, appropriate private sector and donor agencies at the local, national and international levels.

However, the academic world of HIV-prevention has lagged behind the world of policy and practice in recognising and theorising the vital role of the community strengthening strategies of participation and partnerships. Whilst the research reviewed above repeatedly points to the way in which various aspects of school, community and social contexts have the power to undermine HIV-prevention efforts, and pays lip service to the importance of participation and partnerships, these studies tend to be fragmentary and descriptive, and conducted out of the context of comprehensive conceptual frameworks which provide a systematic account of the types of social relationships most likely to facilitate the success of prevention efforts. Furthermore, a large international development studies research literature points to the immense difficulties of promoting and sustaining community strengthening participation and partnerships. Much work remains to be done in exploring the gap between the rhetoric and

reality of community mobilisation, and in promoting understandings of those factors that promote or hinder its success.

A recent study of a multi-sectoral partnership created to manage a large and well-resourced HIV-prevention programme in a South African mining community highlighted a myriad of factors which undermined (i) the development of partnerships within marginalized communities, as well as (ii) collaboration among grassroots communities and partners drawn from provincial and national government, trade unions, mining houses, researchers and international development agencies (Campbell, forthcoming). Marginalized communities were often divided in ways that undermined the likelihood of effective and united participation in projects to achieve goals of mutual benefit (such as reduced HIV-transmission). The effectiveness of multi-stakeholder partnerships was undermined by lack of common understandings of the problem of HIV/AIDS and how to solve it; lack of health systems expertise to synthesise the talents and contributions of such a diverse range of constituencies; the dominance of a biomedical model of disease control over more social perspectives which meant that powerful biomedical actors often didn't have adequate understanding of the rationale for partnerships; varying levels of commitment and motivation by different groups of players; and inadequate incentives/ systems of accountability to motivate more powerful groupings to participate in assisting less powerful ones.

If participation and partnerships are indeed to play such a key role as strategies for supporting HIV-prevention efforts, there is an urgent need for systematic research into the types of relationships and alliances best suited to performing this role, as well as the identification of factors most likely to promote or hinder their success. The concept of 'social capital' is increasingly being cited in debates about what constitutes a health-enabling community context, most likely to provide an environment that supports peer education efforts, and provides a useful starting point for this task (Blaxter, 2000). According to the social capital perspective, people are most likely to adopt health-enhancing behaviours (such as safer sex) in communities characterised by high levels of trust, reciprocal help and support, positive local identities and participation in informal and formal social networks and organisations (Baum, 1998). Kreuter (1997, p. 3) define social capital as 'those specific processes among people and organisations, working collaboratively and in an atmosphere of trust, that lead to the accomplishment of goals of mutual social benefit'. Social capital researchers are

concerned to examine the role of informal and formal social *networks*; and *norms* of co-operation in promoting local community development. They examine the way in which these norms and networks operate both *within* a local community, and in its relationship to *outside* networks and institutions.

Applying the social capital framework to the HIV/AIDS field, our starting assumption would be the belief that even within constraints of poverty, stigma and gender inequalities, young people in the marginalised communities that are most susceptible to HIV infection *are* able to participate in effective collective action improve their circumstances. However the extent to which this participation is effective depends heavily on the quality of the partnerships or alliances that youth are able to form with groupings that have greater access to material resources and political influence. The unequal distribution of social capital is one of the key mechanisms whereby poverty and ill-health are perpetuated, and whereby poor people are hindered from improving their life circumstances (Bourdieu, 1986). Building social capital thus becomes a key challenge for those seeking to work with poor people to improve the life circumstances that place them at particular risk of HIV/AIDS.

Saegert, Thompson and Warren (2001) distinguish between three forms of social capital - which are relevant to the types of relationships most likely to facilitate effective youth-led HIV prevention. **This framework provides a starting point for systematising the types of relationships community mobilisation strategies, such as participation and partnerships, should be seeking to build.** The first of these is *bonding* social capital, which refers to relationships of trust, reciprocity and positive common identity within homogenous groups. This is the kind of social capital that would result from the development of close-knit groups of young people involved in particular HIV-prevention programmes within particular local communities. Such networks would provide young people with contexts for engaging in collective debate and argument about the possibility of behaviour change, as well as facilitating the processes of empowerment and critical consciousness outlined above. However, given that many young peoples' inability to change their behaviour may also relate to their lack of access to various political and material resources, a wider series of linkages and relationships is needed to support them in achieving their goals. These are the linkages inherent in bridging and linking social capital.

Bridging social capital refers to four different sorts of relationships. The first is bridging relationships across different groups within particular geographical communities. An example of this might include relationships between a youth peer education group on the one hand, and e.g. local women's, church or sports groups with an interest in HIV-prevention on the other hand. The second refers to relationships between groups in different low income communities. These might include the development of networks of solidarity between groups of youth peer educators from different geographical communities. The third refers to links between poor and more affluent communities. These might include links between local youth peer education networks and youth or women's or church groups from more affluent areas. The fourth refers to networks that link the three kinds of networks referred to above at a national level.

Linking social capital refers to linkages between local community residents and representatives of mainstream economic and political institutions. Researchers have coined the term 'synergy' to characterise a situation where grassroots community groupings, economic actors and state institutions work together for positive developmental outcomes (Woolcock, 1998). In relation to economic actors, alliances between community groupings, and local businesses or employers may play a role in the development of income generation schemes for youth out of school, for example. The latter may also contribute funding or access to space for youth meetings or drop-in centres, to cite another example. Evans (1996) argues that community development projects are said to have the greatest chance of success in conditions of 'state-society synergy', other words where government policies and practices are supportive of the goals of the local project. Ideally, linking social capital joining up marginalised communities and local or national government networks has the capacity to ensure that government actors are aware of the specific needs and interests of young people, who may not traditionally have had access to formal channels for feeding this information to them.

What are the areas in which young people need support and assistance in furthering the HIV-prevention struggle? What are the challenges facing participants in the different types of alliances or partnerships we have discussed above? In the short-term, youth clearly need assistance with the immediate challenges of implementing participatory sexual health promotion programmes and distributing condoms. However, at the pragmatic level, their

ability to provide effective peer education is influenced by the community and social contexts within which they are located. Thus, we would argue the second challenge facing such alliances is that of assisting young people in small local communities in lobbying for the recognition of their wider needs and interests beyond the health sphere – both locally, nationally and internationally. Following from this, the third challenge is that of developing local community health networks which not only support young people in their efforts to promote sexual health, but also have the potential to strengthen communities to cope with the challenge of providing appropriate support and tolerance for youth already living with HIV/AIDS, as well as the challenge of reconstructing the social fabric of HIV-afflicted communities once the epidemic has run its course. Much work remains to be done in (i) examining which forms of social capital have the potential to assist local communities in meeting each of these challenges, (ii) conducting systematic research into the evolution, nature and effectiveness of different participation and partnership strategies; and (iii) developing understandings of the factors which promote or hinder the success of the different types of alliance/ linkages underlying each type of social capital.

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