WhizzKids United brings football to life:

A theoretical framework for youth HIV prevention in South Africa and throughout sub-Saharan Africa

Abstract

HIV/AIDS is the number one health challenge worldwide, with sub-Saharan Africa being the hardest-hit region and the nation of South Africa being a particular flashpoint. Youth form a sizable segment of the population and as their bodies reach sexual maturity they are especially vulnerable to HIV infection. In this survey of current research we estimate the scope of HIV/AIDS in the region of sub-Saharan Africa and the nation of South Africa and outline the immediate and underlying causes of the epidemic. We highlight prevention via behaviour change as the key to defeating HIV/AIDS, and discuss the necessary ingredients for a youth intervention to achieve behavioural change. Finally, we introduce WhizzKids United as a theoretically sound approach to sustainable behavioural change amongst youth. In an appendix we point out how WhizzKids United is closely aligned with government policy in South Africa and Uganda, two of the countries where the programme runs.

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1. The Problem

The underlying problem to be addressed is the high prevalence of HIV/AIDS amongst youth in South Africa and other sub-Saharan African countries, with all of the negative consequences that the virus brings to individuals, communities and society as a whole.

While it is recognised that the HIV/AIDS epidemic affects people of all ages, we have chosen to narrow our immediate focus to youth, as young people are particularly susceptible to HIV infection:

> "Young adults, particularly females, are at greatest risk of acquiring HIV."[1]

There are a number of reasons for this:

> "Behavioural, physiological and sociocultural factors make young people more vulnerable than adults to HIV infection. Adolescence is a time when young people naturally explore and take risks in many aspects of their lives, including sexual relationships."[2]

1.1. Estimating the scope of the problem

1.1.1. Youth HIV prevalence statistics

South Africa

The Reproductive Health Research Unit's (RHRU) 2004 study, *HIV and Sexual Behaviour among young South Africans*, confirmed that "the high HIV prevalence among young people in South Africa and, in particular, young women's disproportionate risk."[3] The study found that 10.2% of South Africans aged 15-24 are HIV-positive: 15.5% among females and 4.8% among males. Provincially, the provinces with the highest youth HIV prevalence rates were KZN (14.1%), Eastern Cape (12.8%) and Mpumalanga (11.7%).

The Alan Guttmacher Institute's 2004 study, *Risk and Protection: Youth and HIV in sub-Saharan Africa,* came up with considerably higher estimates for South African HIV prevalence in the 15-24 age group: 20.5-30.8% of females and 8.5-12.8% of males[4]; while WHO & UNAIDS came up with lower estimates: 12.7% of females and 4.0% of males.[5]

More recently, the South African National HIV Survey of 2008 found a youth HIV prevalence of 8.7%, down from 10.3% in 2005.

Whichever of these three estimates is most accurate, it is clear that HIV/AIDS is a monumental health problem among the youth of South Africa.

Additionally, the RHRU study found that youth living in urban informal areas had the highest HIV prevalence at 17.4%, followed by those living in rural formal areas (farms) at 13.5%, then urban formal areas at 9.8% and lastly those in rural informal areas at 8.7%.[6]

Among young pregnant women attending antenatal clinics, the RHRU study estimated the nationwide HIV prevalence rates at 12.9% for the 15-19 age group and 28.1% for the 20-24 age group.

Other countries in sub-Saharan Africa

Worldwide, over 80% of those currently living with AIDS are aged 15 to 24; of whom three quarters are in sub-Saharan Africa.[7] Furthermore, half of the 3.0-3.4 million new cases of HIV infection in sub-Saharan Africa in 2003 occurred among the 15-24 age group.[8]

1.1.2. HIV/AIDS impact statistics

The harshest consequence of the HIV/AIDS epidemic is mortality. In 2007 alone, there were an estimated 350 000 AIDS-related deaths in South Africa.[9]

However, the consequences are far broader than the death of infected persons. Economic costs of AIDS include direct costs (such as medical care, drugs, funeral expenses and care of orphans), as well as indirect costs (such as the loss of labour supply and the costs of recruiting and training replacement workers). Additionally there is the destruction of human capital (peoples' accumulated life experiences, human and job skills, knowledge and insights) and the weakening of the mechanisms that generate human capital – such as the family structure.[10]

Sub-Saharan Africa is characterised by a high total fertility rate (TFR). In some countries in the region, the average woman gives birth to more than five children in her lifetime. Even in South Africa, with the largest economy in the sub-region, 72% of 23 year-old women reported having been pregnant before. This means that HIV infection amongst youth affects the next generation almost immediately (this is especially clear when the strong positive relationship between pregnancy and HIV infection is noted).

It is difficult to put a number to the economic impact of HIV/AIDS, but, for instance, the World Bank estimates that in the thirteen African countries with HIV/AIDS infection rates of 8 percent or more, the pandemic has cut 1 percent from gross domestic product.[11]

1.1.3. Youth sexual behaviour statistics

Sexual exposure

In the RHRU study of South African youth, 48% of 15-19 year olds reported ever having vaginal or anal sex, compared with 89% of 20-24 year olds; overall 67% of 15-24 year olds, with no significant difference by gender. 8% of youth reported having their sexual debut before age 14.

In 12 countries in sub-Saharan Africa, more than 70% of men have intercourse before age 20; in 9 countries, at least 50% of women have intercourse before 20.[12]

Number of sexual partners

Among sexually experienced youth in the RHRU study in South Africa, 75% of males and 55% of females reported having had more than one sexual partner in their lifetime.[13] Among those who reported having had sexual intercourse in the past 12 months, 44%

of males and 12% of females reported having had more than one sexual partner during those 12 months.

Condom use

In the RHRU study of South African youth, 57% of sexually experienced males and 48% of sexually experienced females reported using a condom the last time they had sexual intercourse. 31% of those who reported having had sex in the past 12 months reported never using a condom, while only 33% reported always using a condom.

As to sub-Saharan Africa as a whole, "In the majority of countries, 10-35% of sexually experienced adolescent women have ever used a condom."[14] UNAIDS estimates only 19% condom coverage in sub-Saharan Africa overall in 2004...In the context of a highly generalized epidemic such as exists in southern Africa...condom promotion has had very limited success."[15]

1.2. Outlining the causes

1.2.1. Immediate causes

Unprotected sexual intercourse

"Unprotected sex is directly related to sexually transmitted diseases including HIV, early pregnancy and childbearing, unsafe abortions, single parents and so on. As such, unprotected sex jeopardises not only people's physical and emotional health, but also their economic and social well-being."[16]

Unprotected heterosexual intercourse is by far the most common mode of HIV transmission in sub-Saharan Africa. This risk behaviour is exacerbated by other biological factors such as "low rates of male circumcision...[and] high levels of viral STIs."[17]

Early sexual debut

"Sexual debut remains a crucial factor in vulnerability of youth to HIV infection."[18]

Age-disparate sex

"There is increasing evidence of sex between young girls and older men...There is therefore a need to discourage young girls from having sex with men who are five or more years older, as this puts the young girls at even higher risk of HIV infection."[19]

Multiple concurrent partnerships

"A particular socio-cultural factor...was the primary driving force behind our exceedingly high rates of HIV/AIDS in the sub-region [of southern Africa]...Because of the high risk of HIV transmission during the initial acute stage of infection, concurrent multiple partnerships act to disseminate the infection through complex and inclusive sexual networks... It is this common

pattern of concurrent multiple partnerships in the sub-region that has propelled, and continues to propel HIV throughout our urban areas and into our rural hinterlands."[20]

"The densely clustered sexual networks that result from partner overlap pose a high risk for HIV transmission."[21]

1.2.2. Underlying causes

Lack of perceived risk

In the RHRU study of South African youth, 71% stated they were at either no risk or a small risk of HIV infection; only 14% stated they were at a high risk. There was no increase in perceived risk of HIV as risk behaviours increase; and among youth who tested positive for HIV, 62% stated that they thought they had no chance or a small chance of contracting HIV![22]

Socioeconomic context

Gender inequality and violence

"It [has] been generally recognized for years that gender inequalities underlie and drive the HIV/AIDS epidemic in sub-Saharan Africa."[23]

"Females are more vulnerable to HIV and it has been established that the lower status and disempowerment of women contribute to their higher infection rates. Younger women, especially teenage girls, are especially vulnerable to HIV infection, due to the immaturity of their reproductive systems as well as likelier exposure to sexual coercion, the potential to overcome immediate needs through 'survival sex', the potential to utilise sex to provide access to consumer items through 'transactional sex', and the relationship between sex and violence, which includes vulnerability to rape."[24]

"Parental communication with boys is significantly lower than with girls on sex, sexual abuse and HIV/AIDS. Thus, specific interventions must focus on parental communication on these issues with boys...younger children need to be better informed."[25]

"It is estimated that about 30% of the population in the sub-region has experienced forced sex before the age of 18."[26]

Norms of sexual behaviour

"Young peoples' sexual encounters were negotiated within a context where dominant social norms of masculinity portrayed young men as conquering heroes and macho risk-takers in the sexual arena, and where the social construction of femininity predisposed women to use the responses of passivity or fruitless resistance in the face of male advances...Within such a context, sex often took place under conditions of at best, emotional pressure, and at worst, physical coercion of young women."[27]

Driving factors of HIV (multiple concurrent partnerships) are sustained by "entrenched norms that uphold male privilege and allow for unfaithfulness in relationships (most especially for men), gender-based violence, intergenerational and transactional sex, along with stigma and non-openness about sexuality and the epidemic."[28]

Poverty

Most countries in sub-Saharan Africa are predominantly rural; they are poor and have little education; they face cultural and social conditions that increase their risk of HIV.[29]

"Both the primary and secondary drivers [of the epidemic] are further supported by...wealth differentials, high mobility and migrancy, and high levels of poverty and sexual violence."[30]

Stigma

The presence of stigma discourages HIV testing, and open communication about HIV status between sexual partners. Thus it forms part of the social context which allows the infection to spread:

> "Three interacting dimensions of context undermine the likelihood of effective HIV-prevention. Symbolic context includes stigma, the pathologisation of youth sexuality (especially that of girls) and negative images of young people. Organisation/network context includes patchy networking amongst NGOs, health, welfare and education representatives and local community leaders and groups...These challenges are exacerbated in a material-political context of poverty, unemployment and crime, coupled with the exclusion of young people from local and national decision-making and politics."[31]

Poor education

> "In many ways local community conditions...in South Africa...provide scant opportunities for young people to develop a sense of critical confidence in their ability to shape their lives, or by implication, to take control of their sexual health...[Despite progressive government policies, pupils in many schools] are subject to rigidly authoritarian school rules, and didactic teaching methods, which militate against any kind of autonomy or critical thinking by pupils."[32]

Lack of life skills

> "Some socio-economic factors tend to lead adolescents to engage in high-risk behaviours...Reasons for [these behaviours include]...idleness; negative peer pressure; lack of recreation; the desire for money or material items; or absence of legal control/enforcement of the law. They are further exacerbated by a number of factors: inadequate information and lack of life skills, lack of education, poverty, unemployment, and a largely hostile and/or non-supportive environment, especially at home."[33]

Cultural factors

"It is important to point out that some aspects of culture inhibit HIV infection rates while others exacerbate the disease. Customs that discourage initiation of sex at an early age and promote abstinence from sex are inhibitory. Cultural factors related to rites of passage to adulthood, marriage and death are related to HIV/AIDS. Religion also plays an important role in promoting marriage and faithfulness between sexual partners."[34]

Lack of adolescent-friendly health services (AFHS)

The lack of youth-specific health and counselling services, and the failure of generalized health and counselling services to meet the needs of youth, are both well-documented in the literature, as the following quotations show:

> "Currently a number of service delivery factors restrain adolescents from using existing services: the high cost of health care; long distances to health units; lack of transport; shortage of drugs; poor access to information; poor staffing at service points; and negative attitudes of health staff towards them."[35]

> "Health clinics may not be open at hours that are convenient for young people, and services are often designed for married women rather than single women or adolescents. In some countries, health workers display judgmental attitudes toward sexually active young clients."[36]

> "Typical findings [of evaluations of health services in South Africa] are that health services are relatively inaccessible to many young people, especially the poor and those living in rural areas; the services are characterised by a lack of confidentiality and privacy; the health personnel are rude, short-tempered, arrogant, and intrusive; and that there are many missed opportunities for intervention regarding sexual and reproductive health when young people attend health facilities for other reasons."[37]

In the RHRU study in South Africa, 25% of young females and 15% of young males had been tested for HIV; yet overall, 60% of youth indicated that they would *like* to be tested for HIV.[38]

A study of adolescent-friendly health services (AFHS) in Uganda found the following shortcomings as reported by the youth themselves:

> "Dissatisfaction among adolescents with health workers' behaviour was mentioned in all the districts [in a study in Uganda], which according to them, negatively portrays the quality of care. Some health workers were reported to be openly rude, often barking at their adolescents clients, who in turn become reticent decline to ask or answer any questions:
>
> "Health workers are rude to us, especially when we have STD's, they discriminate against our age group and chase us away when we have no money." [*Male adolescents, Rukungiri*]
>
> "If she asks and you don't answer, she barks at you instead of asking you in a good way." [*Female adolescents, Mbale*][39]

"Adolescents also say that they do not use family planning services due to lack of confidentiality, and the unprofessional behaviour of some service providers, who often betray their clients by for example, disclosing confidential information about them to other parties:

"FP providers reveal those girls who ask for pills to the community. This leads to failure to get a partner for marriage because it is believed that you will not produce children. [Local leaders/councillors]"

"We fear to approach the nurses as they ask us where we are taking the pills or condoms." [*Male adolescents, Rukungiri*]

2. The Solution

2.1. The Goal: Prevention via behaviour change

The vision of Africaid's WhizzKids United is to create an HIV/AIDS-free generation in Africa.

Africaid agrees with former South African Minister of Health Manto Tshabalala-Msimang that, "In the absence of a cure, prevention has to be the mainstay in the struggle against AIDS."[40] Marseille et al estimate that "HIV prevention in sub-Saharan Africa...is at least 28 times more cost effective than highly active antiretroviral therapy (HAART)."[41] They go on to conclude that "funding HAART at the expense of prevention means greater loss of life. To maximise health benefits, the next major increments of HIV funding in sub-Saharan Africa should be devoted mainly to prevention."

> "The ultimate goal of all interventions was to effect a change in the behaviour of youth in a direction that would decrease their risk of HIV infection. Such change includes communication with others (especially potential sexual partners) about HIV and AIDS, delay in sexual debut, abstinence, reduction in number of partners, and use of condoms."[42]

Said another way:

> "Only the prevention of HIV transmission can significantly slow down the spread of HIV/AIDS. To reduce their risk for HIV infection, both sexually active adults and youth will have to change their sexual behaviour through, for instance, delay of the onset of sexual activity amongst youths, long-term fidelity and a reduction in numbers of sex partners, and uptake of consistent safer sexual practices such as condom use."[43]

"The challenge, then, is to empower teens to delay sexual initiation, while also preparing them with information and skills to prevent HIV transmission when they do become sexually active."[44] This, however, is easier said than done, as the widespread failure of HIV prevention initiatives to date reveals.

2.2. The challenge of effective prevention interventions

HIV prevention interventions amongst youth in South Africa appear to be meeting with success after years of intense effort. The South African National HIV Survey of 2008 estimated that youth HIV incidence (the rate at which individuals in a population become infected) had declined substantially from 2005 to 2008. This decrease was attributed to the

increase in condom use reported by this age group, as well as the large population reached by HIV communication programmes.

However, the impact of prevention programmes has not measured up to the amount of resources invested in them. As Pisani et al state:

> "Every year, the United Nations releases new estimates of the number of people living with HIV infection. Despite 20 years of experience with prevention programmes, this number continues to rise. To date, around 60 million people have been infected with this preventable, fatal viral infection—a sad indictment of the world's prevention efforts so far."[45]

Although South African prevention campaigns have met with success in promoting condom use, other key behavioural determinants of HIV infection remain unchanged or have worsened, such as early sexual debut, age-disparate sex (which increased by 50% from 2005 to 2008)[46], multiple partnerships, and basic knowledge about HIV transmission (which saw a shocking decrease in South Africa from 2005 to 2008).[47]

Moreover, a reduction in incidence, while encouraging, is far from a victory. Because the HIV prevalence is so high in the population, the potential for transmission is massive if prevention education subsides. This is certainly not the time to let down the guard or scale back investment in HIV prevention programmes.

In the next section we would like to examine why some HIV prevention programmes fail, and what we can learn from their mistakes to create a recipe for success.

2.2.1. Lack of theoretical basis

> "Only a minority of the [health interventions in southern and eastern Africa] drew on an explicit theoretical framework in the design and implementation of the programmes."[48]

> "Various reviews...of HIV-prevention programmes have shown that programme effectiveness is largely dependent on the degree to which programmes 1) are based on a careful analysis of the health problem, problem-causing behavioural and environmental factors, and the options for corrective action, and 2) have a formal theoretical ground."[49]

2.2.2. Too much emphasis on knowledge/awareness and attitudes/intentions

The widely used 'knowledge and attitudes' approach to behavioural change programmes is based on the outdated KAP (knowledge-attitudes-practice) behavioural model, which specifies knowledge and attitudes as the two main determinants of behaviour. This model, however, has been largely discredited.

Knowledge is not even a significant behavioural determinant:

> "A number of studies have demonstrated that the association between knowledge about health consequences of a particular behaviour and the behaviour itself is usually low, and often even close to zero...Providing information and increasing knowledge of health consequences of a specific

behaviour will in the short term most likely lead only to marginal if any changes in this behaviour."[50]

This is not to say HIV awareness is an unnecessary component of behavioural change programmes; only that it is insufficient:

"It is well recognized that although knowledge is not sufficient to affect behaviour change, it may be a necessary condition."[51]

This is significant because, as mentioned above, accurate knowledge about HIV transmission appears to have declined drastically in the past few years in South Africa. The percentage of youth who could correctly answer two basic questions about the method of HIV transmission declined from 66.4% in 2005 to 42.1% in 2008.[52]

Attitudes are also central to many prevention initiatives:

"Many theories specify attitudes, beliefs, and/or intentions as proximal determinants of behaviour. As a result, changes in attitude are viewed as an important goal in many AIDS prevention programmes and intentions to engage in low-risk behaviours are often taken as a sufficient indicator of subsequent behaviour."[53]

Attitude change deserves a more central place than knowledge increase in HIV prevention strategy, but should definitely not be the sole focus. Intentions are not, in fact, always indicative of subsequent behaviour. For instance, when the RHRU study asked sexually experienced young females about their first sexual intercourse, 28% reported that they had not wanted sex. A balanced conclusion on attitudes is that drawn by Aaro et al:

"Recent research on the relationship between attitudes and behaviour has revealed that rather substantial correlations between attitudes and behaviour may exist...The attitude concept, therefore, still deserves to be included in theories and conceptual models on health behaviour. In current theory however, attitudes are not the only predictors of health behaviours."[54]

2.2.3. Ineffective mode of communication

It almost goes without saying that boring, non-interactive programmes will be ineffective in inducing behavioural change amongst youth. The following statements from academics bear this out:

"Health education programmes have to be tailored carefully to the target behaviour, behavioural determinants, and target population."[55]

"Public education campaigns should rely on forms of mass communication that are attractive to young people."[56]

When South African youth were surveyed as to how school-based HIV prevention programmes could be improved, one of the top responses was, "Include more imaginative and stimulating teaching methods." [57]

2.2.4. Beginning too late in adolescence

It is well established in the literature that adolescents need to be reached early in order for interventions to be effective:

> "To be most effective, sex education should be offered before adolescents initiate sex, perhaps beginning as early as age 10, and should use developmentally appropriate instructional approaches and information."[58]

> "Programmes targeting younger, primary school children have had greater success in influencing sexual behaviours compared with those targeting older, secondary school children."[59]

One reason for this is that behaviour is much more difficult to change once it is established. A 1999 study "confirmed that attitudes, subjective norms and self-efficacy were all significant predictors of intention to have sexual intercourse within the next three months. **Prior behaviour, however, was the strongest predictor of intention**."[60]

Older adolescents may be easier to work with because of their more advanced thinking and communication skills. However, the above makes it clear that children must be engaged before their sexual debut – i.e. in primary school – if their sexual behaviour is to be influenced.

2.2.5. Focusing on the individual and not the group

Traditional programmes take a 'classroom' approach which deals with adolescents on an individual basis. Peer Education has developed in response to the perception that individuals make behavioural choices within a group dynamic:

One researcher notes that "Traditional didactic health education seeks to change the views and attitudes of single individuals."[61] However, more recently:

> "[There has been] a conceptual shift away from understanding 'sexual behaviour' as the product of individual decisions, in favour of a preference for the concept of 'sexuality' as a socially negotiated phenomenon, strongly influenced by group-based social identities, and more particularly peer identities."[62]

2.2.6. Failure to address social context

> "Programs for youth must continue to promote partner reduction, consistent condom use and prompt treatment for sexually transmitted infections while also addressing contextual factors that make it difficult for them to implement behavior change."[63]

> Among the primary social contextual issues are multiple concurrent partnerships, gender-based coercion and violence, and age-disparate sex. As long as these behaviours remain socially acceptable, progress in increasing knowledge and changing intentions is unlikely to have an appreciable impact on HIV risk behaviour amongst youth.

2.2.7. Failure to establish 'Peer Educator credibility'

Peer education is a widely used approach in youth HIV prevention, and rightly so, as repeated studies have found "utilising youth as peer educators to be effective in health promotion among young people."[64] However, the effectiveness of this strategy is dependent upon the peer educators being perceived as 'credible' by the peers they seek to educate:

> "Peer educators must be deemed credible in the eyes of their peer group on three levels...Firstly, they must be credible in terms of their personal characteristics (which are often shared), such as their age, sex, religion, ethnicity, and other related factors to the target group. In addition, they must be perceived as having experience based credibility (which may be shared) in that they have undertaken study on the issue or had prior experience, for instance sexually or in drug or alcohol usage...Lastly, the audience should be convinced of the credibility of the message in terms of content and delivery being sent by the peer educator."[65]

Bastien et al concluded from a study of school-based peer education that "positive regard for peer educators was more important than perceived similarity, suggesting that credibility may hinge less on shared characteristics than previously thought."[66] Thus, while it is important that adolescents be able to identify with their peer educators, it is also important that they have some reason to look up to them.

The problem may be stated thus: if peer educators are chosen who are too *different* than the peer group, the peer group may discount what they say as *out of touch*. If peer educators are chosen who are too *similar* to the peer group, the peer group will may discount what they say as *lacking special insight*.

2.2.8. Failure to sustain behavioural change

> "Current social psychological theoretical frameworks...distinguish...seven phases [of behaviour change]: 1) attention to the health recommendations, 2) comprehension of the health recommendations, 3) changes in the attitude towards the health recommendations (changes in e.g. knowledge, values, risk perceptions, health concerns, outcome expectations), 4) changes in social influences regarding the health recommendations (e.g. changes in perceived norms and social support), 5) changes in self-efficacy beliefs regarding the enactment of health recommendations, and subsequently 6) change of behaviour, and 7) **maintenance of behaviour change**."[67]

Successfully initiating behavioural change is a great accomplishment, but is of no avail if these behavioural changes are not sustained and supported on a long-term basis. The study quoted above emphasises the need for "better access to condoms both male and female, voluntary counselling and testing, [and] treatment of bacterial STIs," as well as the permanent integration of the programme into the local community.

2.3. The WhizzKids United approach

WhizzKids United is a comprehensive youth HIV prevention programme built upon a solid foundation of behavioural theory and firsthand experience working with South African youth. Additionally, it addresses the underlying causes of the HIV/AIDS epidemic and circumvents the mistakes discussed above.

2.3.1. Demographic appropriateness

Beginning early in adolescence

Section 2.2.4 discussed the need to begin interventions in primary school, at the beginning of adolescence, before the children debut sexually and develop habits of sexual behaviour. With this in mind, the WhizzKids United programme is designed for kids in Grades 5 to 9, corresponding roughly to the 11 to 16 age group.

The venue: schools and clinics

WhizzKids United's two educational interventions are run in public schools. It is recognised that for youth, outside the school environment there are "limited opportunities for communication about sex."[68] Gallant outlines the rationale for using schools as the forum for youth HIV prevention programmes:

> "School-based HIV prevention programming, starting as early as primary school, has been viewed as a necessary step to protect the general population from further infection...Four reasons are commonly articulated in support of this position. **First**...primary schools are the single location where the largest proportion of young people (approximately 50%) can be reached. **Second**...most youth in sub-Saharan Africa initiate sexual activity while they are still of school age...**Third**...[prevention programmes] conducted prior to sexual debut are the most effective in reducing rates of sexually transmitted infections. **Finally**, schools provide an established venue for intervention. Their location is known, they are sustained within the community, their hours and mode of operation are known, they have established mechanisms for introduction of new programmes and accessing students, and the size of the target population is known."[69]

For purposes of practicality and sustainability, the WhizzKids United programme has been designed to fit into the Life Orientation curriculum in South Africa. Life Orientation is a subject mandated for all learners nationwide, and WhizzKids United meets all of the learning outcomes defined in the curriculum, namely health promotion, personal development, social development, and physical development & human movement (see Appendix A, section A.1.3). WhizzKids United is therefore ideally suited to make the best out of school time as the primary forum for youth HIV prevention interventions.

Working in areas of high HIV prevalence

As discussed in earlier, KwaZulu-Natal is the South African province hardest hit by the HIV/AIDS epidemic, at both the youth and adult levels. For this reason, WhizzKids United concentrates most of its programme resources within this province, and more specifically, within eThekwini, uMgungundlovu, and iLembe – the three district

municipalities with the highest HIV prevalence nationwide, according to the 2007 Department of Health study.

The 2008 South African National HIV Survey makes the following recommendation:

> "There is clearly a need for more targeted interventions in provinces such as KwaZulu-Natal and the Eastern Cape, where HIV prevalence appears to be continuing to increase, as well as in Mpumalanga, where HIV prevalence continues to be very high. It is recommended that interventions, including HIV communication programmes, that take into account epidemiological and socio-cultural factors, be developed and implemented at a provincial level."[70]

WhizzKids United also currently works in one other South African province (North West Province) as well as Uganda and Ghana, and is committed to expanding throughout South Africa and sub-Saharan Africa. Priorities for the near future include launching in Mpumalanga and Eastern Cape provinces in South Africa, and launching in Botswana and Zambia.

2.3.2. Theoretical approach to behaviour change

Leading behavioural scientists working in the health field have stated:

> "The emerging international consensus about the necessary conditions for successful programmatic outcomes...[stresses] the need for interventions to be securely grounded theoretically; to increase skills (such as assertiveness) and self-efficacy; to address social and material barriers to the practice of safer sex; and recognise[s] that unsafe sexual behaviour cannot be understood in isolation from other risk behaviours."[71]

These are precisely the conditions which the WhizzKids United programme was designed to meet.

In terms of formal theoretical grounding, WhizzKids United is founded upon modern theory of human behaviour. While the programme incorporates some elements of older models such as the Health Belief model and the Theory of Reasoned Action, it is more closely related to Bandura's Social Cognitive Theory. This theory argues that **outcome expectancies** (the expected outcome of a specific behaviour), **self-efficacy** (perceived ability to perform the behaviour), **goals** (short-term and long-term) and **socio-structural factors** (facilitators and impediments) are among the most central concepts in the causal processes behind behaviour.[72]

At a conference which brought together the world's leading behavioural scientists to try and reach a consensus on the most important behavioural determinants, the following list was agreed upon: "**Intention, environmental constraints, ability (skills), anticipated outcome (or attitudes), norms, self-standards, emotion,** and **self-efficacy**."[73]

Impacting these determinants is thus the primary focus of the WhizzKids United educational intervention. The following quotation structures behavioural determinants into three classifications:

"Any given behaviour can be explained as a function of three categories of factors. **Predisposing factors** are those cognitive antecedents that provide a rationale or motivation for the behaviour (e.g. knowledge, risk perceptions, attitudes, self-esteem, health locus of control, identity concerns, values, social and cultural norms, and goal priorities). **Enabling factors** are the antecedents that enable the enactment of behavioural intentions (e.g. availability and accessibility of health resources, government laws, as well as individual competencies). **Reinforcing factors** are the factors that, following a behaviour, determine its persistence or repetition (e.g. social support, physical consequences, feedback provided by health-care providers). Consideration of these factors can highlight differences between risk-taking and risk-reducing behaviour."[74]

The WhizzKids United programme contains three components which roughly correspond to these three categories of behavioural determinants: Life Skills Football Training, Peer Education, and Health Academies.

2.3.3. Impacting key behavioural determinants

Predisposing factors

Goal orientation

Pettifor et al are making an understatement when they suggest:

> "Without a sense of future, youth may have little motivation to protect themselves from becoming infected with HIV and without the belief that they can protect themselves (self-efficacy) they may not be persuaded to change their behaviour."[75]

The effectiveness of goal-setting in improving behavioural performance in all kinds of situations is well established:

> "A review of both laboratory and field studies on the effects of setting goals when performing a task found that in 90% of the studies, specific and challenging goals lead to higher performance than easy goals, "do your best" goals, or no goals. Goals affect performance by directing attention, mobilizing effort, increasing persistence, and motivating strategy development."[76]

It is for this reason that encouraging kids to become goal-oriented is a primary objective of the Life Skills Football course. By playing a game of football with no goals, the kids easily realise the futility of football without goals, and can easily apply this lesson to life.

Knowledge and risk perception

While aware that knowledge alone is ineffective in inducing behavioural change, Africaid recognises that "Knowledge of how to protect oneself from HIV infection...and self perceived risk for contracting HIV are all important precursors to behaviour change in response to HIV/AIDS." [77]

Recognising the surprisingly low levels of basic knowledge about HIV transmission amongst South African youth, the WhizzKids United programme devotes a full 1.5-hour session of its Life Skills Football Training course to imparting correct HIV knowledge and dispelling myths. Within the football metaphor, HIV/AIDS is presented as an obstacle or opponent that blocks the path to the goal. This highlights the risk in an intuitive way, which is important as "perceptions of personal risk or susceptibility appear to be the most difficult [factor] to change."[78]

Attitudes/intentions

After introducing goal-orientation and painting HIV/AIDS as an opponent or obstacle, WhizzKids United encourages kids to come up with tactics – a plan of action to overcome the obstacle and achieve their goal. It is within this context that the 'ABC' strategy is introduced as a tactic for overcoming the obstacle of HIV. In this way kids are motivated to modify their attitudes towards sex and their intentions regarding sexual behaviour in light of their goals.

Specifically, the programme seeks to impact attitudes and intentions with regards to abstinence (i.e. fostering the intention to postpone sexual activity altogether), multiple partnerships (i.e. attacking the acceptability of concurrent multiple partnerships and fostering the intention to be faithful), condom use (i.e. fostering the intention to always use condoms during sex), and VCT (i.e. fostering the intention to test regularly for HIV and access health and counselling services).

Self-efficacy

Self-efficacy is one's perception of his/her ability to produce a desired outcome. In the context of HIV prevention, an important application of self-efficacy is one's belief that one is capable of negotiating condom use with a partner and using a condom correctly. This belief is important because:

> "Some studies suggest that intentions to have sex and/or to use condoms are significantly related to such individual level antecedents as perceived susceptibility, attitudes, perceived outcome-efficacy, perceived social support and **self-efficacy regarding coping with embarrassment and social anxieties related to using condoms and refusing high-risk sexual activity**...Some other factors that seem to be related to sexual risk-taking include partner refusal to use condoms, unexpected sex opportunities, substance abuse, peer pressure and passion. Much less is known about how wider contextual factors may facilitate or be a barrier to safe sexual practices."[79]

Specifically, "studies with young adults suggest that self-efficacy for condom use is linked to higher self-reported condom use."[80] The WhizzKids United programme uses role-plays and other participatory activities in order to simulate real-life situations. This builds kids' self-efficacy that when they encounter these situations they will be able to control the outcome. Overall, the goal is:

> "[To] promote a context within which young people can collectively develop the belief and confidence in their power to resist dominant gender norms, in the interests of being able to assert their sexual health."[81]

The WhizzKids United programme also builds self-efficacy through the World Cup tournaments. Each child who completes the Life Skills programme participates in a six-a-side World Cup tournament and receives a good quality football kit emblazoned with the WhizzKids United logo. This gives the kids a sense of pride and achievement and gains them recognition within their community. The accompanying boost in self-esteem is likely to boost self-efficacy with respect to health.

Emotions (stigma)

An expert on HIV/AIDS stigma describes it as "a largely emotional process...not a rational, cognitive process."[82] As such, it is not easily impacted by education. However, the same author states:

> "Educational programmes may have a role to play in challenging stigmatising beliefs...The most effective educational interventions take local contexts and meanings associated with HIV/AIDS into account, are community-based, and are linked to skills-building, counselling and social interaction programmes."[83]

Africaid believes that by facilitating open communication about HIV/AIDS among adolescents, and establishing regular VCT as a social norm, stigma and its effects on HIV transmission can be lessened. This is a further reason why WhizzKids United works with kids as young as 11 – they are of an age where stigmatising beliefs, if they exist at all, are still impressionable.

Enabling Factors

Skills Development

Self-efficacy (the *perception* that one can achieve a desired outcome) goes hand in hand with skills (the actual *competency* to achieve that outcome) to bring about *empowerment*:

> "Educational approaches should focus on helping adolescents develop the self-efficacy and skills needed to abstain from intercourse if they are unmarried or to adopt protective behaviors, such as monogamy or condom use, if they are sexually active, and to talk openly with their families and sexual partners about HIV/AIDS."[84]

> "Much work has been done on the role of empowerment in shaping health-enhancing behaviour change...Disempowered people, who have little control over important aspects of their lives, are less likely to feel that they can take control over their health, and are less likely to engage in health-enhancing behaviours."[85]

Specific skills that are imparted through our programme include assertiveness and negotiating skills concerning sex and condom use – especially for young women, as "a large literature suggests that the empowerment of young women is an important precondition for safer sex among young people."[86]

Social and cultural norms

While Schaalma and Kaaya classified social and cultural norms as a predisposing factor, it could equally be classified as an enabling factor. By altering norms that promote risky sexual behaviour, we creating an enabling environment within which adolescents are free to make healthy choices:

> "Changes in norms and attitudes are required to create supportive environments in which young people are able to instigate and maintain behaviour change."[87]

The Colloquium on HIV/AIDS in Southern Africa (2003) declared that "the greatest challenge is to develop intervention programmes that impact on behaviour change and encourage risk-free sexual behaviour in young people." They emphasised the importance of the socio-cultural setting in meeting this challenge."[88]

When it comes to gender norms, often it is the empowerment of females that gets all the attention. However, gender is a two-dimensional issue, and in order to rectify inequalities and poor social norms it is just as important to engage males:

> "[We must] address gender inequalities especially from the perspective of male involvement and responsibility for sexual and reproductive health and HIV prevention and support. The specific objective should be to reduce multiple concurrent partnerships, intergenerational/age-disparate sex and sexual violence."[89]

The WhizzKids United programme thus endeavours to engage both girls and boys in constructive dialogue and activities designed to shepherd them to a consensus that multiple concurrent partnerships, gender-based violence and intergenerational sex are socially unacceptable behaviour. The programme places girls and boys on the same football pitch at the same time on equal footing, which makes an important symbolic statement about gender norms. Peer Education, however, is the most powerful tool for tackling social norms:

> "The goal [of peer education] is to create a norm that fosters the desired behaviour or outcome and provides alternatives to engaging in the undesired or 'risk' behaviour, typically through a life skills approach. Dispelling myths common among young people, such as widespread belief that everyone in their peer group is having sex is one strategy, since such perceptions may be influential in sexual behaviour."[90]

Reinforcing Factors

Health and psychosocial support

The third component of the WhizzKids United programme is the 'Health Academy.' Health Academies are football-branded clinics designed to offer adolescent-friendly health services (AFHS). The importance of reaching youth on a clinical level with health and counselling services is well-established:

> "The long-term aims must be both to support young people in having healthy sexual relationships and to convince policymakers, health care providers and others that by addressing the needs of young people, it may be possible to slow down and ultimately conquer the HIV/AIDS epidemic."[91]

The study of adolescent-friendly health services in Uganda revealed a number of important insights that WhizzKids United has taken to heart in planning the Health Academy concept:

> "Adolescents want integrated services that are accessible; where there is mutual trust; and prompt attention, with assured confidentiality. Most importantly, adolescents want to be involved in all stages of the development and implementation of their own services."[92]

> "The need for adolescent-friendly health services (AFHS) has emerged especially as a result of increased understanding and better definition of the life stages of adolescents. To that end efforts to meet their age-specific needs have emerged, including meeting their sexual reproductive health needs...Now, more than ever before, young people need reproductive health care – especially through prevention...The emergence of the HIV/AIDS pandemic has...brought this about, especially in view of increased and earlier sexual activity amongst adolescents and young adults."[93]

> "According to the adolescents, factors that would encourage them to use existing services include accessibility (in terms of affordable cost, proximity, and having friendly providers); trust of service providers by the adolescents, and of adolescents by providers; prompt attention; assured confidentiality; and good interpersonal interaction skills of providers with clients. For instance, they said that kindness, receptiveness and showing an interest are among the qualities of a good provider who will make the services more accessible to them."[94]

> Recommendations of the Uganda study include: "Setting up of one-stop centres for adolescents, within communities with appropriate structure, activities and avenues for providing information (IEC), contraceptives, voluntary testing and counselling (VCT), screening services for HIV/AIDS, and treatment of STDs; integrating services at existing established service points to improve quality of care through specific skills training; employment of adolescent peer educators and young persons as counsellors...allocating the necessary funds and budgeting for programmes that will support adolescents' education and health."[95]

A particularly important outcome for the Health Academies is to get adolescents to routinely access VCT:

> "Periodic HIV testing is crucial. There is a need to promote HIV testing widely as it will contribute immensely to both primary and secondary prevention as well as serve as an entree into seeking treatment for opportunistic infections and ARV therapy (in the case of advanced HIV infection)."[96]

The same studies that show that very few young people test for HIV also show that most young people do want to be tested.[97] The challenge, therefore, is to create a safe, confidential, youth-friendly environment in which they feel comfortable testing. This will be a chief aim of WhizzKids United Health Academies.

Community buy-in

Getting the community – parents, teachers, chiefs, community leaders, etc. to buy into the programme will be an important step toward success, as:

> "People are most likely to undergo health-enhancing behaviour change if they live in communities characterized by trust, reciprocal help and support, a positive community identity, as well as high levels of involvement in local organisations and networks."[98]

Moreover, through the empowerment of Peer Educators as youth leaders, and by involving youth in the decision-making process regarding the Health Academy, WhizzKids United hopes to raise the profile and relevance of youth in their communities, causing adults to take them seriously:

> "'Social context' shapes the effectiveness of HIV-prevention programmes...HIV prevention initiatives seeking to promote health-supporting social environments should work closely with social development programmes – to promote young peoples' social and political participation, increase opportunities for their economic empowerment, challenge negative social representations of youth, and fight for greater recognition of their sexuality and their right to protect their sexual health."[99]

> "In the HIV/AIDS field there is now general recognition that HIV-prevention efforts need to go in hand with parallel efforts to promote social environments that are supportive of safer sexual behaviour...there is an urgent need to specify youth as an additional dimension of social marginalisation, and one that is central to HIV prevention efforts. Youth need to be singled out as a marginalized group in addition to women and the poor in talking about the role of social exclusion in both facilitating HIV-transmission and undermining prevention.[100]

When kids are taken seriously and treated respectfully by their community, they are more likely to take their health seriously and treat their bodies respectfully.

2.3.4. Effective education methods

Life Skills Football Training – "Speaking football"

It was mentioned that one reason why youth HIV prevention programmes fail is that they are unable to effectively communicate with adolescents. Earlier, poor education was noted as one of the underlying causes of the HIV/AIDS epidemic. Even in countries where primary education is widely available, such as South Africa, the education system is still struggling to adapt from an authoritarian, unidirectional approach to teaching rather than an interactive approach which engages the learners and exercises their minds.

In Life Skills Football Training, WhizzKids United literally takes kids out of the classroom setting and exercises their minds and bodies on the football pitch. Football is the language and the metaphor through which life lessons are communicated. Instead of being bored by repetitive, unimaginative teaching techniques, the kids are excited about learning and thrilled at the opportunity to participate actively in their own education.

Peer Education

As has already been touched on, peer education is a useful component of a health education programme for several reasons. One reason is that it provides youth with role models they can identify with, who are thus able to positive influence social norms. A second reason is that it ensures the full participation of the youth as a group in the process of their own education. The focus is then not to develop the personal opinions of each adolescent, but to change the social dynamics of the peer group:

> "Peer educational settings promote assimilation or accommodation of a range of individuals' opinions within an evolving group process." [101]

> "Community-based programmes that use participatory approaches are increasingly being favoured above individualistic approaches for HIV prevention, as many social scientists and community activists argue that social dynamics have as much influence, if not more, over individual decisions about sexual behaviour than individual cognition."[102]

The WhizzKids United programme uses the initial Life Skills Football Training to identify its Peer Educators. From each Life Skills group (typically comprising 12 boys and 12 girls), one boy and one girl are selected who demonstrate exceptional leadership and aptitude. The Peer Educators receive 10 hours of intensive training and the schools are encouraged to portray the status of Peer Educator as an achievement and an honour. This ensures that the Peer Educators meet the dual criteria of being identifiable with the peer group as well as being looked up to by the peer group.

2.3.5. Sustaining behavioural change

According to Gallant and Tyndale, successful school-based interventions are "characterized by young age of initiation, long duration of programmes, diversity of activities, and a peer education component."[103] WhizzKids United meets all four of these requirements. In

particular, the long duration of the programme supports youth in maintaining healthy behaviour indefinitely.

This is because the school-based interventions are directly linked into Health Academies which provide a full range of vital services to an exclusively adolescent patient population in a youth-friendly way: VCT, psychosocial support, sexual health counselling, STI counselling, treatment and referral, rape, molestation and crisis referral, ARV treatment and support for HIV positive teens, and youth support groups.

WhizzKids United is not merely a brief visitor in the lives of participating adolescents; the programme uses a diverse set of activities to engage and empower them and then supports them for the long term.

2.3.6. Programme summary

Earlier it was mentioned that youth respondents of school-based HIV prevention interventions requested more imaginative and stimulating teaching methods. The other recommendations they gave were:

> "Promote more trusting relationships between programme facilitators and students; increase the use of small discussion groups and role plays; address issues of concern to them; involve parents and the community members to a greater extent; and offer easier access to the students for individual counselling." [104]

WhizzKids United uses football as an imaginative and stimulating teaching method. WhizzKids United trainers are involved in all three components of the programme which allows students to build trusting relationships with them. WhizzKids United does not shy away from any relevant issue and trainers are taught to encourage and facilitate questions and discussion to ensure all concerns are addressed. Parents and community members are involved through the World Cup tournaments which celebrate the kids' achievement in completing the Life Skills course, and in a more lasting way through the Health Academies. Health Academies provide an accessible environment for counselling and testing of which adolescents can take ownership.

WhizzKids United is therefore a programme built on a strong foundation of theory, the experiences (and failings) of other HIV prevention programmes, and firsthand experience interacting with African youth. To borrow the motto of the 2009 South African AIDS Conference, the programme is primed to "scale up for success!"

Appendix A – WhizzKids United and Government Policy

A.1. South Africa

A.1.1. Overarching policies

The South African National Integrated Plan (NIP) for Children Infected and Affected by HIV/AIDS guides the Department of Health, Education and Social Development and Civil Society Organisations (CSO) and sets out programmes that ensure access to an appropriate and effective integrated system of prevention, care and support services for children infected and affected by HIV/AIDS (South African Government, 2000).

In addition, the National Departments of Health, Education and Social Development have a number of important policy goals in place related to HIV prevention, which together provide a strong public mandate for programmes like WhizzKids United.

A.1.2. Department of Health

The DoH's HIV/AIDS and STI Strategic Plan for South Africa (2007) lays out objectives including:

- promoting equality for women and girls
- protecting and respecting children
- promoting personal responsibility
- ensuring equality and non-discrimination against marginalised groups
- strengthening care systems
- increasing accessibility to health services
- challenging stigma
- monitoring progress

Additionally, the DoH's Budget for 2008/09-2010/11 has earmarked R1.2 billion for The Comprehensive HIV and AIDS Conditional Grant, to be used to expand coverage of the comprehensive plan and strengthen prevention programmes.

This provides a strong justification for a continued partnership between Africaid and the Department of Health to roll out WhizzKids United Health Academies on a national scale.

Furthermore, the DoH's National Policy Framework for Women's Empowerment and Gender Equality (2000) identified HIV/AIDS and violence as key obstacles to the advancement of women.

A.1.3. Department of Education

The DoE's National Policy on HIV and AIDS for Learners and Educators (1999) gave the following as its underlying purpose:

- To prevent the spread of HIV infection
- To demystify HIV & AIDS:
    - Allay fears
    - Reduce stigma
    - Instill non-discriminatory attitudes
- To develop knowledge, skills, values and attitudes in order that learners may adopt and maintain behaviour that will protect them from HIV infection and to support infected and affected

Additionally, the DoE's Strategic Plan for 2008-2010 has a programme for social and school enrichment, which stipulates facilitating school sports in schools and HIV/AIDS training through Peer Education among its objectives.

Furthermore, the DoE's nationwide school curriculum includes a subject called Life Orientation which is mandatory for Grades R to 12. For the intermediate phase (Grades 4 to 6) the desired learning outcomes are as follows:

- Health Promotion (Nutrition, personal hygiene, abuse, healthy lifestyles, sexuality, diseases, HIV and AIDS, safety, etc.)
- Social Development (SA Constitution, National Symbols, diverse cultures, religions and social relationships)
- Personal Development (Self-concept formation, emotions, coping skills and relationships)
- Physical Development and Human Movement (Perceptual motor development, sports and games, gymnastics, physical growth and development, recreation and play)

For the senior phase (grades 7 to 9), the desired learning outcomes are as above, with one addition:

- Orientation to the world of work (Information gathering, planning skills, self-knowledge, general work and further study work, ethics)

The WhizzKids United programme is ideally suited to meet all of the above learning outcomes – especially Health Promotion, Personal Development, and Physical Development and Human Movement.

A.1.4. Department of Social Development

The DoSD's Policy Framework and National Action Plan for orphans and other children made vulnerable by HIV and AIDS 2006-2008 specifies the following objectives and strategies:

- Strengthening and supporting the capacity of families to protect and care;
- Strengthening community-based responses for the care, support and protection of OVC and assuring access for OVC to essential services

Additionally, the DoSD's HIV and AIDS Strategic Response (2007) seeks to:

- Give resource support to civil society organisations working with affected individuals
- Develop a prevention strategy that would address focal themes: gender, youth, social mobilisation, advocacy and awareness
- Address gaps in the HIV/AIDS response by reducing gender-based violence, building AIDS-competent communities, strengthening social cohesion of communities, strengthening of sexual behaviour change programmes and male sexual health
- Reduce stigma
- Address cultural, religious and social barriers to effective management of HIV and AIDS

Finally, the DoSD's Budget and Strategic Plan for 2008-2011 identifies youth development as one of its strategic themes and seeks to:

- Develop and facilitate the implementation of youth development policies and strategies by 2011
- Develop policies, guidelines, strategies and programmes to prevent new HIV infections and to facilitate the provision of care and support

Thus the WhizzKids United programme meets many of the objectives set out by the DoSD in terms of both prevention and care for youth.

A.1.5. Department of Sport and Recreation

The National Sport and Recreation Act (1998, amended 2007) legislates that the Department of Sport and Recreation:

- Seek the assistance of international organisations in sport and recreation to enhance the programmes and to exchange experiences and ideas, to ensure that the people of the Republic are well informed of the benefits of participation in sport and recreation and a healthy lifestyle
- Enhance health consciousness by means of themed programmes aimed at specific interest groups in the society

The National Sport and Recreation White Paper (1998) states:

- Studies show that sport presents the child with life skills in a way that is unsurpassed by any other activity.
- Gender equality and the right of women to participate [in sport] is paramount...Specific resources will be allocated for the development of sports skills and facilities for women and girls."

The WhizzKids United programme is an international organisation devoted to using sport to enhance health consciousness and foster a healthy lifestyle among youth. Furthermore, the programme is wholly committed to gender equality with 50% of the participants being girls.

A.2. Uganda

A.2.1. Ministry of Health

Arube-Wani et al describe the following policies of the MoH, which show there is a public mandate in Uganda for the Life Skills, Peer Education and especially Health Academy components of the WhizzKids United programme:

> "The Ministry of Health (MoH) has developed an adolescent health policy whose overall goal is to mainstream adolescent health concerns in the national development process in order to improve the quality of life and standard of living of young people in Uganda. Among the specific objectives of the policy are: (i) to create an enabling legal and socio-cultural environment that promotes provision of better health information services; (ii) to protect and promote rights of adolescents to health education, information and care; (iii) to promote the involvement adolescent in conceptualisation, design, implementation, monitoring and evaluation of their programmes (iv) to promote adequate development of responsible health-related positive behaviour; and (v) to provide legal and social protection, especially of the girl-child, against harmful traditional practices, and all forms of abuse, including sexual abuse, exploitation, trafficking and violence (Ministry of Health, 2004).
>
> The policy sets out a number of strategies which include: providing guidelines for addressing adolescent health concerns; training and reorienting the health system to focus and meet special needs of adolescents; and creating awareness concerning adolescent health, especially among service providers, the community, and its leaders. The long-term expected outcomes of implementing the above adolescent health policy goals and objectives include: imparting accurate knowledge on health issues; improving health-seeking behaviour; the provision of user-friendly health services to adolescents and young people; and encouraging positive attitudes towards health among adolescents and young people...
>
> The following four elements in particular, are considered to be very important for strengthening AFHS in Uganda:
>
> - The provision of AFHS in health units, schools, youth clubs/groups and key gathering points for adolescents through peer education and counselling, life-skills education, confidential counselling and screening by adolescent-friendly staff;
> - Setting up a referral system for AFHS between health units, hospitals, schools, peer-educators, youth and adolescent organisations;
> - Increasing the demand for AFHS through participation of adolescents in planning, implementation and monitoring; and sensitising key stakeholders in the community, and promotion through the media (UNICEF/MoH, 1998)."[105]

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[93] Arube-Wani, John, Jessica Jitta & Lillian Mpabulungi Ssengooba. Ibid., p. 215.

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