

**HIV/AIDS and Youth in Barbados:**  
**Research Questions and Intervention for Behaviour Change**  
**Christine Barrow**

(Presentation to HIV/AIDS Symposium, Savannah Hotel, Barbados, January 16, 2004)

**1. Introduction**

If the campaign against AIDS is to be successful – if interventions and policy are to make a difference they must be informed by social reality. And, in turn, for this to happen, researchers must ask the right questions.

For this presentation, I would like to spend little time looking at these questions – the questions that researchers ask about social reality and the answers to these questions that inform policy and interventions. Following that, I will make some suggestions, tentative at this stage, for an intervention policy with young people in mind.

**2. Research and Policy Questions:**

There are two main points here:

i. To date, information and intervention has been driven by medical professionals and health economists. This is appropriate, but let us look at the central question to which their interventions are responding.

Essentially, that question is: **how do we cope with the epidemic?**

And the answer to that question leads straight into the following policies and programmes:

- Medical interventions that focus on care and treatment. This primarily involves sourcing and administering drugs (anti-retrovirals) and targeting PLWAs (People living with AIDS). Following this policy, countries can therefore proudly announce that the mortality rate is down (but the magnitude and rate of infection is not)
- Health economists ask the question: **How much is the epidemic going to cost?** and **What are economic implications?** They make demographic predictions in relation to population change and the impact on the labour force of high mortality rates within the working population? They ask: **What about orphans and others dependent on the State? What is the price tag?**
- Another dimension in response the question of coping with the epidemic leads into interventions in the form of campaigns to reduce stigma, stereotyping and the prevailing climate of denial and silence.

This is all well and good. All of this is important and critical in the campaign to deal with HIV/AIDS.

But, I want to suggest that we must now shift the emphasis from the question of **How do we cope with the epidemic?**

To: **How do we reduce the incidence? How do we reverse the spread?**

In other words, we need research that informs the issue of behaviour change, that answers the related question: How do we change behaviour? Sexual behaviour in particular

ii. Related to this is the second issue concerning research and policy questions. This is the need to advance the focus from the what of sexual behaviour to the why – from what people are doing to why they are doing it.

Let me elaborate:

To date a number of social surveys of reproductive health and sexuality (of adolescents in particular) have been conducted. Known as KABP Surveys – (Knowledge, Attitudes, Beliefs and Practices), these have been conducted by Drs. Walrond and Ellis and their team (1990), PAHO (2000), and most recently Carter (2001). All have been excellent and informative.

These surveys have revealed that the adolescents are generally well informed about sexuality, reproductive health and STIs, and that the majority are either abstaining/postponing sexual initiation or engaging in safe sex.

But a minority (estimated at roughly 20%) is not. There is alarming evidence of early sexual initiation, multiple partnering, unsafe sex – that is without condom use. There is also evidence of “*forced sex*” and transactional/commercial sex, that is sex for material gain, in the involvement mainly of school girls (some of them under the age of consent) in regular unprotected sex with older men in exchange for jewelry, brand name gear and other material goods, even food and basic necessities.

In other words, in Barbados we have a solid body of research data on what young people are doing and what they are doing “wrong”, on their ‘at risk’ sexual behaviours.

What we don’t know, apart from anecdotal evidence, is why they continue to practice unsafe sex?

Let me further refine that question:

As mentioned, information has been collected on the knowledge base of young people and the general conclusion is that, while there are gaps, they are well informed about sexuality and reproductive health.

Indeed, until recently, the principal intervention in the HIV/AIDS campaign has been knowledge based in the form of education in schools, specifically Health and Family Life Education (HFLE), information via the media and so on.

This emphasis has been based on the assumption that people are **rational** – that with accurate and appropriate information they will protect their lives by modifying their behaviour and practicing safe sex or abstaining. All this makes complete sense.

But it has become abundantly clear that people are **not that rational**, and therefore that although knowledge is critical and **necessary**, it is not **sufficient** to induce behaviour change.

We can now return to the **why** question and refine it to ask: **Why do people (young people in particular) practice unsafe sex when they know it puts them at risk?** When they **know** it is potentially fatal? In other words, why is there a disconnect between knowledge and behaviour?

I suggest that this is **the critical** research question that needs to be asked and answered and it is the answers to this question that must inform policy - policy which is effective in **reducing the spread** or, more precisely, policy which **changes behaviour to reduce the spread?**

To answer this **Why** question, we must look at the **social context** of HIV transmission, must follow through on the assumption that “**risk behaviours**” are located in, emerge from and are reinforced by the environment in which persons live, by what we refer to as “**risk situations**”

We must therefore, as researchers and policy makers, put ourselves into that environment - into the heads and into the life-styles of those groups of persons practicing **at risk** sexual behaviour. We need to look at their “**risk situations**” – that is total environment in which they live.

This environment includes:

- psychological and cognitive variables,
- relationship dynamics and inequality in gender relationships,
- family background,
- the sub-cultural, social and economic environments that are often neither safe nor secure, and
- importantly, the changing ideologies of femininity and masculinity – how these are imaged, constructed and played out, especially in terms of sexuality.

Now, the logic in what I am saying is that to change “**risk behaviour**” – must change “**risk situations**”. This is an enormous task, requiring fundamental and widespread social transformation. It is also a long-term task; and we need to move fast.

So, maybe we could begin with interventions that change the way that young persons **perceive** and **respond** to their risk situations. And this means empowering them to make different choices, to adopt alternative lifestyles.

And how do we do that? The answer leads us into a discussion of interventions for behaviour change.

**3. Interventions** – In terms of interventions, I would like to make a tentative suggestion (one that might be refined as research fills the gaps) as we begin to construct a model for behaviour change. The suggestion relates to providing dedicated health services for young people both as a policy intervention and as a forum for data gathering, for research.

**To be effective these services must:**

- provide the space for informal and relaxed interaction. The environment must be welcoming to youth - for young people to talk to each other (as well as to adult advisors and specialists)
- involve young people in planning, delivery, and evaluation. They know what will work. Feedback from young people is essential; we must listen to their voices
- be confidential (seen to be and known to be confidential). This will counteract the present perception among youth that anything they say at a clinic will be shared among medical personnel and filter back to their parents and others
- be supportive – the attitudes of officials, especially front-line staff including nurses, must be supportive not judgemental and patronizing. There must be empathy and understanding, not shame, blame and belittling

(NB. If we listen to the views of young persons, it becomes very clear that problems with confidentiality and official attitudes are perhaps the two major deterrents to young persons seeking advice and, paradoxically, the main reasons why they stay away from services established to assist them)

- be accessible – open during evenings and weekends, and located in variety of places, such as schools, communities, shopping malls, even mobile vans and tents
- be called something other than “Adolescent Reproductive Health Clinics”, by adopting informal, drop-in titles like “Bodywise” or “Talk Shop”
- address a variety of health issues, shifting attention from teenage pregnancy to whole range of health and well-being issues
- be based on partnerships, as multi-agency initiatives including health, education and youth services
- have a solid funding base – volunteerism, though important and critical, has limitations particularly in terms of sustainability.

As this list suggests, what young people do not want to do, as they often have to do now, is to sit quietly in a formal clinic waiting room, with adults who might know who they are and report back to their parents and attended by staff who make them feel awkward and uncomfortable.

As mentioned, this is not a blueprint here, merely some ideas for developing a model that we might explore and that might work in the context of a growing emergency that threatens us all.

#### **4. Summary**

The basic assumption of this presentation is simple and straightforward. It is that if interventions in the campaign against HIV/AIDS are to be effective, they must be based on information concerning the status quo, on the reality of sexual norms and values in Barbados. In turn, if that information is to be appropriate and relevant, then research and policy must ask the right questions.

In this regard, my suggestion is that we need **to advance the research agenda** by shifting the emphasis from policy and interventions that answer the question **How do we cope with the epidemic?**, to those that respond to the question **How do we control the epidemic and reduce the spread?**

This entails changing sexual behaviour, and to do that, we need not only to ask **What** people are doing, we must also know **Why** they are doing it – specifically **why** their “at risk” behaviour persists.

The campaign in Barbados must now become more specifically targeted. Different messages must be designed for different groups of people, recognizing variations by age, sex, life-style, and sexuality.

For **young people** we must put **a human face – the face of youth** – into the campaign. In Barbados, we may not have reached the stage at which HIV positive young persons are ready to come forward and share their experiences, but this may happen in the not too distant future.

And we must **hear the voices of young people**. Article 12 of the United Nations Convention on the Rights of the Child (CRC), the Convention that Barbados along with other Caribbean countries rushed to sign and ratify over 10 years ago, states that young people should be heard and listened to on any matter that concerns them (including HIV/AIDS) and their views be given due consideration. Only through the full participation of children and youth, and from a young age, can we hope to empower them and, in turn, influence behaviour change and only then can we achieve success in reversing the spread of the AIDS epidemic.