

The Truth About AIDS

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Why prevention is often swamped by care

What do you do if you are walking along the road one day and two cars spin off the road in quick succession as they reach a dangerous bend? Do you run to help the victims? Do you run up the road to yell a warning to traffic? Do you go into a house and phone for an ambulance and the police?

Most of us respond to the immediate, which is why in many countries care for those with AIDS is eating up most of the AIDS budget. Prevention is usually an afterthought in spending terms, which is madness considering that infection is lethal and incurable, yet almost totally preventable. Infection is also very expensive.

Economics of prevention

Effective prevention campaigns could halve new HIV infections, according to the World Health Organisation. A global programme in all developing countries would cost less than the cost of a can of Coke for each person in the world. The saving in direct and indirect costs could be as great as \$100 billion.

Prevention saves huge care costs

The economics in favour of prevention are staggering, yet little action is taken. Each life saved through education saves not only the costs of care but also the losses to the economy from that person's untimely death. How much does it cost to save a life? The figure is harder to come by, but let us argue from common-sense principles. Let us suppose that a school worker with experience of working in home care spends a whole year taking classes in schools and talking to young people. The person sees up to 8,000 pupils in the year, as well as talking to a large number of staff, parents and others. Let us suppose that only one individual changes behaviour so that infection is avoided. The educator would still probably have saved the government more than the educator's annual salary in care and treatment costs and losses to the economy.

Health education is free

How many lives do you think a good educator could save? Ten? Twenty? Thirty? Fifty? High impact AIDS prevention is quite simply one of the most cost-effective things a government can possibly spend money on. The reason for this extraordinary fact in industrialised nations is that AIDS is such a difficult and expensive illness to treat. The drugs used are some of the most complex and costly ever produced. Until recently anti-viral medicines were so expensive that a doctor in Uganda would have had to save every penny he earned for ten years to pay for one year's treatment of just one person.

But in poorer nations the costs are also very significant, especially when AIDS strikes a significant number of the senior executives, civil servants and community leaders in the country. Then there are the indirect costs caused by loss of business confidence, and companies pulling out to invest in other nations.

The cost of AIDS

The cost of treating one person with AIDS in the UK is the same as the Ugandan government spends on the entire health budget for almost 25,000 people for a year. But as I say, education is cost effective in Uganda too. I am excluding here, of course, any other measure of cost apart from economic. How can you place a cost on human life?

Incidentally, I have sometimes been asked by people in developing countries to help provide supplies of 'wonder' drugs. The trouble is that as we have seen these drugs just delay death and they are toxic, so complex laboratory monitoring is needed. Other cheaper medicines will have a far greater impact for the same price.

For example, many people with AIDS will be helped by receiving antibiotics to treat chest infections, anti-fungals to treat thrush in the mouth, anti-diarrhoeal drugs and painkillers. None of these may be available to those in rural areas on a regular basis. A year's supply of anti-viral medication could be exchanged for medicines to prolong life and control symptoms in up to 200 people with AIDS.

When deaths damage the economy

Indirect costs of AIDS are the biggest problem in many developing countries. When a young person dies who is well educated, highly skilled and a key person in some part of your country's economy, a part of that economy dies. For example, if a factory in Malawi loses four out of six of its directors from AIDS in a year, you can be sure that production will fall, and so will the export orders, further damaging the economy.

If key designers, sales and marketing executives, engineers or people with mechanical skills die, then there is a cost to the government. The economy shrinks. Although this is hard to measure, and you may not think it matters when unemployment is high, in the longer term the loss is significant.

But this talk of finances is to reduce humans to items for sale or purchase. People are worth more than a few thousand pounds. Whether they are famous or unknown, people are people and have value for who they are as individuals. Yet as we have seen, many governments

spend practically nothing on prevention in comparison to care.

Ten years before health savings

Unfortunately, as with anti-smoking campaigns, prevention costs money up front, while government spending will have to continue for at least another decade because HIV, like tobacco, has a very slow effect. With HIV prevention, health services will probably see no real reduction in illness from prevention campaigns today until well into the next decade.

Does health prevention work anyway? How do we know if any of the millions spent so far have had any effect at all? All health promotion tries to show people cause and effect, persuading them that the effects are so terrible that it is worth paying a big personal price to stop doing something they like doing very much.

Behaviour can change

Studies have shown that behaviour does change, and can do so quite quickly. However the most significant shifts in behaviour take some years to achieve. Infection rates among teenage girls in Uganda have fallen dramatically over a decade, from 23% to 5% by 2002, with smaller but significant falls also in Zambia. Similar successes have been seen in Thai men. Infection rates per year have fallen from 143,000 to 29,000 people a year in Thailand over the last decade. We have also seen huge changes in the sexual behaviour of gay men and drug injectors in America and Europe.

However most success stories have happened after the community concerned began to see significant numbers of AIDS deaths. It is far harder to persuade people to change behaviour at an earlier stage of the epidemic. We have seen huge changes among drug injectors in several countries, many of whom have ceased sharing equipment or injecting as a result of education. We have also seen condom sales increase in many areas following AIDS campaigns targeted at the general population. All these changes have been seen in a very short space of time compared to the slow response to anti-smoking campaigns. This gives us some hope for the future.

But relapse is common, and risk-taking is on the rise again in Europe and parts of Africa. Every year is a fresh challenge with a rising generation of new youngsters taking risks for the very first time, and an ageing population of others who decide to take a chance that would have worried them a lot five years ago.

Young people take greatest risks

Half of all new HIV infections globally are in those who are younger than twenty-five years old, so prevention must start young. However, surveys show that those changing behaviour the most as a result of campaigns are those who would be likely anyway to be settling down, changing partners less frequently. For example, in the UK and some other countries, gay men aged thirty-five to forty-five have reduced their number of partners, while younger men unfortunately seem to be taking bigger risks again. We see this in the rising number of young gay men going to sex disease clinics with new cases of gonorrhoea---a sure sign that they are having unprotected sex.

Those in the firing line are young people. Every year in many countries the age of puberty falls a little more for reasons which are unclear, although it is related to increasing body weight in girls. At the same time, the age of settling down is being effectively pushed in the other direction, with longer training and apprenticeships and changing social pressures.

Male sex drive is strongest in those who are youngest and it hits boys at a time when they are least able to handle it all emotionally. A twelve-year-old boy and girl may be experiencing strong urges to explore sex at a time when they are incapable of working out a stable adult relationship. These pressures continue to fuel the debate for and against lowering the age of consent (see Chapter Seven).

Sex education needs to start at a younger age

In many countries the average age of the first sexual encounter has been falling for many years. In Uganda a survey of teenage mothers found that 70% had their first sexual encounter before their fourteenth birthday. We know that in many towns and cities in the UK over half of all sixteen-year-olds are sexually active, possibly with an even higher figure in some other nations. Research in the US has shown that the number of partners people have in their lives

can be directly related to the age they first have sex.

Young girls are particularly vulnerable to HIV and other sex diseases because of the immaturity of the female genital tract, particularly in those thirteen years old and younger. This may be part of the reason why one Ugandan study found that there were five times as many fifteen to nineteen-year-old women with AIDS than men of the same age. It's the same in older women. In Kisumu, Kenya, for example, in 1998, the prevalence of HIV infection among women aged 15-29 was 23%, while, in young men, it was 3.5%.

The other reason may be that young girls in many countries are targeted by older men as less likely to be infected. It is also true that for physiological reasons a woman is twice as likely to get HIV from an infected man than a man is from an infected woman.

As we have seen, it is far easier to prevent risky habits than to change them once established. Parental attitude and religious faith have also been found to be important influences on teenage sexual activity.

Incidentally, we also know there is a big link with smoking. One study in the UK has shown that those who smoke under the age of sixteen are six times as likely to be sexually active as those who do not, possibly because both activities are to do with wanting to take risks, to experiment and to rebel.

For all these reasons it is obvious that we need to start young and that a big part of the national campaigns needs to be directed towards schools, or where youth tend to meet. In some countries, less than half of all teenagers attend full-time education. Those becoming teenagers today are entering a different world. Unless we find a vaccine or cure for HIV, they are going to see some difficult things. With 1 in 200 of the whole global adult population already infected, they are likely to find this has risen to 1 in 100 by the time they have children of their own.

The AIDS generation is growing up

So then, AIDS is a preventable illness, and very expensive to treat. With the epidemic out of

control in most of the world, our young people need to be prepared urgently to live in an AIDS world without dying, but what do we say and how do we put it across? Clearly the way we present a message will need to change with the audience and the context to be most effective. An approach for committed Christian teenagers may need to be different from that used in a secular school.

At the most basic level there is no point in preaching a sermon about immorality based on Bible verses, when your audience does not even believe in God. They are unlikely to be impressed by your arguments. A more pragmatic approach is needed. Yet for those wanting to base their lives on the teachings of Jesus, a talk explaining what the Bible teaches about sex will be very helpful.

AIDS in the church youth group

Because of the time delays between infection and illness, it is far more likely that you will find the church youth leader coming to you than one of the teenagers. Teenagers developing illness are more likely to have been infected at a much younger age--- from infection at birth or from medical treatments for example.

Teenagers in church get pregnant

Surveys show that not only is teenage pregnancy a real possibility in most churches, but also sexually-transmitted diseases, including AIDS. Most churches find these things hard to face. It can be a terrible shock to find that the daughter of the church leader is three months pregnant, or that 'nice young lads' have been buying and selling drugs on church premises.

Unless we think that somehow our church is entirely separate from and irrelevant to the community in which we live, we mustn't be surprised to find that the things which go on in almost every street in the land also go on from time to time in the lives of those connected in some way with our churches.

Starting sex education earlier in churches

We need to take sex education and AIDS prevention seriously with young people in our churches, before they become sexually active. The survey above shows us this means starting before teenagers reach sixteen years old, probably at around the time of puberty, or even earlier.

Some may feel that insensitive approaches to these subjects at such a young age are only bound to encourage experimentation. I agree, and all sex education should be carried out sensitively in a balanced way, emphasising the positive aspects of marriage and family life, waiting for the right person.

Unfortunately, in a video and satellite age the fact is that whether you are aware of it or not, many thirteen- or fourteen-year-olds are regularly watching 18-rated pornography, either in their own homes with borrowed videos, or in their friends' homes while parents are out or busy.

As most parents know, many nine- or ten-year-olds are now regularly watching 15-rated films in the same way---and older people also need to realise that because ratings have become more relaxed, it means ten-year-olds are now seeing things which would have been X-rated some years ago.

Educating parents is vitally important, encouraging parents to take the primary responsibility in these areas which are rightfully theirs.

Sex in the playground

Children are bombarded with images and stories of sex. The playground talk of sex has increased so that parents are now finding their five- to eight-year-olds asking for explanations about sex because of the things they are being told by other boys and girls at school.

In such a sex-obsessed world, the almost complete silence of the church is nothing short of bizarre---especially as the Bible itself is full of stories about sex and sexual imagery, or about sexual standards.

We need to face what is going on and break the sex taboo, bringing our discussions about it into the frame of normal Christian conversation and experience. We can no longer live in this two-worlds unreality. We are letting our young people down.

'Sex is dirty so save it for someone you love'

We need to be careful about the mixed messages we give in church---for example, 'Sex is dirty so save it for someone you love.' This can be the mixed impression left in the mind of an impressionable child brought up in the church. Another conflicting impression can be: 'Sex is wonderful---but don't tell the children about it.'

We need to communicate that sex is a wonderful gift from God, an amazing experience, as we saw in Chapter 8. We need to teach that God loves sex---it's the waste of sex outside marriage that causes him grief. Sex was invented by God as a gift to humankind.

We need to include teaching about sex as part of the overall programme of the church. Possibly a quarter of your congregation may be going home from church to enjoy it with their spouses, their children are obsessed with it, the television and videos from the corner shop are full of it and the Bible is very explicit about it, so why are we still avoiding it?

Role models do matter

We need to make sure youth workers in the church are capable of handling the subject, and more importantly able to set a good example in their own lives. Young people need to see role models worth following; models that are exciting and that work. They need to see marriages in the leaders of the church that are an attractive alternative to the often temporary relationships they see around them. We live in a generation which has almost lost the memory and experience of happy lifelong commitment, yet is searching for it.

The answer is to include sex, sexuality and AIDS as topics in what the church is already doing.

Schools programmes

Teaching in church youth groups will only reach a few. What about schools? There can be few lessons which are more controversial. As soon as we think about education on sex or AIDS in schools, we find ourselves caught up in polarised debate. We find strong opinions expressed about general approach, content, methods, context, teacher support, parental opinion and the age it should happen. Millions of words have been written and tens of thousands of hours have been spent in training or in discussions, yet very little is actually happening in many countries.

Meanwhile, ACET England has developed an education programme with a simple, practical, low-risk approach which has become immensely popular with teachers, with a take-up rate of our materials in up to 60% of secondary schools. While it can hardly be regarded as a blueprint for success, there are general lessons to be learned, a number of which can be adapted to the situation in different countries. Similar programmes are run by members of the ACET International Alliance in countries such as Scotland, Ireland, Russia, Czech Republic, Slovakia and Uganda.

Instead of getting caught up in discussions of educational theory, it is possible to start from the other end of things; from the point of view of a teacher facing a sceptical class for an AIDS lesson. Teachers face real difficulties. Educational committees and self-appointed experts can generate a wide variety of materials that may be 'politically correct' and fit with the latest fashions in education, but which turn out to be completely unusable.

Here is a summary of twenty findings based on the situation in the UK. A similar process in other nations will produce some differences, but fewer than you might think.

REMEMBER - AIDS education is literally a matter of life and death.

You are in a race against time. Your aim is not only to inform but somehow to persuade people to change, to change hearts and minds. Information is useless without action, without commitment. Life's too short to pack pupil's brains with more data about HIV unless their lives are changed as a result. And of course, persuasion is an art: helping people make up their own minds, to take their own decisions, to take hold of their own futures.

Lesson 1: HIV/AIDS education in schools is sensitive

Schools work is a sensitive issue because people cannot agree on what should be taught. Staff, parents, governors and national regulations need to be respected. Be careful to use appropriate language. AIDS prevention is difficult because on the one hand we want to hold attention, to be relevant and to have impact, while on the other we must not upset or offend. AIDS prevention is most effective as an integral part of sex education or education about the risks of addiction. However, in educating about sex or drug abuse, we always have to be careful that we are not just feeding the imagination and encouraging experimentation.

Lesson 2: Facts alone are of limited value

If you go into a classroom and try to give an AIDS talk, you will see that facts alone can be a waste of time. Teenagers are bored rigid with AIDS in low-incidence countries like the UK, and may think they know everything in high incidence countries. The whole subject has been done to death by the media. People need to see AIDS is real before they are going to listen to you talk about it or seriously consider changing their behaviour.

Lesson 3: Family deaths change behaviour

As we have seen, behaviour often changes dramatically when someone experiences the death of a family member or close friend. The trouble is, by the time many young people in schools today begin to see deaths among their friends, we will have a much higher infection rate. We do not have to wait at all in countries like Uganda, where in a schools lesson I asked for a show of hands from all those who had been to the AIDS funeral of a family member. Most of the hands shot up. They needed no persuading that AIDS was for real and they were keen to listen.

Lesson 4: We need to make AIDS real to pupils

One way to help make the illness real to pupils in low incidence areas is to ask people with AIDS to visit schools. Unfortunately, this can be very difficult to organise and is unlikely to be

possible in low-incidence countries, except on a small scale, for several reasons---the commonest given being the risk of anti-heroes. Many schools do not wish to bring in someone with AIDS who might become something of a role model regarding previous lifestyle. Teachers in the UK recently had a shock over prevention of drug abuse. The government produced striking posters with the slogan 'heroin screws you up'. The picture showed a young man with boils on his face, looking quite ill and sorry for himself. A number of schools requested these, but found the posters kept disappearing without trace. It seemed that teenage girls were pinning them up on their bedroom walls. The boy had become an anti-hero, the latest pin-up idol. There have also been sensitivities over someone coming into school who might want to promote gay lifestyles. That leaves only those infected through heterosexual sex or blood products, many of whom are not enthusiastic about being in the public eye in this way.

It takes an act of great courage to walk into a school where you are unsure of people's reactions. Another effective way is to use educators who have been involved in the care of those dying at home with AIDS locally. This has been ACET's approach.

A comprehensive review of prevention programmes by the World Health Organisation has shown that person-to-person prevention is especially effective, particularly when 'peer led'. In other words, where the target audience can identify with the educator--for example, similar age, background or experience. In other areas of prevention this has been very successful - using infected commercial sex workers to reach sex workers, or truck drivers to reach truck drivers.

Lesson 5: Professional educators working within a moral framework

AIDS education is often relatively easy for a church organisation to provide compared to a secular agency, because many schools want sex education within a traditional but compassionate, caring moral framework.

ACET International projects provide educators in various countries to take individual lessons, teams to teach larger groups, and materials and training for school staff. Teaching methods vary from interactive questionnaire, class discussion, role play, dramatic presentations, conferences for large groups and formal teaching assisted by overheads, charts, colour slides or video. Every country and situation is unique. Care credentials are helpful: educators who have helped care for people dying with AIDS are able to talk from experience and have instant credibility. There is no longer a 'boredom factor' when you are talking about real people dying

of a real disease.

Formal educational qualifications are unnecessary so long as individuals are carefully selected for their communication skills with young people, and are properly trained. The personal values and lifestyle example of the educator is a very important part of the message. Extra security is provided by the presence of the class teacher. Paper qualifications do not mean someone will be able to persuasively alter the behaviour of teenagers in school. AIDS is placed in the whole context of sex education, in the framework of relationships and commitment, empowering people to make their own choices and helping them find their own ways to say no to sex or drug abuse if that is their choice.

Lesson 6: Success breeds success

The best advert is personal recommendation based on past experience. A good reputation is essential, and takes time to build. Everything needs to be of the highest standard. Endorsements are helpful from health authorities and other influential bodies including religious organisations where culturally appropriate.

You can transfer reputation and success from one country to another or from city to city, riding on the back of success and solid reputation elsewhere. This is why networking and being part of international Alliances or recognised Federations is important. Anything in fact which has a recognised badge of quality. But conversely take care because reputations can be damaged by actions of others some distance away.

Lesson 7: Compulsory HIV/AIDS education opens new doors

A further impetus has been given to schools work on AIDS in many countries by changes in the national curriculum, as has been happening in Eastern and Western Europe recently.

Lesson 8: Help pupils find their own answers

People often ask whether we preach or why we don't, depending on their position. The answer to both camps is the same: sermons only on Sundays. Pupils need to work out their own answers. There is no point at all in trying to back up what you are saying from the Bible when talking to people who have never read it, don't believe in it and don't even believe God exists.

You will merely undermine your message by convincing people that you are giving a biased view of this confusing epidemic. You will be open to the accusation that you are manipulating the facts to get people to accept Christian lifestyles. We are only in the classroom for an hour or two on a couple of occasions, yet the message needs to last a lifetime. Experience has shown that a long-term impact is more likely if pupils take part in the presentation, and come to their own conclusions about changing behaviour or avoiding risk.

A key is a relationship of trust and respect built between the educator and pupils. They need to feel able to talk freely, and to feel that what is being discussed matters and is being covered in a balanced way.

Lesson 9: No need to preach

While it is true that you cannot preach, our experience is that you do not need to. The facts speak very loudly for themselves. It is also true that the kind of person the educator is, and the way the person comes across, can communicate a lot.

When people see someone who is young, single, who enjoys life, has a sense of humour and a normal sex drive, yet is not sleeping around, a new role model is created. These things can emerge in response to pupils' own questions, which can be quite probing. The lesson is designed to help them also talk very frankly and openly.

Young people are very perceptive and can detect double standards, double talk, lack of integrity and hypocrisy. Teaching one thing and doing another totally destroys any impact you might have, and makes it certain that behaviour will remain unchanged at best or become even riskier at worst. That's a very important reason why Christian educators have proven so popular in many countries with parents and teachers, especially when they know these educators are also linked to care programmes and bring compassion as well as an example that can be safely followed.

The idea of using role models of college age in schools is not new. However, many studies have shown that if pupils are presented with an older person who has an overbearing authoritarian manner telling them to 'be good', they are likely to react. Some may even be more likely to take risks in the future as an expression of rebellion against authority.

Teenagers are often far more concerned about their own health than adults realise. A US study found a high level of concern about AIDS, schoolwork, making friends, sex, discrimination and dental problems. Teenage girls were also worried about violence, rape, menstruation, abuse, pregnancy, sadness and being overweight. Boys were concerned additionally about homosexuality, sex, car accidents and low weight.

Lesson 10: Classes can be large or small

Many theorists say that only small classes are useful. In practice you are often limited by the timetables and priorities of the school. If teachers already have booklets or other usable materials and are teaching the subject themselves, then they may be very grateful for an outside presentation to a large group to help reinforce the message.

Drama can be an effective way to communicate to larger groups, although it is very labour intensive and expensive in terms of pupils reached per hour. Drama has been particularly helpful in reaching populations in developing countries, including variations such as the use of puppets in performances.

The aim is to make the illness real so teachers can teach about the disease with greater attention from their pupils. The greatest impact then comes in smaller groups where there is time for discussion and feedback, and where the educator has an ongoing presence in the school. The key is continuity. Behaviour change is most likely to occur when a group of people are involved in a "journey" together, as a result of which their group culture changes. And that all takes time. But surely it's worth time to save a life?

Believe me: when you've had the deeply distressing experience of caring for lots of people with AIDS who got infected as teenagers or young adults, and a teacher invites you in but says you've only got ten minutes with a large group, you grab the opportunity. Any chance to raise the issues of AIDS is a chance not to be wasted and who knows, you may convince the

teachers that they need to do more, lots more. Of course one also needs to look at cost - benefit and how practical it is to do short visits, if there's a distance to be travelled.

I often say "This is the most important school lesson you will ever have in your entire education, because this is the one that will save your life or the lives of your friends." Or: "Unless your own peer group behaves very differently from those who left this school in the last decade, you too could find yourselves going to the funerals of many of your closest friends." Or: "I'm here today because I don't want to be looking after you with AIDS in ten year's time."

Lesson 11: Teachers need to be closely involved

Most teachers want to be involved, although work pressures are so great that it can often be very tempting to leave the classroom to get on with preparation elsewhere. ACET International Allianceeducators in England and some other countries ask the class teacher to be present during sessions. Although some are surprised because they expect pupils will be more inhibited, we have found the advantages more than outweigh the disadvantages.

The aim is to equip and give confidence to class teachers, not to deskill them so they feel the need to leave it all to outside specialists. Watching us at work gives confidence to others. Teachers often feel able to take over much of the work in future years, thus increasing the impact of our work.

If an outsider comes in to talk on a subject like AIDS, the danger is that the message will be entirely disconnected from everything else in school. Even worse is the possibility that there may be conflicting messages.

When teachers sit in, it guarantees that what is said fits in with what they want. It also guards against complaints from parents. There is a witness to exactly what actually happens in each class - you never know when a pupil might make some kind of accusation about - say - insensitive language, or when a parent might make an (unjustified) complaint. Finally, it ensures that what the school is teaching about HIV is as accurate as possible.

Because every class is not only a pupil presentation, but also a teacher training session, a small number of educators can have a big impact over a year. Between classes there is also the opportunity to talk with staff informally, or to meet the head teacher and advise on syllabus priorities.

Evaluation is essential. Another big advantage of having teachers remain in class during presentations is good feedback. It is essential to evaluate any programme, particularly in schools. I have always encouraged teachers to complete evaluation sheets at the end of presentations. They may prefer to wait until after the following week's lesson when they have had feedback from the pupils themselves. From time to time whole classes are asked to complete evaluation forms rating the presentation and booklets.

Lesson 12: Sexual orientation is a separate issue

As we have seen, many schools in developed countries are very anxious about how gay relationships will be presented in an AIDS talk, because a high proportion of people with HIV in these nations were infected through gay lifestyles. There is always a risk that an AIDS lesson by a visiting educator could open up all kinds of sensitive areas in the classroom, including lengthy discussions about sexual orientation, detailed descriptions of anal sex, oral sex, ways to masturbate, demonstrations of putting on condoms and the promotion of gay lifestyles in schools. The teacher may have to spend the next few weeks sorting out the chaos!

Whatever our own views are on these areas, we need to listen carefully to what parents, teachers, governors or community leaders are saying would be most helpful. Schools usually prefer an objective low-key approach using non-emotive language in a matter-of-fact way. They do not want an AIDS lesson to be hijacked by other issues.

It is always best to use plain language where you can, so, for example, I prefer to talk of sex between people of the opposite sex, or sex between men and women, or sex between people of the same sex, instead of 'heterosexual', 'homosexual' or 'gay'. The latter two terms are very unhelpful and misleading, because many young people are unclear whether you mean someone who has a particular attraction to someone of the same sex or someone who is sexually active.

In the classroom, then, I rarely use the words 'gay' or 'homosexual'. There is another reason. As we have seen, six out of ten men who have homosexual relationships also have sex with women. Some may not think of themselves as gay or bisexual.

When avoiding this kind of language, it is unusual to find problems in the classroom or with parents. We are not there to talk about why or how sexual orientation develops, nor is it the job of schools in most countries to comment on the appropriateness or otherwise of gay or straight sexual activity, except as a health issue.

Lesson 13: Drug use or misuse must be discussed with integrity

A significant proportion of new infection in many countries is caused by injecting drugs, so it is essential that we tackle this important area. Many are likely to have been offered drugs or to have experimented by the time they are seventeen or eighteen. The first thing we have to recognise is that there is something of a double standard in many countries. Many who are against 'drugs' are in fact addicted themselves. We have already seen how dangerous nicotine addiction is, but the most commonly abused drug in many countries is alcohol.

We need to acknowledge these things before we can talk sensibly with young people about the use of cannabis, ecstasy or crack, or the injection of drugs. Cannabis is far less physically addictive than tobacco, and perhaps less dangerous to general health.

However, there is certainly a lot of evidence that those using cannabis regularly may be less careful when it comes to thinking about sex. As a relaxant, it removes sexual inhibitions---but then so does alcohol, and alcohol is a very important element in unsafe sex. Using cannabis may introduce the user to a circle of friends or a way of life where it becomes part of the norm to try other things. These are usually given freely at first. The charging comes later.

In the middle of the process are some who will need to sell drugs to cover the costs of their own habit. The injector may well be injecting all kinds of things---not just heroin, or what has been sold as heroin. We need to get across the message that sharing needles or syringes is the quickest way to get HIV.

An important part of the approach is to help pupils see how they can avoid situations where they know they will be under pressure to accept drugs. We also need to help them see how they can say no in such a situation, while preserving their self-esteem.

Lesson 14: Condoms need to be discussed in context

The most obvious question facing any educator in schools is how to discuss the condom issue. Christians may have all kinds of objections to the way in which condoms seem to have been promoted as the answer to AIDS. These need to be laid aside when we think about going into schools. We need to take an objective look at the facts, and once again listen to teachers before deciding our approach.

Excellent protection, but not 100% safe. We have looked at the failure rates of condoms for pregnancy and HIV in Chapter 6. A survey of eighteen-year-olds in Glasgow asked for a description of 'safer sex', and 84% mentioned condoms, 68% some aspect of partner selection, but only 2% mentioned abstaining from certain sexual activities as an option. A very one-dimensional message is being given, yet abstinence must increasingly be recognised as a valid---and 100% safe---option, and is increasingly becoming a central part of thinking on prevention.

Testing is a real alternative

It is hard to think of a more absurd approach than just promoting condoms, particularly in view of the pregnancy failure rates we saw in Chapter Six. If you think through what the campaigns are saying, the conclusion is that all sexually-active adults should use condoms in all relationships for life if either has ever had sex before.

This is a ridiculous message. What happens with couples who have been faithful to each other for years? Are we really expecting them to go on using condoms in addition to the pill for the rest of their fertile lives? What happens when the woman wants to have a baby? Are we seriously expecting women who have gone through the menopause to continue using condoms with their lifelong partners till they die of old age?

As we have seen, the answer is that HIV testing is an excellent alternative to condom use. It costs less to have a test than it does to buy three months' supply of condoms. If both partners are uninfected, they can enjoy anxiety-free, rubber-free sex for the rest of their lives. They will, however, need to be able to trust each other not to have other relationships or to share needles if injecting drugs.

The testing option has hardly been mentioned by many governments, and has been missing from poster and TV campaigns because it is not politically correct. Various highly-influential pressure groups have persuaded governments that testing is still too sensitive and controversial, mainly because of discrimination.

No need to roll condoms on bananas

People often ask whether we give out condoms in the classroom. Of course the answer may vary from country to country, but my own view is that it is almost always unnecessary and inappropriate. Most parents of teenagers would be horrified if we were to roll condoms onto bananas in front of teenagers. We are in the business of giving an all-round message on AIDS, explaining the value and limitations of the condom.

If schools wish to demonstrate the use of condoms, we would expect that to be a part of their overall policy on sex education, after having carefully consulted with parents and governors. In my experience, few schools feel a demonstration is necessary, desirable or appropriate.

Teaching people to sin safely?

While some outside of schools want all educators to demonstrate condom use and to teach teenagers that it is good to have fun with sex when you are young, others are horrified, saying that even to mention condoms in class is to invite people to 'sin safely'. Surely, they say, there is a danger that in even talking about sex and condoms we may be encouraging promiscuity?

In the context of a school class we are called to give the facts. Christian agencies working in the AIDS field are certainly not wanting to encourage sex outside of marriage, but it would be

absurd to avoid any mention of condoms at all. Even if you say condoms should only be used by people who are married, there may be many situations in the future where a couple have got married knowing that one partner is infected from the past. Are their lives also to be placed at risk through a ban on all information about condoms? Young people live in the real world---so do you and I---and we need to demonstrate that in a realistic down-to-earth approach. (See later for Catholic approach and other church issues in relation to condom discussions.)

Condom summary

In summary, then, we need to make pupils aware that there are several ways to reduce the risk of HIV or avoid it altogether. As the World Health Organisation says, the most effective way to prevent sexual transmission of HIV is to abstain, or for two people who are uninfected to remain faithful to each other. Alternatively, the correct use of condoms will reduce the risk significantly. We need to get across that having sex without using a condom could be suicidal with a partner who may be infected. However, condoms may let you down.

Lesson 15: Ethnic minorities often welcome a Christian approach

Over the years, ACET has gained a lot of experience teaching in different kinds of schools in different cultural areas. The same approach to AIDS has found great favour across the spectrum, including schools which are 95% Asian with Muslim, Hindu and Sikh children and parents.

Parents appreciate educators who have a moral framework for their own lives which is similar to their own. Many from other religious groupings or different ethnic backgrounds are deeply devout or traditional, and find Western sexual standards shocking, upsetting and worrying, as they consider the future of their children.

Lesson 16: Catholic schools also welcome sensitive AIDS education

The sensitivities in Catholic schools tend to be greater, although this varies very much from school to school and from country to country. The big issue for Catholics is whether condoms

will be mentioned.

Some Catholic schools take the view that it is permissible to talk about how HIV spreads, how it causes illness, and how to help with HIV, but not mention condoms unless pupils ask directly. Others are more relaxed, so long as the lesson is placed firmly in the context of the Christian ideal of sex as part of marriage for life. The range of what is permitted varies from area to area and country to country.

As in every other school context, the best approach is to treat each school and each class as unique, discussing with teachers the approach they want, and any particular sensitivities of the school or of the particular class. This is the only reliable way to avoid misunderstandings, to ensure we serve schools well and to make certain we are operating as part of their team.

In Northern Ireland, the same educator, programme and materials have found warm acceptance in both Catholic and Protestant schools. The problems are therefore often more imagined than real. The key is a strong relationship of trust and respect built with individual educators.

Lesson 17: Lesson content needs to vary with age

Some schools will want to educate pupils who have not yet reached their teenage years. This is perfectly possible without offence or difficulty, but the content will need to be adapted under the guidance of teachers. It is not necessary, for example, to explain about sex in order to teach about babies born with HIV. Some aspects of AIDS can be taught in the context of geography, science, hygiene and other school topics.

Countries vary greatly. In Uganda, for example, elements of sex education and AIDS are often taught to children as young as six. The reason is that in towns or villages where up to a third of the population is HIV-infected, most children will have seen members of their own families die from AIDS. The illness dominates local life, and an explanation has been found to be necessary. In comparison, such topics are very difficult to discuss with young children in a country like Thailand.

Lesson 18: AIDS education needed before some leave school

With many pupils leaving school at the age of sixteen in countries like the UK, AIDS education must start earlier. A recent survey in Scotland showed that those leaving school early are often much less likely to take notice of public health messages later, and this group may take greater risks than those who carry on with general education. School education is therefore particularly important for this group.

Lesson 19: Establishing traditional behaviour patterns as most common can be very effective

Behaviour is often influenced by peer pressure, or by what people think everybody else is doing. Media and peer group conversation tends to exaggerate reality, however. For example, it may give the impression: 'Almost all my friends sleep around,' or, 'Most of my friends use drugs,' or, 'Hardly anyone these days is still a virgin by their eighteenth birthday.' A lot of talk, but little or no performance.

Can these impressions be changed? A US study compared two approaches to prevention of smoking, alcohol abuse and use of marijuana by schoolchildren. The first method taught skills to pupils to help them refuse unwanted offers. The second corrected falsely-high impressions of how many other pupils were experimenting, and of what most others in the school thought of these behaviours.

The second 'normative' approach worked well in altering reported behaviour one year after the programme. The first had fewer measurable effects. It is essential also to reinforce the positive behaviour of the large number of teenagers who do not abuse alcohol or other drugs, or take sexual risks. They are without doubt the majority in most parts of the world.

This is really important. Those who say no to drugs or sexual activity as teenagers need to understand that they are in good company. Despite all the noise, most others in the classroom have made exactly the same decisions and share the same values. Far too often teenagers have drifted into risky behaviour after becoming convinced that abstinence is eccentric and that they needed to take risks just to be seen to be normal. This is particularly tragic, since the pressures on them are based on cruel deception, totally false impressions which will ultimately

kill some of them.

Normalisation of abstinent behaviour could be the most powerful weapon we have: using peer group pressure.

Take the use of drugs. Even in a country where most teenagers have tried something by the time they leave school the situation is far less bad than it appears. The majority of those trying drugs will have done so only once or twice, and other regular users give up after a brief phase. Why? Because they didn't like it or because it is "un-cool". Surveys show that "life-time" use of drugs is far higher than figures for how many teenagers have used drugs in the last six months. It's time to talk about the truth. Saying no is normal. It's what most young people do!

Lesson 20: Social skills/peer resistance training works

Many studies have shown that classes designed to help pupils develop the ability to say no are effective in behaviour change. Facts are essential to understand the problem, and personal presentation is vital to make the problem real, but pupils may still take risks against their wishes if they feel insecure about themselves with a poor self-image, and are afraid of being looked down on or laughed at.

Surveys show that problems and issues faced are remarkably similar from country to country. This is also true in the experience of international agencies like ACET. While cultural sensitivities vary and may require adjustment of content and approach, many basic issues such as motivation, communication and long-term behaviour change remain the same. People are people after all.

The impact of schools programmes is likely to be greatest when mass media campaigns are also part of the overall national picture, as studies on teenage smoking have shown.

Dealing with criticism

In such a sensitive area, whatever one does will be criticised. The test of whether you have the balance about right in schools is probably when you are criticised from several different sides equally, but none too severely.

Constructive criticism must always be taken seriously, especially if it relates to conduct or lesson content. That is why evaluation forms are essential. You want to pick up a slight problem with an educator's approach long before there is a complaint.

We need to understand the background to the criticism. For example, there are hundreds of self-appointed experts in the UK when it comes to AIDS prevention. Hardly any of them have any real experience of teaching about AIDS in schools, or if they do it may be in just one or two schools which are unrepresentative of the country as a whole.

Coping with the 'thought police'

Sometimes comments made from 'non-school' sources can be vitriolic. Valid points may be being made, but I often wonder why they have been allowed into so few schools themselves if they are such experts on getting the message right. Why have their own resources and leaflets found so little favour?

The classroom is a uniquely difficult and sensitive environment and my feeling has always been that it is up to teachers and pupils to tell us what they need.

We must allow teachers to get on with the job. They are the experts, we are the assistants. Failure to recognise this has been the reason why so little government-sourced material has been used in schools in some countries such as the UK. It is nothing short of a scandal that a modest schools programme like ACET's, intended as no more than a pilot to show what could be done nationally, should turn out to be the largest programme of its kind in the England.

Perhaps there is little new under the sun when it comes to HIV prevention---or criticisms of it. Negative reactions to schools programmes run by Christian organisations have tended to be

very repetitive along ten main themes.

Objection 1: 'Large classes are a waste of time'

It is obvious that the more time spent with a group of pupils, and the higher the presenter-to-pupil ratio, the greater the impact is likely to be, but we have already seen that larger classes may be the only ones on offer in a school. A school which opts for a single large presentation one year as an experiment, will often open up more of the timetable the following year. Most schools need time to find their way forward.

Objection 2: 'Faithfulness to one partner is a naive suggestion'

Some think it is hopelessly naive even to mention the option of being faithful to one person, let alone staying with one partner for life. It is interesting that in almost every class I have been into pupils have worked out the options of abstention and monogamy for themselves---and the benefits.

When you ask them what 'safe sex' is, there are usually two reactions. If you ask who has seen the slogan 'condoms mean safe sex' or 'for safe sex use a condom', you will often find every hand shoots into the air. Almost always they have misread official slogans by dropping the 'r' off the end of 'safer' to remember 'safe'. However, when you ask pupils what they think, those with an ounce of common sense tell you that safe sex is certainly not using a condom. They know friends or relatives who became pregnant using them.

I would argue that it is hopelessly naive to expect that pupils are going to decide after your lesson to use condoms every time they have sex until the day they die, when the alternative of a test in a long-term relationship is so simple. Also, many people are searching for love that lasts.

Objection 3: 'Suggesting celibacy or monogamy as options is moralistic'

Some say that you should not make any suggestions at all about behaviour, nor propose any role models. 'Pupils should be totally free from any proactive or directive approach.' They say it is moralistic to talk about keeping to one partner or to suggest not having a sexual partner at all.

In reply, three points need to be made. First, medical facts are morally neutral. It is a medical and human fact that it is possible for people to refrain from sexual activity or promiscuity, and that this can be a very healthy way to live---for a start it protects you from sex diseases. Secondly, in countries like the UK there are legal requirements to present sex education 'in such a manner as to encourage those pupils to have regard to moral considerations and the value of family life'. Thirdly, even if such an approach was not required by law, the parents and governors of most schools in the country would insist on it anyway.

Having addressed a number of Parent/Teacher associations, it is obvious that some of the most conservative parents are those who were themselves teenagers in the 1960s and are now deeply concerned about their children living the way they did in a pre-AIDS world. Many still want marriage to work for themselves and most of all for their children.

Objection 4: 'If you don't show people how to use condoms they won't bother or they will make mistakes'

It is true that people should be encouraged to familiarise themselves with a condom before they need to use one. The best place for this to happen is in the privacy of the person's own home, where the packet can be opened, the condom examined, the instructions read and if necessary experimented with. Demonstrating condoms to children under sixteen years of age could be taken to be encouraging under-age sex in many countries, and even over that age you could land yourself in trouble.

Objection 5: 'Visiting speakers are dangerous because they do not fit into the overall work of the school'

We have already discussed the importance of each educator becoming, in effect, an extension of the head teacher's own staff in the school. Nothing is worse than a hit-and-run approach with no continuity, no follow up and little impact.

We have also noticed the huge advantages many schools see in outside carer/educators. They have impact because they are involved in care. They are respected experts. They are seen as non-threatening and not part of the establishment. They are often easier for pupils to talk to. They bring a fresh perspective to the school.

Objection 6: 'Not enough time is given to gay issues'

As we have seen, AIDS prevention is about preventing HIV transmission through risky sexual practices and drug injecting, not about sexual orientation. This important area is a part of overall sex education, as well as personal lifeskills and social education. In any case, as the epidemic unfolds, gay issues are increasingly irrelevant in the global AIDS picture.

Objection 7: 'You fail to point out that you are almost 100% safe in low incidence countries unless you inject drugs or have anal sex with a gay man'

Objections 6 and 7 are almost opposites of each other. If we spend time on the relationship between a gay lifestyle and AIDS, we also create the impression that AIDS is just a gay problem, when as we have seen, AIDS is an increasing threat to heterosexuals in industrialised countries and a huge risk in developing countries. If we spend no time on gay lifestyles we create the false impression that all in our society are equally at risk.

It is 'politically correct' to say there is no such thing as an 'at risk group', but only 'at risk behaviour'. While it is important that we teach people not to hide behind labels and prejudice, we may be in danger of splitting hairs. It is certainly true that the risk of a gay man picking up HIV from a sexual encounter in a gay bar in London is hundreds of times greater than the risk of a heterosexual man picking up HIV from a girl he meets at a party in the North of England. However, in the classroom we have a very short time to put across a simple message that AIDS is real, HIV is spreading and these are the ways to protect yourself and those you love. Although the risks are low, it is a fact that some have become HIV-infected after a single episode of unprotected sex (see Chapter 6).

People object if you talk about the illness as it really is. We know what we are talking about. AIDS is a very unpleasant illness, with many unpleasant symptoms which are difficult to treat. People do not just live with AIDS, they die too.

I often say to classes in schools that I hope we do not ever have to look after any of them. After all, that is why I am there: to try to save their lives if I can. If they carry on behaving like some of those who left the school over the last few years, then it is likely that doctors or nurses will be caring for some of them too. This is a frightening thought and it greatly disturbs me too.

A few years ago people were reluctant to talk about dying with AIDS because it created a negative image. This is ridiculous. If you create the impression that to have AIDS is to be a hero, that living with AIDS can be fun, that you can live for many years and there is a lot of hope for a cure, then don't be surprised when people decide there is nothing to worry about.

Objection 9: 'You are creating a negative view of sex'

Some say that if we talk a lot about the dangers of unrestrained sexual activity, then a new Victorian age of sexually-repressed people will emerge. I have met some HIV educators who have openly told me that one of their purposes is to help teenage boys and girls feel happy about their bodies and about their sexuality, so they feel free to enjoy themselves.

Half the emphasis of their presentations is therefore on sexual enjoyment---for example, teaching young girls about orgasm---and the other half is on how to have fun more safely. They say this is realistic and fits in with what the pupils are doing anyway. As you can imagine, they very rarely get the chance to give such presentations in UK schools. This approach certainly fits well with our culture. You only have to wander into a video shop to see what I mean.

Western culture has produced conditions for the rapid spread of HIV and AIDS by encouraging a casual view of sex, through mass communications with a global influence. Our culture is out of date and needs to change in a post-AIDS world. There is no such thing as free sex without cost. At the same time, Western influence has had a huge effect on liberalising sexual constraint in many traditional tribal cultures. In many people groups, where premarital sex or adultery was prohibited and rare, promiscuity is now common.

As we have seen, surveys show that the younger someone is when they first have sex, the more likely they are to have multiple partners. There is also a strong relationship between the age at which a girl first has sex and her risk of cervical cancer. This cancer is often caused by a virus which is sexually transmitted. It appears that the immature cervix of a young teenager is

particularly vulnerable to infection. Deaths from cervical cancer are increasing, despite intensive screening programmes.

Other sexually-transmitted diseases are emerging for which treatment is difficult or impossible. For example, genital herpes, which produces clusters of highly-infectious and painful blisters from time to time throughout life, and genital warts, which require repeated treatments with caustic substances. In the last twelve months alone, 250 million people worldwide became infected with a sexually-transmitted disease. The highest incidence is in twenty- to twenty-four-year-olds followed by fifteen- to nineteen-year-olds.

In these circumstances, I feel as a doctor that we do our young people a gross disservice by making out sex is always wonderful. This is totally ignoring the pain and devastation felt by many pupils in almost every class as a result of marriage break up, or the collapse of stable relationships outside of marriage.

. On many occasions, unfaithfulness is at the root of the problem. It is always the children who suffer, caught up in conflicts with split loyalties, and with possibly two 'mums' or 'dads'.

A national UK survey showed that children of divorced parents often continue to suffer well into adult life, when they are more likely to be unemployed and experience psychological difficulties. There are real costs attached to so-called sexual freedom and these need to be clearly taught and understood.

It is also vitally important to give a very positive message about sex as a wonderful experience; something which gives great pleasure and can be very fulfilling, especially when it is an expression of love, respect, appreciation, care and commitment. Sex is something well worth waiting for. The UK Population Trends survey shows that couples living together before they get married are more likely to be divorced fifteen years after marriage than those who do not.

At this point we start hearing objection number 3 again, with suggestions that the previous sentence contains highly moralistic, right wing, Christian propaganda. No wonder schools are voting with their feet.

Objection 10: 'You should teach people other ways to have sex'

The AIDS industry continues to churn out large numbers of guides to safer sex which give long lists of 'low risk' or 'no risk' activities. Examples of 'safe sex' given include rubbing each other's thighs, mutual masturbation and 'talking dirty' on the phone to each other while masturbating.

Some seriously suggest we should be discussing some of these options in schools. They have obviously never tried such an approach with pupils. Laughter is the only response you are likely to get from a class if you seriously suggest that rubbing each other's thighs is the same thing as having sex. That certainly is naive. The suggestion may be valid for gay men who know there is a one-in-three chance that their next partner could be infected, but it does not go down too well with teenagers in low-incidence countries.

Why should they bother with such a feeble substitute for the real thing when they know they can enjoy rubber-free, anxiety-free, penetrative sex for life, with the help of an HIV test if they or their partner has been at risk in the past? As we have seen earlier, deciding whether to have a test is a delicate business and all those wanting a test should be carefully counselled first.

Over-promotion can be a problem

Having looked at ten of the commonest criticisms ACET has faced, we need to look at the opposite problem: over-promotion of a church programme by well-meaning Christians who want to help. A lot of damage can be done. For example, if someone known to be a moral campaigner goes to the head teacher and begins a campaign to get you in, it would be better if that person had never started.

Setting up a schools programme

As we have seen above, you need to take very great care indeed before rushing in as an AIDS educator. The reason is that an amateurish and clumsy approach to this sensitive area could jeopardise the work of many other agencies.

If you are already established as a youth or schools worker supported by churches in the area, then you may be able with care to include some aspects of AIDS in what you are doing. However, you will need to make absolutely sure you get your facts and general approach right. The ACET/ABI teacher pack may help in this, together with ACET's training courses. You will have greatest impact, as we have seen, if you have been involved in caring for those with AIDS.

The Truth About AIDS

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