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Challenges

durex network - Raising awareness of sexual health across the globe

Autumn 2008

The power of broadcast media to influence sexual health

Sexual content on TV and the Internet has been found to influence the attitude of teenagers towards sex, leading to calls for more safer sex messages on air

WRITING IN the February 2008 issue of the *Journal of Obstetrics and Gynaecology Canada* (JOGC), Victor C. Strasburger, professor of Paediatrics, Family and Community Medicine at the University of New Mexico, has warned that parents are out of touch with the messages their children are receiving.

"Parents seem to worry most about pornography on the Internet, but the number of sexual messages their children have been given on television and in movies by the time they reach adolescence is astounding: an estimated 14,000 references per year on television alone," Dr Strasburger reported.

"On American television, for example, more than 75% of shows now have sexual content, yet less than 15% provide responsible sexual information about abstinence, birth control or the risks of pregnancy or sexually transmitted infections."

The 2005 report of the *Sex on TV* series of studies carried out since 1999 by the Kaiser Family Foundation has already highlighted the fact that "references to safer sex or sexual risks or responsibilities remain rare on TV" and that "following an increase in 2002, the proportion of shows including such references has levelled off".

The direct effect on teenagers of sexual content on TV has been widely shown through research. A US survey of more than 1,700 12-17 year-olds carried out in 2004 and published in *Pediatrics* found that those who view television programmes containing a significant amount of sexual content are twice as likely to become involved sexually at a younger age as those who watched fewer such programmes.

Psychologist Rebecca Collins, the study's lead researcher, said 12 year-olds who viewed large amounts of sexual content on TV behaved sexually more like children who were two or three years older. "The advancement in sexual behaviour we saw among kids who watched a lot of sexual television was striking," she said.

"The impact of television viewing is so large that even a moderate shift in the sexual

Continued on page 3

Inside News

Page 2-3 Comprehensive condom programming in Zimbabwe

Page 4-5 Using scientific evidence in public health

Page 6 Helping parents talk to their children

Page 7 Focus on the latest UNAIDS report

Turning the tide against the spread of AIDS

Zimbabwe has become the first southern African country to experience a decline in HIV prevalence – with comprehensive condom programming (CCP) proving a key component in its HIV/AIDS response

Gathering for a HIV prevention talk in a Zimbabwean school

ALTHOUGH STILL suffering one of the largest HIV epidemics in the world, Zimbabwe is reporting figures that show the spread of infection is now steadily decreasing year by year.

The country's first case of AIDS was identified in 1985 and, by the end of the 1990s, HIV/AIDS had spread to 29 per cent of its adult population aged 15-49, which is currently some 12 million people.

However, in recent years, the trend has been progressively downwards. The HIV prevalence was reduced to 26.5 per cent by 2001 and to 15.6 per cent last year.

The decline has been recorded both within the general population and in the percentage of pregnant women who are infected, which dropped from 26 per cent in 2004 to 18 per cent in 2006.

In its 2006-2007 Zimbabwe Country Report, the United Nations General Assembly Session (UNGASS) on HIV/AIDS attributed the decline to a combination of mortality and behaviour change.

UNGASS reported that the future course of the epidemic within the country depends on a number of variables, including HIV/AIDS knowledge levels among the general population, modifying risk behaviour and an uptake of prevention services.

It highlighted that the principal mode of HIV transmission in Zimbabwe is heterosexual contact and commented: "Knowledge of how HIV is transmitted is crucial to enabling people to avoid HIV, especially for young people who are often at a greater risk."

Comprehensive condom programming (CCP) has been a key component of increasing this knowledge among all ages of the adult Zimbabwean population.

Established by the United Nations Population Fund (UNFPA), CCP programmes around the world work to create a demand for male and female condoms and ensure adequate supply. The goal is to reduce the number of unprotected sex acts, which will in turn reduce the incidence of unintended pregnancy and STIs.

CCP combines various activities within its programme to promote condom use and behaviour change, while at the same time conducting market research and coordinating supply management.

Daisy Nyamukapa of UNFPA in Zimbabwe, together with Dr Krishna Jafa of Population Service International (PSI) Zimbabwe, gave a joint presentation on the country's CCP initiative to the XVII International AIDS conference in Mexico City in August 2008.

They explained how CCP had been integrated into their country's national HIV prevention campaign and was responding to the characteristics of the local epidemic – focusing on who is vulnerable and at risk and why.

Condom awareness initiatives have ranged from wall murals, community events and road show demonstrations to interpersonal sessions. And training has

Continued on page 3

Turning the tide...

Continued from page 2
been provided not only to professional educators but also those, such as community based distributors (CBDs), hairdressers and beauticians, who talk to their clients on a one-to-one basis.

Hair salons have been among a number of social marketing outlets, along with liquor stores and service stations, through which PSI and the Zimbabwean government sold over 90 million male and female condoms in 2007.

The safer sex message has proved effective when targeted towards adults at highest risk and 71 per cent of men now use a condom during sex with a non-cohabiting partner – although less than 10 per cent do so when they are sleeping with their wives.

And promoting the wider availability of female condoms has proved more successful in Zimbabwe than in many other African countries. An increasing number of women are now buying the condoms for themselves.

Daisy Nyamukapa commented: "We can almost be assured those people are going to be using the condom because they are paying for it."

She said a female condom gives women an extra measure of control over contraception and STI prevention. "That's particularly important for women in cultures where they do not traditionally hold equal power to men. It gives a woman an option when her male partner doesn't want to wear a condom himself."

Young people in Zimbabwe also now have a wider understanding of HIV/AIDS than average for sub-Saharan Africa. A recent UNAIDS report found 55 per cent of those aged 15-24 in the country could identify ways to prevent HIV, compared with only 19 per cent in Nigeria.

Krishna Jafa presenting at the CCP Satellite Session at AIDS 2008

Bidia Deperthes of UNFPA commented: "There has been some significant progress made in Zimbabwe and that is very encouraging for the future. Male condoms, but more particularly female condom distribution and use, have reached levels never seen in the country before. CCP has been identified as a successful element of the National HIV prevention strategy, but with around one-in-seven adults in the country living with HIV there is a great deal more to be done, including targeting remote and marginalized populations." ■

The power of broadcast media...

Continued from page 1
content of adolescent TV watching could have a substantial effect on their sexual behaviour."

Dr Strasburger has called on programme makers to help teach sex education in a responsible way, using public health messages embedded within mainstream programming. Examples where this has been used effectively in the past include an episode of *ER* which increased knowledge of emergency contraception and a storyline in *Friends* that taught teenagers about condoms.

"The television networks could help by airing more commercials for birth control and emergency contraceptives and fewer commercials for erectile dysfunction drugs and commercials that use suggestive sexuality to try to sell more product," he said.

Soap operas can be used to great effect, as has been shown in a case study on American sitcom *Grey's Anatomy.* The Kaiser Family Foundation conducted three national telephone surveys of viewers in order to measure the impact of a storyline involving mother-to-child HIV transmission featured in the 1 May 2008 episode.

The surveys were conducted one week before, one week after, and six weeks after the target episode aired. The results showed that the audience's awareness of the issue increased by 46 per cent one week after viewing the episode, and after six weeks, 45 per cent of the episode's viewers still responded correctly about the chances of mother-to-child HIV transmission.

Victoria Rideout, vice president and director of the Program for the Study of Media and Health at the Kaiser Family Foundation, and author of the *Grey's Anatomy* study, said: "This study shows the enormous potential for entertainment television to serve as a health educator."

Another example of the positive influence of broadcast media on sexual health is that of the award-winning Rwandan radio show *Urunana,* which has an estimated audience of 10 million. The show blends education and entertainment to take on subjects from HIV/AIDS to infertility.

"Before the programme it was taboo to talk about sexuality," said its writer Samuel Kyambagidwa in an interview with the BBC's Network Africa programme. "Now it gives people a starting point; for example, it gives a grandparent the courage to discuss things with their grandchild that they have heard on *Urunana."*

Positive use of television has also been taken up by the Chinese government for the first time this year to promote condom use in the fight against HIV/AIDS. Celebrities such as film star Jackie Chan and actor Pu Cunxin have been taking part in commercials targeting the nation's young people.

Pu Cunxin said it marked a breakthrough that sex was able to be discussed publicly. "That this appears on television is a very big advance," he said. ■

Advancing public health: are we "doing the right thing"?

Programme design and policy making in public health are highly contested and contentious fields. Increasingly, efforts to utilise more reliable strategies to inform decisions are being made, but shaping an evidence base for public health is still very much work in progress

EVIDENCE-BASED strategies are needed if we are ever to overcome HIV/AIDS. This was one of the main themes underlying the XVII International AIDS Conference (AIDS 2008) that was held in Mexico in August 2008.

Do the Right Thing, one of six cross cutting themes for multi-disciplinary contributions at the conference, focused on how to guarantee that public policies and interventions by all concerned partners are based on the best available evidence and on established good practices at the global, national and local levels.

But as International AIDS Society (IAS) president Professor Julio Montaner said in his closing speech: "Over the previous three decades, we have collectively accumulated a tremendous amount of knowledge regarding what needs to be done to combat HIV effectively at the individual and societal levels. Yet, implementation flounders."

The news is full of reports on successful public health interventions and programmes. Yet, for every victory at one end of the world, many setbacks arise somewhere else.

Achieving consistent victories

The issue seems to be a recurrent one: how do we successfully replicate in other contexts programmes that have proven effective in a given environment? In other words, how do we use the informal knowledge base that has been built over the years to inform the development, scale-up and implementation of new interventions?

A volunteer health worker discusses the quality of health services at a maternity clinic in Ecuador

That AIDS 2008 chose to focus on evidence clearly highlights how crucial evidence is in the advancement of the HIV/AIDS response in particular, and public health in general. Without mechanisms to produce and use evidence, it is easy to misinterpret programme results or to rely on ideologies, assumptions or trends as the basis of a new intervention.

In both cases, the consequences can be disastrous: adverse reactions of the target population – these can go as far as endangering livelihoods in some cases – waste of resources and time or loss of trust and support from donors, decision-makers and the general public.

In the light of this, the production, evaluation and utilisation of scientific evidence become a necessity rather than just a bonus. However, when it comes to identifying what constitutes evidence in the public health context, interpretations diverge depending on standpoints.

Defining evidence-based practices

It is generally accepted that the concept of evidence-based practice (EBP) links back to that of evidence-based medicine (EBM), first conceptualised in the 1990s by Prof. David Sackett, head of the Centre for Evidence Based Medicine in Oxford, UK and Prof. Gordon Guyatt of McMaster University in Hamilton, Canada.

The main tenets of evidence-based practice, as for evidence-based medicine, are that decision making must rely on "the informed, explicit and judicious use of current best evidence" (Sackett et al. 1996).

According to the *Glossary for Evidence Based Public Health* published in the *Journal of Epidemiology and Community*

Continued on page 5

Continued from page 4

Health in 2004, in the context of public health, this specifically refers to evidence "that has been derived from any of a variety of science and social science research and evaluation methods".

This definition implies that there should be specific mechanisms to appraise the value of scientific studies in order to identify the strength level of the evidence they are able to provide. It also assumes that once the evidence is evaluated, it is then successfully made available to parties who would benefit from using it to inform their decision making.

But there are a number of problems at different levels of this process. Studies that can provide a strong enough level of evidence – ideally randomised studies, which are considered the gold standard of EBP – cannot always be carried out due to financial or practical reasons.

And if they are carried out, defining their success criteria can prove a challenging task, especially when what is attempted to be measured is the non-occurrence of negative outcomes – non-occurrence of risk-behaviour in behaviour-change programmes for instance.

A high number of studies, however, do satisfy the evaluation criteria to form part – at least in theory – of an evidence base for public health. The issue of accessibility to non-researchers then becomes the next stumbling block which can cause this evidence base to remain elusive.

In *Behavior Change and HIV Prevention: (Re)Considerations for the 21st Century* published in August 2008, the Global HIV Prevention Working Group commented: "Notwithstanding the strong evidence base for HIV prevention, policy makers and affected communities still express a need for such information and/or misunderstand what is known."

It is as though the evidence base remained invisible to those who could most benefit from it. Yet, despite the apparent complexity in getting evidence-based practices to work effectively, the advantages greatly outweigh the inconveniences.

Evidence: not the gold standard?

Evidence bases can be used to inform the planning, implementation and monitoring of programmes to ensure efficacy of pilots and effectiveness when scaling-up in the field. Scientifically proven effectiveness can help secure the recruitment and retention of programme participants. It also makes it possible to extract learnings that can be replicated in different contexts or adapted as part of new interventions.

Furthermore, receiving funding is invariably dependent on the demonstrable satisfaction of pre-determined criteria, such as likelihood to produce positive social or health benefits, accountability, transparency and sustainability.

Secondary school-aged girls learn about contraceptive methods at a youth reproductive health clinic in Thailand

Outside the programmatic world, evidence is also a prime tool for policy making. Where available, scientific evidence can be weighed against political, cultural and economical imperatives to ensure that whichever decision is reached will not be detrimental to the pursuit of social good.

So why is evidence not always seen as a cornerstone of programme design and policy planning?

Miguel Fontes, director of John Snow Brasil, a leading Global Social Marketing consultancy, has had extensive experience working on behaviour-change programmes around the world. He said: "Beyond problems of accessibility, the single, most powerful barrier to the consistent use of evidence-based practices is cost. Such a meticulous methodology requires a huge chunk of any funding grant as well as a great deal of time without a guarantee that any benefits will ever be yielded.

"In resource-limited settings, therefore, programme teams sometimes have to make a choice between establishing an evidence base for the design of their intervention or carrying out the intervention itself. Unfortunately, the fast-moving nature of our society tends to work against the adoption of much needed but costly long-term strategies."

Other barriers also exist beyond that of resource and time cost: reliance on assumptions and expert opinion, reliance on values and ideologies, resistance to existing evidence and difficulty of making sense of such a huge body of knowledge are just a few of them.

And evidence must also be put in context, where it is only one of the building blocks of policy making and programme design processes, alongside an array of other methodologies and strategies.

Fontes added: "All these difficulties are part and parcel of our work. Public health professionals have learnt to take them into account and to cope with them. An increasing number of programmes are having encouraging results so I do think we are going in the right direction." ■

Better informed parents are more ready to discuss sexual health

Courses being held in the UK and the US are proving effective in giving parents the knowledge they need to talk to their children about sex

In the UK, a series of *Speakeasy* courses have been run since 2002 by sexual health charity fpa to encourage parents to gain greater confidence in discussing issues they may previously have considered embarrassing.

The eight-week courses are targeted in areas of the country with multiple deprivation and high teenage pregnancy rates. Topics covered include contraception, sexually transmitted infections and the outside pressures placed upon young people.

In an evaluation of a course organised in the city of Birmingham earlier this year, it was found that people who had attended felt their factual knowledge had been greatly increased. They had gained confidence in talking about sex, sexuality and sexual health issues and were now more open with their children.

The evaluation was commissioned by Birmingham Family Learning Service and carried out by Josephine Ramm and Dr Lester Coleman.

Although noting that the evaluation findings from one course should not be generalised, the authors said the analysis indicated the project was meeting its aims with the parents and young people feeling it had had a positive impact on their relationship.

It was also having a wider effect with the young people reporting that they were sharing the information with their peers.

"Pamphlets from the course were often shared between friends and young people and it was occasionally reported that they talked to their friends about their parent's course," the evaluation recorded.

"Young people also observed that they now had different attitudes towards sex and sex education than some of their peers at school."

The findings confirmed an earlier study carried out in 2007 (Coleman, Cater, Ramm and Sherriff) which also found the courses were achieving their aims. Before taking part, only 61 per cent of parents said they felt able to talk openly to their children about sex, rising to 96 per cent after the course was completed.

A programme underway in southern California – *Talking Parents, Healthy Teens* - is taking a similar approach to promoting parent-adolescent communication about sexual health.

These courses, also spread over an eight-week period, are held at the parents' worksites during their lunch hour to make it as easy as possible for them to attend.

An evaluation of the success of 13 worksite courses – published this summer in the *British Medical Journal* – was led by Dr Mark Schuster of the University of California. This reported that the programme appeared to have significant immediate effects.

It said: "Compared with control parents, intervention parents reported more conversations about new sexual topics and more repeated conversations about topics they had already discussed."

A particularly dramatic illustration of the programme's impact was through reports from the adolescents on whether their parents taught them how to use condoms. "At baseline, few parents had done this, but at the end of the programme a large and significant difference between the groups emerged.

"At three and nine months, the difference not only remained but actually widened, indicating an ongoing influence of the programme on parents' behaviour."

The core programme is being run over a five-year period, ending in 2009, and is aimed at parents of children aged 11-16 years in the 6th-10th grade. ■

Many teenagers trust their parents when it comes to sexual health information

UNAIDS report calls for a refined understanding of local trends in HIV pandemic

Prevention programmes are increasingly successful in reducing new HIV infections and AIDS-related deaths, however the AIDS epidemic is far from being over in any part of the world

WHEN THE UNAIDS 2008 *Report on the Global AIDS Epidemic* was published in July, much media coverage was devoted to success stories in heavily affected countries. In particular, Rwanda and Zimbabwe were cited as countries where changes in sexual behaviour had resulted in declines in the number of new HIV infections.

That, at least, made up the bulk of the mainstream headlines. But a closer look at the report reveals some worrying trends among Western European countries and the North American continent.

For example, in the United States, Canada and the United Kingdom, the number of newly diagnosed HIV infections resulting from unprotected sex between men continued to rise. In the UK, the figure nearly doubled between 2001 and 2006, rising from 1,434 to 2,597, while the USA saw an 11 per cent increase over the same period. Germany, Switzerland and Belgium were other countries that witnessed a significant rise in the number of newly diagnosed infections resulting from unprotected sex between men.

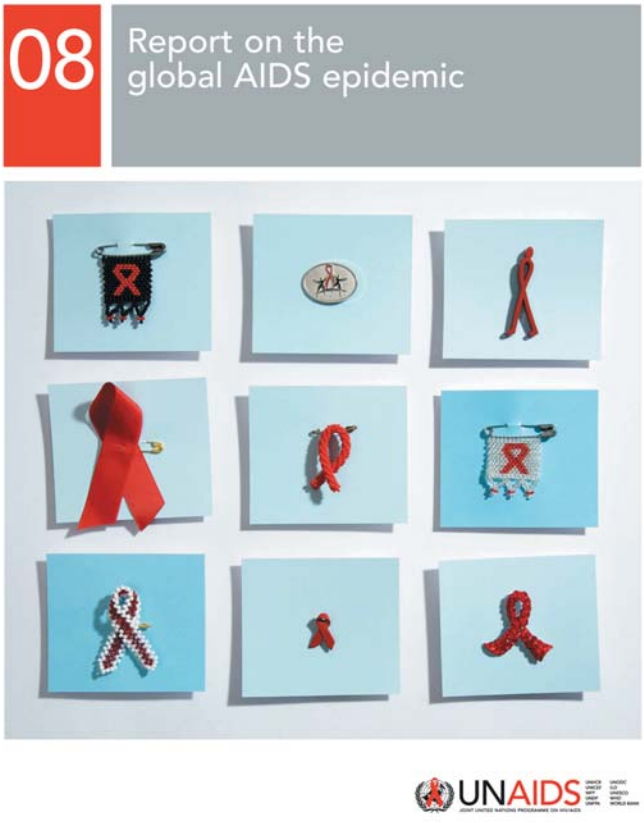
Another striking trend outlined in the report is that ethnic minorities in these countries continue to be disproportionately affected by new HIV and AIDS diagnoses. In North-America, African-Americans represent 13 per cent of the population but accounted for 48 per cent of new diagnoses in 2005. Similarly, Aboriginal persons make up 3.8 per cent of Canada's population but represented 9 per cent of that country's new infections in 2005.

Individual countries in these regions have their specific challenges, according to the UNAIDS report. For instance, in the United Kingdom:

– The annual number of newly diagnosed HIV infections more than doubled from 4,152 in 2001 to 8,925 in 2006. The country has one of the highest rates of new HIV diagnoses in Western and Central Europe

– The HIV epidemic continues to be centred in London, with the capital accounting for 41 per cent of new diagnoses in 2006. However, mention is made of "significant increases" in new diagnoses in the East Midlands, Northern Ireland and Wales

– The number of HIV diagnoses in people who acquired their infection through heterosexual sex almost doubled between 2001 and 2006. Most of these new infections were also found to have been acquired as a result of unprotected sex in high prevalence countries.



In Canada:

– One in four people infected with the HIV virus are unaware of their status

– 16 per cent of new infections in 2005 were in people from regions where HIV is endemic, such as sub-Saharan Africa and the Caribbean.

The report – in line with a recent announcement from the Centers for Disease Control and Prevention – does suggest that an increase in HIV testing may have contributed in part to the large rise in newly diagnosed infections referred to above.

However, there are calls throughout the report for revitalised and newly targeted HIV prevention campaigns. To quote some of the report's most telling words devoted to Western Europe, the United States and Canada: "Knowing your local epidemic remains critical to effective prevention efforts. Over time, trends have changed within regions and countries." ■

To download the full report, log on to http://www.unaids.org and visit the website's Knowledge Centre.

Comprehensive sex education reduces teen pregnancies

New research has revealed that American teenagers who receive comprehensive sex education are 60 per cent less likely to become pregnant

THE RESEARCH, published in the *Journal of Adolescent Health* in April 2008 and led by Pamela Kohler of the University of Washington, focused on heterosexual teenagers aged 15-19 years.

It found that 25 per cent of those surveyed had received abstinence-only education, 9 per cent had no sex instruction and the remaining two-thirds received comprehensive education with discussion on birth control.

While the benefits of comprehensive education were clear, those of abstinence-only teaching were less so. The indications were that instructing teenagers just to say no could reduce the likelihood of pregnancy compared with giving no instruction, however the researchers deemed the numbers were statistically too low for analysis.

Kohler said her findings supported comprehensive sex education. “It is not harmful to teach teens about birth control in addition to abstinence,” she commented. “There was no evidence to suggest that abstinence-only education ever decreased the likelihood of having sex or getting pregnant.”

These findings have been echoed in recent research, including that of adolescent sexuality expert Dr Douglas Kirby. The research, carried out in 2007, was a systematic review of worldwide studies to determine the impact of curriculum-based sex and HIV education programmes on sexual risk behaviours, knowledge and attitudes.

Some 83 studies were reviewed and two-thirds of the programmes, which targeted 9 to 25 year-olds, were found to significantly improve one or more sexual behaviours. Moreover, those programmes were found to delay or decrease sexual behaviours or increase contraceptive use.

Better comprehensive sex education on an international scale has also been called for at a satellite session during the XVII International AIDS Conference in Mexico City this summer.

Brian Ackerman, international policy manager for Advocates for Youth, criticised the US global HIV/AIDS funding mechanism – the President’s Emergency Plan for AIDS Relief – for limiting some HIV prevention education programmes to abstinence and fidelity messages.

He said: "We demand recognition of our right to comprehensive sexuality education, to sexual health services and to commodities. Abstinence, no sex, celibacy, whatever you want to call it, is part and parcel of that package of comprehensive information about sexual health, but it cannot be the only part.

“Society should not be afraid of young people having sex – it is a reality,” he added, insisting that teenagers need more information about condom use. ■

Challenges **is an occasional publication produced by the Durex Network. While the articles are accurate summations of current sexual health matters, the views and opinions expressed are not those of the editor.**

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Sexual health conferences and events

51st Society for the Scientific Study of Sexuality Annual Meeting
The Cultural Dimensions of Sexuality
Date: 5 to 9 November 2008
Location: San Juan, Puerto Rico
Key theme: This conference will highlight the cultural dimensions of sexuality, drawing attention to the ways in which they interface with biological, social, and psychological dimensions of our sexuality.
Contact: http://www.sexscience.org

18th DGSS Annual Conference on Social Scientific Sexuality Research
Sexuality and the Media
Date: 7 to 9 November 2008
Location: Munich, Germany
Key theme: This conference will look at how the media shapes and influences sexuality.
Contact:
http://www.sexologie.org/kongress2008.htm

Dance4Life event
Date: 29 November 2008
Location: Global
Key theme: Connected live via satellite, young people from around the world dance together to raise awareness of HIV/AIDS in front of each other and the world. They dance to inspire the world, to gain their support, and to remind the world leaders of the promises they made regarding the Millennium Development Goals.
Contact: http://www.dance4life.com/

World AIDS Day 2008
Lead – empower – deliver
Date: 1 December 2008
Location: Global
Key theme: Leadership has been the World AIDS Day theme for the past two years. Building on the 2006 theme of accountability, leadership highlights the discrepancy between the commitments that have been made to halt the spread of AIDS, and actions taken to follow them through. Leadership empowers everyone – individuals, organisations, governments – to lead in the response to AIDS.
Contact:
http://www.worldaidscampaign.org/en/Key-events/World-AIDS-Day/World-AIDS-Day-2008

Second Congress of the Asia-Pacific Council on Contraception (APCOC)
Contraception for all: how, why, what and when
Date: 4 to 6 December 2008
Location: Macau, China
Key theme: This conference will cover a wide range of topics addressing issues of clinical relevance, including new and current contraceptive methods, sexuality and sex-related infections.
Contact:
http://www.comtecmed.com/apcoc/2008/