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Making sense of HIV & AIDS in Senegal:

social representations in narratives by urban youth

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Master of Public Health

Global Health

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2006

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An abstract of

a thesis submitted to the Faculty of the

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Abstract

Background: Senegal is considered one of sub-Saharan Africa's success stories in relation to the response to HIV, however the impact of HIV on health and well-being in the country remains considerable. Given that nearly half of all new infections occur in people under 25 years old, there is a need to understand how AIDS is socially constructed among young people in order to inform education and communication efforts aimed at HIV prevention.

Objective: Scenarios from Africa scriptwriting contests invite young Africans to contribute ideas for short fiction films to educate their communities about HIV & AIDS. The purpose of this research is to examine the cultural meanings that frame HIV & AIDS among urban Senegalese youth through the analysis of fictional narratives submitted to the 2008 Scenarios from Africa contest. Findings will explore the symbolic and social dimensions of how Senegalese youth make sense of HIV & AIDS and allow assessment of current communication needs.

Methods: Using qualitative data analysis and narrative-based methodologies, I analyzed a stratified random sample of 60 narratives submitted to the 2008 Scenarios from Africa contest by urban Senegalese youth aged 10-24.

Results: The narratives focused primarily on the circumstances of infection and on the post-infection period. HIV-related vulnerability was framed in terms of high-risk groups rather than specific behaviors that put an individual at risk. Women, poor people, sex workers, individuals with multiple partners, migrants and travelers were depicted as central to the spread of HIV. Despite a predominant focus on the circumstances of infection, many narratives ended with hopeful outcomes for people living with HIV & AIDS, including social support, activism and treatment uptake.

Conclusion: The process of 'othering' characteristic of the dataset presumes that HIV is contracted by high-risk groups through immoral behaviors and has the disadvantage of minimizing risk perception within the general population. The superficiality of mentions of HIV prevention strategies in the narratives suggests the need for a more integrated life skills development approach to HIV programming. Stigma reduction efforts, life skills development, and couples' communication are recommended as priority areas for future HIV prevention interventions.

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Malaïka Libambu Schiller

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Chapter 1: Introduction

The global HIV epidemic represents one of the most severe health and development challenges in history. More than 33 million people currently live with HIV worldwide (UNAIDS 2010), 68 percent of whom reside in sub-Saharan Africa. About 45 percent of all new infections in the sub-Saharan region are in young people between the ages of 15 and 24, and three quarters of these are among young women (UNAIDS 2008). Despite dramatic increases in global investments toward universal access to HIV prevention, treatment, care and support, numerous factors continue to drive the spread of HIV.

In West Africa, HIV prevalence in the general population is substantially lower than in other parts of sub-Saharan Africa, but epidemics among high-risk groups (e.g., sex workers, men who have sex with men) are common (USAID 2011). The HIV epidemic in Senegal can be classified as a concentrated epidemic, where HIV prevalence, though greater than 5 percent in high-risk groups, is lower than 1 percent in the general population (FHI/UNAIDS 2001). Senegal has a population of roughly 12.5 million people (PRB 2010) and an estimated 0.7 percent of the adult population is HIV positive (Ndiaye and Ayad 2006). The impact of early and comprehensive prevention efforts is rightfully acknowledged to have contributed to a historically low and stable HIV infection rate in Senegal (Meda, Ndoye et al. 1999). Although Senegal is considered one of sub-Saharan Africa's success stories in relation to the response to HIV, the impact of HIV on health and well-being in the country remains considerable. In 2009, an estimated 54,000 adults and 5,200 children were living with HIV. In the same year, approximately 19,000 Senegalese children were orphaned due to AIDS and roughly 2,600 people died of

AIDS-related causes (UNAIDS 2010). Across sub-Saharan Africa, women make up 60 percent of people living with HIV (WHO 2011). In this region, the risk of HIV is greater among women due to gender based inequalities, physiological susceptibility and violence against women (USAID 2011). In Senegal, nearly 1 percent of women are HIV-positive compared to 0.4 percent of men (Ndiaye and Ayad 2006). The effects of HIV are multi-layered – not only does HIV affect individual health, but it also negatively affects family and community relationships, livelihood opportunities and a nation's economic growth and development (KFF 2010).

Problem Statement

Youth are disproportionately affected by HIV, with nearly half of all new infections occurring in people under 25 years old (UNAIDS 2010). Despite their vulnerability, young people are the world's greatest hope for reducing the spread of HIV and reversing epidemiological trends (UNAIDS 2008). Prevention is the most critical step to curbing the epidemic, however normative values and misconceptions about HIV infection can minimize risk perception and impede behavior change. Survey data on sexual behaviors have limited explanatory power for understanding the context of youth vulnerability to HIV & AIDS. Few qualitative studies on adolescent sexuality have been conducted in Senegal in the last ten years. In light of this gap, there remains a need to examine youth perspectives on HIV & AIDS in a highly contextualized manner with the purpose of informing the development of locally-appropriate prevention programs. The current study focuses on fictional narratives written by young people. This creative writing

offers the young authors an opportunity to depersonalize sensitive topics and to define the agenda based on their own cultural and moral sense-making (Winskell 2011).

Purpose Statement

The purpose of this research is to examine the cultural meanings that frame HIV & AIDS among urban Senegalese youth through the analysis of fictional narratives submitted to the 2008 Scenarios from Africa contest. Findings will explore the symbolic and social dimensions of how Senegalese youth make sense of HIV/AIDS and allow assessment of current communication needs in urban Senegal (Winskell and Enger 2009).

Significance Statement

I use an innovative qualitative data source, namely fictional narratives, to tap into image-rich social representations of HIV & AIDS. Narratives provide insight into how people make sense of the world, and how they communicate those understandings to others in their cultural community (Bruner, 1990). The analysis is broadly situated within the Theory of Social Representations (Moscovici 1981; Joffe and Bettega 2003) which focuses on the complex symbolic, emotive and social aspects of everyday lay meaning-making. Social representations communicate norms and values in symbolic form. They are often pre-conscious and therefore less subject to informant bias than conscious evaluative judgments like attitudes. Narratives have been identified as a particularly valuable and underused data source for the study of social representations (Laszlo 1997; Murray 2002).

This study is situated within a multi-country research process on young Africans' narratives about HIV & AIDS (Winskell and Enger 2009). In their stories, young people draw on their own lived or imagined experience and on other culturally-determined sources of social understanding to create context, meaning and values (Winskell 2011). Thus, the Scenarios from Africa narratives provide unique insights into young people's explanatory models about HIV & AIDS, and into their appropriation of dominant cultural norms around gender, sexuality and stigma (Winskell 2011).

Definition of Terms

Acquired Immune Deficiency Syndrome (AIDS)*:* A disease of the human immune system caused by the Human Immunodeficiency Virus (HIV).

Anti-retroviral drugs (ARVs)*:* Medications for the treatment of HIV infection.

Higher-risk sex*:* Sex with a non-marital, non-cohabiting partner (Ndiaye and Ayad 2006).

Human Immunodeficiency Virus (HIV)*:* the virus that causes AIDS, which is characterized by progressive failure of the immune system. HIV is transmitted sexually, through infected blood, or from mother to child during pregnancy, childbirth or breast-feeding.

Symbolic stigma: Moral judgments attached to people living with HIV and AIDS (Herek 2002).

Urban: Refers to a city or densely populated area (includes peri-urban locations which are situated near city limits).

Youth: Young people between the ages of 10 and 24.

Chapter 2: Comprehensive Review of the Literature

This chapter synthesizes research on HIV & AIDS and sexuality among young people in Senegal up to the present. The literature provides an overview of the national response to HIV & AIDS, as well as related knowledge, attitudes, and behaviors among young people. The literature comprises publications from 1995 to 2010 that include vital statistics, data from relevant agencies, research findings and communications from public health experts.

The National Response

Senegal is the only country in sub-Saharan Africa that has maintained an HIV prevalence rate below 1 percent since the first case emerged in 1986, an achievement due in part to the early implementation of a comprehensive, well-designed national AIDS program (Meda, Ndoye et al. 1999). In 1986, the Government of Senegal established the National Program for the Fight Against AIDS (renamed the National Council for the Fight Against AIDS in 2002) to spearhead HIV prevention efforts that include compulsory blood transfusion screening, condom promotion, sentinel surveillance, HIV counseling and testing, national STI control, sex worker registration, the integration of HIV into sex education, and social mobilization (USAID 2010). Political support for a comprehensive HIV response was present at an early stage as a result of credible data generated by researchers (UNAIDS 1999). Health officials never denied the existence of AIDS and acted promptly (Diop 2000). Political leaders declared a need for political, religious and community engagement and, with the help of international donors, invested roughly $20 million dollars into AIDS prevention programs in the early 1990s (UNAIDS 1999).

The first National HIV/AIDS Strategic Plan was developed for the period 2002-2006 (USAID 2010). The current national strategic plan (2007-2011) stresses a multi-sectoral approach to HIV prevention. Cross-cutting issues in the plan include HIV and poverty, human rights protection, integration of PLWHA, stigma and discrimination, and gender empowerment (UNGASS 2010). The national plan encourages collaborative participation from government ministries, the private sector, religious and other civil society organizations, and people living with HIV & AIDS (PLWHA) (USAID 2010). . Senegal has a long and active tradition of community participation in health and development issues. Women's groups, youth groups, and other civil society organizations have been involved in HIV-related activities since the first case emerged in Senegal. Similarly, religious leaders have long provided their moral support as active participants in the national HIV response (UNAIDS 1999).

Prevention

State-level and NGO activities have primarily focused on HIV prevention since the onset of the epidemic (Meda, Ndoye et al. 1999). However several challenges in controlling HIV remain, including high population mobility, early sexual debut and high infection rates among high-risk groups (e.g. sex workers and men who have sex with men) (USAID 2010). Further, less than 2 percent of individuals know their HIV status (UNGASS 2008). As in most of sub-Saharan Africa, HIV infection in Senegal occurs primarily through heterosexual transmission. Therefore, most HIV prevention programs discourage multiple sexual partners and promote condom use in risky partnerships (UNAIDS 1999). Other key prevention messages include: sexual abstinence, delayed

sexual debut, mutual fidelity, avoidance of injecting drug use, non-tolerance of gender-based violence, acceptance of PLWHA, male engagement in reproductive health issues, HIV testing and prevention of mother-to-child transmission of HIV (UNGASS 2010). Television, music, film, radio and community theater are the most common media channels for HIV messaging (Gilbert 2008).

HIV prevalence has traditionally been highest among female sex workers, recently estimated at 19.8 percent (UNGASS 2010). In 1969, the Government of Senegal legalized sex work to regulate and control the spread of STIs in the general population (Homaifar and Wasik 2005). The national policy requires that registered sex workers be at least 21 years old, seek monthly health check-ups and STI/HIV testing, and receive treatment for STIs (N'diaye, Drame et al. 2005). Health services for sex workers have served as valuable channels of information for health education. During medical screenings, registered sex workers acquire information on STIs and receive free condoms at each visit. In the mid-1990s, more than 50 percent of sex workers in most African countries were HIV-positive, compared to 15 percent of sex workers in Senegal (1995).

Religious leaders play an instrumental role in Senegalese society, where approximately 94 percent of the population is Muslim and 4 percent is Christian (UNGASS 2010). Beginning in 1989, a non-profit Islamic organization named Jamra took part in a national dialogue about HIV between public health officials and religious leaders (UNAIDS 1999). Members of Jamra met with religious leaders throughout the country to sensitize them on AIDS-related issues and sought their participation, support, and commitment to

public education (Diop 2000). Similarly SIDA Service, a Catholic nongovernmental organization, has provided psychosocial support to PLWHA and has fought against stigma and discrimination since 1992 (UNAIDS 1999). The Government of Senegal organized two national conferences in 1995 and 1996 in which religious leaders became better informed about HIV & AIDS and identified their roles in offering information, guidance and support. Senior Islamic and Christian leaders recognized the priority of HIV prevention and solidified their commitment to collaborate with the health sector to curb the spread of HIV (UNAIDS 1999).

Treatment, Care and Support

Senegal was one of the first countries in Africa to begin treating AIDS patients with antiretroviral drugs (ARVs) (Homaifar and Wasik 2005). The Senegalese Antiretroviral Drug Access Initiative (ISAARV) was introduced in 1998 as the first governmental highly active antiretroviral therapy (HAART) treatment program established in Africa (Desclaux, Ciss et al. 2003). What began as a pilot project to evaluate the feasibility, efficacy and acceptability of HAART in Africa expanded into a successful national treatment program. Before this program, Senegal faced the same obstacles to antiretroviral therapy (ART) access as other African nations. Its health infrastructure was weak, drug costs were high, concerns over treatment adherence loomed, the risk of widening the rich-poor divide based on access to services was considerable, and concerns over the emergence of viral resistance were pervasive. ISAARV proved that these obstacles could be surmounted through a system of subsidies, monthly treatment follow-up by health care personnel, social workers and support groups, and a well-controlled

drug supply and distribution system (Desclaux, Ciss et al. 2003). Findings from the pilot project concluded that the cost and type of ARV drug combination are determinants of high treatment adherence in Senegal (Lanièce, Ciss et al. 2003).

Much progress has been made relative to access to ART. Following the launch of *3 by 5*, a 2-year WHO/UNAIDS strategy (2003-2005) to ensure treatment for 3 million people living with HIV in low and middle-income countries, the Government of Senegal decentralized its health infrastructure and expanded its HIV treatment program (WHO/UNAIDS 2006). With the establishment of new national policies, more physicians are qualified to administer ARVs and, consequently, the number of treatment sites has increased. Further, prevention of mother-to-child transmission services have expanded to all 11 regions of the country (WHO/UNAIDS 2006). As of 2007, WHO, UNAIDS, and UNICEF reported that 56 percent of PLWHA , and in need of treatment, were receiving free ART in Senegal (USAID 2010). Senegal has made great strides in achieving universal access to prevention, treatment and care, however the government must strengthen the health sector, drug procurement and supply, systems for monitoring treatment adherence and drug resistance, and develop sustainable funding schemes in order to fully realize this goal (WHO/UNAIDS 2006).

Knowledge, Attitudes and Behavior among Youth

Young people make up approximately one quarter of the Senegalese population (Ba Gueye, Ndiaye et al. 2005). With urbanization and migration on the rise, young people are increasingly vulnerable to sexual health risks (Pacific Institute for Women's Health

2002). In recent decades, adolescent sexual activity has increased around the world (Naré, Katz et al. 1997), and Senegal is no exception. The average age at marriage has risen steadily in recent years, increasing young people's exposure to premarital sex (UNAIDS 1999). According to the Demographic and Health Surveys (DHS), the median age at marriage is 18.5 years for women and 28 years for men, while the median age of sexual debut is 18.7 years and 20.9 years, respectively (Ndiaye and Ayad 2006). Based on findings from two focus group discussions (FGDs), urban adolescents aged 16 to 20 residing in Dakar and Pikine indicated that young people should wait until marriage to have sex. These young people's attitudes toward premarital sex reflect normative values including "earning your husband's respect", "maintaining family honor", avoiding STIs or avoiding childrearing issues (Naré, Katz et al. 1997). More educated males are more likely to have a higher number of premarital sexual partners over the course of their lives than less educated males (UNAIDS 1999). Females engage in premarital sex too, though it is traditionally uncommon; about 2.2 percent of women reportedly had sex by the age 18, whereas the same is true from about 26.8 percent of men (Ndiaye and Ayad 2006).

Risky sexual practices have led to numerous health issues among young people, of which HIV infection constitutes a growing problem. About 0.15 percent of 15 to 19 year olds are living with HIV, and prevalence is higher among young women than young men (0.2 percent and 0.1 percent, respectively) (Alliance Nationale Contre le SIDA 2010). Nearly 96 percent of Senegalese youth aged 15 to 24 have heard of HIV. Approximately 71.9 percent of young people believe that consistent condom use can prevent HIV, while 87 percent believe that limiting the number of sexual partners can prevent HIV (Ndiaye and

Ayad 2006). FGDs conducted by Naré et al. (1997) indicated a lack of concern about STIs and AIDS and a greater fear of pregnancy among girls residing in Dakar and Pikine. Participants expressed that, unlike AIDS, the outcomes of pregnancy are visible. The same group of participants also reported a belief that AIDS is something that only happens to other people, but not to themselves (Naré, Katz et al. 1997). These findings, though outdated and limited to these two urban settings, suggest that widespread awareness of HIV among young people may not necessarily translate into risk perception or active prevention.

Findings from a comparative study of 586 fictional narratives about HIV & AIDS written by young people in Swaziland, Namibia, Kenya, South-East Nigeria, Burkina Faso and Senegal suggest a roughly inverse relationship between HIV prevalence and stigmatizing representations, as reflected in preoccupation with the circumstances of infection and deflection of risk onto outsiders (e.g. sex workers). However, representations in Burkina Faso and, to a lesser extent, Senegal were found to be much less moralistic than those from Nigeria and Kenya, where HIV prevalence is higher (Winskell 2011). In Senegalese narratives, sex workers, foreigners, and promiscuous people are most commonly blamed for spreading HIV. Further, PLWHA may be demonized, as evident in depictions of characters that deliberately infect others or plan to do so in a spirit of revenge, on the pretext that someone gave it to them, or because they do not want to die alone (Winskell 2011). In addition to undermining the quality of life of those affected by HIV, such symbolic stigma associates infection with those presumed to be immoral, often

reducing risk perception and, potentially, protective behaviors within the general population.

Let's Talk about Sex

Throughout sub-Saharan Africa, HIV prevention efforts focus on information, education, and communication strategies to cultivate open dialogue about HIV & AIDS and encourage behavior change in young people. Despite increased public discourse on youth sexuality among donors and politicians, little has been documented in relation to what young people themselves say about sexuality (Ostergaard and Samuelsen 2004). Historically, young people relied on the extended family to receive information about sexual and reproductive health, but changing family structures and social norms have led many young people to turn to their peers, the mass media and, to a lesser extent, their parents (Pacific Institute for Women's Health 2002).

In 2002, Ostergaard and Samuelsen carried out a qualitative study in Mbour, a large modern city in Senegal with high population mobility and a booming tourist industry. Over the course of two months, young men and women participated in in-depth interviews (n=3) and FGDs (n=61) in which they discussed how they approach sexuality in their daily lives. The FGDs had an even share of young people who were in secondary school, out of school, unemployed, or who had completed a vocational training program. Further, 41 students from two different secondary schools submitted essays that described the most important event in their personal life over the past two years, whether they had any reproductive health problems, and how they had solved their last conflict with a

partner (Ostergaard and Samuelsen 2004). The average age of participants was 18.8 years. The main disadvantage of this study is that findings are not applicable to Senegalese youth as a whole due to the circumscribed research setting. In addition, the authors comment that two months' worth of fieldwork was insufficient to reach the necessary level of depth needed to understand a sensitive issue like sexuality. As a result, findings from this study were combined with other insights gained from work and research in Senegal since the late 1990s (Ostergaard and Samuelsen 2004).

Based on the interviews and essays, young people, especially girls, indicated that their lives are constrained by social and gender norms, and limited access to financial resources. Youth struggle in an environment of conflicting identities, where on the one hand they aspire to embody the urban, sexualized youth identity promoted by the media, but on the other hand fall under the pressure of their parents to conform to the traditional norms expected of them by society (Ostergaard and Samuelsen 2004).

According to youth in Mbour, dating is integral to urban youth culture. In seeking a partner, young women reported that they are primarily motivated by the desire for love and romance, but exchange of gifts or money and group pressure were also cited as motives for being in a relationship. As evident in discussions and student essays, many girls in Mbour talked about the practice of having more than one boyfriend at the same time (Ostergaard and Samuelsen 2004). Male informants expressed that they feel ashamed if they don't have a girlfriend, and that having money is very important because this is what young women want in order to feel financially secure. Despite the

importance accorded to dating by young people in Mbour, sexual dialogue remains hushed between young partners. Young girls in particular are faced with the dual challenge of feeling pressure from their partners to have sex and honoring social expectations to avoid premarital sex. Further, young women are reluctant to talk about sex with their partners because this may be interpreted as a lack of trust. Very few informants in this study said they could discuss condom use, fidelity, or an HIV test with their partner because of their discomfort with openly discussing sexuality (Ostergaard and Samuelsen 2004). What is particularly striking is that young people in Mbour acknowledge that AIDS is a problem, but they deny its potential for interference in their lives. This sample of young informants generally do not recognize themselves as represented in prevention messages, and those who are sexually active say that protective behaviors are only 'for girls with many boyfriends, not someone like me' (Ostergaard and Samuelsen 2004). These findings suggest that urban youth in Mbour do not internalize HIV prevention messages and fail to recognize themselves as exposed to risk.

Young people interviewed in Mbour reported that parents were often unavailable to their children. Informants stated that they preferred to discuss sexuality with maternal aunts and mothers, yet few of them actually lived with their mothers. Further, few chose to discuss sexuality with adults in their extended families because they felt they had limited agency in these social situations (Ostergaard and Samuelsen 2004). As a result, information and pressure from peers shapes young people's socialization and encourages risk-taking behaviors (Ostergaard and Samuelsen 2004). While boys often have a large network of friends with whom they spend time, this is not the case for girls because they

have more responsibilities at home. Some girls do not trust other girls because they fear they will be judged or betrayed if they disclose a personal issue related to sexuality. This mistrust and lack of emotional intimacy among female peers renders them more vulnerable to sexual health risks because they do not capitalize on opportunities to share and learn from each other. With few youth-friendly health services and opportunities for sex education in schools, young people are left with inaccurate sexual health information that derives from rumors and misconceptions (Ostergaard and Samuelsen 2004).

FGDs conducted by both Ostergaard and Samuelsen (2004) in Mbour and Naré et al. (1997) in Dakar and Pikine found that youth preferred receiving information about sexuality from their parents, however parent-child communication was consistently cited as a challenge. As part of a three-year project, the Pacific Institute for Women's Health (2002) gathered qualitative and quantitative data on parent-child communication about sexual and reproductive health in Senegal. Through surveys (n=822) and FGDs with parents and young people in selected areas of Dakar and Pikine, the research team investigated whether parents had discussed reproductive health with their adolescent children, why they had decided to talk to them and what types of messages they conveyed. It should be noted that survey results are not nationally representative. The information gathered here was collected with the purpose of informing programs in local districts and villages (Pacific Institute for Women's Health 2002).

Based on survey results, approximately two-thirds of adults said they discuss sexual health issues with their adolescents, yet nearly 99 percent of parents had weak knowledge

about sexual and reproductive health. For example, while 97.5 percent had heard of HIV & AIDS, only 47 percent knew about syphilis (Pacific Institute for Women's Health 2002). Few could cite how to prevent STIs/HIV, with about one-third reporting fidelity or abstinence as a prevention method and only 19 percent reporting condom use. The most commonly cited explanation for why parents talk about sexual and reproductive health with their adolescents was a concern that their daughter would engage in premarital sex. At the same time, parents feared that communicating with their adolescents would encourage sexual activity. In FGDs, young people cited embarrassment and respect for their parents as barriers to communication (Pacific Institute for Women's Health 2002). Parents had very unfavorable attitudes toward youth access to sexual and reproductive health services, suggesting that such services might encourage sexual activity, promiscuity or sex work.

Parents reported providing more information about HIV prevention to their sons than daughters. Conversely, unwanted pregnancy was commonly discussed with daughters, but not with sons. The adults surveyed stressed abstinence as the primary method of preventing STIs/HIV. Parents give strong messages to daughters to avoid boys, to the point where they may threaten to disown them, while sons are relatively free to "go out and discover life" (Pacific Institute for Women's Health 2002). Young people desire more in-depth information about sexual health from their families. Parents and young people alike identified a need to strengthen sex education within the family through communication training. This study, though confined to a select urban setting, highlights a need for more effective messages about safer sex to complement parents' messages

about abstinence because a clear disconnect exists between adult attitudes and adolescent sexual behavior (Pacific Institute for Women's Health 2002).

Seeking Information on Reproductive Health

Young people face challenges when they seek family planning services or information on reproductive health. As a part of Naré et al.'s (1997) mixed-methods study to measure young adults' access to family planning education and services, twelve participants from the study's two FGDs volunteered to conduct mystery client visits in clinics offering family planning services in Dakar. Following each visit, mystery clients completed a questionnaire designed to measure accessibility of services, reception, providers' attitudes, counseling and satisfaction. Based on 26 visits, young volunteers reported difficulties accessing information due to their marital status, embarrassment, and poor reception, and negative attitudes from health providers. At the time of this study, there was no official government statement designating adolescents as an eligible category for family planning services, therefore, the provision of care to young sexually active adults was based on providers' own moral values (Naré, Katz et al. 1997). Some health care providers from the seven clinics visited in the study told young female clients to avoid premarital sex and to watch out for boys, while young men were denied information about contraception because they would be "embarrassed" to use it (Naré, Katz et al. 1997). These small-scale findings confirm results from a systematic review of the literature in adolescent reproductive health which indicates that young people are more likely to treat themselves for STIs or acquire medication through informal circuits to

avoid the shame and stigma associated with seeking out reproductive health services (Ba Gueye, Ndiaye et al. 2005).

In 2005, the Ministry of Health (MOH) identified adolescent reproductive health (ARH) as a strategic priority for increasing contraceptive prevalence and reducing maternal mortality in Senegal (Population Council 2008). What preceded this political shift was operations research that identified a need to address young people's sexual health risks in the wake of social, economic and population shifts. *Improving the Reproductive Health of Youth in Senegal* was a pilot project implemented in two urban areas of northwestern Senegal from 1999-2003. In partnership with government agencies, this multi-sectoral intervention was designed to enhance young people's knowledge and behavior regarding reproductive health and HIV prevention (Diop, Bathidja et al. 2004). Affordable youth-friendly services were established at public health facilities, teachers and peer educators were trained to deliver curricula, parents were educated about youth reproductive health, and a peer education program was established to support community outreach. Findings from the pilot study confirmed that abstinence was the main source of protection among young people, followed by secondary abstinence (limiting sexual activity following sexual initiation) and being faithful to one partner (Diop, Bathidja et al. 2004). The use of condoms or other contraceptive methods was less common. Following the intervention, a significant positive impact on awareness and understanding of reproductive health issues among youth was observed. Abstinence increased and the incidence of multiple sexual partners among sexually active youth decreased (Diop, Bathidja et al. 2004).

Due to the successes demonstrated through this pilot study, an ongoing follow-up project was implemented in 2004-2007 to sustain ARH activities in the pilot areas and scale-up activities in other areas of Senegal and throughout West Africa (Diop and Diagne 2007). Efforts to reach youth have led to mainstreaming ARH within the MOH and the Ministries of Education, Sports and Youth (Dann 2009). Initiatives have included the development and revision of curricula for peer educators, training for teachers, reproductive health norms and guidelines created for adolescents (Dann 2009). The national strategy on adolescent health, technical forms (to assist planning) and training mechanisms have been put in place to scale up ARH activities in Senegal.

Similarly, the Senegal Adolescent Reproductive Health study (Population Council 2008) developed and tested multi-sectoral, multidisciplinary interventions in three urban communities to improve reproductive health knowledge and behavior, delay the onset of sexual activity and meet the needs of sexually active youth while reducing risky behavior. Interventions included youth-friendly services, community outreach and mobilization, and school-based education using a life skills curriculum. After implementation, knowledge of ARH among youth increased, the average number of partners decreased slightly, reported sexual activity decreased and use of health centers increased. The study was initiated with an objective to eventually integrate these reproductive health activities into public institutions' routine activities (Population Council 2008). The study concluded that multi-sectoral interventions that draw on participation from government ministries, community and religious leaders, families and youth are effective in improving sexual knowledge and practices in young people. Lessons learned from the

study state the importance of response and sensitivity to local needs and context in order to create a supportive environment for dialogue. With the expectations to adapt, expand and scale-up these intervention models, policymakers and the NGO community could benefit from additional insight into how young people make sense of HIV. The perspective guiding the current study is that investment in young people's sexual health should begin with listening to their voices.

In light of efforts to scale-up activities, few evaluations of national routine prevention programs have been conducted to gauge how messages are disseminated and perceived by the target population (Wade, Enel et al. 2005). Wade et al. (2005) carried out a study of HIV/STI prevention events recorded by 26 sentinel observers in 3 rural communities in Senegal from 2000 to 2003. More than half of the events were radio broadcasts, followed by booklets/posters, newspapers, television programs, informal discussion between villagers, public meetings and training or information from health center personnel. Sentinel observers most frequently recorded events that addressed AIDS treatment, STIs, condoms and testing (Wade et al., 2005). Results demonstrate that between 2000 and 2001, the proportion of events addressing AIDS treatment increased from less than 3 percent to roughly 10 percent, while those addressing condom use and STIs decreased from about 25 percent to less than 15 percent. Testing remained the subject of only about 3 percent of events over the course of the study period (Wade, Enel et al. 2005).

To assess how messages are perceived, Wade et al. (2005) surveyed 1,000 adults aged 15 to 59 in one of the 3 original rural communities. The prevention events recorded (e.g. press, meetings, radio, casual discussions, training sessions, etc.) disseminated messages about AIDS-related knowledge, attitudes and stigma towards PLWHA. Findings demonstrate that survey respondents who were more educated, more religious, and more mobile, and who frequently listened to the radio were more likely to report prevention events. Further, greater knowledge of AIDS, more positive attitudes towards AIDS prevention, and lower levels of stigma toward PLWHA were observed among those who reported prevention events. Men were more influenced by informal discussions and radio programs, while women were more influenced by collective events such as public meetings (Wade, Enel et al. 2005).

Wade et al.'s findings based on sentinel informant reports are disconcerting. Though the shift in focus from prevention to treatment messages may be explained by the timing of the study, which coincided with the introduction of free ARVs in Senegal in 2000 (Laurent, Diakhate et al. 2002; Wade, Enel et al. 2005), this change could nonetheless minimize the importance of adopting preventive behaviors in the population. Furthermore, findings suggest that knowledge about AIDS is displacing the population's knowledge about other STIs. This is an important factor to consider given that successful management of STIs is based on informed awareness. Findings from the survey component of the study point to the importance of using radio to disseminate messages in rural areas, and highlight a need to reverse the marked decline in STI and condom-related messages (Wade, Enel et al. 2005). Though insightful, these findings should neither be

considered exhaustive nor representative of the general population in Senegal, given that they were limited to three rural communities with low rates of HIV infection (Wade, Enel et al. 2005).

Much of the language used in HIV awareness campaigns is dictated by Western policy and biomedical discourse, however there is limited understanding of how the local population makes sense of HIV & AIDS and the factors that challenge prevention (Ostergaard and Samuelsen 2004). Evidence-based research has shown that disseminating messages about behavior change without knowledge of how those messages are internalized or negotiated among sexual partners is an inadequate approach to prevention (Ostergaard and Samuelsen 2004). Together, these studies highlight the gaps in understanding the cultural meanings that frame HIV & AIDS among Senegalese youth, a vulnerable subset of the population. The select data that are available are either out of date, or pertain to specific study and program sites. Based on previous research, an important step to developing effective, culturally sensitive HIV communication activities begins with integrating local knowledge, language and voices into prevention programs (Ostergaard and Samuelsen 2004). Further, a unilateral focus on high-risk groups may ignore the broader sexual health concerns of young people in the general population. It is critical that we understand young people's explanatory models of HIV & AIDS in the context of the historical, political and economic circumstances that shape their environment (Cole 2004; Ostergaard and Samuelsen 2004).

Summary of Current Problem and Study Relevance

Adolescence is a period of significant physical, social and emotional growth, as well a period of increased vulnerability to sexual health risks. The public discourse on sexuality has historically turned a blind eye to the realities faced by young people. Many studies conducted in Senegal use epidemiological monitoring of high-risk groups and repeated behavioral surveys to track sexual behavior and attitudes. Surveys of Senegalese youth's knowledge, attitudes and practices are limited in providing a contextualized understanding of the HIV epidemic (Winskell and Enger 2005), and are vulnerable to social desirability bias. Data exploring adolescent sexuality in Senegal are limited to a few qualitative studies that explore this topic through IDIs and FGDs in select settings. Relatively little is known about young people's social constructions of HIV & AIDS. Through analysis of fictional narratives written by young Senegalese people, this study uses a non-directive approach to explore the symbolic and social aspects that shape how Senegalese youth make sense of HIV & AIDS. Moreover, findings will highlight existing communication needs. This is the first analysis of stories submitted to the 2008 Scenarios from Africa contest. Findings will contribute to a longitudinal, multi-country research process examining stories about HIV & AIDS written by young Africans.

Chapter 3: Project Content

Methods

Since 1997, the Scenarios from Africa contest has invited young Africans to produce scripts for short fiction films about HIV/AIDS (Global Dialogues 2010). Non-governmental and community-based organizations and local, national and international media sources mobilize youth across sub-Saharan Africa and distribute leaflets with instructions on how to participate in the contest. The winning narratives are then selected by national and international juries, adapted, and brought to life by critically acclaimed African filmmakers. To date, thirty-seven films have been produced (Global Dialogues 2010). The short films are translated into over 25 languages and mass distributed to television stations, internet media, non-governmental and community-based organizations. By 2008, the Scenarios from Africa communication process had collected roughly 55,000 narratives from 47 countries (Winskell, Obyerodhyambo et al. 2011).

Study Sample and Population

The narratives analyzed for this study were submitted to the 2008 Scenarios from Africa contest in Senegal, held from December 1, 2007 to March 15, 2008. Approximately 4,018 young people in Senegal participated in the contest, submitting roughly 1,643 narratives. Scenarios were ineligible for inclusion in the study sample if they were written by rural participants, team-authored or written in response to one of twelve thematic story-starters provided on the contest leaflet (e.g. “The other day at the market, I observed some surprising things in relation to the dangers of HIV/AIDS”). After eliminating these scenarios, the data were stratified by sex and age (10-14, 15-19, 20-24)

in order to maximize representation of participants across demographic strata (Figure 1). Ten narratives were randomly selected for each of the six strata, resulting in a study sample of 60 narratives. The contest leaflet included a questionnaire on which participants indicated whether they had a mobile phone, a home phone, a television at home, and whether they were enrolled in school (Table 1).

Data Processing and Analysis

The sampled narratives were transcribed verbatim in French for analysis using MaxQDA10 qualitative data analysis software. The methodologies combined qualitative data analysis, focusing on thematically-related text segments and memoing for emergent themes, and a narrative-based approach, focusing on plot summary and thematic keywords (Winskell 2011). Our analytical approach was guided by grounded theory (Corbin and Strauss 2008) and thematic narrative analysis (Riessman 2008), with the narrative-based approach providing a comprehensive perspective to offset any fragmentation of the data resulting from its organization into thematically-related segments (Winskell, Obyerodhyambo et al. 2011).

Descriptive codes were identified inductively and deductively, and then applied to segments of text with reference to a detailed codebook of 76 HIV-related themes (e.g. labor migration, poverty, biomedical treatment). The codebook was developed through an iterative process, drawing on themes used in data analysis of narratives from the 2005 Scenarios from Africa contest (Winskell 2011), and included a detailed description of each code, and inclusion and exclusion criteria. In addition to thematic coding, a one-

paragraph narrative summary was written for each story and coded with up to six keywords per story. This study, comprising the secondary analysis of existing data, was approved by Emory University's Institutional Review Board.

Figure 1: Sampling Flowchart

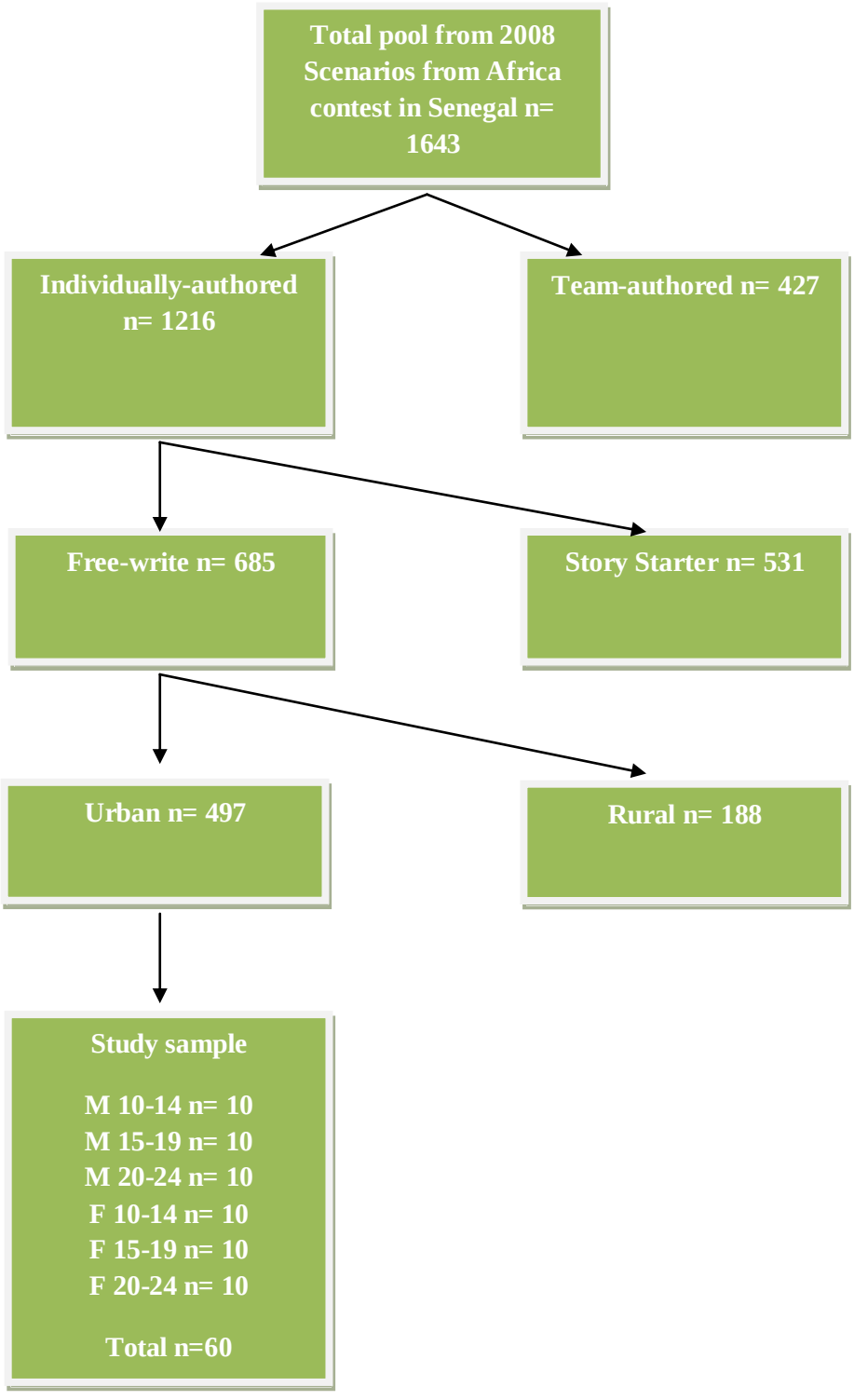

Table 1: Demographic distribution of study sample

Demographic Variables	Figure
% male-authored	50%
% aged 10-14	33.3%
% aged 15-19	33.3%
% aged 20-24	33.3%
average age	16.6
% with a cell phone[1]	96.7%
% with a landline[2]	100%
% with a television at home[3]	98.3%
% enrolled in school[4]	88.9%

[1] This figure is based on the 60 out of 60 participants that responded to this question.
[2] This figure is based on the 19 out of 60 participants that responded to this question.
[3] This figure is based on the 58 out of 60 participants that responded to this question.
[4] This figure is based on the 54 out of 60 participants that responded to this question.

Results

The young authors focus primarily on the circumstances of infection and on the post-infection period, in which HIV-related vulnerability is framed in terms of high-risk groups rather than specific behaviors that put an individual at risk. Women, poor people, sex workers, individuals with multiple partners, migrants and travelers are depicted as central to the spread of HIV. The single most important cause of HIV infection in the narratives is having unprotected sex with multiple partners. With one exception, HIV is not intentionally transmitted in the narratives.

Young authors depict girls and women as more vulnerable to infection and more responsible for the spread of HIV than men. Poverty is typically the catalyst that drives women into the sex industry and leads them into a life of sexual risk-taking. Several narratives also describe girls who chase after rich men to satisfy their desire for money. In these situations, girls do not become involved with rich men to meet basic needs, but instead to gain material goods, popularity and status. The young women portrayed are generally depicted as beautiful and charming, but also weak, desperate and with very little agency. A greater number of female authors depict the central role that sex workers play in the spread of HIV.

Although 60 percent of narratives focus on the circumstances of infection, only one quarter of the narratives portray a protagonist that dies as a result of HIV (i.e. of AIDS-related causes, murder or suicide). Less than one quarter of the narratives end with diagnosis or disclosure, or with the protagonist in deep distress. The remaining narratives

end with hopeful outcomes, including support from friends or family, activism, ART uptake, and the birth of a healthy child. A greater number of male authors portray the themes of support for PLWHA and activism.

Despite descriptions of social support and positive outcomes for some PLWHA in the narratives, young authors nonetheless represent these individuals as separate from mainstream society. More often than not, they are depicted as social deviants rather than as average, integrated citizens.

Support for PLWHA

The theme of support for PLWHA is prominent in one quarter of the total narrative sample. Thirteen male-authored narratives feature an element of social support for PLWHA, while the same is true for seven female-authored narratives Male and female protagonists are nearly equally represented as receiving social support across the narratives, with friends represented as the most common source of support. Overall, social support appears to improve physical health, emotional balance, and inspires a renewed sense of confidence and optimism in PLWHA.

Supportive figures include friends, family, significant others, employers, mentors, and community associations. Protagonists who have at least one supportive figure in their life pre-diagnosis are likely to maintain and strengthen that relationship post-diagnosis, regardless of how far the lifestyle choices of the two characters diverge. Support manifests through advice, assistance, love and attention. An 11-year old male author

writes, "After being tested Oumy has AIDS and she cried and cried some more. She even wants to die right at this moment. But since I am her friend, I advise her: Oumy don't be discouraged I will help you until the end because you are my closest friend and we will fight this disease together" (M 10-14). Aside from declaring their commitment, supportive figures also assure that health needs are met. They may accompany a PLWHA to visit a doctor or counselor, help them acquire medication, or show a PLWHA how to take medication. A forum for support is available through active membership in a community association, which provides a strong moral and emotional foundation for an HIV-positive protagonist. Community associations offer PLWHA a sense of belonging, purpose and responsibility. Overall, many young authors overtly convey the importance of social support for PLWHA, however in doing so they portray PLWHA as helpless, fearful individuals. Young authors imply that stigma toward PLWHA is pervasive, such that they face challenges with openly disclosing their status and accessing community resources. As depicted in the narratives, support systems step in and guide PLWHA down a path to positive living.

Three female-authored narratives discuss support within an HIV discordant couple, whereas none of the male-authored narratives do the same. These narratives highlight important themes of within-couple dialogue and disclosure. In each of these narratives, one of the partners proposes an HIV test as an important condition for marriage. When the lab tests reveal discordant results, the HIV-positive partner entertains thoughts of suicide because of shame and fear that his or her partner will walk away from the relationship. However following disclosure, the HIV-negative partner makes a

commitment to always love and support the HIV-positive partner. A 16 year old author describes how Mariame finds her love, Pape, depressed by the news of his diagnosis and joins him to talk. She says to him, "Pape, know that I am aware of the news it really affected me but I must always be there for you, I will never abandon you. As long as there is life, there will always be strain and we will fight this disease together" (F 15-19). These three scenarios are unique in that they depict a happy, respectful and loving HIV discordant couple. An HIV-positive partner is not rejected based on his or her serostatus, but fully loved and accepted. These female authors express that proposing an HIV test as a pretext to marriage can save a life and a relationship, and even with a positive result a PLWHA can still be desired by his or her partner.

The narratives portray the multiple benefits of social support for PLWHA. Social support buffers suicidal thoughts and improves physical and mental health. Five narratives written by authors under 20 years old depict the power of social support in suppressing suicidal thoughts and a desire to die. Recently diagnosed protagonists share common sentiments of no longer wanting to live, feeling ashamed, and fearing rejection. "My friends are gone, alcohol has lost its taste what used to be fun now infuriates me. I wanted to die, disappear this disease made me scared," writes a 16 year-old author, as he narrates the emotions of a returnee migrant who just discovered he contracted HIV in Switzerland (M 15-19). In these cases, simple words of encouragement go far to promote positive living. Stigma and mistreatment appear to scare HIV-infected characters more than the illness itself. Thus, small gestures of support are powerful enough to transform

the self-esteem and outlook of a PLWHA. Six narratives feature a protagonist who is put on ARVs as a result of encouragement from a supportive figure.

Social support also serves as a vehicle for community activism, as demonstrated by seven young authors. Of these authors, five are 20 years or older and five are male. Support grants PLWHA the confidence to speak out publicly about HIV. These protagonists achieve a remarkable sense of confidence and feel a social obligation to inform others about HIV. Through sensitization activities, radio and television broadcasts (M 15-19), press conferences (M 20-24) and neighborhood-wide meetings (M 20-24), male and female activists alike living with HIV spread educational messages and serve as role models in their communities. In these instances, young authors positively portray how social support leads PLWHA to be involved, respected and visible members of the community. An interesting finding is that, of the seven characters who become activists, only three are explicitly described as high-risk individuals (i.e. traveler, sex workers), while the remaining four are characters who lead very normal lives. These four constitute a share of the small number of narratives that acknowledge that HIV can affect anyone, not just high-risk individuals.

Migration and Travel

This theme encompasses labor migration (i.e. rural-urban and international) and visits to foreign countries. Migration and travel is a prominent theme in about one-fifth of the total narrative sample. In these narratives, authors represent HIV as an illness that originates outside of Senegal and permeates her borders via migrants. Migration is

described as a period of vulnerability, HIV-related risk, and carelessness. In the thirteen narratives that feature this theme, eleven of the migrants are male. In the two instances where female migrants are featured, both are young girls from poor families that travel to urban centers in Senegal. Eight narratives situate the risks of migration within the context of marriage or an intimate relationship, but four female authors uniquely narrate their stories from the perspective of the spouse or partner who has been affected by her partner's sexual risk-taking. Overall, young authors emphasize the importance of testing vis-à-vis migration and stress that a woman can never fully trust what her partner does when he is away from home.

All male protagonists who migrate to foreign countries leave with the intention to earn money to provide for their families, but return home with HIV. Migrants travel to European (i.e. Italy, Switzerland and France) and African countries (i.e. Congo), leaving their wives and families behind from anywhere to a few months to as many as ten years. At their destination sites, they become sexually involved with foreign women. Though only one narrative explicitly describes casual sex with a female sex worker while away from home (M 20-24), the narratives make it clear that migrants contract HIV from foreign women.

In all cases, male migrants have no knowledge of the personal lives, sexual histories, or HIV statuses of the women they become sexually involved with. In nearly all the narratives, a male protagonist has casual sex with a foreign woman out of personal choice, except for one case in which a man confesses that white people forced him to

have sex in exchange for money to send home to his family (F 15-19). This idea that self-control is relinquished symbolically illustrates that migration may present men with multiple sources of temptation that can negatively transform even the most faithful of husbands. In describing a married migrant's circumstances once he arrives in Europe, a 22 year-old male author writes, "Once life starts to smile at him and he begins to earn money he forgets his wife that he left back home and begins throwing himself in the arms of European women" (M 20-24). Male migrants become blinded in a milieu of abundant money, alcohol, women and entertainment and fail to consider HIV-related risks.

Clear links exist between migration, HIV and family consequences. All protagonists contract HIV during migration or travel, except for one. Their increased incomes, isolation from family, and unstable friendships lead them to engage in risky behaviors. In six narratives, a male migrant transmits HIV to his spouse or steady partner when he returns home. These men are unaware of their own HIV status, do not seek testing, and keep their infidelity a secret. Their wives, having patiently and faithfully awaited their husbands' return (M 10-14), have sex with them when they return. There is physical desire between the couple after their long separation, but no communication between the couple. Migrants' spouses and steady partners are depicted as passive figures that trust their mates and are financially dependent on them. In these representations, a wife generally has no voice – she neither questions her husband's behavior nor does she propose condom use after their long period apart. This absence of communication leads couples to avoid the appropriate measures needed to reduce HIV-related risk.

Two male-authored narratives follow a plotline in which a spouse contracts HIV from her migrant husband, becomes pregnant and gives birth to a baby who is HIV-positive. Conversely, two female-authored narratives end in a positive pregnancy outcome, where a baby is born free of HIV. Pregnancy outcomes appear related to overt communication between the couple early in the pregnancy. When a pregnant spouse discusses HIV with her husband following a positive diagnosis, she is more likely to seek a consultation, receive information about prevention of mother-to-child transmission and take appropriate measures (F 15-19). This indicates that in the context of migration, explicit discussion of HIV between partners is valuable for encouraging risk-reducing behaviors and positive birth outcomes.

Two male authors represent men who are warmly accepted, loved and supported by their wife or family after a period of sexual risk-taking overseas. The positive attention received from loved ones appears to safeguard these protagonists from feelings of guilt, shame, and stigma. In female-authored narratives, this degree of support is not demonstrated toward migrants, namely because they are unaware of their status and thus fail to disclose it. The protagonists face an eventual death without achieving a sense of resolve in their relationship.

Two narratives uniquely feature young female migrants/travelers. In one, a young girl leaves her village to vacation in Dakar with her cousins (F 15-19), while in the other a young girl migrates from her home town to a larger city to seek gainful employment to support her family (F 20-24). Both girls are lured by the promise of money from older,

wealthy men and as a consequence, are sexually exploited. What is interesting is that both girls have extended family nearby, yet they face their risks alone. The combination of desperation and naiveté that characterize their circumstances increases their HIV risk.

Two female-authored narratives illustrate how cultural beliefs and practices exacerbate the risks associated with migration. One author describes how a community's beliefs in witchcraft lead to misattribution of the causes of an entire family's death. The third and youngest wife in a polygamous marriage is blamed for the deaths of her husband and his co-wives from Senegal and Congo. Due to the community's accusations of witchcraft, she is mistreated, inherited by her late husband's brother, and beaten by her new husband. A few weeks later, she dies of AIDS (F 20-24). Here, the young author explicitly stresses the importance of dispelling rampant myths. Rather than acknowledge the link between unsafe sex practices and HIV transmission, local beliefs conceal the realities of HIV. The author informs her reader to "open your eyes" (F 20-24) because lack of awareness compromises the health and well-being of those infected and affected by HIV.

Four narratives authored by 10-14 year olds depict bleak outcomes (i.e. death and suicide) in the context of migration and HIV. These young authors represent HIV as an irreversible physical and emotional burden. They explicitly describe how risky behavior during a long absence from home jeopardizes a family's health and stability. Their representations of migrants are the most hopeless because they do not demonstrate any models of positive living post-infection. The common thread between these four narratives is an absence of social support and knowledge about HIV.

Three narratives portray how protagonists that have contracted HIV during a period of migration become HIV activists. Their actions consist of sensitizing the population through radio and television broadcasts (M 15-19), issuing an appeal to the government to institute compulsory HIV testing for returnee migrants (M 20-24) and becoming an ambassador for HIV awareness and education (F 20-24). These older authors tap into the social and cultural resources available to educate others about HIV and show examples of protagonists taking ownership of their health and future, as well as that of their communities.

Activism

The theme of activism is prominent in one quarter of the total narrative sample, of which ten narratives are male-authored and five narratives are female-authored. Social support is an integral component of activism, as it inspires motivation and encouragement, particularly for PLWHA. Young authors stress that activism renews the vigor and sense of life purpose of a PLWHA. Of the nine PLWHA depicted as activists, six are female. Conversely, of the six HIV-negative community members depicted as activists, five are male and one is a mixed-gender group of students. Over half of the narratives that feature activism were written by 20-24 year-olds. Five authors from this age bracket illustrate the transformation of PLWHA into role models and community advocates, and three of these narratives devote attention to the activities of community associations.

Across the dataset, nine narratives portray PLWHA that initiate HIV-related activities, whereas six narratives portray community members as activists. For PLWHA, activism

is intricately related to disclosure and social support. The act of disclosure represents a turning point in the life of an HIV-positive protagonist. Disclosure that is met with acceptance and support encourages an HIV-positive protagonist to make the conscious decision to live positively. In young authors' representations, being accepted and supported by a friend, family member, co-worker, or community association boosts morale, increases knowledge-seeking behavior and encourages knowledge-sharing about HIV. The authors convey a salient message that when an HIV-positive protagonist feels a sense of belonging with one or more people, his or her confidence and optimism increases. Young people acknowledge that PLWHA have the potential to live positively, however this is heavily determined by their level of social capital. With the right amount of support, they can become strong, empowered and influential community leaders that educate others.

Fewer HIV-positive male protagonists become activists and educators than females. This may imply that in the sense-making process of this sample of authors, an HIV-positive male is less likely to receive social support in his immediate environment, and this may be the case because he is also less likely to disclose his status initially. Interestingly, in the narratives that do depict a male advocate living with HIV, activism occurs on a regional or national scale, unlike HIV-positive female advocates who operate at the community level. The male protagonists featured advocate for changes to the national HIV testing policy (M 20-24), sensitize the population through widespread radio and television broadcasts (M 15-19) and organize a rights-based press conference to support PLWHA who have lost their jobs.

Conversely, five HIV-positive female protagonists lead activities through community associations, or gather community members in social settings. Community associations are portrayed in a very positive light. They are described as a storehouse of knowledge, moral and emotional support (F 20-24) and community influence. Associations for PLWHA in particular inspire positive living, provide a safe space to share personal experiences and build autonomy among their members. HIV-positive female activists generally come from high-risk, marginalized groups (i.e. divorced and widowed women, sex workers). They spread educational messages about the realities, causes and consequences of AIDS, prevention, testing, risky behaviors and support for PLWHA. Several authors explicitly emphasize the value of HIV-positive community role models for poor girls, divorced women and youth, all of which represent the most vulnerable subsets of the population.

HIV-negative community members that are active in the HIV response include students, radio personalities and family members. Students are, by far, the most active citizens. Through individual and collective efforts, students make their voices and concerns heard in formal school settings and social gatherings. Overall, community activists typically have the social pull, visibility, smarts, and/or resources to engage social interest and influence.

Active community members are predominantly educated male students. The authors stress that in their position of social consciousness and intellect, these students see it as their social obligation to sensitize at-risk youth about HIV. They engender a sense of

patriotism, and seize any opportunity to denounce risky behaviors and dispel rampant misconceptions. These male students stand out from their peers because they behave responsibly, perform well in school and are not caught up in chasing young girls. Young authors represent these students as positive deviants because they promote abstinence, condom use and testing in what appears to be a highly sexualized youth culture.

Other students are motivated toward community engagement as a result of lessons learned. Between calling a strike at school to sensitize the neighborhood following a course on STIs/HIV (F 10-14) and inviting the president of an association of PLWHA to show-and-tell at school (M 10-14), student leaders like to share their knowledge and experiences with their peers. The protagonists reflect on sexually relevant information and collectively pool their mental resources to educate their communities. They feel a sense of social responsibility and seize available opportunities to gather the masses and promote positive sexual health and well-being. In these few scenarios, authors effectively demonstrate examples of self-efficacy and collective efficacy by depicting students who are steadfast in their beliefs about abstinence, protected sex and testing.

Biomedical Treatment

One-fifth of the narratives prominently feature ARVs in reference both to therapy and prophylaxis. ARVs are mentioned by nine male authors and four female authors. Across the dataset, biomedical treatment is typically introduced by a doctor during HIV post-test counseling and antenatal counseling. Explicit reference to treatment adherence is characteristic of five narratives, and in all cases leads to positive health outcomes.

Within-couple dialogue appears to be a critical element that reinforces the benefits of biomedical treatment. Overall, authors express optimism about the potential of ARVs to transform the lives of PLWHA.

Discussion of ARVs is typically introduced into the narratives immediately following diagnosis as a PLWHA is receiving advice. The large majority of medical advice comes from doctors, followed by friends and significant others. Doctors reassure their newly-diagnosed patients that medical treatment slows the progression of death (F 15-19) and makes it possible to stay healthy for many years (M 10-14). In a few narratives, reference to biomedical treatment is coupled with the assertion that there is no cure or vaccine for AIDS. Doctors are generally represented as trusted sources of information that advise their HIV-positive patients in a safe, private setting. With the exception of one narrative where a doctor discloses a young girl's results to her parents without her consent (M 15-19), doctors in the narratives generally do not breach confidentiality and they adopt a supportive, open and encouraging attitude with their patients. Young characters do not demonstrate resistance to seeking medical help following a positive diagnosis.

In the two instances when friends or significant others initiate discussion about ARVs, there is no dialogue between the protagonist and the doctor following communication of the results. Friends and partners step in to push the protagonist to take medication because either the protagonist does not trust modern medicine (M 10-14) or the

protagonist views this diagnosis as a death sentence (F 15-19). Having the support of intimate friends and partners leads to positive health outcomes.

Four narratives go beyond the simple mention of biomedical treatment to highlight the benefits of ARVs. Young people emphasize how ARVs add years to one's life, visibly improve one's physical condition, prevent mother-to-child transmission of HIV and allow for a healthy, fulfilling life. These narratives depict characters involved in a relationship of open dialogue, or supported by a family member. Thus, the young authors concerned represent a link between support from loved ones, treatment adherence and good health.

Five narratives reference biomedical treatment in the context of prevention of mother-to-child transmission, however only three indicate pregnancy outcomes. The standard plot follows a pregnant woman who seeks a prenatal consultation, discovers she is HIV positive, and worries about the health of her unborn baby. Following her doctor's advice, the expectant mother is put on ARVs to decrease the likelihood of transmitting HIV to her baby. In two out of these three instances, the baby is born HIV-positive. What distinguishes these two cases from the third is the absence of a husband or partner during pregnancy. Though one of these expectant mothers has the encouragement of a friend, she has lost her husband to AIDS and claims she is already dead, but will do everything to save her son (M 15-19). In the other scenario, there is no indication of a partner and the single expectant mother dies during childbirth (F 15-19). No conclusions can be drawn about timing, dosage or adherence to ARVs, but a distinctive factor among these cases is the presence and support from a partner.

There is a pervasive misconception that everyone who is HIV-positive should be put on ARVs immediately following a positive test result. Aside from this, young people understand that ARVs are not a cure for HIV and that, when taken correctly, they can extend the life of a person living with HIV.

Denial of the Existence of AIDS and Perceived Invulnerability

The theme of denial and perceived invulnerability to HIV is prominent in one quarter of the narrative sample. Characters that deny the existence of AIDS, or who perceive themselves as invulnerable, are generally between the ages of 15 and 30. They represent all walks of life – students, bachelors, sex workers, married men and poor girls. They are portrayed as individuals that exude a certain beauty or charm that lends them seductive prowess and leads them onto a path of sexual destruction. Seven of the narratives feature protagonists that explicitly deny the existence of AIDS, while another eight feature protagonists that acknowledge that AIDS exists but do not perceive themselves as vulnerable to infection. Of the narratives that feature a protagonist who denies the existence of AIDS or perceives him or herself as invulnerable, over three quarters end with a positive test result.

High-risk individuals that have unprotected sex, are unfaithful, have multiple partners, and inject drugs are represented by young authors as ignorant, and fuel the spread of HIV. These characters are generally defiant, unreceptive to advice and believe they are immune to HIV infection on account of their good looks, money and popularity. The

young authors drive home the message that beauty, status, and money do not safeguard sexual health.

Ten narratives introduce a well-informed friend or community member that warns the protagonist of his or her risky behaviors and highlights the real dangers of AIDS. This theme of warning is equally represented in male and female-authored narratives. With the exception of one scenario, warnings are delivered between same-sex peers. Peers that deliver warnings are portrayed as wise, educated and responsible, and several are sexually abstinent. Despite their expressed concern and helpful advice, protagonists typically blow off their warnings and continue to behave recklessly. In describing an exchange between two friends, an 11-year old male author writes "Oumy beware because us boys are all the same and the AIDS virus is all over the world." Oumy, the ignorant, high-risk character responds, "AIDS, what is that, that doesn't scare me" (M 10-14). Warnings generally prime at-risk protagonists, but they don't directly cause behavior change. A high-risk protagonist typically doesn't change his or her risky behavior until he or she experiences symptoms of poor health, or makes a conscious decision to get tested.

Three narratives feature a protagonist who uses *gris-gris,* or a charm used to ward off evil and illness, as a method of prevention. Feelings of sexual invincibility incite unprotected sex with multiple partners in each of these scenarios. A 25-year old man approaches his *marabout,* or spiritual leader, to seek a *gris-gris* that will protect him from AIDS. Once he uses the *gris-gris,* he frequently has unprotected sex with homosexuals and sex

workers (F 10-14). Based on the authors' representations, the use of *gris-gris* creates a false notion of protection and encourages more high-risk behavior. All three of the narratives that feature the theme of traditional remedies were written by 10-14 year-old authors. This may be because the use of charms and amulets is deep-rooted in Senegalese culture as a method to protect one from evil and sickness. In fact, a survey in the 1980's concluded that *gris-gris* were one of the top three methods of contraception known to women in Senegal (Goldberg et al., 1986). Although the power of gris-gris in Senegal is perceived to be much broader than just in relation to sexual and reproductive health, the young authors convey the challenges in swaying deep-rooted traditional beliefs in the context of HIV prevention and treatment.

Three narratives feature female protagonists whose desire for rich men clouds their perception of HIV-related risk. For one character, this desire is partly motivated by meager economic circumstances (M 10-14), while for the other two it is simply a matter of liking a man for his money. A young, beautiful girl named Aïcha meets a wealthy man from South Africa. The author writes, "Modou declared his love for Aïcha and she accepted because she saw that Modou has a lot of money…Modou invites her to his place and she accepts. Suddenly, Aïcha asks him for money, he sees that Aïcha likes his money. He asks her for her body, and she has no idea what she has accepted" (F 15-19). Young authors represent girls that desire wealth as blinded, careless and ignorant of the risks of STIs.

Despite previously defiant attitudes, friends and family members step in to offer their love and attention to a PLWHA in five male-authored narratives. These narratives depict transitional models of change, whereby a protagonist moves from complete ignorance to a motivation to change their behavior following a positive test result. Conversely, five narratives, all authored by females, that feature the theme of denial and perceived invulnerability end in negative outcomes including suicide, death, and persistent disbelief in AIDS. These narratives are characterized by a lack of support, fear of rejection and sense of shame and embarrassment following a positive test result.

Family Consequences

The impact of HIV & AIDS on family is a prominent theme in one-fifth of the narrative sample. The consequences of HIV go beyond biological factors to include social, psychological and economic effects. A greater number of male-authored narratives portray mother-to-child transmission of HIV, economic distress as a result of HIV, and sacrificing future dreams to care for a sick family member. A few young authors depict how the chances of orphans and vulnerable children (OVC) becoming productive citizens are compromised by HIV & AIDS. Also, a greater number of female protagonists are represented in narratives that end in bleak outcomes, in which they die from AIDS-related causes or suicide.

The young authors depict AIDS killing people during their most productive years. Of the 27 narratives that feature the theme of family consequences, 14 narratives end in death. Nine of these deaths occur among female protagonists, five of which are suicides. Across

the sample, suicide is a common reaction to fear of or actual rejection from one's family or partner, typically occurring immediately after diagnosis. As depicted by the young authors, the impact of social disapproval is often too heavy to bear, and young women avoid shame and blame through suicide. This is well-illustrated in the story of Penda, a young girl who contracts HIV after she is violently raped. When she discloses her status, her family disowns her and faults her for contracting HIV. She is discriminated against and mistreated by everyone and eventually resorts to ending her own life (M 15-19).

As illustrated by Penda's case, the social attitudes surrounding HIV & AIDS cause PLWHA to suffer more than the illness itself. Many protagonists are driven to fear and distress because of shame, embarrassment, and a preoccupation with acceptance by family and friends. These affective components lead to the general dissolution of relationships within a family affected by HIV. As envisaged by young authors, public image is very important in Senegalese culture, as it is a reflection of values and family honor. A person's "deviant" sexual activity, especially outside of marriage, is usually cause for judgment and disapproval by the community.

Five narratives portray the death of an entire family due to AIDS. In these narratives, sexual risk-taking occurs in the context of migration and polygamy. The actions of male head-of-households are to blame for the destruction of an entire family's health and well-being. Some young authors express sympathy for the spouses and children who involuntarily fall victim to HIV. A 15-year old female author writes, "…even his first wife the poor woman who took care of her husband and here one day, she finds herself

with AIDS, she and her children, what a mess, what life betrayal and what a shame at one point the entire family died: father, son, daughter, and the two wives flew away into the universe without a trace. That life is sometimes cruel. And here lies a fate that one could never believe" (F 15-19).

Similarly, seven narratives depict a husband who unintentionally infects his spouse following a period of migration, an extramarital affair, or a polygamous marriage, but the outcomes do not result in death. HIV transmission between spouses compromises trust, health and well-being between partners. A 20-year old female author portrays how HIV alters relationship dynamics between a married couple. During a prenatal consultation, Mariéme learns that she is HIV-positive and is confident that she became infected through Ibrahim, who contracted HIV during his 18 months away in Paris. She is convinced that he knew his status all along and ran the risk of infecting her. They only exchange angry words, and Mariéme takes advantage of Ibrahim's poor health and helplessness to make him pay for the misery he has caused (F 20-24). In other cases, words don't exist – only silence. Fatim is a loving, faithful newlywed to a man who recently migrated to Europe. Following his last visit home, Fatim becomes pregnant. The author writes, "she gives birth to a beautiful baby boy, but alas, Fatim will receive the biggest surprise of her life: she and her baby are HIV-positive. Fatim never knew a man other than her husband who didn't know he just ruined the future of his wife and child. Several years later Fatim, the child and the husband die of AIDS" (M 10-14). Following diagnosis, the couple remains emotionally distant in their relationship. There is no discussion of sexual behavior, risk or ways to take care of their health. The

relationship simply dissolves. Narratives with a similar plot generally emphasize testing before marriage, or following migration, to avoid consequences such as these. Interestingly, young authors' overt messages about getting tested as a couple or before marriage appear mechanical. Though the primary purpose of couples testing *is* to learn each other's status, it should also serve as a channel for honest, open communication about sex between partners.

Seven narratives feature orphans and vulnerable children (OVC). OVC are subject to social and financial hardship, as they must care for a sick parent or cope with the loss of one or both parents to AIDS-related causes. Three narratives portray a baby born into a family where at least one parent has died of AIDS, and of these, two are born HIV-positive. The young authors express pity and concern for young OVC, "Oh poor child! Double suffering: the loss of his mother and his own seropositive status. Will he survive? ...this child born with no idea what awaits him" (F 15-19). Only one narrative describes the burden of HIV on young ones forced to grow up quickly and provide and care for an HIV-positive parent. Cedric must sell newspapers to pay for his mother's medication and meet basic family needs (M 10-14). Just like Cedric's vanished dream to become a pro soccer player, young Hawa has always wanted to become MISS SENEGAL. One day her father becomes hospitalized and is diagnosed with HIV. Days later, her entire family is diagnosed with HIV, except for her, because her father has been living with the virus for 10 years. Each member of her family eventually dies. When she is finally elected MISS SENEGAL 2007, she commits suicide (M 20-24). Hawa achieved her dream, but it lost meaning in light of the misery her family had suffered.

Support for OVC is barely mentioned across the sample. Cedric's story is the only narrative to depict an OVC who receives support. For the majority of OVC, young authors leave no room to describe their adolescent and young adult outcomes. There is a lack of uplifting narratives about OVC, who are represented as destined to a dismal future characterized by few financial resources, little education and a lack of support.

Two narratives, both authored by males, depict the crippling economic consequences that follow a positive diagnosis. Interestingly, both of these scenarios begin in a climate of fear and distress and end in positive outcomes thanks to social support. In one narrative, a young professional is reluctant to disclose his status to his boss because he's heard of other PLWHA losing their jobs, and fears losing his own (M 20-24). Through their narratives, young authors demonstrate that an individual may be physically well-suited to work, but discrimination in the workplace (or the fear thereof) hampers economic productivity. A 14-year old author presents the story of a single mother who loses her job as a housemaid because she contracts HIV through clandestine sex work. The author writes, "one day upon return from practice, she informs him [her son] that she has HIV/AIDS and that she was dismissed from her job by her boss, who couldn't keep an employee with AIDS" (M 10-14). What is inspiring however is that both authors introduce supportive figures in the narratives that offer financial and moral support, suggesting that there is potential for PLWHA to lead positive, healthy and productive lives. In the case of the young professional, his boss supports him after disclosure and encourages him to organize a press conference to support PLWHA that have lost their

jobs (M 20-24). In both narratives, positive outcomes result from facing fears of disclosure and relying on a supportive person for assistance.

Mbarane

Mbarane is the Wolof word for having multiple partners. This theme is prominent in nearly one-fifth of the total narrative sample. Protagonists with multiple sexual partners are generally migrants, older married men, female sex workers, students and young adults. Across the diverse character profiles, twelve males are cited as having multiple partners or being unfaithful, compared to nine females.

The scenarios that feature *mbarane* are evenly split in their depictions of migrants and travelers, sex workers and young males. The migrants are typically men with spouses or steady partners whom they have left behind. Infidelity is common among migrants at their destination sites - once they start to earn money, they turn to partying, alcohol and women to fill the physical and emotional void once occupied by their partners and families. They have no consideration for the personal lives, sexual histories and HIV status of the women they become sexually involved with, they simply use them to satisfy their sexual urges. The young authors portray the practice of having multiple partners as an expected component of migration. Migrants become unfaithful because they make money and new friends who behave likewise. They are portrayed as undisciplined and express no guilt or regret for their actions regardless of how long they have been married or how many kids they have.

Three of five narratives that explicitly discuss the theme of multiple partners in the context of sex work describe the protagonist's life prior to the sex industry. In all three scenarios, the protagonists were not promiscuous before they became sex workers. One protagonist is a 14-year old divorcée (F 20-24), the second a young girl from a poor family who must migrate to the city (F 20-24) and the third is a wife who has been abandoned by her migrant husband and has no money to feed her children (F 10-14). The authors depict these protagonists as vulnerable, poor and desperate. Poverty pushes them to give up their bodies in exchange for money. With a quick fix for money and little understanding of the health risks they face, sex workers have unprotected sex with multiple people and do not get tested regularly.

Male protagonists with multiple partners are generally wealthy, good looking guys who are well-liked by their peers, are easily tempted and have a certain indescribable quality that women lust after. They typically have sexual relationships with their female peers, although a few have sexual encounters with sex workers. The young authors' social representations suggest that it may be more socially acceptable for a young man to have multiple partners because in the narratives, their peers do not denounce this behavior and the practice increases a man's social status and popularity. .

Young female protagonists who have multiple partners (but who are not sex workers) are featured in three male-authored narratives and one female-authored narrative. They are described as very beautiful girls, but flawed because of their infidelity. These young women are portrayed as sexual predators who seek out sex in exchange for money,

popularity, or good grades. They are represented as unaware, with little respect for themselves. They typically have sex with their male peers, except in the case of Nafi, a protagonist who also has sex with her professors in exchange for good grades (M 20-24). Nafi's story is the only explicit example of consensual intergenerational transactional sex in the total sample.

Two narratives feature older married men that have extramarital affairs with neighborhood sex workers. Despite how much they love their wives and children, they have a weakness for other women. There are no indications of unstable marriages or hard financial circumstances that push them to infidelity, they are simply vulnerable men who are easily tempted by female beauty.

Protagonists with multiple partners always have unprotected sex. Three narratives feature protagonists who use *gris-gris* as a method to prevent HIV, while the remainder fail to even consider their risks. In two scenarios, a casual female partner proposes condom use with a promiscuous protagonist. In both instances, the protagonist refuses. Conversely, casual male partners never propose condom use with promiscuous female protagonists. Even when presented with the opportunity to have safe sex, young authors portray individuals with multiple partners as ignorant and risky. They either perceive themselves as invulnerable or they deny that HIV exists.

Of the 21 narratives that make explicit reference to the theme of multiple partners, 20 feature a protagonist that contracts HIV. Seven of those protagonists go on to infect at

least one of their regular or casual partners. Some protagonists are introduced into the story as HIV-positive but unaware of their status, while others contract HIV after having unprotected sex with multiple partners. They don't learn about their status until a friend or community member urges them to get tested. The story of *Cool Graoul* is atypical in that the protagonist does not contract HIV by the end of the story. Cool Graoul is a popular, attractive, and educated adolescent with eight girlfriends. His peers nickname him Cool Graoul because whenever a girl asks him out he says, "cool graoul" or "not a problem". Following an act of unprotected sex with one of his girlfriends, HIV threatens Cool Graoul in a dream. It warns him of the dangers he faces and tells him it will destroy his health and he will die. Cool Graoul asks for redemption and agrees to never have unprotected sex again. From that day forward, he asks his friends to call him c*ool mais attention*, or "cool but be careful," as he becomes increasingly cautious (M 10-14). What is interesting about the outcome is that the threat of HIV changes his condom practices, but does not necessarily cause him to limit his sexual partners.

Sex Work

Sex work is a prominent theme in almost one-fifth of the total narrative sample. Female sex workers are portrayed as young and middle-aged, single and married, and Senegalese and foreign alike. Four female authors and one male author narrate from the perspective of the sex worker (where sex work is often contextualized within material need), while three female authors and three male authors narrate from the perspective of her clients, or a community member.

Female sex workers are represented as inevitable sources of HIV infection. Men who seek out sex workers are mainly migrants and foreigners (married and single), and other married men. Men approach sex workers to relax and satisfy their sexual appetites, with little consideration of the risks of unprotected sex. Six scenarios, five of which are narrated from the perspective of a client, end in HIV infection of a client. In all cases, infection appears unintentional. There is no indication of routine HIV testing among sex workers therefore they, along with their clients, are unaware of their HIV status.

Of the five authors who narrate from the perspective of the sex worker, poverty is a common theme. Typically they are single mothers, divorcées, or young girls whose entry into the sex industry is triggered by financial distress. Poor girls and women resort to sex work to support their families or meet basic needs. Young adolescent sex workers in particular are vulnerable because they are driven by their need for money and are exploited by men. Being in the sex industry is rarely a source of pride in the narratives, but a circumstance of material need. Blinded by the perils of poverty, they head down a path of self destruction. Young authors often empathize with those sex workers who come from a life of hardship.

Young authors depict various life outcomes, depending on the life circumstances of a sex worker. Three authors portray sex workers who learn to lead optimistic and fulfilling lives despite being HIV-positive. For example, they follow their course of treatment and restore their health (M 10-14), join a women's association and become an educator and role model in the community (F 20-24), and become a community ambassador for people

living with HIV (F 20-24). Such positive outcomes appear to be cushioned by a safe and supportive social environment. Those who do face the blame and shame of their sex work are fated to death (M 20-24), suicide (F 10-14), and a prison sentence for infecting clients with HIV (F 15-19). Such negative outcomes are linked to an absence of social support, a lack of community awareness, and negative attitudes toward PLWHA.

Chapter 4: Discussion, Conclusion and Recommendations

Young Senegalese authors that submitted narratives to the 2008 Scenarios from Africa contest focused primarily on the circumstances of infection and on the post-infection period. Sexual transmission is the primary mode of transmission, and high-risk groups, including women, poor people, individuals with multiple partners, sex workers, and migrants and travelers, are portrayed as responsible for the spread of HIV. In concentrated epidemics in low prevalence countries, there are epidemiological grounds for HIV being associated in the lay imagination with higher-risk groups and behaviors (Winskell 2011). Unfortunately, the process of 'othering' characteristic of the dataset presumes that HIV is contracted by high-risk groups through immoral behaviors and has the disadvantage of minimizing risk perception within the general population.

The narratives are generally optimistic in tone, as young authors demonstrate PLWHA living fulfilling and healthy lives thanks to support from family and friends. Social support promotes in PLWHA improved physical health, emotional balance, and a renewed sense of confidence and optimism. Support also serves as a catalyst for community activism, which increases the visibility and influence of PLWHA in the community. Nonetheless, young authors rarely represent PLWHA as normal, integrated members of a community. Stories in which social support is absent frequently result in bleak outcomes, including immediate death and suicide.

One quarter of the narratives illustrate a character (not necessarily the chief protagonist) who takes action to avoid infection by demanding an HIV test from a partner or spouse,

abstaining from sex, proposing condom use, taking prophylaxis to prevent mother-to-child transmission or avoiding contact with infected blood. HIV testing, in particular, is represented as an important method of prevention. However abstinence, fidelity, and condoms are generally referenced in a formulaic manner through quick mention of the ABC (Abstinence, Be faithful, Condoms) model of prevention (Winskell 2011).

The superficiality of mentions of HIV prevention strategies in the narratives suggests the need for a more integrated life skills development approach to HIV programming. Life skills are defined as the capacity for adaptive and positive behaviors that help in decision-making, problem solving and effective communication (Naré, Katz et al. 1997). Based on the authors' representations, modeling of negotiation skills and strategies, particularly between couples and in peer-pressure settings, is inadequate. Beyond mastery of HIV facts, young people must understand how to communicate, negotiate and exhibit agency because these skills, along with self-esteem and self-efficacy, are critical to healthy sexuality. Incorporating life-skills activities into prevention programs would empower young people who feel burdened by the expectations imposed on them by society (Ostergaard and Samuelsen 2004), their peers and themselves. Learning how to challenge power structures with respect to economics, gender, age and authority is a crucial part of reducing HIV-related risk.

Despite favorable representations of treatment, erroneous biomedical facts illustrate that young people lack an in-depth understanding of HIV. The brief time frame between high-risk sex and a positive test result, the speed of progression of HIV, the lack of

distinction between HIV & AIDS, and the immediacy of ARV drug use are examples of inaccurate information in the narratives that merits attention.

This study is not without limitations. Given that contest participants self-select, the data is not representative of the youth population. Contest participants are likely to be better educated, and more knowledgeable and motivated about HIV than the general youth population (Winskell 2011). Furthermore, findings cannot be extrapolated to young people in rural areas because the sample focuses exclusively on narratives written by urban youth. Performative and rhetorical considerations may be playing a role in these representations i.e. the young authors' motivation to tell what they consider to be a good story, and thus win the contest, may be influencing their HIV-related social representations (Farmer and Good 1991). Despite these limitations, the insight the narratives provide into young people's social representations of HIV & AIDS in Senegal is unique. Future longitudinal research on narratives submitted to the Scenarios from Africa contest between 1997 and 2011 will allow changes in social representations of HIV to be tracked over time.

The creative, non-directive stories written by Senegalese youth provide a compelling look at social representations of HIV & AIDS. Understanding how AIDS is socially constructed in the collective lay imagination of young people is critical to influencing education and communications efforts aimed at HIV prevention (Winskell 2011). Based on the analyses, I recommend stigma reduction, life skills development, and the

promotion of couples' communication as priority areas for future HIV prevention interventions.

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