



International Center  
for Research on Women

*Findings from the  
Women and AIDS  
Research Program*



## Adolescents and HIV/AIDS in the Developing World





**don't trust boys**

**all  
claimed sex**

**safely?**

**facing**

**wanting**

**avoid**





**Vulnerability and Opportunity:**

**Adolescents and HIV/AIDS  
in the Developing World**

*Findings from  
the Women and AIDS Research Program*

by  
Ellen Weiss  
Daniel Whelan  
Geeta Rao Gupta



**International Center for Research on Women**



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## INTRODUCTION

**ACCORDING TO** the World Health Organization, the period of adolescence is defined as the progression from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity, the development of adult mental processes and adult identity, and the transition from total socioeconomic dependence to relative independence (WHO 1975). Young people between the ages of 10 and 19 currently constitute 20 percent of the world's population, and the United Nations estimates that their numbers will grow by 20 percent over the next 15 years (United Nations 1994).<sup>1</sup>

As the WHO definition implies, adolescents are no longer fully under the control of adults, but not yet entrusted with adults' rights and responsibilities. As they enter a new world of social relationships, they are challenged with reconciling social and familial norms of behavior with emerging sexual feelings and desires. Survey data show that many young people initiate sexual activity during their adolescent years and prior to marriage (Senderowitz 1995). Consequently, an ever-growing body of data has revealed that early sexual initiation and unprotected sexual activity can lead to tragic social, economic, and health consequences. In developing countries, it is estimated that as many as 60 percent of all adolescent pregnancies and births are unintended. Early pregnancy can compromise young women's health through childbearing or unsafe abortion. Early parenthood can also interrupt schooling, which can lead to fewer job possibilities and lower income (McCauley and Salter 1995). Every year, millions of young people contract a sexually transmitted disease (Population Reference Bureau and the Center for Population Options 1994). It has been well established that, besides a host of debilitating reproductive health sequelae of sexually transmitted disease (STDs), including infertility, the presence of an STD can increase the likelihood of HIV transmission (Elias and Heise 1993). Approximately half of all HIV infections thus far have occurred in

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men and women younger than age 25, and in many developing countries recent data indicate that up to 60 percent of all new HIV infections are among 15-24 year olds, with females outnumbering males by a ratio of two to one (Family Care International 1995; WHO 1995).

What the statistics on adolescent sexual behavior and its consequences do not reveal, however, is the context in which that behavior takes place, including the factors that contribute to sexual risk-taking among young people and how these factors differ for males and females. Such information is critical for designing effective interventions that meet the gender-specific needs of young people.

While previous research has identified a number of factors that influence sexual risk among youth, such as the lack of information and services (McCauley and Salter 1995), this paper will argue that such factors are not gender-neutral. There are social, cultural, and economic forces that result in gender differences in sexual experiences, expectations, as well as the ability to adopt HIV/STD preventive behaviors. This paper will illustrate that the power imbalance characteristic of gender relations among adults—with women having less access to critical resources than men—has many of its roots in childhood and adolescence.

Eight key findings are presented that challenge commonly held assumptions and provide additional insights about:

- young women's sexual activity outside of marriage;
- adolescent vulnerability to STDs and HIV/AIDS;
- strategies for helping young people—particularly girls—safeguard their sexual and reproductive health; and
- conducting research on sexuality.

A comprehensive set of policy and program recommendations based on these findings are also presented for the consideration of local and national policymakers and program practitioners.

The data supporting these findings were gathered as part of the first phase of the Women and AIDS Research Program conducted by the International Center for Research on Women (ICRW).<sup>2</sup> The aim of the program is to examine the factors that influence adolescent and adult women's risk of HIV infection and identify opportunities for policy and program intervention. The first phase of the program supported 17 studies in Africa, Asia and the Pacific, and Latin America and the Caribbean. The studies examined sexual beliefs, attitudes, and behavior; communication about sexual matters and AIDS; sexual and reproductive decision-making; and sexual coercion and violence. Research teams utilized a mix of quantitative (e.g., survey) and qualitative (e.g., focus groups, individual interviews, participant observation, and diaries) methods of data collection. Study populations included women in rural and urban communities, school-going and non-school-going adolescent girls, adolescent and adult women at the workplace, and community leaders. Eleven of the 17 studies also collected data from similar groups of men and adolescent boys. Researchers working with adolescent populations used a variety of techniques to establish rapport and encourage honest disclosure of attitudes and experiences. These techniques included picture codes, using peers as interviewers, and interactive group exercises, games, and stories. The design features of all 17 studies are described on pp. 12–13.

Some of the studies included samples representative of the population on which they were conducted, whereas the samples of others were small and purposive. What is noteworthy about the data is the degree of commonality of experiences from diverse social and cultural settings. Another important feature of the results is that they provide an in-depth understanding of family, peer, partner, and societal dynamics that impact upon the sexual lives of young people.

Because young people are in the early stages of developing attitudes, communication patterns, and behavior related to sex and relationships, intervening at this stage can have a profound effect on slowing the course of the HIV/AIDS epidemic. Worldwide, this window of opportunity is increasingly being recognized, as evidenced by the attention paid to youth at the 1994 United Nations International Conference on Population and Development held in Cairo and the 1995 U.N. Fourth World Conference on Women held in Beijing. This paper contributes to the growing body of data that support the commitment of the United Nations in focusing resources on young people as a cornerstone of national health and development policies. ♦

## *Principles Agreed to at the Cairo and Beijing Conferences*

**DESPITE THE SENSITIVITY** and controversy that surrounds frank, honest discussion and action to safeguard adolescents' sexual and reproductive health, the global community, through the Cairo and Beijing plans for action, has agreed to many principles aimed at reducing adolescent vulnerability to HIV/STD and unintended pregnancy. Highlighted below are principles that appeared first in the Cairo Programme of Action at the International Conference on Population and Development and were later reiterated by the Beijing Platform at the Fourth International Conference on Women.

Among the stated **goals** are to:

- Protect and promote the rights of adolescents to sexual and reproductive health information and services, and reduce the number of adolescent pregnancies.

In the realm of **policy and law**:

- Develop integrated service, information and educational programs for adolescents that address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, STDs, and HIV/AIDS.
- Safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, with the support and guidance of their parents and in line with the Convention on the Rights of the Child.
- Provide material, financial, and logistical support to youth non-governmental organizations in order to strengthen their involvement in the design, implementation, and evaluation of sexual and reproductive health programs and policies that concern them, including on teenage pregnancy, sex education, STDs, and HIV/AIDS.

In the area of **services and training**:

- Reorient health education and services... to meet the needs of adolescents. Integrated sexual education and services for young people should include: *family planning information*, counselling, and services for sexually active adolescents as well as promotion of voluntary abstinence; *counselling on gender relations*, violence against adolescents and sexual abuse, sexual and reproductive health and responsible behavior, and sex education and information for the prevention of STDs and HIV/AIDS; *confidential mental health services* for girls and young women who have experienced any form of violence, and prevention and treatment of sexual abuse and incest.
- Train health care providers on adolescents' needs and perspectives in the area of sexual and reproductive health, including on the need to respect their right to privacy, confidentiality, and informed consent and to avoid judgmental attitudes.

And finally, in terms of **public information, education, and research**:

- Develop an integrated approach to the general and reproductive health, education, and social needs of girls and young women, by establishing school- and community-based programs on a whole range of health issues, including on basic health and nutrition, the physiology of reproduction, reproductive and sexual health, family planning, STDs, and HIV/AIDS prevention.
- Special attention should be given to the sexual and reproductive health needs of adolescents in order to develop suitable policies and programs and appropriate technologies to meet their needs.

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Source: *Family Care International. 1995. Commitments to Sexual and Reproductive Health and Rights for All: Framework for Action. New York: Family Care International.*

## KEY FINDINGS

**Sexual Initiation for Girls Can Occur Before Menarche.** The ICRW studies corroborated previous research to show that many young women are sexually active prior to marriage. Of particular concern was that some girls have sex before menarche and/or before their teenage years (13 to 19). In Malawi, 56 percent of 300 female adolescents surveyed in 10 villages reported being sexually experienced, and of those, 58 percent had sex before menarche.

The mean age at first intercourse was 13.6 years while the mean age of menarche was 14.5 years. Moreover, 59 percent had sex before attending a traditional ceremony to mark girls' initiation into adulthood. The aim of this ceremony is to prepare girls to assume their subsequent sexual and reproductive roles (Helitzer-Allen 1994). In the Papua New Guinea study, the age at first intercourse was reported to have occurred as early as

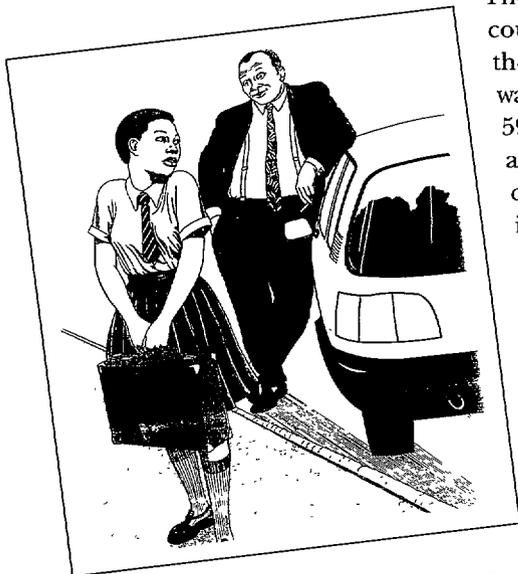
11 years of age (Jenkins et al. 1995). In the Brazil school-based study, 36 percent of those reporting sexual intercourse (one-fourth of a total sample of 255 adolescent females) had their first sexual experience before age 13 (Vasconcelos et al. 1995).

These data highlight that the biological event of menarche is not a prerequisite for the sexual initiation of girls, thereby challenging the conventional wisdom that family life education for girls should begin with the onset of menstruation or when girls enter their teen years. Instead, these findings support the importance of early discussions about sex and relationships.

**Economic Gain and Sexual Coercion Underlie Many Young Women's Sexual Experiences.**

As expected, the studies found that the desire to love and be loved is one of the principal reasons why girls begin sexual relations. According to a female student from Zimbabwe, "You have sex so that you can strengthen your love" (Bassett and Sherman 1994). Young women also described experiencing sexual desire—an important finding given that young women's sexual feelings are often not recognized nor acknowledged. A young, unmarried woman working in an export processing zone (EPZ) in Mauritius commented: "My partner would sneak in my room at night when my parents were asleep and we would have sex. But it has been a year now since I last had intercourse. When one is used to sex, one cannot do without it, and as soon as the man touches me, I feel hot" (Schensul et al. 1994). The sexually active girls living in rural Malawi reported that they look forward with excitement to having sex. They noted that they and their friends make appointments to meet their boyfriends in very secluded places, such as a forest, cave, or under a bridge where people cannot see them. As one young woman noted, "Then it is right in those places where boys and girls do sex peacefully" (Helitzer-Allen 1994).

But love and desire only partially explain young women's sexual experiences. Several of the studies found that economic and material gain was a motivating factor in some girls' sexual activity. Young women in the Zimbabwe school-based study, for example, acknowledged the existence of "sugar daddies" in their communities—older men who seek out adolescent schoolgirls for sex in exchange for money or gifts. Several of the respondents mentioned being approached by these men, and reported that the money (particularly for school fees, lunch, and transportation) was the reason underlying girls' relationships with these men. Very few, however, mentioned that their peers might actually be in love with an older man. As one girl remarked, "These days there is ESAP (Zimbabwe's structural adjustment program) so maybe this girl is not getting enough money from home so she will be hoping to get a lot of money from a sugar daddy." The girls perceived



To find out about sexual relationships between older men and schoolgirls in Zimbabwe, Bassett and Sherman (1994) used this picture to stimulate discussion among students on the topic.

that older men desire relationships with school-girls rather than with women their own age because the men want someone who is “free of disease” and has “few expectations.” At the same time, respondents acknowledged that some girls try to attract an older man and initiate a relationship for economic and material gain (Bassett and Sherman 1994).

Exchanging sex for economic gain was reported by female respondents in other studies. In the Malawi study, two-thirds of 168 female adolescents who reported having sexual intercourse acknowledged accepting money or gifts for sex (Helitzer-Allen 1994). Eighteen percent of 274 sexually active Nigerian university women admitted having sex for favors, money, or gifts (Uwakwe et al. 1994). A number of young women interviewed in the Papua New Guinea study stated they had sex with men in exchange for beer, food, and favors. For example, one 19-year-old related the following:

*When I went to dance parties, the sex partner paid my gate fees and gave me money. When I was by myself, the second sexual partner would come with gifts of food and money and make me agree to have sexual intercourse with him. The food he brought was cooked and eaten with my girlfriends after he had gone away to his house. I earn my income from this man and my own parents (Jenkins et al. 1995).*

Some of the studies also uncovered instances of sexual coercion and rape. More than half of the 168 sexually experienced young women in the Malawi study said they had been forced to have sex. One female respondent noted that some boys become furious if girls refuse their sexual invitations. According to another:

*When her boyfriend approached her to have sex she refused, so the boy forced her until he removed her pants and at last they had sex. She told me that she even cried because she was afraid of getting pregnant and stopping school (Helitzer-Allen 1994).*

In the Nigeria study, 20.6 percent of 274 sexually active university women surveyed said they had been forced to have sex (Uwakwe et al. 1994). More than half of 130 married and unmarried, rural and peri-urban women queried

on the matter in the Papua New Guinea study said they had been forced to have sex against their will. These women reported being coerced into unwanted sex at gun or knife point, being bound with rope, and being attacked verbally, including threats of being killed, thrown out into the night, exposed to the village and her parents, or threats of being forced into having sex with other men. A 16-year-old female from the Schrader-Ramu area of Papua New Guinea described her experience:

*When my boyfriends ask me to have sex, I put my mind on it... and go ahead. If I refuse, they threaten me with knives. I have been frightened for my life, so I just give in to each of them. Sometimes these boyfriends get drunk and come and force me to have vaginal intercourse. I fear my body getting spoiled from rough sex. This takes place at social parties. Rough, forced sex makes me feel bad (Jenkins et al. 1995).*

Findings from the interviews with males in Papua New Guinea corroborated women’s accounts of forced sex, particularly those in which more than one male participated. For example, in interviews with 70 men where the issue of group sex was raised, 44 men recounted 74 events in which they participated. In over half of these events, the men acknowledged that the women were coerced into having sex. For example, according to one 18-year-old male from the Sepik Plains area:

*[I] took part in one occasion where my friend and I forced an 11-year-old school girl to have sex with us. She sexually aroused me and there were two of us and we forced her to have sex and told her to take it easy (Jenkins et al. 1995).*

Findings from the above cited studies show that young women’s sexual experiences are driven by a wide range of factors—romance, sexual desire, economic gain, and sexual coercion. These results underscore the need for strategies that acknowledge the range of young women’s sexual experiences, and the limitations that each of those experiences places on their ability to protect themselves from unwanted pregnancy, STDs, and HIV/AIDS.

**The Social Expectation of Virginity Does Not Necessarily Protect Young Women from STDs and HIV/AIDS.**

In many cultures around the world, a high value is placed by the family and society on maintaining girls' virginity prior to marriage. According to one young woman in Mauritius who works in the EPZ, "Virginity is the pride and honor of the girl and also her family. It is a guarantee for the girl being well treated by her husband, especially if she is having an arranged marriage" (Schensul et al. 1994). To unmarried adolescent factory workers in Chiang Mai, Thailand, not being a virgin means "losing face for oneself and one's family" and having "people say that you are bad" (Cash and Anasuchatkul 1995). Male and female students in Khon Kaen, Thailand, denoted the loss of virginity for girls as "to lose the body." Such girls were described in the local vernacular as being a "dead thing" (Thongkrajai et al. 1994). Adolescents from Recife, Brazil, reported that there are many negative repercussions for losing one's virginity, including negative gossip, pressure from boys to have sex, and neighbors not allowing their daughters to play with non-virgins (Vasconcelos et al. 1995).

Although delayed sexual initiation should be a goal of pregnancy and HIV/STD prevention programs for adolescents, in some instances, social pressure to remain a virgin can contribute to girls' risk of STDs and HIV/AIDS and act as a barrier to their adoption of preventive behaviors. For example, in cultures where virginity is highly valued, alternative sexual practices may be substituted for vaginal intercourse in order to protect the girl's virginity. Respondents in Brazil and Guatemala mentioned that young people practice anal sex as a means to protect a girl's virginity and prevent conception (Vasconcelos et al. 1995; Bezmalinovic et al. forthcoming). In Mauritius, loss of virginity is associated with the pain and bleeding related to the breaking of the hymen, and therefore serves as a barometer in establishing sexual limits. Any sexual activity that does not cause pain is perceived as "safe" in terms of protecting virginity. Female respondents in the Mauritius study described the practice of "light sex" (*dans bord*) which they consider to be distinct from sexual intercourse. In-depth questioning,

however, revealed that light sex involves rubbing the penis against the vagina and penetration up to the point of pain. According to one young woman in Mauritius:

*Once we were both alone at his place and we started kissing and caressing each other. He wanted to have sex with me, but I said no at first, then he insisted and I told him to do it dans bord. I did not feel any pain and I am still a virgin (Schensul et al. 1994).*

Beyond its physiological definition, virginity is associated with passivity and ignorance about sexual matters (Parker 1991; Carovano 1992). Findings from Brazil, India, Mauritius, and Zimbabwe—countries diverse yet similar in terms of societal emphasis on premarital chastity for girls—revealed that young women lack basic knowledge about their bodies and sexuality (Vasconcelos et al. 1995; Bhende 1995; Schensul et al. 1994; Bassett and Sherman 1994). For example, none of the 21 girls participating in focus group discussions in the India study had been told about bodily changes that accompany puberty, such as breast development and growth of pubic hair (Bhende 1995). Only 12 of 62 girls who completed a self-administered questionnaire in the Zimbabwe school-based study reported that they knew about menstruation prior to its onset (Bassett and Sherman 1994). More than half of 500 female university students surveyed as part of the Nigeria study did not know when was a woman's fertile period (Uwakwe et al. 1994). This lack of knowledge is supported by norms that dictate that "good" women should not know about sex or the functioning of their sexual and reproductive organs. In societies that promote such a culture of silence, girls are reluctant to seek information for fear they will be suspected of being sexually active. At the same time, adults are reluctant to provide sex education, particularly to girls, for fear that this will lead to sexual activity.

The studies found that girls face tremendous social pressure to maintain an image of innocence regardless of the true extent of their knowledge or sexual experience. Young, unmarried women working in factories in Chiang Mai, Thailand, noted that even though they know about sex, they must remain silent among friends,

**S**ocial and sexual inequalities promulgated during childhood and adolescence increase the vulnerability to HIV/STD of these men's sexual partners—namely adolescent and adult women who cannot negotiate safe sexual behavior as equals in a relationship.

especially men, and pretend that they do not know anything, “otherwise people might think badly of us.” Many remarked that if a young woman shows she knows about sex that is taken to mean she has had sexual experience and, therefore, she risks stigmatization (Cash and Anasuchatkul 1995). Male and female respondents interviewed in the Guatemala study felt that women are expected to be uninformed about issues related to sex, and that an unmarried woman who knows about sexual matters is viewed suspiciously. These respondents also believed that men should be more knowledgeable and experienced in sexual matters and be women’s teachers. According to a male respondent, “It’s better that he [the husband] is the one to open her eyes. It should be him” (Bezmalinovic et al. forthcoming).

Girls also are reluctant to take precautions against pregnancy, STDs, and HIV because this implies assuming the outward appearance of an active sexual life which is not congruent with traditional norms of conduct for adolescent girls. For example, young women in Mauritius described their concern that just talking about sex-related issues with their boyfriends would make them suspicious about where the girls received such information (Schensul et al. 1994). Adolescents in Brazil noted that they are afraid to access gynecological services. According to one Brazilian girl:

*For an adolescent to go to a health post she has to go with her mother. Imagine if I ask my mother to take me to a gynecologist! She will say I am no longer a virgin.*

It is interesting to note that of the 39 adolescent females in the Brazil study who had been pregnant, 21 had undergone an abortion and only four had seen a gynecologist for prenatal care (Vasconcelos et al. 1995). Some young women and men suggested that carrying condoms

can make a girl appear promiscuous. According to one Brazilian girl, “People will think she must be having sex with the whole world” (Vasconcelos et al. 1995). Similarly, a male factory worker from Chiang Mai, Thailand, commented, “If a girl carried a condom in her purse, I would think she was very bad” (Cash and Anasuchatkul 1995).

These data underscore that:

- promoting virginity does not necessarily result in protecting girls from the risk of infection;
- societal emphasis on virginity leads to a failure to provide young women with information and services; and
- social norms deny young women the right to access the tools of disease and pregnancy prevention.

In order to change societal notions about the norms of behavior for girls, it is important that the community be involved in intervention strategies. Often there is support among adults for their children to be more knowledgeable about sex than they themselves were as adolescents. For example, when describing their first sexual experience, the vast majority of low income, urban women who were interviewed for the Brazil community-based study noted that they did not want their daughters to be as ignorant about sex as they were (Goldstein 1995). How to tap that support is key to the success of educational efforts. In India where young girls are well protected and their mobility tightly restricted, the Bombay research team working on the adolescent study organized an interactive street play that addressed women’s low social status, their lack of information about growing up, and the implications for the health of families and communities. As a result, the community elders not only permitted the girls to attend the sex education sessions, they encouraged the girls’ families to let them attend (Bhende 1995). This suggests that communities are more likely to support educational efforts that challenge beliefs about what is appropriate for girls if they are made aware of the positive outcomes such programs can have for girls and their families.

**Gender Differences in Socialization Contribute to HIV/STD Vulnerability.** In most societies gender relations are characterized by an unequal balance of power, with women having less access than men to education, training, and productive resources such as land and credit (Sivard 1995). The construction of male and female sexuality reflects the inequalities of the social and economic spheres of life. As a result, men are more likely than women to initiate and control sexual interactions and decision-making, which has implications for women's vulnerability to HIV infection (du Guerny and Sjoberg 1993; Schoepf 1993; Elias and Heise 1993).

Two studies conducted in Bombay, India, suggest that the power imbalance characteristic of gender relations among adults can be shaped by family and household dynamics that occur during childhood and adolescence. Differences in household roles and responsibilities ascribed to girls and boys have implications for women's ability to communicate, make decisions, and seek information and services throughout their life cycle. In focus group discussions and interviews conducted with low income Indian adolescents, the data from the study conducted by Bhende (1995) show that girls live in a constricting and limiting environment due to gender-based discrimination. The young unmarried women offered these observations:

*Of course boys are given more importance in the house. After all, a girl is like a stranger who lives in the house only temporarily (before marriage). The boy has a right over the house. It is not the same with the girl.*

*A girl is beaten up by her father, mother, and also her elder brother. A boy is never abused by anyone.*

Results from the community survey conducted as part of the same study showed that over 80 percent of girls compared to 29 percent of boys were responsible for household chores. This translated into increased mobility, spare time, and time spent away from the household for boys. Furthermore, most boys reported that they were consulted by their parents when important family decisions were made. The same was not true for girls.

Data from a second study conducted by George and Jaswal (1995) demonstrated the similarities in gender roles between adolescent girls and adult women. The low-income, ever-married adult women who participated in a series of group discussions perceived themselves to be economically dependent on their husbands, and reported that their mobility is restricted and that they have little say in household and sexual decision-making. Few knew about menstruation and sexual intercourse prior to their occurrence. Through verbal comments and the use of force, the women understood that they were expected to fulfill the sexual needs of their husbands. According to one woman, "A woman does not have much say in the house. He is the husband. How long can we go against his wish?" The women also pointed out that they felt powerless to ask their husbands to use condoms, especially when sex was demanded through force, violence, or when the husband was using alcohol.

Beyond household roles and responsibilities, studies conducted in Guatemala, Zimbabwe, Thailand, and Mexico found that while adults regularly admonish girls to avoid boys and remain virgins, boys encounter fewer restrictions regarding their own sexual behavior (Bezmalinovic et al. forthcoming; Wilson et al. 1995; Thongkrajai et al. 1994; Givaudan et al. forthcoming). Some boys are actually encouraged to use their adolescent years as a time to experiment. According to male and female respondents in the Guatemala study, for example, it is commonly believed that sex is necessary for the mental and physical health of young men (Bezmalinovic et al. forthcoming).

As a result of family, social, and peer influences, sexual experience is seen as a desired goal for boys and linked to their developing concept of masculinity. In the study conducted by Wilson et al. (1995), Zimbabwean boys noted that it is considered prestigious to engage in sexual intercourse and reported talking about their sexual experiences (both real and imagined) with their friends, brothers, and cousins. When asked which sexual topics they wanted to know more about, many boys said they wanted to learn about how to attract a woman and start a sexual relationship. No girl in this

study reported wanting similar information about how to initiate sex with a boy. Cues from family, peers, and society also impact upon boys' and girls' attitudes about sex and its consequences. When boys and girls in the Zimbabwe school-based study were asked to state what was good about having sex, most girls said there was nothing good about sex before marriage, whereas the most common response from boys was sexual satisfaction. When asked about the negative aspects of sex, no boy mentioned shame and abandonment as a result of losing one's virginity, which was the most common answer given by girls (Bassett and Sherman 1994).

*The research team also found that being a peer educator gave girls social legitimacy to talk about sex without the risk of being stigmatized as someone who is sexually promiscuous.*

The recognition and condoning of multiple partner relationships for men but not for women, a social norm common in many countries (McGrath, Rwabukwali, and Schumann 1993; Orbuloye, Caldwell and Caldwell 1992; Elias and Heise 1993), appears to be well entrenched by adolescence. Among the young female factory workers interviewed in Thailand, there was widespread acceptance of a young man's infidelity and, to a lesser extent, multiple sexual partnerships. Some young women noted that if a young man does not visit prostitutes, they would think he is a homosexual (Cash and Anasuchatkul 1995). All of the 30 young, male co-workers of the female EPZ workers who were interviewed as part of the Mauritius study reported having serial or simultaneous sexual relationships with both married and unmarried women (Schensul et al. 1994). During group discussions, male Zimbabwean students noted that having more than one girlfriend is seen as "heroic" and a way to "gain experience in kissing and love making." Although most felt it was acceptable for them to have more than one girlfriend, the boys agreed that their girlfriends should not have other boyfriends. According to one teenage boy, "It's not nice for

a girl to have many boyfriends but for men it's allowed." Interestingly, while these male Zimbabwean students displayed a bravado during male-only group discussions, their written comments on an anonymous questionnaire revealed confusion over their maturing sexuality and male-defined sexual roles. According to one boy:

*If too many girls propose to you, will you ever be able to say no all the time? Well, it happens like this. Since Form 1, I think about 10 girls have tried to get me to kiss them. Is it that I am weak in a way, or I should never talk to a girl alone (Bassett and Sherman 1994) ?*

Despite some uncertainty on the part of the Zimbabwean male students, the findings overall indicate that having many sexual experiences and starting sexual activity during adolescence is a socially acceptable facet of masculinity. As a result, young men's sexual attitudes and behavior clearly increase their own risk of HIV and STDs. The data also highlight that social and sexual inequalities promulgated during childhood and adolescence increase the vulnerability to HIV/STD of these men's sexual partners—namely adolescent and adult women who cannot negotiate safe sexual behavior as equals in a relationship. Moreover, data from the Zimbabwe school-based study reveal that some boys are confused about peer pressure and societal expectations regarding their sexual behavior. Therefore, it is important that interventions target boys as well as girls and include opportunities for them to discuss concepts of masculinity and femininity and their relationship to sexual risk and responsibility.

**The Social Costs of HIV Prevention May Be Too High to Motivate Behavior Change.** Logically, abstinence, partner reduction, condom use, and seeking treatment for STDs should be embraced as beneficial actions because they reduce the risk of HIV and STDs, as well as pregnancy. For adolescents, however, who generally have an inability to see life choices in terms of long-term consequences, the costs of HIV/STD prevention may be too high in terms of peer and partner relationships and emerging sexual desires.

### Summary Description of Studies Supported by the Women and AIDS Research Program

Country	Study	Institution	Report Authors	
AFRICA	<b>Malawi</b>	An Investigation of Community-Based Communication Networks of Adolescent Girls in Rural Malawi for HIV/STD Prevention Messages	Johns Hopkins University School of Public Health and Center for Social Research, University of Malawi	Helitzer-Allen, D.
	<b>Mauritius</b>	Young Women, Work, and AIDS-Related Risk Behavior in Mauritius	Mauritius Family Planning Association, University of Mauritius, University of Connecticut, and Institute for Community Research	Schensul, S., G. Oodit, J. Schensul, S. Seebuluk, U. Bhowan, J. Prakesh Aukhojee, S. Ragobur, B. L. Koye Kwat and S. Affock
	<b>Nigeria</b>	A Psycho-Educational Program to Motivate and Foster AIDS Preventive Behaviors among Female Nigerian University Students	University of Ibadan	Uwakwe, C.U.B., A. A. Mansaray, and G.O.M. Onwu
	<b>Senegal</b>	Sociocultural Factors which Favor HIV Infection and the Integration of Traditional Women's Associations in AIDS Prevention in Senegal	Université Cheikh Anta Diop, Dakar	Niang, C.I
	<b>South Africa</b>	Women and AIDS in Natal/KwaZulu, S. Africa: Determinants to the Adoption of HIV Protective Behavior	Albert Lituli Fdn., Medical Research Council, University of Natal, African National Congress	Abdool Karim, Q., and N. Morar
	<b>Zimbabwe</b>	Female Sexual Behavior and the Risk of HIV Infection: An Ethnographic Study in Harare, Zimbabwe	Department of Community Medicine, University of Zimbabwe	Bassett, M., and J. Sherman
	<b>Zimbabwe</b>	Intergenerational Communication within the Family: Implications for Developing STD/HIV Prevention Strategies for Adolescents in Zimbabwe	Department of Psychology, University of Zimbabwe	Wilson, D., J. McMaster, M. Armstrong, N. Magunje, T. Chimhina, E. Weiss, and G. Rao Gupta
ASIA & THE PACIFIC	<b>India</b>	Evolving a Model for AIDS Prevention Education among Underprivileged Adolescent Girls in Urban India.	World Vision Relief and Development	Bhende, A
	<b>India</b>	Understanding Sexuality: An Ethnographic Study of Poor Women in Bombay	Tata Institute for Social Sciences, Bombay	George, A., and S. Jaswal
	<b>Papua New Guinea</b>	Women and the Risk of AIDS: A Study of Sexual and Reproductive Knowledge and Behavior in Papua New Guinea	Papua New Guinea Institute of Medical Research	Jenkins, C. and the National Sex and Reproduction Research Team
	<b>Thailand</b>	AIDS Prevention among Adolescents: An Intervention Study in Northeast Thailand	Khon Kaen University and the Population Council, Bangkok	Thongkrajai, E., J. Stoeckel, M. Kievying, C. Leelkrawan, S. Anusornteerakul, K. Keitsut, P. Thongkrajai, N. N. Winayakul, P. Leelaphanmet, and C. Elias
	<b>Thailand</b>	Experimental Educational Interventions for the Prevention of AIDS among Northern Thai Single Female Migratory Adolescents	Chiang Mai University	Cash, K., and B. Anasuchatkul
LATIN AMERICA & THE CARIBBEAN	<b>Brazil</b>	Sexuality and AIDS Prevention among Adolescents from Low-Income Communities in Recife, Brazil	Casa de Passagem	Vasconcelos, A., A. Neto, A. Valença, C. Braga, M. Pacheco, S. Dantas, V. Simonetti, and V. Gracia
	<b>Brazil</b>	The Culture, Class, and Gender Politics of a Modern Disease: Women and AIDS in Brazil	Associação Brasileira Interdisciplinar de AIDS (ABIA), Coletivo Feminista Sexualidade e Saúde	Goldstein, D.
	<b>Guatemala</b>	Guatemala City Women: Empowering a Vulnerable Group to Prevent HIV Transmission	Asociación Guatemalteca para la Prevención y Control del SIDA (AGCPS) and DataPro S.A.	Bezmalinovic, B., W. Skidmore DuFlon, and A. Hirschmann
	<b>Jamaica</b>	Female Low Income Workers and AIDS in Jamaica	University of California at Los Angeles and the University of the West Indies	Wyatt, G. E., M.B. Tucker, D. Eldemire, B. Ban E. Le Franc, D. Simeon, and C. Chambers
	<b>Mexico</b>	Intergenerational Communication within the Family: Implications for Developing STD/HIV Prevention Strategies for Adolescents in Mexico	Instituto Mexicano de Investigación de Familia y Población (IMIFAP)	Givaudan, M. S. Pick de Weiss, M. Alvarez, M.E. Collado, E. Weiss, and G. Rao Gupta

In the studies conducted in Thailand, Zimbabwe, Malawi, and Brazil—countries that have been hard-hit by the epidemic—adolescents were generally knowledgeable about AIDS. Males and females knew how the disease was transmitted and that it was fatal. But many young people interviewed did not think they were at risk for HIV/AIDS (Thongkrajai et al.

1994; Bassett and Sherman 1994; Helitzer-Allen 1994; Vasconcelos et al. 1995). For example, 86 percent of 300 girls surveyed in the Malawi study said it was not likely they would get AIDS despite the fact that 56 percent of the sample reported being sexually experienced (Helitzer-Allen 1994). In Nigeria one-fourth of the young university women surveyed agreed with the

Methodology	Sample
Community-based study that included a hypothesis-building research phase (a household census, participant observation, in-depth interviews, and focus groups) and a hypothesis-testing phase (a survey).	Village leaders, including <i>Nankungwi</i> , adolescent girls aged 10-18 years, and their mothers. 120 girls interviewed in-depth in 2 rural villages; 300 girls surveyed in 10 rural villages.
Workplace-based study that used key informant interviews, observation, an open-ended structured interview schedule, and a survey.	Unmarried women, aged 15-24 years, employed in export processing zone factories and male co-workers. In-depth interviews conducted with 90 women and 30 men; survey administered to 500 female workers.
University-based study with an intervention component. Data from focus groups and a survey used to catalyze the formation of a Campus Women's Alliance Against AIDS.	Female university students, aged 16 years and older. Survey administered to a random sample of 500 students.
Community-based study with an intervention component. Methods: participant observation, key informant interviews, sexual life history interviews, and a survey. Data used to design strategies to involve <i>Dimba</i> and <i>Laobe</i> groups in AIDS prevention.	<i>Dimba</i> members, <i>Laobe</i> women, and community leaders. Survey administered to 250 women and 250 men of reproductive age living in Kolda. Sexual life histories collected from 11 male and 14 female survey respondents.
Community-based descriptive study that used group discussions, interviews, observation, and a questionnaire.	Questionnaires were administered to 219 women and 99 men from 2 communities outside of Durban: 1 rural and 1 peri-urban.
School-based descriptive study with an intervention component. Group discussions and anonymous questionnaire used with male and female adolescents; group discussions and interviews conducted with the mothers of female adolescents. Teachers trained to lead discussion groups with students on growing up, sex, relationships, and AIDS.	70 girls and 40 boys attending Forms 3, 4 and 5, aged 14-19 years, from 5 schools: 1 urban school (Harare), 1 peri-urban school, 2 rural boarding schools, and 1 rural government school.
Community-based study that used key informant interviews, focus groups, and in-depth structured interviews.	40 male and 40 female school-going adolescents, aged 14-18 years; 40 mothers and 40 fathers of children aged 14-18 years living in high-density residential areas of Harare.
Community-based study with an intervention component. Formative data from a community census, focus groups, and a survey used to develop a sex education program for adolescent girls.	School-going & non-school going females and males aged 12-20 years, & mothers of adolescent girls living in 6 slum settlements in Bombay. Survey administered to 85 girls & 125 boys; 76 girls participated in the intervention.
Community-based study that used group discussions (18-20 sessions per group) and in-depth interviews.	Hindu, Dalit, and Muslim low-income women; 35 women participated in group discussions; in-depth interviews conducted with 8 of the 35.
Community-based study that used sexual life history interviews and focus groups.	Women and men, aged 15-50 years, living in rural and peri-urban communities located in 14 major culture areas. Sexual life history interviews conducted with 263 women and 160 men.
Quasi-experimental design to evaluate a school-based peer counseling intervention. Phases included: focus group discussions, baseline survey, 6-month intervention program, follow-up survey and focus group discussions.	Male and female students attending four vocational and high schools in Khon Kaen: 2 experimental and 2 control schools. Total of 2,909 matched pre- and post-intervention questionnaires.
Quasi-experimental design to assess three educational interventions for female factory workers: materials-only, materials plus nonformal education facilitated by health promoters, and materials plus nonformal education facilitated by peer leaders. Methods: focus groups, in-depth interviews, pre- and post-intervention survey, and participant observation.	240 unmarried females, aged 14-24 years, working in 4 factories in Chiang Mai.
School-based study that used group exercises and a questionnaire. Adolescents were trained to be interviewers.	255 females, aged 13-19 years; 199 females from 17 schools and 55 females interviewed in public spaces frequented by street girls.
Community-based study with an intervention component. Data from group discussions and in-depth interviews used to develop a video and booklet to help women negotiate safer sex.	3 rounds of group discussions conducted in 3 communities in Rio de Janeiro and São Paulo. 60 in-depth interviews with factory workers; 40 women and 20 men.
Clinic-based study with an intervention component. Data from focus groups and in-depth interviews used to modify and expand an ongoing HIV/AIDS educational intervention for prenatal clinic attenders. Pre- and post-intervention questionnaire used to assess intervention outcomes.	20 focus groups conducted with women attending the prenatal clinic, male & female STD patients, female sex workers, & women and men with HIV/AIDS. In-depth interviews conducted with 37 focus group participants. 100 pregnant women interviewed prior to the intervention; 50 after the intervention.
Workplace-based study with an intervention component. Data from focus groups, a survey, and in-depth interviews used to develop a video for women on STD/HIV prevention.	4 focus groups and 225 structured interviews conducted with female Free Trade Zone workers; 4 focus groups, 120 structured interviews, and 17 in-depth interviews conducted with female Informal Commercial Importers.
School-based study that used focus groups and structured interviews.	50 male and 49 female school-going adolescents, aged 13-16 years, and their mothers (96) and fathers (57) living in a lower-middle income neighborhood of Mexico City.

statement “young people cannot get AIDS” (Uwakwe et al. 1994). Instead of feeling vulnerable themselves, young people tend to believe that AIDS is a disease of “outsiders”—bargirls, prostitutes, homosexuals, and truck drivers. According to one young woman from Mauritius, “AIDS is only for bad people. They have sinned and are most likely to die” (Schensul et al. 1994).

Sexually active girls in rural Malawi did not feel they were vulnerable to HIV infection because they know the boys with whom they develop relationships. According to one girl, “My mother knows his mother,” so this boy could not be infected (Helitzer-Allen 1994). Unmarried female and male factory workers in Chiang Mai, Thailand, also believed that good people do

not get AIDS. According to one male worker, “If she asks me to wear a condom, I tell her there is nothing to worry about—I am a good boy” (Cash and Anasuchatkul 1995).

As expected, condom use among young, sexually active women was reportedly low. For example, only one of the 90 women interviewed in-depth in the Mauritius study reported using condoms despite the fact that 20 percent of the sample reported having had sexual intercourse (Schensul et al. 1994). Of the 30 school-going girls in the Brazil study who reported being sexually active, only three said they use condoms (Vasconcelos et al. 1995).

Findings from the studies conducted with adults found that condoms were associated with illicit sex and signified a lack of trust and intimacy, therefore they were not seen as desirable options for HIV prevention (Abdool Karim and Morar 1995; Goldstein 1995; Wyatt et al. 1995). Similar results were reported with adolescents.

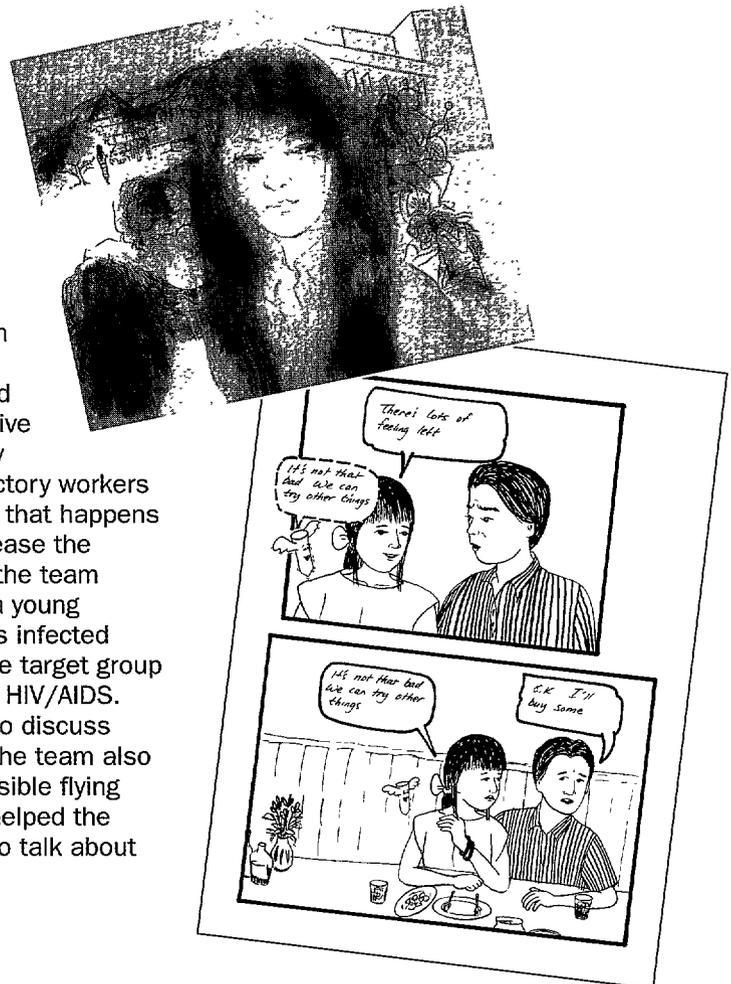
In the Brazil study, the following situation was presented to female respondents: “Laura likes Walter. They have slept together once. The second time they were together Walter brought out a condom. If you were Laura and saw the condom how would you feel?” Nearly two-thirds said they would feel badly about the experience. The reasons they gave had to do with condoms being associated with either the girl or her partner having a disease or being unfaithful (Vasconcelos et al. 1995). Nigerian university women who participated in focus group discussions reported similar barriers to condom use, as follows:

*It's really a delicate matter; a few [women] do ask. Very few boys don't need to be asked before using it... but there are many who would get angry and feel you don't love them or you don't trust them.*

## Reaching Young Women Through Popular Media

**THE CHIANG MAI** research team developed a variety of educational materials based on findings from the formative research. For example, they found that young female factory workers believe that HIV/AIDS is something that happens outside of their peer group. To increase the young women's perception of risk, the team developed a romantic novel about a young female factory worker who becomes infected with HIV. After reading the novel, the target group recognized their own vulnerability to HIV/AIDS.

To help young women learn how to discuss condom use with their boyfriends, the team also created a comic book about an invisible flying condom. The humorous approach helped the unmarried female factory workers to talk about an otherwise embarrassing topic.



*For some boys, you don't dare offer them a condom. They will immediately feel you play around and that you are cheap* (Uwakwe et al. 1994).

In Malawi, more than half the adolescent girls surveyed from 10 rural villages reported that they would rather risk pregnancy than ask a boy to use a condom (Helitzer-Allen 1994). The majority of young women in the Chiang Mai, Thailand, study viewed the consequences of asking their partners to use condoms for HIV prevention in terms of the potential losses—loss of the relationship, loss of trust, loss of belief in their and their partner's goodness or virtue, and loss of acceptance by peers (Cash and Anasuchatkul 1995). For these and other young women, the potentially negative social consequences of adopting preventive behaviors appear to be more significant than the health consequences of STDs or HIV/AIDS.

The research team from the Chiang Mai study found that peer education can help young women overcome the social costs of adopting preventive behaviors. After the intervention as compared to before, more young women who were reached by peer educators expressed the need for both males and females to take responsibility for contraception, and condoned women who discuss STDs and AIDS with a boyfriend, ask their boyfriend to use a condom, and buy condoms themselves. The research team also found that being a peer educator gave girls social legitimacy to talk about sex without the risk of being stigmatized as someone who is sexually promiscuous. This may be particularly important for girls who live in societies where it is not proper for them to talk about sexual matters. Equipped with communication skills, educational materials, and a certificate that recognized their role, the study found that the peer educators were successful in facilitating group discussions about sex, educating their peers about their bodies, helping them to develop communication and assertiveness skills, and changing social norms. According to one peer educator, "It is not shameful now [to talk]; if you don't protect yourself, you are out of date" (Cash and Anasuchatkul 1995).

### **Adolescents Need and Desire Communication with Trusted Adults.**

While research has shown that peers can help fill gaps in adolescents' knowledge about HIV/AIDS and support for behavior change (Rickert, Jay and Gottlieb 1991; Center for Population Options 1993), several studies from the ICRW research program highlight that young people need and desire communication with trusted adults. Adults have traditionally played a wide range of roles in the sexual education and orientation of young people. These adults include parents, aunts and uncles, grandparents, and community leaders (Hanks 1964; Bourdillon 1987). The research results indicate, however, that various factors have acted to diminish the involvement of adults in providing sexual guidance to young people.

In Zimbabwe, the orientation of adolescents with regard to puberty and growing up was traditionally the responsibility of the paternal aunt for girls—the *tete*—and maternal uncle for boys—the *sekuru*. The two studies conducted in Zimbabwe by Bassett and Sherman (1994) and Wilson et al. (1995) confirmed that this system is no longer functioning because of geographic distance as well as differences in class and educational status within families. In the community-based study, for example, many adults and adolescents interviewed said they only saw their extended family a few times a year or less frequently. During encounters with their *tetes* and *sekurus*, adolescents reported that conversations were mostly limited to greetings, education, proper behavior, and life in general. A few adolescents mentioned that their *tetes/sekurus* attempted to discuss boy/girlfriend relationships but these were in the minority. More than two-thirds of the adults interviewed said they had never discussed sexual matters with their nieces or nephews. One woman said, "How can I talk to my nieces and nephews about sex when they never bother to ask me? In any case, they act as if they know it all and so why should I bother?" Another woman commented, "What should I talk about? I was never educated by my *tete*. I would not know what to say" (Wilson et al. 1995).

Findings from both Zimbabwe studies showed that parents have not assumed responsibility for this role because of taboos associated with

*Peers alone cannot fulfill all of the roles necessary to ensure a healthy transition from childhood to adulthood in terms of sexual and emotional development.*

sexual communication between parents and children. Moreover, many parents interviewed believe that detailed sexual information will encourage experimentation. In the community-based study none of the 40 mothers and 40 fathers interviewed said they had discussed sexual intercourse or contraceptives with their adolescent children. Although many parents claimed to have discussed AIDS, none of the adolescents interviewed cited parents as an important source of information about AIDS. Adolescents reported that parental communication on AIDS was largely limited to threats and warnings not to “play” with boys or girls, without explaining what this euphemism means. A typical comment from one mother interviewed was, “Of course she knows what I mean by not ‘play’ with boys. She has never asked what it means and this shows that she understands.” Most parents said they did not know whether anyone had spoken to their children about a wide variety of sex-related topics. According to one parent, “I don’t think my child knows anything about sex. She is still too young. Do you really think they know? It should not be like that at their age.” Nearly three-fourths of adults interviewed said they had never discussed with their spouse the issue of sex education for their adolescent children. Reasons for failing to do so included that they had never thought about it and they felt it was too early to worry since their children were under the age of 18 years (Wilson et al. 1995).

In the Mexico study, a significant proportion of female adolescent respondents (22 percent) and male adolescent respondents (30 percent) reported that they had never talked about

sexual matters with their mothers. A higher proportion (40 percent) of respondents said they had never engaged in any sex-related communication with their fathers. Although many parents and their adolescent children mentioned having discussed HIV/AIDS, related topics such as sexual relations, STDs, and contraception—including condom use—were not discussed. For example, the number of boys who reported that their mothers spoke to them about HIV/AIDS was twice the number who said their mother spoke to them about sexual relations. Barriers to communication cited by Mexican adolescents included their parents’ time/work constraints, not getting along with their parents, embarrassment in discussing sex, lack of trust in their parents’ advice, and fear of talking about sexual topics (Givaudan et al. forthcoming).

Sexual communication between parents and adolescents must be considered in the context of overall communication between parents and children. Several studies documented the physical and emotional absence of the father in many families. For example, the majority of fathers of young women who work in the export processing zones in Mauritius were absent from the household or impaired by chronic disease or alcoholism (Schensul et al. 1994). In the community-based Zimbabwe study over 40 percent of boys and 65 percent of girls said they shared no activities with their fathers. When interaction and communication between fathers and their sons and daughters did occur, adolescents perceived that it frequently focused on disciplinary problems. According to one adolescent male, “My father has no time for general talk. When he is at home, life becomes unbearable for us children. He orders us around and never has anything nice to say.” Though not the norm, a few fathers did not see it as their role to communicate with their children. According to one father, “It is not my duty to talk to children, that is the job of the mother. They know the rules. If they want something from me, they tell their mother and she would inform me” (Wilson et al. 1995).

Drinking was reported to be a barrier to communication between fathers and children

in the Zimbabwe community-based study (Wilson et al. 1995) and the India study (Bhende 1995). According to one Indian boy, “I don’t even feel like going close to him. He stinks of liquor. I only talk to my mother.” Another noted: “I don’t talk much with my father because he drinks heavily and then abuses everyone in the house.” In families with alcoholic fathers, there is less opportunity for personal communication between mothers and children. As noted by one Indian mother, “My husband is a drunkard and I have to look after him. I have no time to listen to what my daughter has to say.”

Despite the numerous barriers documented by the studies, young women and men want increased communication with adults on sexual matters. For example, nearly 80 percent of female adolescents in the Mexico study said they would like to talk more about sexuality with their mothers, and 60 percent would like more communication with their fathers. Sixty percent of Mexican male adolescents reported they want increased communication about sex with both their mothers and their fathers. The majority of parents interviewed also want increased communication with their adolescent children on sexual matters (Givaudan et al. forthcoming). Similarly, in Zimbabwe, more than two-thirds of boys and girls interviewed in the community-based study said they would like to talk more with their *sekuru* and *tete*, respectively, on sex-related topics (Wilson et al. 1995).

The Khon Kaen, Thailand, school-based study also found that adolescents wanted access to trusted adults. While peer counselors were shown to play an important role in helping adolescents use information and health service resources, significant numbers of students approached the research staff for private talks during the researchers’ monthly visits to the schools. One researcher shared her telephone number and received many calls about contraception and the students’ sexual and emotional relationships during the course of the intervention (Thongkrajai et al. 1994).

This finding from Thailand coupled with those from the other cited studies indicate that peers alone cannot fulfill all of the roles necessary to ensure a healthy transition from child-

hood to adulthood in terms of sexual and emotional development. They also show that a gap exists between the level of communication that adolescents want with adults and the level that actually exists. Despite the many cultural and social barriers, the majority of male and female adolescents interviewed on the topic want increased involvement of adults in their lives. Therefore, the challenge is how to assist families and communities establish new roles for adults that fit the changing physical and emotional needs and experiences of young women and men in light of the HIV/AIDS epidemic.

In response to this challenge, Casa de Passagem, the organization that conducted the Brazil school-based study, used the research findings to mobilize health providers to improve adolescents’ access to reproductive health education, counseling, and services. This group of health providers now meets regularly to discuss how service providers can reach young people and improve the quality of services (personal communication 1995). In Zimbabwe, Bassett and Sherman (1994) trained teachers to facilitate discussion groups with students on sex and relationships—a role not previously undertaken by Zimbabwe teachers. Most teaching related to sex was limited to biological facts about sex, reproduction, and AIDS and was carried out using a didactic approach. However, it was clear from the research phase of the study, which relied on focus groups, that group discussions could serve as a way to help young people analyze the different options available to them with regard to sexual decision-making. What was not apparent was how responsive students and teachers would be to this new role for teachers and how effective teachers would be in stimulating discussions on sensitive issues. Results from the pilot intervention indicate that when properly trained, teachers can successfully assume this new role and that both students and teachers respond favorably to teachers’ involvement in sex education in a more participatory manner. In addition some teachers were approached by students for individual discussion and counseling. A critical component of the training was to help teachers feel comfortable discussing sexual topics, including their own sexuality.

**A Combination of Qualitative and Quantitative Methods Works Best for Collecting Data on Sexual Behavior from Young Women.**

To find out about adolescent sexuality, some research teams from the Women and AIDS Research Program used structured questionnaires, either self-administered or administered by an interviewer. Such instruments were useful for examining individual attitudes and levels of knowledge about sex and HIV/AIDS, and social norms regarding sexual behavior. They were not as useful, however, for gathering contextual data about sexual activity nor in eliciting honest disclosure of sexual behavior by young women in communities where pre-marital sex is strongly proscribed for females. For example, in the Zimbabwe school-based study, adolescent females and males were asked to complete an anonymous questionnaire to find out about individual sexual beliefs and practices. Even though good rapport and a high degree of trust had been established between researchers and study participants during group discussions conducted prior to administration of the questionnaire, female students remained reluctant to disclose their sexual activity. Out of the 62 girls who completed the questionnaire, only two girls admitted having had sexual intercourse. Although the sample was smaller (n=30), one-third of the boys reported having had sex. The researchers later discovered that four girls who had been recruited to participate in the study left school because of pregnancy. They also found out that such an occurrence was not uncommon among the study population, suggesting that more girls were in fact sexually experienced and casting doubt on the validity of the findings (Bassett and Sherman 1994).

The research team from Chiang Mai, Thailand, had a similar experience. Data from structured interviews conducted with 240 young, unmarried female factory workers revealed that 85 percent of the women had a boyfriend. None, however, admitted that they had ever had sex. When later asked to complete an anonymous, self-administered questionnaire, all 240 young women either denied sexual activity or did not answer the question. Yet most women estimated that the vast majority of their peers are sexually active before marriage. In contrast, when

*Involving adolescents in the research process helps to guarantee the relevance of the research, the applicability of the findings, and the continued involvement of adolescents in program activities.*

in-depth interviews were conducted over a period of time with a sub-sample of young women from the factories where the study took place (n=45), approximately one-quarter of the women disclosed they had sexual intercourse (Cash and Anasuchatkul 1995).

Data from the Mauritius study also highlight the difference in reported levels of sexual behavior among young women according to method. Using a survey, only 8.6 percent of a sample of 500 never-married young women who work in EPZ factories reported that they had sexual intercourse. However, among a different sample of 90 women who also work in the EPZ, during in-depth interviews that took up to two hours to complete, 20 percent admitted to being sexually active. During these interviews, research team members answered questions, drew sketches of male and female anatomy, shared problems, and commiserated over lost love affairs (Schensul et al. 1994).

These results suggest that in-depth private interviews conducted by an individual who will answer their questions and concerns may be the most effective method in eliciting sensitive data on sexual behavior from girls. It is commonly believed that self-administered questionnaires, because of their guarantee of anonymity, are an effective way to gather data on sensitive, private matters such as sexuality. However, in some cultures a written statement—regardless of its guarantee of anonymity—is perceived to be more powerful and incriminating than an oral response given to an unknown person. According to one young woman from Zimbabwe interviewed for a different study, the problem with reporting honestly about sexual behavior is that “... by writing it down, it’s like I have to face my own life”—a life, for girls in many communities, of lost honor and respect as a result of losing their virginity (personal communication 1993).

### **Enlisting the Participation of Young People Enhances Research and Program Outcomes.**

Research on adolescent sexual behavior has tended to treat adolescents as the objects of research, with little attention paid to enlisting their participation in the research process and establishing a closer link between research and intervention. Findings from the studies conducted with adolescents indicate that participatory research methods facilitate the cooperation of young people in answering questions on sensitive topics such as sexuality, catalyze community responses to identified needs and problems, and foster sustained participation in the resulting actions. Young people participated in the research process by serving as field interviewers, by helping to design data collection instruments, by discussing and interpreting research results, and by planning intervention programs based on the research findings.

The Nigeria study provides an example of the benefits of using participatory methods. The research team first held a series of focus group discussions with university women to collect qualitative data on the factors that place them at risk of HIV infection. During one of the sessions, the women were asked to give feedback on the survey to be administered to their peers. Their comments and use of local expressions to describe sexual topics contributed to an increased understanding of the questionnaire by their peers. Focus group participants were also enlisted to distribute the anonymous, self-administered questionnaire to women in the residence halls. Results from the survey were then shared with focus group participants, who mobilized students to form a Campus Women's Alliance Against AIDS (CWA). At the first meeting, the women requested more information about STDs and HIV/AIDS and training in communication and peer education. A peer educator training workshop was subsequently organized for 30 CWA members. The peer educators and other CWA members went on to conduct educational and awareness-raising activities, thereby taking ownership of the intervention on campus (Uwakwe et al. 1994).

In Brazil, a series of group exercises was first held with 10 adolescents who had been involved in activities sponsored by Casa de Passagem (an NGO that provides health, psychological, vocational, and educational services to low income girls). The purpose of the exercises was to understand the vernacular used by adolescents and to obtain input from participants in designing the questionnaire. This group of 10 young women was subsequently trained to administer the questionnaire to their peers and to talk with respondents afterwards to answer their questions. Evidence from this study suggests that involving adolescents in the research process helps to guarantee the relevance of the research, the applicability of the findings, and the continued involvement of adolescents in program activities. The following comments from the peer interviewers reveal the advantages of this research strategy when working with adolescents:

*I felt that the adolescent girls were interested in replying to the questionnaire. They felt good opening up to a girl like themselves.*

*During the period that I worked on this survey I got over my shyness a lot. I learned a lot of things and became even more informed. I started to express myself more, my embarrassment gradually disappeared and I started to clarify my doubts, discuss things, say what I thought and pay attention.*

The active role played by the young women was perceived very positively by the community. Very often adolescents are seen as a problem because of the perception that they are sexually active and use drugs. The adolescents also perceive themselves to be troublemakers and believe they can do nothing to change their lives. Involving young women in the research process allowed them to realize they can help their peers who have the same doubts and anxieties. In addition, parents, teachers, and local leaders began to understand that young people can make a positive contribution to the community. As a result of the study, the schools requested that the interviewers return and begin a program of training peer educators in HIV/AIDS prevention (Vasconcelos et al. 1995). ♦



## CONCLUSIONS AND RECOMMENDATIONS

**FINDINGS FROM** the Women and AIDS Research Program demonstrate that young women are at risk of unintended pregnancy, STDs, and HIV infection because of unprotected sexual activity. But the data also reveal that cultural and socioeconomic factors restrict their ability to adopt protective behaviors. These behaviors include accessing condoms and reproductive health services, seeking information about sexual matters, and discussing sex and condom use with their partners. Young women's

*P*olicymakers should advocate for a broader response to the epidemic that addresses the root causes of young women's vulnerability.

vulnerability can be attributed, in part, to family and societal concepts of masculinity and femininity that are communicated during childhood and adolescence, and that ultimately influence sexual and household roles throughout the life cycle. The studies show that young women have sex for romance, sexual desire, economic gain, and because of coercion; that they lack knowledge about their bodies; and that they are more concerned about the social costs of adopting preventive behaviors than the health consequences of not doing so. The studies also show that female and male adolescents have little or no communication with parents and other adults, yet they would like them to provide information and guidance. These realities indicate that young women need more than warnings and simplistic messages such as "don't play with boys" and "stay a virgin until you get married." They also highlight that interventions designed to safeguard young women's health must involve adolescent boys as well as adult women and men. Moreover, the data underscore that a health framework alone cannot guide the development of policies and programs that safeguard young women's sexual and reproductive health.

The following policy and program recommendations emerged from the data:

**Broaden HIV/AIDS Education to Include a Discussion of Sexuality, Relationships, and Gender Roles.** Both young women and men need information about physical and sexual development, STDs, and HIV/AIDS. And they need this information before they begin sexual activity. But young people also need opportunities to ask questions and to discuss their sexual feelings, relationships (including those in which sex is exchanged for economic gain), and concepts of masculinity and femininity. Girls and boys need to talk among themselves, with the opposite sex, and with adults to discuss and debate social norms, values, and gender expectations. Such opportunities are critical in helping young women overcome negative social norms that restrict their role in sexual interactions and in developing a healthy and positive approach to their own sexuality. Besides providing opportunities to talk, these forums should also help young people, particularly girls, develop communication and assertiveness skills to resist physical and psychological pressure to have unwanted sex.

While schools can reach many young people, significant numbers of adolescents are not part of the formal educational system. Therefore, community- and work-based programs that address HIV/AIDS in a broader context are needed. In addition to face-to-face education, mass media and social marketing can play an important role in modifying concepts of masculinity and femininity and their relation to sexuality and HIV risk. These tools should be used not only to promote condoms but also to change notions about women's and men's roles in sexual communication and decision-making.

**Involve Adolescents, Including those Living with HIV/AIDS, in Research and Intervention.** Some studies revealed that involving young people in the research process

improves the relevancy of the research, catalyzes responses to needs and problems, and fosters participation in the resulting actions. Besides research, a few studies highlighted the importance of involving adolescents in program design and implementation. The findings also underscored that young people living with HIV/AIDS need to be engaged in designing and carrying out educational activities targeted to adolescents in order to promote a better understanding of the disease and a more effective community response.

**Equip Adults to be Trusted Sources of Information and Guidance.** Several studies showed that adolescents want increased communication with adults on sexual matters. While progress has been made in developing models that foster communication and information exchange between adolescents (such as through peer education), much less attention has been focused on equipping adults to become

trusted sources of information and guidance for young people. More effort is needed to design and test interventions that establish constructive roles for adults (such as parents, other family members, teachers, health service providers, and community leaders) in which they can contribute to the healthy development of youth.

**Make Reproductive Health Services User-Friendly.** The studies highlighted the need to make reproductive health services<sup>3</sup> more user-friendly for adolescents by making them private, confidential, affordable, and accessible in terms of hours of operation and location. An important step in this process is sensitizing service providers to the needs of young people. Research findings such as these can be used to increase service providers' understanding of the barriers adolescents face in safeguarding their reproductive health and to catalyze changes in service delivery.

### *Sex Education and Sexual Behavior among Youth*

**IT IS A MISCONCEPTION** that school-based programs that teach young people about sexuality and contraception lead to early sexual experimentation. The Global Program on AIDS of the World Health Organization reviewed 19 studies to examine the age of first sexual intercourse and reported levels of sexual activity among students who had been exposed to sex education. It found the following:

- There was no evidence that sex education leads to earlier or increased sexual activity in young people.
- Six studies showed that sex education either delayed the onset of sexual activity or reduced its overall frequency.
- Two studies showed that access to counseling and contraceptive services did not encourage earlier or increased sexual activity.

- Ten studies showed that sex education increased the adoption of safer practices by sexually active youth.
- School programs that promoted both the postponement of sexual activity and the use of condoms when sex occurs were more effective in reducing risk than those that promoted abstinence alone.
- Sex education for youth is more effective when it is administered before young people become sexually active, and when skills and social norms (rather than knowledge) are emphasized.

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*Source: "Sex Education Leads to Safer Behavior," Global AIDS News (Newsletter of the Global Program on AIDS of the World Health Organization), No. 4 (1993).*

**Mobilize Communities against Sexual Violence.** Particularly disturbing is the extent to which sexual coercion characterizes young women's sexual experiences, leaving them powerless to protect themselves against pregnancy and disease. Other research data suggest that sexual abuse in childhood and adolescence is associated with high-risk sexual behavior later in life (Heise, Moore and Toubia 1995). To deal with sexual coercion, violence and rape, multiple strategies are needed. Young women who have experienced sexual abuse need access to counseling and legal services, therefore these services need to be developed and expanded. Family planning, school-, community-, and work-based programs that target young women must establish linkages with community-based efforts that provide these services.

It is also crucial that efforts be made to move the topic of sexual violence from the private to the public sphere where it is more likely to receive public policy attention. This can be done by including sexual coercion as a topic for discussion in face-to-face education, using social marketing and mass media to challenge notions about sexual violence and rape, and widely disseminating research results that document the prevalence of sexual coercion in the lives of adolescent and adult women. In addition, policymakers and NGOs must advocate for appropriate legal action to punish perpetrators of sexual violence.

**Increase Adolescent and Adult Women's Access to Education and Economic Resources.** Programs and policies must facilitate both adolescent and adult women's access to resources, information, education (both formal and informal), and employment. For young girls, a commitment to their primary and secondary education is the first step in enabling them to access other critical resources later in life, such as employment and higher education. Ministries of Education need to work with other key governmental ministries to address the wider environment within which education is provided, such as conditions of declining economic growth, the impact of structural adjustment programs, and parental unemployment that contribute to young girls' need to

resort to sexual networking in order to cover school fees, clothing, and books.

Improving women's status via economic, political, and legal reforms yields benefits on two levels:

- it allows women to obtain training, employment, property ownership, and credit, which in turn strengthens the economic viability of the family; and
- it fosters an environment in which women achieve the autonomy necessary to enjoy a state of reproductive and sexual health, thus providing a role model for young girls.

**Conduct Research to Develop and Test Interventions.** The ICRW studies draw attention to the need for new, gender-specific initiatives that respond to the realities of young women and men. In order to develop and test educational methods and materials, and strategies for providing reproductive health services, evaluation and operations research will be needed. However, it is important that appropriate indicators be developed that detect social and cultural changes that support the adoption of HIV/STD preventive behaviors by young women and men. These include changes in communication patterns and perceptions of male and female roles and responsibilities.

In conclusion, HIV/AIDS policymakers should advocate for a broader response to the epidemic that addresses the root causes of young women's vulnerability. An approach that focuses on the socioeconomic and cultural context of their vulnerability—instead of on changing isolated risk behaviors—may have a wider and more lasting impact, not only on the spread of HIV/AIDS, but on social and economic development. ♦

## ENDNOTES

<sup>1</sup> For the purpose of this paper, the terms adolescents, young people, and young adults are used interchangeably, reflecting the adoption by the World Health Organization of the United Nations definition of the adolescent age category as those individuals ages 10 to 24.

<sup>2</sup> This program is funded through a cooperative agreement with the Offices of Health and Women in Development of the U.S. Agency for International Development (USAID). The first phase of the program was

conducted from 1991 to 1993. Currently in its second phase, the program is supporting eight research teams to use the findings from the first phase to develop and test interventions. The results from the second phase will be available in late 1996.

<sup>3</sup> Reproductive health services include prenatal and postnatal care; prevention, detection, and treatment of STDs and other reproductive tract infections and gynecological morbidities; and provision of contraceptives, and family planning information and counseling.

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