Chapter 10

Adolescents in the Context of HIV/AIDS: Crisis and Opportunity

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Background

No group stands to be as affected and infected by HIV as adolescents. Diverse and evolving, this population defies generalizations and ready-made solutions with respect to the growing HIV/AIDS epidemic. The figures bear repeating, even to those familiar with the situation. At the end of 2001, HIV/AIDS prevalence among young people aged 15–24 was estimated at 11.8 million. Of these, 7.3 million (62 percent) were young women and 4.5 million (38 percent) were young men (UNAIDS/UNICEF 2001). Looking at new HIV infections as a whole, over half of new post-infancy infections worldwide now occur before the age of 25 (UNAIDS 1999). In short, we have our work cut out for us.

Many children will reach adolescence as orphans, even if they are not infected themselves. In 2000, the number of children who lost a mother or both parents to AIDS totaled 15.6 million; that number is expected to double by 2010 (UNAIDS/UNICEF 2000). By the time they have reached adolescence, these children may have dropped out of school to care for an ailing parent, may have been stigmatized and discriminated against by their peers and community, and may have struggled to procure basic material goods. They may also be heads of households and primary wage-earners for their families.

More difficult to quantify are the macro-level effects of the HIV/AIDS epidemic on economic, social, and educational sectors, which optimally provide structure and

security for young people preparing to enter the most productive stage of their lives. With AIDS considered as much a developmental as a health crisis, governments are facing lower productivity, higher health costs, and crises in schools resulting from the death of teachers and dwindling education budgets.

This chapter argues that the issue of adolescents and HIV has reached a point of global crisis—and also opportunity. The dramatic statistics have shocked the field, stimulating research and discourse, as well as new activities for adolescents. Missing, however, is a rigorous analysis of the heterogeneity and complexity of adolescents' lives, informed by an attitude that respects youth as full participants in society. This is not a time for familiar modalities that seek solutions to the "problem" of adolescents. We have an opportunity to ask new questions, dig deeper, and develop an appreciation for adolescence as a discrete demographic, as opposed to a "transitional," phase of life. Seizing this opportunity is a matter of great urgency in light of the HIV/AIDS epidemic.

To Act or to Study—a False Dichotomy

Many of us who have lived and worked among those most affected by the HIV/AIDS epidemic struggle to find the right balance between research and programming. On one hand, we recognize the need to respond to the urgency and magnitude of the epidemic; on the other hand, we have limited funds and time, which we must devote to the most appropriate and effective programs. Research and analysis are not a luxury; they are an imperative. But we must advocate for research with impatience.

The multitude of programs that have either sprung up from the grassroots or have been spawned by nongovernmental organizations throughout the world are central to the struggle and to the solution. Our research must not be antithetical to the energy and

determination fueling those programs; ideally, it would nourish and sustain the innovation and creativity that exists on the ground. In particular, we need to be watchful for initiatives undertaken by adolescents themselves. Most formal education teaches us to program *for*, and conduct research *on*, the target population. If we are to take the participation of adolescents seriously—bringing them into the planning, implementation, and evaluation of their own programs—then a new research paradigm characterized by a participatory process is required.

Two strains of research are urgently needed: 1) the gathering of data that provide a fuller picture of individual adolescents and their environment; and 2) evaluations of existing programs, many of which are initiated locally and known only anecdotally.

Gather Data, Differentiate by Subgroups, Contextualize Data, and Challenge Assumptions

The most dangerous approach to programming for adolescents is to assume that they fit into one category or another, such as "high-risk" or "problem" children. It may be more productive to view them as individuals inhabiting a context in which they are often highly vulnerable to infection.[1] This perspective breaks down the "problematization" of adolescents, while acknowledging the need for individual behavior change as well as structural transformation.

The culture of adolescence is ever-changing and evolving. As a consequence, it is difficult for the researcher or program planner to even know what questions to ask. A good start is to challenge our assumptions about adolescents and be ready to learn from local knowledge. What are the strategies that an adolescent may adopt as a coping

[1] Baylies et al. 2000 used this construction to explain vulnerabilities experienced by women as opposed to their being labeled as vulnerable human beings.

mechanism? We find youth avoiding risky situations (including school for some), practicing positive behaviors in the face of peer pressure, protecting a sibling, and fleeing home. What do these strategies tell us about his/her evolving context? How can positive mechanisms be communicated and replicated?

In gathering and differentiating data, we need to search for vulnerability factors beyond those found in the general population. An adolescent's experience is shaped by a unique web of individual and environmental variables, including, among other factors, the adolescent's age, gender, and living arrangements; her/his sexual, marital, socioeconomic, and educational status; and the age of the adolescent's partner (if there is one).

Before going to the expense of collecting additional data, it is important to exhaust the information on the above variables that is hidden in existing data sets. For example, is it feasible to break a current data set into age subgroups corresponding to the different stages of life represented by 15–19- and 20–25-year-olds? Can the data be delineated by gender, shedding light on what appears to be the increasing feminization of the HIV/AIDS epidemic? Among the factors least analyzed in the data, in relation to the HIV epidemic and adolescents, are living arrangements, gender, and marital status.

Living arrangements—the assumption of a supportive environment

One cannot assume that adolescents live in a supportive environment (see Chapter 3). In reality, children (often female) frequently provide full-time support and care for ailing parents or siblings, necessitating their absence from school. If a child's parents have passed away from AIDS, that child is faced with the economic challenges of orphanhood, compounded by the stigma and discrimination of having an AIDS death in

the family. How intergenerational relations and societal structures respond to this crisis differs from context to context.

UNAIDS statistics show that for younger adolescents (aged 10–14), losing both parents is a risk factor for dropping out of school. In Mozambique, 68 percent of children living with at least one parent are in school, while 24 percent of those who have lost both parents are in school. By contrast, in neighboring Zambia, 78 percent of those with at least one parent are in school, while 65 percent of those who lost both parents are in school (DHS/UNICEF 1993–2000). We need to know more about what accounts for these differences. Are school fees involved? Governmental policies? Do AIDS orphans suffer different degrees of stigma and discrimination in these two countries? Are intergenerational relations structured in a way that makes up for the loss of parents (through parenting by a grandmother, for instance)? How do these relations differ in urban and rural environments?

Two examples of programmatic approaches that attempt to mitigate the effect on orphans:

- The Horizons program of the Population Council, along with Plan International, is currently evaluating an intervention that helps HIV-positive parents plan for the care of their children. The program helps these parents to select a guardian, make a will, and prepare a memory book for their children. Another aspect of the program is counseling parents on how to tell their children about their illness and impending death (Gilborn et al. 2001).

- Another approach, used in Manicaland, Zimbabwe, is to link adolescent-headed households to community services and community support. The study in Zimbabwe found that when extended-family safety nets cannot cope with the burden of AIDS orphans, community groups can assist through the establishment of volunteer visiting programs to at-risk families and by channeling material support to families in need (Foster et al. 1997).

The gender factor

Critical to prevention programming is debunking the assumption that adolescents' sexual relations, especially girls', are consensual, exist between peers, and occur in the absence of violence, coercion, and power. Nowhere are constraints on agency more pronounced than in an adolescent girl's inability to protect herself from unwanted sexual relations, unwanted pregnancy, and sexually transmitted infections (STIs), including HIV infection. Gender roles and expectations introduced in childhood are solidified in adolescence, when economic and social constraints become barriers—often violent barriers—to a girl's agency.

To date, there is no source for population-level data on HIV infection in adolescents disaggregated by gender. However, we have anecdotal evidence from small samples in sub-Saharan Africa and Trinidad/Tobago suggesting that young females are becoming infected at rates three to seven times higher than the rates among young males their age. For example:

- In Dar es Salaam, Tanzania, where 60 percent of secondary-school students surveyed were infected with HIV, girls' infection rate was five times higher than boys' (PAI 2001).
- Rates of infection in Trinidad/Tobago were found to be five times higher among 15–19-year-old girls than among boys of the same age (UNIFEM 2001).
- A UNAIDS study of four urban areas in sub-Saharan Africa in the late 1990s found that in Kisumu, Kenya and Ndola, Zambia, three and four percent respectively of 15–19 males were infected with HIV, compared to 23 and 15 percent respectively of same-aged females. (Baylies et al. 2000:10)
- In Mwanza, Tanzania, figures for 1990–91 demonstrate an infection ratio between 15–24-year-old females and males of 11:1 at rural roadside sites and 3:1 at urban sites (Staneki 2001).
- In Yaoundé, Cameroon, a 1998 multi-center study found an infection ratio of 5:1 between 15–19 year-old girls and boys (Staneki 2001).

The difference between HIV infection rates among young females and males has not been wholly accounted for. However, the following biological and social factors have been found to contribute to the disparity:

- Physiologically, the virus transfers more efficiently from males to females than vice versa.
- Females are more vulnerable than males to other STIs, partly because they have a larger surface of mucosa (lining the vagina and cervix) exposed to partner secretions during intercourse. A young female is at even higher risk of infection because her immature cervix and fewer vaginal secretions provide less of a barrier against HIV and because lacerations of vaginal mucosa are more common in young females.
- The presence of another STI greatly facilitates the transmission of HIV. The STIs that cause genital ulcers most significantly increase the changes of acquiring HIV in any given sexual act. Herpes Simplex Virus - 2 infection, which is more prevalent among young females than young males, is of particular concern (Glynn et al. 2001).
- Sexual coercion and violence, experienced most often by females, can result in genital lesions and sores, increasing susceptibility to HIV infection. Violence also renders females unable to negotiate safe sexual behavior.
- Out of economic necessity, females may exchange sex for school fees, food, housing, and/or clothes (often not on their own terms). Using sex as currency increases females' risk of infection.
- Sexual mixing, in which partners are characterized by a wide age gap, is common among married and unmarried adolescents alike, contributing to their high risk of infection. In many countries, younger age groups have higher rates of STIs, which may reflect increased sexual mixing(Hawkes and Santhya 2001).

The programmatic implications of gender disparities in infection are vast. Protecting adolescent girls from HIV infection requires intervention at a number of levels. It requires undertaking an analysis of power, coercion, and violence in the sexual arena; providing girls with access to nonjudgmental, confidential reproductive health services, including STI services; and offering them access to economic opportunities (issues already addressed in previous chapters).

In the midst of developing programs that address the HIV epidemic among adolescents, we cannot afford to lose track of adolescents' sexuality. Accepting and affirming that adolescents are sexual beings is as critical as the programming opportunities named above. In spite of the vulnerable context women can find themselves in, young females, in particular, need positive representations of their sexuality and fewer experiences of being subsumed and defined under the label of "vulnerable." This space can be difficult to claim in the face of an epidemic, but confining sexuality to the "danger" category is neither a healthy nor a sustainable message.

Marital status

As noted in the previous chapter, married adolescent girls constitute a severely neglected and underserved majority of the adolescent population in the developing world. The invisible status of married adolescent girls is particularly evident in the context of HIV prevention. Up to now, there has been no protocol for HIV prevention that can be offered to a young married female who is expected to become pregnant immediately, cannot control frequency of intercourse, and cannot change her partner. The message to practice fidelity may not be protective in the many cases in which an adolescent girls' male partner is 10–15 years older and has had or has other sexual liaisons. In the midst of this, there is still a belief in many countries with high HIV prevalence that marriage is a protective state for young females. It is imperative that we explore early marriage as a risk factor for HIV infection.

A recent multi-center study of factors determining differences in HIV prevalence in sub-Saharan Africa found the primary distinguishing factors to be: 1) young age at first

marriage; 2) females' young age at sexual initiation; and 3) large age difference between spouses. These factors outweighed other seemingly relevant factors, including contact with sex workers, lifetime number of sexual partners, rate of acquisition of new partners, and lack of condom use. Specifically, the study found that early marriage "appears to be a risk factor for both HIV and HSV-2 seropositivity, perhaps reflecting relatively intense exposure through repeated sexual intercourse, or high levels of susceptibility during sexual debut" (Caraël and Holmes 2001).

Population-level data on the effect of marriage on HIV levels are lacking; however, smaller studies point to a possible correlation between marital status and HIV infection. For instance, a study in Uganda found that girls aged 13–19 who were HIV-positive were twice as likely to be married as same-aged girls who were HIV-negative (Carpenter et al. 1997). In a forthcoming article, Shelley Clark uses DHS data to explore the relative risk factors for HIV infection among adolescent girls in three categories—virgins, unmarried sexually active girls, and married girls aged 15–19—in selected West African countries. Preliminary information indicates that married adolescent girls in Burkina Faso are less knowledgeable about HIV infection than their unmarried peers, are about one-tenth as likely to be able to negotiate condom use, and have very different reproductive goals (Clark 2002).

Where marriage can be defined as a risk factor for adolescent girls, a two-pronged HIV-prevention strategy might be employed. The immediate need is to provide females and their spouses with methods to avoid both pregnancy and HIV infection early in marriage (e.g., use of male and female condoms). The long-term structural strategy might be to promote (from the community to the policy level) an increase in females' average age at marriage.

The role of marriage and the process leading to marriage in countries in the grips of the HIV/AIDS epidemic need careful analysis. Both married and unmarried adolescents in sexual or marital relationships may be relatively powerless, and both may exchange sex for status, a true or false sense of security, and sometimes explicitly for money. What is different between married and unmarried adolescent girls is the degree to which they desire pregnancy and their relative ability to leave their sexual relationship. Any advocacy for increasing females' average age at marriage needs to be accompanied by a transformation of social norms concerning marriage. Strategies must be developed to give unmarried adolescent girls who choose to become sexually active more negotiating power with sexual partners. Without such efforts, unmarried, sexually active girls may be vulnerable to exploitation: "The social norms relating to women their age in the past assume they were married; there are few exceptions to guide either the behavior of these girls or the behavior of others towards them. The girls may be at high risk of STIs, pregnancy, and abuse, in addition to HIV infection." (National Research Council 1996). In sum, very little thought has been given to either married or unmarried girls' power to negotiate sexual relationships in a rapidly changing social and disease environment.

Programming Considerations

This section outlines a few program examples, but it raises even more questions that can be asked when developing effective programs for adolescents that address HIV. There is no one protocol to adopt in developing such programs for adolescents; in fact, many strategies to prevent STIs and pregnancy among adolescents can be incorporated into HIV-prevention programs. It is imperative, however (as noted earlier), that programs

address the heterogeneity of the adolescent experience. They also need to balance their focus on short-term, individual-level behavior change with the long-term goal of creating an environment in which that behavior can be sustained and affirmed.

Unfortunately, few HIV-prevention programs for adolescents in the developing world have been rigorously evaluated. While there is a remarkable record of such studies and evaluations within the United States, the transfer of this knowledge to very different developing-country settings is problematic. When possible, program budgets should incorporate funding for adequate evaluation and analysis of the program.

The critical issue in the evaluation of HIV-prevention programs is defining which outcomes to measure. One could use the "old faithful" behavioral outcomes of condom use, frequency of intercourse, number of partners, frequency of service use, and quality of service received. But how does one measure the complex interactions between economic influences and health behavior and the impact of livelihood programs for adolescents? What about an outcome that will only be evident in a client's life 10 years down the road, or the structural changes that occur at a snail's pace? It may be necessary to develop and track a matrix of short- and long-term changes at the individual and environmental/structural levels.

Build on community capacity

Programs grounded in the community are often the most effective and sustainable. The community is the natural multi-sectoral unit in which to carry out development efforts. Building on existing capacity within a community can also be cost-effective—a critical consideration in contexts where resources are scarce, notably communities in which the HIV/AIDS epidemic is maturing and resources are stretched. Community

work is also unpredictable and demands that one be open to creative, spontaneous, and emergent initiatives within the community, especially those initiated by youth.

Identify existing programs and services

Part of building on community capacity is identifying 1) to what degree current programs are accessible and utilized by adolescents; and 2) whether these programs could be adapted to include adolescents. Involving adolescents in this assessment process is critical.

Insufficient research and documentation exists to determine whether stand-alone services are more cost-effective than services offered within an existing facility. Such studies are necessary, keeping in mind that the most cost-effective approach may not be attractive or acceptable to adolescents.

Although it is critical that "youth-friendly" services be established and maintained, it is important not to segregate youth and keep them from being integrated into the community as full members of it. This balance is best achieved through the participation of youth in the planning and implementation of HIV-prevention programs in the community.

STI prevention and care

Of the 333 million new cases each year of STIs other than HIV infection, at least 50 percent occur in people under the age of 25 (UNAIDS 2001) and one-third occur in 13–20 year-olds (Islam 1996). Thus, STI prevention is critical for its own sake, as well as for its role in reducing the risk of HIV transmission and acquisition. This was illustrated by a study in rural Tanzania, which revealed that an STI intervention program not only

reduced the number of STIs being treated, but also resulted in a 42 percent reduction in HIV incidence two years following the study. The greatest reduction was among 15–24-year-old females, followed by 25–34-year-old men (Grosskurth et al. 1995).

Important elements of STI prevention and care programs include:

- Integrated services. Consider integrating STI prevention and care into existing reproductive health services, along with additional services and service providers that meet the needs of the adolescent population.

- Syndromic approach. Given that many settings lack the laboratory facilities for STI testing, the syndromic approach has been widely introduced. This approach bases diagnosis on patients' self-reported symptoms as well as on clinical findings. The danger of this approach is overtreatment, because the diagnoses are not specific enough. It may be the best alternative in resource-poor settings, but its limitations must be acknowledged.

- Youth-friendly environment. Make the STI testing and care facility as inviting and pleasing to the population as possible. Consider offering services during late afternoon and evening hours and dressing clinicians in something other than clinical garb.

Voluntary counseling and testing

Voluntary counseling and testing (VCT) programs are widely advocated as a critical part of an HIV/AIDS prevention strategy among adults. Critical elements of a typical program include pre- and post-test counseling and a risk reduction plan. By helping clients to learn their HIV sero-status and by creating personalized HIV risk reduction plans, VCT programs have demonstrated effectiveness in changing risky behaviors that lead to HIV infection or transmission. There is little experience or documentation in servicing the adolescent population with VCT programs. However, a recent study conducted by the Horizons program of the Population Council found that youth would like to access HIV testing and counseling, but want services to be

confidential and inexpensive, and want results to be reported honestly. The VCT sites that were explored in this study (in Nairobi, Kenya and in Kampala and Masaka, Uganda) were not equipped to respond to adolescent issues (Horizons 2001).

Things to consider in developing a VCT program for adolescents include:

- How might VCT serve married adolescents: as individuals or couples? Does testing of couples lead to more gender-equitable relationships? Less violence?
- A VCT program operating in an antenatal clinic may offer a married adolescent girl her first opportunity for HIV testing. What are the consequences of testing couples in these clinics?
- How does the counseling element differ for the adolescent population? How can this contact be used as an entry point for education and referral to additional services? What type of training is required?

New social, economic, and livelihoods opportunities

Because girls' risks arise in large measure from their paucity of power, status, and safety, programmatic efforts need to reshape girls' social and economic opportunities. "Young women need a way to achieve status, define identify and acquire resources that are not related to their sexuality" (Hulton, Cullen, and Khalakho 2000). Examples of programs that are beginning to provide adolescent girls with alternative social support systems and basic self-esteem are found throughout this programming document. Some of these could, perhaps, be used as springboards for HIV-prevention measures, for example:

- Creating safe spaces for girls (see Chapter 7) may be an intelligent first step in helping girls to protect themselves against HIV infection. In many settings with high HIV prevalence, adolescents—particularly unmarried ones—often have a great deal of knowledge about HIV, but little power to implement their understandings. Programs that create safe spaces for girls provide a context in which girls may empower themselves to act on their knowledge about HIV infection and prevention.

- Married adolescents may be especially ignorant of issues related to HIV prevention and infection (particularly in settings where a high proportion of sexually active adolescents are married) (Clark 2002) and may believe that marriage gives them a strong measure of protection against HIV. Programs that target married adolescent girls provide a context for educating these girls about their risk of HIV infection and their options for protecting themselves against this risk.

The HIV crisis has prompted a look for solutions outside the normal confines of the health sector to include a multi-sectoral approach. The exchange of sex for money inside or outside of marriage may render girls particularly vulnerable (see Chapter 8a). Further, it is hypothesized that boys' access to cash may put them and their partners at greater risk (see Chapter 6). New HIV campaigns must not only target adolescents at the workplace but also must address adolescents' need and desire for employment. Innovative combinations of reproductive health and livelihood programs need to be explored and developed, combining, for instance, savings clubs or micro-finance schemes with information about HIV prevention and available testing/counseling/treatment services.

Information

Information is essential, but it is insufficient in and of itself to address the HIV/AIDS epidemic among adolescents. Early in the epidemic there was an assumption that the solution to this problem depended on providing information to "educate youth out of risk." The resulting strategy was an emphasis on information, education, and communication (IEC) materials and knowledge, attitude, behavior, and practice (KABP) surveys. While many of these programs are successful in raising awareness, few adequately assess issues of sexuality.

Contexts in which information about HIV prevention can be conveyed to adolescents include schools, nonschool community settings, and the media.

Schools

School-based HIV-prevention programs should be sensitive to the age at which adolescents begin having sex in the local population, and should begin programs for children prior to sexual debut—as young as 8–10 years in some settings. These programs should start with activities that promote gender-equitable, respectful relationships.

Regrettably, most life skills (i.e., sex education) curricula lack an analysis of the power and gender dynamics that drive much of the risky behavior among adolescents. As noted earlier, the assumption underlying the material is that sex is consensual, takes place among peers, and is free of power dynamics. Yet power and gender issues dictate much of the life of an adolescent girl, including her sexual relations, be they at home, in school, or in the community.

Nonschool community settings

Adolescents often express a desire to receive sexual education from a trusted adult. A pilot project of the Population Council and the Kenya Family Planning Association used young adults as honorary aunts and uncles, mimicking the tradition of aunts and uncles educating children on sexual matters. In the area of the intervention, Nyeri, Kenya, family structure has broken down as a result of urbanization, migration, and other factors; consequently, information about sexual matters was no longer reaching young people. The project was successful in linking adolescents with adults in whom they could confide and from whom they could receive information formerly handed down through an extended-family mechanism.

Media

The media continue to be underutilized in spreading HIV prevention messages; but where it has been attempted, there have been surprisingly positive results. For example:

- In Kenya, the Population Council sought to educate members of the media as well as the public by way of a weekly call-in show on health. Each week's guest host—either a Population Council staff member or another health expert in Kenya—presents a brief message on a health topic, then provides answers to questions from callers for 45 minutes. After the show, the program is transcribed by a journalist, reviewed by Population Council staff for accuracy, then presented as a column in the national newspaper. The anonymity of call-in questions has provided a forum for youth and others to inquire about sensitive topics that they cannot discuss in any other venue.
- *Soul City*, an internationally acclaimed television program, is now in its third season in South Africa. *Soul City* is the most widely watched dramatic series in South Africa: 75 percent of all South Africans with access to television watch it. The show does not fit the standard soap-opera mold; rather, it is a large, goal-oriented, media-driven information and training initiative that is tackling issues of AIDS, women's and children's rights, and housing problems.

  Soul City is meticulously researched by public health professionals, and great care is taken to identify viewers' needs and linguistic/cultural characteristics so as to make the episodes as relevant as possible. Funding is received from the South African government, SABC (the television station that carries the program), leading corporations, UNICEF, the British DFID, and the European Community. In addition to its three seasons of prime-time television programming, this initiative includes a radio drama broadcast to rural areas in all major languages, in-depth information and resources printed in leading daily papers, and comic-book-style workbooks distributed around the country. *Soul City* has been exported to a number of African countries, including Ghana, Côte d'Ivoire, Nigeria, and Zambia. (Information about this initiative can be found at the Websites for California Newsreel and the Communication Initiative: www.newsreel.org/films/primetim.html and www.comminit.com/Danida/sld-1954.html)

Areas of Future Research

Research agendas evolve out of, and into, programming, in response to recognized gaps in knowledge. While the following are critical research needs in the area

of adolescents and HIV, they are in no way exhaustive, and may not be relevant in all settings.

Gender dynamics of violence, power, and sexual coercion

Very little research exists on the gender dynamics of violence and power in the context of adolescent life. There is growing evidence that an appreciable share of new cases of HIV infection are due to sexual relations that are to some degree coerced in homes, schools, workplaces, and other social spheres (UNAIDS Special Session Factsheets 2001b)

A recent study among women in a VCT clinic in Dar es Salaam explored the links between HIV infection, disclosure of test results, and partner violence among women attending the clinic. Fifty-two percent of women who chose not to reveal test results to a partner did so out of fear of the partner's reaction (e.g., abuse or abandonment). Study results suggested that HIV-positive females aged 18–29 were 10 times more likely than young HIV-negative females to report partner violence; however, these results cannot be fully validated because of the limitations of cross-sectional surveys (Maman et al. 2001). The study found that HIV-positive females were 2.7 times more likely than HIV-negative females to have experienced an episode of violence with a current partner.

Further work is required to investigate the issues of violence, power, and sexual coercion in adolescents' lives. Researchers must, for example:

- Examine the levels, patterns, and nature of sexual coercion and related violence among adolescents.
- Consider economic and psychological manipulation to be a form of violence.
- Identify links between partner violence and HIV infection (Maman et al. 2001).
- Determine whether the presence of violence and coercion affects a woman's ability to negotiate and make choices in the sexual/reproductive arena and to control her own sexual/reproductive health.

- Explore variables that are effective in measuring power.

Adolescent sexual partnerships

Linked to the above topic is the need for studies looking at the patterns of formation of adolescent sexual partnerships. Research in this area must address such questions as:

- What social meaning is ascribed to these partnerships?
- What is the expected conduct of adolescents in sexual partnerships?
- What is the nature, duration, and frequency of sexual relations of these relationships?
- Who decides critical issues regarding sexual behavior, pregnancy intentions, etc. in adolescents' partnerships?
- What are the conditions that foster gender-equitable relationships and sophisticated negotiation skills in these partnerships?

A critical angle on this research is examining both adolescent boys' and girls' perceptions of their partnerships. If these perceptions differ, in what ways? What is the basis for this difference and what are their implications for behavior?

Early marriage and HIV

There is an urgent need to conduct in-depth research on early marriage in order to better understand the phenomenon in its various cultural expressions and its link to health outcomes, including HIV infection. Such research might include:

- Identifying economic and social determinants that influence age at marriage.

- Conducting quantitative and qualitative research on the risks and protections associated with early marriage, including health and economic outcomes.

- Examining early marriage from a human rights perspective. What are the trends and what is the impact of these trends on individuals and societies?

- Exploring incentives (e.g., economic and educational) that could be used to delay marriage and to encourage a smaller age gap between spouses. How do national policies affect females' average age at marriage?

- Identifying services and strategies available to married adolescents to help them protect themselves against HIV.

Concluding Thoughts

The danger of writing a relatively short piece on a topic of this magnitude lies in the omissions that necessarily occur, consciously and unconsciously. The diversity of the adolescent experience within regions and continents is almost as great as the diversity across them. Adolescent homosexual relationships have not been covered, nor has the spread of HIV by drug use. There has also been little mention of the critical involvement of people living with HIV/AIDS and issues related to treatment and care. If nothing else is taken from this chapter, I hope that it at least reinforces the perception that there are great gaps in knowledge about the lives of adolescents all around us—in this case, with respect to HIV/AIDS. Despite our best intentions to serve and protect youth, we may be imposing our own assumptions, prejudices, and biases on them with respect to who and where they are and what they need.

Let us dismiss the phrase that "adolescents are our future"—this is an assumption that we dare not make when 50 percent of today's 15-year-olds will die of AIDS in some countries. Adolescents are our *present*—and only if we recognize their presence among us will they continue to guide us into the future.

Resources

The World Health Organization (WHO) publishes a series of factsheets that can be accessed on the web at: www.who.int/health-topics/hiv.htm.

The Horizons program of the Population Council and other partners is a global operations research program on HIV/AIDS. Research reports, including *Making a Difference for*

Children Affected By AIDS and *Voluntary HIV Counseling and Testing: Will it Attract Youth?,* can be found at: www.popcouncil.org/horizons.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is a resource for statistics, charts, papers, and meeting announcements related to HIV/AIDS. Resources focused on young people can be found at: www.unaids.org/youngpeople/index.html

The United Nations Population Fund (UNFPA) has identified the prevention of HIV infection among young people as one of its strategic areas of focus. See the programme brief, *Preventing HIV infection in young people* at www.unfpa.org/aids/docs/probgrief03.pdf

Safe Passages to Adulthood is a joint five-year program of the University of Southampton and the Institution of Education of the University of London. Research and program guidelines are available at the web site: www.socstats.soton.ac.uk/cshr/SafePassages.htm#Top

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