Gender and the HIV Epidemic
Adolescent Sexuality, Gender and the HIV Epidemic

By Kim Rivers and Peter Aggleton
Thomas Coram Research Unit
Institute of Education, University of London

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1. INTRODUCTION

Approximately one-third of the world's population is between 10-24 years of age, and four out of five young people live in developing countries, a figure which is expected to increase to 87% by the year 2020 (Friedman, 1993; Ainsworth and Over, 1997). In many countries the majority of young people are sexually experienced by the age of 20 and premarital sex is common among 15-19 year-olds. For example in recent surveys it was found that 73% of young men and 28% of young women in this age group in Rio de Janeiro reported having had premarital sex, compared with 59% and 12% respectively in Quito, and 31% and 47% respectively in Ghana (Population Council, 1996)

Sexually transmitted infections (STIs) including HIV are most common among young people aged 15-24 and it has been estimated that half of all HIV infections worldwide have occurred among people aged under 25 years (World Health Organisation, 1995). In some developing countries, up to 60% of all new HIV infections occur among 15-24 year-olds. Yet, vulnerability to STIs including HIV is systematically patterned so as to render some young people more likely to become infected than others. Gender, socio-economic status, sexuality and age are important factors structuring such vulnerability. Unequal power relations between women and men, for example, may render young women especially vulnerable to coerced or unwanted sex, and can also influence the capacity of young women to influence when, where and how sexual relations occur (Rivers & Aggleton, 1998).

The consequences of HIV/AIDS can be far-reaching for young people. Not only does HIV disease have terrible consequences for the individual, causing serious illness and eventual death, it has the potential to trigger negative social reactions. Across the world, people with HIV/AIDS routinely experience discrimination, stigmatization and ostracization (Auer, 1996; Malcolm et al, 1998). Children and young people who are orphaned by the epidemic, and who themselves may be infected, are sometimes left without the support of adults (Levine, Michaels & Back, 1996). For women and adolescent girls, the consequence of AIDS can be particularly dire. There is strong evidence, for example, that in some countries women may be "blamed" for HIV disease even in circumstances where they have been infected by remaining faithful to their husband or other male partner (Bharat & Aggleton, 1999). There is also evidence to suggest that women are less likely to receive the kind of care and support made available to male household members (Warwick et al., 1998). Moreover, where the male head of household has died there may be loss of social support for young women, ostracization from the community, and lack of legal protection to inherit land and property. Some young women may find themselves unwelcome in the extended family and may even be coerced into sex work (Levine, Michaels & Back, 1996).

Given the significant number of young people living in developing countries seriously affected by the epidemic, it is crucial that work is undertaken to ensure that they are able to protect themselves. This involves providing them with access to information and resources, as well as promoting a climate which is understanding of young people and their sexual and reproductive health needs. In recognition of the enhanced risks faced by young people, UNAIDS and its cosponsoring organisations including UNDP, has identified young people as a key group for HIV-related prevention activities. World AIDS Day 1998 gives special emphasis to this fact in its identification of young people as a key group with which to work.

A patterned vulnerability

Epidemiological studies across the developing world show that young people are not equally affected by HIV/AIDS. Rather, those who are most socially and economically disadvantaged are at highest risk (Elford, 1997). The risk of HIV infection for young people in developing countries is increased by socio-cultural, political and economic forces such as poverty, migration, war and civil disturbance (Sweat and Denison 1995). Young people may also face the increased risks of HIV infection by virtue of their social position, unequal life chances, rigid and stereotypical gender roles, and poor access to education and health services.

Major changes over the last few decades have affected the sexual and reproductive health of young people in developing countries. Rapid urbanisation and rural-urban migration has meant that greater numbers of young people are living in precarious and impoverished conditions. Traditional, multi-generational extended families have been increasingly replaced by nuclear families, lone-parent families and, in some cases, the complete absence of parents (Fuglesang, 1997). There are increasing pressures on young people to be sexually active and, in the case of boys, to have

had several different partners (Rivers & Aggleton, 1998). Evidence from a variety of countries suggests that the age at which young people become sexually active may be falling (Fee & Yousef, 1993). Certainly young people become sexually active at an early age in many countries. In Uganda, for example, almost 50 per cent of young men and nearly 40 per cent of young women recently surveyed reported having had sex by the age of fifteen years (Konde-Lule et al, 1997). In Dar es Salaam, Tanzania 60 per cent of 14 year-old boys and 35 per cent of girls have reported that they are sexually active (Fuglesang, 1997). In a recent Brazilian school-based study, 36% of females reported having had intercourse by the age of 13 (Weiss, Whelan & Gupta, 1996). In parts of the world such as India where there is sparse evidence about sexual activity among young people and it is widely assumed that sexual initiation takes place within the context of marriage, recent studies show that approximately one in four unmarried adolescent boys report that they are sexually experienced (Jejeebhoy, 1998).

In both developed and developing countries, there are a number of obstacles which make it difficult for young people to protect their sexual and reproductive health.

Young people often have less access to information, services and resources than those who are older (Friedman, 1993; Aggleton and Rivers, 1999). Health services are rarely designed specifically to meet their needs, and health workers only occasionally receive specialist training in issues pertinent to adolescent sexual health (Friedman, 1993; Zelaya et al, 1997, World Health Organisation, 1998). It is perhaps not surprising therefore that there are particularly low levels of health seeking behaviour among young people. For example, even where they are able to recognise signs and symptoms of STDs, young people recently interviewed in Tanzania indicated that they were hesitant to go to public clinics or hospitals, but were more likely to treat themselves with over-the-counter medicines (Fuglesang, 1997). Similarly, young people in a variety of contexts have reported that access to contraception and condoms is difficult (e.g. Zelaya et al, 1997). Most importantly, legislation and policies which prevent sex education taking place, or which restrict its contents, prevent many young women and men from maximising their sexual and reproductive health.

Images of "adolescence"

One of the most important reasons why young people are denied adequate access to information, sexual health services and protective resources such as condoms, derives from the stereotypical and often contradictory ways in which they are viewed. It is popularly believed that all young people are risk-taking pleasure seekers who live only for the present. Such views tend to be reinforced by the uncritical use of the term adolescent (with its connotations of "storm and stress") in the specialist psychological and public health literatures. This term tends not only to homogenise and pathologise our understanding of young people and their needs, it encourages us to view young people as possessing a series of "deficits" (in knowledge, attitudes and skills) which need to be remedied by adults and the interventions they make (Aggleton & Warwick, 1997).

Hoffman & Futterman (1996) have commented that adults often hold ambivalent attitudes towards young people, viewing them simultaneously as ' ... small adults and as immature inexperienced and untrustworthy children' (ibid, p.236). Many adults also have difficulty acknowledging adolescents as sexual beings, and therefore adolescent sexuality is viewed as something which must be controlled and restrained. These stereotypes have also informed much HIV-related research and practice with young people. Warwick and Aggleton (1990), for example, have described the central images to be found in the literature on young people and AIDS. These include the "unknowledgeable or ill informed adolescent", the "high-risk adolescent", the "adolescent who is unduly conforming to peer pressures", and the "tragic but innocent adolescent" who inadvertently becomes infected by HIV.

These powerful images and assumptions influence policy and practice in relation to young people and their sexual health. Some adults believe that young people are of their nature sexually promiscuous and that giving them information about sex will make young people more sexually active (Friedman, 1993). As a result, sex education in schools either does not take place or promotes only certain risk reduction measures (most usually abstinence). Yet there is now clear evidence that well-designed programs of sex education, which include messages about safer sex as well as those about abstinence, may delay the onset of sexual activity, and reduce the number of sexual partners, and increase contraceptive use among those who are already sexually active (Grunseit et al, 1997; Grunseit 1997).

While formal health education programs have been influenced by stereotypical attitudes about young people's sexuality, parents and families across a wide variety of cultures have also sought to deny young people information about sex and reproduction. In countries as different as India and Nicaragua, parents and children report that they do not talk to each other about sex (George & Jaswal, 1995; Zelaya et al, 1997). Often parents and family members do this in the belief that they are 'protecting ' young people from information which they believe may lead to sexual experimentation. However, evidence suggests that young people who openly communicate about sexual matters with their parents, especially mothers, are less likely to be sexually active or (if girls) become pregnant before marriage (Gupta, Weiss and Mane, 1996).

While young people have been commonly stereotyped as uniformly hedonistic and irresponsible, they are in fact a remarkably heterogeneous group. Their experiences vary widely according to cultural background, gender, sexuality and socio-economic status among other variables. While some young people may take risks, the majority are at least as responsible as their parents, and some may be even more so. Moreover, it is important to recognise that in many developing countries, the onset of puberty signals greater economic and family responsibility rather than increased pleasure-seeking and risk taking (Aggleton & Rivers, 1998). That said, there are a number of structural as well as individual factors which may heighten young people's vulnerability to HIV and AIDS.

2. UNEQUAL LIFE CHANCES & HIV INFECTION

While developing countries in Asia, Africa and Southern and Central America vary in terms of culture, religion and socio-economic factors, young people living in them share a number of experiences which render them particularly vulnerable to HIV infection. Access to education and information is often limited, levels of literacy lower, and poverty is more prevalent. Young people living in poverty, or facing the threat of poverty, may be particularly vulnerable to sexual exploitation through the need to trade or sell sex in order to survive (World Health Organization, 1998).

Estimates suggest that as many as 100 million young people under the age of 18 live or work on the streets of urban areas throughout the world (Connolly & Franchet, 1993). Many are at heightened risk of acquiring STIs including HIV. More than half of 141 street children recently interviewed in South Africa, for example, reported having exchanged sex for money, goods or protection, and several indicated that they had been raped (Swart-Kruger & Richter, 1997). Street children in Jakarta, Indonesia, have reported that being forced to have sex is one of the greatest problems that they faced living on the streets (Black and Farrington, 1997). In Brazil, where it is estimated that 7 million young people live on the streets, between 1.5 to 7.5% of those tested for HIV are infected (Filgueiras, 1993). In addition to risk from unprotected sexual activity, rape and coercion, the high prevalence of injecting drug use on the streets in Brazil and some other countries may heighten young people's vulnerability to HIV (Filgueiras, 1993).

It is important to recognise, however, that children and young people who live and work on the streets of urban areas, do not commonly list HIV/AIDS as an over-riding concern. Instead, the day-to-day need for shelter, food and clothes take higher priority (Swart-Kruger & Richter, 1997). For young people struggling for daily survival, a disease like AIDS, which may or may not kill them in years to come, can seem unimportant (Finger, 1993).

It is not only the most socio-economically deprived children and young people in developing countries who are vulnerable to sexual exploitation. Other young people living in precarious economic circumstances report having been forced to exchange sex for material benefit. Two thirds of 168 sexually active young women recently interviewed in Malawi, for example, reported having exchanged sex for money or gifts (Helitzer-Allen, 1994), and eighteen per cent of 274 sexually active female Nigerian University students reported that they have exchanged sex for favours, money or gifts (Uwakwe et al, 1994).

Sometimes, the exchange of sex for goods and money may be regularised in the form of what have been called "sugar daddy" and "sugar mummy" relationships. In Tanzania, for example, young girls not infrequently report having older men or Mshefas (those who provide) as sexual partners (Fuglesang, 1997). In Kenya, young girls report that they are courted by older men seeking sex, and may find themselves in situations which it is difficult to negotiate a way out of (Balmer et al, 1997).

Gender and vulnerability

Stereotypical gender roles place young women, and to a lesser extent young men, at heightened risk of HIV infection. Young women in many parts of the developing world have little control over how, when and where sex takes place (Gupta, Weiss & Mane, 1996). In perhaps the majority of countries, there are strong pressures on young unmarried women to retain their virginity (Weiss, Whelan & Gupta, 1996; Petchesky & Judd, 1998). However, the social pressure to remain a virgin can contribute in a number of ways to the risks of STIs and HIV which young women face. In some contexts, young women may engage in risky sexual practices, such as anal sex, as means of protecting their virginity (Gupta, Weiss and Mane, 1996).

The high social value placed on virginity in unmarried girls may pressure parents and the community to ensure that young women are kept ignorant about sexual matters. Female ignorance of sexual matters is often viewed as a sign of purity and innocence, while having 'too much' knowledge about sex is a sign of 'easy virtue' (Gupta, Weiss and Mane, 1996). Young women in cultures as diverse as Thailand and Guatemala report that being knowledgeable about sex would compromise others views of them (Weiss, Whelan & Gupta, 1996).

This emphasis on 'innocence' prevents young women from seeking information about sex or services relating to their sexual health. Sexually active young women are also discouraged from discussing sex too openly with their own partners, since women are encouraged to be ignorant and inexperienced. This means that young women are unlikely to be able to communicate their need for safer sex with partners. In Kenya, for example, a recent study revealed that young women felt that they did not have control over their sexuality - instead girls learned that sex was something that happened to them. It was not something they could initiate or actively participate in (Balmer et al, 1997).

In addition to the emphasis widely placed on remaining 'chaste', girls are commonly socialised to be submissive to men (Zelaya et al, 1997). Girls are often pressured by boys to have sex as a proof of love and obedience. Not surprisingly under conflicting pressures, girls have little influence over decision-making or the use of contraception (Zelaya et al, 1997). In a recent review of research conducted in seven countries, including Nigeria, Egypt, Mexico and the Philippines, Petchesky and Judd (1998) concluded that even where sexually active young women are aware of HIV/AIDS and measures to protect against infection, rarely do they have the power to ensure that condoms are used.

While dominant ideologies of femininity promote ignorance, innocence and virginity, dominant versions of masculinity encourage young men to seek sexual experience with a variety of partners. In some cultures, boys are actively encouraged by both their peers and family members to use their adolescent years to experiment sexually (Weiss, Whelan & Gupta, 1996).

In Nicaragua, for example, where virginity is highly valued among young women, having multiple sexual partners is taken as a sign of virility in young men (Zelaya et al, 1997). Here, teenage boys face social pressures from older men (including fathers, older brothers and uncles) to have sex as early as possible and, in the recent past, it was not uncommon for fathers to arrange for their son's sexual initiation with a sex worker (Zelaya et al, 1997). So while for girls, public disclosure of sexual activity

leads to dishonour, bragging about sex is common for boys. Berglund et al (1997) note that for young Nicaraguan men the pressure to be sexually active and multi-partnered may be so great that those who do not fulfil this expectation are open to ridicule by their peers for not being a real man.

Similar patterns prevail elsewhere in the world. In South Africa, for example, having many sexual partners is reported as being equated with popularity and importance among young men (Abdool Karim and Morar, 1995). Interviews with high school students in Zimbabwe indicate that while boys can have (and indeed should have) many girlfriends, girls should stick to one (Bassett & Mhloyi, 1991). Although not all young men conform to the dominant versions of masculinity described above, those who fail to do so are often ridiculed and subjected to peer pressures to conform.

Homophobic bullying of the form which implies that any man who fails to conform to the dominant gender stereotype must be "homosexual"1 is but one of the many tactics employed in this process. Not only does such behaviour stigmatise sexual minorities, it serves to police the boundaries of a heterosexual masculinity in which multiple partnerships with women becomes the norm.

While gender norms dictate that girls and women should remain poorly informed about sex and reproduction, young men are expected to be more knowledgeable, often as an indication of their sexual experience.

However, research in a variety of contexts shows that they may be often poorly informed, but because sexual ignorance is not socially acceptable young men are reluctant to admit that they are lacking in knowledge (Weiss, Whelan & Gupta, 1996). So while young women risk their sexual health because they must appear to be ignorant and so cannot openly seek information, young men risk their sexual health because they must appear to be knowledgeable and so cannot openly seek information either.

Importantly, the epidemic of HIV/AIDS has served to further entrench some gender inequalities and has placed young women at increased risk of HIV infection. Central among these is the tendency for some older men to seek partners who are less likely to be sexually experienced or, in their eyes, infected by HIV (Petchesky & Judd, 1998). This places young women at increased risk of becoming infected by older men who may have wide sexual experience (Panos, 1996). It is important to recognise that many young women who have HIV infection have had only one sexual partner, namely their husband (UNDP, 1993). Furthermore, families affected by HIV/AIDS may seek economic security by marrying their daughters prematurely to older men. Not only may this have serious implications for the sexual and reproductive health of the young women concerned, it may cut short their education and hold back social development.

Sexuality and vulnerability

While male-to-male sex exists in every culture, the activities concerned are rarely understood as "homosexual" still less as "gay" (McKenna, 1996). More likely than

not, they will not be widely talked about, or named only within local vernaculars often inaccessible to outsiders (Aggleton, Khan and Parker, 1998). That said, in many countries of the world a not insubstantial number of young men have their first sexual experience with other men, and for some this may be the beginning of a longer lasting bisexual behavioural repertoire. For example, 50 per cent of male university students recently interviewed in Sri Lanka reported that their first sexual experience had been with another man (Silva et al, 1997), and there are well documented studies of behavioural bisexuality among men in countries as diverse as the Philippines (Tan, 1996), India (Khan, 1996), Morocco (Bourshaba et al, 1998), Brazil (Parker, 1996), the Dominican Republic (de Moya and Garcia, 1996) and Peru (Cáceres, 1998). While it would be quite wrong to see male bisexuality as a purely "adolescent" "phenomenon or triggered by men's lack of access to women, the restrictions many cultures place on socialisation between the sexes may have an important role to play in facilitating this alternative means of sexual expression.

For a few young men, trading or selling sex to other men may offer a means of survival in otherwise difficult circumstances. In countries as diverse as Sri Lanka (Ratnapala, 1998), Thailand (McCamish and Sittitrai, 1997), Mexico (Liguori and Aggleton, 1998) and Peru (Cáceres, 1998), male prostitution or sex work may take this form, with young men selling sex in order to provide for themselves and their families. While not all male sex workers are ignorant of the risks of STIs and HIV infection, and some may be better informed than other young people of a similar age, the risks associated with trading or selling sex in circumstances which are not of your own choosing are very real. Not only is such behaviour illegal and/or heavily stigmatised in many societies, the ability of young men to communicate and negotiate for safer sex with older male partners may be limited by inequalities of status and power (e.g. Fordham, 1998) Where anal sex is practised, the unavailability of condoms and lubricant may compound the risks some young men face (e.g. Khan, 1998).

Much less is known about current patterns of homosexual and bisexual behaviour among young women, although such behaviours should be assumed to occur not only during youth and "adolescence", but also for some women as part of a longer lasting lifestyle. The role of such behaviour in contributing to, or protecting against, HIV-related risk requires further investigation. It seems reasonable to suppose, however, that the stigmatised, denied and marginal status of their behaviour makes it difficult for young homosexually active women in developing countries to access the full range of information or resources to protect their sexual health;

Age and vulnerability

Inequalities of age interact with the inequalities of socio-economic background, gender and sexuality to determine young people's vulnerability to STIs including HIV. We have already seen how this is the case for younger women who may be sought as sexual partners by older men in the belief that they are less likely to be infected. But age and generation just as strongly influence the vulnerability of young men, not only those who sell or trade sex, but also those who engage in sexual activity as a means of gaining adult status and the privileges it offers. Recent research in

Tanzania, for example, has suggested that young men may attempt to address intra-generational inequalities through engaging in sexual activity, which represents adulthood and enhanced social status (Seel, 1996).

Beyond these behaviours which carry clear HIV-related risks are others no less embedded in local cultures and traditions. These include female genital mutilation (FGM) and male circumcision, both of which are perpetrated upon young people by those who are older. When practised as part of group initiation ceremonies or in ways involving the sharing of razors, knives and other cutting instruments, the risk of HIV infection being transmitted from one person to another can be considerable (see Petchesky & Judd, 1998). The World Health Organisation and other bodies have condemned the practice of FGM on both medical and human rights grounds and, in 1993, passed a resolution at the 46th World Health Assembly calling for member states to act to eliminate harmful traditional practices (World Health Organisation, 1993). Where male circumcision continues to take place, it should be practised in ways commensurate with the need both to prevent HIV and other blood borne infections and the rights of young people to be involved in decisions about their bodies and what becomes of them.

3. SEX EDUCATION WITHIN THE FAMILY AND COMMUNITY

In many societies, the family and immediate community traditionally provided young people with information and guidance about sex and sexuality. In some societies, including many throughout the continent of Africa, the provision of information about sex used to be formalised as part of initiation into adult roles. Elsewhere, the provision of information about sex through the family has been more informal, while in some cultures open discussion of sexual matters between parents and children may actually be rare. It is important to recognise these variations in how sex education takes place within the family and community, and how they affect the sexual beliefs and behaviour of young people. In many parts of the developing world, recent and rapid urbanisation and migration have meant that families and community networks have become more widely dispersed. This may have impacted on sexual socialization and education as well as on the sexual behaviour and sexuality of young people.

In parts of East and Central Africa, traditional rituals of initiation prepared young people for their adult role, including education on the responsibilities of sex, marriage and child-rearing. In this context, sexuality serves ' ... as a source of relations, of kinship and affinity, thereby the basis for solidarity, reciprocity and cooperation' (Fuglesang, 1997: 1248). Because sexuality contributed to social cohesion, communities developed 'rules' concerning the expression of sexuality as well as mechanisms for controlling sexual behaviour (Fuglesang, 1997). Sexual behaviour's potential to cause harm - through jealousy, emotional discord and infection - as well as good, was widely recognised. Communities therefore developed codes of conduct relating to when, where and with whom sexual relationships might take place.

In order to communicate these principles to young people, initiation ceremonies were held, often separately for girls and for boys. In Tanzania, for example, initiation rites for girls, referred to as Unyago, were led by a ceremonial leader or Somo (Fuglesang, 1997). The Somo was not a relative, but an older woman recognised as knowledgeable and experienced in child-bearing and rearing. She continued to advise young women from puberty and throughout married life. Menstruation and the codes of conduct associated with it were explained to young girls, as well as information about pregnancy and ways of preventing conception. Importantly, sex education was contextualised in terms of preparation for adult life (Fuglesang, 1997).

In Kenya, rituals associated with the transition from childhood to adulthood and which included sex education have also been documented (Balmer et al, 1997). Until recently, the transition from childhood to adulthood, which did not constitute a period of "adolescence" as contemporarily understood, was sharper and less protracted. With increasing urbanisation, however, these rituals have lost their significance and the transition from childhood to adulthood has been complicated by ".. the development of the phase of adolescence ... [as well as] by the decline of traditional sources of authority, such as the extended family" (Balmer et al, 1997: 34). Sexual début, Balmer et al (1997) note, takes place earlier than in the past, young people have a greater number of partners, and yet lack access to effective contraception.

Similar processes of transition in sexual socialisation have been documented in Zimbabwe where, as a consequence of rural to urban migration and urbanisation, extended family members including tetes or paternal aunts, are no longer available to offer advice to young women, and young men lack the guidance they used to receive from village elders, many of whom themselves have embraced lifestyles different from those of the past (Runganga & Aggleton, 1998). In Zimbabwe, traditional channels of communication about sex and marriage have reportedly lessened in importance because of social and economic factors. Recent in-depth interviews with 80 young people aged between 14-18 years confirmed that nowadays credible sexual information tends to be obtained not from family members, but from the media, school and friends. In contrast, information from aunts and uncles was described by young people as generalised, one-sided, authoritarian and prescriptive (Wilson et al, 1994).

Runganga and Aggleton (1998) in their recent examination of transformations in Shona society in Zimbabwe, highlight the processes of adult tutelage which in pre-colonial times helped ensure a degree of conformity to prescribed sexual norms. While these norms were not universally adhered to, sanctions existed to help maintain certain standards of sexual behaviour: for example, men who were known to have had extra-marital sex were subject to fines. Colonialism played a large part in changing sexual norms, however, by encouraging male migration to the cities and making it difficult for men to take their partners with them. Families were split for long periods of time, extra-marital sex increased and sex work proliferated.

Nowadays, children whose parents must seek work in the cities tend to be raised by various family members and may be subject to conflicting messages about sexual behaviour. Some children are left in the care of siblings without consistent adult supervision, thus increasing opportunities for sexual activity. The effectiveness of traditional family expectations and structures in shaping sexual beliefs, expectations

and behaviours appears to have been substantially weakened by population movement. With little continuity in sex education within the family, young people report that their peers are more relied upon for information and guidance about sex (Runganga and Aggleton, 1998).

There is evidence from elsewhere in Africa to suggest that peers have become a more important source of knowledge, advice and support. In Malawi, for example, sixty per cent of girls recently interviewed reported having learned about menstruation from friends, not from their grandmothers or advisors as traditionally occurred (Helitzer-Allen, 1997). The media is relied upon more than was the case in the past to provide information and guidance about sex and sexual relationships.

From countries across the world, there is there is also evidence that young people and adults talk only infrequently to one another about sex. In India, young people and especially young girls are reported as having consistently poor knowledge about sex and reproduction, including modes of transmission for HIV and the use of condoms as a preventive measure. Parents and family members are reluctant to discuss sexual matters with young people. Women interviewed in a variety of contexts report that they were told very little about sex and reproduction prior to marriage (Bang et al, 1989). In rural and urban areas young people, especially girls, remain uninformed since sex and reproduction are considered distasteful and embarrassing subjects (Jejeebhoy, 1998). In a recent study conducted in Mumbai, one mother interviewed said that adults do not want to frighten young girls by talking about sex (George & Jaswal, 1995). By way of contrast, and like many of their counterparts in countries elsewhere in the world, young men in this same context are encouraged to be sexually experienced, but reliable sources of information are few and far between. The peer group therefore constitutes an important source of information, as does the developing mass media (Jejeebhoy, 1998). In Thailand, where many young people migrate from rural areas to cities in order to work in factories, the peer group may provide the only means of finding out about sex and has been reported as having a key role to play in shaping sexual beliefs and behaviour (Cash et al, 1997).

Recent research in Brazil has shown that discussions of sex and related topics may be discouraged for girls because of the common belief that to inform them about sex is to encourage sexual activity (Vasconcelos et al, 1997). Mothers traditionally attempt to delay their daughters' discovery and exploration of sexuality by preventing them from getting access to such information. Consequently, girls reported avoiding talking to their mothers about sexual matters for fear that showing a curiosity about sex which could arouse suspicions about their behaviour (Vasconcelos et al, 1997).

This perhaps modern day reluctance to talk to young women about sex is widespread and has been reported in many different contexts. For many young women, discussion about sex has often limited to warnings about dangers and the importance of preserving their "honour". Recent research in countries as varied as Nigeria, the Philippines, Egypt and Mexico has shown that for fear of encouraging sexual activity, mothers withhold vital information about sexuality and reproduction from their daughters ' ... imparting instead messages of danger, fear and shame' (Petchesky & Judd, 1998: 305). However, there is some evidence that the advent of HIV is leading to some changes, particularly in large cities where HIV/AIDS has high visibility. In São Paulo, Brazil where AIDS is the leading cause of death among women aged

between 20-35 years, the taboo about talking with young women about sexuality and reproduction is reportedly breaking down. Mothers recently interviewed in this city described how they are beginning to urge their daughters to 'be safe' rather than to 'stay pure' (Grilo Diniz, de Mello E Souza & Portella, 1998).

However, recent research recently conducted among a variety of groups of young people in Costa Rica, Chile, Cameroun, Zimbabwe, Cambodia, the Philippines and Papua New Guinea has shown that while young women may expect to receive some sex education within the family, albeit centering on the technicalities of reproduction and menstruation, young men report a virtual absence of parental information or guidance about the physiological changes associated with puberty or sex, and the responsibilities of a sexually active adult life. Information is almost solely acquired from the media, and from peers and siblings, many of whom have themselves been similarly deprived of reliable adult guidance (Dowsett & Aggleton,1997).

While in some countries there have been important changes in the role played by adults in the sexual socialisation of young people, we must take care not to paint too idealised a picture of the past. First, not all the information previously provided by adults and other community members would nowadays be recognised as accurate or useful for the promotion of sexual and reproductive health. Second, not all young people were persuaded by the education they received. Conceptions did take place outside of a recognised union, sexually transmitted and reproductive tract infections were not unknown, and some initiation practices themselves (e.g. group circumcision) carried health risks.

Neither should we adopt too unproblematic a view of the changes in sexual socialisation and behaviours brought about by rural-urban migration. It is just as probable that sexual practices in the city may represent the adaptation of cultural rules to a new environment, as any wholesale abandonment of traditional customs. As Caraël (1997) has recently suggested, urban inhabitants may adapt traditional practices, beliefs and understandings to life in their new setting. For example, the long period of sexual abstinence among women after the birth of a child, which in some rural areas of Africa may be supported by polygamy, may in some urban settings be substituted for by the male's sexual relations with "free" women outside of marriage (ibid, 113).

That said, where some communication between adults and young people continues to exist, it may be infrequent, of poor quality, and carried out by adults who are less sure of their roles than in the past (Weiss, Wheland and Gupta, 1996). This is no less true for teachers in schools as it is for adult kin and family members. In many countries, teachers have reported being embarrassed to talk about the topic of sex, and ill prepared for teaching about sexual matters (e.g. Jejeebhoy, 1998). It is important that they be offered training and support so as to undertake this kind of work with young people, and so as to be able to work with parents and community leaders in preparing the ground for it to take place. Important challenges therefore remain in relation to efforts to promote the sexual and reproductive health of young people in ways attuned both to social and cultural contexts and local needs.

4. HIV-RELATED WORK WITH YOUNG PEOPLE

Evidence from a variety of countries suggests that open communication about sex between family members and young people remains the exception rather than the rule. In cultures where traditional systems for helping young people learn the roles and responsibilities of adult life existed, changing social circumstances and family structures have affected these channels of communication. In the absence of open discussion about sex within the family or wider community, and in recognition of the needs of young people for information which might help them to protect their sexual health, a number of formal programs of HIV-related health promotion including sex education have been instituted in countries across the developing world.

Styles of HIV-related prevention work aimed at young people have changed over the years. Early in the epidemic, individualistic approaches based on theoretical frameworks such as the Health Belief Model and Social Learning Theory were quite common (Aggleton, 1996). These emphasised the importance of helping young people to acquire accurate information and skills relating to the prevention of HIV/AIDS. It was assumed then that if young people could only develop appropriate knowledge and skills, they would be able to change their behaviour in order to enhance their sexual health. However, such approaches are now recognised as being over-simplistic and are criticised for failing to take account of contextual, environmental and structural factors influencing young people's "choices", actions and behaviours. These include economic constraints, the effect of migration and war, power relations between women and men, inequalities between young and old, and relationships between dominant versus minority ethnic groups.

In the most extreme circumstances, young people living in stressful situations may, for example, engage in 'survival sex' in order to meet their need for shelter, food and adult protection (e.g. Rotheram-Borus, Mahler & Rosario, 1995). In such precarious circumstances, young people are not well placed to make rational decisions on the basis of new information or to practice newly acquired skills, but are often constrained by the circumstances they find themselves in.

The middle years of the epidemic were characterized by the increasing development of HIV-prevention programs aimed at the level of community (Aggleton, 1996). These programs shared a common acknowledgement that decisions about behavior, including sexual decision- making, are made in the context of shared social experiences. In particular, peer education programs have attempted to address the social processes which influence the gender and sexual norms of young people. Several studies have demonstrated that peers are important in shaping gender identity and roles and attitudes towards sexual behavior among young people (Svenson, Hanson & Johnsson, 1995). Programs which attempt to work at the level of community, go some way towards a recognition of the social construction of gender roles and sexual attitudes and behavior.

More recently though, researchers and practitioners working with young people for the prevention of HIV/AIDS have shown interest in bringing about structural and environmental change. A burgeoning research literature has demonstrated that

young people are constrained in their behaviours by social, economic, legislative and other factors which are beyond their personal control. Gender inequality, for example, means that many young women across the world are not able to participate as equal partners in sexual decision-making, and so cannot easily control their sexual health. There is now widespread acknowledgement that HIV prevention programs need to address public policy concerns so as to enable young people to protect their sexual health, while persuading them to take action that helps to protect them from becoming infected with HIV (Tawil, O'Reilly and Vester, 1995).

A broad variety of prevention programs have now been undertaken in developing countries with the aim of reducing the risks of HIV infection among young people. While some have been formally evaluated to determine whether or not young people's behaviour has been influenced, a good number are yet to be systematically evaluated. Broadly speaking, these programs can be divided into four main types: (i) programs designed to help adults improve their skills and increase effective communication about sex with young people, (ii) work with young people in schools, (iii) work with young people out of schools and (iv) work with young people at heightened risk. Here we offer some examples of recent programs which fall within each of these categories, and discuss their major strengths and weaknesses.

Helping adults improve their skills

In acknowledgement of young people's need to talk with adults about sex, and the breakdown of some of the traditional mechanisms for doing so, a number of programs and projects have attempted to foster improved sexual communication between adults and young people. In Dar es Salaam, Tanzania, for example, traditional female healers have set up contemporary Unyago clubs for girls living in the urban setting. Parents are able to register their daughters at the club where girls are instructed in accordance with their own traditions and customs. While the Unyago clubs have not yet been evaluated, Fuglesang (1997) argues that contemporary sex education has much to learn from traditional rites of passage. For example, while modern sex education tends to be overly technical and biomedical, and somewhat removed from the socio-cultural context, the traditional approach may be more comprehensive and community-based. However, it should be noted that many traditional forms of sex education do not take gender inequality into account and may entrench these inequalities further.

Research in Mexico has revealed that many parents want to talk to young people about sex, but do not feel that they have the appropriate skills to do so (Givaudan et al, 1997). Following a training programme involving videos and group discussion, parents reported feeling better equipped to talk with their children about sex. However, it proved difficult to recruit fathers to the project, and since being of the opposite sex was reported as being a barrier to open communication, the project team concluded that male adolescents were at a clear disadvantage (Givaudan et al, 1997).

In Kenya, where it is estimated that some 70-80 per cent of people belong to a Christian denomination, ministers and priests have been targeted with messages

about HIV and AIDS (Black, 1997). An intensive training course reached 160 ministers, priests and other church leaders. A guide was also developed designed to improve communication between parents and children and 5,000 copies were distributed through churches. Clergy also used the guide to help advise parents in how to improve communication with their children. One measure of success for this project was that the Methodist Church initiated a HIV prevention program for young people in Nairobi and appointed a full-time director for this work as a result of participation in the awareness training for church leaders (Black, 1997).

It is important to recognise that teachers, like many other adults, find discussing sexual matters with young people difficult and embarrassing (Jejeebhoy, 1998). However, a supportive school environment can help teachers to overcome some of their worries. A program designed to train teachers for HIV/AIDS prevention in Zimbabwe found that teachers were keen to undertake HIV/AIDS education, but that experience had taught them that support from head teachers and key personnel from the education department was key to the successful programs of HIV/AIDS education (Woelk et al, 1997).

Work with young people in schools

In contexts where large numbers of young people attend school, school-based programs can offer an appropriate setting for HIV-related education. In Tanzania, for example, a school-based program called Ngao (shield), was designed to reduce risks of HIV infection and reduce discriminatory attitudes towards people living with AIDS. The program consisted of factual information, posters, songs, poetry and performances for younger pupils generated by the students. Panel discussions were also held with elders and parents. Six months after the program, pupils who had been exposed to Ngao reported significant increases in AIDS-related knowledge and more positive attitudes to people living with AIDS in comparison to those who had not (Klepp et al, 1994).

Broader political and religious forces may, however, restrict the kind of work which takes place in schools. School-based programs in Tanzania and South Africa, for example, have been prohibited from teaching young people about condoms (Klepp et al, 1994; Matthews et al, 1995). Similarly, legislation and public opinion often means that it is not possible to teach young people about sex and reproduction until they are of secondary school age. This may exclude many young people who do not attend beyond primary school. Moreover, since evidence suggests that young people are becoming sexually active at an earlier age than in the past, sex education may be required prior to secondary schooling. Importantly, in reviewing a number of programs of sex education for young people, Grunseit (1997) has noted that sex education programs have greatest impact if undertaken prior to the onset of sexual activity.

Although school-based programs are useful, it is important to note that in many parts of the developing world some of the most vulnerable young people do not attend school. That said, school-based programs may help reach some out-of-school youth

through the messages about safer sex disseminated to their school-attending peers (Blake et al, 1996).

Work with young people out of school

Many young people in the developing world do not attend school consistently, and there is evidence that this may be especially true in communities impacted upon by war, famine and other catastrophe including HIV and AIDS. In many parts of the world, including South Asia, young women spend much of time at home, and so may be particularly difficult to reach (Weiss, Whelan, Gupta, 1996).

In Mumbai, practitioners designing a HIV-prevention program targeting girls found that it was crucial to first gain the support of parents and others in the wider community (Bhende, 1993). A program of HIV/AIDS awareness for the wider community then, including local leaders, parents and young men, was launched prior to the initiation of the work targeting girls. Program designers also learned that young women and girls had heavy domestic workloads, including responsibility for the care of younger siblings. It was important therefore to provide creche facilities to ensure that young women would be free to attend the program. Rather than concentrating solely on HIV and AIDS, the program designers included a range of topics on reproductive and sexual health, as well as discussion of gender issues. Methods included storytelling, role play and games. The average age of the girls involved in the program was fourteen years. The program proved very popular with the young women and participation increased as the sessions went on. After seven sessions, the young women requested additional sessions. A follow-up survey found that 62 percent of the girls who took part in the session reported that they had subsequently discussed HIV/AIDS with others.

A number of initiatives designed to help to prevent HIV among young people have focused on the peer group. Broadly defined, peer education programs attempt to target groups of young people in an effort to influence established norms, values and behavior (Svenson, Hanson & Johnsson, 1995). Young people, who are thought to constitute a credible and influential group among themselves, are most usually trained in disseminating messages about HIV prevention to their peers. Peer educators might use a variety of methods including informal discussion with individuals or groups and use of video or drama presentations. Similarly, peer educators work in a variety of locations including schools and colleges, playgrounds, sports fields, the street and the workplace (Williams, 1996).

Some peer education programs aimed at young people out of school have claimed to have helped to bring about significant reductions in HIV-related risk behaviour. In the Rakai District of Uganda, for example, where high rates of HIV infection have been reported among young people, researchers found that sexually active young people involved in peer education programs were five times more likely to report using condoms than those who had not been involved in peer education. The figure for those trained as peer educators was higher still, with six times as many peer educators reporting regularly using condoms (Kelly et al, 1995).

Another peer education program aimed to address the needs of young migrant workers working in factories in Thailand. Prior to being involved with a peer education program, young women reported that they did not feel they were at risk of HIV infection, since they commonly associated HIV with sex work. Although many of the young women were sexually active, they reported that condom use was not appropriate in the context of loving relationships with partners. A peer education program was initiated and young women were given information about AIDS, encouraged to discuss the ways in which dominant images of masculinity and femininity present obstacles to safe sex, and offered training in negotiating condom use. Young women who worked as peer leaders demonstrated highly significant improvements in knowledge and enabling skills, and the largest increase in perceived vulnerability to HIV infection. Young women involved in the program, who had earlier been concerned that 'too much knowledge' about sex might compromise their reputation with others, reported that the award of certificates on completion of the course allowed them to discuss HIV more openly with others without fear of reprisal (Cash et al, 1997).

Work with young people at heightened risk

Some young people are at heightened risk of becoming infected with HIV. They include young people who live in abject poverty, those who are denied regular or appropriate adult support, and they are stigmatised and discriminated against. Young people who are marginalised in these ways are more vulnerable to rape and coercive sex, may be forced to exchange sex in order to meet their needs for food and shelter and are routinely denied access to education, accurate information and health services. Young people living in particularly precarious circumstances are often difficult to reach with programs about HIV/AIDS since they are more concerned with their daily survival.

A number of innovative programs have attempted to reach young people considered to be at particular risk of HIV/AIDS across the developing world.

Civil unrest and war mean that some young people in developing countries are living in refugee camps where conditions increase the risk of HIV infection. Rwandan refugees, for example, may be at particular risk of HIV infection because of the destruction of families, deterioration of social structures, loss of income and inadequate health services. One project attempted to reach adolescent refugees living in camps in Tanzania (Benjamin, 1996). In addition to 'Adolescent Health Days', sporting events, which attracted large numbers of young men, were among the vehicles used to disseminate messages about HIV infection. Girls in refugee camps are at particular risk of becoming infected with HIV because they are forced to exchange sex for economic advantages or protection. The same project is now developing income-generating activities to enable young women to earn some money without endangering themselves.

Children and young people who live on the streets are especially vulnerable to HIV infection. These young people have a myriad of other pressing concerns, including the need for shelter, food, money, protection and love and affection. Young people

living on the streets of Rio de Janeiro, for example, have reported that hunger and violence will kill them before AIDS (cited in Mann, Tarantola & Netter, 1992). Additionally, young people who live on the streets do not usually have access to adequate health services. In order to achieve good results, HIV-related programs must therefore address issues which are of perceived relevance to young people living on the streets and to help them to address their basic needs. Projects providing food, access to health services, shelter and schooling have been established for street children in Brazil for example (Vasconceles et al, 1993). An emphasis on helping young people to develop feelings of self-worth and taking full account of self-perceived needs has been given precedence over work specifically on sexual health. The project workers believe that meeting immediate needs and developing self-confidence will help street children to protect themselves from the risks of HIV infection (Vasconceles et al, 1993).

Same-sex relationships are highly stigmatised in many developing and developed countries, and homosexually active young men and women may experience marginalisation and social sanctions. Where such behaviours remain stigmatised, accurate information about the risks of HIV infection is rare. Although male-to-male sex exists in every culture, widespread official denial often renders homosexually active men socially invisible. This may place them at enhanced risk of HIV and other sexually transmitted diseases since the expression of their sexuality must be covert. Relatively few programs have targeted homosexually active men in developing countries, and even fewer have concentrated specifically on the needs of younger men (Parker, Khan and Aggleton, 1998).

5. PROGRAM IMPLICATIONS

HIV-related prevention with young people must continue to be given high priority in developing parts of the world, since by working with young people it will be possible to have a significant impact on the future course of the epidemic. Those working with young people now have access to an increasing body of knowledge about successful approaches to use. The most effective programmes

- respond to diversity of young people and their needs;
- encourage youth participation in design and implementation;
- work in a climate of openness that recognizes realities that young people face;
- focus on young men's sexual health needs as well as those of young women;
- focus on the positive aspects of sexual health as well as unwanted pregnancy and sexually transmitted infections;
- promote greater awareness of sexual and reproductive health rights; and
- offer improved access to education and health services.

(Piot and Aggleton, 1998)

There is also increasing information about the kinds of work which are less successful. Programs which fail to recognize diversity in young people and provide opportunities to think about and talk about gender and sexuality, for example, are

rarely if ever successful. It is important for adults to suspend their stereotypes and presuppositions about young people and listen to the expressed needs of young women and young men. Additionally and importantly, young people must become genuine partners in dialogue and decision-making (Hoffman and Futterman, 1996). While in much development work the importance of participation of by primary stakeholders is increasingly recognised, young people are still infrequently included in the design and development of programs designed to help protect their sexual health.

It is important that future programs foster greater trust and more open communication between young people and adults. Where open channels of communication are absent, or where there are suspicions about motives of adults, young people may be hindered in protecting themselves from HIV infection. Young people recently interviewed in Kenya, for example, suggested that AIDS was a scare campaign perpetrated by older people to prevent them from enjoying sex (Balmer et al, 1997).

Until relatively recently, much work with young people in developing countries has centred on the prevention of pregnancy and sexually transmitted diseases including HIV and AIDS, rather than the promotion of sexual health. Only rarely have programmes focused on the positive aspects of human sexuality including sexual pleasure. It is important to shift the emphasis from pregnancy and disease prevention towards multi-dimensional and rights-orientated conceptions of sexual health (Dixon-Mueller, 1993). Programs which do not offer relevant and realistic accounts of sexuality are unlikely to be well-received by young people.

Variations in rates of HIV infection among young people cannot be accounted for by differences in levels of knowledge and skills alone. Instead, some groups of young people experience greater risks by virtue of their position in society. Structural factors such as gender relations, the distribution of income and wealth, and relationships between young people and older people, systematically render some people more vulnerable than others (Piot & Aggleton, 1998). In many parts of the developing world, the broader social, economic and political context within which young people live constrain their ability to protect themselves. Young people who are marginalised from mainstream society may not be able to access the health services and resources which can help them protect their health. Work needs to be undertaken to promote the social inclusion of such young people.

Gender inequalities have serious consequences for adolescent sexual health. In many parts of the world, women and girls are economically dependent on men, may face domestic violence and non-consensual sex, and are encouraged to remain ignorant and passive. So long as women and girls are denied access to information and education, economic resources and health services, they will continue to face increased risks of HIV infection. The needs of young men have until recently been relatively ignored by program planners, with consequences both for the health of young men concerned and that of their sexual partners. It is unlikely therefore that young people will be able to maximise their sexual and reproductive health unless there are major changes in relation to gender and other inequalities which facilitate the transmission of HIV. Those concerned with the prevention of HIV and adolescent health must seek to influence public policy agendas to lay the foundations for greater equity in the future.

6. PRINCIPLES FOR SUCCESS

A number of principles can be identified for future work to prevent HIV infection among young people in developing countries.

- Prevalent ideologies of masculinity and femininity which prescribe virginity in unmarried girls and promiscuity for boys facilitate the transmission of HIV to young women and young men. These ideologies need to be challenged at policy and programme levels, as well as in the media, family and community.
- Unhelpful stereotypes about young people and adolescent sexuality inform the attitudes of parents, other adults and even those involved with HIV-prevention. Wherever possible, program designers should attempt to challenge these stereotypes, since they serve as an obstacle to the development of appropriate and relevant programs of sex and HIV-related prevention.
- There is evidence to suggest that young people across the world are having sex earlier than in the past. It is important then that sex and HIV-related education are provided in a timely manner.
- The widespread denial of adolescent sexuality leads to attempts by adults to constrain and control young people's sexual behaviour. Since this is often unrealistic, it means that young people are denied access to information, services and resources which help them to protect their health.
- Young people benefit from open and honest communication with adults, and this is absent in many cultural contexts and declining in others. It is important that programs encourage better and more open forms of communication within families, and between families, communities and young people. There is some evidence to suggest that the epidemic of HIV infection may in itself provide increased awareness among parents about the importance of helping young people to protect their sexual health.
- Formal programs of sex education and HIV-related education are most successful when they include messages about safer sex as well as abstinence. Convincing messages which inform parents as well as policy-makers that timely and relevant sex education does not propel young people into premature sexual relationships must be disseminated.
- Teachers also require training in delivering sex education and developing confidence in talking to young people about sex. Supportive environments, including support from policy makers, educationalists and head teachers, are important in helping teachers to deliver effective programs of HIV-related education.
- There is evidence to suggest that peer education programs support young people in making changes to their behaviour.
- Programs might also provide opportunities to address issues relating to gender, social status and sexuality in work to promote young people sexual and reproductive health.
- Program designers and others concerned with HIV-infection must promote a greater awareness of structural issues affecting sexual and reproductive decision making, including rights and protection for young people, as well as improved access to education and health services.

- Young people living in developing countries, particularly girls and those young people living in especially precarious circumstances, need protection from rape, sexual exploitation and coercion. It is important that communities and governments are mobilised to take action to ensure that all young people can enjoy increased safety and freedom from sexual abuse.
- More work with young men is required to enable them to think about their role in relation to both their own sexual health and that of their partners, as well as improving programs for young women. Additionally, work should target adult men and the wider community in order to help adults to reduce the pressures on young men who are developing their masculine identities to behave in ways which jeopardize their own health and the health of others.
- When working with particularly vulnerable young people, including those who live on the streets, it is crucial that programs seek to address the daily risks which they face. As well as acknowledging the need for shelter, food, safety and support, those concerned with the prevention of HIV must work with policy-makers to reduce the hardships faced by street children.
- Work should be undertaken to reduce the marginalisation of young men who have sex with other men, alongside preventive work to ensure that young men are accurately informed and have access to health services and resources such as condoms.
- Improved access to non-judgemental and user-friendly sexual health services is crucial for young people. Training in adolescent health issues should be provided to health workers in the field of sexual and reproductive health.
- Young people need improved access to good quality condoms; it is important that confidential and non-judgmental provision is improved for young people.

Endnotes:

1. It should be emphasised that the term "homosexual" is rarely the term used. Instead, phrases and descriptions within the local language and vernacular are employed. Sometimes these connote supposed passivity in sexual relations (with other men), sometimes they simply suggest that the individual concerned is not entirely "heterosexual"

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