
Poverty, Gender, and Youth

Social and Behavioral Science Research (SBSR)

2004

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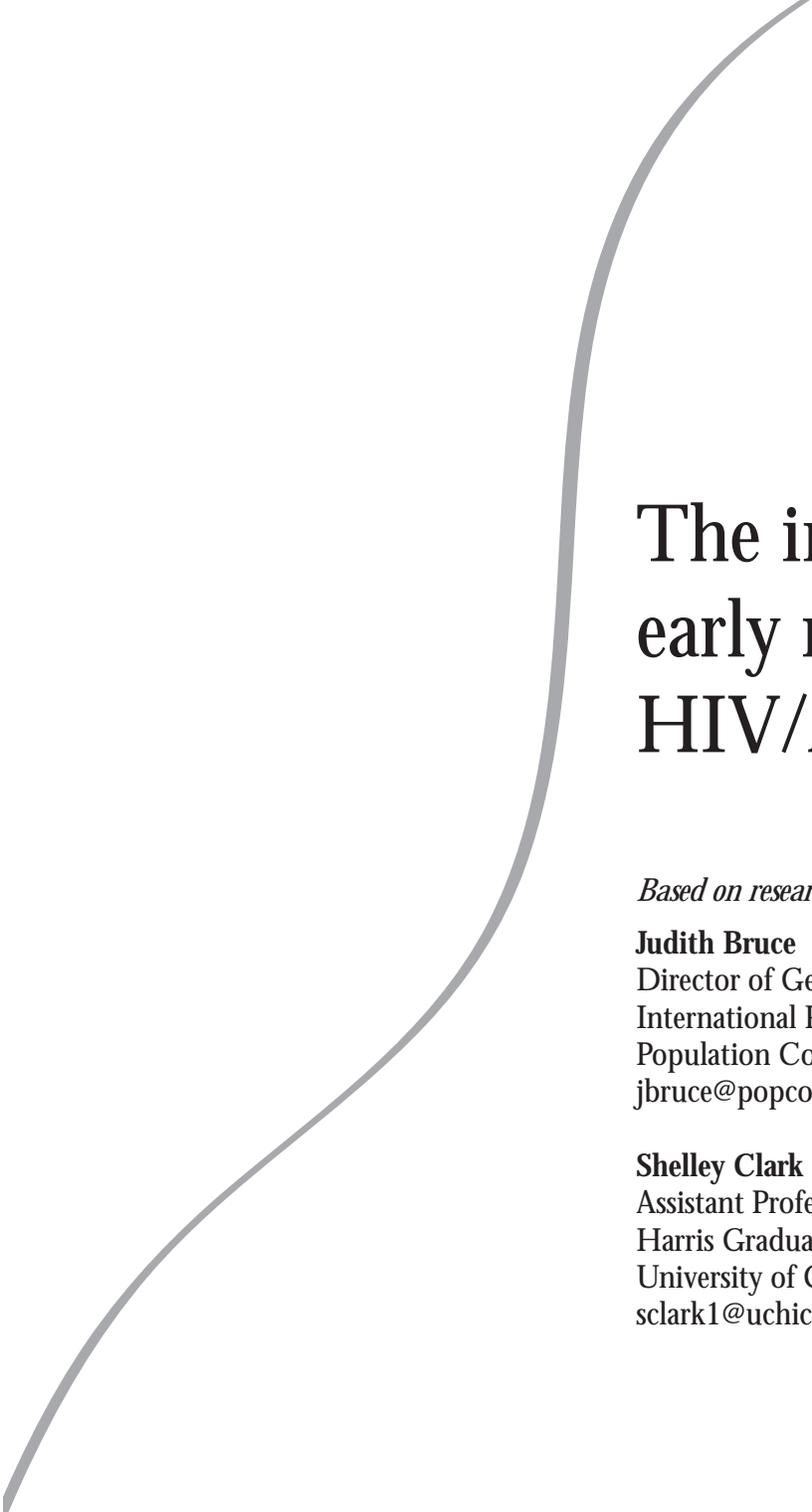
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Recommended Citation

Bruce, Judith and Shelley Clark. 2004. "The implications of early marriage for HIV/AIDS policy," brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents. New York: Population Council.

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The implications of early marriage for HIV/AIDS policy

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B R I E F

This brief is based on a background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, held in Geneva, Switzerland, 9–12 December 2003 (the final paper, “Including married adolescents in adolescent reproductive health and HIV/AIDS policy,” by Judith Bruce and Shelley Clark, is forthcoming and will be available at www.popcouncil.org in June 2004). The Consultation brought together experts from the United Nations, donors, and nongovernmental agencies to consider the evidence regarding married adolescent girls’ reproductive health, vulnerability to HIV infection, social and economic disadvantage, and rights. The relationships to major policy initiatives—including safe motherhood, HIV, adolescent sexual and reproductive health, and reproductive rights—were explored, and emerging findings from the still relatively rare programmes that are directed at this population were discussed. The meeting and specific papers were supported in part by funding from The Ford Foundation, the Bill & Melinda Gates Foundation, The John D. and Catherine T. MacArthur Foundation, the Population Council, U.K. Department for International Development, UNFPA, and WHO.



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Suggested citation: Bruce, Judith and Shelley Clark. 2004. “The implications of early marriage for HIV/AIDS policy,” brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents. New York: Population Council.

INTRODUCTION

In the past decade, policy attention has turned toward adolescent reproductive health and social development issues. During that same decade, women came to comprise half of those infected with HIV/AIDS. In some parts of the world, most notably sub-Saharan Africa, HIV prevalence rates among young women aged 15–24 outpace those of men in that age group by two to eight times.¹ Of substantial consequence, yet largely ignored, is the fact that the majority of sexually active girls aged 15–19 in developing countries are married,² and these married adolescent girls tend to have higher rates of HIV infection than their sexually active, unmarried peers.³ Thus married adolescent girls not only represent a sizeable fraction of adolescents at risk, but they also experience some of the highest rates of HIV prevalence of any group.

Nonetheless, married adolescents have been marginal in adolescent HIV/AIDS policies and programmes and have not been the central subjects for programmes aimed at adult married women.⁴ It is time—indeed past time—to give substantially greater attention to the role that early marriage plays in potentially exposing girls and young women to severe reproductive health risks, including HIV. Protecting these young women may not only serve to help prevent the disease from spreading from “high-risk” groups to the general population in their own generation, but also to the next generation by reducing mother-to-child-transmission among this most intensive childbearing group.⁵

THE TRADITIONAL OMISSION OF MARRIED ADOLESCENTS

Early marriage and the needs of married adolescents traditionally have been neglected. The adolescent policy agenda, in its brief history, has been framed by the priorities and cultural experience of developed countries, where the proportions of married adolescents are relatively low. Given their small numbers in these countries, married adolescents’ needs and conditions have been, at best, a minor consideration. Rather, the experience of unmarried—often in-school—adolescents’ sexual initiation, risk-taking behaviours, and, more recently, social environments have been major themes of both research and policy interventions.

Legally, married adolescents have been sidelined. The Convention on the Rights of the Child (CRC) offers an extremely useful cross-cultural definition of “childhood” (up to age 18) and a detailed vision of the needs and rights of children and their evolving capacities; yet it allows countries to apply these rights and protections only to the unmarried. The CRC permits signatory countries to determine whether marriage removes girls (who form the vast majority of married children)⁶ and boys from the protected space of childhood. Indeed, some countries might not have signed the CRC without potential exemption to child rights protection for married girls and women. This legal construction reflects and is justified by a long-standing cultural norm—that marriage, regardless of age, confers adult status. A third closely related reason for the invisibility of

¹ Laga, M., B. Schärtlander, E. Pisani, P.S. Sow, and M. Caraël. 2001. “To stem HIV in Africa, prevent transmission to young women,” *AIDS* 15(7): 931–934; and UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic*. Washington, DC: UNAIDS.

² This is based on analysis of Demographic and Health Survey (DHS) data from 26 countries. It excludes China, where marriage is typically later and data are missing. For details see paper from which this brief is excerpted (Bruce, Judith and Shelley Clarke. 2004. “Including married adolescents in adolescent reproductive health and HIV/AIDS policy,” background paper. New York: Population Council.)

³ Glynn, J.R., M. Caraël, B. Auvert, M. Kahindo, J. Chege, R. Musonda, F. Kaona, and A. Buvé for the Study Group on Heterogeneity of HIV Epidemics in African Cities. 2001. “Why do young women have a much higher prevalence of HIV than young men? A study in Kisumu, Kenya and Ndola, Zambia,” *AIDS* 15(suppl 4): S51–S60; and Kelly, R.J., R.H. Gray, N.K. Sewankambo, D. Serwadda, F. Wabwire-Mangen, T. Lutalo, and M.J. Wawer. 2003. “Age differences in sexual partners and risk of HIV-1 infection in rural Uganda,” *Journal of Acquired Immune Deficiency Syndromes* 32(4): 446–451.

⁴ Because early marriage is a largely female phenomenon, girls have higher HIV rates in most countries where heterosexual transmission is dominant, and little data exist on boys, this paper focuses on the situation of married girls.

⁵ Childbearing is expected soon after marriage. Indeed, while age at marriage has generally increased, the average number of months between marriage and first birth has decreased in all regions. Source: Mensch, Barbara. 2003. “Trends in the timing of first marriage,” paper presented at the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, WHO, Geneva, 9–12 December.

⁶ In nearly all countries girls aged 15–19 are at least twice as likely to be married as boys; sometimes the probability is much higher. For example, in Brazil the probability of marriage for girls is five times higher, while in Indonesia it is seven and a half times higher. In Kenya girls are an astounding 21 times more likely to be married than boys of the same age. Source: United Nations. 2000. *World Marriage Patterns*. New York: United Nations Population Division, Department of Economic and Social Affairs.

needs of married adolescents is the thought that a married girl is “taken care of” and has passed from the “protection” of her natal kin to that of her husband.

These historical, legal, and cultural influences, while understandable, have led to a collective denial of the continuing and widespread occurrence of child marriage. Of the 331 million girls currently aged 10–19 who live in the countries of the developing world excluding China, 163 million will be married by their twentieth birthday, if present trends continue. Over the next ten years, more than 100 million girls in those countries will be married before their eighteenth birthday.⁷

The initial successful strategies to protect against HIV transmission addressed the needs of the first wave of infections. In the United States, the epidemic was first reported among relatively affluent, well-educated men who had sex with men. In sub-Saharan Africa, the first wave of infections was found among “wealthy men who could afford to travel, have multiple sex partners, and pay for sex.”⁸

Increasingly, however, the epidemic in all regions is moving rapidly among the poor and those powerless to negotiate the terms of sexuality and, as a result, is becoming increasingly selective of young people, especially girls and young women. Strategies that have been effective for the previous groups of at-risk populations will not necessarily be appropriate or feasible choices for disempowered young women under pressure to become pregnant.

WHY ARE MARRIED ADOLESCENT GIRLS AT RISK?

Girls married before the age of 18 will face significant risks of HIV. Crossing the threshold into marriage greatly intensifies sexual exposure via unprotected sex, which is often with an older partner who, by virtue of his age, has an elevated risk of being HIV-positive. This dramatic rise in the frequency of unprotected sex is driven by not only the implication of infidelity or distrust associated with certain forms of contracep-

tion, such as condoms, but often also by a strong desire to become pregnant. We examined data collected in Demographic and Health Surveys from 31 countries to determine adolescent girls’ potential exposure to HIV risks via early marriage (see table, page 4). We found that, on average, 80 percent of unprotected sexual encounters among adolescent girls occurred within marriage. In six countries (Bangladesh, Egypt, India, Indonesia, Senegal, and Turkey) we do not have data on sexual behaviours of unmarried girls, so this figure refers only to the remaining 25 countries. Since sexual activity among unmarried girls in the omitted countries is expected to be low, the overall estimate of sex within marriage in all 31 countries is probably higher than 80 percent.

Moreover, the increase in the numbers of young females infected with HIV has led some policymakers and researchers to conclude that large age differences in sexual partners leave adolescent girls at particular risk of infection. The risks associated with large age differences are most often recognised in relationships between young single girls and older “sugar daddies.” Although highlighted less often, significant age differences between husbands and young brides (women married before the age of 20) are common, ranging from 4.7 years in Guatemala to 14.1 years in Guinea (Column 4 of the table). Indeed, the younger a bride is at the time of marriage the greater her age difference with her spouse. Not only are husbands, on average, older than boyfriends, they are also more likely to be infected. Clark (2004) calculates that in Kisumu, Kenya, 30 percent of male partners of married adolescent girls were infected with HIV, while only 11.5 percent of the partners of unmarried girls were HIV-positive. Similarly, in Ndola, Zambia 31.6 percent of married girls’ partners compared to 16.8 percent of unmarried girls’ boyfriends were found to carry HIV.⁹ A concern about large age gaps between sexual partners is increasingly present in national AIDS policies. Yet these policies often fail to acknowledge the role of marriage in creating and entrenching such large age differences.

Finally, in most countries married girls report marriage as lonely, cutting them off from friends and family, restricting social and geographic mobility, and limiting access to information, schooling, and community participation. For example, Column 5 highlights the low rates of school participation among married adolescent girls. Social isolation is a loss in its own right and is increasingly identified as a predisposing factor for HIV risk as it undermines the benefits of “social cohesion.” Social contact and networks are

⁷ Population Council analysis of DHS data, with special thanks to Carey Meyers and Brian Pence.

⁸ Kiragu, Karusa. 2001. “Youth and HIV/AIDS: Can we avoid catastrophe?” *Population Reports* series L, no. 12, Fall. Baltimore: Johns Hopkins University Bloomberg School of Public Health, Population Information Program, p. 5.

⁹ Clark, Shelley. 2004. “Early marriage and HIV risks in sub-Saharan Africa,” Harris School Working Paper Series no. 04.06. Chicago: University of Chicago.

becoming widely recognised as vital to transmitting information and supporting behaviour change. Similarly, media and schools are increasingly enlisted to convey HIV prevention messages and support HIV programmes.

Not only are married adolescent girls often isolated within their new households and from external public and private support, but their needs have not been prioritised or sometimes even considered in current reproductive health initiatives. Moreover, many of the most common HIV/AIDS policies and messages are not appropriate for them.

Four main types of adolescent reproductive health programmes consume the vast majority of adolescent reproductive health resources: family life education programmes that include HIV/AIDS education, youth centres, peer education as a primary communication strategy, and youth-friendly health services. More recently there have been efforts to engage youth through diverse media. Married girls often have received no schooling or are early school leavers and consequently may not receive the benefits of family life education. Girls in general, and certainly married girls, are either not served or less well-served in youth centres than males.¹⁰ As the above data on married adolescent girls indicate, they have distinctive patterns of social mobility and more limited social networks than unmarried girls, placing them arguably outside the reach of conventional peer-to-peer programmes. Finally, and paradoxically, youth-friendly health services, meant to be a major means of improving adolescent reproductive health, are largely contraceptive services with some sexually transmitted infection (STI) and HIV information, counseling, and testing included, and, where available, treatment. Adolescent reproductive health programmes to date still give scant attention to marriage preparation and often explicitly exclude antenatal, delivery, and postpartum care as key services.

Apart from adolescent sexual and reproductive health services, there are other key avenues to reaching married adolescents via safe motherhood initiatives or maternal health services. Adolescent girls, however, may be inadequately served by these antenatal and postpartum programmes given the elevated (combined social and clinical) risks of first births to the youngest mothers.¹¹ Moreover, many of the services offered, such as contraception and sterilisation, are not sought by recently married young women.

Similarly, currently recommended strategies for HIV/AIDS protection and risk reduction have been:

- to abstain from sexual activity,
- to reduce sexual frequency,

- to change sexual partners (to a safer partner),
- to use a condom (male or female), and
- to observe mutually monogamous relations with an uninfected partner.

Not one of these, save the last idealised situation (mutual monogamy with an uninfected partner), offers a feasible choice for newly married girls/women under pressure to become pregnant with more powerful and/or older husbands.

EXERCISES TO GUIDE COUNTRY-SPECIFIC ASSESSMENTS OF HIV RISKS FOR MARRIED ADOLESCENTS

Governments can determine how vulnerable their married adolescent populations are to HIV and the magnitude of the problem in terms of spreading the epidemic to the “general population,” usually meaning married men and women. These analyses are intended to help identify which HIV and reproductive health interventions are most urgently needed for married adolescents and/or married women in general. There are four key pieces of this analysis.

Estimating levels and distribution of HIV/AIDS in the current population

Estimating the age- and sex-specific prevalence and, when possible, incidence of HIV among different populations is the first step in assessing what, if any, role early marriage or marriage per se will play in either stemming the tide of HIV or serving as its bridge to the general population. It is important, though often difficult, to gather prevalence data from groups generally considered to be at low risk, like young married monogamous women.¹²

¹⁰ Erulkar, Annabel. 2003. “Examining the gender dimensions of popular adolescent programs: What they could offer adolescent girls and boys,” in *Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second Generation of Programming*, background document for a workshop of UNFPA in collaboration with the Population Council. New York: Population Council.

¹¹ Miller, Suellen and Felicia Lester. 2003. “Re-orienting information, social support and services for the youngest mothers,” paper presented at the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, WHO, Geneva, 9–12 December.

¹² Though some married girls are picked up in sentinel data drawn from antenatal clinics, there have been no dedicated surveys of married young women.

**MEASURES OF ADOLESCENT GIRLS' POTENTIAL EXPOSURE TO HIV RISKS
VIA EARLY MARRIAGE, BY COUNTRY (DHS DATA)**

Country	Year	Column 1	Column 2	Column 3	Column 4	Column 5	N ^b adolescent girls (aged 15–19)
		Percent married by age 18 ^a	Percent married among girls who had unprotected sex last week	Relative risk of having unprotected sex last week (prob. married/ prob. unmarried)	Mean spousal age difference (bride < age 20)	Percent of married adolescents in school	
South and East Africa							
Ethiopia	2000	49.1	97.9	141.6	8.7	N/A	3,366
Kenya	1998	24.6	72.3	14.1	7.9	2.0	1,827
Malawi	2000	46.9	92.6	24.3	5.7	N/A	2,788
Mozambique	1997	56.6	82.0	5.4	7.7	2.2	1,816
Rwanda	2000	19.5	97.2	491.4	6.3	N/A	2,713
South Africa	1998	7.9	12.6	4.3	6.2	37.7	2,357
Tanzania	1999	39.3	77.0	9.7	N/A	0.0	909
Uganda	1995	54.1	96.3	27.7	N/A	1.2	1,578
Zambia	2001/02	42.1	81.7	13.4	6.7	N/A	1,756
Zimbabwe	1999	28.7	94.7	63.9	8.3	N/A	1,454
West Africa							
Benin	2001	36.7	68.1	7.0	9.5	N/A	1,216
Burkina Faso	1998/99	62.3	86.0	11.9	11.5	0.2	1,461
Cameroon	1998	43.4	69.9	4.4	11.1	6.0	1,269
Gabon	2000	33.6	53.2	4.9	8.5	38.1	1,552
Ghana	1998	35.5	49.0	6.0	8.5	3.5	866
Guinea	1999	64.5	84.0	6.5	14.1	2.8	1,317
Mali	2001	65.4	89.6	9.6	12.1	N/A	2,477
Nigeria	1999	39.6	89.3	45.4	11.9	2.3	3,365
Senegal	1999	36.1	N/A	N/A	N/A	N/A	1,935
Latin American and the Caribbean							
Brazil	1996	23.7	71.7	15.3	5.7	11.1	2,453
Colombia	2000	21.4	77.6	19.8	6.2	N/A	2,192
Dominican Republic	1999	31.0	95.6	89.4	7.2	38.5	249
Guatemala	1998/99	34.3	100.0	N/A	4.7	2.9	1,366
Haiti	2000	24.1	82.6	23.8	7.1	N/A	2,367
Nicaragua	2001	50.3	97.3	112.3	5.5	N/A	3,074
Peru	2000	18.7	81.2	37.2	4.8	N/A	5,679
Asia							
Bangladesh	1999/2000	65.3	N/A	N/A	9.5	N/A	1,571
India	1998/99	47.6	N/A	N/A	6.3	N/A	6,888
Indonesia	1997	29.6	N/A	N/A	N/A	1.3	1,066
Middle East							
Egypt	2000	19.5	N/A	N/A	7.9	N/A	579
Turkey	1999	23.0	N/A	N/A	5.2	0.5	1,759

^a Among women age 20–24.

^b Formerly married adolescent girls are excluded from all analyses.

Determining prevalence of early marriage for the entire country and for specific subpopulations

The prevalence of early marriage varies tremendously by country (e.g., Column 1) or within a given country among specific cultural or geographic settings. For example, while the nationwide median age at marriage is an important indicator, many countries have very low ages at marriage in some specific parts of the country.

Determining the magnitude of the HIV risks accompanying early marriage

To determine the degree to which marriage marks an abrupt increase in HIV risk, two main measures should be considered: the percent of unprotected sexual activity occurring within marriage by age group (Column 2) and the average age difference between young brides (i.e., those married under age 20) and their spouses (Column 4). As discussed above, the age differential between partners may serve as a proxy for not only the relative power in the relationship, but also the probability of infection among the older spouse, typically the husband.

Assessing the availability of and access to programmes and services for married women, particularly younger or newly married women

Analyses should be undertaken by governments and NGOs to evaluate the reach of programmes that currently target or could target married adolescent girls. Regardless of whether such programmes prioritise HIV messages, any social, economic, or health programme that reaches married adolescent girls can be seen as a vital vehicle to stem the epidemic. Some countries may have exceptional systems of contact with the engaged, marrying, and young married populations. If such procedures and service infrastructures exist, these may afford convenient, culturally acceptable points of contact and intervention. In other countries, however, recently married couples may have little or no contact with public services such as health care or education (see Column 5 for the low rates of school enrollment among married adolescent girls).

CASE STUDIES

While it is beyond the scope of this brief to identify the specific needs for all countries based on their marriage and HIV profiles, below are four illustrative scenarios to suggest how the assessments described above can help identify the importance of reaching married women, particularly married adolescents. Each country must assess its own needs and tailor its response to suit its unique context.

Burkina Faso has low, but increasing, HIV rates in high-risk subpopulations. The prevalence rate is substantially higher among young women aged 15–24, with estimates ranging from 7.8 percent to 11.7 percent, than among young men (3.2–4.8 percent).¹³

Marriage profoundly shapes the sexual behaviours of girls in Burkina Faso, given that approximately two-thirds of women aged 20 to 24 were married by age 18. Indeed, the contrasts between married and unmarried girls are strong, perhaps stronger than in many settings. Married girls are much more likely to have had unprotected sex; indeed, married girls are 12 times more likely to report having had unprotected sex in the last week than are unmarried girls (Column 3). Most strikingly, the mean age difference between spouses is nearly 12 years, suggesting that husbands are likely to have considerably more sexual exposure than their wives prior to marriage and are more likely to be infected. Given this profile, we could classify Burkina Faso as a country where early marriage for girls may be a particularly vulnerable point of entry for HIV into the general population.

The **Dominican Republic** can also be characterised as having low but rising HIV rates especially among specific groups. Some 31 percent of women were married before the minimum legal age of marriage of 18. And, although over a quarter of girls aged 15–19 are sexually active, nearly 80 percent of these girls are married. Married adolescent girls have much lower rates of condom use than their unmarried counterparts. When adolescent girls were asked about their sexual encounters in the last week, it was revealed that fully 96 percent of unprotected sexual encounters occurred within marriage. Among currently married 15–19-year-old girls, the mean age difference between partners is 7.2 years. By virtue of their age, older partners are likely to have had previous sexual partners. Finally, married adolescent girls are more socially isolated than their unmarried peers. Although over 90 percent of unmarried girls aged 15–19 are currently in school in the Dominican Republic, three out of five married girls are neither in school nor working. Thus, although the overall prevalence of HIV is low by international standards, the high frequency of unprotected sex occurring within marriage and substantial difference in spouses' ages, coupled with the social isolation of married adolescent girls, makes

¹³ UNAIDS. 2000. "Report on the global HIV/AIDS epidemic." Washington, DC: UNAIDS.

them a particularly important group to monitor and safeguard in the Dominican Republic.¹⁴

India exemplifies the importance of evaluating the characteristics of each country (and sometimes even regions within a country). Like the Dominican Republic the current prevalence of HIV is relatively low, with less than 1 percent of the population infected (although rates are already twice as high in women as in men). While conclusive data are lacking, about 20–25 percent of unmarried school- and college-aged boys reported engaging in premarital sex—often with a sex worker.¹⁵ Unmarried girls, however, are expected to refrain from sexual activity. Early marriage continues to be common with 47.6 percent of women married by age 18. Marriage, consequently, is the main route to unprotected intercourse, and thus we can infer that the transition to marriage and the coinciding HIV risks are especially stark. Marriage also marks a transition to greater social isolation for many women in India.¹⁶ Upon marriage girls often leave their natal homes and frequently move in with their husbands' families, who may reside in another town or village. Despite the fact that for females, unprotected intercourse is primarily in the context of marriage, there is extremely limited knowledge or perception of risk for HIV among married women. This is true even among monogamous, HIV-positive women in Mumbai.¹⁷ While HIV has hit the high-risk populations such as sex workers in Mumbai, there are warning signs that the second wave will be among married women and that these women are ill-prepared to protect themselves and their children.

In **Zambia** HIV/AIDS has already reached epidemic levels in the general population. Low estimates of HIV preva-

lence rates indicate that 10 percent of men aged 15–24 and 26 percent of women aged 15–24 are infected. Early marriage is common in Zambia: 42 percent of women were married by age 18. Perhaps more unique to Zambia is that less than half (44 percent) of sexually active adolescent girls are married, suggesting relatively high rates of premarital sexual activity. Strikingly, however, married adolescents represent a clear majority of those who reported having unprotected sex in the last week (82 percent), due mainly to a greater frequency of sex within the marital relationship rather than a decrease in condom use. Thus as shown in Column 3, married girls are more than 13 times as likely as unmarried girls to have had unprotected sex last week. On average, husbands of girls married before age 20 are 6.7 years older than their wives. While Zambia has promoted several large youth outreach and family life education programmes, these programmes, by and large, do not reach the sizeable proportion of adolescent girls who are married. Thus Zambia represents countries where the need to implement special efforts to reach married adolescents with protection strategies is especially pressing and where ignoring the risks to married women may undermine its existing HIV intervention programmes.

PREVENTION EFFORTS TO MINIMISE HIV RISKS ARISING FROM MARRIAGE

Secular and religious leaders must play an important role in successful efforts to combat HIV transmission within marriage. A key policy decision that leaders need to make is whether delaying marriage to at least age 18 and calling attention to the risks of HIV transmission within marriage will be explicit elements in the HIV-prevention policy. Provided there is political will, other specific policy measures for mitigating the risks of contracting and spreading HIV via marriage can be identified and implemented. We have organised these policy options in chronological order from pre-marriage to post-first birth. The order does not, however, represent a ranking of importance, and we are certain it does not cover the full range of options.

Pre-marriage options

Evaluating the legal basis for eliminating underage/child marriages

In most countries, minimum ages of marriage were established as part of a charter of rights in a society to define

¹⁴ Goldberg, Rachel. 2003. "Structures of risk: Gender and HIV/AIDS in the Dominican Republic," master's thesis, Columbia University Mailman School of Public Health.

¹⁵ Santhya, K.G. and Shireen Jejeebhoy. 2003. "Sexual and reproductive health needs of married adolescent girls," *Economic and Political Weekly* 38(41): 11 October.

¹⁶ Elul, Batya. 2003. "Induced abortion in Rajasthan, India: Prevalence estimates from two quantitative methodologies," personal communication from a working paper.

¹⁷ Gangakhedkar, R.R., M.E. Bentley, A.D. Divekar, D. Gadkari, S.M. Mehendale, M.E. Shepherd, R.C. Bollinger, and T.C. Quinn. 1997. "Spread of HIV infection in married monogamous women in India," *Journal of the American Medical Association* 278(23): 2090–2092; and Newmann, S., P. Sarin, N. Kumarasamy, E. Amalraj, M. Rogers, P. Madhivanan, T. Flanigan, S. Cu-Uvin, S. McGarvey, K. Mayer, and S. Solomon. 2000. "Marriage, monogamy and HIV: A profile of HIV-infected women in south India," *International Journal of STD & AIDS* 11(4): 250–253.

“adult” or majority status, and to offer protections to young men and women and boys and girls. In that spirit, countries need to review the logic and justice of their laws, their cultural interpretation, levels of compliance, and the implications for HIV risk if these laws are violated. In some settings, assuring the legal basis for deferring marriage to age 18 or beyond requires confronting competing parental rights. In some settings, girls as young as 12 can be married with “parental consent.” The construction of such laws, of course, assumes the situation of young people seeking marriage against their parents’ will. What is far more likely is parents’ exercising absolute control over their children’s, principally their daughters’, lives by forcing early marriage, nominally for economic or cultural reasons, such as protecting the family’s reputation.

Developing community-based initiatives that redefine acceptable ages of marriage and offer incentives to parents and girls to delay marriage to legal age

Considerable attention has been given to the role that education plays in delaying marriage. The relationship between work and delayed marriage has received less attention, but there is some evidence that girls who work for wages tend to marry later. Indeed in some communities, the very prospect of working for wages (which requires some higher level of schooling) may itself play a role in deferring marriage.¹⁸

Given the dearth of examples of community-based efforts to promote later marriage, we may look to the literature on efforts to reduce the extensiveness and degree of female genital cutting (FGC). Though many countries in which FGC is widely practiced have prohibited it for decades, these laws were unenforced and often unknown. Further, FGC—like early marriage—has often been portrayed, even defended, as an integral part of local culture. Community-based efforts to end FGC typically combine accurate information dissemination; social mobilisation of parents, elders, and other leaders in the community; retraining of practitioners of genital cutting; and—in some instances—legal action against purveyors of FGC or parents.¹⁹

New initiatives to make marriage safer may build directly on existing FGC mobilisation structures. Though we will likely be unable to effectively or acceptably deal with early marriage unless there is community-level mobilisation, at some point national governments will have to be ready to hold accountable through legal measures those who promote or force early marriage upon children.²⁰

Emphasizing the importance of safe, age-appropriate spouses

While HIV cannot be diagnosed by an individual’s appearance, that does not mean that certain characteristics are not associated with greater probability of infection. Parents and adolescent girls need to be aware of the correlations among age of suitors, their previous sexual experience, and likelihood of HIV infection. One of the most important factors increasing the age at marriage for men is the need to secure enough resources to pay an often substantial brideprice. Policies designed to minimise or eliminate the practice of brideprice or other economic exchanges at the time of marriage may help to diminish age differences between spouses.

Weighing whether later marriage will plausibly expand the number of unmarried, sexually active, and at-risk adolescents

The reluctance to promote later marriage as part of HIV prevention may be founded on a widespread belief that later marriage increases the number of unmarried, sexually active adolescents, a concern that is primarily applied to adolescent girls. Above we have provided reasons to challenge the common image of the irresponsible and dangerous, sexually active, unmarried adolescent contrasted with presumably safe, mutually monogamous sexual relations within marriage. In addi-

¹⁸ Amin, Sajeda, Ian Diamond, Ruchira Tinaved, and Margaret Nubi. 1998. “Transition to adulthood of female factory workers in Bangladesh,” *Studies in Family Planning* 29(2): 185–200.

¹⁹ Mohamud, Asha, Samson Radeny, Nancy Yinger, Zipporah Kittony, and Karin Ringheim. 2002. “Protecting and empowering girls: Confronting the roots of female genital cutting in Kenya,” in Nicole Haberland and Diana Measham (eds.), *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York: Population Council, pp. 434–458; Ismailly, Jumbe. 2003. “Three get 30 years after FGM victim dies,” <http://www.ippmedia.com>, 11 October; and Ghana News Agency. 2003. “Woman gets five-year jail term for performing FGM,” <http://www.ghanaweb.com>, 24 September.

²⁰ In Kenya, where marrying off girls is illegal, the African Inland Church Girls Primary School provides quality education and shelter to young girls who have been “rescued” from early marriages. Source: “FAWE: Centering on excellence,” *Carnegie Reporter* 1(3): Fall 2001, www.carnegie.org/reporter/03/eduafrika/fawe.html.

²¹ For instance, in a recent review of 120 surveys conducted since 1990 in 71 countries as part of the DHS, we see that while the proportions of young girls reporting premarital sexual experiences were relatively constant, among the 15 countries in sub-Saharan Africa with two or more surveys during this time period, the median age at first marriage increased by about four months. For details see paper from which this brief is excerpted (Bruce, Judith and Shelley Clarke. 2004. “Including married adolescents in adolescent reproductive health and HIV/AIDS policy,” background paper. New York: Population Council.).

tion, there is little evidence to support the fear that adolescent girls who delay marriage will initiate sex before marriage.²¹

The marriage transition

In many cultures, marriage is a process rather than a discrete event.²² Indeed, the formal marital boundary in some societies is not the important one, but rather there is a parallel social process—rituals, customs, and so forth—that demarks marriage eligibility and active pregnancy-seeking. This social process (pre-marriage ceremonies, celebrations, customs, and registrations) may provide a series of entry points for promoting information about couple communication, voluntary counseling and testing, condoms, sexual health, safer marriage, and childbearing—including ensuring healthy, disease-free children—to newly engaged couples.

Redefining the first year of marriage as a health zone

It may be worthwhile in many settings to characterise the first year of marriage as a “health zone” on the part of public health professionals. In the context of a new marriage and the prospect of future children, assuring the safety of both mother and child can become weighty arguments for behaviour change.²³

Fostering more intimate and trusting relationships between new spouses

The youngest brides and their partners are often not only socially isolated from their peers—especially in the case of the bride—but also embedded in larger family structures. Research on the youngest first-time parents reveals a desire on both sides for greater intimacy and information

exchange.²⁴ Efforts to strengthen this link between partners—particularly those close to each other in age—may lay an important foundation in creating the first year of marriage as a safety or health zone.

Decreasing the imminent pressure for pregnancy

Perhaps the greatest challenge to making sex within marriage safe is to find ways to increase the acceptability of delaying childbearing for at least one year while the couple is “getting to know each other”—and there is still doubt about HIV status. Framing delayed childbearing in terms of protecting future fertility and ensuring that children grow up in a stable and healthy family may make this approach more accepted.²⁵

Destigmatizing condoms and protection from STIs/HIV within marriage

Numerous studies have argued that condoms are unacceptable within marriage, but the rise in condom use within marriage in some settings refutes these beliefs.²⁶ It may be possible to increase condom use in marriage in some cultures if we reshape the image of condoms to represent not distrust or infidelity but rather respecting a partner’s health, protecting one’s own health, and preserving future fertility. Emphasizing the link between infertility and HIV may prove compelling as new studies have shown that HIV-positive women are less than a third as likely to conceive as HIV-negative women.²⁷

First births and beyond

Refining maternal health and adolescent sexual and reproductive health services to bring married adolescents into the circle

To date, adolescent sexual and reproductive health pro-

²² Bledsoe, Caroline H. and Gilles Pison (eds.). 1997. *Nuptiality in Sub-Saharan Africa: Contemporary Anthropological and Demographic Perspectives*. Oxford: Clarendon Press.

²³ Zulu, Eliya Msiyaphazi, Susan Cotts Watkins, and Gloria Chepngeno. 2002. “Spousal perceptions, comprehension and management of HIV/AIDS risk in rural Malawi,” presentation at University of Pennsylvania Conference on HIV in Malawi, October.

²⁴ Sundari Ravindran, T.K. 2001. “Programming for low-income married adolescents: An experience from rural Tamil Nadu, India.” Geneva: WHO, Department of Gender and Women’s Health.

²⁵ Brady, Martha. 2003. “Differentiating risk perception and protection needs of young women across the marital transition,” draft paper presented at the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, WHO, Geneva, 9–12 December.

²⁶ Maharaj, Pranitha and John Cleland. 2003. “The quiet revolution: Condom use within marriage,” working paper presented at Taking Stock of the Condom in the Era of HIV/AIDS, Gaborone, Botswana, 13–17 July; and Clark, Shelley. 2003. “Suspicion, infidelity and HIV among married couples in Malawi,” paper presented at the Population Association of America annual meeting, Minneapolis, 1–3 May.

²⁷ Glynn, Judith, Anne Buvé, Michael Caraël et al. 2000. “Decreased fertility among HIV-1-infected women attending antenatal clinics in three African cities,” *Journal of Acquired Immune Deficiency Syndromes* 25(4): 345–352.

²⁸ Santhya and Jejeebhoy. 2003. See note 15.

grammes have either ignored the needs of married adolescent girls or assumed these were identical to those of unmarried adolescents.²⁸ Similarly, maternal and child health services—the key vehicle for nominally “adult” reproductive health support—have made minimal, if any, efforts to reach the youngest married women (and their partners). Maternal and child health services, which are often extensive even in the poorest countries, could be reconfigured to give priority attention to the youngest and first-time mothers. This focus would lend significant new energy to safe motherhood initiatives, reviving interest in them and rendering them more relevant.

Creating awareness of HIV and enhancing safety within marriage through services at first birth

Intervening during the first pregnancy is justified not only by the objective risk it carries, but also as an opportune social and psychological moment to lay a foundation for future positive reproductive health habits. If these young women have not yet been reached, first pregnancies provide a timely and potentially powerful opportunity to provide essential information about HIV. Intervention during first pregnancy can set the stage for the future dialogue and joint decisionmaking that are crucial to the long-term well-being of not only both spouses, but also of their future children.²⁹

CONCLUSIONS

Married adolescent girls are outside the conventionally defined research interests, policy diagnosis, and basic interventions (family life education, youth centres, peer education, and youth-friendly health services) that have underpinned adolescent reproductive health programming and many HIV/AIDS prevention activities. They are an isolated, often numerically large, and extremely vulnerable segment of the population, largely untouched by current intervention strategies.

In many countries early marriage is a multi-faceted assault on girls’ rights and may serve as a bridge for the HIV virus into the general population. Promoting later marriage, to at least age 18, and shoring up the protection options including condoms, and, when they become available, microbicides,³⁰ within marriage may be essential means of stemming the epidemic.

These measures could help marriage fulfill its idealised role as a protective haven from many of life’s dangers, and particularly from HIV. In order to make marriage safe, however, we must first be willing to recognise an unpleasant reality that currently for many it is not. Denying the risks of marriage and holding interventions at bay outside the private sphere of marriage will not protect those inside it from the increasing threat of HIV.

²⁹ Graft, Auralice, et al. 2003. “Addressing married adolescents’ needs: A review of programs,” and Haberland, Nicole, Erica Chong and Hillary Bracken. 2003. “Married adolescents: An overview,” draft papers prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, WHO, Geneva, 9–12 December.

³⁰ Given the pressure and desire for children, microbicides are a particularly appealing option. For pregnancy and infection prevention, condoms (male and female) are ideal.

