The HIV epidemic is increasingly young, poor, and female

As we enter the third decade of the HIV epidemic in sub-Saharan Africa, the proportion of new infections among young women is on the increase. Half, or more, of new infections in sub-Saharan Africa are among the under-24 age group. Seventy-five per cent of these are among young women. A common ratio of young women to men living with HIV is 3:1 in some regions. This reaches 4:1 in countries such as South Africa, where there are eight new cases of infection among females to every one among males, in the 15 to 24 age group (Shisana et al. 2005).

The HIV epidemic often begins among males, and in upper- or middle-class groups, but, over time, it increasingly and disproportionately affects the poorest, youngest, and least powerful segments of society (Baylies 2000). These are composed of individuals with limited social and economic assets, who are unable to avoid, mitigate the effects of, or leave unsafe sexual relationships. Even in the most economically advanced Western societies, adolescent girls’ and young women’s relative vulnerability is reflected in relatively higher rates of HIV infection.¹

Factors driving girls’ risk

What makes girls and young women more vulnerable to HIV? The nature and degree of this greater vulnerability differs from place to place. Yet, in general terms, hundreds of millions of girls and young women living in the path of HIV have had little or no...
benefit from schooling, feel unsafe in their communities, face a significant risk of sexual coercion, and – having little or no direct access to economic assets, or prospects for making a livelihood – feel compelled to exchange sex (inside or outside of marriage) for money, gifts, food, and shelter. Out-of-school girls, especially those aged 10 to 14, living apart from their families, are particularly vulnerable (Chong et al. 2006). Those who are new to urban areas, especially those in domestic service, and girls who are taking care of HIV-infected families or otherwise serving as heads of households, may be under substantial pressure to support themselves, parents, or siblings (Erulkar and Mekbib 2007a). Married girls are subject to frequent unprotected sex, often with older partners, and may, therefore, face higher risk of HIV infection (Clark 2004; Clark et al. 2006).

This article explores these issues in more detail. In the first section, we identify five factors that relate to risk: living without the support of parents; social support and social connectedness; schooling status; marital status; and poverty and preparation for livelihoods. In the second part of the article, we suggest the kinds of development programming which might better respond to these realities, and give examples of innovative interventions piloting these approaches.

Orphans and children who live apart from one or both parents

The HIV epidemic has focused the attention of policy makers on vulnerable children, in particular those orphaned by AIDS. Orphanhood is officially defined in different ways in various countries. In some, the legal definition includes all children under 18 who have lost either or both parents, while in others it includes all children under 15 who have lost their mother. Among them, older adolescents (aged 15–19) face challenges, but it is younger adolescents (aged 10–14), particularly those out of school, who may be particularly susceptible to abuse and exploitation. Most programmes for ‘AIDS orphans’ focus on very young children, since orphaned infants risk having contracted HIV from an infected mother, and orphaned children may be more vulnerable to sexual abuse.

Regardless of the official definition used, making the transition to adulthood without one or both parents is believed to be a risk factor for abuse, different forms of unsafe sexual behaviour, and HIV infection among young people (UNFPA 2002; UNICEF 2003; UNAIDS et al. 2004) – and among girls in particular. Yet although there is a wealth of anecdotal evidence, the extent to which living without the support of a parent increases the risk of adolescents contracting HIV is still not well-known. This holds true even in sub-Saharan Africa, where HIV prevalence remains high, and rates of orphanhood are on the rise. Only three cross-sectional studies and one longitudinal study, as described below, have addressed this issue.

One study among young people in eastern Zimbabwe found orphaned females aged 15 to 18 had significantly higher HIV infection rates than non-orphaned females. Yet the same study found that orphan status was not associated with HIV infection
among males aged 17 to 18 (Gregson et al. 2005). In KwaZulu-Natal, South Africa, a
study found a correlation between orphan status, and having first sex at an earlier age,
for both sexes (Thurman et al. 2006). A nationally representative study from South
Africa (Operario et al. 2007) has revealed that 15 to 24-year-old girls who have suffered
the death of their parents are more likely to have had vaginal sex at least once; to be
HIV-positive; and to have had multiple sexual partners in the year before the survey.
Males of the same age group who had lost their parents were more likely to say that
their last experience of sex was unprotected.
Kelly Hallman (2004, 2005) studied the effects of poverty and orphanhood on
young people’s behaviour in South Africa. Each of these influenced sexual behaviour
and experiences, but the effects differed greatly for young women and young men.
Poverty increased girls’ risks, but not boys’, while orphanhood conferred risks for both
sexes. Young people who had lost their fathers started to have sex at an earlier age;
young women who had lost their fathers were more likely to have older sexual
partners; and young men who had lost their fathers were less likely to abstain from
sex. Among both young women and men, the death of a mother correlated to less
likelihood that they had discussed safe sexual practices with their most recent sexual
partner.
In more recent work that uses longitudinal data from KwaZulu-Natal and
examines the effects of orphan type (maternal, paternal, or double), Hallman (2008a)
found that the death of a parent – a mother or father for girls, versus a father for boys-
hastened sexual initiation. In contrast, living in a poor household led to the earlier
sexual initiation of girls but not boys. Consistent with findings from other sub-Saharan
African countries (UNAIDS et al. 2004), this study also confirmed that the likelihood of
being orphaned rises with age, and that orphaned young people are more likely to live
in poorer households than non-orphans are. Young people who have lost both parents
or fathers are the most economically disadvantaged.
Among younger adolescents living apart from their parents, there are some who
are particularly vulnerable and neglected. Among these are underage girls in domestic
service. In most settings, these are overwhelmingly female adolescents, often migrants
from rural families with little or no education (Erulkar and Mekbib 2007a). In a case
study of boys and girls living in low-income areas in Addis Ababa, girls in domestic
service reported abuse by employers and high levels of harassment (some reported
rape) on the street and a lack of any public response. Their window of safety on a daily
basis could be measured in hours, because they have little social support. Most
reported having no place to spend the night and no way to borrow money in an
emergency. The working conditions and pay of those in domestic service closely
resemble slavery. The research indicates that girls in Addis Ababa in general, and most
particularly working girls, had little contact with any of the conventionally configured
youth-serving initiatives. This insight takes us to the next issue of concern: social
support and ‘connectedness’.
Friendship networks and social support

Good friendship networks and social support are important in helping vulnerable young women to protect themselves from HIV. A study from KwaZulu-Natal, South Africa (Hallman and Onabanjo 2005), compared young women’s experience with that of young men, but also compared the experiences of poorer and richer girls, and found that girls in wealthier households had more social connections than girls residing in poor households. Across all wealth categories, though, girls were less well-connected than boys. Strikingly, girls in the highest income group still had fewer friends than boys in the poorest income group. For girls in all income categories, having poor social connectedness increased the likelihood that they had experienced sexual coercion. Yet the picture was worse for young women in poverty: fewer than half of them reported their first sex act as willing, in comparison to three-quarters of young women categorised as ‘non-poor’ (Hallman 2005). Subsequent research by Hallman (2008b) indicates that residing in a non-cohesive community and/or having thin social networks are, even after controlling for other factors, significantly correlated with earlier sexual initiation and a higher likelihood of experiencing non-consensual sex for girls and boys.

In some urban studies from sub-Saharan Africa, it is not uncommon to find that one-third (and sometimes more than half) of girls report that their first sexual experience was forced, or that they were tricked into it, or otherwise ‘unwilling’. It was often at the hands of someone the girl was acquainted with, and in a familiar setting. Using nationally representative data from South Africa, Pettifor et al. (2004) found that 98 per cent of young men reported they ‘really wanted’ or ‘wanted’ to have sex their first time, versus only 71 per cent of young women. A study from KwaZulu-Natal (Hallman 2005) reports that only 55 per cent of females, versus 94 per cent of males aged 14–24 who have had sex report themselves as having been ‘willing’ at the first encounter.

Consistently, in many settings (South Africa, Ethiopia, Bangladesh, India, Burkina Faso, Malawi, Uganda, Ghana), young women’s friendship networks have been found to be less robust than those of male peers. Two studies undertaken in Ethiopia, one urban and one rural, featured specific questions about friendship networks, as well as safety nets. Questions included asking girls and boys whether there was someone to turn to in need, a place to spend the night during an emergency, or someone to borrow money from. Girls reported they felt substantially more uncomfortable than their male peers in their neighbourhood; many had experienced harassment or some degree of sexual assault. In addition, whether or not they were in school, boys reported spending more time than girls do in recreational and social pursuits, whereas girls spent more time than boys doing unpaid domestic work, in their own and others’ homes. The social isolation of girls in domestic work is particularly poignant. It is linked to substantial economic and often sexual
exploitation; only 14 per cent agreed with the statement that they ‘have many friends’ (Erulkar et al. 2004a; Erulkar and Mekbib 2007a).

A study in rural Amhara, Ethiopia explored a number of dimensions not only of social connectedness but also of social mobility, which have implications both for access to HIV-related messaging, and for the promotion of protective behaviour (Erulkar et al. 2004b). It was clear that both married and unmarried girls were disadvantaged in comparison to male peers. Married girls had virtually no channels of social connections apart from going to churches or mosques, and had markedly less access to social messaging via media and community activities. Being married further disadvantaged girls, who already have fewer social assets and options than male peers.

**Schooling status and reproductive health behaviour**

Schooling is the most widely recognised and articulated right of adolescents, and this is reflected in government policy making directed at adolescents. Understandably, policy makers concerned with reproductive health and HIV prevention and management have directed much attention towards school-based HIV-prevention programmes. However, while it is obviously important to reach those in school, there has been insufficient attention to the (often starkly elevated) reproductive health risks of those adolescents who are out of school – especially girls. This has resulted in a shortage of effective programmes to reach them.

Analyses of schooling and its relationship to reproductive health behaviour have often focused on correlations between grades completed, and delays in getting married and having children, lower lifetime fertility, and higher earnings in the labour market (Summers 1994; Odago and Heneveld 1995). More recent analyses, conducted by Cynthia Lloyd (2008), looking across 38 countries, the majority of which are poor developing countries, have focused attention on the benefits to reproductive health for girls of being in school during adolescence, regardless of educational attainment and school quality. Research shows that the social aspect of being in school is a very important factor in protecting the reproductive health of adolescent girls.

Cynthia Lloyd’s cross-country analysis, using Demographic and Health Surveys dating from 1998–2006 centres on the reproductive behaviour of adolescents aged between 15 and 17, who are enrolled in school. Most adolescents have reached sexual maturity by this age. Perhaps her most important finding is the proportion of girls in this age group who report having ever had sex. Girls who were enrolled in school were substantially less likely to have had sexual relations than non-school-going girls. This holds even in sub-Saharan Africa, where the majority of 15 to 17-year-olds who are in school are studying at primary level. The trend of a rising percentage of adolescents attending school does not appear to reduce the strength of the positive association between school-going and favourable reproductive health outcomes. Enrolled girls are less likely to have had sex, and if they are sexually active, they are more likely to use...
contraception than non-students of the same age (Lloyd 2007). The risk of dropping out of school increases significantly for girls who have had premarital sex (Biddlecom et al. 2007). In addition, girls who are now at school, and have had few or no interruptions to their past schooling, are less likely than their counterparts with a history of more interruptions to become pregnant (Grant and Hallman 2008). They are also less likely to drop out if they do become pregnant (ibid.). A recent study by Hallman (2007) found that a past experience of non-consensual sex was correlated with lower chances of school enrollment for girls and boys, and lower educational attainment among girls in South Africa.

While school enrollment is necessary to ensure girls’ health and well-being, school quality is also a factor that must not be overlooked. Girls’ perception of being treated equitably in the classroom is crucial if they are to stay in school (Lloyd et al. 2000). School quality can be measured by traditional factors such as material resources and pedagogical practices as well as by less traditional elements such as teacher attitudes, and safety in the schools (affording pupils protection against sexual harassment and gender-based violence), and the extent to which staff and students show a commitment to gender equality through their attitude and behaviour, and the extent to which schools support pupils to develop self-confidence and skills in decision-making (ibid.).

These findings underscore the value of developing interventions for the excluded populations – those who are both the most likely to suffer ill health, and at the same time have the least access to school and/or the least access to school of sufficiently high quality. Initiatives must re-double efforts to get girls to primary school at the time at which they should enrol, keep them there through adolescence, and support a timely progression to secondary school. In most settings, particularly in sub-Saharan Africa, a shrinking but still significant proportion of girls will be out of school around the critical time of puberty (National Research Council and Institute of Medicine 2005). For these girls, it is essential that informational, social support, and asset-building strategies are developed that do not rely solely on school as the programme venue.

**Marital status and reproductive behaviour**

The majority of sexually active girls aged 15–19 in the developing world are married. This holds for many of the countries with mature HIV epidemics. Demographic and Health Survey data indicate that about 38 per cent of the 52 million young women aged between 20 and 24 in less-developed countries were married before the age of 18 (Mensch et al. 2005). Married girls are often subjected to unprotected sex. Indeed, in many settings with mature HIV epidemics, most unprotected sex experienced by adolescent girls takes place within the context of marriage (Bruce and Clark 2003; Clark 2004; Clark et al. 2006).

Married girls are typically much younger and less educated than their husbands, and have fewer assets (Quisumbing and Hallman 2005). They are often under intense pressure to become pregnant, and have limited opportunities to pursue friendships or
move freely outside their homes. In addition to lack of access to schooling, they may also have limited contact with modern media (television, radio, and newspapers) (Haberland et al. 2003).

Yet the idea of married girls as disadvantaged and of relatively low status contrasts with the high value placed on marriage in many societies. Community leaders, parents, and girls themselves, may see marriage as a safety zone: a protected sanctuary, within which sex takes place voluntarily, and a girl acquires the social status of womanhood.

However, marriage is not a refuge which protects girls from HIV. The partners of married girls on average are older than the partners of unmarried girls; indeed, the younger the girl, the larger the age gap is likely to be between her and her husband (Mensch 2003). The older the man, the more likely he is to have a premarital sexual history. An analysis by Clark (2004) found that in two urban settings with high HIV-prevalence – Ndola, Zambia, and Kisumu, Kenya – married girls’ husbands were more than twice as likely to be HIV-positive than the partners of unmarried sexually active girls.

Conventional HIV-prevention measures are mainly either impossible (given the nature of marriage as a relationship which legitimises sex, and is expected to result in the birth of children), or extremely difficult to implement on the part of married girls, given inequalities in bargaining and decision-making power between spouses, and the relative immaturity of married girls. Married girls normally cannot abstain, reduce sexual frequency, or change to a partner who seems to present a lower risk to their health; they have great difficulty negotiating condom use, insisting on HIV testing and counselling, and mutual disclosure of results, and have little control over their spouse’s extramarital sexual activities. Married girls are much less likely (11 times less likely in Kenya and Uganda, for example) to be able to negotiate condom use than their unmarried sexually active counterparts (Clark et al. 2006).

Millions of married adolescent girls may be at serious risk of HIV infection. Policy makers need to develop supportive strategies, which take into consideration the married girl’s physical and emotional maturity, the nature of her social networks, the age and premarital sexual behaviour of her partner, the power differentials between the spouses (in terms of the ability of the bride to communicate and negotiate with her partner), the relatively high frequency of sexual relations for married girls (compared with sexually active unmarried girls), and the pressure – and often desire – to get pregnant. Girls need support from health and development policy makers to assist them in delaying marriage until at least age 18, and making and sustaining safer marriages – and these interventions need to be evaluated.

**Financial literacy and preparation for safe livelihoods**

Both relative and absolute poverty are critical determining factors in HIV risk for girls and young women. The poverty of those adolescents living on their own, or who move
among households, is often not captured by survey instruments; and other adolescents are embedded in families whose overall wealth status (as measured by income and household assets) is seen as an indicator of overall household wealth, which benefits all household members equally. Adolescents in such households may be assumed to be wealthy, but not all members of households have equal access to these resources and the benefits that flow from them. This is particularly true of young females (Quisumbing 2003).

In research undertaken by Kelly Hallman and colleagues in Kwa-Zulu Natal (Hallman 2006), poor girls in urban areas appeared to be even more disadvantaged than their rural counterparts. Poor girls aged 14 to 19 in urban areas are more likely than poor rural girls to report ever having sex (55 per cent, versus 41 per cent), ever exchanging sex for gifts and money (9 per cent, versus 0 per cent), and reporting their first sexual experience as unwilling (a very startling 56 per cent, as compared with a significant 37 per cent among poor rural girls). High levels of first sex being reported as tricked or forced are commonly found in urban studies in sub-Saharan Africa. 4

Addressing the economic vulnerability of girls, whether they are on their own or embedded in households, is a challenge. However, research attests to girls’ strong interest in acquiring livelihoods skills, and the potential impact of even modestly successful interventions on girls’ positive sense of their possibilities, which has in turn been correlated with more accurate perceptions of risk and greater protective behaviours (Dunbar et al. forthcoming; Amin 2008; Austrian 2008; Erulkar et al. 2006; Hallman et al. 2007a; Population Council 2005). Giving girls livelihood skills and economic access improves their ability to protect themselves from HIV infection (Bruce and Joyce 2005; Erulkar and Chong 2005; Erulkar et al. 2006; Hallman et al. 2007a). Bringing together the research evidence regarding the importance of social connectedness in protecting girls from HIV, and the link between economic disadvantage and increased risk, suggests that there is great need for a wave of interventions that attempt to build social support as well as financial literacy and the provision of financial services (including credit, where appropriate, and savings facilities), and introduce the concept and skills of entrepreneurship. 5

Supporting girls while building their protective assets

HIV-prevention strategies and methods have grown up in the context of significant cultural and geographic diversity, but many programmes are still constrained by Western or middle-class expectations. Adolescent girls are presumed to be in school, with family support and reliable access to media, and operating with some degree of personal agency over their lives. Older girls and young women may be considered to be safe by being in school, in transit to decent work, and/or soon to enter into the ‘protection’ of marriage.
However, for a substantial proportion of girls and young women in many developing-country contexts, these optimistic scenarios do not apply. This is particularly true if they live in the poorest parts of the cities, or in the countryside. These girls, whose conditions and images are increasingly evoked in policy circles, are only on the edges, at best, of current HIV protection, care and support, and treatment programmes. They are the face of HIV, but they are not the primary targets of prevention, treatment, or mitigation programmes. Girls at risk of sexual exploitation are not a small minority; they are counted in the hundreds of millions. Yet despite their numbers, most are untouched by existing conventionally configured interventions (Bruce 2003; Lardoux et al. 2006a,b,c; Mekbib et al. 2005; Weiner 2007).

Far too little has been done in developing-country contexts to address HIV issues in adolescence, and most of it is only generally targeted at ‘youth’ – a term which can encompass girls aged 10, to men as old as 30. Furthermore, many developing countries have demonstrated that they have limited ability even to reach young people who are more advantaged (those in school, from better-off families, and living with their parents). To date, the largest share of attention (and, sometimes, blame) has been concentrated on sexually active ‘youth’, who are presumed to be voluntarily taking risks. HIV-prevention campaigns, which focus their energies and attention on ‘youth’ may render vulnerable girls invisible. Indeed, the majority of health, social development, livelihoods, and youth programmes are failing to reach the most vulnerable girls living in the path of HIV.

Below, we focus on key issues for those aiming to provide better support and protection to adolescent girls.

The need for early intervention
Current frameworks for action to reduce HIV infection typically target young people aged between 15 and 24. Yet this may be too late. Delayed intervention may miss the ‘sensitive’ moments at which disadvantage is consolidated for marginalised girls, after which there is little prospect of ‘catch-up’. By the age of 12, girls may have a very heavy burden of caring and domestic work, and are influenced by messages from the media which promote sexualised images of women, and market consumer goods. Around this age, girls become sexually mature, and as a result become subject to an entire spectrum of restrictive gender norms – most with the expressed intention of ‘protecting’ girls, and maintaining their families’ social reputation – but which often play out as policing girls’ behaviour. This may result in a withdrawal from school, and/or loss of opportunities to pursue and maintain friendships, and pressure to marry. Girls may become involved in sexual relationships as a means of ensuring economic survival. Girls in households trying to weather change may find themselves called on to migrate for work, with all its associated risks.
The provision of girl-only safe spaces to act as ‘programme platforms’

For vulnerable girls (both young and old, married and unmarried), the creation of dedicated, safe, physical spaces, which function as ‘service platforms’, is a key strategy which provides social support and raises self-esteem, while imparting new skills and creating new opportunities. A safe space can offer girls:

- activities and fun
- experience of participating as part of a team, and co-operating and leading
- friends: a dense network of non-family peers
- mentors and role models from whom to learn, who can intercede on a girl’s behalf
- help for girls to protect themselves and cope with crises
- referral and management of challenges and crises (pregnancy, rape, violence)
- literacy, health knowledge, social mobility: building the foundations of autonomy
- financial literacy and savings
- assistance in obtaining legal documentation for health, work, and citizenship
- accessing entitlements, including HIV-related entitlements
- planning for seasonal stresses, like school fees and food shortages, which often increase pressure to exchange sex for gifts or money
- dealing with family illness, death, inheritance, and identifying and preparing alternative caring and living arrangements
- referral to testing, counselling, and/or delivery of anti-retroviral treatments for HIV and AIDS

Safe spaces can be set up and run at relatively low cost, if they are established at existing publicly provided venues like youth centres, community centres, and schools, or voluntary institutions like faith-based organisations, churches, mosques, and local NGOs.

*Biruh Tesfa* (‘Bright Future’) is a programme for poor girls who have recently migrated to Addis Ababa. It is a joint project run by the Ethiopian Ministry of Youth and Sport and the Addis Ababa Youth and Sport Commission, with technical assistance from the Population Council and support from UNFPA, DFID, and the Turner Foundation. Implemented in the Mercato area of Addis Ababa, the project creates a safe and supportive space for out-of-school girls aged 10 to 19, most of whom are migrants (and often in domestic service), living away from parents and family members, and unlikely to be reached by other programmes. Not only do these girls have virtually no social support, but they face high risk of sexual coercion, and are often engaged in extremely exploitative work. The girls meet once a week with mentors drawn from the community (trained over a four-month period) for training in reading, writing and financial literacy. In the context of an HIV epidemic and high levels of sexual exploitation, this programme serves as a base from which to refer girls for voluntary testing and counselling, emergency contraception, and post-rape intervention (*Erulkar et al.* 2008).
Part of the work of supporting social networks is to increase girls’ prospects of encountering role models, or being mentored. Even in the poorest communities, there are some older girls who are secondary school graduates, and many will not be employed. They constitute a huge potential resource. Experiences across a range of adolescent girls’ programmes show that it is not difficult to recruit female mentors from the community who have some level of literacy, or exceptional educational attainment. They are typically aged 17 to 30, and for support during the training phase and a small stipend, they are eager to build their own skills while serving as mentors and role models to girls in their community.

**Strengthening vulnerable girls in relation to marriage**

Wherever possible, child marriage should be prevented. Working effectively in communities with high levels of child marriage requires several interlinked actions. In the first instance, there must be substantial community engagement and a variety of layered tactics to encourage the delay of marriage until the age of 18 (the legally established age in most countries and that which is affirmed under the Convention on the Rights of the Child). The engagement typically includes promoting girls’ continuation of schooling, and communicating to girls and parents and community gatekeepers that marriage is not a sexual ‘safety zone’. Such programmes, depending on their setting, may need to draw attention to the special risks that forced marriage to older partners brings. As the transition to the commitment to later marriage takes place at the community level, there will remain high proportions of girls married young, and they and their partners must be provided with appropriate and realistic means to protect themselves – including the encouragement of voluntary testing and counseling (important for more equal and open partner communication) and appropriate measures to prevent the transmission of HIV from mother to child.

Newly married girls are disproportionately likely to be unschooled, and therefore benefit from ‘catch-up’ schooling initiatives and meeting venues in which they can receive functional literacy, life skills, livelihood training, effective support for a safe pregnancy and birth processes (the interval between marriage and first birth is actually declining in many places), and crucial access to HIV testing, services, and treatment.

In rural Nyanza province of Western Kenya, rates of HIV infection are extremely high – particularly among adolescent girls and young women, where one quarter of young women aged 20 to 24 are HIV-positive, compared to 6 per cent of young men the same age (a female to male ratio of about 4:1). Further, there is mounting evidence that girls who are married are much more likely to be HIV-infected compared with their unmarried counterparts who are sexually active. Based on their research among married girls and their families, Population Council and partners designed a programme aiming to delay marriage through conveying messages via drama troupes and radio spots in local languages. Premarital (and marital) voluntary counseling and testing is promoted to girls in the process of marriage, and to young couples and the
people in their families or societies who got them together, so that they know each other’s status before marriage. Married adolescent girls are gathered into groups, and local women leaders provide HIV and reproductive-health information and referrals. In addition, they provide awareness-raising about gender-based violence, and the need for couples to communicate (Erulkar and Bello 2007).

In remote and nomadic areas of Burkina Faso, to reach married girls in extremely isolated circumstances, a programme was built around a cadre of mères-éducatrices (mother-educators). After the initial visits by these mères-éducatrices, and some rapport-building, the married girls were permitted by their husbands to leave their homes to meet with their peers for a weekly educational session. This space has evolved into a club and an informal school for married adolescent girls, as well as a vital health platform through which to offer Vitamin A, iron supplements, and information and support for access to health. (Girls were escorted sometimes in groups for prenatal visits and educational sessions at local clinics.) (Brady et al. 2007).

In northern Nigeria, which has a high prevalence of child marriage, the Population Council and partners have organised 24 clubs comprised of married and unmarried adolescent girls aged 10 to 24. The clubs meet on a monthly basis, and the girls are exposed to 14 modules, including life skills, health, social support, legal literacy, and financial literacy – led by trained peer mentors. The programme is reinforced by social peers, and lay religious leaders who advocate religious support for delaying marriage. The content is harmonised with local religious beliefs, and has the support of religious leaders (both Muslim and Christian). A clear connection is made between the risks of early marriage, maternal mortality, and exposure to HIV, and the activities of the groups are supplemented by community awareness campaigns and small group discussions (Erulkar and Bello 2007).

Finally, catch-up child-health initiatives are another important way of targeting girls made vulnerable by early sexual activity. These initiatives usually target girls aged up to 15, and employ house-to-house visiting and community-level campaigns. These are particularly important in locations where there are high numbers of vulnerable girls migrating for work – both ‘sending’ and ‘receiving’ areas. It can be practical and cost-effective to identify girls who are likely to be particularly vulnerable to HIV infection (those out of school, in unsafe work, those who are to marry, or who are already married) in the course of such contacts. In urban areas, it may be feasible to establish health posts or rescue centres at in-migration transit points (bus stations), where vulnerable girls arrive and their adult predators congregate.

Livelihoods activities and financial knowledge for vulnerable girls

Livelihood activities that claim to reach youth have largely bypassed younger, unmarried, rural, indigenous, and poor girls (Hallman et al. 2007a). These girls are enormously interested in developing livelihood skills, and express interest in group affiliation, savings, and financial literacy targeted to their age, gender, and context.
Safe spaces created for girls and young women can be the basis of savings clubs and ideal vehicles for the delivery of health information, providing a needed bridge to voluntary testing, counselling, and other services.

One intervention in KwaZulu-Natal, South Africa featured three main components – the provision of safe spaces, financial education, and HIV and AIDS education. The programme has been piloted and is now accredited by the South African Qualifications Authority, the government body responsible for accrediting all education and training curricula. The pilot results indicated that girls who were saving and considering their future finances were more likely to assess their HIV risk realistically, to be knowledgeable about HIV, and to adopt modes of behaviour which would prevent HIV (Hallman et al. 2007a). Participants were more likely, compared to non-participants, both to talk about financial matters, and to act on what they had learned, by taking actions such as starting to save money (Hallman et al. 2007b). Seventy-five per cent of participants had discussed financial decision-making, compared with 21 per cent of non-participants (up from 27 per cent and 6 per cent, respectively, at baseline); and girls in the intervention group saved 50 per cent more money from the start of the project, compared to almost no change among the control group (ibid.).

In Kibera, Kenya, the ‘Tap and Reposition Youth Programme’ (a partnership between the Population Council and the Kenya Rural Enterprise Programme) was an experimental development programme, running over several years. It provided social support, savings and credit opportunities, and mentoring (over the course of different experiments), with the aim of building up girls’ health as well as economic resources. By the end of the programme, participants had doubled their savings, and the amount of savings that they had was significantly larger than a control group of non-participants (Erulkar and Chong 2005). Girls who had participated were also nearly three times more likely to be able to insist on condom use, and 1.7 times more likely to refuse sex. While the programme has passed through a cycle of experiment and assessment, it has evolved a package of social support and age, gender, and lifecycle-tailored financial literacy services. In the second phase, the programme is expanding spaces in which girls can congregate, using them as venues for the delivery of life skills, health information, financial literacy, and specially developed savings products tailored to the needs of vulnerable subsets of girls (Austrian 2008).

Conclusion

The policy analyses and programme experiences presented in this article add up to a central message. It is vital and possible to address girls’ social, economic, and health vulnerabilities, and build up their protective assets. Without such measures, a substantial proportion of vulnerable girls will be ‘left behind’, and as a result will carry a rising and disproportionate share of HIV infection in decades to come.
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Notes

1 For example, African-American adolescent girls in the southern states of the USA have the highest prevalence, 6.4 per 1000, relative to adolescents from other geographic regions and relative to white, Hispanic, and African-American male peers (Diclemente et al. 2004).

2 The National Surveys of Adolescence conducted by the Guttmacher Institute and country partners in Burkina Faso, Malawi, Uganda, and Ghana revealed data on density of friendship networks, showing that across all groups (rural/urban, schooling achievement), boys have more close friends on average than girls (A. Biddlecom (2008) correspondence with researcher). For a fuller discussion, see also Hallman 2004 (South Africa); Erulkar et al. 2004a; 2004b (Ethiopia); Amin et al. 2002 (Bangladesh); Haberland et al. 2003 (India); UNICEF and Population Council 2002; and Alexander et al. 2006.

3 The Demographic and Health Surveys (DHS) are nationally representative household surveys that provide data for a broad set of analytical exercises in order to advance understanding of trends in the areas of population, health, and nutrition in developing countries. They are conducted by ORC Macro – in partnership with a number of
institutions – and are funded by USAID. Currently, there are over 200 surveys from 75 countries dating from 1985 to 2007 from all geographic regions.


5 For a fuller discussion, see Population Council’s Adolescent Girls Livelihoods Meeting Report 2004.

6 For a fuller discussion, see also Demographic and Health Survey of Burkina Faso 1999; Lloyd 2005; and Population Council 2006.

7 Illustrative programme experiences include: Brady et al. 2007; Erulkar et al. 2006; 2008; Erulkar and Mekbib 2007b; Hallman and Roca 2007; Austrian 2008.

8 These findings are from small sample sizes and so should be viewed cautiously.

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