

AIDSTAR-One SPOTLIGHT ON GENDER

Evidence-Based Approaches to Protecting Adolescent Girls at Risk of HIV

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Despite decades of investment in HIV prevention, a large and vulnerable population—that of adolescent girls—remains invisible, underserved, and at disproportionate risk of HIV. When the HIV epidemic was first recognized in the early 1980s, prevention messages reflected the context of the same-sex male relations in which the epidemic was first identified. As it became clear that the epidemic also included a large heterosexual component, messages expanded to promote negotiation and responsibility within presumptively voluntary partnerships. However, recommended protection measures assumed relative equality between girls and women and their sexual partners: presuming, for example, that girls and women possessed the ability to avoid pregnancy or choose abstinence, the agency to select a safe partner, and the power to use condoms consistently. In fact, these protection strategies were not feasible and some, such as avoiding pregnancy in child marriage, were virtually unachievable for the vast majority of sexually active adolescent girls.

Given the changing shape of the epidemic and the leveling off or shrinking of resources, there is an urgent need to rebalance HIV investments between treatment and prevention and to develop evidence-based approaches for protecting the large and vulnerable populations of adolescent girls who remain at risk of HIV. Failure to do so already has had, and will continue to have, serious and long-term consequences.

How Girls Got Left Behind

When the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was established in 2003, the ratio of female-to-male HIV infections among young people was already high. In 1997, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported that in sub-Saharan Africa about 60 percent of new HIV infections were among young people aged 15 to 24, and that girls and women living with HIV outnumbered male peers 2:1. By 2009, girls represented 74 percent of new infections among younger populations, and the ratio of infected young females to young males in highly affected countries was 3:1. In a few settings, the ratio appeared to be rising beyond this (Shisana et al. 2005). In global terms, UNAIDS reports that in 2010, 26 percent of new HIV infections occurred in girls aged 15 to 24, and that the number of girls aged 10 to 14 living with HIV had increased six-fold since 1999, reaching 300,000 in 2010 (UNAIDS 2011). Despite the increasingly lopsided ratio between female and male infections in young populations, policymakers have persistently failed to engage directly with girls, too often submerging girls' needs within generalized health sector activities, male-focused and male-dominated community-based activities, and generic "youth" prevention initiatives, all of which widely miss the mark.

Expansion of HIV funding in the early twenty-first century led to increased prevention, mitigation, and

treatment action, particularly operating through the health sector, but only to those girls and women who were already inside the health system. These strategies typically exclude girls on the brink of sexual activity, girls whose first sexual encounter was coerced, girls who engage in occasional poverty-driven exchanges of sex for gifts or money, and girls who have never been pregnant or had primary responsibility for a child. The number of at-risk, socially disconnected girls is large. In Mozambique, there are about 400,000 girls aged 10 to 14 years who live apart from parents and are not in school (Population Council 2009d). In the Amhara district in Ethiopia, over 40 percent of young females now aged 20 to 24 were married before the age of 15 (Population Council 2009b).

Youth programming, a primary vehicle for prevention messaging, disproportionately benefits older young people (over age 20), males over females, urban over rural, native over migrant, unmarried over married, and well-connected over socially disconnected. In many cases, youth programs create new structures of exclusion. Girls' attendance at youth programs can be stigmatizing, even dangerous, and there is rarely a female mentor available to whom they can relate. Where comparable numbers of females and males partake in youth-oriented programming, they are typically receiving aftercare for an unfavorable outcome (such as an unplanned pregnancy or forced sex) rather than receiving assistance to enhance their health, social, or economic assets (Bruce and Chong 2006; Hallman 2011; Liberia Institute of Statistics and Geo-Information Services 2009; Lloyd 2005; Macro International 2011; Mekbib, Erulkar, and Belete 2005; Population Council 2006, 2009c; United Nations Department of Economic and

Social Affairs, Population Division 2009; Weiner 2010). Programs can be created that have safe single-sex spaces for both boys and girls and also incorporate constructive ways to facilitate interaction between the two. These programs, however, have to be designed thoughtfully and purposefully, keeping girls' needs at the forefront.

Finally, girls are left behind because the measures of program success are simplistically designed to track the avoidance of bad outcomes (i.e., HIV infections and pregnancies). Defining positive, widely achievable, measurable benchmarks of success provides a far more positive vision against which to allocate resources and to indicate the progress of individual programs. Constructive benchmarks to gauge success might include the acquisition of protective assets, such as specific and realistic safety plans, social support, skills for claiming rights, schooling, and the control of financial resources.

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The error of not directly investing in girls can be illustrated by observing fields closely aligned to HIV prevention, such as the prevention of gender-based violence. Despite the conventional wisdom that programs should focus on both prevention of and responses to gender-based violence, in fact current practice prioritizes investments in “duty-bearers”—police, lawyers, judges, health care workers, teachers—over investments in building the protective assets of girls themselves. (Bruce 2012; Bruce et al. 2011)

Priorities for Now: Getting Resources to Girls

To address the inequities that shape girls' disproportionate HIV risk, advocates must articulate a positive vision that realigns both allocation of resources and

measurement of results. Here we outline a stepwise engagement process for improving girls' lives and reducing their HIV risk.

Use available data to identify geographic concentrations of girls at exceptional risk.

Communities with large proportions of adolescent girls at high risk of exploitation, human rights abuses, and poor outcomes, including HIV infection, can readily be identified with existing data. In many settings, highly risky conditions—such as being in a child marriage, living apart from parents, and not being enrolled in school between ages 10 to 14 years—correspond closely to HIV prevalence and high female-to-male infection ratios.

Intensifying investments in girls to prevent these and other conditions that are direct social precursors of HIV may be a strategic middle path between a narrow emphasis on reaching conventionally defined “high-risk” or “core transmitter” groups and more general socioeconomic empowerment strategies for poor girls and women (Bruce 2007b; Bruce et al. 2006).

Specific indicators that provide guidance on which girls are at risk, and where, are available for 50 countries, largely drawing on census and Demographic and Health Survey data. The multi-country presentation of these indicators, titled *The Adolescent Experience In-Depth* (Population Council 2009a), includes age-disaggregated data, providing insight as to the timing at which interventions must take place to prevent bad and sometimes irreversible outcomes (Chong, Hallman, and Brady 2006).

Develop the social infrastructure for adolescent girls—a protective asset in and of itself and a vital program platform.

Creating dedicated social spaces for girls is a key strategy for changing girls' self-concepts and is a proven approach for transforming the very circumstances that put them at risk of acquiring HIV. These

spaces—which can be established inexpensively at existing community facilities like schools (after hours) and community centers—function as platforms for the delivery of new skills, increased social support, and greater opportunities for girls (Austrian and Ghati 2010; Bruce 2007a; Bruce and Hallman 2008). Vulnerable girls and young women gather regularly at these spaces to meet peers, consult with mentors, and acquire skills to help them headoff or mitigate crises (e.g., threats of marriage, leaving school, or forced sex). In generalized HIV epidemics, community-based girl-only spaces can assist girls in:

- Planning for seasonal stresses, like school fees and food shortages, which often increase pressure to exchange sex for gifts or money
- Accessing entitlements, including HIV-related ones such as social grants for HIV-affected households
- Dealing with prolonged illness, death, inheritance, and succession planning
- Accessing voluntary counseling and testing for HIV or antiretroviral therapy directly or on referral.

Reframe current investments to respond to girls' needs and engage their talents.

In recent years, some programs have blossomed—both piloted and at scale—that aim to redirect critical investments productively and promote the essential elements that girls need to thrive and grow. The following examples have direct relevance for making HIV prevention programming more feasible and effective.

- *Provide programs for girls in unsafe and underage work:* In Ethiopia, Biruh Tesfa,¹ funded in part by PEPFAR, provides domestic workers, orphans,

¹ A collaboration among the Population Council, the Addis Ababa Youth and Sport Commission, and the Ministry of Youth and Sport, supported by PEPFAR through the U.S. Agency for International Development (USAID), George and Patricia Ann Fisher Family Foundation, Nike Foundation, the Turner Foundation, United Nations Foundation, and United Nations Population Fund.

and migrants with HIV information and life skills in response to the high female-to-male HIV infection ratio among younger urban populations. Biruh Tesfa (“Bright Future”) offers girls regular meetings with female peers and mentors, basic financial literacy, valid identification cards, and a wellness checkup. A recent evaluation showed significant benefits for participants: girls involved in the project were more likely to have accurate knowledge about HIV, were more likely to know where to go for voluntary counseling and testing, were more likely to want to get tested for HIV, and were twice as likely to have social support and safety nets as girls in a control site (Erulkar, Semunegus, and Mekonnen 2011).

- *Eliminate child marriage:* Married girls form the vast majority of sexually active adolescent girls in many countries with generalized HIV epidemics, and yet adolescent reproductive health programs have largely neglected them. In Amhara, Ethiopia, Berhane Hewan² (“Light for Eve”) and PEPFAR-supported Meserete Hiwot³ (“Base of Life”) are located in a child marriage hotspot. Berhane Hewan provides incentives for girls’ school attendance and creates non-formal girls’ clubs that have had a measureable impact. An assessment showed that girls between the ages of 10 and 14 were significantly less likely to be married in the project area (2 percent) compared with girls in the control area (22 percent). This trend seems to reflect a delay in the age of marriage into later adolescence: fewer girls were married before age 15 and more girls were married between ages 16 and 19. Married girls’ clubs (in both Berhane Hewan and Meserete Hiwot) provide regular mentoring and peer support groups to married girls, including reproductive health information with an emphasis on safe maternity and contraception. In some Berhane

Hewan sites, 74 percent of married girls were using contraception—a significant finding. This program has successfully delayed marriage among 10- to 14-year-old girls and encouraged HIV testing for married girls and their partners (Erulkar and Muthengi 2008; Santhya and Erulkar 2011).

- *Make schools safer for girls:* In Zambia, Girl Spaces in School: Our Girls, Our Future⁴ is creating mentor-led girls’ groups in schools. Responding to the results of a study on girls’ protection strategies, which revealed that one-third of girls reported that they knew girls who had been sexually harassed by a teacher and half knew girls who were exploited by a family member (Simbaya and Brady 2009), the program provides weekly sessions that explore HIV, reproductive health, and sexual safety, and develop specific safety strategies.
- *Reach girls in the critical puberty period with community-based health initiatives:* In Rwanda’s pilot 12-Plus program,⁵ 12-year-old girls are grouped in small teams with mentors who provide interactive sessions on health, social issues, and finances, leading the girls on a year-long “health adventure.” This program offers girls a first-time visit to a health center as well as bimonthly meetings where they learn about their reproductive health and rights, malnutrition, prevention of HIV, infectious disease, and civic rights that allow them to access health services.
- *Dedicate sessions for girls in youth programming:* Liberia has convened an Adolescent Girls’ Working Group⁶ that is developing dedicated sessions for girls, including HIV information sessions, as part

² A collaboration by the Population Council, the United Nations Population Fund, and the Amhara Regional Bureau of Youth and Sports, supported by the Turner Foundation, UK Department for International Development, United Nations Children’s Fund, and United Nations Population Fund.

³ A collaboration by the Population Council and the Amhara Regional Bureau of Youth and Sports.

⁴ A network consisting of Zambian nongovernmental organizations, the Population Council, and the Adolescent Girls’ Legal Defense Fund of Equality Now, supported by the United Nations Trust Fund to End Violence Against Women through Equality Now.

⁵ A collaboration between the government of Rwanda and Rwanda Girl Hub, supported by the Nike Foundation and the UK Department of International Development with technical support from the Population Council.

⁶ Created under the auspices of the Ministry of Youth and Ministry of Gender, supported by the United Nations Population Fund and United Nations Foundation.

of the post-conflict redevelopment of the youth service network.

- *Increase access to services and opportunities through financial, social safety net, and health skills education:* In Durban, South Africa, the Siyakha Nentsha (“Building with Young People”) randomized intervention⁷ delivered financial, social, and health skills to female and male secondary school students. The intervention was gender-sensitive in its design, recognizing the distinctive needs and likely differential responses of girls and boys. Relative to the control group, intervention girls were more likely to have a savings plan, obtain an official birth certificate, feel higher self-esteem, have more confidence in their ability to obtain a condom, and report greater levels of social inclusion in their community. Boys in the intervention group were more likely than boys in the control group to report remaining sexually abstinent between survey rounds, and boys in the intervention group who had sex reported having fewer sexual partners than boys in the control group (Hallman and Roca 2011).

What Success Looks Like

Programs should define and measure the skills, safety strategies, and assets that girls need to prevent and mitigate the risk of HIV. Community-based platforms that provide safe spaces for girls (see box) are a core program strategy that allows girls to develop these key skills, safety strategies, and assets. Girls eagerly participate in interactive processes that allow them to identify operational safety nets, such as having a trustworthy person to borrow money from and a secure place to spend the night in an emergency. Because HIV risk so often occurs in the context of economic vulnerability, programs should help girls to see themselves as economic actors and prepare them to pursue decent and safe livelihoods. In challenging high HIV prevalence settings, girls can ob-

⁷ A collaboration among the KwaZulu-Natal Department of Education, the Isihlangu Health and Development Agency, and the Population Council, supported by the Economic and Social Research Council, the William and Flora Hewlett Foundation, and the UK Department for International Development.

“Must Haves” that Safe Spaces can Offer Girls

- **A safe, reliably available space apart from home and formal schooling**
- **Friends: a dense network of non-family peers**
- **Mentors and role models to learn from and intercede on girls’ behalf**
- **Experience in being part of a team/ cooperating and leading**
- **Skills and knowledge to access services and exercise health, social, and economic rights**
- **Age-graded financial literacy and savings**
- **Documentation for health, work, and citizenship**
- **Self-protection plans**
- **Specific knowledge of community resources to manage and mitigate crises (forced marriage, pregnancy, rape, violence)**
- **Participation and activity with peers to develop agency and voice.**

tain valid identification cards, become financially literate, create incubator savings, learn about social grants and services—including available HIV services—and develop the skills to access them. Finally, data on girls’ risk must guide program resource allocation decisions, and programs must be evaluated based on their ability to build girls’ knowledge and assets. Introduction of indicators to track these outcomes will increase program planners’ consciousness and direct programmatic experience of the value of investing directly in girls.

The battle against HIV is a battle for people, but girls have never truly been included in the struggle. Girls’ voices must be added to the voices of the millions who have been affected by the HIV epidemic—and they must be heard. By centering our efforts to

prevent the epidemic on “the least of them,” we will get to the rest of them. ■

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