EGM/DVGC/2006/EP.11

United Nations
Division for the Advancement of Women (DAW)
in collaboration with UNICEF
Expert Group Meeting
Elimination of all forms of discrimination and violence against the girl child
UNICEF Innocenti Research Centre
Florence, Italy, 25-28 September 2006

A note on the social and economic development and reproductive health of vulnerable adolescent girls

Prepared by *

Judith Bruce

* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations.

I. Introduction and policy context

This present note offers a précis of four papers developed by Population Council staff, based on the adolescent girls' program (a partnership between the Council and NGOS and governments in developing countries):

> *"The Girls Left Behind: The Failed Reach of Current Schooling, Child Health, and Youth-serving Livelihoods Programs for Girls Living in the Path of HIV" Synthesis paper, edited by Judith Bruce and Amy Joyce, Population Council 2006. All Rights Reserved. Copyright © 2006.*
>
> *"The Girls Left Behind: The Failed Reach of Current Schooling, Child Health, and Youth-serving Livelihoods Programs for Girls Living in the Path of HIV" Executive Summary, prepared by Judith Bruce, Population Council 2006. All Rights Reserved. Copyright © 2006.*
>
> *Bruce, Judith and Erica Chong. "The diverse universe of adolescents, and the girls and boys left behind: A note on research, program and policy priorities," background paper to the report Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. New York: UN Millennium Project. 2006.*
>
> *"Reaching MDGs (marginalized, disadvantaged girls) to Achieve the MDGs" (sub-zero draft guidance document), prepared by Judith Bruce, June 23, 2006.*

This note summarizes key points of special relevance to this meeting. When citing this paper, please carefully also cite the papers from which much of the information and the original text was drawn, as noted.

Two decades into adolescent and youth development policies and three decades into the HIV/AIDS epidemic—increasingly selective of girls and young women—conventionally configured reproductive health, including HIV-prevention, programs largely fail to reach the most vulnerable adolescent girls.

Marginalized, disadvantaged girls are a very large population in the developing world,[1] and reaching them is essential development and social justice strategy, and **critical** for the **achievement** of the **Millennium Development Goals**.

The 'first criterion' defining the 'marginalized' is that they are not reached by conventionally defined services, benefits, or entitlements. Indeed, even as society extends programs for 'disadvantaged' children and adolescents, the resources are not effectively reaching marginalized girls; "more of same," such as the doubling of existing efforts or resources will not proportionately increase their effective access.

Not only are marginalized, disadvantaged girls largely excluded by current strategies, **some elements** of existing strategies **may actually increase their exclusion.** Thus the gap between their ability to achieve their rights and access entitlements relative to other groups may actually be declining—**c0.31959cess.**

case of males, many are considered candidates for (if not already participants in) military or national service.

Many current strategies group adolescent girls together with adolescent boys and young men and women in one large group variably called "youth," "teenagers," "young people," and "adolescents," but **girls and young women from very different social contexts are similarly homogenized.**

Disproportionate attention to better-off adolescents and misplaced assumptions about agency

Adolescent reproductive health and HIV-protection strategies and methods have grown[3] up in the context of significant cultural and geographic diversity, but many programs are **still confined by Western or middle-class expectations** insofar as 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 safely through school, in transit to decent work, and soon to enter into the 'protection' of marriage. However, in many developing country contexts for a substantial proportion of girls and young women, and in the poorest districts of large cities and rural areas for the great majority, these optimistic scenarios do not apply.

Hundreds of millions of girls and young women living in the path of HIV have had no or limited benefit from schooling, feel unsafe in their communities, face a significant risk of sexual coercion (typically in poor urban enclaves in sub-Saharan Africa about two-thirds of the girls will report their first sexual experience as forced or "tricked")[4] and—having few or no assets or livelihood prospects—have been compelled to exchange sex (inside and outside of marriage) for money, gifts, food, and shelter. Girls married as children, particularly without their consent and abruptly, often to older men, cannot be accurately portrayed as having voluntary sexual activity; even by their own report married girls as old as 16 may report sexual relations and forced.

Though much of the adolescent reproductive health debate has centered around those proponents of abstinence and, at the other extreme, sexual pleasure, the girls with whom we are concerned do not have sufficient agency to pursue their choice. Indeed, their "choices" rest somewhere in between, having limited decisionmaking power and few opportunities to control or benefit themselves from their labor, sexuality, and fertility. Reproductive health policy must be more realistically targeted to the structural dimensions of girls' sexual engagement—their inability to make free choices, whether it be about marriage or liaisons, their limited social and economic assets, and their narrowly scripted and confined role in society. Thus, **the reproductive health needs of these**

[3] This section was closely adapted from *The Girls Left Behind:r1pleic s 0(ited sc73F5B01 Tf:)5)-1.1.15TDSls wiTf:3(d'.8(selvef:)6f1*

girls includes, but is certainly not limited to, information about their bodies and access to services, but must develop realistic strategies that build their protective assets to assist them in avoiding, mitigating, or leaving unsafe sexual relationships (inside or outside of marriage).

II. Large, vulnerable, unprotected populations[5]

Other writings referred to here give much expanded information on all the four populations of girls mentioned at the beginning of this note. This present discussion excerpts material focusing on girls 10 to 14 living outside the protective structures of family and school, and married girls.

Demographic and Health Survey data reveal that a striking proportion of urban girls in sub-Saharan African countries with mature HIV epidemics—indeed the majority (except for Nigeria)—are not living in two-parent households, and that surprisingly high proportions of girls are not living with either parent (typically, from 3% up to 23% of girls 10-14 who are either living with one parent or none).

When these data on young adolescents' parental residence are cross-referenced with data on schooling status, a core of potentially very vulnerable girls is revealed who lack both presumptively protective factors (Table 2). In some countries, ten percent of young girls or more are living with neither parent and are not in school. We must learn more about the social composition and diversity of girls living apart from parents—particularly those who are not in school—and the family, community, and other factors that have shaped their living arrangements.

A study of the conditions in two lower-income neighborhoods in Addis Ababa (one of them centred around the main bus station) painted a stark picture of their conditions and allowed a view into young peoples' internal diversity (Table 2). Girls were greatly disadvantaged in comparison to boys and migrant girls—many of them in domestic service—were in the most extreme circumstances. Boys' social assets are substantially more robust than girls; **boys are more than three times more likely than**

[5] Bruce, Judith, and Amy Joyce. "Envisioning vulnerable girls and young women: Numbers, transitions and social context," chapter 2, *The Girls Left Behind: The Failed Reach of Current Schooling, Child*

girls (in both urban and rural settings) to report that they had a place other than home or school in which to meet same-sex friends (47% for boys as opposed to 13% for girls in urban settings).

The educational levels of the girls, the proportion of working girls living apart from parents, and the friendship networks of girls contrast dramatically with the boys; in all these respects migrant girls in domestic service are at extreme disadvantage. The girls also reported high levels of harassment (some reported rape) on the street and as telling, a lack of any public response. So **limited is their social capital that their window of safety on a daily basis could be measured in hours**, with most having no place to spend the night or borrow money in an emergency; the qualitative description of working conditions of those in domestic service reveal work conditions and compensation closely

and also make them prostitutes and use them as their means of income. All this terrifies me." (Erulkar et al., 2004, p. 16)

Girls (10-18) at risk of child marriage in highly affected districts[6]

While the proportion of girls who marry as ch

Although there is little evidence that large numbers of girls are withdrawn directly from school to get married, investments in girls' schooling are among the most powerful ways to address the conditions of poverty and gender norms that drive the marriage timing decision.[8] An emerging body of evidence is confirming that **school enrollment is an important determinant of girls' health and well-being**: globally**, 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 (NRC and IOM, 2005). Thus it is essential both to get girls to primary school on time and to keep them there for the duration, assuring a timely progression to secondary school.

Table 5. In most sub-Saharan Africa countries with mature HIV epidemics the vast majority of unprotected sexual activity among sexually active adolescent girls took place within the context of marriage

Country	Percentage married among sexually active girls	Percentage married among girls who had unprotected sex last week
Ethiopia	94	98
Haiti	52	83
Kenya	36	72
Mozambique	67	82
Nigeria	61	89
Rwanda	51	97
South Africa	7	13
Tanzania	50	77
Uganda	80	96
Zambia	44	82

Source: Bruce and Clark, 2003.

Married adolescent girls are the majority of sexually active girls 15-19 in the developing world—including many of the countries with mature HIV epidemics. Demographic and Health Survey data indicate that about 38 percent of young women aged 20-24 (52 million) in less developed countries were married before age 18 (Mensch, Singh, and Casterline, 2005). Married girls are often subject to high levels of unprotected sexual relations. Indeed, in many settings with mature HIV epidemics, **the great majority of adolescent girls' unprotected sexual relations takes place within the context of marriage** (Table 5) (Bruce and Clark, 2003; Clark, 2004; and Clark, Bruce, and Dude, 2006). Married girls typically have large age gaps with their marital partners, are under intense pressure to become pregnant, are typified by low educational attainment, face highly limited or even absent peer networks, experience restricted social mobility and freedom of movement, and have little access to schooling options or modern media (TV, radio, and newspapers) (Haberland, Chong, and Bracken, 2003).

Conventional HIV prevention measures are in the main either impossible (given the nature of marriage) or extremely difficult to implement given the low power and relative immaturity of married girls. **Married girls cannot abstain, reduce sexual**

[8] For a fuller discussion see Mensch, Singh, and Casterline, 2005. They examined changes in the age of marriage as a function of the change in educational attainment, and found that for 15 countries, the decline in early marriage between cohorts (20–24-year-olds and 40–44-year-olds) is less than would be expected given the increase in schooling.

frequency, or change partners (to safer partners); they have great difficulty negotiating condom use, insisting on voluntary testing and counseling and mutual disclosure of results, and have little control over their spouse's extramarital sexual activities. Married girls, even those who do not desire pregnancy, 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, Bruce, and Dude 2006).

III. Puberty: a critical moment when, for many girls, vulnerability is consolidated[9]

As more is understood about adolescent psychological and physical development,

removed. **Twelve may be the last moment at which one can still reach the most vulnerable girls in many communities befo**

woman." Indeed, many studies of young women who are engaged in wage labor note their desire to garb themselves in a modern way, to move with confidence, and to take on a new, more global identity (Amin et al., 1998).

It is consequential for the HIV epidemic that, for many girls, sexual maturity coincides with declines in social networks, family support, and confidence and sense of agency. A poor girl without social capital or economic assets is at risk of being pressured

Adolescent girls need substantial **new decision-making power**, **safe spaces and peers, mentors** and resources to find alternatives to and resist pressures for school-leaving, for illegal or unsafe work, substance abuse, early marriage, exchanges of sex for gifts or money, and unsafe sexual relations inside or outside of marriage.

Because the rising cohorts of young people in the developing world are the largest in history (and will be for another 25 years to come) **experimentation must be of substantial scale**, **build practically on existing initiatives**, and operate mindful of the current sectoral approach of most governments and indeed, many of the large nongovernmental organizations. This note, with appropriate modesty, seeks to suggest some of the ways in which we can better connect existing structures with disadvantaged adolescents.

1. **Safe schooling of adequate quality remains the overarching priority both because it provides a significant social and economic asset in and of itself, and because it supports girls' negotiating position as they seek to deflect family, male, and community pressures for premature, uninformed, forced, and unsafe sexual relationships—including child marriage.** We must fully explore what can be done to expand benefits under existing schooling entitlements, and make fuller use of existing school personnel and facilities—to provide age- and gender-safe and supportive spaces within the schooling experience which offer social connection, learning skills, and support for both health promotion and building active citizenship.

We need specific strategies to pick up poorer, younger, and rural adolescents and girl children who might otherwise be left behind. **Critical analyses should be conducted within each context to reveal the most likely moments when boys and girls drop out of school** (such as the Mayan girls in Guatemala example, given above), when interventions can target age and gender groups to encourage a continuity of schooling from primary to secondary. Much more needs to be done to **get boys and girls to school on time**, reduce grade repetition, **keep them there through secondary schooling, and guarantee universal access by removing user fees**. For adolescents who have either never been in school or are currently out of school, informal schooling and one room options might be beneficially directed to their needs and have been successful in large scale programs—such as through BRAC in Bangladesh.

2. **Youth centers continue to receive heavy investment** (by the international community and national governments) and offer a network of standing facilities often under official auspices. These centers could be

Box A. The *Ishraq* program: Spaces to play, grow and learn

In four villages in traditional Minya governorate of Upper Egypt, Save the Children and the Population Council joined forces with CEDPA, Caritas, and the Egyptian Ministries of Youth and Sports, and Education to create an innovative two and a half year program for out of school girls aged 13-15. Using youth centers and local schools, girls meet four times a week for three hours a day for a program of literacy, life skills, and sports. Girls learn to read and write, make educational visits to neighboring villages, learn about their rights, develop confidence and ownership over their bodies, and begin to envision new roles for themselves in Egyptian society. With strong support of parents and community leaders (indicated by the waiting lists for girls wanted to participate), *Ishraq* has been sufficiently successful in improving girls capabilities and opportunities, leading to plans for expanding the program to 120 villages across three of the most conservative Upper Egyptian governorates.

Prepared by Martha Brady, for more information see http://www.popcouncil.org/me/ishraq.html.

3. The **revivified interest in childhood immunization** provides a potential avenue of effective contact, as there is an overlap between the oldest ages of many new child health initiatives, picking up those who never received or are lacking final immunizations, and the youngest adolescents (10-14). To the extent that such programs are **creating new social and health platforms, some of these might be permanentized as a way of serving isolated, poorer, at risk 10- 14-year-olds**. As the AIDS epidemic penetrates to younger and younger ages, there needs to be more consistent thought given to linking child health initiatives with adolescent policy. This may be particularly urgent when seeking to protect adolescent girls, plausibly triply affected as older siblings involved in care and support in AIDS affected families, as orphans, and as individuals subject to sexual coercion and exchanges of sex for gifts or money. [12]

4. To stem the tide of new infections in girls and young women, we must field new initiatives which **build up the social, economic, and health assets of vulnerable girls and young women in specific communities with severe HIV epidemics**; existing programs will require significant reorientation to create safe and supportive spaces for marginal girls and young women, significant protective assets in and of themselves and a potential bridge to services.

Given what we know about girls' limited security and high levels of sexual harassment and coerced sex in their environments, **the importance of 'girl-friendly' community based facilities is crucial as the radius of safety and practical mobility** for the most vulnerable girls—married and unmarried—**is highly limited.**

partner with whom to forge a moral commitment to act on behalf of the most marginalized girls. **These girls** in desperate circumstances, such as those living apart from parents, out of school and often in exploitive domestic service, and married girls, **need advocates** on their behalf.

5. Given the special vulnerability of **migrant adolescents**, particularly those between 10 and 14, much more attention must be paid to **learning about and addressing the specific vulnerabilities that propel them (the push factors in their environment) and those that confront them (in the receiving points)**. In sub-Saharan Africa, parts of Latin America, and Asia there are large concentrations of young girls in domestic service in urban areas, a high proportion of whom are in-migrants. Migrant girls in most settings have markedly poorer social indicators than native born and their moments of transit may bring special risks. It may be feasible **to establish social support, rescue, and health stations where vulnerable girls transit or congregate**, such as migration collection points in poor urban areas.

6. In most settings (including those with high levels of girls' school leaving, child marriage, and HIV), there are available but **underutilized cadres of females** (**teachers and female health agents**) and **a few outstanding programs** on which we can build. Existing cadres of females **should be given more support and training and perhaps some very limited resources (micro-grants)**, and encouraged to establish **girl-centered programs in the communities in which they live and serve**. which have learned a substantial amount about how best to reach girls and women. NGOS should be provided with technical support and small grants to expand upon what they have learned about serving vulnerable girls, and extending the reach of the young women (**female peer educators, promoters, mentors**) whose energies (and precious local knowledge, language ability, and sense of culture) could be engaged to conduct assessments and devise plans, and **function as change agents** within their own communities.[13]

7. Maternal and child health/safe motherhood initiatives are well accepted, and these too might be **refocused to reach out more purposely to the newly married, and the youngest and first-time parents.** Combined social and health promotion activities could effectively engage girls leading up to marriage, from marriage to pregnancy, and through the postpartum period; assist them in developing more equal communication with partners; and address the extreme social isolation and often poverty of married girls. Recent activities undertaken in Gujarat and West Bengal, India suggest that married girls—provided gatekeepers and family are included in dialogue—are able (and eager) to form regular meeting groups, and establish momentum in reaching out to successive waves of girls as they are engaged, married, pregnant, or parents for the first time (Box B).

[13] This section was closely adapted from "The Girls Left Behind: The Failed Reach of Current Schooling, Child Health, and Youth-serving Livelihoods Programs for Girls Living in the Path of HIV" Executive Summary, prepared by Judith Bruce, Population Council 2006.

Box B. Connecting young married girls in India

In India the Deepak Charitable Trust (in Vadodara, Gujarat) and the Child In Need Institute (in South 24 Pargana, West Bengal) with research support from the Population Council, have organized groups of married girls as a key component of the First Time Parents Project. Group formation addresses social vulnerabilities and isolation of married adolescent girls/first time mothers. The vast majority of these girls have never met their husband before they were married (69 percent in Vadodara, 80 percent in South 24 Pargana), and few had friends in their new home. Less than 2 percent were members of a group or club. Groups increase married girls' contact with peers and mentors, expose them to new ideas, and help engage them in a participatory learning approach covering subjects such as legal literacy, vocational skills, pregnancy and postpartum care, government schemes that women can access, public amenities, gender dynamics within and outside of the family, relationship issues, and nutrition. The project has been able to mobilize over 750 girls into dynamic groups of roughly 8 to 12 girls per group who work together on development projects, celebrate common festivals, and organize welcome ceremonies for newly married members.

8. New **livelihoods approaches**, including microfinance, have provided creative and practical solutions for poor women (and men) in some of the most densely populated countries in the world (India and Bangladesh). Yet, most of these successes have been among adult, married women, and although many of them are still young, they have numbers of children, or even completed family size. Much remains to be done to **adopt what has been learned from these initiatives** (the social support, peer-to-peer guarantees, and the slow but steady building of the asset base) to the life conditions of the **most socially isolated and economically disadvantaged adolescents.**

Box C. Adapting microfinance to reach girls at risk in Kenya

The K-Rep Development Agency and the Population Council have collaborated on the development of a livelihood program for adolescents including savings, credit, financial education and social support activities. The program design incorporates social mobilization and group lending strategies and adapts them to address the needs of socially and economically vulnerable girls aged 16-22. This program provides more intensive social support than what is offered in mainstream group lending programs, creating a cohesive group process and a reliable safe space. Another adaptation has been to include an option of voluntary savings for less experienced girls, who may or may not subsequently join the mainstream credit program. In the context of an HIV crisis in Kenya that increasingly is selective of young women, and in an atmosphere where forced sex, exchanges of sex for gifts and money are not uncommon, the project partners have been mindful to incorporate support within the program to assist girls in preventing, mitigating the effects of, or leaving unsafe sexual relationships.

9. **Finally, societies must make specific operational plans to build young people's stake in their societies and acknowledge their rights and citizenship**. Puberty is a moment that brings elevated risk to girls and boys alike of school-leaving, as well as moving out of the parental home for often unsafe and exploitative work, and in

the case of girls, premature marriage. Yet, most societies—particularly the poorest—make little official contact with the neediest young people between the completion of their immunizations (usually under the age of five) and the commencement of their military service (circa age 18 and applicable often only to boys). It would make strategic sense for governments to define a **sequence of check-ins** where nations reaffirm a direct relationship between society and the young individual – the issuing of a birth certificate, receipt of immunizations and the immunization record, formal registration for school at around age six, and, proposed here, **citizenship-oriented programs** around the time of puberty. Initiating such programs **around age**

References

Amin, Sajeda, Ian Diamond, Ruchira T. Naved, and Margaret Newby. 1998. "Transition to adulthood of female garment-factory workers in Bangladesh," *Studies in Family Planning* 29(2): 185–200.

Bruce, Judith. 2006. *Reaching MDGs (marginalized, disadvantaged girls) to Achieve the MDGs.* Sub-zero draft guidance document, June 23.

Bruce, Judith, and Erica Chong. 2006. *The diverse universe of adolescents, and the girls and boys left behind: A note on research, program and policy priorities.* Background paper to the report Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. New York: UN Millennium Project.

Bruce, Judith, and Shelley Clark. 2003. "Including married adolescents in adolescent reproductive health and HIV/AIDS policy," background paper presented at WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, Geneva, 9-12 December.

Bruce, Judith, and Amy Joyce, editors. 2006. *The Girls Left Behind: The Failed Reach of Current Schooling, Child Health, and Youth-serving Livelihoods Programs for Girls Living in the Path of HIV.* Synthesis paper and Executive Summary. New York: Population Council.

Clark, Shelley. 2004. "Early marriage and HIV risks in sub-Saharan Africa." *Studies in Family Planning* 35(3): 149-160.

Clark, Shelley, Judith Bruce, and Annie Dude. Forthcoming 2006. "Protecting girls from HIV/AIDS: The case against child and adolescent marriage."

Hallman, Kelly. 2005. "Gendered socioeconomic conditions and HIV risk behaviours among young people in South Africa," *African Journal of AIDS Research* 4(1): 37-50.

Hallman, Kelly. 2006. "HIV vulnerability of urban poor and non-enrolled girls in KwaZulu-Natal, South Africa." Powerpoint presentation at Population Council, New York.

Hallman, Kelly and Judith Diers. 2004. "Social Isolation and Economic Vulnerability: Adolescent HIV and Pregnancy Risk Factors in South Africa," presentation at the Annual Meeting of the Population Association of America, Boston, MA, April.

Hallman, Kelly, and Julitta Onabanjo. 2005. "Reducing Girls' HIV Risk Through Social Support and Livelihood Skills," presentation at the UN 49th Session of the Commission on the Status of Women, *What can you give a 12-year-old girl that no one can take away?*, 28 February.

Hallman, Kelly, Sara Peracca, Jennifer Catino, and Marta Julia Ruiz. Mimeo 2004. "Causes of low educational attainment and early transition to adulthood in Guatemala." Guatemala City: Population Council.

James-Traore, T.A. 2001. *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents.* FOCUS Tool Series 4.

Lloyd, Cynthia B., Cem Mete, and Zeba A. Sathar. 2005. "The effect of gender differences in primary school access, type, and quality on the decision to enroll in rural Pakistan," *Economic Development and Cultural Change* 53(3): 685-710.

Mensch, Barbara S., Susheela Singh, and John Casterline. 2005. "Trend a l a e