



Can economic assets increase girls' risk of sexual harassment? Evaluation results from a social, health and economic asset-building intervention for vulnerable adolescent girls in Uganda



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ABSTRACT

For adolescent girls in Sub-Saharan Africa, social isolation and economic vulnerability are critical problems that prevent a healthy transition from girlhood into womanhood. This study examines the effect of a multi-dimensional intervention on social, health and economic assets, as well as experiences of sexual harassment, among vulnerable adolescent girls aged 10–19 living in the low income areas of Kampala, Uganda. The study compares two treatment groups to a comparison group. The first treatment group received the full intervention – safe spaces group meetings with reproductive health and financial education plus savings accounts – while the second group only received a savings account. Findings indicate that the full intervention was associated with improvement in girls' health and economic assets. While girls who only had a savings account increased their economic assets, they were also more likely to have been sexually touched (OR = 3.146; $P < 0.01$) and harassed by men (OR = 1.962; $P < 0.05$). This suggests that economic asset building on its own, without the protection afforded by strengthening social assets, including social networks, as well as reproductive health knowledge, can leave vulnerable girls at increased risk of the sexual violence.

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1. Introduction

This study examines the effect of a multi-dimensional intervention on social, health and economic assets, as well as experiences of sexual harassment, among vulnerable adolescent girls aged 10–19 living in the low income areas of Kampala, Uganda. For adolescent girls in Sub-Saharan Africa, social isolation and economic vulnerability are critical problems that prevent a healthy transition from girlhood into womanhood. The issues that girls are confronted with – high rates of gender based violence, unsafe sex that puts girls at risk for unwanted pregnancy and HIV infection, school dropout, lack of economic resources and income generating options, lack of agency and participation – are linked with one another through their root causes. Therefore, the solutions must be interconnected as well, helping girls to build their social, health and economic assets.

2. Background and theory

The asset building framework for vulnerable adolescent girls is the theoretical underpinning guiding this intervention (Austrian & Ghati,

2010; Bruce and Sebstad, 2004). Assets are a store of value that girls can use to both reduce vulnerabilities and expand opportunities. For example, self-efficacy is an asset. A girl can draw on her self-efficacy to negotiate for safer sex (reduce vulnerabilities) or to excel at a job interview (expand opportunities). Another example of an asset is savings. A girl can use her savings in case of an illness in the family to pay for the hospital bill instead of getting money in a risky way (reducing vulnerabilities). Savings can also be used to pay for a vocational training course (expand opportunities).

The literature speaks to the importance of social, health and economic assets individually as means to improve sexual health outcomes. There is a growing literature on social capital (Putnam, 2004) and the association of increased social capital with decreases in risky behavior and more successful health programs. Social capital has been defined both as networks, i.e. participation in community groups, and group norms, i.e. high levels of trust and reciprocity among community members (Putnam, 1993). One study identified social capital as a variable that mitigates the negative effect of increasing income inequality on poorer health outcomes (Kawachi, Kennedy, Lochner & Prothrow-Stith, 1997). Lack of social capital can prevent adolescents from taking control of decisions regarding their sexual behavior (Campbell & MacPhail, 2002), while the presence of a social network, one component of social capital, may lead to risk reduction and changes in the community norms about risk-taking behavior (Latkin & Knowlton, 2005). One HIV prevention intervention that addressed community factors, in

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addition to individual and group factors was associated with lower HIV rates (Jana, Basu, Rotheram-Borus & Newman, 2004). Another study of an intervention with adolescent girls in Zimbabwe showed that participation in local community groups was associated with lower rates of HIV, which was in turn associated with improved psychosocial attributes of knowledge, perceived vulnerability, and self-efficacy (Gregson, Terceira, Mushati, Nyamukapa & Campbell, 2004). Another study that combined micro-finance with a community based intervention health intervention showed a positive impact on economic, sexual health and gender based violence outcomes (Kim et al., 2009). Finally, stepping stones, a program that combines community development with participatory training on HIV and gender equitable relationships, has been shown to also have a positive effect on health outcomes (Jewkes et al., 2008).

Social isolation, as a vulnerability factor, is a window of opportunity for intervention through making programs available to adolescent girls. However, overall this has been a missed opportunity. Adolescent girls are overlooked by places which could potentially help them because their unique status is not recognized. They are unrecognized by terms and structures such as youth, households, and health systems (Mabala, 2006). A study from South Africa showed that girls who were more socially isolated were more likely to have experienced sexual coercion and transactional sex (Hallman, 2005). Similarly, girls that belong to an organization and girls that have a role model were found to have fewer sexual partners (Hallman, 2011). In a study from a social and health asset building program for girls in rural Ethiopia, 10–14 year old girls were 3 times more likely to be in school and less likely to be married and girls who were sexually experienced were more likely to be using contraceptives (Erulkar & Muthengi, 2009).

In addition, there are some examples in the literature of programs that help to increase economic assets, which in turn result in more positive reproductive health outcomes for the participants. The Hallman (2005) study in South Africa showed that girls with financial goals had more realistic assessments of their HIV risk, had more knowledge about HIV transmission, and were more likely to have been tested for HIV, while girls with savings were likelier to know about family planning. In addition, girls who were more economically vulnerable were more likely to have experienced sexual coercion and engaged in transactional sex (Hallman, 2005). In Uganda, a savings-based economic intervention for AIDS-orphaned adolescents was associated with improved HIV-prevention attitudes (Sewamala, Alicea, Bannon, & Ismayilova, 2008). A study on cash transfers to adolescent girls in Malawi showed that girls who received the cash transfer had a decline in early marriage, teenage pregnancy and self-reported sexual activity (Baird, Chirwa, Mcintosh & Ozler, 2010). A study with adolescent girls in Bangladesh showed that adding a financial education component to life-skills resulted in significantly greater positive impact in changing sexual behaviors (Amin et al., 2010).

The theory of change behind this intervention posits that girls need a combination of social, health, and economic assets in order to make a healthy transition into adulthood, which in turn will reduce poverty. One kind of asset (i.e. knowledge of HIV and pregnancy) is not sufficient because often girls' economic situation trumps their knowledge of risky behavior. Similarly, only having a savings account or a vocational skill is also not enough to take control of their health or to have the self-efficacy and networks through which to capitalize on economic opportunities. In addition, it is possible that economic assets alone might pose a risk for vulnerable girls.

Due to the linkages between the root causes of gender based violence, negative sexual and reproductive health outcomes, and a lack of economic resources – in addition to the role that strong social assets and voice can play across all three areas – investments must be made to build the full range of assets in order to see results in either the health or livelihood arena. The lack of economic resources and agency increases dependency within sexual relationships and makes negotiation for safer sex out of reach. Therefore, successful program strategies must

address these linkages, and underlying causes, and build a range of girls' assets by providing safe spaces where girls can build their social networks and gain basic financial and health education, and be linked to formal savings accounts and clinical health services.

3. Intervention model

The intervention model contains four main components: safe spaces, reproductive health training, financial education and savings accounts.

3.1. Safe spaces

The core of the safe spaces component is a weekly girl group meeting in which a group of 15 to 25 girls meet with a mentor – a young woman from their community – for short training sessions (30–90 min – depending on girls' availability) on a variety of topics, as well as a chance to discuss the events of the past week. These regular, stable group sessions serve two critical functions: 1) to build a platform in which girls are organized and can be reached with a variety of interventions and education topics (e.g. a health clinic; a financial institution); and 2) to build social assets – including friends, trusting relationships, and self-efficacy that have positive influence on other livelihood and health dimensions of their lives. In addition, because groups meet on the weekend, after school, or during school breaks (if school-based), there is no competition with formal education.

Mentors are young women ages 20–35 residing in the same community as the girls in the groups. Mentors are recruited by program staff for their experience in working with youth and training skills, as well as interest in working with vulnerable adolescent girls. Prior to starting the mentors go through an intensive five-day 'training of trainers' in which they are trained on the content of what they will teach the girls, as well as training skills. In addition, mentors meet once a month with program staff to review successes and address any challenges that may be arising. Every 3–4 months the program organizes a two to three day 'refresher training' on a topic that the mentors need further information on.

Mentors meet the girls in their group once a week at a designated time and location. If a girl misses more than two or three sessions in a row, the mentor is expected to make a home visit to follow up and determine the reason for her absence.

3.2. Reproductive health training

The health education that is delivered to the girls is based on *Tuko Pamoja: Adolescent Reproductive Health and Life Skills Curriculum* (PATH & Population Council, 2005). This curriculum includes 30 sessions on a range of topics including: information on puberty, reproduction, family planning, HIV/AIDS and other STIs, drug abuse, communication, sexual feelings, self-efficacy, gender based violence, and peer pressure.

3.3. Financial education (FE)

While not the only education topic in the group meetings, FE sessions are critical for building a base of knowledge and skills on personal money management – including prioritizing spending based on needs and wants, setting financial goals, budgeting and saving – as well as exploring options for earning money in formal and informal economies. Mentors use a simplified set of financial education sessions, entitled "Young Women: Your Future, Your Money" that was adapted for girls in Uganda from Microfinance Opportunities "Young People: Your Future Your Money" universal youth financial education curriculum.

3.4. Savings accounts

The Council worked with four financial institutions to develop a formal savings account based on extensive market research. As part of the

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