



Child marriage and HIV: Thematic brief

Around the world, girls and young women are disproportionately affected by HIV.¹ While there is limited evidence about the direct causal relationship between child marriage and HIV, many of the factors which put girls and young women at greater risk of HIV infection also put girls at increased risk of child marriage. Once married, child brides face profound health consequences as a result of their early marriage, and in some contexts, increased risk of HIV infection. There are therefore strong arguments for investing in girl-centred programmes which can simultaneously tackle the drivers of child marriage and new HIV infections among adolescent girls.

Child marriage and HIV: The scale of the problem

- Despite global gains in expanding access to HIV prevention and treatment, in 2017 7000 adolescent girls and young women aged 15–24 years became newly infected with HIV every week. Globally women represent more than half of people living with HIV and in 2017 there were **1 million adolescent girls aged 10–19 years were living with HIV**.^{1,2}
- **Adolescent girls and young women account for a disproportionate number of new infections:**
 - Globally every 3 in 5 new infections among 15-24 year olds are among girls and young women.
 - In sub-Saharan Africa, **3 in 5 new HIV infections among 15–19-year-olds** are among girls.²
 - In Eastern and Southern Africa, despite making up only 10% of the population, girls and young women aged 15-24 account for around one in five new infections, and for every 3 new HIV infections among men and boys aged 15-24 there were 7 new HIV infections among girls and women of the same age.²
 - In the countries with the most gender disproportionate distribution of new HIV infections, adolescent girls accounted for more than 80% of new HIV infections in their age group.²
- **In 2017, AIDS-related illnesses were the leading cause of death globally among women and girls aged 15–49** and one of the five most common causes of death among girls aged 10-14. Every day, 50 adolescent girls died from AIDS-related illnesses and 460 adolescent girls became newly infected with HIV. More than 90% of deaths worldwide from AIDS-related illness among adolescents occurred in sub-Saharan Africa.²
- Some **61% of all 15-19-year old girls living with HIV were infected through sexual transmission**, while 39% acquired HIV through mother-to-child-transmission (MTCT). This compares to 55% of males who were infected through MTCT and **45% were infected through sexual transmission**.³
- Child marriage is a global problem: **12 million girls are married every year before the age of 18**. If there is no reduction in the practice of child marriage, 150 million more girls will marry before the age of 18 by 2030.⁴
- Many countries in East and Southern Africa, where the epidemic is at its peak, also have very high prevalence of child marriage. These include: Mozambique (child marriage prevalence 53%), Malawi (42%), Uganda (34%), Zimbabwe (32%), Zambia (31%), Tanzania (31%) and Kenya (23%).⁶
- Due to population growth in sub-Saharan Africa, the region will likely overtake South Asia as the region with the highest absolute numbers of child brides.⁶ As the population grows, the proportion of the population made up by young people will increase.⁵

Child marriage and HIV: what do we know about the links?

There is little published research which explores the links between child marriage and HIV infection. However, it is clear that some of the factors which put girls at higher risk of HIV infection are the same as those that put girls at risk of child marriage. These include poverty, low educational attainment, and gender

inequalities which limit girls' ability to make decisions about their own health, who to have sex with or who and when to marry.^{6,7}

Once married, there are a number of factors which can make child brides particularly vulnerable to HIV infection. Among these are:

- In many contexts, **early sexual debut**, including that which takes place within child marriages, is associated with increased lifetime risk of HIV infection.⁸
- Child brides are exposed to **frequent unprotected sexual activity**, in part because there is pressure on them to demonstrate their ability to have children.⁹
- Child brides **often marry men who are older than them** and who have (or have had) multiple sexual partners, which in turn, increases the risk of HIV infection.^{10,11}
- Child brides often **lack the agency needed to negotiate safe sex or access vital sexual and reproductive health (SRH) services** such as contraception or HIV testing: 80% of married 15-19-year-old girls in Burkina Faso, Cameroon, Côte d'Ivoire, Niger and Senegal report that they do not have the final say on their own healthcare.¹²
- There is some evidence that **adolescent girls may be more biologically susceptible to HIV infection** than older girls and women, and new evidence suggests that the **risk of acquiring HIV increases during pregnancy and the postpartum period**.¹³ Child marriage increases both the number of children a woman has and the number of years she faces this increased risk.
- Adolescent girls **lack information about HIV** and HIV prevention: globally, only 30% of girls aged 15-24 have comprehensive and accurate knowledge about HIV.¹⁴ Lack of information on HIV prevention undermines young women's ability to negotiate condom use and other safer sex practices.¹⁵
- Over 50% of girls married before the age of 18 globally have no more than three years of schooling.¹⁶ Their **lower levels of education** further increase their risk of contracting HIV.¹⁷
- Globally, girls who were married before the age of 18 report experiencing higher levels of intimate partner violence (IPV) than those married after age 18.¹⁸ In turn, women who experience IPV are at greater risk of HIV¹⁹: One study in South Africa found that women who experience IPV were **50% more likely to be infected with HIV** than those who don't.²⁰

Ending child marriage and making progress on tackling HIV: what more needs to be done?

1. Recognise adolescent girls as a priority population and focus on them in HIV programming

- In East and Southern Africa where girls are most at risk of HIV infection, both married and unmarried adolescent girls should be **recognised as among the most vulnerable to HIV infection, and prioritised for HIV prevention, treatment and care services**, as well as SRHR services and initiatives to empower girls and women more broadly.
- Efforts to target adolescent girls with HIV programmes must also **involve families and communities** including in efforts to address household poverty and harmful gender norms. Men and boys, in particular, need to be **engaged as positive agents of change** including efforts to tackle gender violence and end broader discrimination against girls and women.
- Combining interventions into a comprehensive package which addresses different risk factors may be more effective than single interventions (see below).

2. Invest in integrated programmes which tackle the shared structural risk factors for HIV infection and child marriage

- There are strong practical arguments for investing in programmes which can, at the same time, tackle the drivers of new HIV infections, and can improve the well-being of girls, including reducing child marriage.²¹ These include investments in girls' primary and secondary education, addressing gender discrimination and harmful norms, ensuring that adolescent girls and boys understand their rights and have access to comprehensive and youth-friendly sexual and reproductive health

information and services, and promoting economic opportunities for girls and women. Annex A highlights examples of emerging evidence from programmes and policies which have been shown to reduce girls' vulnerability to HIV and/or child marriage.

3. Invest in programmes which support married and unmarried girls living with HIV

- Adolescent girls living with HIV should be supported with access to anti-retroviral treatment to help them manage their health as well as ensuring access to programmes to help them prevent HIV transmission to their own children. Promoting testing and treatment for adolescent girls should be a programming priority, particularly in sub-Saharan Africa where there are both high HIV prevalence and high adolescent fertility rates.²²
- Support should go beyond access to health services: adolescent girls living with HIV should also be supported to remain in school, and to have access to mentoring programmes and safe spaces which can provide peer support, help tackle stigma and discrimination, and reduce the social isolation that can put girls at risk of gender-based violence and child marriage.
- Adolescent girls who are already married are often excluded from basic services and greater efforts are needed to ensure they have access to empowerment, education, health, and sexual and reproductive health and rights (SRHR) programming.

4. Ensure programmes reach all girls in need, including those at greatest risk

- Interventions to tackle HIV and child marriage should be designed on the basis of a solid understanding of the local context, including identifying and targeting the girls who are most at risk. Programme implementers should ensure that these children are included. This may require particular efforts to reach the poorest girls, girls out of school, orphaned children, those living without parental care, those who have been displaced, those engaging in transactional sex, and those affected by HIV (see below).

5. Provide protection, care and support to children affected by HIV

- Even when children are not HIV infected, they may be negatively impacted by the epidemic through the chronic illness or death of parents or other close family members, and may face stigma, discrimination, and negative economic impacts on their household. They may also be at greater risk of child marriage, due to their loss of economic and family support. At the end of 2016, 16.5 million children had lost one or both parents to AIDS. 54% of these children were in East and Southern Africa.²³
- Particular attention is needed to identify the most vulnerable children affected by HIV, and to ensure that they are included in interventions to prevent child marriage and support married girls. These can include educational support, psychosocial support services, SRHR information and services, and protection from all forms of abuse and neglect.

6. Increase research on the links between child marriage and HIV

- There is still relatively little evidence on the links between HIV and child marriage, and how one may lead to the other. It is therefore vital that **research is undertaken that expands and strengthens the evidence base** to understand the associations and causal pathways between the two issues. This will be invaluable to ensure programmes tackling both child marriage and HIV are of high quality and are having the maximum positive impact.
- Research is also required to **better understand the diverse needs of girls** who are at risk of child marriage and married girls. This will help ensure HIV and child marriage programming is more targeted and relevant, including by recognising the need for age-appropriate interventions for younger and older adolescent girls in diverse contexts.
- There is growing evidence on the different interventions that work to end child marriage. However, further evidence on **what works and how best to implement multi-component programmes girl-centred programme is** needed, to help inform both comprehensive child marriage and HIV

prevention and treatment programming. In particular there are few rigorous evaluations that assess impact on child marriage of programmes using girls' empowerment approaches, that engage with men and boys, or that provide youth friendly sexual and reproductive health services in sub-Saharan Africa.

About Girls Not Brides: The Global Partnership to End Child Marriage

Girls Not Brides is a global partnership of more than 1,000 civil society organisations in almost 100 countries, united by a commitment to work together to end child marriage and enable girls to fulfil their potential. In consultation with more than 150 members, partners and experts, *Girls Not Brides* created a common [Theory of Change](#), which outlines the range of approaches needed to end child marriage.

Annex 1. Promising practice of integrated programming to address child marriage and HIV

There is growing evidence of the importance of integrated girl-centred programming which can tackle the structural drivers of both HIV and child marriage. This section highlights programmes which have proven to have impact as well as some promising new initiatives which have yet to be fully evaluated.

The programme examples presented below have the potential to address a number of priorities for adolescent girls, as the structural risk factors for child marriage and HIV are often overlapping. Examples are presented in categories of interventions identified in the *Girls Not Brides Theory of Change*:

I. **Empower girls**

- The Population Council's *Biruh Tesfa* programme in Ethiopia is one of the few rigorously evaluated girls' empowerment programmes targeting vulnerable girls in sub-Saharan Africa. Working with the poorest urban adolescent girls, the programme aimed to build their social support networks and improve their skills to prevent HIV infection through a combination of girls' clubs, mentoring, and training on HIV/AIDS, life skills, and basic literacy. Participating girls were more than twice as likely to report social support compared to girls in the control group, and were twice as likely to score highly on HIV knowledge questions, to know where to obtain voluntary counselling and testing, and to want to be tested.²⁴
- A cash transfer scheme in South Africa conditional on school attendance which paid money *directly to girls themselves* as well as their parents/guardians was also found to be effective in reducing some of the risk factors for HIV. Girls who received the cash transfers experienced 34% less intimate partner violence (IPV) than those in the control group, probably because those girls reported fewer sexual partners and were less likely to have undergone sexual debut.²⁵
- The *Intervention with Microfinance for AIDS and Gender Equity (IMAGE)* study in South Africa, combined training sessions on HIV and gender inequalities with microfinance loans to girls and women aged 14-35. Participants showed improvements in economic well-being and multiple dimensions of empowerment, higher levels of HIV-related communication and HIV testing, and increased confidence to negotiate condom use among younger participants. The programme also decreased physical and sexual IPV by 55%.²⁶

II. **Mobilise families and communities, including men and boys**

- *Stepping Stones* is a behaviour change programme which promotes gender equitable relationships and better communication between partners through participatory learning sessions involving both men and women. An evaluation of the programme in South Africa found that while it did not have a direct impact on HIV prevalence, it had a significant impact on HIV risk behaviours among men who took part, including reduced perpetration of intimate partner violence, payment for sex, and alcohol abuse. It also decreased the number of new HSV-2 infections (which is a significant biological risk factor for HIV infection) in both sexes by 33%.²⁷
- *SASA!* is a community mobilisation programme run by Raising Voices that aims to prevent violence against women and reduce HIV-risk behaviours in Uganda through community dialogue engaging both men and women. A 2016 evaluation found that *SASA!* reduced the incidence of IPV by 52% and nearly halved the number of men reporting concurrent sexual partners.²⁸
- South Africa's *Child Support Grant* is a large scale national programme that provides an unconditional monthly payment to households (as opposed to directly to girls themselves) below the poverty line.²⁹ Evaluation of the programme found that not only did it increase learning and the number of years of schooling completed, it also reduced HIV risk behaviours, including risky sexual behaviour, adolescent pregnancy, and alcohol and drug use.³⁰
- A comparative study of cash transfers in South Africa looked at the impact on adolescent HIV-risk behaviour of economic support in combination with psychosocial support (in the form of improved parenting and pastoral support from teachers) versus economic support alone. It found that cash alone was associated with reduced HIV risk behaviours of 37% in girls, while

“cash plus care” was associated with reductions of 45% for girls and 50% for boys. The study suggests that cash transfers in tandem with other interventions may be more effective in reducing risky behaviours than cash transfers alone.³¹

- The Population Council’s *Meseret Hiwott* programme in Ethiopia targeted young married girls with the aim of increasing their social networks, and their knowledge and skills for reproductive health and HIV prevention, and also engaged with the husbands of participating girls. While participating girls increased their use of family planning and were nearly 8 times more likely to receive voluntary HIV counselling and testing (VCT) than nonparticipants, girls whose husbands participated were more than 18 times more likely.³²

III. Provide adolescent-friendly services, including education, and sexual and reproductive health

- There are few evaluated examples of interventions targeting the SRHR needs of adolescents living with HIV. The *Young4Real* programme run by the Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) in Zimbabwe delivered a combination of SRHR trainings for young people, and community dialogue and edutainment focused on gender, SRHR, and HIV. The programme improved knowledge and understanding of the role of condoms in STI prevention among 15-24-year olds of both sexes, and decreased the number of concurrent sexual partners among girls of the same age.³³
- A large scale randomised control evaluation in Kenya compared different school-based interventions for HIV prevention. The interventions included school-based debates and essay writing competitions on HIV and the role of condoms in prevention; training teachers in the national HIV curriculum; and subsidising access to education through provision of free school uniforms. Reducing the costs of schooling reduced child marriage, school dropout and early child bearing, while the debates and essay writing increased knowledge of HIV and use of condoms. The study suggests that a combination of school-based interventions related to school retention and HIV awareness could yield the best results.³⁴
- A cash transfer study in Zomba, Malawi looked at increasing girls’ access to education through cash transfers, while also tracking impact on other outcomes including adolescent pregnancy, marriage, and HIV prevalence. In the short term, the programme reduced HIV prevalence by 64% and HSV-2 prevalence by 76%, and also reduced rates of pregnancy and child marriage.³⁵ However, in the long run, the impacts were not sustained, with rates of marriage, pregnancy and new HIV infections among girls who had the received cash transfers catching up with the control group within two years of the end of the programme. This suggests that cash transfers may need to be extended and expanded to older adolescents and married adolescents to maintain their protective effects.³⁶

IV. Establish and implement relevant laws and policies, particularly in high HIV prevalence contexts

- The Uganda *2014- 2020 National Strategy To End Child Marriage And Teenage Pregnancy* recognises that child marriage can place adolescent girls at higher risk of contracting HIV, and includes specific indicators in its implementation plan for youth-friendly sexual health services, including HIV testing, counselling and treatment. It also lists interventions to reach adolescent girls with HIV/ AIDS testing and treatment that are ongoing as part of the strategy.³⁷
- Malawi’s *National HIV prevention strategy 2015-2020* recognises the particular vulnerability of adolescent girls to HIV infection, and identifies early marriage as a driver of the epidemic in country. The strategy lists campaigns to stop early marriages and to keep girls in school as part of the package of interventions to be implemented to prevent HIV infection among adolescent girls. It also highlights the need to increase the legal minimum age of marriage to 18, which in fact was passed into law by the Malawian parliament in February 2017.^{38,39}

While the effects of these policies have not been evaluated, the existing evidence suggests that supportive laws and policies are necessary, albeit insufficient on their own, to effect change.

Girl-centred programmes to watch: There are a number of promising girl-centred programmes and initiatives which are ongoing and will add to the evidence base in the near future. These include:

- [DREAMS](#), a \$750 million partnership led by the U.S. government's PEPFAR program, aims to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries. DREAMS programming combines health sector interventions with programming which tackles the structural risk factors of HIV.⁴⁰
- [STRIVE](#) is a research consortium led by the London School of Hygiene and Tropical Medicine which is dedicated to researching the structural drivers of HIV, and evaluating programmes which attempt to prevent HIV by tackling poverty, gender inequalities, stigma and discrimination, and alcohol abuse.⁴¹
- [Gender and Adolescence: Global Evidence \(GAGE\)](#) is a global, longitudinal research programme of the Overseas Development Institute tasked with generating evidence on social norms related to gender and adolescence, and on what works to empower adolescent girls and enable them to emerge from poverty.⁴²

¹ UNAIDS, 2018, [UNAIDS Data Book](#)

² UNAIDS, 2019, [Women and HIV — A spotlight on adolescent girls and young women](#)

³ UNAIDS, 2018, National HIV estimates file. 2018. Retrieved from

<http://www.unaids.org/en/dataanalysis/datatools/spectrum-epp>

⁴ UNICEF, 2020, *Global child marriage database*, available here: <https://data.unicef.org/topic/child-protection/child-marriage/>

⁵ United Nations, 2017, *World Population Prospects: The 2016 Revision*

⁶ LSTHM, 2018, STRIVE, [Drivers of HIV webpage](#);

⁷ Girls Not Brides, 2018, [Child marriage, why does it happen?](#)

⁸ Stöck, et.al, 2013, [Is early sexual debut a risk factor for HIV infection among women in sub-Saharan Africa? A systematic review](#), *American Journal of Reproductive Immunology*, 2013 Feb;69 Suppl 1:27-40. doi: 10.1111/aji.12043. Epub 2012 Nov 26.

⁹ Clark S, Bruce J, Dude A., 2006, [Protecting young women from HIV/AIDS: the case against child and adolescent marriage](#). *International Family Planning Perspectives*. 2006 Jun; 32(2):79-88.

¹⁰ Clark, S., 2004, *Early marriage and HIV risks in sub-Saharan Africa*, *Studies in Family Planning*, 2004 Sep;35(3):149-60.

¹¹ ICRW, 2016: [Child Marriage in Southern Asia: Context, Evidence and Policy Options for Action](#).

¹² UNAIDS, 'The Gap Report', 2014

¹³ Increased Risk of HIV Acquisition Among Women Throughout Pregnancy and During the Postpartum Period, [Journal of Infectious Diseases](#), 2018.

¹⁴ UNAIDS, 2015, *World AIDS Day 2015 report On the Fast-Track to end AIDS by 2030*, Focus on Location and Population,

¹⁵ UN Women, *Fact and figures: HIV and AIDS*, June 2016

¹⁶ ICRW, 2006, [Child Marriage and Education fact sheet](#).

¹⁷ UNICEF, 2004, [Girls, HIV/AIDS and Education](#), UNICEF Division of Communication 3 United Nations Plaza, H-9F New York, NY 10017, USA

¹⁸ Kidman, 2017, [Child marriage and intimate partner violence: a comparative study of 34 countries](#), *International Journal of Epidemiology*, Volume 46, Issue 2, 1 April 2017, Pages 662–675

¹⁹ World Health Organization (WHO), London School of Hygiene & Tropical Medicine and South African Medical Research Council, 2013, [Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence](#). WHO

²⁰ Jewkes et al. [Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study](#). *The Lancet*, 2010, 376(9734):41–48

²¹ Parkhurst, 2013, [Structural Drivers, Interventions, and Approaches for Prevention of Sexually Transmitted HIV in General Populations: Definitions and an Operational Approach](#). Structural Approaches to HIV Prevention Position Paper Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1, and London: UKaid's STRIVE research consortium.

²² United Nations Children's Fund, 2016, [Towards an AIDS-Free Generation — Children and AIDS: Seventh Stocktaking Report](#)

²³ UNAIDS, 2017, *Right to health*, Geneva

²⁴ Erulkar, Ferede, Girma & Ambelu, 2012, [Evaluation of "Biruh Tesfa" \(Bright Future\) program for vulnerable girls in Ethiopia](#), *Vulnerable Children and Youth Studies*, 8:2, 182-192, DOI: [10.1080/17450128.2012.736645](https://doi.org/10.1080/17450128.2012.736645)

²⁵ Kilburn et. al., 2018, [Conditional cash transfers and the reduction in partner violence for young women: an investigation of causal pathways using evidence from a randomized experiment in South Africa](#), *Journal of the International AIDS Society*

²⁶ Kim et. al., 2009, [Assessing the incremental effects of combining economic and health interventions: the IMAGE study in South Africa](#), *Bulletin of the World Health Organization* 2009;87:824-832. doi: 10.2471/BLT.08.056580

²⁷ Jewkes et al., 2008, [Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial](#), *BMJ* 2008; 337:a506

²⁸ Watts, et.al., 2015. [The SASA! study: a cluster randomised trial to assess the impact of a violence and HIV prevention programme in Kampala, Uganda, 3ie Impact Evaluation Report 24](#). New Delhi: International Initiative for Impact Evaluation (3ie)

²⁹ UNDP, 2014, [Cash transfers and HIV prevention](#)

³⁰ UNICEF, 2012, [The South African Child Support Grant Impact Assessment, Evidence from a survey of children adolescents and their households](#)

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- ³¹ Cluver, et al., 2014, [Cash plus care: social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa.](#), AIDS, 28 (Suppl 3): S389-S397
- ³³ Impact Research International Zimbabwe, 2013, [Endline evaluation report of the Young4Real Programme](#)
- ³⁴ Duflo et. al, 2007, [Education and HIV/AIDS Prevention: Evidence from a randomized evaluation in Western Kenya](#), World Bank Policy Research Working Paper 4024, October 2006
- ³⁵ Baird et al., 2012, *Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial*, Lancet, 379: 1320-29.
- ³⁶ Baird et al., 2018, *When the Money Runs Out: Do Cash Transfers Have Sustained Effects on Human Capital Accumulation?*
- ³⁷ Uganda Ministry of Gender, 2015, [Labour and Social Development, The National Strategy To End Child Marriage And Teenage Pregnancy 2014/2015 – 2019/2020](#)
- ³⁸ Malawi National AIDS Commission, 2014, [National HIV Prevention Strategy 2015-2020](#)
- ³⁹ Girls Not Brides, 2017, [Malawi: Constitution no longer allows child marriage](#),
- ⁴⁰ DREAMS Partnership, 2018, [DREAMS Partnership website](#)
- ⁴¹ LSHTM, 2018, [Strive Website](#)
- ⁴² Overseas Development Institute, 2018, [GAGE Website](#),