Vulnerable Girls and HIV in Sub-Saharan Africa: A Literature and Program Review
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Introduction

The PEPFAR Gender Initiative on Girls’ Vulnerability to HIV (“the Initiative” hereafter) aims to reduce vulnerable adolescent girls’ risk of HIV infection in Botswana, Malawi and Mozambique. For purposes of the Initiative, and of this literature review, vulnerable girls are defined as those most at risk of contracting HIV. Since heterosexual transmission is the dominant mode of transmission in the Initiative countries, the proximate determinants for risk of HIV infection are being sexually active, having multiple partners (concurrently as well as serially), having older sexual partners or engaging in unprotected sex. This selective literature review was designed to assess how others define vulnerable girls, extract from published articles factors statistically associated with either the aforementioned proximate determinants of HIV infection or HIV-positive status amongst adolescent girls, draw attention to factors that have been associated with protecting vulnerable girls from contracting HIV, identify gaps in the literature regarding vulnerability to HIV among adolescent girls, learn from policy or programmatic interventions that have reduced vulnerable girls’ risk of HIV infection, and provide directions for future study.

Due to time limitations, this literature review is selective rather than systematic. Therefore, the focus is primarily on the Gender Initiative countries. For purposes of exploring the risk as well as protective factors with respect to HIV infection, we used the key words HIV or HIV/AIDS in tandem with one or more of the following words or terms: vulnerable girls, vulnerable adolescent girls, girls’ vulnerability, resilience, and/or resiliency. In addition, we restricted the review to sub-Saharan Africa, with particular attention given to Botswana, Malawi and Mozambique. In our review of programmatic interventions, we used the following criteria: (1) designed for adolescent girls (ages 13-19) or some component was specifically for adolescent girls or their support systems, so the intervention could include programs for parents, teachers, communities if adolescent-focused; (2) documented in a peer-reviewed journal or, in selected instances, in the gray literature (articles or reports that have not been peer reviewed; and (3) were implemented between 2003 and 2008. Programs with evaluations were given precedence, but many did not report even cursory attempts at evaluation.

Background

Although HIV/AIDS has touched every region of the world, the highest prevalence rates are found in southern Africa. The feminization of HIV/AIDS is a well-established and troubling fact in sub-Saharan Africa; of the approximately 22.5 million living with the virus in sub-Saharan Africa, 61 percent are women (UNAIDS, 2007). The disparity is particularly stark among young women aged 15-24 who are three to six times more likely to be infected than young men, due to a variety of biological and social factors (Quinn & Overbaugh, 2005). Younger girls are often even more susceptible; the physiological, social, cultural and economic
factors that render women vulnerable to HIV are even more pronounced among this population.

Among the multifaceted and complex factors that fuel the epidemic among adolescent girls in sub-Saharan Africa are economic vulnerability; inequitable or limited access to schools; lack of social cohesion; pervasive gender inequalities, including fewer legal rights; the social acceptability—even expectation—of multiple concurrent sexual partnerships; the tacit acceptance of cross-generational sex between older men and younger women; and biology. Given the complexity of the situation, there is a clear and urgent need to move beyond the single-level interventions of the past by acknowledging and addressing the contextual factors that place girls in harm’s way.

Recently, key figures in the global struggle to avert new HIV infections have lamented that we are losing the battle against HIV (“US President’s top adviser,” accessed 7 August 2008). Given that the majority of new HIV infections occur amongst female adolescents and youth, particularly those between the ages of 13 and 24, there is widespread agreement that HIV prevention programs must be designed and implemented to reduce this key population’s vulnerability to transmission. While there have been documented cases of successful interventions, many programs for adolescents lack age-appropriate, skill-based lessons on partner reduction, mutual fidelity, and cross-generational and transactional sex (MEASURE Evaluation, 2007). Many of these programs also lack gender-specific materials, ignoring the very different expectations faced by female and male adolescents. Moreover, these same programs often fail to address the larger social, cultural and economic factors that impede individual-level change even when the will to change is evident. In tandem with the implementation of adolescent-appropriate programs, arresting the epidemic requires programs that address the social and structural factors that stand in the way of sustainable behavior change.

In response to the dearth of multilevel programs for girls and the failure to arrest the epidemic in the most-affected countries, the Initiative seeks to develop multifaceted programs for adolescent girls in Botswana, Malawi and Mozambique, where 14 percent or more of the population aged 15-49 is HIV positive. Here, too, adolescent girls are at least three times as likely as their male counterparts to be HIV positive. To develop the program interventions, we need to understand more fully girls’ susceptibility to HIV. Moreover, the Gender Initiative mandates work with “vulnerable” or “the most vulnerable” girls, thus taking us beyond examining what factors place adolescent girls as a whole at risk of contracting HIV and focusing more clearly on the characteristics of vulnerable adolescent girls.

The purpose of this literature review, therefore, is fourfold. The first is to synthesize existing findings regarding the factors that render girls vulnerable to HIV infection in sub-Saharan Africa, with a primary focus on the Initiative countries, to help us answer the question “Who are the most vulnerable girls when it comes to HIV risk?” The second is to examine the resiliency literature and summarize the factors that protect girls from HIV. The third is to scan the
literature for lessons learned from programs or interventions in sub-Saharan Africa—particularly in the Gender Initiative program countries of Malawi, Mozambique and Botswana—that focus on protecting vulnerable girls from HIV. The fourth is to help identify gaps in the literature regarding what factors or interventions can protect the most vulnerable girls from contracting HIV. These gaps will help to inform future studies in this area.

**Conceptual Framework**

The Gender Initiative explicitly shifts the focus from the individual-as-risk-taker, which places the onus on the individual, to the contextual factors that render girls vulnerable, which are systemic and foundational. Girls are vulnerable to HIV in large part because the social systems in which they live have failed them. Given this understanding, a social ecological conceptual framework guides both this literature review and the Initiative it is intended to inform.

The social ecological perspective views individuals as nested or embedded within a system of socio-cultural relationships—families, social networks, communities, nations—that are influenced by and influence their physical environments. Each of these contexts potentially influences, directly or indirectly, individuals’ ability or propensity to act. This approach draws attention to the role of extra-individual factors in health outcomes (Rose, 1985), and yet does not ignore the individual. Rather, individuals’ choices, decisions and behaviors are theorized to depend not only on their own characteristics, but also on group- or community-level attributes and understandings. These group- or community-level attributed and understandings also implicate larger social and environmental contexts, as shown in Figure 1. In sum, social ecology is a systems approach that examines the “degree of fit between people’s biological, behavioral, and socio-cultural needs and the environmental resources available to them” (Stokols, 1996).

**Defining Vulnerable Girls**

Settling upon a clear and consistent definition of “vulnerable girls” based on the
literature proved a rather elusive task. In much of the HIV prevention literature reviewed, adolescent girls were grouped together with women or with adolescent boys; the first instance ignores the effects of age-related permutations within female gender roles, while the second fails to take into account the gendered nature of adolescence (Mabala, 2006; Mandevu, 1995; Phaladze & Thlu, 2006). Moreover, the term “vulnerability” is not clearly defined, if defined at all, in much of the literature. Many authors provide a blanket statement regarding vulnerability to HIV, such as “girls are at risk of contracting HIV largely due to culturally predetermined disadvantages” (Simwaka, 2005, p.1).

Although orphans and vulnerable children (OVC) is an often-used term in literature discussing groups vulnerable to HIV, authors typically do not clearly define “vulnerable children.” (An “orphan” is usually defined as a child whose mother and father are both dead, with the specifications “maternal orphan” and “paternal orphan” reserved for a child who has the female or male parent, respectively, but not both parents.) In one of the few definitions provided in the literature reviewed for this article, Gregson et al. (2005) defined an OVC “...as being a person aged below 19 years who is an orphan, has a parent who is HIV-infected or seriously ill, or lives in a household that has experienced death in the past 12 months” (p.787). As this article will demonstrate, there are many factors that contribute to children’s vulnerability to HIV and it is necessary to clearly define “vulnerability” in order to develop effective interventions.

In one discussion of the term “vulnerability,” Mabala (2006) explains that vulnerability refers to inequity, which falls hardest upon women as well as upon young people. He explains that because women are a disempowered majority and young people are an invisible majority, girls and young women have far less power and resources than anyone else in society. Mabala emphasizes the need to rethink the model that is currently used to analyze the spread of HIV/AIDS. Presently, the paradigm emphasizes “risk before and vulnerability after” which gives the impression that vulnerability is only an impact of the epidemic rather than one of the key causes of the epidemic (pp.411-412).

In a discussion that highlights the tension between biological vulnerability and social vulnerability, Bates et al. (2004) note:

Vulnerability encompasses the factors that lead to variation in the impact of disease between different communities and individuals....health programmes for malaria, tuberculosis, and HIV infection have focused on biologically vulnerable groups such as infants, children under 5 years old, pregnant women, young mothers, and people of reproductive age. However, this approach ignores other important non-biological features of vulnerability, such as poverty, education, and health-service promotion. (p.268-269)

Bates and colleagues touch on an important point by reaching beyond the
individual to include social-structural factors.

De Guzman (2001) contributes further to our understanding of social vulnerability to HIV/AIDS. She explains that one can think of vulnerability as being the opposite of empowerment. This concept encompasses the idea that there are many factors (economics, social cohesion, etc.) related to an individual’s social position that affect that individual’s risk to HIV/AIDS:

Empowerment involves access to information, comprehension of the information, the ability to make a decision regarding behavior change and being able to enact that decision. A person who cannot act on decisions, or even obtain information necessary for an informed decision, is less empowered or more vulnerable. A focus on empowerment recognizes the political, social and cultural constraints to health and addresses the underlying barriers, both at the individual and societal level, that place an individual in a position of heightened vulnerability. (p.665)

These articles provide a useful backdrop against which to explore further, and by level of influence, the factors associated with vulnerability to HIV.

**Factors that Render Girls Vulnerable to HIV**

As the social ecological framework informs us, it is necessary to consider factors at all levels\(^1\) if we are to understand and address the multi-level aspects of girls’ vulnerability to HIV, especially in sub-Saharan Africa. We now turn to an examination of factors by social-ecological levels.

Although individual-level interventions alone are not the solution to protecting girls from HIV, the individual-level factors that render girls vulnerable to HIV are important. Strengthening girls’ HIV-related knowledge, attitudes, risk perceptions, self-efficacy, perceived social norms and intentions to take protective actions or avoid risks are all necessary components of comprehensive HIV prevention interventions, but are rarely sufficient.

We treat educational attainment as an individual-level variable in keeping with the literature. Yet we recognize that whether or not a girl attends school is largely beyond her control; family or household members often make that decision for her and, in too many cases, there are no schools in close proximity to her home. Early school leavers are at increased risk of contracting HIV, as noted by Gavin and colleagues (2006). A study in Tanzania also found that girls who left primary school before standard 5 appeared to be at greater risk of contracting HIV (Obasi et al., 2001). Recently, the Interagency Task Team on Education reported that educating girls “dramatically” reduces their vulnerability to HIV (UNESCO, 2008).

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\(^1\) Biology is one major factor in HIV acquisition among women and girls, but one that we will not discuss as it does not help distinguish vulnerable girls from girls in general.
A global review of school enrollment found that unmarried girls aged 15-17 years who were currently enrolled were far less likely than girls of the same age who were not enrolled to have had sex, contracted STIs or been pregnant (Lloyd, 2005). Gregson, Waddell and Chandiwana (2001) found that women educated to the secondary level in rural Zimbabwe acquire HIV at a slower rate due to later sexual debut and safer sex behaviors.

Adolescent girls who are forced or choose to work are often at increased risk of HIV infection. In addition to female commercial sex workers being at increased odds of contracting HIV, Munthali and colleagues (2006) note that other work, such as petty trade, can also render an adolescent more vulnerable. Likewise, girls who are work away from home, as is the case with domestic workers, are at increased risk of HIV acquisition (UNFPA, 2006).

Interpersonal-Level Factors: Families, Households and Social Networks

Household factors beyond the control of the individual girl dramatically influence her lifetime probability of contracting HIV.

Orphanhood is a significant factor that plays a role in HIV acquisition among adolescent girls. In their study of 1,283 15- to 19-year-old girls in a high-density suburb of Harare, Zimbabwe, Birdthistle and colleagues (2008) found that female adolescent orphans were at increased risk of HIV and HSV-2 infection. Prevalence of HIV and/or HSV-2 was higher among orphans than non-orphans; 17 versus 12 percent. Maternal and double orphans were most likely to initiate sex early and to have had multiple partners. Maternal orphans were least likely to have used a condom at first sex and to have a regular sexual partner. All orphan groups had experienced high rates of forced sex.

Household composition is another factor associated with vulnerability. Girls who live in households without adult supervision or with low parental supervision have higher rates of sexual activity and lower rates of condom use than do girls who live with adult supervision (Kelly & Parker, 2000). A review by Eaton, Flisher and Aarø (2003), however, found that both supervision and a lack of supervision from parents contribute to unsafe sexual behavior among adolescents. For example, if parents forbid their children to have sex then adolescents may fear to carry condoms whereas on the other hand, parents who take their daughters to get an injectable or hormonal contraceptive to avoid pregnancy may inadvertently reduce the likelihood of condom use. Living on the street exposes young women to risk through sexual abuse, rape, consensual sex, multiple partners, low condom use and substance abuse (Eaton, Flisher, & Aarø, 2003). In addition to these factors, a review of the research on street children and HIV/AIDS revealed that street children also tend to lack knowledge about HIV, have a low perceived risk, and face competing

Vulnerable girls
- Orphans, particularly maternal and double orphans
- Out of school
- Socially isolated
- Living in poverty
- Migrants
- Illegal immigrants
priorities based on immediate needs for survival. They also have lower access to health care and HIV/AIDS information (Kruger & Richter, 2003).

Social isolation, too, has been associated with vulnerability to HIV. We treat this as a household-level variable rather than an attribute of the individual because it is typically the family or household that is socially isolated. Research demonstrates that the children of migrants as well as illegal immigrants have a higher likelihood of acquiring HIV than do others (Mabala, 2006; Munthali et al., 2006; Rassjo, Mirembe & Darj, 2006), due in part to social isolation. Girls who have migrated from rural areas to cities, often without the family intact, are at increased risk of exploitation, abuse and HIV (Mabala, 2006). Simwaka (2005) also found that girls who do not participate in development activities are more vulnerable to HIV.

Community Factors

The physical and organizational environment influences the proportion of vulnerable girls in a given community. Communities located on truck routes, communities with low social cohesion and communities with little or no girl-friendly sexual and reproductive health services all work against protecting girls from HIV (Mabala, 2006; Mandevu, 1995; Simwaka, 2005). Moreover, girls who live in communities without safe passage to schools or who are not within walking distance of a school are less likely to attend school than are those in closer proximity to school. Risky sexual behavior has also been found to be linked to alcohol use. A study in Rwanda found that young people aged 15-24 who consumed alcohol were less likely to abstain from sex (Babalola, Awasum & Quenum-Renaud, 2002). In Jamaica, adolescents who had experimented with alcohol were more than twice as likely to say they had sexual activity, other factors being equal (Jackson et al., 1998). Thus, communities with unregulated alcohol retail outlets that allow adolescents access will have more vulnerable girls than those who regulate or limit access to such establishments.

Cultural Factors

A cultural norm of no communication about sex (especially between mothers and/or grandmothers and girls) and a lack of sex education render girls vulnerable to HIV (Bates et al., 2004; Mandevu, 1995). Peer pressure from friends and boyfriends to engage in (potentially unsafe) sexual relationships is also a risk factor for girls (Hawkins, Mussà & Abuxahama, 2005; Munthali et al., 2006; Poulin, 2007). Moreover, as Simwaka (2005) and Munthali and colleagues (2006) discuss, in many sub-Saharan African countries, there is a socially sanctioned expectation around premarital relationships and the exchange of sex for gifts. Similarly, an age gap between sexual partners is a significant risk factor for HIV (Bates et al., 2004; Mandevu, 1995; Phaladze & Thlu, 2006; Poulin, 2007). The literature on this specific topic is rather broad and this paper will not go into detail on this topic. However, for the purpose of this paper, it is important to note that when cultural norms in a community dictate that certain practices are acceptable (e.g., exchanging sex for money or gifts, having an older male partner, or having
several overlapping sexual relationships), adolescent girls often do not have sufficient power to defy such cultural norms in order to protect themselves from HIV.

Marriage patterns also influence vulnerability to HIV. In settings where early marriage is a cultural norm, girls are at a disadvantage for many reasons (Clark, 2004). Early marriage often forecloses a girl’s chance to continue her education, increases the likelihood that she will begin childbearing before she is physiologically ready, and reduce her life options (such as whether, when, and where to work, among others). In addition to these negative consequences, Clark (2004) found that early marriage significantly raises the risk of acquiring HIV in a high-prevalence environment. On the other hand, Bongaarts (2007) found an association between late marriage and HIV risk but highlighted that it is the timing of first marriage in relation to the timing of first sexual intercourse that is a key factor. He does not discount Clark’s argument of the risk of HIV infection for married women and argues neither that early marriage or late marriage is better. Instead, he points out that very early marriage raises the risk of infection for girls and adolescents if the marriage occurs before the time when the girl would otherwise be sexually active. On the other hand, marriage after the age of first intercourse raises the risk for unmarried women because it increases the length of pre-marital exposure and the associated risks of higher rate of partnership change and higher infectivity of partners. It is this interval that he identifies as a key factor in countries with high prevalence rates.

Inequitable gender norms constitute another culture factor that contributes to the likelihood of a girl acquiring HIV. Gender inequality reinforces women’s economic dependency on men and women’s subordinate role in the household among other things (Bates et al., 2004; Mabala, 2006; Machel, 2001; Poulin, 2007). Because men are usually the decision-makers at the household, community, and political levels, women do not have decision-making power over many aspects of their lives. For instance, in sub-Saharan Africa, the expectation that women will become mothers and caregivers weakens, and may eliminate, a woman’s ability to negotiate HIV-prevention strategies like contraception use (Bates et al. 2006; Munthali et al., 2006; Phaladze & Thlu, 2006; Poulin, 2007).

Structural Factors

There are many structural factors that render girls vulnerable to HIV. These factors touch most aspects of life and serve as the foundation for many of the HIV-risk factors that exist at the community-level.

Laws and Policies

Laws and policies tend to codify cultural norms, including inequitable gender constructs. By failing to pass or enforce laws that enable women to own property, many sub-Saharan African countries accentuate and enforce women’s poverty and/or dependence. Also, in many countries, laws to “protect” women and girls from exploitation or abuse either do not exist or are not enforced (Mabala, 2006;
Mandevu, 1995; Phaladze & Thlu, 2006). For example, each of the program countries has laws against child defilement, yet none systematically enforce laws designed to protect minors from sexual exploitation (Mulinge, 2002).

**School Fees**

As discussed previously, the evidence is clear: girls who are in school have a lower risk of engaging in sex and, concomitantly, have a lower risk of HIV infection (UNESCO, 2008). Yet, many girls never attend school or leave school prematurely because their families cannot afford school fees and/or other costs of attending school. Many governments in sub-Saharan Africa impose school fees, including Malawi and, except for those living in extreme poverty, Botswana. Even then, some families that are not considered “impoverished” are not able to afford school fees. School fees were abolished in Mozambique in 2004, but the inadequate number of schools in the country means that many girls cannot attend even primary school.

One of the most successful strategies for increasing access to education—and, therefore, lowering HIV vulnerability—is the elimination of school fees. When the governments in Kenya, Tanzania and Uganda eliminated school fees, an additional 8 million children enrolled in primary school (UNESCO, 2008). Since girls are less likely to be enrolled in school than are boys in economically straitened conditions, this policy change was particularly beneficial to girls.

Yet governments do not act alone in this arena. In fact, governments began to impose school fees when the International Monetary Fund and the World Bank forced governments to collect school fees as part of the agreement to obtain loans. This began in the mid 1980s as part of structural adjustment policies and continues to this day in many countries.

**Poverty**

Research demonstrates that poverty is strongly linked to adolescent sexual activity, including transactional sex, physical abuse and sexual coercion within relationships. Poverty also interacts with other risk factors, such as access to the media, recreational facilities, living on the street, and the unequal gender distribution of sexual power (Eaton et al., 2003).

Indeed, Kelly and Parker (2000) found that the most significant vector for predicting sustained adoption of risk prevention measures is socio-economic (SES) status. Those from poor SES backgrounds were less exposed to HIV messages, had fewer resources and lacked appropriate prevention support services. The authors note that it is not the effect of poverty on the minds of youth that is mediating HIV risk but rather the effects of an impoverished environment on the resources available to them. Even when prevention behaviors do not require financial resources, those from poor communities were found to have less interpersonal capacity, self-efficacy, self-confidence and less hope for the future. Girls from lower SES backgrounds were more likely to engage in transactional sex and sexual
relationships with older men. Sexual activity at a young age was also seen as a direct result of having no other recreational opportunities.

Hallman (2005) examined the effects of socioeconomic status, measured by a relative household wealth index, on HIV risk and prevention behaviors known to be associated with HIV transmission. Low relative household wealth was found to be associated with a range of unsafe sexual behaviors, especially for females. Statistically significant differences, controlling for other factors, were found for: (1) low relative household wealth and much higher rates of having ever had sex, (2) fewer reports among females that first sex was willing, (3) greater chances of having been physically forced to have sex and (4) higher rates of ever having received money, goods or favors in exchange for sex. Large and statistically significant effects were also found for females in the lower wealth quintiles having a much greater chance of having had multiple sex partners. Females in lower wealth quintiles were also significantly less likely to have used a condom at last sex (or to have had a condom to use) or discussed safe-sex topics with their most recent sexual partner. No significant difference was found for socioeconomic status and median age difference with first sex partner or with most recent sexual partner.

Machel (2001) finds, in her investigation into unsafe sexual behavior among schoolgirls in Mozambique, that working-class young women aged 14-20 were less assertive and tended to depend on their partners for material needs more than their middle-class counterparts. Machel's research highlights the idea that while gender dynamics work against women overall, working class women and girls experience the combined negative effects of gender and class.

**Factors that Protect Girls from HIV**

Just as there are factors that render girls vulnerable to HIV, there are factors that play a role in protecting girls from HIV. As Rosenblum and colleagues (2005) state, “An emerging view of adolescence is that, rather than representing a period of ineluctable ‘storm and stress’ or a period of extreme adjustment problems, it is a period that increases opportunities for growth as well as the potential for internal and external conflict” (p.584). While it is important to review the literature on resiliency, two things should be noted. First, much of the research in the area of resilience and protective factors is focused on adolescents’ (boys and girls together) avoidance of high-risk behavior and general positive development (the direct link between protective factors and HIV acquisition is not often examined). Second, much of the research has taken place among adolescents in the United States. However, many of the basic findings in this area of research can be extrapolated to inform future interventions targeted to protect girls living in sub-Saharan Africa from HIV.

In the reviewed literature, many authors discussed protective factors at the individual- and interpersonal-levels, or in Leffert and colleagues’ (1998) language, internal and external assets that an adolescent has that “serve to protect from, or inhibit, health-compromising behaviors and enhance the opportunity for positive
developmental outcomes” (p.211). This literature typically did not address community- and structural-level factors.

**Individual-Level Protective Factors**

An often mentioned protective factor was self esteem and self-efficacy (Bogenschneider, 1996). As Leffert and colleagues (1998) note, a positive identity—the feeling that one likes his/her life, feels like his/her life has a purpose, and has control over things that happen to him/her—is an essential internal asset for avoidance of high-risk behavior and positive development. Personal responsibility is another oft discussed factor. Brown and Wells (2005) note that concern over shaming family by getting pregnant or fear of punishment from family (in regards to an unintended pregnancy) serve to guard against adolescents engaging in high-risk sexual behaviors.

Bogenschneider (1996) cites well-developed problem-solving skills and well-developed social and interpersonal skills as important protective factors. Leffert and colleagues (1998) concur and highlight some specific examples of such behaviors, including knowing how to plan ahead and make choices, placing a high value on helping other people, having empathy, sensitivity and friendship skills, and having the ability to resist negative peer pressure.

Female adolescents with high aspirations for the future seem to be more likely to abstain from sex than is true of those without such goals according to a recent qualitative study (Munthali et al., 2006). Kelly and Parker (2000) also found that goal-oriented youth who were optimistic about their futures were more likely to take preventive measures than were others.

Two additional internal assets that were mentioned were a commitment to religion/religious activities and a commitment to learning (Bogenschneider, 1996; Brown & Wells, 2005; Leffert et al., 1998).

**Family and Social Networks as Protective Factors**

Many authors cite positive interpersonal relationships as a key factor in an adolescent’s level of resiliency. Brown and Wells (2005) noted that having positive role models and positive friends is important, just as is having a close relationship with at least one person (Bogenschneider, 1996; Leffert et al., 1998). In a World Health Organization report on balancing the protective and risk factors in programming for adolescents, positive relationships with both parents and teachers were protective factors against early sexual initiation (WHO, 2002).

Leffert and colleagues (1998) also provide a clear organizing structure for four other external assets. First, support for adolescents from all levels of the community—family, school and neighborhood—is an integral factor in the positive development of adolescents. Tied to this is the need for positive family communication, other supportive adult relationships (other than parents and teachers), a caring neighborhood and school and positive school experiences.
(Bogenschneider, 1996; Leffert et al., 1998; WHO, 2002). A second protective factor is the level of youth empowerment at the community level. A community which values youth and views youth as a resource helps adolescents resist engaging in high-risk behaviors (Leffert et al., 1998). The third category of external assets is that of boundaries and expectations. When families, schools and neighborhoods have clear rules and consequences and when adolescents are supervised in all spheres, adolescents are less likely to engage in risky behavior (Leffert et al., 1998). Related, the fourth area is constructive use of time. Adolescents who are engaged in after-school activities, such as sports, clubs, religious activities or organizations at school or in the community are less likely to engage in high-risk behaviors (Brown & Wells, 1995; Leffert et al., 1998; WHO, 2002).

Gregson and colleagues (2004) found that participation in local community groups was positively correlated with the avoidance of HIV. In a nuanced look at the role of group membership, they noted that how well a group functions, the purpose of the group, and the individual participant’s educational level all affected that correlation. Overall, they concluded: “Young women with secondary education participate disproportionately in well-functioning community groups and are more likely to avoid HIV when they do participate” (p.2129).

**Interventions to protect vulnerable girls from HIV**

**Individual-Level Interventions**

Many individual-level interventions focus on increasing HIV-related knowledge among adolescents. For example, the Masedi Abstinence and Empowerment Project in Botswana aimed to support youth aged 8-18 to delay sexual debut through the formation of school-based Masedi clubs that deliver abstinence education, as well as sports, music and drama. Evaluation has noted that it does however remain taboo to talk to young people about sex.

In Mozambique, an intervention launched in 2002 by the Mozambican Association for Promoting Girls (AMORA) aimed to empower adolescent girls through building income-generation skills such as sewing, pottery and cooking, holding school- and community-based lectures on HIV prevention, distributing condoms, and providing literacy classes to those girls who had left school. No evaluation data is available.

In Egypt, the Ishraq program targets out-of-school adolescent girls aged 11-15 to provide access to formal learning opportunities, alleviate limitation to mobility and social networks and reduce the large number of forced marriages at a young age. Ishraq participants were over three times as likely to have visited a health facility as non-participants and only eight percent of participants believe female genital mutilation is necessary compared to 68% of non-participants. The project is ongoing and so final outcome data is not yet available (Ishraq, accessed 7 August 2008)

In the Geração Biz (Busy Generation) program in Mozambique, a school-based
program (for in-school youth) and an outreach component (for out-of-school youth) provides sexual and reproductive health information, as well as counseling.

The program partners directly with youth-friendly, gender-sensitive health services. Evaluation of the program found that after the introduction of youth-friendly services, the number of youth accessing services in 2000 rose to 11,669. Condom distribution also rose from 26,800 in 1999 to 230,661 in 2001. In 2001, a total of 5,762 young women and 2,087 young men received some combination of sexual and reproductive health information, counseling, referrals, and condoms. (Hainsworth, 2002).

Family and Peer Network Interventions

Family and peer networks are the focus of the MOZARQ program in Mozambique, launched by World Vision in 2007, which forms parents’ adviser’s groups and youth adviser’s groups that work with other parents and students on HIV prevention. Unfortunately, no evaluation is available.

The Peer Education for HIV Program in Tanzania, launched by Plan International, targeted the most at-risk youth who were out-of-school. The program goals are to: (1) promote behavior change among youth to prevent HIV, other STIs and unplanned pregnancy; (2) protect youth against sexual abuse and gender-based inequality; (3) empower them to resist sexual coercion by peers or older persons; and (4) enhance collaboration between parents and youth. Peer educators organized community meetings and youth groups and delivered a comprehensive program for HIV prevention and sexual health and promotion of gender equality. Peer educators were linked to a livelihood and microfinance component. Evaluations showed a marked increase in knowledge about HIV/AIDS among young people and the number of condoms distributed by peer educators increased steadily. In 2002, the peer educators started a village savings and loan club with 35,000 Tanzanian Shillings (apx $35 USD). By the end of 2005, the group had 218,000 TS in their account and had already used some of their profits to buy an additional acre of land for farming. (Plan, 2006).

During 2006 to 2008, the Shaping the Health of Adolescents in Zimbabwe (SHAZ) project targeted a group particularly vulnerable to HIV/AIDS—out-of-school female orphans aged 16-19. All girls first receive training in life skills: reproductive health, HIV prevention and negotiating condom use, vocational training, classes in entrepreneurship, help in developing a business plan, etc. Each girl is paired with a local businesswoman who acts as a mentor. Those with viable business plans, backed by a market feasibility study, will receive a loan of up to $100 from a microcredit firm in Harare. Evaluation found increased knowledge and more equitable gender attitudes; furthermore the proportion of participants that went to bed hungry dropped from 33% to 17%. Decreased levels of violence were also reported. (Chase, 2004).

Community-Level Interventions
In Mozambique, the Association for Children Development and Young Girls’ Education (Namuali) began training community leaders and teachers in 2007 on HIV issues and provided school kits and school uniforms to students. Other activities include creating a center where young people can learn skills, working with the school counsel to provide a food garden in the school, and working with the women responsible for initiation rites. No evaluation data is available.

**Multi-Level interventions**

Several interventions covered more than one level of the social ecological framework.

In Ethiopia, Biruh Tesfa, or “Bright Future,” is a community-based intervention that targets out-of-school girls aged 10-19, most of whom are migrants, living away from parents and family members. These girls are at risk of coerced sex, transactional sex and exploitative labor. They often work as domestic workers, where they are exposed to low pay, long hours and physical and sexual abuse, and often drift into sex work. The program seeks to protect the rights of these girls by reducing their social isolation and providing them with health information, including HIV prevention and services to address sexual exploitation and abuse. It is designed to create safe spaces for isolated girls through which they can build support networks with other girls, as well as relationships with supportive adults. The program provides functional literacy, life skills, livelihoods skills, and HIV and reproductive health education through girls’ clubs led by adult female mentors (most are local women’s leaders, and are active and well-known in the community). It also addresses structural issues by providing identity cards and linkages to social support agencies. Over 3,700 out-of-school girls are participating in Biruh Tesfa groups, one third are 10-14 years old, 21% are double orphans, 34% single orphans and 79% have never attended school (Erulkar, Mekbib & Tegegne, 2008).

Stepping Stones in Botswana worked at the individual, family and community levels via job skills training, life skills education, psychosocial support and counseling, study skills, income-generating projects, expression activities, outreach to families and community advocacy. The program targeted orphans and other children aged 12-18 who were vulnerable to HIV, to empower them to become leaders of the next generation by nurturing their mental, physical and spiritual well-being. Evaluation of the program is ongoing. (Stepping Stones International, accessed 7 October 2008)

In Kenya, the Tap and Reposition Youth (TRY) Livelihoods Project for Girls and Young Women aimed to reduce adolescents’ vulnerabilities to adverse social and reproductive health outcomes, including HIV infection, by improving their livelihoods options. The program targeted out-of-school adolescent girls and young women, aged 16-22, and adapted a group-based adult microfinance model to suit their needs. It included specialized business training, an integrated mentoring program that provided social support, counseling, referral for vulnerable young women, and a voluntary saving program. The effectiveness of TRY was evaluated through pre- and post-test intervention surveys among participants and among
controls and had a significant impact on girls’ earnings and savings. At both baseline and endline, TRY girls were significantly more likely than girls in the control sample to have savings. Repayment rates were lower than standard (50% by December 2004), probably as a result of the program’s experimental nature and focus on learning what works best for adolescents, but partners considered losses in repayment as tradeoffs for other benefits that girls accrue. TRY participants were not more knowledgeable than girls in the control sample about reproductive health issues, but they held more liberal gender-role attitudes than the control girls and were significantly more likely to be able to insist on condom use and to refuse sex. (Erulkar et al., 2006)

The Kenya Adolescent Reproductive Health Project (KARHP) worked at the individual level to provide reproductive health services for adolescents aged 10-19 by increasing access to health facilities and providing education to in-school adolescents within a framework of information about life-skills and development. The project also worked at the family and community levels to create a supportive environment within which the educational and service delivery activities could be implemented by addressing sensitivity to sexual and reproductive health issues among parents and other community members. Activities included participatory community mobilization, sessions with parents and adolescents during religious and community meetings, talks on sexual and reproductive health by religious leaders to their congregation, and teaching parents to talk to their children. An evaluation of the program found that the school-based intervention raised awareness of basic sexual and reproductive health functions among all adolescents, except older boys. Non-consensual first-time sex significantly decreased, and an increased likelihood of first having sex with a friend rather than someone else was reported. (Askew et al., 2004)

One project that worked at all levels of the social ecological framework was the Promoting Safer Choices for Adolescents (ProSCAd) project in Uganda, which aimed to reduce inequalities in sexual and reproductive health and improve implementation of sexual and reproductive health laws and policies by 2007. At the individual level, the project collected, produced and distributed communication materials on sexual and reproductive health. At the peer and family network level, peer supporters were identified and sensitized, and at the community and societal levels, the project compiled existing laws and policies on sexual and reproductive health to facilitate community awareness campaigns. The project targeted vulnerable and hard-to-reach adolescents, along with parents, guardians, community leaders, church groups, traditional birth attendants and health services. ProSCAd stimulated and supported behavior change, which led to a decrease in the proportion of adolescent pregnancy to 30%; improved self-esteem and trust, improved quality of health care services and increased reconciliation between adolescents and parents. The project also led to national advocacy that informed an amendment of the law on defilement under the Penal Code. (WHO, 2007)

While there are many HIV-prevention programs underway in southern Africa, few are designed specifically for the most vulnerable female adolescents. Maclean’s
(2006) lament still holds today: “. . . young people who are particularly marginalized or vulnerable—for example, orphans, street and working children, young people engaged in illegal or socially sanctioned activities such as sex work or drug use—are [rarely] reached through mainstream YRH2/HIV interventions, including those specifically targeting out-of-school youth” (p.26). The need for more detailed analysis and rigorous evaluation of interventions designed for marginalized or vulnerable adolescent girls is needed as we seek to refine approaches to youth and community involvement in HIV prevention.

Discussion

This review helped identify gaps in the literature on girls’ vulnerability to HIV. It will be important to address these gaps in future studies in order to protect vulnerable girls from contracting HIV.

First, in many research studies and interventions, girls are not often the sole target group. Girls are often grouped together with adolescent boys or with women, which may misrepresent girls and the factors that render them particularly vulnerable to HIV. Many of the factors that render boys vulnerable to HIV are very different from the factors that affect girls. Although many of the factors that render women vulnerable to HIV are the same for girls, grouping girls together with women (and boys) overshadows the details of how certain factors affect girls. To effectively address girls’ vulnerability to HIV, researchers and programmers need to view girls as their own group. They need to examine the factors that affect girls—regardless of whether those factors also affect women or boys—and they need to develop interventions specifically for girls.

Another serious gap in the literature is the need for a clear definition of vulnerability as it relates to girls acquisition of HIV. Authors of many of the reviewed articles circumvented this topic or provided a general statement which encompasses the word vulnerability, never providing a definition of vulnerability. It is necessary to define vulnerability in order to properly address the vulnerability of girls in future interventions. Also, many of the reviewed articles confused the ideas of vulnerability to HIV and vulnerability from HIV. Defining these terms in future interventions should also clarify this point.

A third gap that was uncovered during the literature review was the need to link together programs in sub-Saharan Africa aimed at protecting girls from HIV. Many well-planned and well-executed programs are underway throughout sub-Saharan Africa. However, there is little to no link between them. Moreover, only a few were identified that attempt to change structural factors (e.g., by increasing access to educational, health, and financial resources). A patchy network of programs can lead to girls losing out on participating in interventions offered by various organizations. In addition, planning and conducting interventions in

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2 YRH: youth and reproductive health
A fourth gap is that relatively few programs were evaluated systematically. Most evaluation reports were limited to process evaluations—how many were reached, whether they liked the programs, etc. They did not link participation to specific attitudinal, social normative, behavior or social-structural change outcomes. Unless and until interventions for vulnerable girls are rigorously tested, we will not know what works, what to replicate, what to change, and what to forego as we develop programs in the coming years.

Through interviews and focus groups with adolescents in South Africa, Campbell and colleagues (2005) uncovered three interacting dimensions of context undermining the likelihood of effective HIV prevention programs that should inform future studies in this area. The first dimension—symbolic context—includes stigma and negative images of young people in society. The second dimension is the patchy network of organizations that exists throughout South Africa (and sub-Saharan Africa). The third dimension is the political context, including poverty, unemployment and crime, and exclusion of young people from local and national decision-making and politics. The dimensions highlighted by Campbell and colleagues (2005) echo the three levels of societies discussed earlier: individual, community and system-levels. Only if we examine and address the constellation of factors in girls’ lives that render them vulnerable to HIV infection will we be able to arrest this deadly disease. There is an urgent need for multifaceted, multilevel interventions and programs to protect girls in sub-Saharan Africa from HIV.
### Annex 1: Table of Interventions

<table>
<thead>
<tr>
<th>Country</th>
<th>Title</th>
<th>Goals/ Objectives</th>
<th>Time</th>
<th>Target</th>
<th>Interventions</th>
<th>Evaluation</th>
<th>Notes</th>
<th>Lead Org</th>
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<tbody>
<tr>
<td>Botswana</td>
<td>Masedi Abstinence and Empowerment Project</td>
<td>Support youth to delay their sexual debut / promotes abstinence</td>
<td>2003-</td>
<td>Youth between 8 and 18 (primary school pupils and out-of-school youth)</td>
<td>School-based Masedi Clubs provide their members with abstinence education as well as sports, music and drama</td>
<td>It is still a taboo to talk to young people about sex</td>
<td>No detailed evaluation information available.</td>
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<tr>
<td>Botswana</td>
<td>Stepping Stones International</td>
<td>To empower youth to become leaders of the next generation by nurturing their</td>
<td>2007-</td>
<td>Orphaned and vulnerable children aged 12-18+</td>
<td>After school program (job skills training, life skills, psychosocial support and counseling, study skills, volunteer activities, income</td>
<td>Ongoing</td>
<td>Targets OVC, but not girls specifically</td>
<td>Stepping Stones Intl</td>
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<td></td>
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<td>mental, physical, and spiritual well-being. To motivate 75% of the orphan</td>
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<td>generating projects, expression activities, outreach to families, advocacy in the community)</td>
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<td></td>
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<td>centre's participants to either continue education or obtain employment by the</td>
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<td>age of 18.</td>
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<td>Egypt</td>
<td>Ishraq</td>
<td>Provide access to formal learning opportunities, alleviate limitation to mobility</td>
<td>2001-</td>
<td>Out-of-school adolescent girls 11-15</td>
<td>Program consists of learning and recreational modules. The latter use sports to develop girls' leadership and decision-making skills. Ishraq also engages parents, adolescent boys, and community leaders and works with schools and youth centers to provide a sheltered environment for girls</td>
<td>Participants were over 3 times as likely to have visited a health facility as non participants; only 8% of Participants believe FGM is necessary compared to 68% of non-participants; Change of attitudes towards early marriage</td>
<td>Targets vulnerable girls…but not specifically about HIV/AIDS</td>
<td>Population Council</td>
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<td>Country</td>
<td>Title</td>
<td>Goals/Objectives</td>
<td>Time</td>
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<td>Ethiopia</td>
<td>Biruh Tesfa (Bright Future)</td>
<td>To assist out-of-school adolescent girls by creating safe spaces through which they can build support networks with other girls, as well as relationships with supportive adults.</td>
<td>2005-ongoing</td>
<td>Out-of-school girls 10-19</td>
<td>The program promotes functional literacy, life skills, livelihoods skills, and HIV/reproductive health education through girls’ clubs led by adult female mentors. Biruh Tesfa recruited adult female leaders from the community to be trained as mentors and ultimately lead groups of girls. Following training, mentors conducted initial household listings to identify eligible out-of-school girls aged 10–19. It was necessary to reach girls within households and to negotiate participation for such girls directly with their employers.</td>
<td>Formative research and monitoring data showed that over 3,700 out-of-school girls are participating in Biruh Tesfa groups: Nearly 2,400 participants are from Addis Ababa slum areas. Overall, one-third of participants are in the younger age group, 10–14 years. 21% are double orphans, and 34% are single orphans. One-quarter of Biruh Tesfa girls are domestic workers living with their employers. Girls, especially those who had migrated, were more likely to live without their parents and were considerably poorer than others; and many girls were in low-paid jobs, such as domestic work.</td>
<td>Includes HIV component</td>
<td>Ethiopia Ministry of Youth and Sports and Population Council</td>
</tr>
<tr>
<td>Kenya</td>
<td>Kenya Adolescent Reproductive Health Project (KARHP)</td>
<td>To improve knowledge about reproductive health and encourage a responsible and healthy attitude towards sexuality among adolescents; To delay the onset of</td>
<td>1999-2003</td>
<td>Adolescent girls and boys aged 10 to 19 years; Mothers and fathers.</td>
<td>Peer education, guidance and counseling in schools, and introduction of youth-friendly services in participating health facilities. Sensitization and guidance efforts conducted by trained</td>
<td>Conducted. School-based intervention raised awareness of basic SRH functions among all adolescents except older boys. Using a condom for prevention was better known among girls and boys in site A</td>
<td>Targets out-of-school youth through community interventions, but not specifically girls</td>
<td>Population Council &amp; PATH</td>
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<td>Country</td>
<td>Title</td>
<td>Goals/Objectives</td>
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<td>Kenya</td>
<td>Tap and Reposition Youth (TRY) Livelihoods Project for Girls and Young Women</td>
<td>To reduce adolescents’ vulnerabilities to adverse social and reproductive health outcomes, including HIV infection, by improving their livelihoods options.</td>
<td>1998-2005</td>
<td>Out-of-school adolescent girls and young women aged 16–22</td>
<td>Adaptation of a group-based adult microfinance model for young women. It includes specialized business training; an integrated mentoring program that provides ongoing social support, counseling, and referral for vulnerable young women; and a voluntary saving program.</td>
<td>The effectiveness of TRY was evaluated through pre- and post-test intervention surveys among participants and among controls and had a significant impact on girls’ earnings and savings. At both baseline and endline, TRY girls were significantly more likely than girls in the control sample to have savings. Repayment rates were lower than standard (50% by December 2004), probably a result of TRY participants not being more knowledgeable than girls in the control sample about RH issues, but they seemed better able to negotiate sexual relationships. At the same time, they held more liberal gender-role attitudes than the control girls. TRY girls’ responses showed that they were significantly more likely than girls in the control group to be able to insist on condom use and to refuse sex.</td>
<td>Population Council and K-Rep Development Agency (KDA)</td>
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<td>Country</td>
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<td>Mozambique (Nampula Province)</td>
<td>AMORA (Mozambican Association for promoting girls)</td>
<td>Empower girls at school level and give them life skills (with culinary courses, and sewing)</td>
<td>2002- onwards</td>
<td>Adolescent girls</td>
<td>Provides school kits (including to COVs), provide literacy classes for girls that have abandoned school; teach income generation skills like sewing, pottery, and cooking classes; Lectures in schools and public places about HIV and distribution of condoms.</td>
<td>the program’s experimental nature and focus on learning what works best for adolescents. The partners in TRY consider losses in repayment as tradeoffs for other benefits that the girls accrue.</td>
<td>No further information available</td>
<td>Mozambique (Nampula Province)</td>
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<td>Mozambique (Zambezia province)</td>
<td>MOZARQ (World Vision)</td>
<td></td>
<td>2007- onwards</td>
<td>Adolescents and young people</td>
<td>Areas: Abstinence and condom use. Use parents' adviser's groups and youth adviser's group that in turn work with other parents and other students in schools.</td>
<td>No further information available</td>
<td>No further information available</td>
<td>Mozambique (Zambezia province)</td>
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<td>Mozambique (Zambezia province)</td>
<td>Namuali (Association for children development and young girl's education)</td>
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<td>2007- onwards</td>
<td>OVCs and young people, especially young girls</td>
<td>Training of community leaders and teachers on HIV issues; school kits and school uniforms given to students of a school, Plan to create a center where young girls can access resources.</td>
<td>No further information available</td>
<td>No further information available</td>
<td>Mozambique (Zambezia province)</td>
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<td>Country</td>
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<tr>
<td>Mozambique</td>
<td>Geração Biz (Busy Generation)</td>
<td>Improve adolescent SRH, increase gender awareness, reduce the incidence of unplanned pregnancies, and decrease young people’s vulnerability to STIs, HIV, and unsafe abortion.</td>
<td>1999 - ongoing (2009)</td>
<td>In- and out-of-school youth</td>
<td>A school-based program for in-school youth and an outreach component for out-of-school youth provides sexual and reproductive health information and counseling and is linked to youth-friendly, gender-sensitive health services.</td>
<td>Young people expressed their preference for YFS in clinics. After the introduction of youth-friendly services, the number of youth accessing services in 2000 rose to 11,669. Condom distribution also rose from 26,800 in 1999 to 158,000 in 2000 to 230,661 in 2001. In 2001, a total of 5,762 young women and 2,087 young men were reached through the adolescent corners with ASRH information and counseling as well as provided with referrals and condoms when needed.</td>
<td>Pathfinder</td>
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<td>Tanzania</td>
<td>Peer education for HIV</td>
<td>- To promote adoption of safer behavior among youth for the prevention of unwanted</td>
<td>2001-</td>
<td>Most at-risk youth who are out-of-school</td>
<td>30 candidates selected for training as peer educators. Comprehensive training program included</td>
<td>Repeated evaluations showed a marked increase in knowledge about HIV/AIDS among young people. The</td>
<td>Out-of-school youth, but not specifically girls</td>
<td>Plan Intl</td>
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<td>Country</td>
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<td>Goals/Objectives</td>
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<td>Uganda</td>
<td>Promoting Safer Choices for Adolescents (ProSCAd)</td>
<td>To reduce inequalities in SRH &amp; improve implementation of SRH laws and policies by 2007 (increase access to services, strengthen community dialogue, document and communication skills, community mobilization, gender awareness, information about HIV and other sexual health issues. After training, they organized community meetings and youth groups. Through education and entertainment, they delivered a comprehensive program for HIV prevention, promotion of gender equality and sexual health promotion. Supported by livelihood component in which Plan provided training in vegetable gardening, established a savings and credit association and donated a water pump and other farming supplies.</td>
<td>2004-2007</td>
<td>Vulnerable/ unreached adolescents (self-excluded, sexually abused/exploited and neglected) e.g., boda-boda cyclists, pregnant</td>
<td>number of condoms distributed by peer educators increased steadily. In 2002, the peer educators started their traditional village savings and loan club with 35,000 Tanzanian Shillings (apx $35 USD). By the end of 2005, the group had 218,000 TS in their account and they had already used some of their profits to buy an additional acre of land for farming. By the end of 2005, all 30 peer educators selected in 2001 were still active in the program.</td>
<td>Out of 14,799 adolescents reached, 1371 (972 females, 399 males) were unreached adolescents. ProSCAd stimulated and supported behavior change, which led to a decrease in the proportion of Vulnerable youth….but not HIV/AIDS specific</td>
<td>CARE Uganda</td>
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<td>Country</td>
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<td>Goals/ Objectives</td>
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<td>Zimbabwe</td>
<td>SHAZ Project (Shaping the Health of Adolescents in Zimbabwe)</td>
<td>To evaluate the effectiveness of a combined intervention to reduce economic vulnerability and HIV risk</td>
<td>2006-2008</td>
<td>Female, out-of-school orphans aged 16-19</td>
<td>Life Skills and home-based health care education; Livelihoods (vocational training w/ micro grant); Integrated Social Support</td>
<td>Increased knowledge and more equitable gender attitudes and the proportion of participants that went to bed hungry dropped from 33% to 17%. Decreased levels of violence were also reported.</td>
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<td>UCSF</td>
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</table>
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