



**Integrating Youth into Health Programs:
Considerations for Implementing the Youth in
Development Policy in Global Health Activities**

**September
2013**

Integrating Youth into Health Programs: Considerations for Implementing the Youth in Development Policy is intended to *assist* global health staff and health officer to understand the importance of addressing the health needs of youth in their programming, and it *suggests* tools that staff can use to assess the needs of youth and to develop programs. This document is the first of an occasional series of resources and tools to be developed on youth health programming

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PURPOSE

The Global Health Bureau has long recognized the importance and relevance of adolescents and youth in health programming. With the recent launch of the Agency's **Youth in Development Policy**, the Bureau is well-positioned to lead Agency efforts to mainstream and integrate youth into its health programming. This document can be used as an additional support to implement the Agency's policy and provides suggestions and resources to advance and improve youth and adolescent health within current health priorities.

In the following pages we briefly describe USAID's Youth in Development Policy, present evidence and recommendations supporting the importance of considering youth within health programs, and provide references to resources and tools that can assist in planning for enhanced attention to youth.

The annexes offer key definitions (*Annex 1*), outline the stages of adolescence (*Annex 2*), and provide evidence-based programming recommendations (*Annex 3*).



GLOBAL ATTENTION TO ADOLESCENTS AND YOUTH

The rights of young people and their importance to the development of countries are recognized by many international organizations and global agreements. The 1994 **International Conference on Population and Development Programme of Action** advocated for member states to “promote to the fullest extent the health, well-being and potential of all children, adolescents and youth, as representing the world’s future human resources.”¹ In the preamble to the declaration of the International Year of Youth (2011), the UN General Assembly noted that “the ways in which the challenges and potential of young people are addressed will influence current social and economic conditions and the well-being and livelihood of future generations.”²



Photo credit: photoshare.com

The **World Development Report (WDR)** 2007 discusses how the key choices and decisions made by youth in the five life domains (learning, working, developing a healthy lifestyle, beginning a family, and exercising citizenship) will have a long-term impact on human capital. Governments must increase their direct investments in each life domain, and cultivate an environment of investment in and for young people and their families. A youth lens on policies affecting these domains should focus on expanding opportunities, enhancing capabilities, and providing second chances.³

The 45th Session of the **UN Commission on Population and Development (CPD)** urged member states to protect and promote human rights and fundamental freedoms “by protecting the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health.”⁴

Further, the 65th **World Health Assembly** recognized the importance of addressing the consequences of early marriage and young pregnancies for young women and their infants.⁵

The achievement of the **Millennium Development Goals** requires investments in young people’s health. The 2012 **Bali Global Youth Forum Declaration** recognized young people’s rights and states that “governments should work in partnership with adolescents and youth, media, religious leaders and the private sector to create enabling environments that are conducive to ensuring young people have access to comprehensive affordable health services that are free from coercion, discrimination, violence and stigma – and provide for basic needs through increased funding, improved legislation and policies, accessible and affordable services.”⁶



USAID’s **Youth in Development Policy** defines youth as “(A) life stage, one that is not finite or linear. Key multilaterals such as UNFPA and WHO define youth as 15 to 24 years for statistical purposes, yet for policy and programming many countries and organizations expand this range to reflect the broader range of youth changes and developmental needs in the transition to adulthood, as well as the diversity among cultural and country national contexts.

USAID uses the terms youth and young people interchangeably and while youth development programs often focus on youth in the 15 to 24 year age range, USAID programs also are likely to engage individuals aged 10-29 as a broader youth

Box 1: The population of youth aged 10-24 as a share of total population in 2006 and 2025

Region	Number in 2006 (millions)	Share of population in 2006 (%)	Number in 2025 (millions)	Share of population, 2025 (%)
World	1,773	27	1,845	23
Africa	305	33	424	32
Asia	1,087	28	1,063	22
North America	71	21	74	19
Latin America & Caribbean	161	28	165	24
Europe	140	19	111	16

Source: *Population Reference Bureau, Youth in a Global World*
<http://www.prb.org/pdf06/YouthInAGlobalWorld.pdf>

cohort.”

The World Health Organization’s (WHO) definition of adolescents and adolescence is particularly pertinent for USAID’s global health programs. USAID’s health programs are more likely to work with youth between the ages of 10 and 19.

“WHO identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. It represents one of the critical transitions in the life span and is characterized by a tremendous pace in growth and change that is second only to that of infancy. Biological processes drive many aspects of this growth and development, with the onset of puberty marking the passage from childhood to adolescence. The biological

determinants of adolescence are fairly universal; however, the duration and defining characteristics of this period may vary across time, cultures, and socioeconomic situations...

“The process of adolescence is a period of preparation for adulthood during which time several key developmental experiences occur. Besides physical and sexual maturation, these experiences include movement toward social and economic independence, and development of identity, the acquisition of skills needed to carry out adult relationships and roles, and the capacity for abstract reasoning. While adolescence is a time of tremendous growth and potential, it is also a time of considerable risk during which social contexts exert powerful influences.”

TODAY, approximately one in four persons is between the ages of 10 and 24. As Box 1 indicates, the number of youth will continue to grow some parts of the world, offsetting declines in other regions

- **In all developing countries, youth are about 29 percent of the total population with regional variations.**
- The proportion of Asia’s population (excluding China) aged **10-24 is only 20 percent**; however, Asia’s total youth population is nearly three times that of Africa’s (1.1 billion compared to 344 million).
- **There will be about 72 million more youth in 2025 than there are today,**⁷ meaning that in many regions - especially in Africa - young people will drive economic growth, but *only* if policies and programs are in place to enrich their opportunities and encourage smaller families.
- About 16 million girls aged 15 to 19 years and two million girls under the age of 15 give birth every year. The majority of these births occur within marriage.
- **More than 30% of girls in developing countries are married before age 18, with 14% married before age 15.** Unprotected sexual activity contributes to a number of health and social risks and negative outcomes for many young women, including: early pregnancy, sexually transmitted infections like HIV, obstetric fistula, unsafe abortion, poor nutrition, and gender-based violence.
- Data suggests that unmet need for family planning is often high among sexually active adolescents who would like to postpone pregnancy, particularly married adolescents who are often under great pressure to demonstrate fertility.⁸

WHY CONSIDER YOUTH IN HEALTH PROGRAMMING?

Approximately 2.6 million adolescents die each year, largely of preventable causes, even as child and maternal mortality have declined. In a longitudinal study of 50 countries, childhood mortality was reported to have declined by more than 80% in the past 50 years, and since 1990, maternal mortality has declined by 47%. By contrast, adolescent mortality has only marginally improved.

Source: Patton et al, <http://www.who.int/mediacentre/factsheets/fs348/en/index.html>

In nearly every country where USAID works, the youth population's size will influence the global health agenda for decades to come. As the current generation of young people moves into its childbearing years, there will be more women of reproductive age than at any other time in history. Their fertility patterns will dictate future population growth, especially in Africa, the Near East, and South Asia regions – which are only now beginning to experience fertility decline. And, the views, attitudes and actions of today's young people will influence the health and wellbeing of their peers and of future generations.

Adolescence is often considered one of the healthiest phases of life, and has received limited attention in the global public health arena. Yet the most recent review of available evidence suggests that 2.6 million adolescents die every year and the majority of these deaths are preventable. In adolescence, young people may begin to engage in behaviors that put them at risk for health problems both today and in the future. These behaviors include unprotected sexual activity, smoking, alcohol use, and poor patterns of nutrition and exercise. Young people's health is further compromised by poverty, community norms and practices such as early marriage and childbearing, transactional and intergenerational sex, gender norms and inequities, and gender-based violence.

Negative attitudes among health care providers, restrictive policies and laws also limit young people's access to comprehensive and age appropriate health information and services, particularly sexual and reproductive health. Research in the US demonstrates that more focused attention to strengthening protective factors (both internal and external) and

Box 2: What are protective factors?

Efforts to improve child and adolescent health have typically addressed risk behaviors, such as early initiation of sexual intercourse, or lack of contraceptive use. Results from a growing number of studies suggest greater health impact might be achieved by enhancing protective factors that help young people avoid the behaviors that put them at risk for adverse health outcomes.

Protective factors are individual or environmental characteristics, conditions, or behaviors that reduce the effects of stress and risk factors. They promote social and emotional competence to thrive in all aspects of life, now and in the future. Examples of protective factors include school connectedness, parental connectedness and self-efficacy.

Source: *World Health Organization*

http://whqlibdoc.who.int/publications/2005/9241593652_eng.pdf

empowering young people to better understand and advocate for their own health buffers against risks, prevents negative outcomes, and contributes to positive outcomes (see Box 2).

USAID's Global Health Bureau has long recognized the importance of addressing adolescent health, especially in its reproductive and sexual health programs. The Bureau has supported two global projects that identified a number of best and promising practices in adolescent health programming. Regrettably, few programs have gone to scale.

DRAFT

A BRIEF OVERVIEW OF USAID'S YOUTH IN DEVELOPMENT POLICY

The Youth in Development Policy was developed through a participatory and consultative process, involving USAID Washington and Mission staff, as well as youth serving organizations and young people. Launched in October 2012, the Policy is timely given the sizeable global youth population and their acute need for support, protection, preparation and engagement. Families, communities and governments need to provide opportunities for education and employment, and ensure access to appropriate health services.

More deliberate and focused attention to youth within and across all of USAID's programming – including health – is essential to the achievement of USAID's development objectives.

A. *Goal and Objectives*

The Policy's goal is to improve the capacities and enable the aspirations of youth so that they can contribute to and benefit from more stable, democratic, and prosperous communities and nations.

The Policy establishes two objectives:

- 1: Strengthen youth programming, participation, and partnership in support of Agency development objectives.
- 2: Mainstream and integrate youth issues and engage young people across Agency initiatives and operations.

The Youth in Development Policy is aspirational. It does not establish new requirements for programming and reporting, nor does it allocate new funding. Instead, it makes the case that intentional consideration to this key demographic can accelerate and enhance the achievement of USAID core objectives, and suggests ways that Missions and Global programs can mainstream, elevate, and integrate youth considerations into their programming portfolios.

Box 3: Positive Youth Development

USAID is increasingly interested in adapting and applying lessons learned from positive youth development (PYD) programming low and middle income countries. USAID recognizes that building and supporting young people's potential, capacities, and abilities is as integral to success as efforts to reduce risk, and to ensure positive behaviors and outcomes across a range of sectors, including health.

For more information on PYD, see: the Journal of Youth "Development, Vol. 6, No 3, Fall 2011 at http://www.nae4ha.com/assets/documents/JYD_110603final.pdf

B. Programming Framework

The Policy encourages a paradigm shift away from viewing youth primarily as beneficiaries of programs designed to reduce their risk of poor health, social, and economic outcomes towards one that advances and strengthens youth capacity and potential as partners and leaders in development. The programming framework of “*support, protect, prepare, and engage*” facilitates USAID’s efforts to:

- Mainstream youth into core initiatives;
- Ensure youth issues and participation are integrated throughout the program cycle; and
- Apply relevant USAID Forward reforms and operational processes to youth.

USAID has identified the following principles as essential to the development of programs for youth. These are to:

- Recognize youth participation as vital;
- Invest in assets that build resilience;
- Account for youth differences and commonalities;
- Create second chance opportunities;
- Involve and support mentors, families and communities;
- Pursue gender equality; and
- Embrace innovation and technology by and for youth.

Health program managers and technical specialists are encouraged to review the complete policy, which can be downloaded here:

http://transition.usaid.gov/our_work/policy_planning_and_learning/documents/Youth_in_Development_Policy.pdf

Box 4: Changing gender norms

Changing harmful gender norms that affect the wellbeing of women and men is essential to USAID’s efforts to improve health. Adolescence is an important time to intervene and to help young people develop positive values, beliefs, and behaviors around gender equality. USAID’s Gender Equality and Female Empowerment Policy recognizes that adolescents are key to ensuring gender transformations.

Source: USAID Gender Equality and Female Empowerment Policy, http://transition.usaid.gov/our_work/policy_planning_and_learning/documents/Gender_EqualityPolicy.pdf

HOW YOUTH FIT WITHIN GLOBAL HEALTH SPECIAL INITIATIVES AND PRIORITIES

USAID's Global Health Strategic Framework identifies the Agency's core global health priorities. Improved attention to and mainstreaming of youth in the Agency's health programs is pivotal to achieving and sustaining better health outcomes in many of these priority areas.⁹

Youth focused health programming builds on and leverages earlier investments in newborn and child health programs. It ensures that children not only survive their fifth birthday, but also thrive into adolescence and adulthood and even to the next generation. It assists young people, their families and communities to establish healthy and protective patterns of behavior.

Yet, youth continue to face many social, economic, cultural, and legal barriers to comprehensive health information and services – including reproductive and sexual health.

New research strengthens our understanding of the development of the adolescent brain and how it influences adolescent behaviors and health. This improved understanding suggests the need for policies, programs, and health services that promote enabling environments and limit restrictions to young people's access to high quality and equitable health services.

Policies, programs and services should:

- **Be age, developmentally and culturally appropriate**
- **Be gender sensitive**
- **Build on positive family and community support for adolescent health and healthy behaviors**
- **Provide greater opportunities for participation and engagement in their design, implementation, and evaluation.**

USAID's enhanced and more sustained commitment to the identification of best practices in youth health and development and the accelerated implementation of evidence-based health programs and policies for youth are likely to significantly contribute to the achievement of USAID's key health initiatives and programs.

1. CREATING AN AIDS-FREE GENERATION

USAID contributes to PEPFAR's overall goals to prevent 12 million HIV infections by 2014; provide treatment for 6 million people living with HIV by 2013; and support care for more than 12 million people and OVCs by 2014. Youth are essential to reaching PEPFAR's prevention, care, and treatment goals. Young people are particularly vulnerable to HIV infection:

- **Almost half of all new HIV infections in the world occur to people under age 25: over 40% of infections are among young people aged 15-24.**
- **Nearly five and a half million young people are living with HIV. Over half (57%) of those living with HIV are young women.**
- **HIV prevalence among young women aged 15-24 is more than four times higher than among young men aged 15-24 in the hyper-epidemic countries of Southern Africa.**
- **There needs to be a greater focus on the specific needs of adolescents within OVC programs, as many OVCs are adolescents.**
- **Programs for people living with HIV must better address the needs of young people living with HIV (YPLHIV). (See Box 5.)**



PEPFAR's Blueprint for Creating an AIDS-Free Generation focuses on women, girls, and key affected populations, and identifies youth as a priority population. It discusses key drivers of the epidemic, such as gender inequality in education and economic opportunities, and the importance of male engagement. The Blueprint calls for improving girls' access to education, increasing economic opportunities for women, addressing harmful gender norms, preventing gender-based violence and exploitation, engaging men and boys, and supporting the human rights of women, girls, lesbian, gay, bisexual, and transgendered (LGBT) populations.

Box 5: Young People Living with HIV

Recent data shows that many children infected vertically are now entering adolescence, especially in sub-Saharan Africa. These young people are expected to live a long and healthy life. However, they live with a host of clinical and psychosocial concerns that many health systems are not equipped to address, especially as youth transition from pediatric to adult management of HIV. As vertically infected adolescents emerge as a unique population of people living with HIV, policymakers, programmers, and service providers must focus attention and develop a stronger understanding of their special health and social support needs, which in general mirror the needs of all adolescents. Poorly planned transitions from pediatric to adult care can result in harmful consequences, such as non-adherence to treatment and loss to follow up in care and support services.

Source: Transitioning of care and other services for Adolescents living with HIV in Sub-Saharan Africa
http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_TechnicalBrief_ALHIV_Transition.pdf

It also recognizes the need to promote more effective linkages and integration with other services including FP/RH and MNCH, as well as among HIV services including linking HIV testing and counseling for youth with youth-friendly HIV/AIDS care. Young people living with HIV (YPLHIV) need adequate support as they transition to adulthood, seek youth-friendly HIV care and treatment programs, develop sexual relationships, and plan their own families.



Effective HIV prevention for young people requires tailored interventions that address their needs, risks, and interests. In addition to

comprehensive sexuality education, PEPFAR will target and tailor programming for sexually active and most-at-risk youth with a focus on improved condom use.

Comprehensive packages of programs for highly vulnerable youth, including young members of key affected populations are also needed. Key affected populations -- men who have sex with men (MSM), sex workers, and people who inject drugs (PWID) -- also include young MSM, young sex workers, and young PWIDs.

The Blueprint spells out the need to evaluate the impact of PEPFAR-funded youth programs to strengthen the evidence base and requests “to the extent feasible” that data be disaggregated by sex and age in all health service programs.

Three of the Blueprint’s six major actions are specifically related to youth. These are to:

- Strengthen programmatic commitment to and emphasis on reaching youth with HIV services;
- Strengthen and continue to focus on women, girls and gender equality; and
- Reach OVCs affected by AIDS and support programs that help them develop full potential.

The strategies identified as most appropriate to operationalize these actions are to:

- Target programming for sexually active/at risk youth
- Provide information and skills to help youth transition to safe sexual activity
- Work with parents and guardians to support youth
- Engage adults and create an enabling environment for youth behavior change
- Expand programs for out of school youth
- Support youth access to HIV Testing and Counseling (HTC) and ensure care for HIV + youth

- Encourage sexually active youth to practice safer sex, have fewer partners and use condoms
- Prioritize evidence-based interventions for prevention, care and treatment
- Provide packages of interventions for vulnerable youth and young key populations
- Support structural interventions to reduce exposure to risk for young people
- Strengthen and expand gender sensitive programs for young men and women
- Evaluate PEPFAR funded youth programs for better evidence base.

Access the PEPFAR Blueprint here: <http://www.pepfar.gov/documents/organization/201386.pdf>



2. ENDING PREVENTABLE MATERNAL AND CHILD DEATH

Helping young women to delay marriage and/or first pregnancy and improving their access to appropriate reproductive health and family planning services, antenatal care, safe delivery services, and postpartum support can contribute to reducing both maternal and under-five morbidity and mortality. In fact, complications from pregnancy and childbirth are the leading cause of death for young women aged 15-19 in a number of countries, especially in Sub-Saharan Africa.

Young women under age 18 face a 28% greater risk of maternal mortality,¹⁰ and are more likely to experience pregnancy related morbidities, including preeclampsia, anemia, and urinary tract infections, as well as fistulae from prolonged or obstructed labor. Rates of preterm birth, low birth weight, and asphyxia are higher among the children of adolescent mothers as compared to older women. In low- and middle-income countries, stillbirths and death in the first week and first month of life are 50% higher among babies born to mothers under age 20 than those born to mothers aged 20–29 years.¹¹

The children of adolescent mothers are likely to be more malnourished, less likely to be immunized and to have longer durations of hospitalization. USAID must continue and accelerate its efforts to

prevent early marriage, delay first pregnancy, and to pay more focused and specialized attention to the needs of the adolescent first time mother.

This also depends on an enabling policy and legal environment that includes programs to keep girls in school and to prevent early marriage. Comprehensive sexuality education and youth friendly health services will also support the ability of all young people to practice healthy behaviors, including increased use of contraception and health services.

3.

Box 6: Unsafe abortion and adolescents

59% of all unsafe abortions in Africa are estimated to occur to women aged less than 25 years, and mortality is frequently highest among adolescents. Studies among different populations of adolescents in Cameroon and Nigeria found that approximately 20% of adolescents report having had at least one abortion, usually performed by a physician or nurse, and complications were common.

Source: Preventing Unsafe Abortion and its Consequences Priorities for Research and Action, <http://www.guttmacher.org/pubs/2006/07/10/PreventingUnsafeAbortion.pdf>

3. THE GLOBAL HEALTH INITIATIVE

Among other goals, GHI aims to reduce maternal mortality by 30 percent across assisted countries and reduce from 24 to 20 percent the proportion of women aged 18-24 who have their first birth before age 18.

- **Nearly one-third of girls in developing countries are married before the age of 18, and 14% marry before the age of 15.**
- **About 16 million girls aged 15 to 19 years and two million girls under the age of 15 give birth every year. Worldwide, one in five girls has given birth by the age of 18.¹² In the poorest countries this can be as many as one in three girls.**
- **Births among adolescents account for 11% of all births worldwide, yet they contribute 23% of the burden of disease due to pregnancy and childbirth among women of all ages.**
- **Adolescent girls under 18 have a 28% higher risk of dying from maternal causes compared to women in their 20s and 30s with risk increasing as maternal age decreases.¹³**

One of the core principles of the GHI is gender equity. Youth specific approaches to improving gender equity include programs that foster and strengthen the social networks of girls and young women, ensure educational opportunities and build the economic assets of adolescent girls. The prevention of early marriage and early pregnancy are also essential to empowering adolescent girls and achieving gender equity.

Family Planning 2020

USAID supports this global initiative, which will provide 120 million women in the world's poorest countries with access to contraceptives by 2020.

See more information at <http://www.londonfamilyplanningsummit.co.uk/>

Most adolescent births occur in marriage, and many married adolescents would like to delay their first pregnancy or better space their second pregnancy. Only about one-third of married adolescents in low and lower-middle-income countries who want to avoid pregnancy use a modern method. The majority of sexually active unmarried adolescents do not want to become pregnant, and despite improvements in the use of modern family planning methods among sexually active, unmarried adolescents, there are still high levels of unmet need for family planning. A significant proportion of unsafe abortions – almost 15 percent -- are to adolescents and young women under the age of 20, with 41 percent of all abortions occurring to women aged 15-24. An increased focus on addressing unmet need among youth will considerably contribute to the achievement of FP2020's targets.

4. *THE PRESIDENTIAL MALARIA INITIATIVE*

Malaria in adolescents has largely been overshadowed by the huge burden of disease in children under five. Adolescents, however, are also at risk from malaria infection, illness and death particularly in areas of unstable malaria transmission.

PMI supports universal coverage of insecticide treated nets (ITNs), indoor residual spraying and case management of malaria illness, all of which will contribute to preventing and treating malaria in adolescents. Of note is that malaria infection and its consequences are more severe for both mother and fetus in women who are pregnant with their first child, many of whom may be adolescents.¹⁴

It is important to continue to promote proven malaria prevention interventions, especially for first time mothers, which includes sleeping under an ITN, intermittent preventive treatment in pregnancy (IPTp), and immediate treatment if malaria is acquired.



A teenage girl sits under a makeshift mosquito net.

5. TUBERCULOSIS

After years of neglect, there is now greater global attention to pediatric TB, with a focus on infants and children under five. Older children and adolescents may not receive such attention, however, as they are not perceived to be at high risk for TB. Young people, however, are often disproportionately affected by TB. Many countries do not even report TB cases under the age of 15 and prevalence surveys do not include children and adolescents under the age of 15. There is little data on burden of disease and treatment outcomes for younger adolescents aged 10-14.



Young people in India raise awareness of TB.

The lack of data is due in part to the difficulty in diagnosing TB in children and adolescents. The data that is available show that TB should be considered a priority issue for young people. Malnourished and marginalized adolescents (including those who use drugs and/or alcohol, are conscripted into armies, work in unsafe settings such as mines, and/or who are trafficked for illicit labor or sex) have little ability and/or agency to seek care for TB.

Since TB is the most common opportunistic infection and cause of death among people living with HIV, TB is likely to have a disproportionate effect on the well-being of adolescents where adolescents are highly vulnerable to HIV. Pregnant adolescents with TB may expose their infants to the disease during and after pregnancy, further contributing to TB's spread. Young people are also affected if they are taken out of school to care for a family member with TB.

A 2012 prevalence survey in Ethiopia revealed a very young epidemic, with the highest concentration of cases in the 15-24 year old age group. Future surveys in other high burden countries will provide further insight into the age specific nature of the disease.

TB Treatment for Adolescents Poses Special Challenges

A TB diagnosis for a young person can result in disruption of education, especially where community-based care is not available, and stigmatization. In some conservative communities, adolescent girls may not be allowed out of the house or to travel to a clinic on their own to seek care, while in other settings, particularly South and South East Asia, a TB diagnosis is so stigmatizing for a young woman that she may be ostracized by her family and community and not considered suitable for marriage.

Adolescents may also feel reluctant to seek ongoing care, especially if they feel unwelcome or uncomfortable attending clinics geared for mothers and infants. They may lack resources to pay for care, especially when services are far from home. And the long window of diagnosis and treatment may test the young person's ability to remain focused and disciplined towards the distant goal of cure, especially once they begin to feel better after the first phase of treatment. MDR-TB treatment requires up to two years of drugs with serious side effects, and a cure can seem unreachable to many adolescents.

6. NUTRITION

Despite current awareness of the establishment of poor nutrition habits in adolescence as well as global obesity trends, adolescents are not a top priority for nutrition programs. Adolescence, however, has physiological, psychological, and social features that influence nutrition problems and interventions. Since adolescents are relatively healthy, they are often overlooked, even though they may be nutritionally vulnerable.



Photo credit: photoshare.com

In many transitioning developing countries, western lifestyles and eating patterns are spreading. This brings a number of nutrition-related problems. These nutrition problems are likely to be quite similar for the majority of adolescents living in countries in transition or in rapidly developing economies, for the more affluent teens in poor countries, and for adolescents of industrialized countries.

Healthy eating habits are essential for adolescents to achieve optimal performance in school and ensure proper growth, and healthy diets must include key micronutrients and iron-folate to prevent anemia. Undernourished adolescents are at risk of poor pregnancy outcomes which threaten the health and growth of their children both immediately and in the longer term. Children who are born to underweight, anemic mothers are more likely to be stunted and have limited cognitive ability.

The current focus on the first 1,000 days – the days between a woman’s pregnancy and her child’s second birthday - to reduce stunting in young children, is being extended to include greater emphasis on strengthening women’s nutritional status *before* they become pregnant. The U.S. supports the international Scaling Up Nutrition (SUN) movement, which focuses on collaboration, results, harmonized multi-sector approaches, and the first 1,000 days of a child’s life. Since the children of adolescent mothers are more likely to have poor health outcomes, it is important to identify effective approaches and partnerships to reach adolescent mothers.

Visit FeedtheFuture.gov to learn more.

7. US GOVERNMENT ACTION PLAN ON CHILDREN IN ADVERSITY (APCA)

The U.S. Government Action Plan on Children in Adversity (APCA) was launched at the White House in December 2012 and focuses on creating positive youth outcomes from birth forward.

APCA will encourage and track projects that stimulate, protect and build resilience for young people under the age of 18, which include adolescents and youth. It also aims to demonstrate the results of diverse U.S. Government assistance towards 0-17 year olds, and emphasizes that projects and implementing partners that have the ability to measure APCA's specific outcomes should do so, and furthermore, should commit to improving such efforts over time.



One focus of the APCA is to increase programming designed to enable youth, their families and their communities to prevent and overcome adversity, so that young people can reach their full potential and positively contribute to development. There are important opportunities within USAID's Global Health Bureau to do this through an adolescent/youth development lens, which will complement its more mainstreamed assistance to younger children.

The USAID Youth in Development Policy programming framework “supports, protects, prepares and engages” youth. The policy further addresses the concept of “protection” and its relation to the APCA:

“Protection efforts focus on preserving young people’s rights, and bolstering and aligning programs in adherence to national and international legal frameworks regarding vulnerable youth, conflict and disaster response. Protection programs will incorporate commitments, policy and best practices per the forthcoming U.S. Government Action Plan on Children in Adversity. Particular attention will be given to early marriage, gender-based violence, trafficking in persons, and the rights of lesbian, gay, bisexual and transgender (LGBT) populations.”

The APCA can be downloaded at the following link:

http://transition.usaid.gov/our_work/global_health/pdf/apca.pdf

8. CHILD MARRIAGE

Each year, over 14 million girls under the age of 18 marry. A significant number of girls are forced into marriage. Child marriage and its consequences cut across a range of USAID priority issues, including health. Girls who marry early usually leave school, which can result in social isolation, limited social development, and poor mental health outcomes.

Married girls are expected to demonstrate their fertility, even though early pregnancy can have severe health and social consequences for both mother and child. In many places, marriage is a risk factor for HIV infection, as young girls are often married to older men who are likely to be more sexually experienced.



USAID published **Ending Child Marriage and Meeting the Needs of Married Children: A Vision for Action** in October 2012 which affirms the Agency's commitment to preventing and responding to gender-based violence as part of its overall mission. And the March 2013, Violence Against Women Act (VAWA) includes a mandate for the Department of State to develop a national strategy to end child marriage. Health programs should consider the effect of child and early marriage in the development of global and country level activities.

USAID's Vision for action can be found here: http://pdf.usaid.gov/pdf_docs/PDACU300.pdf

Future health program considerations: Non-communicable diseases and injuries (NCDIs) and adolescents

Of the 57 million global deaths in 2008, 36 million, or 63%, were due to NCDIs, and the large majority of the 2.6 million deaths among young men and women aged 10-24 were from NCDIs that are largely preventable. Over half of NCD-related deaths are associated with behaviors that begin or are reinforced during adolescence, including tobacco and alcohol use, poor eating habits, and lack of exercise. Patterns of behavior that are initiated in adolescence persist throughout life and are often hard to change. In 2011, the World Health Assembly endorsed a resolution calling upon member states to address the needs of youth in the context of NCDs. USAID is currently considering ways to better address NCDIs in its work.

Source: World Health Association, News Release, 64th World Health Assembly Close After Passing Multiple Resolutions, http://www.who.int/mediacentre/news/releases/2011/world_health_assembly_20110524/en/

9. ADDRESSING GENDER BASED VIOLENCE

Gender based violence (GBV) stems from unequal power dynamics between women, men, girls and boys and can include sexual, physical, verbal and/or psychological harm. The forms and prevalence of GBV varies across the globe and can occur at any point across the life span – from infancy, to childhood and adolescence to and through adulthood. Manifestations of GBV against children and adolescents include female genital cutting (FGC), early, forced and/or child marriage, intimate partner violence (IPV), trafficking of girls and boys, commercial sexual exploitation, sexual harassment and more. The consequences of GBV range from chronic sexual, reproductive, physical, and behavioral health issues such as unwanted pregnancy, HIV, fistula, and depression, among many other problems, to even death.

The Youth in Development Policy's programmatic framework of "support, protect, prepare and engage" has the potential to comprehensively address GBV across the lifecycle. Family, community and institutional gender norms and inequities foster vulnerability to GBV among young people. The Global Health Bureau's approach to gender addresses how girls and boys interact with each other, and also considers the power dynamics (for example, between teachers and students or boyfriends and girlfriends) and norms that influence them.

The Global Health Bureau invests in both prevention of and responses to sexual violence, intimate partner violence (IPV), female genital cutting (FGC), child/forced marriage, traumatic fistula, and institutional violence. The Bureau also invests in strengthening the collection of data to measure GBV experienced by youth as well as data that assesses the effect of programmatic interventions. Programmatic approaches include integrated programs, strategic planning and policies that actively engage boys (and men), the promotion of equity in services, ensuring legal rights and protection, and improving access social and economic resources for girls and boys.

TOOLS AND RESOURCES FOR YOUTH HEALTH PROGRAMMING

The following information is intended to assist Bureaus and Missions to expand current programming to address the health of youth and adolescents within and across programs and sectors.

YOUTH ASSESSMENT TOOLS DEVELOPED BY USAID FOR “YOUTH-FRIENDLY” HEALTH PROGRAMMING

The Agency’s Youth Policy expects USAID operating units to consider how mainstreaming youth can support the achievement of their development objectives. Assessments that examine demographic trends, country context and indicators, national priorities and the availability of appropriate programming will contribute to improved understanding of how to achieve this objective. (See Annex A of the Youth in Development Policy for further guidance.)

Youth assessments are suggested as part of the development of the Country Development Cooperation Strategies (CDCS) and Project Appraisal Document (PAD). Youth assessments provide a detailed understanding of the needs of the diverse youth population including the identification of vulnerable youth, the areas of greatest need, the conditions that may drive youth toward risky behavior or may support positive behaviors, and the potential for impact.

Other considerations should include barriers that adolescents may face in adopting healthy behaviors. These include the policy and legal environment and the behaviors and attitudes of gatekeepers, such as parents, teachers, service providers and other influential community members. Assessments for health programs should ideally focus on adolescent and youth aged 10-19.

The **Demographic and Health Surveys (DHS)** remain an essential source of information for health programming. To facilitate greater understanding of youth health needs, Measure DHS has created a “youth corner” with data specific to youth aged 15 – 24. DHS does not collect data on 10-14 year olds. <http://www.measuredhs.com/topics/Youth-Corner/index.cfm>

The Population Reference Bureau (PRB) also regularly produces the **World’s Youth Data** sheet which compiles global data into a handy wall chart. <http://www.prb.org/pdf13/youth-data-sheet-2013.pdf>

UNICEF conducts the **Multiple Indicator Cluster Survey (MICS)** which assists countries to collect and analyze data on children and women. The MICS has enabled many countries to produce statistically sound and internationally comparable estimates of a range of indicators in the areas of health, education, child protection and HIV/AIDS. http://www.unicef.org/statistics/index_24302.html

Other global data sets include the **Global School Health Survey** <http://www.cdc.gov/gshs/> and the **Global Youth Tobacco Survey**, <http://www.who.int/tobacco/surveillance/gyts/en/> which are implemented by WHO and CDC.

While USAID does not as yet have an established tool or guidelines for conducting youth analyses or assessments, a number of assessment tools have been developed by USAID partners that can be adopted and utilized by Missions and Bureaus. The use of these tools will provide a more detailed understanding of the health status of youth, their information and service delivery needs, and potential opportunities to strengthen and expand existing programs.

USAID implemented two global youth health projects:

FOCUS on Young Adults which was implemented from 1994 – 2000. The end of project report can be found here: http://www2.pathfinder.org/pf/pubs/focus/pubs/eop_report.pdf

YouthNet was implemented from 2000- 2006. Many materials developed under YouthNet as well as new publications and resources can be found here:

<http://www.fhi360.org/resource/youth-infonet>

A third global youth project known as EQUIP3 (Education Quality Improvement Program) was supported by the Bureau for Economic Growth, Education and Environment (E3) which ended in April 2012. Resources from EQUIP3 can be found here:

http://www.equip123.net/equip3/index_new.html



LISTING OF KEY YOUTH ASSESSMENT TOOLS

YouthNet Country Needs Assessment Tool

The **YouthNet project** developed a country assessment tool for youth reproductive health and HIV. It is a systematic approach that assesses a country's needs and opportunities, and provides useful methodologies, recommendations, and lessons distilled from in-country experiences. Using an integrated framework, the tool examines policy, behavior change communication, gender, community involvement, and other areas. By incorporating multiple technical viewpoints, a broader range of findings – and consequently a richer and more comprehensive analysis of a country's youth and youth programs – is possible.

Link: <http://www.fhi360.org/NR/rdonlyres/eogazrvyyc5auu6vbrhedzo5nyeyyspfqbx57fs2debqtwqcgbfjxwrjr7mupcb4vaoebanf3foi/CNAPrinted304.pdf>

Guide for Conducting Cross-Sectoral Youth Assessments

The **EQUIP 3 project** implemented by E3 developed a guide for youth assessments in the areas of education, employment, agriculture, democracy and governance and health. The guide includes a conceptual framework, instruments and tools. See the guides here:

http://pdf.usaid.gov/pdf_docs/PNADZ193.pdf

Country experiences in adapting the EQUIP 3 tool to conduct youth assessments included:

- *USAID/Haiti* which adapted the participatory rapid appraisal tools developed by EQUIP3 and trained in- and out-of-school youth to map their communities. The youth developed a comprehensive checklist to assess all informal economic activities and formal types of business.

An observational survey was developed to collect specific data on sample businesses of each type that could inform livelihood programming and sustainability initiatives. The link to the report, *Economic Realities and Opportunities for Out-of-school Youth in Haiti* is http://pdf.usaid.gov/pdf_docs/PNADZ252.pdf

- *USAID/Angola* partnered with youth to conduct a cross-sectoral rapid assessment in 2006 to inform its programming with the Government of the Republic of Angola, non-governmental organizations, and the private sector. The assessment systematically examined the needs, aspirations and experiences of youth in education and employment,

and compared these with the capacity of government, private sector and youth-serving NGOs.

Three development sectors were considered: employment/livelihoods, health, and civic engagement. Cross-sectoral opportunities for engagement with youth were prioritized and strategic interventions were identified. The link to the report, *Youth Assessment in Angola* is http://pdf.usaid.gov/pdf_docs/PNADR510.pdf

- *USAID/Dominican Republic (DR)* conducted a Cross-Sectoral At Risk Youth Assessment in 2010 to analyze the structure and characteristics of youth in the DR, review the issues facing youth and assess the resources available to address them education, economic growth, health, and democracy and governance.

The report recommended that USAID/DR establish a single youth program providing a social safety net for vulnerable youth within targeted geographic areas for out-of-school youth ages 10-13 and youth ages 14-17 who were both out of school and unemployed. The link to the report, *USAID/Dominican Republic Cross-Sectoral at-risk Youth Assessment: Final Report* is http://pdf.usaid.gov/pdf_docs/PNADY160.pdf

Community Youth Mapping: a Tool for Youth Participation and Program Design

Community Youth Mapping is a youth-centered participatory development strategy that engages young people and adults in canvassing their communities to document community-based resources, needs, and opportunities. Seeing the community through the eyes of young people is, to many, a more comprehensive assessment of what a community has to offer. See more here: http://pdf.usaid.gov/pdf_docs/pnadz225.pdf

Engaging Communities in Youth Reproductive Health and HIV Projects: A Guide to Participatory Assessments.

This comprehensive resource outlines how to conduct participatory assessments with youth and community members for improved youth reproductive health and HIV prevention. Attention is paid to youth participation, guidelines for training community participants, and suggestions for adapting the methods and tools for use at other project stages.

This resource is available at: <http://www.fhi360.org/resource/engaging-communities-youth-reproductive-health-and-hiv-projects-guide-participatory>

Listening to Young Voices: Facilitating Participatory Reproductive Health Appraisals with Adolescents

This guide equips fieldworkers with the necessary techniques to carry out a participatory appraisal with adolescents and youth on sexual and reproductive health.

See the guide here: <http://www2.pathfinder.org/pf/pubs/focus/RPPS-Papers/pla1.pdf>

Youth:Map

The Africa Bureau implements Youth:Map to conduct comprehensive, cross-sectoral youth assessments. To date, assessments have been completed in Senegal, Uganda, and Mozambique. The assessments examine education, workforce development, democracy and governance and health. Executive summaries of the reports are available here:

Mozambique: http://library.iyfnet.org/sites/default/files/library/YouthMap_Moz_ExecVersion.pdf

Senegal:

http://library.iyfnet.org/sites/default/files/library/YouthMap_Senegal_Executive_Summary.pdf

Uganda:

http://library.iyfnet.org/sites/default/files/library/YouthMap_Senegal_Executive_Summary.pdf



OTHER ASSESSMENT TOOLS

Other organizations have developed tools that Missions and Bureaus may also find useful.

- **Rapid Assessment and Action Planning Process**

This is a tool developed by the World Health Organization which facilitates the development of school health programs. See the tool here:

http://www.who.int/school_youth_health/assessment/raapp/en/index.html

- **Quality Assessment Guidebook: A guide to assessing health services for adolescent clients**

Also developed by the World Health Organization, this tool can be used to improve the quality of services provided to adolescents. Available here:

http://whqlibdoc.who.int/publications/2009/9789241598859_eng.pdf

- **Clinic Assessment of Youth Friendly Services: A tool for improving reproductive health services for adolescents**

Developed by Pathfinder International, this tool assesses the “youth friendliness” of available clinical services. Available here: <http://www.pathfinder.org/publications-tools/Clinic-Assessment-of-Youth-Friendly-Services-A-Tool-for-Improving-Reproductive-Health-Services-for-Youth.html>

- **Assessment of Youth-Friendly Postabortion Care Services: A Global Tool for Assessing and Improving Postabortion Care for Youth**

Pathfinder International has also developed a similar tool to assess the “youth friendliness” of postabortion care services, which can be downloaded here: http://www2.pathfinder.org/site/DocServer/YFPAC_assessment_tool.pdf?docID=13121

- **The Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings**

Developed by UNFPA and Save the Children this tool assesses the health needs of youth in crisis or conflict settings and is a companion piece to the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. See the toolkit here: <http://www.unfpa.org/public/home/publications/pid/4169>

- **Supporting Youth Participation in Program Planning**

A number of tools have been developed that promote strategies for effective and meaningful youth participation:

- **Youth Participation Guide: Assessment, Planning, and Implementation**

Developed by FHI360's YouthNet project, this guide seeks to increase the level of meaningful youth participation in reproductive health (RH) and HIV/AIDS programming at an institutional and programmatic level. The target audience includes senior and middle management, program managers, staff involved in implementing activities, and youth who may be engaged at all levels of an organization's work.

Available at: <http://dev.iywg.org/resources/youth-participation-guide-assessment-planning-and-implementation-0>

- **Youth Participation in Development: A Guide for Development Agencies and Policy Makers**

Developed by Restless Development, this guide provides tools to engage the young decision makers of tomorrow in the development decisions of today. The guide can be downloaded from the website here: <http://www.ygproject.org/>

INTEGRATING YOUTH INTO LONG TERM PLANNING AND SOLICITATIONS

The **Agency's Youth in Development Policy** calls for USAID Washington Bureaus, Offices, and USAID Missions to prioritize youth within their respective organizations and designate and hold accountable youth portfolio leads to coordinate youth programs and issues.

An **Agency Policy Implementation Team** has been established. This team has been charged with developing recommendations and concrete next steps for the Policy. An **Agency-wide Youth Working Group** exists, and is made up of Washington- and Mission-based staff with interest and expertise in youth. The working group is currently chaired by Clare Ignatowski of E3 and Christine Adamczyk of OHA.

Within the Global Health Bureau, there is a number of staff with interest and expertise in youth programs. The Office of Population and Reproductive Health (PRH) has a dedicated **Youth Advisor**, as youth is a technical priority for PRH's programming. Cate Lane is currently the Youth Advisor in PRH, and Elizabeth Berard is the portfolio lead in OHA.

Youth analysis is an optional element of the CDCS and PAD process. While optional, most USAID projects and missions work in countries with young and growing populations and greater attention to youth is increasingly seen as important to program development



To integrate youth into long term and strategic planning documents such as concept notes and PADs:

- Read and reference the Operating Unit’s current long term planning documents ensure that youth issues are identified and appropriately addressed.
- Include any information from host country youth assessments, any prior work done at global or Mission level on youth and other partners, or donor efforts to promote improved adolescent health and development. These could include comprehensive sexuality education, delaying sexual initiation, peer education programs, “youth friendly” health services, keeping girls in school, preventing child marriage, etc.
- Expand the examination of youth issues beyond the individual level (e.g. the number of youth infected with HIV or the number of young women who give birth before age 18) to consider implications for youth at the family, community, institutional and policy level. In other words, what are the laws, policies and practices around age of marriage, age of consent to sexual intercourse, age of consent for medical services, intergenerational sex, transactional sex (i.e., sugar daddies/sugar mummies), and gender norms/inequities that contribute to poor health outcomes for youth, especially for girls.

Indicators that measure youth outcomes should also be incorporated in Performance Monitoring Plans. Measure Evaluation’s Family Planning and Reproductive Health Database suggests a number of adolescent and youth sexual and reproductive health indicators:

http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/arh

There is a pressing need for age-disaggregated data, especially data that is disaggregated into at least five year increments (10-14 and 15-19). The following resources provide additional guidance for monitoring and evaluating youth programs:

The Guttmacher Institute and IPPF have just published ***Demystifying Data: A guide to using evidence to improve young people’s sexual health and rights*** which is available at:

<http://www.guttmacher.org/pubs/demystifying-data.pdf>

The FOCUS on Young Adults Project produced ***A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs***, which includes a section on recommended process and outcome indicators. This publication can be found here in English, French and Spanish:

<http://www.pathfind.org/publications-tools/index.jsp?topics=monitoring-and-evaluation&page=2>

WHO has produced ***A Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programs for Young People***: http://www.who.int/hiv/pub/me/en/me_prev_intro.pdf

There is also a ***Compendium of Indicators for Evaluating Reproductive Health Programs***, which includes a section on adolescent reproductive health indicators:

http://www.rhrc.org/resources/general_fieldtools/toolkit/52c%20INDICATORS.pdf

ANNEX 1 – KEY TERMS AND DEFINITIONS

Youth

The **Youth in Development Policy** defines youth as “(A) *life stage, one that is not finite or linear. Key multilaterals such as UNFPA and WHO define youth as 15 to 24 years for statistical purposes, yet for policy and programming many countries and organizations expand this range to reflect the broader range of youth changes and developmental needs in the transition to adulthood, as well as the diversity among cultural and country national contexts.*

USAID uses the terms youth and young people interchangeably and while youth development programs often focus on youth in the 15 to 24 year age range, USAID programs also are likely to engage individuals aged 10-29 as a broader youth cohort. The transition to adulthood involves multiple and overlapping physical, cognitive, emotional, political, social and cultural changes. Successful youth engagement and programming is based on a lifecycle continuum, beginning with deliberate attention to the critical years of children entering adolescence and into young adulthood.

USAID views early adolescence as the onset of transition with recognition that those under age 18 are universally considered children and subject of numerous national and international norms and legal protections that this policy seeks to reinforce.

At the same time, this policy is reflective of youth voices and perspectives. When consulted, some younger youth have identified themselves as teens or youth, rather than as children. Recent research provides new understanding about brain development, physical changes, and social and emotional development that can be used to inform and target programming along the youth life span from adolescence through early adulthood.”

Adolescence

Adolescence is difficult to precisely define. Each individual experiences this period differently depending on her or his physical, emotional and cognitive maturation as well as other variables. While onset of puberty is often seen as the clear line between childhood and adolescence, this is straightforward definition does not resolve the complexities of this phase of life. **WHO identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19, which represents one of the critical transitions in the life span and is characterized by a tremendous pace in growth and change that is second only to that of infancy.**

Biology drives many aspects of this growth and development, with the onset of puberty marking the passage from childhood to adolescence. The biological determinants of adolescence are fairly universal; however, the duration and defining characteristics of this period may vary across time, cultures, and socioeconomic situations. This period has seen many changes over the past century namely the earlier onset of puberty, later age of marriage, urbanization, global communication, and changing sexual attitudes and behaviors. This is the age group that is most important for USAID's global health programming.

Youth, teens, adolescent, young people, and young adult

These terms are often used interchangeably, and definitions of the specific age range vary. The United Nations for statistical purposes defines 'youth' as those persons between the ages of 15 and 24 years, "without prejudice to other definitions by Member States and noting that within the category of 'youth,' it is also important to distinguish between teenagers (13-19) and young adults (20-24), since the sociological, psychological and health problems they face may differ. The UN also defines young people as those aged 10 to 24, youth as those aged 15 to 24 and adolescents and those aged 10 to 19.

Life cycle approach

UNFPA notes that a life cycle approach (which is also sometimes called life course or life span approach) to health programming is needed. Health in general, and reproductive health in particular is a lifetime concern for both women and men, from infancy to adolescence to old age, and health programs should be tailored to the different needs and challenges individuals face at different times in life. More on a life cycle approach to reproductive health can be found here:

<http://www.unfpa.org/rh/lifecycle.htm>



ANNEX 2 – THE STAGES OF ADOLESCENCE

Stages of Adolescence	Physical Development	Cognitive Development	Social-Emotional Development
<p>Early Adolescence (11 – 13 years old)</p>	<p>Puberty: grow body hair, increase perspiration and oil production in hair and skin</p> <p>Girls – breast and hip development, onset of menstruation</p> <p>Boys – growth in testicles and penis, wet dreams, deepening of voice</p> <p>Tremendous physical growth: gain height and weight</p>	<p>Growing capacity for abstract thought</p> <p>Mostly interested in present with limited thought to the future</p> <p>Intellectual interests expand and become more important</p> <p>Deeper moral thinking</p>	<p>Struggle with sense of identity</p> <p>Feel awkward about one’s self and one’s body; worry about being normal</p> <p>Realize that parents are not perfect; increased conflict with parents</p> <p>Increased influence of peer group</p> <p>Desire for independence</p> <p>Tendency to return to “childish” behavior, particularly when stressed</p> <p>Moodiness</p> <p>Rule- and limit-testing</p> <p>Greater interest in privacy</p> <p>Growing sexual interest</p>

Stages of Adolescence	Physical Development	Cognitive Development	Social-Emotional Development
<p>Middle Adolescence (14 –18 years old)</p>	<p>Puberty is completed</p> <p>Physical growth slows for girls, continues for boys</p>	<p>Continued growth of capacity for abstract thought</p> <p>Greater capacity for setting goals</p> <p>Interest in moral reasoning</p> <p>Thinking about the meaning of life</p>	<p>Intense self-involvement, changing between high expectations and poor self-concept</p> <p>Continued adjustment to changing body, worries about being normal</p> <p>Tendency to distance selves from parents, continued drive for independence</p> <p>Driven to make friends and greater reliance on them, popularity can be an important issue</p> <p>Feelings of love and passion</p> <p>Increased sexual interest</p>

Stages of Adolescence	Physical Development	Cognitive Development	Social-Emotional Development
Late Adolescence (19 – 24 years old)	<p>Young women, typically, are physically fully developed</p> <p>Young men continue to gain height, weight, muscle mass, and body hair</p>	<p>Ability to think ideas through from beginning to end</p> <p>Ability to delay gratification</p> <p>Examination of inner experiences</p> <p>Increased concern for future</p> <p>Continued interest in moral reasoning</p>	<p>Firmer sense of identity, including sexual identity</p> <p>Increased emotional stability</p> <p>Increased concern for others</p> <p>Increased independence and self-reliance</p> <p>Peer relationships remain important</p> <p>Development of more serious relationships</p> <p>Social and cultural traditions regain some of their importance</p>

Source: American Academy of Child and Adolescent Psychiatry

ANNEX 3 – CONSIDERATIONS FOR YOUTH PROGRAMMING

In childhood, health is related to communicable diseases which can be addressed through straightforward interventions such as immunizations, insecticide treated bed nets to prevent malaria, oral rehydration therapy to treat diarrhea and the availability of antibiotics to treat respiratory infections. In adolescence, however, morbidity and mortality are more closely related to the adoption of new and potentially unhealthy behaviors such as smoking, alcohol use, and unprotected sexual activity. These behaviors often have an immediate impact on adolescent health (e.g. HIV infection, unsafe abortion, injury and accidents) as well as a long term impact on the incidence of obesity, diabetes, and cancers.

The majority of health programs targeted to youth have focused on improving health outcomes in relation to sexuality and reproductive health, with a primary focus on risk reduction and the prevention of early pregnancy and HIV/AIDS. Programs have begun to consider other aspects of health including nutrition, healthy lifestyles, violence, injury, substance abuse, mental health and non-communicable diseases, and to look at those factors in a young person's life that act as protective buffers against risk. Research and program experience show it is neither feasible nor productive to focus on one isolated behavior without addressing a broader set of adolescent health concerns and there is mounting evidence that the most effective interventions enhance protective factors and do not simply attempt to reduce risk.

USAID's *Knowledge for Health (K4H)* compiles resources and tools on a number of health topics, including adolescents and youth.

Search the K4H website at: <http://www.k4health.org/>

The World Health Organization has published *Preventing Early Pregnancy and Poor Reproductive Health Outcomes among Adolescents in Developing Countries*.

Download at: http://whqlibdoc.who.int/publications/2011/9789241502214_eng.pdf

WHO has also published a technical brief on HIV prevention, *Preventing HIV/AIDS in young people: Evidence from developing countries on what works, A summary of the WHO Technical Report Series No 938*

See:

http://www.who.int/maternal_child_adolescent/documents/pdfs/en_hiv_y_people_evidence.pdf

Advocates for Youth has also published *Science and Success in Developing Countries: Holistic Programs that Work to Prevent Teen Pregnancy, HIV and Sexually Transmitted Infections*

Download at:

http://www.advocatesforyouth.org/storage/advyf/documents/sciencesuccess_developing.pdf

\CDC has compiled *Effective HIV and STD Prevention Programs for Youth: A summary of scientific evidence* based on domestic programming experience.

Download at: http://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/effective_hiv.pdf

UNICEF has published *The State of the World's Children (2011): Adolescence an Age of Opportunity*

Download at:

http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf

Finally, the *Lancet Special Series on Adolescent Health* (2012) is an excellent source of information on all things adolescent health

Download at:

<http://www.thelancet.com/series/adolescent-health-2012>



Photo credit: photoshare.com

The table below, which was developed for the Youth in Development Policy, also identifies recommended program approaches and elements for success, based on program evaluations.

Program Intervention	Programmatic Elements	Strength of Evidence	Select projects and impact evaluation
Curriculum-based school programs	<p>Comprehensive information, including abstinence and contraception/condoms</p> <p>Experiential learning with life skills focus</p> <p>Trained facilitators</p> <p>Links to community services, including health</p>	Strong	<p>Howard and McCabe, 1990</p> <p>Kirby et al 1991</p> <p>Kirby et al 2004</p> <p>Okonofua et al 2003</p>
Clinic-based programs/ “youth friendly services”	<p>Culture/gender appropriate</p> <p>Trained staff</p> <p>Skills focus, including identification and reduction of risk behaviors</p> <p>Confidentiality</p>	Strong	<p>Jemmott et al 2005</p> <p>Korte et al, 2004</p> <p>Winter et al 1991</p>
Community-based programs	<p>Comprehensive information</p> <p>Experiential/participatory</p> <p>Gender/age appropriate</p> <p>Links to other services (health, sports, academics, jobs, etc)</p>	Strong	<p>Jemmott et al 1992</p> <p>Speizer et a 2001</p> <p>Chao-hua et al 2004</p>
Mass media	<p>Tailored to youth audience</p> <p>Mutually reinforcing messages through multiple channels (school, community etc)</p> <p>Coordinated with other programs</p>	<p>Strong results re: knowledge</p> <p>Weaker behavioral results</p>	WHO 2005

Endnotes

¹UNFPA, *Report of the International Conference on Population and Development, Cairo 5-13 September, 1994*, http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf

² United Nations General Assembly 64th Session, *Resolution Adopted by the General Assembly*, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N09/469/87/PDF/N0946987.pdf?OpenElement>

³ World Bank, *World Development Report 2007*, <http://documents.worldbank.org/curated/en/2006/09/7053031/world-development-report-2007-development-next-generation>

⁴UNFPA, The Commission on Population and Development, *Adolescents and Youth Resolution 2012/1* http://www.un.org/en/development/desa/population/pdf/commission/2012/country/Agenda%20item%208/Decision%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf

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⁶ UNFPA, Bali Global Youth Declaration, http://icpdbeyond2014.org/uploads/browser/files/bali_global_youth_forum_declaration.pdf

⁷Rachel Nugent, Population Reference Bureau, *Youth in a Global World* <http://www.prb.org/pdf06/YouthInAGlobalWorld.pdf>

⁸ UNFPA, *State of the World Population 2003, Meeting Reproductive Health Service Needs, Unmet Need for Family Planning*, <http://www.unfpa.org/swp/2003/english/ch5/page2.htm>

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¹² Elizabeth Presler-Marshall and Nicola Jones, Overseas Development Institute and Save the Children, *Charting the Future: Empowering Girls to Prevent Early Pregnancy*, http://www.savethechildren.org.uk/sites/default/files/docs/Charting_the_Future.pdf

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¹⁴ Machteld E Boel et al, *Malaria Journal, The Epidemiology of Postpartum Malaria, A Systematic Review*, <http://www.malariajournal.com/content/11/1/114>