USAID
FROM THE AMERICAN PEOPLE

USAID YOUTH REPRODUCTIVE HEALTH AND HIV ASSESSMENT

MARCH 2010
This publication was produced for review by the United States Agency for International Development. It was prepared by Joy Riggs-Perla and James E. Rosen through the Global Health Technical Assistance Project.

USAID YOUTH REPRODUCTIVE HEALTH AND HIV ASSESSMENT

DISCLAIMER
The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

This document (Report No. 10-01-332) is available in print or online. Online documents can be located in the GH Tech website library at www.ghtechproject.com/resources.aspx. Documents are also available through the Development Experience Clearinghouse (www.dec.org). Additional information can be obtained from:

The Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
info@ghtechproject.com

This document was submitted by The QED Group, LLC, with CAMRIS International and Social & Scientific Systems, Inc., to the United States Agency for International Development under USAID Contract No. GHS-I-00-05-00005-00.

CONTENTS

ACKNOWLEDGEMENTS

The assessment team is grateful to the staff of the USAID Global Health Bureau who helped support this assessment process, which included providing copies of documents, reviewing workplans, and facilitating access to the many USAID staff we interviewed. Special thanks go to Jenny Truong of the Population and Reproductive Health Office, and Shanti Conly and Debbie Kaliel of the Office of HIV/AIDS. We are also grateful to the USAID field staff, and colleagues from all of the other agencies, foundations, UN organizations, and other experts who have shared their knowledge as well as their insights. This assessment would not have been possible without these numerous individuals who gave generously of their time and ideas.

ACRONYMS

ABY	Abstinence, Be faithful for Youth
ADS	Automatic Directives System
BCC	behavior change communication
CA	cooperating agency
CDC	Centers for Disease Control and Prevention
COP	Country Operational Plan
CRTU	Contraceptive and Reproductive Health Technologies Research and Utilization Program
CSW	commercial sex worker
DHS	Demographic and Health Survey
EGAT	Economic Growth and Trade Bureau
ESD	Extending Service Delivery Project
FHI	Family Health International
FP	family planning
GBV	gender-based violence
GH	Global Health Bureau
GHI	Global Health Initiative
GLP	Global Leadership Priority
HIDN	Office of Health, Infectious Diseases and Nutrition
HOP	Headquarters Operational Plan
IATT	Interagency Task Team
IDU	intravenous drug use
IQC	Indefinite Quantity Contract
IUD	intrauterine device
IYWG	Interagency Youth Working Group
JHU	Johns Hopkins University
MARP	most at-risk population
MCH	maternal and child health
MDG	Millennium Development Goal
MSM	men who have sex with men
NGO	non-governmental organization
NPI	New Partners Initiative
OGAC	Office of Global AIDS Coordination

OHA	Office of HIV/AIDS
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PRB	Population Reference Bureau
PRH	Population and Reproductive Health Office
PTA	Prevention Technologies Agreement
RH	reproductive health
RTU	Research, Technology and Utilization Division
SOPA	State of the Program Area
SOTA	state of the art
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Education, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
YRH	youth reproductive health
WHO	World Health Organization

EXECUTIVE SUMMARY

Since the mid-1990s USAID's Global Health (GH) Bureau has understood the importance of shaping health programs to respond to the special needs of adolescents and young people, because in many of USAID's partner countries, youth from 10–24 years of age represent roughly a third of the total population. This is especially true of sexual and reproductive health and HIV prevention, where the strategies for working with older adults may be quite different from those for working with various age groups of youth.

After a decade of co-funding and co-managing projects focused on youth issues, the Office of HIV/AIDS (OHA) and the Population and Reproductive Health Office (PRH) developed new approaches to addressing youth issues. PRH began to mainstream youth activities within a variety of existing headquarters-managed projects in 2006 rather than developing a new youth-specialized project. OHA initiated specific youth activities as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)-mandated programs. A small knowledge management program, aimed at disseminating the results of research and evidence related to best practices, was jointly funded and managed by the two offices.

The GH Bureau was interested in determining how well the revised approach was working. An external assessment was planned, the purposes of which were to review the extent to which GH's youth-focused activities have: (1) achieved sufficient advocacy for youth-focused activities and programs; (2) resulted in relevant and high-quality research; (3) disseminated information on evidence-based youth interventions; and (4) met the needs of the country and regional programs for information and scale-up of youth programs, or youth components of programs. The assessment also included examining the integration and linkages across various technical areas within the health sector as well as within broader development sectors. Finally, the assessment team was asked to make recommendations for a strategic portfolio of the GH Bureau investments in youth reproductive health (RH) and HIV, including suggesting possible mechanisms.

The following were key findings of the assessment:

ADVOCACY

Achievements

- PRH maintains youth as a technical priority area and prioritizes youth-focused activities in annual project workplans, signaling to internal staff as well as to implementing partners that the office expects to see investment in youth-focused activities. OHA likewise includes youth as part of its broader prevention program and reviews Country Operational Plans (COPs) to determine whether there are appropriate kinds of intervention programs that address this age group, based on the pattern of disease in each country.
- In terms of supporting field programs, the missions have been able to develop stronger youth programs in countries where there are strong youth policies in place and where the local government partners are committed, with technical support from the GH Bureau.

Problems and Constraints

- Advocacy for youth programs, both in reproductive health and HIV prevention, has suffered from the political sensitivity of topics related to youth sexuality. The GH Bureau has been unable to exercise strong global leadership in youth RH/HIV based on scientifically established best practices. External partners feel that strong, political-level advocacy from the U.S. Government for youth RH/HIV at this juncture would be highly welcome.

RESEARCH

Achievements

- About a dozen research activities supported by PRH and OHA on a range of topics have been conducted since 2006. With one exception, all activities were of relatively small scale and confined to single countries. The research was of high quality and relevant to advancing the knowledge base. Support for research synthesis has also been a highly useful contribution.

Problems and Constraints

- A clear and prioritized research agenda is lacking, which has contributed to a scattered approach and hampered the efficient application of dwindling research resources.
- Many interviewees have perceived a general decline in research on youth-specific topics as compared to previous periods. This is partly related to reduced overall budgets available from PRH for research, which has crowded out youth-specific research activities.
- Research was not a priority under PEPFAR I. Although PEPFAR II offers more possibilities for research, the often cumbersome processes in place, and the lack of clarity on responsibilities for research, are continuing sources of frustration.
- Because of decreased volume of and funding for research, field mission staff feel that their current research needs are not being met.

DISSEMINATION OF BEST PRACTICES

Achievements

- The primary dissemination activity has been the creation of the Interagency Youth Working Group (IYWG), a network of non-governmental agencies, donors, and cooperating agencies. The IYWG was successful in bringing together the U.S.-based organizations interested in youth RH/HIV and in disseminating best practices and research findings through the web and various publications. Another useful knowledge management activity is the "Youth Corner," a section of the Demographic and Health Survey (DHS) website that highlights youth-related DHS findings.

Problems and Constraints

- A serious challenge for PRH is uneven access to detailed information about youth activities in bilateral programs, which has made it difficult to monitor the uptake of best practices. Because of the annual COP review process, and the large number of staff who visit missions to provide technical oversight of the country programs, OHA has much more information on mission activities.
- Awareness of best practices on effective youth interventions is lacking. This is a larger problem at the mission level, but also exists at headquarters to a certain extent. USAID has done a better job of disseminating best practices with the cooperating agencies (CAs) that implement USAID's programs than it has within USAID. While the IYWG has been successful, there remain areas where it could improve, given greater resources and a broader mandate. As it is, it is too Washington-centric.

SUPPORT TO USAID FIELD MISSIONS

Achievements

- Visits from PRH and OHA staff to field missions for youth-related work were very well received and felt to be highly useful. Technical support on youth is clearly making a difference. Staff better understand the factors that make youth vulnerable to pregnancy and HIV, and are committed to finding ways to make services more youth-friendly. Staff have considerable awareness about HIV prevalence by age group and can use different strategies to segment youth into sub-groups.

- There is some scale-up of programs initiated by headquarters projects within bilateral (USAID field mission) programs. Furthermore, the assessment revealed a very high level of interest among mission staff in youth, both among staff managing HIV/AIDS and RH programs.

Problems and Constraints

- Mission staff were largely negative about the Abstinence, Be faithful for Youth (ABY) programs as a means for advancing their work on youth. Many cited the early age of sexual debut and urged their need for services rather than just messages about abstinence.

- On the importance of addressing youth within the context of HIV prevention, missions are receiving mixed messages from headquarters. Consistency of messages to the field is important.

- The majority of mission staff interviewed said that they would like to have a GH Bureau project specialized on youth RH/HIV issues to which they can turn for expertise on how to develop strategies and interventions for youth-focused programs using the most current technical and programmatic information available. Staff see advantages to having long-term technical inputs that come from a headquarters "youth" project that works with local institutions to build capacity and ensure that interventions respond to the unique needs of youth populations.

INTEGRATION

Value of Integration

- Good models exist for integrating HIV prevention and reproductive health programs, and reaching youth with both HIV and pregnancy prevention is a cost-effective strategy. The models for integrating RH/HIV with other health programs, such as dealing with managing pregnancy in younger adolescents or dealing with anemia, are far less clear.

- Inter-sectoral youth interventions are promising but are as of yet unproven in terms of ensuring strong outcomes for RH and HIV.

Extent of Integration in Current Programs

- Integration of RH and HIV programs is evident in field programs, although there is room for improvement. At the headquarters level, the jointly funded knowledge management activities are a positive example of sensible integration.

- There is widespread conceptual support for integrating youth RH/HIV programs with broader youth initiatives in education, livelihood development, and so on. However, missions need better information on best practices and evidence that integration enhances program

outcomes. Efforts to explore these integrated programs at the headquarters level have been driven by technical staff rather than by senior-level staff.

- The stovepiped funding accounts within USAID present practical challenges for integrating programs, as most missions do not have an optimal balance of funds from the various accounts, and strict guidelines exist on the use of various accounts.

OPPORTUNITIES

A number of factors in the current environment offer opportunities to improve youth RH/HIV programming. Commitment to youth is high at the country level, and partners welcome a stronger USAID advocacy role. USAID can play a leadership role in this field with the Global Health Initiative themes and resources. We know more and have better data on youth. Trends in youth RH/HIV are positive, although needs remain high. While global knowledge of effective youth HIV prevention interventions is moving forward incrementally, the Agency still has a long way to go. Likewise, our understanding of effective pregnancy prevention and care interventions is growing but remains incomplete.

RECOMMENDATIONS

A window of opportunity has opened for USAID to move toward stronger youth programming, but there must be concomitant political-level advocacy for youth in order to achieve maximum impact.

Strengthen Global Leadership for Youth with a High-Profile Youth Advocacy Strategy Under the Global Health Initiative (GHI)

- Organize a high-level youth summit, hosted by senior officials in the Department of State and USAID and featuring partner-country leaders, that would help provide visibility and political commitment to a new policy and strategy for youth. The summit should be linked to GHI themes and should promote opportunities to highlight youth reproductive/sexual health and HIV prevention issues in relevant international conferences scheduled in the near future.

- Advocate for an Agency-wide youth policy and strategy, enlisting input from other partners, the CA community, NGOs, and academia. This policy should present clear guidance on how inter-sectoral youth programs may be developed, including the specific parameters for using various funding accounts in such programs. Ties with international donors, foundations, and other organizations working on youth programs should be strengthened.

Goals and Priorities for Future GH Youth RH/HIV Programs

The GH Bureau mandate is to provide technical leadership on YRH/HIV, including knowledge management, dissemination of best practices, support for scale-up of evidence-based interventions, and testing innovative approaches to advance the knowledge base. The following are actions needed to achieve that mandate.

Research and Knowledge Management

- Develop a new set of research priorities and a long-term research agenda.

- Continue to leverage the research synthesis capabilities of WHO.

- Develop indicators on RH/HIV that reflect *outcomes* for various age groups, including the 10–24 age range. For example, output indicators that reflect only the numbers of people trained are not useful at the level of USAID field missions. More meaningful indicators might include the proportion of the population which has increased knowledge about a selected topic or exhibit certain changed behaviors.

- Build on and continue successful knowledge management efforts.

Supporting Missions

- Put greater focus on encouraging mission scale-up of proven, effective interventions. Use the new data to target activities to the most vulnerable youth. Expand efforts to address the underlying drivers of youth risk.
- Conduct strategic information campaigns for missions and their partners on country-specific youth-related data.
- Continue to innovate, test youth RH/HIV interventions, and improve integration where appropriate. Provide core funds for pilot activities that can be scaled up within missions' bilateral programs.
- Conduct staff trainings, update USAID's Reproductive Health E-learning course, and use State of the Art (SOTA) technical updating conferences and other regional meetings to disseminate best practices and research findings for youth RH/HIV.

GH Bureau Internal Management Improvements

- Develop a tracking system for bilateral youth activities, as well as an improved system for tracking and assisting with mission design and evaluation activities.
- Address problems that are constraining OHA's ability to carry out research under PEPFAR.

Implementing Mechanisms

- In addition to strengthening advocacy for youth RH/HIV, the GH Bureau should develop a new youth-specialized project (or a new youth program within an existing project) to fulfill some of the research, dissemination of best practices, and mission support functions that are the essence of the GH Bureau mandate.
- A new youth flagship project must have sufficient core resources from PRH and OHA, as well as other offices and bureaus, and have the capacity to accept funding from USAID field missions for country-specific programs.
- Mainstreaming of youth programs with central projects should be encouraged as relevant.

1. BACKGROUND AND PURPOSE

1.1. EVOLUTION OF GH BUREAU YOUTH RH/HIV STRATEGIES AND THE CURRENT PROGRAM

During the mid-1990s staff at USAID's Global Health (GH) Bureau came to the understanding that unique strategies are required to reach adolescents and young people with information and services about family planning (FP), reproductive health (RH), and HIV prevention. After the Cairo International Conference on Population and Development in 1994 and the Fourth International Conference on Women in 1995, it became clear that adolescent reproductive health must incorporate societal factors, household conditions, and the community environment, as well as the individual factors relating to adolescents themselves, including physical and psychosocial development.

Therefore, from 1995 to 2006 the GH Bureau supported two headquarters-managed youth projects, FOCUS on Young Adults (1995–2001) and YouthNet (2001–2006), which operated worldwide and provided global leadership on the subject of youth reproductive health (YRH) and HIV. These projects were co-funded by the Office of Population and Reproductive Health (PRH), the Office of HIV/AIDS (OHA), regional bureaus, and field missions (field support). The majority of the funding, however, came from the PRH office. The FOCUS project made a significant contribution to understanding how various policy and program approaches help young people practice healthier sexual and reproductive behaviors, and to establishing a body of evidence on youth programming. The YouthNet Project, building on the lessons of its predecessor project, also made an important contribution in expanding knowledge about the development of youth RH/HIV interventions and in forging a two-way linkage between global leadership activities and field-level activities. (Adamchak and Senderowitz 2005)

Following an assessment conducted in 2005 about future needs, cited above, GH decided not to develop another youth project, but rather to try to "mainstream" youth in other ways. PRH set aside core funds to apply toward several relevant central projects to encourage a focus on youth. When funding became limited, workplans were reviewed and promising youth activities were prioritized within the workplans submitted on an annual basis by each project—not by setting aside additional funds for youth activities, but within existing workplan budgets. PRH has been using this mainstreaming approach since YouthNet ended in 2006. Some USAID missions have also continued to prioritize youth in their programming, using their own bilateral funds.

Due to the unique PEPFAR program implemented in 2004, which includes specific activities aimed at youth in Track 1.0 (Abstinence, Be faithful for Youth (ABY); and orphans and vulnerable children (OVC)) programs, OHA has pursued a different strategy. The first PEPFAR authorization required that a third of prevention funds be applied to programs emphasizing abstinence, delaying sexual debut, and urging marital fidelity The mandated Track 1.0 ABY programs are a key prevention strategy targeting youth ages 10–24, focusing on "abstinence and be faithful" messages and implemented by non-governmental and faith-based organizations. All grants awarded through the Track 1 ABY program were managed centrally from headquarters and are due to end this year.

Ten percent of the total PEPFAR funds each year are also allocated to the orphans and vulnerable children (OVC) programs, which target orphans and children under 18 who are affected by HIV/AIDS, either directly or as a result of family and societal problems arising from the epidemic. OVCs, especially girls, are at increased risk for economic hardship, exploitation, and trafficking, as well as HIV infection. OVC programs provide support so that children can attend

school and become involved in after-school activities; they also assist the out-of-school youth population. OVC programs are mandated to continue under the second PEPFAR authorization.

Other HIV prevention activities targeting youth are administered within the PEPFAR programs in each country as appropriate, depending on the nature of the HIV/AIDS epidemic. In addition, a jointly funded program of activity through the Contraceptive and Reproductive Health Technologies Research and Utilization Program (CRTU) with Family Health International (FHI) was developed in 2007 to improve the knowledge management elements of youth RH/HIV. This program included a website providing best practices, research findings, policy briefs, and other documents. It also funded the Interagency Youth Working Group (IYWG), a network of NGOs, donors, and USAID cooperating agencies (CAs). . The website was originally developed during the YouthNet project but has been modified and rebranded under the current FHI-managed program. (See Figure 1.)

1.2. PURPOSE OF ASSESSMENT

The purpose of this assessment, commissioned jointly by PRH and OHA, is to determine whether their objectives for youth-focused programs have been met since the YouthNet project ended in late 2006. Specifically, this assessment aims to:

- assess the extent to which GH's youth-focused activities have (1) resulted in relevant and high-quality research, (2) disseminated evidence-based youth programs, (3) met the needs of country and regional programs for information and scale-up of youth programs, or youth components of programs, and (4) provided sufficient advocacy for youth-focused activities and programs.
- assess integration and linkages across various technical areas within the health sector, as well as broader development sectors.
- make recommendations for a strategic portfolio of GH investments in youth RH/HIV, including possible mechanisms

This assessment analyzed the program investments made primarily with GH funds, as well as the extent to which GH investments and technical leadership have influenced and met the needs of field missions.

1.3. METHODOLOGY

1.3.1. Analytic framework

The assessment team developed a workplan that organized the three main objectives by pairing specific questions under each objective in the scope of work with information that clarified the terminology or the scope of inquiry, and describing expected sources of data, analysis procedures, and criteria for making judgments. This analytic framework (workplan) is included in the report as Appendix 3.

1.3.2. Methodology

The assessment methodology consisted of reviewing a list of documents (see Appendix 2) and interviewing a wide range of key informants about youth activities. Informants were drawn from the GH Bureau, OHA, PRH, the Office of Health, Infectious Diseases and Nutrition (HIDN), the Economic Growth and Trade (EGAT) Bureau, the Centers for Disease Control and Prevention (CDC) for PEPFAR, USAID's Public Law 109-95 Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005, regional bureaus, USAID missions, selected GH Bureau cooperating agencies (CAs), other donors, UN organizations, foundations, NGOs, youth advocacy organizations, and other youth experts. In selecting these organizations and individuals

to interview, the team aimed to solicit as many views as possible on topics such as how well GH was supporting the needs of field missions for youth programming, the extent to which USAID was providing global leadership and expertise in youth RH/HIV, understanding the challenges faced by implementing partners, and exploring various approaches to youth employed by other donors and foundations.

A total of 91 individuals were interviewed, some via telephone and others in the greater Washington, D.C. area in person. The proportion of interviewees deliberately favored USAID field and headquarters staff but did include a large number and wide range of other partners. Staff from nine missions (India, Jamaica, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, and Zambia) and one regional office (East Africa-Nairobi) were interviewed, with HIV/AIDS and other health program staff being included in the call where possible. Of the 91 interviewees, 27 were mission staff. (See Appendix 1.)

The team also analyzed the limited financial data that were readily available in order to estimate youth investments in OHA and PRH. For OHA, a list of FY 2009 PEPFAR youth programs by title and country was available. For PRH, the team was given a list of 2008 and 2009 headquarters-funded activities by project and activity, and estimates for previous years.

This assessment was intended to examine strategic issues as well as programmatic progress, challenges, and opportunities, and to provide recommendations for the future. This report does not provide a detailed inventory or analysis of all youth-related activities in USAID or an extensive review of previous experience or current literature. The full scope of work is presented in Appendix 6.

1.3.3. Team composition

The team consisted of two GH Tech Project consultants. One of the consultants has specialized evaluation expertise and programmatic experience in youth reproductive health and HIV/AIDS programs with USAID, other donors, and development organizations. The other consultant is a retired USAID Foreign Service Officer with health program experience in overseas missions and with the GH Bureau. The assessment was conducted between January 20 and March 5, 2010.

2. FINDINGS AND CONCLUSIONS

2.1. ASSESSMENT OF GH YOUTH RH/HIV PROGRAMS 2006–2009

The Youth Global Leadership Priority Strategic Plan developed by PRH in 2005 outlined three results:

1. youth reproductive health (YRH) evidence base expanded through rigorous program evaluations and operations research.
2. YRH best practices utilized by
   - replicating, adapting, and evaluating promising models;
   - identifying, disseminating, and facilitating the application of best practices.
3. enabling environment for YRH improved by
   - identifying and helping develop key YRH policies at national and local levels;
   - supporting implementation of policies and
   - mobilizing financing resources to support YRH.

No parallel strategic document exists for OHA apart from the PEPFAR-mandated ABY and OVC programs mentioned earlier, with their specifically defined objectives for youth.

The following sections describe the assessment team's findings on achievements, gaps, and constraints in each of the four objectives of GH's youth programs as defined in the scope of work.

Because of the differences between PEPFAR and USAID programming, PRH and OHA have slightly different ways of investing their funds and operating. PRH is mandated to provide global leadership, supply technical support to the field, fund research, and promote innovative activities within mission programs that will allow eventual scale-up by bilateral programs, local government, non-governmental, or private-sector entities. Activities are carried out through centrally managed projects that help fulfill its mandate. PRH makes its staff available to provide technical help to missions.

Due to the PEPFAR Country Operational Plan (COP) review process, OHA more intensively oversees the programs developed and funded by the HIV/AIDS allocations to missions. OHA also has core funds for a variety of activities, as reflected in annual Headquarters Operational Plans (HOPs). OHA staff directly manage the Orphans and Vulnerable Children (OVC), ABY, and New Partnership Initiative (NPI)[1] grants that cover multiple countries and fund some central technical assistance and research projects. Often the technical assistance to missions is provided directly by the OHA staff, as they have fewer large headquarters-funded projects to manage as compared with PRH.

The assessment team questioned a variety of stakeholders and reviewed documents in order to determine how well these functions are being performed.

2.1.1. Advocacy

Advocacy on specific health topics and strategies within the Agency, and on behalf of the Agency to the broader global health world, is an important and unique function of the GH Bureau. USAID

[1] NPI grants were established to build the capacity of community-based organizations to fight HIV/AIDS in PEPFAR countries.

is the largest single donor for HIV/AIDS and FP/RH globally, and has historically been regarded as a leader for both programs.

Achievements

Youth was identified as a priority. Both PRH and OHA consider youth-focused programs to be a priority. In PRH there is an annual opportunity to review the workplans of relevant central projects to prioritize youth-focused activities if they are deemed important. This includes activities related to research and evaluation, behavior change and communications, and provision of services. Centrally funded CAs and headquarters project managers are aware that the PRH front office considers youth as one of the technical priority areas. In OHA the State of the Program Area (SOPA) on General Population and Youth HIV Prevention developed by the Technical Working Group (TWG) provides guidance on approaches that center on youth prevention activities. The TWG also serves as a forum to discuss youth strategies and activities. OHA has assigned one staff member to function as a Youth Advocate on a part-time basis.

Problems/Constraints

USAID is no longer viewed by external partners as a global leader in youth RH/HIV. Based on interviews with dozens of individuals from USAID and a broad range of NGOs, foundations, donors, and others, the assessment team concluded that USAID is no longer considered a global leader on youth reproductive health or HIV/AIDS issues. The consistency of responses on this question was notable.

Reasons for this included (1) the difficulties for USAID during the previous administration to take a strong position on adolescent sexuality given that some White House officials and members of Congress considered this a sensitive, occasionally controversial area; (2) the legislatively mandated focus on ABY which many feel was driven by ideological motivations rather than evidence or best practices; and (3) dropping the youth-specialized (flagship) project, which appeared to be a retreat from giving priority to youth.

While these circumstances have prevented USAID from being more vocal on youth issues, other donors, foundations, and UN agencies have made youth a major focus of their programs. A large number of organizations are conducting youth-related research, working on a variety of youth programs at the country level and developing increasingly better strategies for reaching youth in the areas of RH/FP/HIV. Many interviewees from outside USAID, however, still feel that a major political push for youth reproductive health by the U.S. Government would be highly desirable.

Advocacy within USAID is not as strong as it could be. While youth is said to be an important crosscutting technical priority in PRH, less than one person's time is devoted to working on youth issues. Gender, another crosscutting issue, receives more staff attention (three staff members with full or part-time responsibility for gender) and appears to be far more mainstreamed, possibly due in part to the Automatic Directives System (ADS)[2]-mandated analysis that accompanies new project design. While assessing the value of including a formal youth analysis as one of the ADS-mandated analyses for project design is beyond the scope of this assessment, it may be worth considering how to strengthen any guidance on youth-specific approaches in the ADS or other Agency documents that govern program design.

In terms of advocacy to the field missions, there is little clarity within OHA on the importance of youth; in fact, there is confusion due to mixed messages on the subject. The SOPA on General Population and Youth HIV Prevention does not emphasize youth or address issues and concerns that would encourage program managers to consider the unique social/cultural circumstances or the needs and vulnerabilities of younger population groups. Some interviewees stated that as the epidemiology of the disease has become better understood, it appears that the burden of disease is

[2] Official USAID regulations, polices, and procedures.

higher in older age groups in many countries, and that prevention activities have been disproportionately skewed toward youth. On the other hand, many interviewees stressed the public health importance of a stronger focus on youth for HIV prevention, given the proportion of most at-risk populations (MARPs) that fall in the under-20 age group. Furthermore, in countries with generalized epidemics, staff also recognized that it is critical to intervene with youth because attitudes and behaviors become established during adolescence.

Clearly, on the youth advocacy front USAID has lost ground in recent years, and the Agency needs to rejoin the international community regarding youth, particularly youth sexual and reproductive health.

2.1.2. Effectiveness of research

The Global Health Bureau has a long-standing reputation as a leader in supporting research on a wide range of health topics, as a way to broaden the knowledge base about effective and cost-effective interventions and thus provide guidance to the Agency's country activities.

Achievements

GH has funded a number of mostly small-scale research projects. The assessment team identified about a dozen centrally funded research activities conducted during the assessment period on a range of topics (Table 1). However, with the exception of the multi-country, multiyear, OHA-funded *Gender Initiative to Reduce Girls' Vulnerability to HIV*, all were of relatively small scale and confined to a single country. Although not the focus of its assessment, the team was also aware that USAID has funded other research on youth through its bilateral programs.

GH has funded innovative research topics. Part of GH's technical leadership role is to support cutting-edge, innovative research. In this it has largely succeeded, supporting research in relatively unexplored areas such as delay of early marriage; reaching vulnerable populations; parent involvement; cross-generational sex; gender-based violence; youth-friendly pharmacies; and family planning-HIV integration. One example of such innovation is an operations research project in Ethiopia to reach married adolescents, a vulnerable and underserved population, through faith-based structures. This study, conducted through the Frontiers operations research project and funded through PEPFAR and PRH, used faith-based structures at the community level to educate newly married girls and their families about their vulnerability to RH/HIV, empower them through membership in peer support groups, and facilitate their access to relevant RH/HIV services (Truong 2008, *Youth GLP Results*).

Research has been high-quality and relevant. The research carried out has been generally of high quality and relevant to the needs of the broader YRH/HIV field and to USAID's country programs. This was confirmed in interviews with those knowledgeable about USAID's research activities. One example is the *Gender Initiative to Reduce Girls' Vulnerability to HIV*, begun in October 2007. This program, funded by OHA and conducted by Johns Hopkins University, has been implemented in 16 communities in Botswana, Malawi, and Mozambique. It aims to reduce vulnerability by focusing on the social milieu and socioeconomic structural characteristics that fuel the HIV/AIDS epidemic, and uses a rigorous evaluation design to assess the impact of interventions working in schools and communities. Another study reflecting the high quality of GH-funded research was carried out by MEASURE Evaluation in Haiti using the Priorities for Local AIDS Control Efforts (PLACE) methodology. The study found that youth meet sexual partners predominately in public commercial or transport locations and at educational sites. This report suggested that strategies targeting youth at school-based sites should include programs both *within* the schools and *in the vicinity* of the schools at the end of the school day.

GH has supported development of valuable research syntheses and specialized best practices tools. As summarized in Table 2, these tools include, for example, the WHO-led systematic

review of the effectiveness of interventions to prevent too-early pregnancy, maternal mortality, and unsafe abortion in adolescents. This study, a companion to the 2006 Steady, Ready, Go report on effective HIV prevention interventions for young people (WHO 2006), is led by the Child and Adolescent Health Department, which has received a small but dedicated portion[3] of the funding from a PRH umbrella grant to WHO to support continued work on research, implementing best practices, and integrating family planning and HIV programs. GH headquarters funds have also supported WHO in producing two documents reviewing current programs that involve parents. One document summarizes the 34 identified projects, while a companion piece, *Helping Parents in Developing Countries Improve Adolescent Health,* outlines five key dimensions of parental support and provides recommendations to programs and researchers to help them advocate effectively for increased attention to the influence of parents in developing adolescent health programs. In addition, MEASURE DHS has used funding from PRH to complete a comparative report of youth sexual and reproductive health data from 38 countries (Khan and Mishra 2008) Furthermore, the Population Reference Bureau's Bridge Project has compiled a desk review of cross-generational sex interventions, *Addressing Cross-Generational Sex: A Desk Review of Research and Programs*, which summarizes the range of programmatic approaches available to prevent or reduce risks to youth generated by cross-generational sexual relationships (those in which one partner is at least 10 years older than the other).

Problems/Constraints

Decreased volume of and budget for research. Although the assessment team did not formally compare the volume of and budget for research with earlier periods, many interviewees have noticed a general decline in research on youth-specific topics over the past three years. The two stand-alone youth flagship projects, FOCUS and YouthNet, contained substantial research components. YouthNet alone carried out four major research projects in the 2002–2006 period and several smaller efforts (YouthNet EOP Report, 2006). Focus also conducted several research projects. In addition, GH funded large YRH/HIV multi-country research activities in the late 1990s and during the first half of the previous decade under the Frontiers and Horizons programs. Such a broad program of research was not evident in the 2006–2009 period. This apparent decline in USAID funding for YRH/HIV research runs counter to what interviewees familiar with YRH/HIV research have noted as a general increase in major research in this area. In particular, there has been a surge in funding from private foundations to examine closely a range of YRH/HIV research topics, for example, the Hewlett-funded research on the relationship between population and poverty, as well as a torrent of research in recent years exploring the micro effects of early sexual activity, pregnancy, and childbearing.

The current lack of a clear and prioritized research agenda on YRH/HIV issues is perhaps the greatest constraint on GH research efforts. USAID staff reported that YouthNet developed a prioritized research agenda in 2002, which, although challenging due to the variety of stakeholders involved, ultimately proved to be a useful exercise. However, no such USAID research agenda currently exists from either PRH or OHA. This lack has contributed to a scattered approach and hampered USAID's ability to use dwindling research resources in the most efficient manner.

Reduced overall budgets available to PRH for research have crowded out youth-specific research. Several USAID staff noted the general decline in budgets for PRH research in recent years. Because youth has become less of a priority, research on youth has generally been left out of budgets. For example, the team was told that, because of funding constraints, USAID had instructed the PROGRESS-FP operations research project (the successor to the Frontiers project) to choose three research priorities; youth was not among them.

[3] In FY 2009, $150,000 out of $3 million.

Research was not a high priority for PEPFAR I. Another likely reason for the reduced funding is that research was not a priority under PEPFAR I. Because it was an "emergency" program, PEPFAR emphasized service provision over research. One mission staff person told the assessment team, "During PEPFAR I, research ground to a halt as it was considered a 'bad word.'" Funds were available for small-scale program evaluations but not for major research. This reduced opportunities for USAID to fund HIV research on all topics, including youth. Many interviewees pointed out that PEPFAR II[4] provides more possibilities for research.

PEPFAR mechanisms for conducting research have been cumbersome. While PEPFAR II offers more possibilities for research, the often cumbersome processes surrounding PEPFAR-funded Public Health Evaluations (PHEs) are a continuing source of frustration. As one USAID interviewee stated, "Right now research is being done in an ad hoc fashion because of the problems with the PHE mechanism." Another mission staff person admitted, "We call it a 'program evaluation' instead of 'research' to skirt around the PHE nightmare."

Mission research needs have not been met. A recurring theme in interviews with mission staff is that their current research needs are not being met. (See list of research needs in Annex 4.)

2.1.3. Dissemination of best practices

Dissemination of the evidence base on best practices in youth reproductive health and HIV/AIDS was another principal aim of the GH Bureau during the past three years. USAID uses the term "best practices" to refer to the array of evidence-based tools, materials, and practices, e.g., guidelines, norms, standards, experiences, and skills, that have proven their worth in the field of youth reproductive health.

Achievements

The FHI-led knowledge management activity has been largely successful. The primary dissemination activity in the post-YouthNet era was the creation of the Interagency Youth Working Group (IYWG), led by Family Health International and involving a network of non-governmental agencies, donors, and cooperating agencies. The knowledge management effort began in late 2006, with PRH and OHA jointly investing about $700,000 annually through the Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) Program (now the Prevention Technology Agreement (PTA)), a program managed by PRH's Research, Technology and Utilization (RTU) Division. The IYWG concept has evolved since its inception. Initially the IYWG convened meetings of "IYWG partners"—cooperating agencies to which PRH allocated dedicated youth funds on a quasi-competitive basis. These partners met as a working group to discuss topics of upcoming meetings or to outline priorities for planned activities. The last meeting was held in March 2008, when dedicated funding ended. After PRH strategy shifted from dedicated funding to mainstreaming, the IYWG ceased to operate as a true working group and became synonymous with FHI's knowledge management activities.

As Table 3 shows, the IYWG was very active in several areas. The assessment team believes the IYWG was quite successful in bringing together the U.S.-based organizations interested in YRH/HIV and in disseminating best practices and research findings through its website and various electronic and print publications.

The annual or semi-annual Washington meetings of the IYWG typically drew 100 or more participants and were widely viewed as a unique opportunity for those working on youth issues to gather and discuss technical issues. One CA interviewee described how she first heard about a model for involving communities in YRH/HIV programs at an IYWG meeting, and later drew

[4] PEPAR II refers to the reauthorization of PEPFAR, which covers the period FY 2009–2013. For more information, please see the *PEPFAR Five Year Strategy*, 2009.

upon the contacts made there and materials obtained through the IYWG website to design an innovative program in Haiti. The most recent IYWG meeting in June 2009 drew participants from the GH Bureau, PEFPAR, UNICEF, WHO, and several youth-serving non-governmental organizations to identify programmatic interventions that can address the needs of young people most at risk for HIV/AIDS. The meeting included information-sharing about successful programs, discussion of best practices, and a call for a strong research agenda to improve programming. Experts agreed that existing programs could do more to reach vulnerable youth populations, which include adolescent sex workers, men who have sex with men, and injecting drug users. Subsequently, FHI collaborated with the Most-At-Risk Young People Working Group of the UN Interagency Task Team on HIV and Young People to prepare policy and provide programmatic and research recommendations in a guidance document (FHI 2010).

The Youthlens series produced 19 new policy briefs, all on key cutting-edge topics such as HIV-infected youth, hormonal contraception for youth, and community involvement. The IYWG also distributed 37 issues of *Youth Infonet*, a monthly electronic summary of research and information. The IYWG's website, maintained by the Global Health Bureau's Knowledge for Health Project, with content supplied by FHI and other partners, received 15,677 unique visitors in the latest one-year reporting period (FHI 2009).

Of the interviewees contacted by the team, almost all who regularly work on youth issues were familiar with the IYWG's activities. Cooperating agencies, donor partners, and some missions appreciate the IYWG website and the monthly e-mail *Youth Infonet* as an important means of receiving the latest information on youth-related best practices and research findings. It is notable that the website appears to draws from a wide variety of sources, not merely within the USAID community. There was general agreement that the role played by the IYWG in convening players and disseminating information is a valuable one.

One of the elements that led to the success of the IYWG was the good working relationship between USAID and its principal implementing partner, FHI. FHI's November 2009 internal evaluation of youth knowledge management found "strong evidence that the Interagency Youth Working Group is achieving its mission of providing technical leadership to improve the reproductive health and HIV/AIDS outcomes of youth in developing countries." (FHI 2009). The team concurs with that assessment.

Through other headquarters-funded mechanisms, GH has supported other useful knowledge management products. Such products include:

- a 2010 policy brief from the BRIDGE project, *Investing in Youth Development.*
- the January 2007 launch of the MEASURE DHS "Youth Corner," a section of the website that highlights youth-related survey data. In its first year, 14,245 visits to the site were reported.
- the Youth-policy.com website, hosted by the Futures Group Health Policy Initiative Project, a compendium of over 100 youth reproductive health and HIV/AIDS policies, and information on policy-making.
- a course on youth reproductive health posted on the USAID E-learning website, last updated in June 2006.

Problems/Constraints

Difficulty in tracking use of best practices in bilateral programs. The assessment team noted the difficulty in identifying and obtaining detailed information on youth activities in bilateral programs. Lack of information on missions' youth RH activities is a real constraint for PRH in providing technical guidance on youth activities. The August 2009 youth RH mapping exercise

(Simon and Truong 2009), which examined YRH programs in 29 countries, concluded that there is a dearth of knowledge, and that what exists is highly individualized rather than systematic. OHA has a better sense of mission activities because of its involvement in reviewing PEPFAR Country Operational Plans (COPs), which in FY 2010 were prepared for 31 countries plus the Caribbean region (PEPFAR July–September 2009, *PEPFAR. U.S. Government Survey on Youth Prevention Priorities*,). A related issue is that the USAID mission operational plans and PEPFAR indicators do not require missions to report accomplishments on youth specifically, as most suggested indicators with a breakdown by age for prevention are optional. In the absence of meaningful indicators, incentives remain weak for improving the efficacy of youth-related outcomes.

Extent to which GH activities incorporate best practices. Because of the problem described above, it was difficult for the assessment team to gauge the success of dissemination by examining how well GH activities incorporate best practices findings. The team intended to gauge the extent to which programs funded with GH core money have been consistent with the 2006 Steady-Ready-Go guidance on evidence-based practices.[5] However, it became apparent that available information was not sufficiently detailed to make an accurate judgment.

Lack of awareness of best practices. A related finding is that to some degree there remains a lack of awareness of best practices on effective youth interventions, despite the existence of the seminal Steady, Ready, Go report and the multi-pronged knowledge management efforts described above. The assessment team found this to be more of a problem at the mission level, but also encountered key staff at headquarters who were not up to date on this key evidence. The team believes this gap may be related to a failure to include youth issues adequately in USAID regional meetings or state of the art (SOTA) meetings, which are reported by mission staff as an effective way to update their technical knowledge. This finding is corroborated by a general perception on the part of interviewees that missions are receiving insufficient dissemination of best practices. A recent survey of PEPFAR field staff to explore whether staff are receiving the information they need on youth programming makes it clear that deficiencies exist. (PEPFAR 2009, *USG Survey on Youth Prevention Priorities)*. Interviewees also noted that PEPFAR staff are handling large prevention portfolios with little time to pay special attention to youth, and that field missions generally lack staff with specialized youth expertise.

The IYWG mandate is too narrowly focused and Washington-centric. Although the assessment team's judgment is that the Interagency Youth Working Group accomplished a great deal, there are certainly areas where it could improve, given greater resources and a broader mandate. As it exists, it is too Washington-centric. As one interviewee remarked to the team, the IYWG is good for the Washington-based youth crowd, but did not draw in many people from the field.

---

[5] The 2006 report by the UNAIDS Interagency Task Team on Young People, *Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries*, is known as the Steady-Ready-Go report. The report aims to provide a comprehensive review of the evidence on the effectiveness of interventions to prevent HIV among young people in developing countries, with the goal of informing the choices of policymakers. The report, based on a review of 85 relatively rigorous evaluation studies, divides 23 identified types of interventions into four groups:

- interventions the task team can support with confidence (**Go**);
- interventions that must be implemented more cautiously and that must include careful evaluation of their impact on key health outcomes (**Ready**);
- interventions requiring further development and demonstration of effectiveness before they can be recommended for widespread implementation (**Steady**); and
- interventions that should not be implemented because evidence has proved their lack of effectiveness (**No go**).

Moreover, as a group the IYWG lacks a formal definition as well as criteria for partnership or membership. The general sense of youth experts is that the IYWG has not been a vibrant platform for YRH issues. One interviewee stated, "These youth issues and the group are so incredibly important. Quietly churning out an online library is not enough." Another observed that USAID has not been as clear as it should in helping define the IYWG mandate and the role of the collaborating organizations, both within the cooperating agency realm and among USAID's international partners. This confusion stems partly from the evolution of the IYWG beyond its original function as a true working group, as noted in the Achievements section above.

External dissemination is better than internal dissemination. To summarize, the team's view is that USAID has done better on dissemination with the cooperating agency community than it has within the Agency, both at headquarters and to the field.

2.1.4. Meeting mission needs

Achievements

Whether for HIV/AIDS or FP/RH programs, the assessment team attempted to determine how the two offices were assisting missions and allocating headquarters funding for youth programming. Several themes emerged from discussions with mission staff:

Technical assistance provided by PRH and OHA staff has been effective. Interviews with mission staff who had received visits from a GH Youth Advocate, or from those in PRH and OHA providing youth-specific technical assistance, were highly positive. Missions stressed the need for internal USAID staff to help with designing new youth programs or components within ongoing programs, and personally working with them in a timely way to provide the evidence and best practices needed to develop youth activities.

Many staff said that focusing on youth is essential for HIV prevention given the proportion of most-at-risk populations (MARPs) who are in the 10–24 age category, such as sex workers, IUD users, young girls and women engaged in transgenerational or transactional sex, and so on. Much, they say, depends on the nature of the HIV/AIDS epidemic in each country or region. The availability of better data is helping missions to focus their resources more strategically. The technical and programming input from headquarters staff in identifying and addressing these issues was evident during interviews, and appreciated by missions.

Technical input from headquarters staff can be crucial for developing or shaping programs. USAID staff reported that approaches to youth must be tailored to the specific ages and life stages (school leavers, newly married, unemployed young adults, etc.) within the broader youth population. In Malawi and in many other countries, field mission staff mentioned that marriage itself makes girls and young women more vulnerable to HIV infection. In Nigeria and Zambia individuals as young as 12–14 years of age need more than advice on abstinence, since the age of sexual debut continues to be early. These youth need counseling on partner reduction and access to reproductive health services, including condoms and contraceptives. With technical support from headquarters staff, commissioning youth assessments that examine these particular issues seems a good way to collect and analyze the data available on youth, and to suggest areas for investment by USAID. While a few missions have carried out such assessments, or are planning to, there have been not been many in recent years, according to the August 2009 youth activity mapping report. (Simon and Truong 2009)

Some scale-up of headquarters-funded programs is evident. There is evidence that some GH investments using core resources for youth programs have been implemented and expanded by missions through bilateral programs. Among the country staff the assessment team interviewed, India, Tanzania, and the East Africa Regional ROADS program are good examples of activities that were initiated through USAID headquarters projects but expanded by missions. Egypt has

also expanded youth activities introduced initially by the PRH Office's Extending Service Delivery (ESD) Project within its bilateral Takamol Project, and there are likely to be many others. It is not always easy to know which headquarters-funded programs are likely to be scaled up; often this depends on the local environment and how interested the host government is on youth-focused approaches, as well as mission interests, which may change over time depending on staff rotations. PRH staff have emphasized the importance of sustained technical assistance to field programs even when the mission has assumed the local costs of an expanded program.

Problems/Constraints

ABY programs are viewed as a setback for youth HIV prevention programs. Echoing the views of USAID's partners, the majority of mission and regional staff agreed that the ABY programs have been an ineffective component of youth HIV prevention programs. Staff do not consider the ABY approach to be evidence-based and have had concerns about its effectiveness, even while they were required to use it. Staff would prefer to devote resources to youth programs that are more cost-effective.

Determining how much emphasis to put on youth programming is not clear to mission staff. Like OHA staff, mission staff have differing opinions about the proportion of effort that should go to youth-focused programs for HIV prevention. Staff at one mission stated that with better understanding of the epidemic, they decided to put more emphasis on prevention in older age groups because of the relative burden of disease. Staff at other missions feel that working with youth presents an important opportunity to establish healthy lifestyles that will help avoid high-risk behaviors later in life. While diverse approaches are necessary to address HIV/AIDS in different countries, a clear message within USAID is also important. The Agency needs to make sure that missions know which age-specific groups should receive priority in various settings. It was obvious to the team that the field is receiving mixed messages from OHA on this subject.

The majority of missions interviewed would like to see the return of a youth flagship project. Six of the eight missions who expressed an opinion about the subject felt that a youth flagship project was desirable, primarily as a way of having a readily identifiable organization with expertise on youth which missions can access for technical assistance and information on youth programming. One mission said that youth was already a major focus throughout its program and that staff would not use a central project. Another mission said that staff can get what they need from existing projects, while two missions had no strong opinions one way or another.

Mission staff did not emphasize the need to program their funds through field support transfers to a central project, but many did say that they needed information on lessons learned, best practices, evidence-based interventions, and project design or strategy development assistance. However, mission staff felt that development of bilateral projects was being encouraged over field support or associate awards although the time line for completing an award or contract was becoming untenably protracted. One mission staff member said that if a youth project were available, she would buy in until they could develop a bilateral project.

PRH and OHA lack a systematic way to provide timely technical assistance on youth. An important challenge for the GH Bureau in general, not just for youth programs, is to establish a formal mechanism for offering technical assistance to field missions when it is needed. Some field missions know when they need help, some have personal contacts at the GH Bureau whom they can call, and some GH Bureau country teams or individuals are very attuned to country programs. But this is not always the case. There must be a consistently reliable and less personalized way for the GH Bureau to anticipate when missions will need information and technical assistance and to offer that support.

2.2. ASSESSMENT OF INTEGRATION AND LINKAGES WITH OTHER PROGRAMS

Integration of youth programming is a complex and nuanced issue. This section explores what is known about the value of integrating youth programming at various levels, as well as the extent to which GH is effectively and appropriately integrating youth programming into its current portfolio.

2.2.1. What is known about the value of integrating youth programming

RH/HIV integration models exist and should be exploited. Particularly regarding young people, it makes sense to integrate pregnancy and HIV prevention programs, particularly for education, stigma reduction, and access to services. Like older adults, youth have interrelated information and service needs that health services and other venues such as schools can meet in comprehensive ways. Models to integrate these programs efficiently in a variety of settings already exist, and the general consensus of experts is that integration should be pursued, albeit in a thoughtful way (Scholl and Finger 2007; LSHTM 2009).

Interventions that integrate RH/HIV with other health concerns are less well-defined but promising. The arguments for and against integration of RH/HIV with other health concerns—particularly those in the field of maternal and child health—are similar for young people and adults. Intervention models that promote this convergence specifically for young people are less well-defined, however. (Scholl and Finger 2007)

Inter-sectoral youth interventions are promising but generally unproven. Interventions that link youth RH/HIV activities with activities in other sectors hold great appeal conceptually because of the connections between young people's health status, educational attainment, and economic well-being (World Bank 2006). Many of the interventions addressing the structural factors that underlie risk are by nature inter-sectoral, for example, micro-finance and other livelihoods. However, the field is still struggling to find the right combination of interventions and how best to evaluate them. Outside of well-established links between school participation and improvement in youth reproductive health (NRC and IOM 2005), few interventions of this type have been rigorously evaluated, and those few have not shown significant impact (LSHTM 2009).

2.2.2. Integration—is it happening? Why or why not?

Given this background, the assessment team tried to gauge the extent to which USAID is appropriately integrating youth programming at different levels, and to explore some of the reasons why appropriate integration is, or is not, occurring.

RH/HIV youth integration is already taking place to some extent, but missed opportunities exist. Many missions interviewed by the team reported that they are already integrating HIV prevention with FP/RH programs aimed at youth, especially in their behavior change communication programs. Some missions were providing HIV/AIDS or family planning monies to their education office efforts to work with schools on "family life" education curricula or after-school education programs. Where both family planning and HIV funds were available, this was not difficult. Some missions with only PEPFAR funds (e.g., Namibia) complained about the difficulty of inter-sectoral activities in the absence of funding from other sources. Regarding the integration of RH/HIV with MCH, very little is happening largely because headquarters MCH staff do not view youth-specific programming as a priority need. Despite these advances, the team and many interviewees across the spectrum of stakeholders feel that missed opportunities exist for integration within RH/HIV programs, with perhaps the most prominent being comprehensive school-based sexuality education programs.

There is broad consensus that integration is useful and necessary. One factor encouraging appropriate integration is the broad pro-integration consensus from donors, CA staff, and most USAID headquarters and field mission staff, especially in terms of linking RH with HIV interventions, and linking RH/HIV with other sectors. There is a general understanding of the importance of integrated youth programming, and many interviewees see the value of integrated inter-sectoral models. The fact that PRH and OHA are co-funding the Interagency Youth Working Group helps support appropriate integration, although integration per se has not been a primary focus of the IYWG.

Missions show widespread support for integration across sectors but find it difficult to develop integrated programs. Most mission staff interviewed were attracted to the idea of integrating youth programs across other sectors, such as education and livelihood development, as an important means for reaching youth, but many felt that they lack either information on best practices for such programs, or reliable evidence that integrated programs offer improved outcomes for reproductive health and HIV prevention. Staff at five of the missions interviewed felt that these topics should receive more research attention. One mission staff member was opposed to integrated programs, primarily due to a lack of confidence in USAID's ability to carry out effective livelihood or jobs programs.

The stovepiped funding situation is not conducive to integration. Another key issue emerging from conversations with CA and USAID staff, particularly at the mission level, was the restrictions on how USAID's stove-piped funding streams can be spent. The relative size of PEPFAR resources compared with all other health monies, as well as other development accounts, was frequently mentioned as an impediment to well-balanced, integrated programming. Many internal USAID interviewees stated that if the "integration" objectives of the Global Health Initiative (GHI) are to be met, the Agency must deal with these kinds of challenges.

Youth inter-sectoral programming is being promoted almost exclusively at the technical level. Another factor hindering the broader spread of integrated inter-sectoral youth programming is the lack of the attention from USAID's senior leadership, such as the Administrator or Assistant Administrator. Almost the entire impetus for integration is coming from USAID's technical staff.

Youth is generally not a focus of integration research. A final factor working against the broader spread of integrated youth programming is a lack of research. Although integration itself is heavily researched, research with a youth focus is rare. For example, only one of the 58 studies recently examined in a systematic review of linked sexual and reproductive health/HIV programs appears to have focused on adolescents (WHO et al. 2009).

3. ANALYSIS OF FUTURE OPPORTUNITIES

The following section examines the assessment team's findings on some of the key elements that shape future opportunities.

3.1. ENVIRONMENT

In the policy and funding environment, several issues stand out.

3.1.1. Other donors and the USAID role

International commitment to YRH/HIV concerns is stronger than ever. USAID's global partners in the UN, donor, NGO, and foundation community are strongly committed to youth reproductive health and HIV/AIDS concerns—such commitment is probably higher now than it has ever been. The UN Millennium Development Goals (MDGs) at their inception included youth HIV prevalence as an indicator, and recently added adolescent fertility as an indicator for achievement of MDG 5 on maternal health. Many donor and technical assistance partners have strong YRH/HIV policies, structures, and programs in place. For example, the United Nations Population Fund (UNFPA) produced a 2007 report, *Framework for Action on Adolescents and Youth*, outlining a corporate strategy for working with governments and partners to promote the comprehensive development of young people worldwide (UNFPA 2007). UNFPA has consistently emphasized adolescent reproductive health issues and co-chairs with UNICEF the UN Task Force on Adolescent Girls (UNFPA 2010). UNAIDS, in its 2009–2011 *Outcomes Framework*, made youth one of nine key priority areas (UNAIDS 2009). The World Bank established a Children and Youth Unit and published the seminal 2007 *World Development Report* on youth issues. Moreover, key bilateral organizations, including many European donors, have a strong focus on youth reproductive health and HIV/AIDS. In addition, several major foundations target youth reproductive health and HIV/AIDS programs and contribute significant funding to them (Funder's Network 2008).

No single agency has global leadership on YRH/HIV issues. There is currently no single organization taking global leadership on these issues. It is instead the UN system, with the collaboration of its various agencies, that is in the vanguard. The United Nations lacks a single strong central organization that focuses on youth issues, and responsibility is split among several UN organizations, including UNAIDS, UNESCO, UNFPA, UNICEF, WHO, and the World Bank (see Appendix 7). Coordination is done through various bodies including the UNAIDS interagency task teams (on young people and on education), and through bodies such as the UN Task Force on Adolescent Girls (see above). Policy and programming on these issues thus remain somewhat scattered and decentralized. The interagency task teams have been functioning for nearly a decade and have recently broadened their membership to reach out to groups outside the UN system, including USAID.

The commitment to youth is reflected at the country level. More developing countries than ever have developed broad youth policies, recognizing the social, economic, and security challenges presented by the youth bulge. In fact, conversations with several mission staff confirmed the team's own perception that many developing country governments are ahead of the donor community—including USAID—in recognizing youth concerns and understanding the relationship between youth investment and national socioeconomic progress. Partner-country-led advocacy for youth provides a positive environment for vigorous programs. At the field level in countries where strong youth policies are in place and where the local government partners are committed (e.g., India, Jamaica, Nigeria, Russia, Tanzania), USAID and other donors are getting good traction on programming for youth.

Partners welcome a strong USAID advocacy role. The assessment team heard universally, from a range of colleagues in the donor and CA community, that international partners would welcome energetic political-level advocacy on youth issues from USAID and the U.S. Government. The general sentiment is that, given the recognized U.S. global leadership role on reproductive health and HIV, an invigorated policy push on youth issues would be highly welcome and would assist the efforts of other donors and national governments.

Supportive advocacy efforts are taking place. A stronger advocacy role for USAID would occur in the context of important recent efforts by foundations and U.S. non-governmental groups to attract attention to youth reproductive health and HIV/AIDS needs, including efforts by the UN Foundation and the Nike Foundation-led Adolescent Girls Coalition and the authors of several recent "Girls Count" publications (Levine et al. 2009; Temin and Levine 2009) Another U.S. NGO-led coalition is conducting a campaign to promote adolescent reproductive health concerns among USAID and other major international donors.

Commitment to youth is also reflected in U.S. domestic structures. The U.S. Department of Health and Human Services has established its first office for adolescent health, signaling greater U.S. domestic commitment to adolescent health issues. Moreover, adolescent and youth health concerns, including such issues as unwanted early pregnancy, smoking, and obesity, remain on the priority list in the United States.

3.1.2. Policy/Advocacy/New initiatives

The assessment team believes that USAID is poised at a critical juncture that offers a unique opportunity to reassert its global leadership role related to youth RH and HIV/AIDS. Regarding adolescent sexuality and reproductive health, the current perception is that USAID has made almost no policy changes since the last administration. Without an Administrator until very recently, and lacking Assistant Administrators at the Bureau level, USAID's ability to formulate a new vision or change existing policy has been somewhat constrained. Nevertheless, opportunities have arisen from the Global Health Initiative (GHI) and other developments that may present opportunities to take on new global leadership and high-level advocacy on youth.

The GHI "business model"[6] and its key principles of implementing a girl and woman-centered approach, strategic coordination and integration, and strengthening partnerships with multilateral organizations (among others), provides a good platform for launching a renewed effort to focus on youth health issues. There seems to be widespread consensus that youth programs must include boys and men. However, some of the most challenging problems that make adolescent girls so vulnerable to HIV infection, unwanted pregnancy, STI infection, sexual exploitation, and gender-based violence need to be highlighted. Because these vulnerabilities are often caused by socioeconomic issues, a more youth-centered and holistic approach to address these challenges should be encouraged.

The GHI is also notable because it is a broad health effort involving multiple U.S. Government agencies. The fact that there is almost nothing in the Consultation Document about how this new initiative will be organized, managed, and led has caused many USAID interviewees to be neutral or pessimistic about its potential. Nevertheless, the assessment team believes that at both the political and policy levels, the GHI presents an opportunity to generate renewed enthusiasm and support for addressing adolescent sexuality and reproductive health issues in a way that breaks with the past and offers new approaches, strategies, and policies for USAID. As the GHI is rolled out in the Phase I GHI Plus countries, PRH and OHA plan to field joint teams that will help

[6] *Implementation of the Global Health Initiative: Consultation Document*, U.S. Department of State, February 2010.

develop specific strategies within GHI (which presents another opportunity to include staff with youth expertise).

With the very recent appointment of a new GH Bureau Deputy Assistant Administrator who is also the Deputy for the GHI, the GH Bureau is now in a good position to formulate a much higher policy-level profile for youth health issues in a way that is consistent with the principles established for GHI and that is part of that overall effort.

The PEPFAR reauthorization and the new PEPFAR strategy present important new opportunities. An explicit prevention goal in countries with generalized epidemics is to "provide 100% of youth with comprehensive and correct knowledge of ways in which HIV is transmitted and ways to protect themselves."[7] If HIV/AIDS programs are to become more sustainable within the broader health and development context of each country, future efforts related to HIV prevention among youth must fit within the institutions and programs of the partner government and the NGO or private-sector entities of the country, and much more attention must be paid to capacity development within those institutions.

The team encountered limited knowledge among interviewees about the Global Engagement Initiative. The Global Engagement Initiative began as a partnership effort with Muslim-majority countries after President Obama's Cairo speech in Cairo in June 2009, but was later expanded. Unfortunately, the team was not able to find any public documentation that provided a full description of the Initiative or to interview anyone very knowledgeable about it. Therefore, the team could not determine whether the Initiative offered any special opportunities for advocacy on behalf of youth health issues.

3.1.3. Funding

Current spending on youth by USAID headquarters is not large. USAID spending worldwide on youth HIV/AIDS activities is substantial ($247 million in 2009), but only a small amount is allocated from OHA's own budget. Within the $247 million, $20–25 million are allocated for the Track 1 ABY grants, all of which are managed by OHA and ending this year. Apart from the mandated Track 1 ABY grants, OHA staff estimate that roughly $450,000 in the 2009 Headquarters Operational Plan (HOP) is allocated for youth-specific activities.

PRH also provided the team with a list of youth activities and funding amounts for 2009 within various centrally funded projects managed by the office. That total is less than $4 million on average, but this represents only the funds allocated from PRH, not the bilateral programs. The $3.4 million allocated in 2009 represents 3.6% of the office's total budget. This is somewhat lower than the annual average from 2001 to 2006. Estimates of bilateral allocations for youth are not currently available.

The budget environment for youth RH/HIV appears to be favorable. Through GHI, spending is supposed to increase to $63 billion over a six-year period, although how much will be designated for USAID is not yet clear. As PEPFAR moves from an emergency to a sustainable country-level program in the second authorization, HIV/AIDS programs will be linked to other programs affecting women and children, and explicit objectives will be developed to strengthen health systems and ensure their sustainability. Resources for population and reproductive health are also increasing. Given the themes of and possible additional resources allocated to the GHI, programs should evolve toward more comprehensive and durable approaches for meeting the needs of all age groups, including the 10–24 age group.

[7] *PEPFAR Five-Year Strategy*, December 2009, page 6.

3.2. EPIDEMIOLOGY AND DEMOGRAPHY OF YOUTH RH/HIV CONCERNS

Some important trends in the epidemiology and demography of youth RH/HIV are shaping USAID's efforts.

Youth are and will continue to be a large proportion of the population. For the developing world, the size of the current youth cohort is enormous and compelling in terms of need—both in the short term and as these young people move into their prime productive and reproductive years. The sheer size of the youth cohort will require special attention and resources for the foreseeable future, especially in the poorest regions such as sub-Saharan Africa and south-central Asia (see Figure 2). As these youth mature, countries will have to provide even more information and services simply to remain at current contraceptive prevalence rates. This is in contrast to many of the generally wealthier developing countries where, because they have already gone through this demographic transition, youth cohorts are shrinking.

Trends in youth reproductive health/HIV are positive, but youth needs remain high. Adolescent fertility rates continue their long-term downward trend, but remain high in many countries (Table 5). In addition, evidence for the negative impact of early sexuality and early childbearing on health and socioeconomic success is growing (WHO MPS Department 2010; Greene and Merrick forthcoming). Similarly, unmet need for contraception remains high. The age group with the highest levels of unmet need for contraception are women aged 15–24 years (see Figure 4). The decline in HIV incidence and prevalence is steepest among young people, and data are emerging that "bursts" of infection appear to occur during life transitions, especially leaving school. For example, in South Africa, incidence climbs rapidly from about age 17 in females, and from about age 20 in males (LSHTM 2009). Although condom use has increased among youth, it remains low in many countries (Figure 5).

There is a geographic confluence of YRH/HIV problems. Generally speaking, those countries with the highest adolescent fertility rates also show the highest rates of maternal and child mortality, and the worst HIV/AIDS problems. Many of these countries are in sub-Saharan Africa.

We know more and have better data on youth. Although our knowledge remains imperfect, the field has more and better data about youth problems, underlying factors influencing these problems, and youth health needs. For example, we have more precise information on who is getting infected with HIV and at what ages. This knowledge will allow more cost-effective targeting of resources and interventions to specific age groups, and to reaching prevention and treatment goals.

3.3. PROGRAMMATIC CONSIDERATIONS

There are key emerging issues that affect YRH/HIV programming for young people.

Global knowledge of effective youth HIV prevention interventions is moving forward incrementally, but there is still a long way to go. The recent update of the 2006 systematic review moved a few interventions from the "Steady" to the "Ready" category, particularly peer-led interventions in schools (see Appendix 8). However, additional strong evidence remains lacking for several of the youth-focused interventions. Many of these interventions have showed an impact on knowledge, self-efficacy, reported behaviors, and use of health services. However, only a few have tried to demonstrate a reduction in the incidence of pregnancy or HIV (LSHTM 2009).

Understanding of effective pregnancy prevention and care interventions is growing but remains incomplete. The WHO-led systematic review of effective interventions to prevent early pregnancy and provide care for pregnant adolescents (forthcoming in late 2010) should provide specific guidance along the lines of the Steady, Ready, Go report, many findings of which already apply to pregnancy prevention efforts. One key area where the new review should break ground is

in its systematic look at adolescent pregnancy *care* interventions. This report will be an important followup to the soon-to-be published WHO *Position Paper on Mainstreaming Adolescent Pregnancy in Efforts to Make Pregnancy Safer*.

Structural interventions are increasingly seen as an important way to influence YRH/HIV behaviors and outcomes. Several interviewees stressed the importance of a renewed prominence on "structural" interventions, which work to alter factors linked to early marriage and childbearing and HIV risk, including policies, social values, and the family and community environment. Such an emphasis on factors that go far beyond the health sector will require greater inter-sectoral collaboration (LSHTM 2009). Analysis of what works in terms of structural interventions for the general population will be needed in order to provide better guidance to USAID field missions.

There is need for increased investment in especially vulnerable subgroups. There is fast-growing recognition of the need to increase investment in the most vulnerable youth, including those at highest risk of reproductive health problems such as early marriage, too-early pregnancy, unsafe abortion, and the most-at-risk populations (MARPs) for HIV. As noted by several interviewees and discussed at the most recent IYWG meeting, most MARPs—men who have sex with men, commercial sex workers, intravenous drug users—are young. While this creates opportunities for working on targeted programs with these young people, many experts point out the difficulties in reaching these populations (FHI 2010; PEPFAR 2009; GP and Y TWG SOPA). Meeting the reproductive health needs of older orphans and vulnerable children (OVCs) is an increasing concern (OVC TWG SOPA). An additional underserved and growing population are those youth already infected with HIV. Many of these young people acquired HIV through sexual transmission in their adolescent and young adult years. Increasing numbers of these youth were infected perinatally, have remained alive on AIDS drugs, and now require special attention for care and treatment, and for addressing their unique reproductive health needs (WHO 2010).

Primary prevention of HIV in the general youth population remains the highest priority. Although a greater focus on the most vulnerable subgroups is warranted in many countries, the highest priority remains primary prevention of HIV for young people, especially young women, in those high-prevalence generalized epidemics that have a youthful profile. These include many of the hardest-hit countries in sub-Saharan Africa. Focusing on these young people represents an opportunity to change the future course of the epidemic.

Programming will diversify to reflect the diverse needs. Greater knowledge of youth problems facilitates more focused programming, and thus a likely diversification of efforts as the field works toward the most efficient way of addressing specific youth health problems. This will require a shift in mentality among youth programmers and more precise targeting of efforts. HIV prevention efforts may target very different groups of young people than will efforts at preventing too-early or unwanted pregnancies.

Those working in gender increasingly recognize youth as a starting point for action. A number of interviewees highlighted the convergence of issues surrounding gender and youth. Some of the most creative programming efforts are emerging from synergies created by these two crosscutting issues. A key point in the work on gender is the importance of boys to achieving positive YRH/HIV outcomes.

Knowledge of the cost and cost-effectiveness of YRH/HIV programs is growing but remains limited. UNESCO recently commissioned a major exercise to assess the cost of school-based sexual and reproductive health education programs. In addition, the Center for Global

Development has undertaken preliminary estimates of the cost of adolescent health services, including for RH/HIV. WHO is also conducting research on the cost of youth-friendly services. For the most part, however, knowledge of costs is scant, which limits the ability to advocate for, plan, and scale up YRH/HIV interventions.

4. RECOMMENDATIONS

A clear conclusion from this assessment is that the GH Bureau has lost ground on youth programs since 2006 because of political constraints in recent years. There are opportunities to reinvigorate development efforts in youth RH/HIV issues that are appropriate to the circumstances in each partner country, and to link them more strategically with other youth-targeted development efforts. The assessment team believes that a window of opportunity has opened for USAID to improve youth programming, but that this cannot be achieved simply by developing a new youth flagship project or by providing better technical support to missions. There must be increased senior-level commitment to, and advocacy for, the effort as well as more programmatic interventions. Listed below are steps the team believes should be taken to reinvigorate USAID's focus on youth-focused programs in RH and HIV.

4.1. STRENGTHENING GLOBAL LEADERSHIP FUNCTIONS

4.1.1. Develop a high-profile Youth Advocacy Strategy under the Global Health Initiative

An advocacy strategy might include the following:

- A high-level youth summit hosted by Secretary of State Hillary Clinton and USAID Administrator Rajiv Shah, with partner-country leaders speaking on the importance of youth as a large demographic cohort and future leaders. Other donors and stakeholders should be involved, and a pledge of global collaboration for youth should be developed, led by interested developing countries. GHI themes should be central, but applied to youth.
- Advocating for an Agency-wide youth policy and strategy, enlisting input from other partners, the CA community, NGOs, and so on. Such a policy should present clear guidance on how inter-sectoral youth programs can be developed, including specific parameters for using various funding accounts in such programs.
- Strengthening ties with international donors, foundations, and other organizations working in youth programs by:

- encouraging closer collaboration at the country level, in particular by participating in partner-country-led strategy and planning for youth policy or programs, and other joint efforts aimed at providing strategically harmonized support to governments, such as country compacts and sector-wide planning.
- sharing youth-related training materials, curricula, BCC materials, research results, and so on.
- having senior GH Bureau representation at appropriate youth-related meetings sponsored by other donors, UN agencies, and foundations.
- full participation in existing working groups, such as the interagency task teams (IATTs), or in new ones that are created as appropriate.

4.2. GOALS AND PRIORITIES FOR FUTURE GH YOUTH RH/HIV PROGRAMS

The GH Bureau still plays an important role in providing technical leadership on YRH/HIV, including knowledge management, dissemination of best practices, support for scale-up of evidence-based interventions, and testing innovative approaches to advance the knowledge base. However, GH needs to stay focused on the goals and priorities listed below.

4.2.1. Research and Data

Develop a new set of research priorities and a long-term research agenda. To remedy the current scattered approach, GH needs a prioritized, long-term research agenda (5–10 years or more), developed in collaboration with partners, bilateral and multilateral agencies, foundations, and academics, and drawing on previous efforts. GH planners should take into consideration recent exercises aimed at developing a research agenda on YRH/HIV, including those summarized in the *Growing Up Global* report (NRC and IOM 2005); the World Bank's 2007 *World Development Report* (World Bank 2006); *Disease Control Priorities in Developing Countries Chapter on Adolescent Health* (Lule and Rosen 2006) the IYWG 2007 report on YRH/HIV research needs (Adamchak 2007); the 2006 Steady Ready Go report (IATT 2006) and the 2009 report of the Steady Ready Go update meeting held in Tanzania (LSHTM 2009). The team has also identified several areas for research focus, as summarized in Table 4.

Address research problems in PEPFAR. As noted earlier, there are challenges for PEPFAR in research, which will have to be addressed by OGAC and the PEPFAR partners. Doing so will improve the chances for USAID to support meaningful youth-focused research.

Develop better indicators. Mission staff feel that there should be better indicators for youth RH and HIV—that measure outcomes rather than simply counting inputs and outputs (e.g., numbers of people trained). PEPFAR thus needs to develop better indicators for youth programs in order to ensure that progress can be measured and problems identified. PEPFAR has no separate indicators for youth prevention programs. Development of such indicators should be coordinated with development of indicators for the GHI, which should also include appropriate youth indicators, given its focus on adolescent girls.

4.2.2. Knowledge management and best practices/research utilization

Continue and build on the successful knowledge management activities of the past three years. There is a continued need for more knowledge management, as almost everyone acknowledges. Documenting best practices and disseminating information on successful youth programs remains critical. Knowing what *doesn't* work is as important as knowing what does work. While dissemination of best practices at headquarters and within the CA community is still a priority, USAID should focus dissemination efforts more on the country level, which will require greater resources. GH can facilitate this by producing short, easily understood materials focused on key youth interventions and aimed at missions and country counterparts. GH should also put more resources into translation of materials into languages other than English (especially, but not limited to, Spanish, French, and Portuguese). Additionally, GH should better document and disseminate information on mission-funded (as compared with headquarters-funded) youth activities. GH should also provide the resources to carry out the recommendations of the IYWG's 2009 evaluation (FHI 2009), which are endorsed by the assessment team.

4.2.3. Programming efforts

Put greater focus on encouraging mission scale-up of proven, effective interventions. As discussed in section 3.3 and summarized in Appendix 8, much is already known about how to administer youth RH/HIV programs, and USAID's field missions should be encouraged to work with their partners in country to scale up proven interventions. Regarding the two "Go!" interventions recommended for immediate widespread implementation—school-based sexual health education programs and mass media programs—USAID needs to continue its support for mass media efforts and focus more attention on school-based programs, an intervention that USAID has underemphasized in the past. USAID should also support carefully evaluated large-scale implementation of interventions classified as "Ready," including provision of "youth-friendly" health services that involve training of health workers and modifications to service protocols.

Put the new data to use and better target activities to the most vulnerable youth. Drawing on the latest data, GH should focus programs on the most vulnerable young people. In doing so, GH should expand its efforts to address underlying drivers of youth risk, as well as ensure that all young people get the information and services they need to protect themselves. USAID should support carefully evaluated widespread implementation of interventions that provide information and services for most-at-risk young people through health facilities and outreach. In addition, analysis of structural interventions for the general population of youth in order to determine what works to reduce risk should be conducted to provide better guidance to USAID field missions

Continue to test and innovate. Although scale-up of proven interventions is important, at the same time the Agency should keep testing and innovating—in particular, looking for models of integrating with other health and development sectors where doing so can enhance outcomes. Interviewees identified many important gaps in programming, as summarized in Table 6.

4.2.4. Helping field missions

Conduct a strategic information campaign for missions and partners. As noted above, missions need better access to timely technical assistance, state-of-the-art information, and encouragement for youth programs or youth components of programs. GH should organize a strategic information campaign with USAID missions, sending them country-specific information about youth sexual and reproductive health issues from the Demographic and Health Survey (DHS) and other sources; encourage and support youth assessments where appropriate; and provide other means for engaging with local colleagues in partner governments and other development partners as appropriate. The purpose of providing this information is simply to assist field mission staff, who are often overburdened with the daily tasks of managing their programs. They may be grateful to have analytical information provided to them in a form they can easily share with colleagues or use for their own analyses as they develop new strategies or programs. In addition, having such information may trigger new interest and commitment to dealing with youth-specific challenges in their programs.

Track bilateral youth activities. It is important for the GH Bureau, especially PRH, to have a better way of tracking the youth RH activities within the bilateral programs. As noted, it is difficult to help missions apply best practices, use relevant research findings, and understand gaps with insufficient information on bilateral programs.

Update staff knowledge. Staff should be kept updated by having SOTA sessions on youth, conducting regional training sessions where possible, updating the USAID E-learning website on adolescent reproductive health, and ensuring that newly hired staff are trained in youth issues. To address the problem of mixed messages to HIV/AIDS program managers in USAID field missions, OHA might consider developing a separate SOPA on youth rather than combining youth with HIV prevention in the general population. This would present clearer guidelines and provide for greater detail on youth issues. OHA should also consider updating all relevant SOPAs to reflect the latest findings on the effectiveness of youth interventions to prevent HIV infection.

4.2.5. Structural and management changes

Formalize the USAID network of staff working on youth, including field missions. USAID should specifically identify youth focal points, as appropriate in Global Health, regional bureaus, and field missions, making it a part of their job description. OHA should officially designate a Youth Advocate, while PRH should continue its designation of an official youth champion. To encourage greater integration, the HIDN office should do likewise.

Develop a system in GH for proactively helping missions. Timely technical support to missions is critical. Some of the functions of such support, such as aid in design and developing procurements, can only be provided by staff within the Agency and not via external technical

assistance agencies. The GH Bureau needs an institutionalized system for knowing when missions need help with youth program evaluation or design, and for offering assistance at the right time. Requesting that missions designate a health-sector staff member as a youth coordinator could help develop a network of mission and headquarters managers that would facilitate communications.

4.3. IMPLEMENTING OPTIONS

If the GH Bureau chooses to reinvigorate its youth RH/HIV program, there are three options available:

Option 1: (recommended option) Strengthen advocacy for youth RH/HIV tied to the GHI, develop a new youth-specialized project, and continue to encourage mainstreaming of youth programs as relevant.

Option 2: Strengthen advocacy for youth RH/HIV tied to the GHI, and continue with the mainstreaming efforts with increased funding.

Option 3: Strengthen advocacy for youth RH/HIV tied to the GHI, and develop a new youth-specialized project, but discontinue attempts to mainstream.

The advantages and disadvantages of each option are presented in Table 7. The team believes that Option 1 offers the best alternative to revitalize youth programs and provides the resources and emphasis on youth that is needed at this point.

4.3.1. Develop a flagship project for youth within the GH Bureau portfolio of projects.

While not universal, there is a general feeling, both within and without USAID, that a youth-specialized flagship project is desirable in order to aggregate expertise on youth in one easily identifiable entity. This would be a significant benefit to mission staff, who would know that centrally located, youth-specific technical capacity exists, and that such capacity can provide them with a readily available source of support. Without such a project, missions cannot be sure whether that technical capacity exists or how to access it. From the perspective of the GH Bureau, a youth-specialized project would also facilitate the process of managing a more coherent strategic approach to meeting youth-related objectives. The "mainstreaming" mechanism used by PRH (where workplans of various PRH-managed projects are reviewed annually and promising youth activities prioritized for funding) is insufficient for PRH to provide strong, creative, and proactive leadership in the field of youth reproductive health.

This new project should be able to provide strategic and technical expertise to field missions, fund youth assessments, and initiate (and, in some cases, fund) innovative pilot programs within missions' bilateral programs. The expertise of project staff should span sexual and reproductive health, HIV/AIDS, adolescent anemia, maternal and newborn health, and other youth-related issues. The project should also include staff with expertise in integrating RH/HIV youth work with youth activities of other sectors such as education, livelihood development, and democracy and governance. The project mechanism should have the capacity to take funds from the broader set of development accounts to respond to the growing interest in inter-sectoral youth programming. Furthermore, the project should be able to carry out and expand the knowledge management functions already in place (including convening regular IYWG meetings); work with USAID to develop an updated research agenda; conduct practical operations research; and establish the evidence base as needed, particularly in the areas identified by field missions, such as inter-sectoral youth programs.

The flagship project does not have to be a new project if an existing mechanism will serve, such as a new Task Order within an Indefinite Quantity Contract (IQC), or an Associate award within

a Leader with Associates Agreement. In general, the assessment team believes that field missions may not necessarily use this project for the purposes of program implementation and service delivery, except perhaps as a way to initiate a program prior to developing a new bilateral project. Using core money, the project should be sufficiently well-funded to be able to fund youth assessments or pilot activities at the mission level as needed, in order to initiate or promote field programs without becoming a substitute for programs that should be bilaterally supported.

GH Bureau Youth Advocates and other staff with youth expertise will still be needed to provide support to USAID field missions interested in developing youth programs. These staff can help missions decide how to proceed with youth assessments or other analytic exercises needed to gather the information to determine the nature of the development problem and how to address it. They can work with the missions on strategy development for programs (or components within ongoing projects) focused specifically on youth. GH Bureau staff can help develop scopes of work for technical assistance or develop requests for proposals and other procurement-related documents that are procurement-sensitive and cannot be delegated to external institutions. GH Bureau staff can also assist missions to access and work with a new youth-specialized project for whatever support missions need to move their programs forward.

These are highly important supporting tasks that will have to continue and expand. A new youth flagship project, and the apparent interest in expanding work related to youth programs at the field mission level, will increase the need to involve GH Bureau staff in youth work at the mission level. PRH and OHA need to consider assigning youth advocacy responsibilities to larger numbers of staff, and need to provide additional training if required.

The team believes that a new flagship, youth-specialized project should serve the needs of both PRH and OHA and be jointly funded, as in most cases youth sexual and reproductive health, and HIV prevention, must be addressed together. Moreover, such a mechanism could also provide technical expertise as appropriate on adolescent-specific elements of maternal and newborn health programs managed by the HIDN office, especially those focusing on pregnancy care and maternal anemia.

5. CONCLUSION

Given the large proportion of the population in USAID partner countries between the ages of 10 and 24, USAID has an important opportunity to help these youth make improvements in their health and well-being that could have significant payoffs for generations. The spillover effects of avoiding early marriage and unwanted pregnancy, reducing the risk of HIV and STI infections, and avoiding gender-based violence and exploitation will help adolescents stay in school, find better jobs, and become more productive citizens. Because development is all about transforming the capacities and lives of people, investing in youth will ultimately have an enormous impact on entire societies for years to come.

TABLES

TABLE 1: GH HEADQUARTERS-FUNDED RESEARCH ON YRH/HIV, 2006–2009				
Country(ies)	**Topic/Title**	**Project/Mechanism**	**Funding**	**Dates**
Botswana, Malawi, Mozambique	Gender Initiative to Reduce Girls' Vulnerability to HIV Mapping gender-based violence, developing vulnerability measurements, and creating interventions.	Johns Hopkins University (JHU)	OHA, $4.5 million over three years	2007–2010
Haiti	Applying the Priorities for Local AIDS Control Efforts (PLACE) methodology to study youth.	MEASURE evaluation	PRH, $200,000	2006–2007
To be determined	Researching the impact of youth-integrated FP and HIV service delivery models.	FHI/CRTU, will be in new PTA project	PRH, $94,000	FY 2009, starting in 2010
India	Operations research project to explore interventions to delay age of marriage.	Pathfinder	PRH (gender), $325,000	2008–2009
India	Saathiya youth-friendly pharmacies. Support for evaluation to inform expansion and replication.	PSP-One/SHOPS	PRH, $315,000 for activity implementation; $150,000 for evaluation	2009
Multi-country	Improving Dual Protection Counseling for Youth: Formative research and Operational Research to assess dual-method counseling messages and provider performance.	FHI/CRTU	$162,829	FY 2008
Kenya	Testing Service Delivery Models for Youth Integrated FP and HIV, Kenya. Collaboration with APHIA Bilateral.	FHI/CRTU	$100,552	FY 2008
Zambia	Evaluation of Student Partnerships Worldwide (SPW) Model of Peer Education–Zambia. Assessment of behavioral impact and cost of school-based curriculum.	FHI/CRTU	$76,631	FY 2008
Bangladesh, Cameroon,	Reaching married adolescents with RH services through faith-based structures in the	Population Council/ Frontiers	$3.3 million (PRH and HIV	2006–2010

TABLE 1: GH HEADQUARTERS-FUNDED RESEARCH ON YRH/HIV, 2006–2009				
Country(ies)	**Topic/Title**	**Project/Mechanism**	**Funding**	**Dates**
Kenya, India, Mexico, Nepal, Peru, Senegal, Uganda	community; adolescent reproductive health curriculum in vocational training courses; peer education; youth in urban slums; communication with families.		funds)	

TABLE 2: GH HEADQUARTERS-FUNDED RESEARCH SYNTHESES, 2006–2009			
Topic/Title	**Project/Mechanism**	**Funding**	**Dates**
Preventing too-early pregnancy and mortality and morbidity during pregnancy in adolescents	WHO	$300,000	2006–2009 Final product expected December 2010
Comparative report on YRH in 38 countries (Khan and Mishra 2008)	MEASURE DHS	$130,000	2008 (?)
Addressing Cross-Generational Sex: A Desk Review of Research and Programs	BRIDGE	$65,000	2007

TABLE 3: INTERAGENCY YOUTH WORKING GROUP ACTIVITIES, 2006–2009	
Type of Activity	**Activities/Accomplishments**
IYWG partner meetings	Partner organizations were funded directly by USAID via the Global Leadership Priority (GLP) for Youth through February 2008. The partners met on November 2, 2006, February 8, 2007, July 24, 2007, and March 13, 2008.
IYWG meetings	June 25, 2009—IYWG events at "Young People Most at Risk for HIV/AIDS" Meeting June 23, 2008—Global information-sharing of "Youth Deliver the Future" Conference April 28–30, 2008—IYWG events at "Youth Deliver the Future"; Peer Education, Working with Faith Organizations, and Curricula-Based Standards December 7, 2007—Monitoring and Evaluation for Youth Programs: Capturing Social Change December 6, 2007—Parents and Young People's Health; and Integrating HIV and Reproductive Health Services for Youth May 8, 2007—Filling the Gap: New Tools Available for Youth Programs May 7, 2007—Youth: New Research, Program Experiences, and Applications
Youthlens publications	19 research briefs have been produced, including: No. 19. Community Involvement in Youth Reproductive Health and HIV Prevention No. 20. School-Based Reproductive Health and HIV Education Programs—An Effective Intervention No. 21. Integrating Reproductive Health and HIV Services for Youth No. 22. Scaling Up Youth Reproductive Health and HIV Prevention Programs No. 23. New Web Sites Make Information About Youth More Accessible No. 24. Youth Peer Education No. 25. Helping Parents Improve Adolescent Health No. 26. Youth and Injecting Drug Users No. 27. Addressing the Needs of Young Adolescents No. 28. Communicating with Youth: Using the Internet and Mobile Phones in Reproductive Health Programs No. 29. HIV-Infected Youth No. 30. Hormonal Methods of Contraception for Youth
Youth Info monthly summary	Produced 37 issues of a one-stop monthly and fully electronic source for new publications and information on youth reproductive health and HIV prevention.
IYWG website http://info.k4health.org/youthwg/	Hosted by K4health.org

TABLE 4: PRIORITY RESEARCH AREAS SUGGESTED BY INTERVIEWEES
Risk Factors
Factors that put young people at risk, both for HIV infection and unwanted pregnancy.
The proximal causes—i.e., partner reduction, condom use, and male circumcision—of what puts youth at risk for pregnancy or HIV, not the more distal causes.
Social and sexual norms, especially in situations where they are changing.
Environmental issues, such as employment, that affect youth.
Structural factors, including community influences.
Why progress on reducing maternal mortality has been backsliding and the role adolescent pregnancy might play.
Impact of Policy Interventions
Impact of legal systems on reproductive health and vulnerability to HIV/AIDS.
Impact of policy and legal issues.
Research on Vulnerable Groups
Study the effectiveness of interventions on particularly vulnerable subgroups of youth.
Work to understand better what is happening with most-at-risk groups, including sex workers.
Work to understand better the needs of youth and why some young people are motivated to engage in inter-generational sex; the behavior of the older men should also be studied.
Livelihoods models that are complementary to work with high-risk groups.
Programming Approaches
Show how to create effective and holistic youth programs.
Scale up work on religious leader counseling of about-to-be married couples.
Test an inter-sectoral youth approach using a strong evaluation design.
Develop effective community education materials on reproductive health.
Conduct behavioral research to develop effective behavior change communication (BCC) messages to encourage condom use among youth.
Generating a *new* body of knowledge on cutting-edge programming.
Information on Use of Services
Show how youth access maternal health services.
Generate more information about the various age groups within youth, and the challenges facing each.
Ascertain which youth actually use services.
Research Methodology or Approaches
Show how to evaluate and implement an inter-sectoral approach.
Conduct more qualitative research.
Generate research locally rather than relying on research results from other countries or regions.
Conduct youth-focused behavioral research, especially with respect to abortion.

TABLE 5: FERTILITY RATES OF 15–19-YEAR-OLD WOMEN AND PERCENTAGE CHANGE, BY REGION, 1995–2000, 2000–2005, AND 2005–2010

Region	Period			Change 2005–2010 vs. 1995–2000	
	1995–2000	2000–2005	2005–2010	Absolute change	% change
World	63.3	56.6	52.0	-11.32	-18%
More-developed regions	28.5	24.3	21.3	-7.21	-25%
Less-developed regions	69.4	61.8	56.5	-12.90	-19%
Least-developed countries	124.1	115.9	103.3	-20.86	-17%
Less-developed regions, excluding least-developed countries	59.7	51.7	47.1	-12.51	-21%
Less-developed regions, excluding China	85.4	76.3	68.9	-16.48	-19%
Sub-Saharan Africa	133.4	127.5	117.7	-15.72	-12%
Africa	115.3	110.2	102.9	-12.36	-11%
Eastern Africa	121.6	119.4	111.3	-10.34	-9%
Middle Africa	197.2	188.8	167.1	-30.08	-15%
Northern Africa	44.4	37.5	31.8	-12.57	-28%
Southern Africa	81.9	72.4	60.8	-21.10	-26%
Western Africa	138.5	130.6	122.8	-15.66	-11%
Asia	53.6	45.0	40.1	-13.50	-25%
Eastern Asia	9.3	9.2	9.2	-0.06	-1%
South-Central Asia	90.1	73.2	62.9	-27.17	-30%
Southeast Asia	42.7	38.7	33.3	-9.35	-22%
Western Asia	55.9	50.4	48.2	-7.61	-14%
Europe	23.8	19.7	17.2	-6.64	-28%
Eastern Europe	34.7	26.8	24.3	-10.46	-30%
Northern Europe	24.1	22.1	19.4	-4.69	-19%
Southern Europe	12.2	12.1	10.8	-1.36	-11%
Western Europe	9.7	9.0	7.2	-2.48	-26%
Latin America and the Caribbean	85.6	80.4	72.3	-13.23	-15%
Caribbean	77.7	68.5	64.5	-13.18	-17%
Central America	87.6	79.7	74.0	-13.53	-15%
South America	85.6	81.9	72.5	-13.09	-15%
North America	49.2	40.5	33.8	-15.39	-31%
Oceania	40.3	33.7	28.2	-12.11	-30%
Australia/New Zealand	21.4	18.6	16.3	-5.11	-24%
Melanesia	81.3	64.8	51.0	-30.36	-37%
Micronesia	61.6	45.3	36.9	-24.75	-40%
Polynesia	45.7	43.9	37.9	-7.81	-17%

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2009.

TABLE 6: PROGRAMMING GAPS AND OPPORTUNITIES SUGGESTED BY INTERVIEWEES	
Programming Gaps/Opportunities	**Suggested By**
Private-sector issues are huge; some work has previously been done on pharmacies and youth. USAID is missing a huge bet if it doesn't look at issues of pharmacies and social marketing.	USAID/Washington
Young men are important too, not much on men in the GHI.	USAID/Washington
Older OVCs The whole issue of integration and how you bring it together. We tend to be more siloed. We need evidence and data to show results. USAID also needs to repackage some of the information on evidence—need to really get strong evidence out so that it becomes common knowledge. Figure out how to foster public-private partnerships to help youth (jobs, etc.) We lack information on how to do this. We need to stop simply following the funding streams and think more broadly about how to meet youth needs. We should look for clarity on the integration piece, how to operationalize.	USAID/Washington
Regarding school-based programs, working with curricula is tricky; this will always be a hot button. More work is needed on integration at the policy level, including developing a "youth RAPID" presentation, along the lines of a "gender RAPID."	USAID/Washington
MARPS are quite young, but it is difficult to gather data on young commercial sex workers (CSWs) because they are considered trafficked. That's been a gap in our programming.	USAID/Washington
Young MARPs are a huge gap. There is also a gap on youth living with HIV, what their needs are. There is some work being done on that, but relatively little research.	NGO
Parenting and community interventions are important, but we are a long way from defining what these are and have little implementation experience.	UN agency
HIV/AIDS care and treatment for adolescents.	Cooperating agency
More attention to adolescent maternal health needs. Mainstreaming or recognizing married young people within flagship RH programs. Need to address HIV+ youth.	Cooperating agency
Young MARPs. There are probably mainstream projects serving youth (e.g., for sex workers), but they don't even ask the age of beneficiaries because it is too controversial for legal reasons. HIV+ adolescents is another gap area. Learn about the link between gender-based violence (GBV), gender norms, and HIV to know what tools and messages are effective. Beyond condoms, what effective messages can providers give on FP methods?	Cooperating agency
We have to reach young people with the basics in terms of information and services, in settings like schools. USAID could do more work in that area. Also out-of-school youth.	Foundation

TABLE 6: PROGRAMMING GAPS AND OPPORTUNITIES SUGGESTED BY INTERVIEWEES	
Programming Gaps/Opportunities	**Suggested By**
Serving underserved young women in Africa with family planning services once they are out of school.	Cooperating agency
A current gap is that we don't look at gender and youth issues together. In our country, adolescent girls may drop out of school when menstruation begins, which leads to early marriage and higher fertility. Special needs of girls need to receive focused attention.	USAID field mission
Large scale analyses are needed to determine whether programs like religious leader counseling of about-to-be-married young people (e.g., Indonesia) are effective in delaying first pregnancy. The outcomes from programs like those need to be widely disseminated to missions.	USAID field mission
One programmatic gap is dealing with youth who are HIV+ (by providing counseling, services, support, etc.).	USAID field mission
Linking violence prevention with reducing the risk of pregnancy and HIV should receive much more emphasis.	USAID field mission
Little information is available on best practices with respect to integrated programming for youth. What are the barriers, what works, and what doesn't?	USAID field mission
Lack of integration of FP/HIV remains a problem. Another gap is comprehensive youth programs—very few are providing youth and family services, youth leadership around RH, and prevention in general	Foundation
A big gap in the OVC program is dealing with vulnerable children in relation to adult care and protection beyond just HIV. Many OVCs live in environments where they have no adult to nurture them or protect them from various forms of exploitation. Not enough is known about how to formulate programs to protect children in these circumstances. Also the cross–sectoral programming is difficult for missions but essential for successful programs that respond to what youth need. Trafficking, labor, conflict situations, etc., for kids under 18. Another gap is the extent to which USAID programs are paying attention to most-at-risk youth who are living in households with intravenous drug use (IDU) problems and in households where the mother is a commercial sex worker, in addition to MARPs who are themselves adolescents.	USAID/Washington
For thirty years we have focused on providing contraceptives, but I think we can also do things to affect fertility significantly in a more sustainable way, e.g., by improving girls' education.	Foundation

TABLE 6: PROGRAMMING GAPS AND OPPORTUNITIES SUGGESTED BY INTERVIEWEES	
Programming Gaps/Opportunities	**Suggested By**
We learned some lessons about adult involvement in youth programming, but these have not been widely applied. I would like to see this more rigorously evaluated. Gender is a key issue, and we know more than we used to. We need to pay equal attention to boys and young men as we do to girls. Trying to define and measure outcomes for 10–14-year-olds is challenging. From our gender work, we find that the earlier we start, the easier it is to change social norms. If USAID could make it easier for us to address GBV in our programming, integrate it into our programming, that would be great. This could be done through some PEPFAR language or guidance, as new central projects, or when IQCs come out. Urban youth is another new focus area. There is a high rate of urbanization, and social support systems are not what they are in rural areas.	NGO
The women-centered approach is still too women-centered. We need to make sure men and boys don't fall off the radar screen.	USAID/Washington
We may need to adjust our discussion of impact of early pregnancy on maternal and neonatal mortality to reflect that fact that we can't lump together all 10–24 year olds; they have different needs, different risks.	USAID/Washington
We need to do more FP/HIV integration.	USAID/Washington
I would like to work more with more ministries to institutionalize comprehensive sex education.	USAID/Washington
We have equated youth prevention with sex education, and not adequately focused on the services piece.	USAID/Washington
We need to focus more on the young MARPs.	USAID/Washington
Maternal health programs need to become more linked to HIV and RH.	USAID/Washington
The big need is to work with ministries of education to standardize comprehensive sex education curricula.	USAID/Washington
We need to engage sectors other than health in looking at the impact of youth YRH/HIV interventions.	Cooperating agency
There needs to be more attention to services; there remains a great unmet need for FP for adolescents.	Cooperating agency
We need more field-oriented work on the unmet need for young limiters.	Cooperating agency
There is tremendous need for capacity-building and training of local groups.	Foundation
We need more long-term community programming that works in partnerships to mobilize on child marriage and cross-generational sex. Unsafe abortion is still a problem among adolescents.	Foundation
Most missions cannot dedicate staff to just youth activities, but youth can be incorporated within the broader prevention strategies of each mission.	USAID/Washington

TABLE 6: PROGRAMMING GAPS AND OPPORTUNITIES SUGGESTED BY INTERVIEWEES	
Programming Gaps/Opportunities	**Suggested By**
In Latin America and the Caribbean countries facts are emerging about the predominance of youth among the MARPs for HIV (MSMs, those engaging in transactional sex, traditional commercial sex workers, those engaging in cross-generational sex, etc.).	Cooperating agency
Among 10–14-year-olds, early marriage is a problem, as is lack of services.	UN agency
One of the challenges in the next couple of years is for health services to define better what health systems improvement means in terms of specific interventions for youth.	UN agency
There has been underinvestment in the whole area of supporting communities and getting them to come on board and support adolescent development, and to support programs.	UN agency
One challenge is whether to promote dual versus double protection. De facto, we are just promoting condoms, but in countries where the bigger risk is unintended pregnancy rather than HIV, there has been too much emphasis on condom use alone for dual protection.	Cooperating agency
We need to provide technical guidance for youth living with HIV, who will require services, treatment protocols, etc.	UN agency
Promoting the HPV vaccine for adolescent girls.	UN agency
All kids need to be exposed to school-based programs. But we need to recognize that structural factors are so huge that sex education may be totally inadequate in the absence of other things that address the school environment.	Youth expert
In line with the findings from gender work, more attention needs to be paid to boys and young men.	Youth expert
We should explore using new communications technology to reach young people with information and services.	UN agency
We still need to do better in reaching the poorest youth.	UN agency
We need to gather information about unsafe abortion.	UN agency
We still need “bread and butter” reproductive health programs to help young people get through those middle years.	Cooperating agency

TABLE 7: OPTIONS FOR YOUTH RH/HIV IMPLEMENTING MECHANISMS			
Option	**Implementing Option**	**Advantages**	**Disadvantages**
0	Status quo	• Other donors and organizations continue to take global leadership role, so fewer staff and resources are needed.	• Does nothing to clarify ambiguity about USAID's youth policy and commitment.
1	(1) Strengthened advocacy tied to GHI, (2) new youth-specialized project, and (3) youth main-streaming as relevant.	• Sends clear message to all stakeholders about USAID focus on youth. • Offers opportunity to showcase what GHI principles mean when put into play by USAID. • New DAA-Deputy for GHI could play pivotal role. • Provides central knowledge source for missions looking for help and expertise. • Stimulates CAs with existing youth expertise to continue their work. • Provides opportunity for more integrated FP/RH and HIV support to field missions.	• Requires strong support and involvement by Secretary of State and USAID Administrator, whose commitment to this is unknown. • Would require greater allocations of core resources by both PRH and OHA. • It is unclear how other PEPFAR partners would react.
2	(1) Strengthened advocacy tied to GHI, and (2) youth mainstreaming with same or additional resources, *but no new youth-specialized project.*	• May stimulate CAs to do more on youth. • Avoids headache of new procurement. • Easier on the central budgets.	• There will continue to be no clearly defined youth technical focal organization for missions. • Central youth expertise is not focused on a common agenda or common challenges. • It is administratively complicated to monitor and influence investments.
3	(1) Strengthened advocacy tied to GHI, and (2) new youth-specialized project, *but no youth mainstreaming.*	• Provides central knowledge source for missions looking for help and expertise. • Helps Youth Advocates centralize resources and react with CAs more strategically on youth issues.	• Undermines the contributions ongoing in other projects, as well as their potential.

FIGURES

FIGURE 1: EVOLUTION OF USAID'S YRH/HIV PROGRAMMING

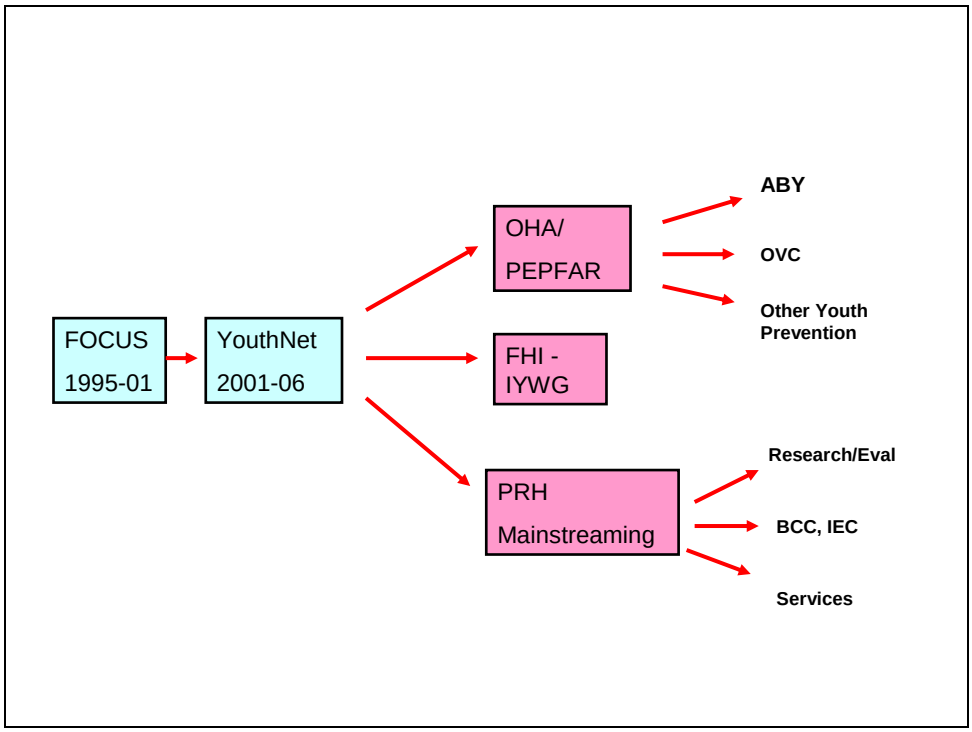
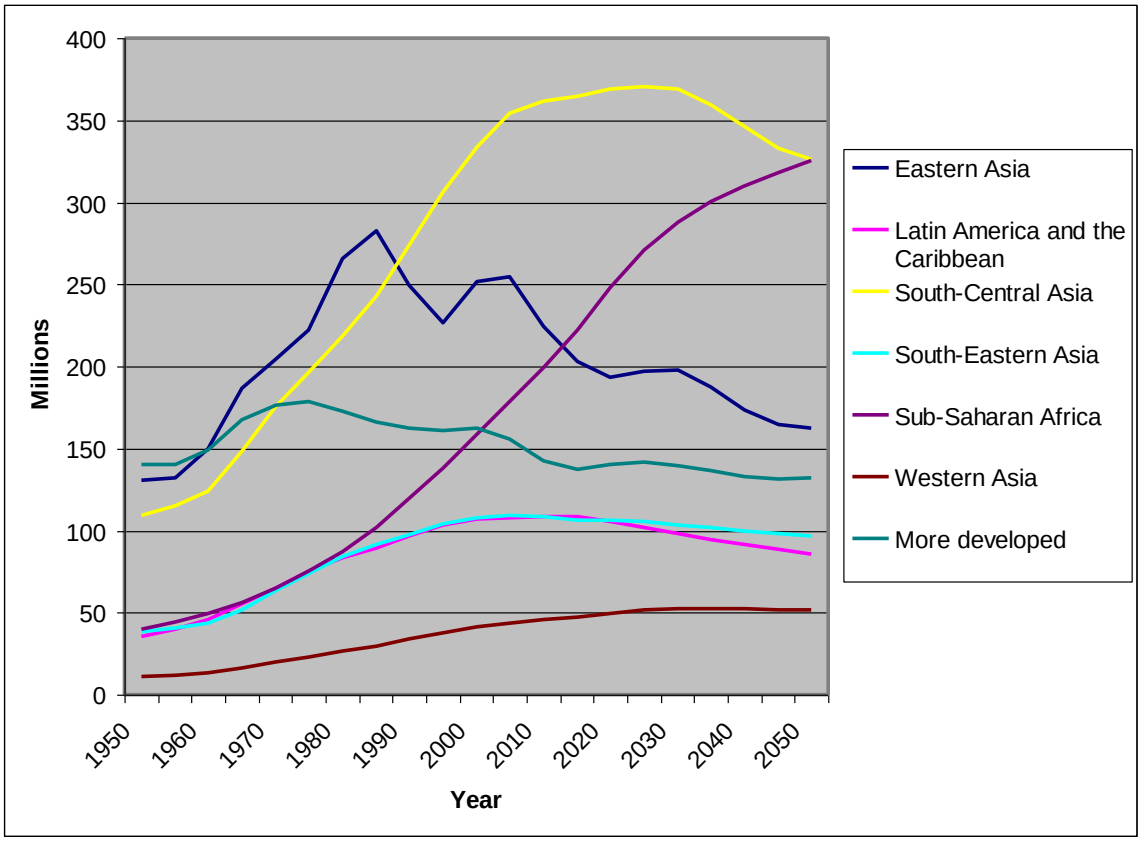
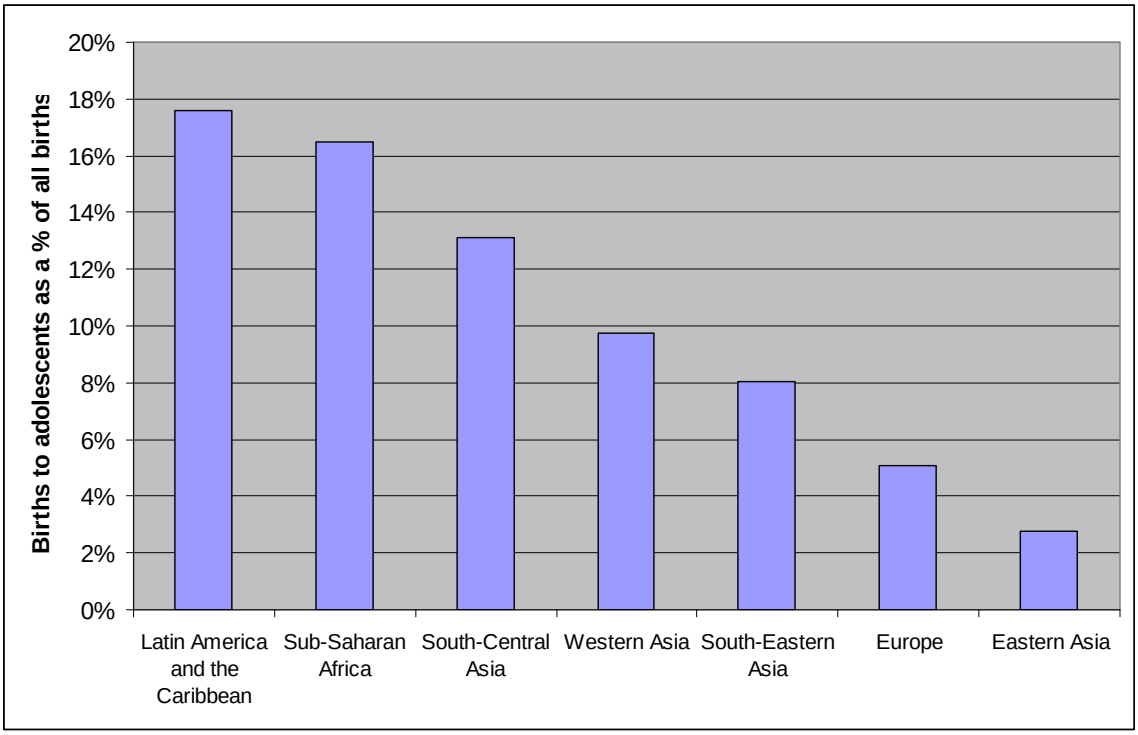


FIGURE 2: POPULATION OF 10–19 YEAR-OLDS BY SELECTED REGION AND ECONOMIC LEVEL, 1950–2050



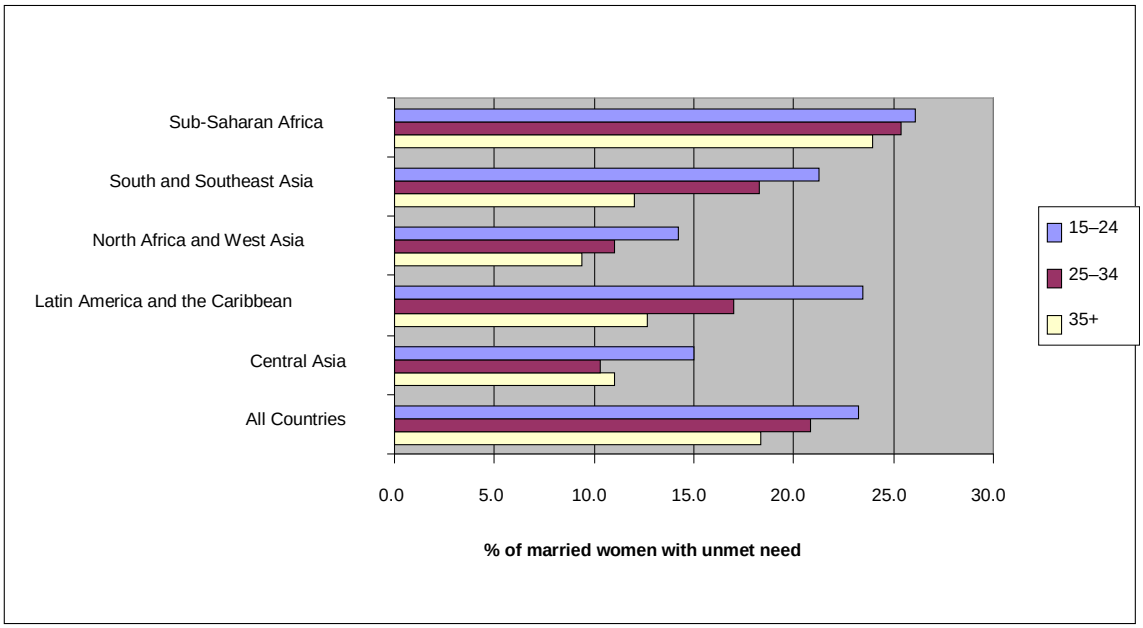
Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2009.

FIGURE 3: BIRTHS TO 15–19 YEAR-OLDS AS A PROPORTION OF ALL BIRTHS, BY REGION, 2005–2010



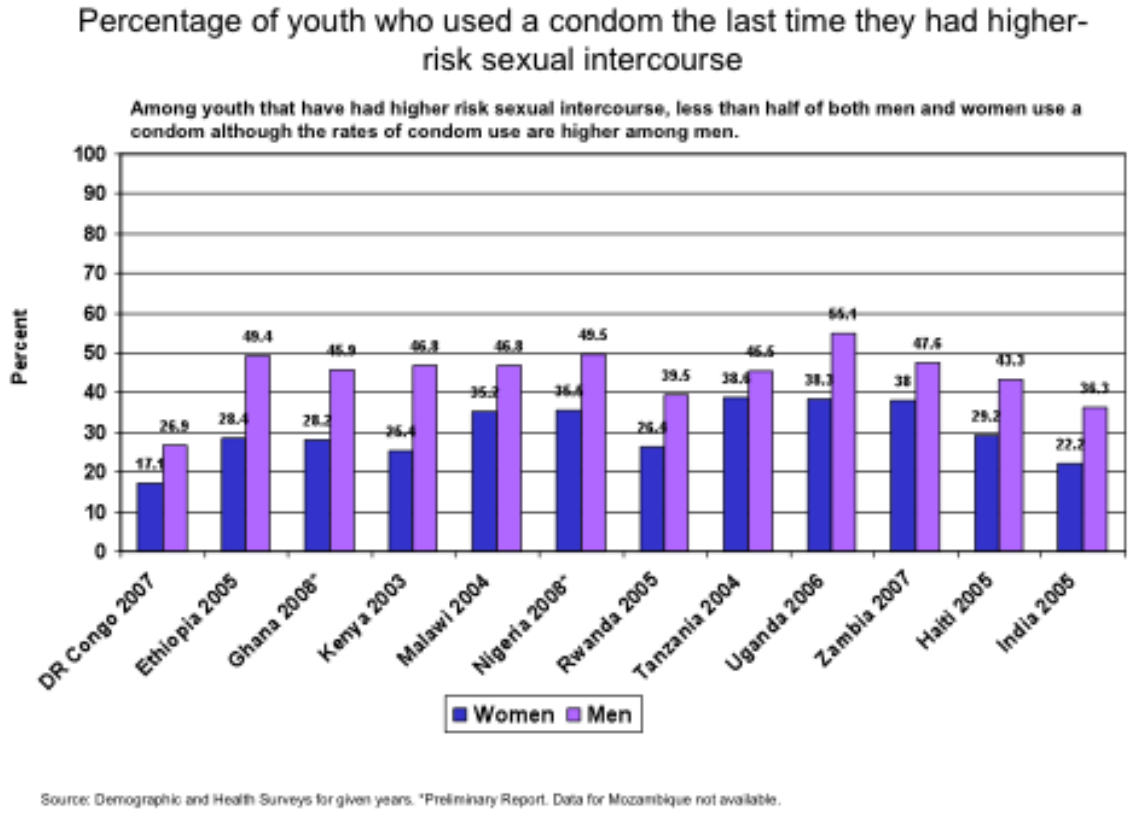
Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2009.

FIGURE 4: UNMET NEED FOR CONTRACEPTION BY AGE GROUP AND REGION



Source: (Sedgh *et al.* 2007)

FIGURE 5: CONDOM USE AMONG YOUTH ON LAST OCCASION OF HIGH-RISK SEX



Source: Demographic and Health Surveys for given years. *Preliminary Report. Data for Mozambique not available.

APPENDIX 1: LIST OF INTERVIEWEES

USAID MISSION STAFF

East Africa Regional Office

Shelagh O'Rourke, HIV/AIDS
Mary Skarie, Director, Regional Health and HIV/AIDS Office
Wairimu Gakuo

Zambia

Rene Berger, HIV/AIDS Office
George Sinyangwe, Health Office

India

Monique Mosolf, Reproductive Health Division Chief
Sheveta Verna, MCH
Sanjay Kapur, HIV/AIDS Division Chief
Anchita Patil, MCH
Sheen Chhabra, Private Sector and Cross-Cutting Issues Division Chief
Rajiv Tandon, Education

Malawi

Beth Deutsch, HIV Prevention Advisor
Martin Mtika, HIV Specialist
Nidasowa Chitule, HIV Specialist
Lilly Banda-Maliro, Deputy Team Leader (RH focal person)

Mozambique

Sereen Thaddeus, HIV Prevention Technical Lead

Nigeria

Sharon Epstein, Health Team Leader
John Quinley, Deputy Team Leader
Stella Akinso, Adolescent Reproductive Health Advisor
Kayode Morenikeji, Family Planning Advisor

Namibia

Melissa Jones, Director HIV/AIDS Office
Karla Fossand, Deputy Director
Sillke Felton, OVC Manager

South Africa

Roxana Rogers, Director Health Office
Olga Mashia, HIV Prevention Advisor

Jamaica

Catherine Zilber, Health Officer

Tanzania

Laura Skolnik, HIV Prevention Advisor

DONORS AND UN AGENCIES

Elizabeth Lule, World Bank, AIDS TA – Project Manager
Mary Otieno, UNFPA, Technical Advisor for HIV Prevention for Young People
Sylvia Wong, UNFPA, RH Focal Person
Pierre Robert, UNICEF, HIV/AIDS Section
Jyothi Raja, UNAIDS Secretariat Geneva
Dhianaraj, Chetty, UNESCO, HIV/AIDS Education
Matilde Maddeleno, PAHO, Family and Community Health
Jane Ferguson, WHO, Child and Adolescent Health

FOUNDATIONS

Sahlu Haile, Packard Foundation, Ethiopia
Heather Boonstra, Guttmacher Institute, Adolescent program– WashDC office
Doortje Braaken, IPPF London, HIV Team Youth Specialist
Liz Maguire, IPAS, President and CEO
Judith Bruce, Population Council
Nicole Gray, Hewlett Foundation, Program Officer, Population
Suzanne Petroni, Summit Foundation, Adolescent Program Officer

COOPERATING AGENCIES AND NGOS

Bill Finger, FHI, now with Progress FP
Joy Cunningham, FHI, IYWG management
Neil Mckee, AED, Director C-Change Project
Antje Becker, AED, Deputy Director C-Change Project
Lynn Bakamjian, EngenderHealth, Director, Respond Project
Gwyn Hainsworth, Pathfinder
Maxine Eber, PSI RH Department
Christine Bixiones, PSI RH Department
Donna Sherard, PSI, HIV Department Youth Champion
Jay Gribble, PRB, Director, Bridge Project
Robin Kouyate, JHPIEGO, Behavior Change Advisor
Ed Scholl, JSI, Director of AIDSTAR, formerly Deputy Director of YouthNet
Lindsay Lincoln, American Red Cross, Project Officer ABY programs
Carol Underwood, JHU, HIV, Gender and Vulnerable Girls Initiative
Kim Buttonow, Food for the Hungry, ABY focal person
Brad Kerner, Save the Children, Youth Specialist
Doris Bartel, CARE, Sexual and RH team
Ilene Speizer, UNC Measure Evaluation

USAID/W

PL 109-96

Linda Sussman

PRH

Scott Radloff, Office Director
Ellen Starbird, Deputy Director
Jenny Truong, Youth Advocate
Jim Shelton, GH Bureau Science Advisor
Kathryn Panther, Division Chief, SDI
Sarah Harbison, Division Chief, RTU
Patty Alleman, Gender Champion
Bev Johnston, Policy Advisor
PRH retired – Margaret Neuse

OHA

Robert Clay, Office Director
John Crowley, Division Chief
Janice Timberlake, Senior Advisor, OHA Front Office
Debbie Kaliel, Prevention Advisor
Shanti Conly, General Prevention, Youth TWG Co-Chair
David Stanton, Division Chief, Research
Emily Osinoff, Prevention and Gender Advisor
Diana Prieto, Gender Advisor
Milly Kayongo, FP/HIV Integration Advisor

HIDN

Richard Greene, Office Director
Mary Ellen Stanton, Maternal Health
Enuyong Chung, Acting Nutrition Division Chief

Regional Bureaus

Jennifer Mason (ME and Asia)
Lindsay Stewart (LAC)
Jewel Gausman (for E&E)
Ishrat Husain (Africa)

Other Bureaus and PEPFAR

Clare Ignatowski, EGAT, Education Office
Melissa Poulsen, CDC/Atlanta, PEPFAR Youth Programs

YOUTH ADVOCACY ORGANIZATION

Advocates for Youth

Nicole Cheetham

Youth Experts

Susan Adamchak,
Meg Greene, independent consultant, formerly with ICRW

APPENDIX 2: LIST OF DOCUMENTS

Adamchak, Susan E. "Youth Reproductive Health and HIV Prevention: Assessment of Need for a New Synthesis Report and Identification of Emerging Issues." Washington, DC: Concept Paper for Family Health International and USAID/Youth Team Leaders-Global Health, July 18, 2007. (Unpublished, not for circulation)

Adamchak, Susan E. and Judith Senderowitz. *Assessment of Youth Reproductive Health Programming Options.* Poptech Assignment Number 2004.208, March 2005.

ACQUIRE Project. "Mobilizing Married Youth in Nepal to Improve Reproductive Health: The Reproductive Health for Married Adolescent Couples Project, Nepal, 2005–2007." *E&R Report Number 12*. New York: EngenderHealth/ACQUIRE Project, 2008.

AIM. "HIV Prevalence by Age and Sex for 15 Countries." Washington, DC: OHA, 2009. (Not for citation or distribution)

Clinton, Hillary. Remarks on Development in the 21st Century. Speech on January 6, 2010. http://www.state.gov/secretary/rm/2010/01/134838.htm.

Conly, S. "HIV Prevention for Young People in Sub-Saharan Africa: The Way Forward." Tanzania: WHO/LSHTM Workshop, Debriefing Notes, September 2009.

Family Health International. *Cross-Sectoral Youth (CSY) DR Congo Project "LifeWorks" Youth Enterprise Development.* Final Programmatic Report Under Award Number DFD-A-00-06-00243-00. Research Triangle Park, NC: 2010.

Family Health International. *Evaluation of the Interagency Youth Working Group (IYWG) Activities*. Research Triangle Park, NC: November 6, 2009.

Family Health International. *Work Plan for FHI Global Youth Funds from USAID/W, July 1, 2009–June 30, 2010.* Research Triangle Park, NC: August 17, 2009.

FOCUS on Young Adults. *Advancing Young Adult Reproductive Health: Actions for the Next Decade.* End of Program Report, 2001.

Funders Network on Population, Reproductive Health & Rights. *Annual Funding Analysis Number 9 Highlights from the Grants Database, 1999–2007*. 2008.

Greene, Margaret E. and Thomas W. Merrick. "Adolescent Sexual Activity and Childbearing in Developing Countries: Challenges and Supports for Girls." Washington, DC: World Bank, 2010 (forthcoming).

Haberland, Nicole and Deborah Rogow, eds. *It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV, and Human Rights Education.* International Sexuality and HIV Curriculum Working Group, 2009.

Hanold, Mitzi J., Thomas P. Davis Jr., and World Relief. *Choose Life 3.0 with Adaptations and Skills for Healthy Relationships by Food for the Hungry: For Youth Ages 15 and Older.* Washington DC: Food for the Hungry, 2008.

Hargreaves, "Thinking and Acting 'Structurally' in HIV Prevention." Presented at 2009 Tanzania meeting.

International Planned Parenthood Federation. *Healthy, Happy and Hot: A Young Person's Guide to Their Rights, Sexuality and Living with HIV*. London: IPPF, 2010. Available at:

http://www.ippf.org/NR/rdonlyres/B4462DDE-487D-4194-B0E0-193A04095819/0/HappyHealthyHot.pdf.

Kennedy, B., A. Burns, S. Conly, and S. Roach. *Assessment of G/PHN Young Adults Reproductive Health Programming Options.* POPTECH Assignment Number 99-162, October 1999.

Khan, S. & Mishra,. *Youth Reproductive and Sexual Health*. DHS Comparative Reports 19, Calverton, Maryland, USA: Macro International, V. 2008.

Kirby, Douglas, B.A. Laris, and Lori Rolleri. *Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries* Research Triangle Park, NC: Family Health International, Youth Research Working Paper No. 2, 2005. Available at: http://www.fhi.org/en/Youth/YouthNet/

Publications/YouthResearchWorkingPapers.htm.

Leclerc-Madlala, S. "AIDS in Southern Africa: A Socio-Cultural Perspective." Presentation at World Bank, February 2010.

London School of Hygiene & Tropical Medicine (LSHTM) and the Mwanza Research Centre of the Tanzanian National Institute for Medical Research. *HIV Prevention Among Young People in Sub-Saharan Africa: The Way Forward.* Report from a workshop held September 14–17, 2009, White Sands Hotel, Dar es Salaam, Tanzania.

Lopez, Carla and Ilene Speizer. *Curricula Review of Emergency Plan Centrally-Funded HIV Prevention Programs for Youth.* Working Paper Series 09-112. Chapel Hill, NC: MEASURE Evaluation, May 2009. Available at: http://info.k4health.org/youthwg/PDFs/MeasureEval/wp-09-112.pdf

Lopez, Carla and Ilene Speizer. *Field Assessment of Emergency Plan Centrally-Funded HIV Prevention Program for Youth.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Population Center, MEASURE Evaluation, March 2007.

Miriam Temin and Ruth Levine. *Start with a Girl: A New Agenda for Global Health*. Washington, D.C.: Center for Global Development. 2009.

National Research Council and the Institute of Medicine. *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries.* Washington, DC: The National Academies Press, 2005.

Newton, Gary. *Third Annual Report to Congress on Public Law 109-95, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005.* 2009.

Oki, Judith, Amy Medley, Leah Wanjama, and Ademola Ajuwon. *Preventing HIV Infections in Youth Aged 10–24 Years: Report of the USAID Track 1.0 ABY Program Review.* Washington, DC: GH Tech Project, 2009. Available at: http://www.ghtechproject.com/resources.aspx.

Olson, R. "HIV and Young People. Some Data and Issues for Consideration." Tanzania: Presentation at meeting on HIV and youth in Sub-Saharan Africa, September 2009.

PEPFAR. *Five-Year Strategy.* December 2009. Available at: http://www.pepfar.gov/

about/c19380.htm.

PEPFAR. *General Population and Youth HIV Prevention: State of the Program Area Report.* FY 2009.

PEPFAR. *HIV Counseling and Testing State of the Program Area*. 2009.

PEPFAR. *List of PEPFAR Priority Countries.* 2010.

PEPFAR. *Making a Difference: Funding Trends 2004–2011.* 2010.

PEPFAR. *PEPFAR State of the Program Area Report for Gender.* Gender Technical Working Group. January 30, 2009.

PEPFAR. "State of the Program Area (SOPA): Orphans and Vulnerable Children." (Forthcoming, not for citation or distribution)

PEPFAR. *State of the Program Area: Prevention of HIV in Persons Engaged in High-Risk Behaviors* (PHREHRB)–FY09. 2009.

PEPFAR. U.S. Government survey on youth prevention priorities, July–September, 2009. (Includes responses from Angola, Botswana, Kenya, Lesotho, Namibia, Nigeria, Rwanda, South Africa, Tanzania, and Uganda. Input provided by country teams and individuals from USAID, CDC, and the Department of Defense.)

Politz, Bonnie and Clare Ignatowski. *Youth Strategic Framework and Program Recommendations for USAID/Jamaica*. February 5, 2010

Respond Project. "RESPOND Concept Paper: Gender Operations Research." 2008. (Unpublished concept note for project that has yet to be funded.)

Rosen, James E. *Meeting Report—Moving the Agenda Forward: A One-Day Forum on Adolescent Health and Development for USAID Staff and External USAID Partners*. Washington: Poptech, June 8, 2000. Available at: http://www.ghtechproject.com/Documents/poptech_archive.pdf

Ross, David A., Bruce Dick, and Jane Ferguson, eds. *Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries.* WHO Technical Report Series No. 938. New York: WHO, 2006. Available at: http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf.

Ross, D. *Unpacking the 3 Cluster Randomized Trials in Schools &/or Health Services &/or Geographically-Defined Communities with Biological Outcomes.* 2009.

Ruth Levine, et al. *Girls Count: A Global Investment & Action Agenda.* Washington, D.C.: Center for Global Development, 2008.

Scholl, E. and W. Finger. 2007. *Integrating Reproductive Health and HIV Services for Youth. Youthlens on Reproductive Health and HIV/AIDS, no. 21*. Family Health International.

Simon, C. "PEPFAR Youth Activities FY09." Excel spreadsheet. 2009.

Simon, C. and J. Truong. *USAID-Funded Youth Family Planning Activities Brief: A Summary of Youth Activities in 29 Countries.* August 20, 2009.

Truong, Jenny, ed. "FY09 Priority Area Matrices." Excel spreadsheet.

Truong, Jenny. "Results Review for 2008, Accomplishments by PRH SO1 IRs." 2009.

Truong, Jenny. "TP-GLP Ranking Template: FY08 Final." Excel spreadsheet. 2008.

Truong, Jenny. *Youth GLP Results for 2007: Major Accomplishments Organized by PRH SO1 IRs (October 1, 2006–September 30, 2007).* 2008.

Ultra Fabs Youth Cross-Cutting Issues. 2009.

UNESCO, Education Sector. *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators.* Volume 1: "The Rationale for Sexuality Education." Paris: UNESCO, 2009. Available at: http://hivaidsclearinghouse.unesco.org.

UNESCO, Education Sector. *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators.* Volume 2: "Topics and Learning Objectives." Paris: UNESCO, 2009. Available at: http://hivaidsclearinghouse.unesco.org.

USAID. *APS for Inform Decision Makers to Act (IDEA)*. 2010.

USAID. *Fiscal Year 2009 Users' Guide to USAID/Washington Health Programs*. June 2009. Available at: http://pdf.usaid.gov/pdf_docs/PNADO916.pdf.

USAID. *FY 2010 Priority Area Budget Request Codes and Champions.* 2010.

USAID. *PRH Results Framework and Indicators*. Electronic document. 2009.

USAID. "Proposal: Headquarters Interagency Youth Prevention Initiative." 2009.

USAID. *Supporting Youth: Educating Young People about Reproductive Health So They Can Achieve Their Fullest Potential.* Electronic issue brief. August 2007. Available at: http://www.usaid.gov/our_work/global_health/pop/techareas/youth/prh_issuebrief.pdf.

USAID. "Youth Family Planning Activities: A Summary of PRH Priority Countries." Excel spreadsheet. 2010.

USAID. *Youth Global Leadership Priority Strategic Plan.* November 2005. Available at: http://info.k4health.org/youthwg/iywg/YouthStrategicPlan.doc.

USAID, Office of HIV/AIDS. *Priority Pillars.* 2010.

USAID, Office of HIV/AIDS. *Vision, Mission and Key Strategies Statement.* 2009.

USAID, Office of Population and Reproductive Health. *List of 13 Priority Countries.* 2010.

WHO, Making Pregnancy Safer Department. *Position Paper on Mainstreaming Adolescent Pregnancy in Efforts to Make Pregnancy Safer.* Geneva: WHO. 2010.

WHO, *Preventing HIV/AIDS In Young People: A Systematic Review of the Evidence from Developing Countries.* Geneva: WHO. 2006

World Bank. *World Development Report 2007: Development and the Next Generation.* Washington, DC: World Bank, September 16, 2006. Available at: http://econ.worldbank.org/.

World Health Organization. *Adolescent Job Aid.* 2009.

World Health Organization. *Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients.* Geneva: WHO, 2009. Available at: http://www.who.int/child_adolescent_health/documents/fch_cah_9789241598859/en/index.html.

World Health Organization, Department of Making Pregnancy Safer. *Position Paper on Mainstreaming Adolescent Pregnancy in Efforts to Make Pregnancy Safer.* Geneva: WHO, 2010.

Yates, DeeDee, Christopher O'Connell, Nicky Davies, and Muyiwa Oladosu. *President's Emergency Plan for AIDS Relief Track 1.0 Orphans and Other Vulnerable Children (OVC) Program Evaluation.* Washington: GH Tech Project, December 2008. Available at: http://pdf.usaid.gov/pdf_docs/PDACO348.pdf.

Young People Most at Risk for HIV/AIDS: A Report from the Interagency Youth Working Group of the U.S. Agency for International Development, the United Nations Interagency Task Team on HIV and Young People, and Family Health International. Research Triangle Park, NC: Family Health International, 2010.

Youthnet. *Taking Action: Recommendations and Resources.* End of Program Report. Arlington VA: Family Health International, 2006.

APPENDIX 3: WORK PLAN

YOUTH REPRODUCTIVE HEALTH AND HIV ASSESSMENT WORK PLAN MATRIX

TASK/EVALUATION QUESTION	DATA SOURCE	ANALYSIS PROCEDURE	CRITERIA FOR ASSESSMENT
Task 1. To assess to what extent USAID Global Health youth-focused activities met the four main objectives and the extent to which there have been gaps or redundancies in the portfolio: (50% LOE)			
1.a. Research quality and relevance improved and innovative models tested			
i. What kinds of YRH/HIV research is being conducted? Are we spending money on really relevant questions and challenges? Are we studying new, innovative areas or models?	Simon, C. 2009. *Mapping exercise of PEPFAR and PRH activities*. Simon, C. and J. Truong. 2009. *USAID-Funded Youth Family Planning Activities Brief. A summary of youth activities in 29 countries.* Truong, Jenny. 2008. *Youth GLP Results for 2007* Truong, Jenny. 2009. *Results Review for 2008,* Interviews with USAID HQ, field staff, CAs Interviews with YRH/HIV research experts	Synthesize in body of report; include annex table with details on GH-funded research.	Relevance based on combination of expert opinion and recommendations from previous reviews, documents
ii. What are the gaps and additional needs for YRH/HIV research? On what issues?	Other reviews and syntheses of YRH/HIV research needs. Interviews with USAID HQ, field staff, CAs Interviews with YRH/HIV research experts	Synthesize in body of report;	Compare the current research against research recommendations from various documents; ask key informants

TASK/EVALUATION QUESTION	DATA SOURCE	ANALYSIS PROCEDURE	CRITERIA FOR ASSESSMENT
1. b. Evidence base on youth programs disseminated			
i. How well do GH YRH/HIV activities promote best practices as reflected in the latest findings from the 2006 WHO review as updated in 2009 How well do these activities use tools that are evidence-based?	Documents with information on GH-funded activities (GLP + CAs) Interviews with CAs Interviews with USAID HQ and field staff	Compare programming against the "steady, ready, go" framework (2009 update), break down by what % is steady vs ready vs go.	A passing grade would be 80% of programs meet best practice standards.
ii. Are Headquarters and field staff aware of these best practice models and evidence-based tools? Do they put these to use? Examples?	Structured interviews of HQ and field staff	Comparison of responses on structured interview	Hold off until we have some better information
1.c. Needs of country and regional programs met and evidence-based models scaled-up			
i. What is the level of awareness Missions and HQ staff about HQ resources, services, and TA in youth RH/HIV?	Structured Interviews of HQ and field staff	Comparison of responses on structured interview	Hold off until we have some better information
ii. Has research conducted by GH responded to missions' needs and informed programming?	Structured Interviews of field staff and selected HQ staff	Synthesis based on responses	Hold off until we have some better information
iii. Has knowledge of evidence-based models and tools reached the field at all levels?	Structured Interviews of field staff and selected HQ staff	Synthesis based on responses	Hold off until we have some better information
iv. To what extent has the field scaled up YRH/HIV programs? What have been the challenges to scaling up evidence-based models at the country level?	Documents from CAs, PEPFAR Interviews with HQ, field, CAs	Synthesis based on responses	Hold off until we have some better information
1.d. Evidence-based programs that meet youth's needs advocated to key decision makers and policy makers.			

TASK/EVALUATION QUESTION	DATA SOURCE	ANALYSIS PROCEDURE	CRITERIA FOR ASSESSMENT
i. Are decision makers aware of the evidence for youth programming?	Documentation of advocacy activities Interviews with HQ, field, CAs, other donors, advocacy experts	Synthesis based on responses	Hold off until we have some better information
ii. How is evidence shared with policy makers? Is it adequate?	FHI. 2009. Evaluation Of The Interagency Youth Working Group (IYWG) Activities Other documentation Interviews with HQ, field, CAs, other donors	Synthesis based on responses	Hold off until we have some better information
Task 1.e. What have been the gaps and redundancies in the recent GH YRH/HIV portfolio?			
i. What have been the gaps? How significant were the gaps?	Documents to reference for gold standard of what needs to be done: WDR, Growing Up Global, previous assessment, Adamchak 2007, GH Brief on YRH/HIV, 2005 Youth strategy, 2009 Transition team paper. Interviews with HQ, field, CAs, other donors	Synthesis based on responses	Hold off until we have some better information
ii. What have been the redundancies? How problematic were these redundancies?	Interviews with HQ, field, CAs, other donors Possibly some information gleaned from documents	Synthesis based on responses	Hold off until we have some better information
Task 2: Assess integration and linkages across different technical areas within Global Health and to youth programs in other sectors within			

TASK/EVALUATION QUESTION	DATA SOURCE	ANALYSIS PROCEDURE	CRITERIA FOR ASSESSMENT
USAID. (15% LOE)			
2.a To what extent has GH appropriately integrated youth RH and HIV activities? How effective have they been? Have there been missed opportunities?	Interviews with HQ, field, CAs, other donors Some information gleaned from documents	Synthesis based on responses Differentiate between the HQ and field experiences	Criteria for effectiveness: combined effect is greater than separate
2.b How could GH promote and scale up best practices in integration of RH and HIV among youth for country and regional programs?	Interviews of HQ, field, CAs opinion	Synthesis based on responses Assessor opinion Differentiate between the HQ and field experiences	n.a.
2.c What are the advantages and disadvantages of integrating RH/HIV into maternal and child health, nutrition, and infectious disease, health systems strengthening programming for youth?	Interviews of HQ, field, CAs, other donors Cursory literature review	Synthesis based on responses Matrix of advantages and disadvantages	n.a.
2.d How could GH promote and scale up best practices in integration of YRH/HIV into MCH, nutrition, ID, and HSS in country and regional programs?	Interviews of HQ, field, CAs,	Synthesis based on responses Assessor opinion	n.a.
2.e What are advantages and disadvantages of integrating youth RH/HIV with other development sectors?	Interviews of HQ, field, CAs, other donors Cursory literature review	Synthesis based on responses Matrix of advantages and disadvantages	n.a.

TASK/EVALUATION QUESTION	DATA SOURCE	ANALYSIS PROCEDURE	CRITERIA FOR ASSESSMENT
2.f How could GH promote and scale up best practices in integration among YRH/HIV and other development sectors when advantageous?	Interviews of HQ, field, CAs,	Synthesis based on responses Assessor opinion	n.a.
2.g What has been the experience of Missions attempting major integration efforts related to youth (both RH and HIV integration, RH/HIV into other health areas-nutrition, maternal and child health and malaria, and YRH/HIV into other sectors)? How successful have these efforts been? What have been the challenges and barriers to this work?	Documents summarizing USAID-funded youth programming Interviews with field staff, HQ, CAs	Synthesis of the experiences. Case example (1/2 page)	Criteria for success: combined effect is greater than separate
2.h. To what extent do USAID Missions perceive a need for more integration of RH and HIV youth activities, RH/HIV into other health areas-nutrition, maternal and child health and malaria, and GH youth activities with activities in other USAID sectors?	Interviews with field staff and selected HQ	Synthesis based on responses	Hold off until we have some better information
Task 3: Make recommendations for a strategic portfolio of future Global Health investments in YRH/HIV, including options for implementing mechanisms. (35% LOE, first priority)			
3.a What are current priorities in USAID Missions for YRH/HIV programming?	PEPFAR 2009 *USG Survey on Youth HIV Prevention* Interviews with field staff, HQ	Synthesis of survey and interview responses	Frequency of mention of a particular topic
3.b How could GH better meet the priority needs of the field?	Interviews with field staff, HQ, Assessor opinion	Synthesis of responses	Needs as expressed by USAID and CA field staff
3.c Which YRH/HIV evidence-based best practices are USAID country and regional programs adopting? What are the barriers to adopting these practices?	Analysis of programming documentation Interviews with field, HQ, CAs	Synthesis of responses and documented experiences	n.a.

TASK/EVALUATION QUESTION	DATA SOURCE	ANALYSIS PROCEDURE	CRITERIA FOR ASSESSMENT
3.d In relation to current gaps in USAID youth RH/HIV programming, what could a new activity potentially fill?	Previous reviews and assessments Broader literature on what's needed for YRH/HIV Assessor opinion	Synthesis of responses and documented experiences	Significance and importance of gaps based on current knowledge about high impact interventions
3.e What should be the goals, technical priorities, and high impact activities for GH youth RH/HIV investments over the next three years? What is the minimum level of investment required to achieve these goals?	All findings and assessor opinions	Analysis of findings	Prioritization based on current knowledge about best practices and USAID's and GH Bureau's comparative advantage
3.f What might be options for implementing mechanisms to help GH realize these goals? What are the advantages and disadvantages of each? What are actions GH would need to undertake to implement each?	Interview of field, HQ, CA All findings and assessor opinions	Matrix of options with advantages and disadvantages	Administrative and bureaucratic feasibility. Likelihood of positive impact over 3-5 year period, within mandate of GH Bureau. Likelihood of GH program influencing broader mission programs
3.g. What are concrete ways to set youth priorities within new USG initiatives including GHI, PEPFAR II, and the Global Engagement Initiative (Muslim youth)?	Review documents related to each initiative Interviews with selected knowledgeable staff involved in each initiative	Synthesis of responses	Stage of development of various initiatives and potential benefit of encouraging

TASK/EVALUATION QUESTION	DATA SOURCE	ANALYSIS PROCEDURE	CRITERIA FOR ASSESSMENT
	Assessor opinion		focused youth activities
3.h How can GH strengthen its global leadership role for YRH/HIV? What are it's comparative advantages in relation to other international funders/technical assistance agencies?	Interviews with other donors, HQ, field, CAs Assessor opinion	Synthesis of responses	n.a.

APPENDIX 4: YOUTH ASSESSMENT INTERVIEW GUIDE

Youth Assessment Interview Guide
February 1, 2010

TABLE OF CONTENTS

1 Interview set-up procedure

1. The interviewee will be contacted by phone or email to request a date and time. The introduction to requesting the interview could include the second and third paragraphs from the "Intro to Interviews" blurb. Ask for 30-45 minutes of time unless the person is an interviewee from whom we definitely need more time. (*Most people –in my experience- will end up talking for longer, especially if they have things to say that they feel are important.)*

2. After the time and date have been set, one the day before the interview, send the individual at reminder of when you will call and attach 10 or fewer of the most important questions so that they can be thinking about the topics in advance.

2 Interview write-up procedure

After each interview, evaluator will write up the findings using the interview guide as a template.

Evaluator will include date, place of interview (phone; in person), name and position of interviewee, and organization.

3 Introductory language

Thank you for meeting with me today. My name is ___. I am a consultant for the GH Tech project, commissioned by USAID's Global Health Bureau to assess the Bureau's recent work on youth reproductive health and HIV/AIDS.

The results of this assessment will be used by USAID to inform GH strategy for future USAID investments in the broad range of RH and HIV activities that intentionally focus on young people ages 10-24 including those that promote delaying sexual debut, preventing unintended pregnancy, delaying early marriage, HIV prevention, care and treatment, and services for OVCs.

The assessment team is interviewing a range of stakeholders in USAID HQ and field missions, USAID implementing partners, organizations working on behalf of youth, experts, and other international donors.

I promise to be efficient and not take too much of your time. To make sure we get through some of the important topics, I have a list of reference questions to draw upon your experiences and expertise. So unless you have questions, lets start by clarifying information about you and your position in your organization.

4 Questions related to Task 1: Assess extent USAID Global Health youth-focused activities met their four main objectives and existence of gaps or redundancies in the portfolio

4.1 General questions

Since the end of the stand-alone Youthnet project in September 2006, the YRH/HIV strategy in GH has focused on disseminating knowledge through a knowledge management component implemented by FHI and through encouraging the inclusion of youth activities in centrally-funded projects. This approach had goals related to improved research; dissemination; meeting mission needs; and advocacy. GH is interested in knowing how well this approach has worked.

4.1.1 What is your general sense of how has the arrangement of the past 3 years worked? (HQ, field; CAs; other donors)

4.1.2 Have the GH-supported activities moved the YRH/HIV community forward, broadly speaking? In what ways? Was it sufficient? (HQ, field; CAs; other donors)

4.1.3 Looking at the entire array of support you get from GH, has it helped you do more on YRH/HIV or do a better job in your country (field)

4.2 Questions about research quality and relevance (1.a)

GH YRH/HIV activities in the October 2006 - present period have aimed to increase the quality and relevance of research (mainly in RH) and to explore new and innovative areas and models. One goal of this assessment is to examine the extent to which these objectives have been achieved in the past 3 years.

4.2.1 What is your general sense of the *quality* of the GH-supported research (or, by extension, research funded through bilateral means that may be influenced by HQ)? Has it improved? Stayed the same? Gotten worse? (HQ-especially research staff; field; CAs; other donors; research experts)

4.2.2 Have GH research investments focused on *relevant* questions and challenges? Is GH funding the right types of research? [relevant defined as: (1) meets the needs of USAID missions and informed programming; (2) is on a topic that has been identified as a high priority by YRH/HIV experts] (HQ-especially research staff; field; CAs; other donors; research experts)

4.2.3 Can you give *specific examples* of YRH/HIV research carried out in the 2006-present period? What do you think of its *quality* and *relevance*? (HQ-especially research staff; field; CAs; other donors; research experts)

- Probe on how the research was funded; obtain any documentation of this specific research

4.2.4 What is your sense of the extent to which GH-supported research has tested *new, innovative* areas or models? (HQ-especially research staff; field; CAs; other donors; research experts)

4.2.5 What do you see as the most pressing areas for *new research*? (HQ-especially research staff; field; CAs; other donors; research experts)

- E.g., new topics or issues or countries or regions; documenting the experience and lessons learned in bringing existing programs to scale; new age groups; special populations; new research methodologies

4.2.6 What have been the *gaps* in GH-supported research? (HQ-especially research staff; field; CAs; other donors; research experts)

4.2.7 To what extent have there been *overlaps* in the research portfolio? (HQ-especially research staff; field; CAs; other donors; research experts)

Different CAs doing similar research; GH-funded research overlapping with research funded by other agencies?

4.3 Questions about dissemination of the evidence base on youth programs (1.b)

Another of principal aims of GH activities in the past 3 years has been to disseminate the evidence base on best practices.[8] Through this assessment we are trying to understand the extent to which GH has been able to effectively support this dissemination.

4.3.1 One way to gauge the success of dissemination is by examining how well GH activities incorporate best practice findings. To what extent do you feel that GH YRH/HIV activities have incorporated best practices? (HQ; field; CAs; other donors-to the extent they know about what USAID does)

4.3.2 You may be aware of the 2006 WHO review of effective programs for HIV prevention among youth. Specifically, what is your sense of how well GH YRH/HIV activities have reflect the evidence on best practices as summarized in the WHO report? (HQ; field; CAs; other donors-to the extent they know about what USAID does)

[8] Best Practices are intended to maximize the quality, efficiency and effectiveness of reproductive health services for women and men worldwide. When the term "Best Practice" is used, it refers to an array of evidence-based tools, materials and practices, including guidelines, norms, standards, experiences and skills, among others, that have proven their worth in the field of youth reproductive health, including HIV.

4.3.3 Of the GH YRH/HIV activities that you are familiar with, to what extent do they use tools that are evidence-based? [provide examples of types of tools] (HQ; field; CAs; other donors-to the extent they know about what USAID does)

4.3.4 How aware are HQ and field staff of these best practice models and evidence-based tools? [To be asked selectively of a few people in the know]. In what ways have HQ staff and field staff put these to use? Ask respondent to elaborate on examples. (HQ; field; CAs; other donors-to the extent they know about what USAID does)

4.3.5 What is your sense of the adequacy of the evidence base for YRH/HIV programming? What evidence-based practices have you implemented? Are you aware of the WHO 2006 review and update or other research that synthesizes best practices (HQ; field; CAs)

4.3.6 Where do you turn for information on best practices in YRH/HIV? (HQ; field; CAs; other donors)

4.3.7 Have you ever:

- Attended one of the IYWG technical meetings (which one?)
- Used the IYWG web site
- Used youth-policy.com
- Read one of the youth lens products
- Read or used the regular research summaries
- Used the youth corner of the DHS web site

How useful were these resources? (**HQ; field; CAs; other donors)**

4.4 Questions about meeting the needs of HQ and country and regional programs and scaling up evidence-based models (1.c)

USAID's HQ and country and regional programs have a range of technical needs that youth-focused HQ programs and people can help meet. These include needs for program design, program evaluation, development of mission strategies in FP/RH/HIV, procurement panels, etc. GH is interested in knowing the extent to which HQ has been able to meet these needs since 2006.

LEVEL OF AWARENESS OF HQ SUPPORT RESOURCES

4.4.1 What is your sense of how aware field and HQ staff are about HQ resources, services, and TA in youth RH/HIV? Has knowledge of evidence-based models and tools reached the field at all levels, i.e. PHN officers PEPFAR field staff, and CA field staff (HQ staff [Jenny and Debbie especially]; field staff**)**

4.4.2 Are you aware of the range of HQ resources, services, and TA in YRH/HIV? Alternatively, Can you name some ways in which HQ can provide you with resources, services, and TA? (HQ; field staff**)**

4.4.3 When you want help on YRH/HIV-related activities, who or what do you turn to in HQ? (HQ and field staff**)**

4.4.4 What specific help have you requested? (HQ and field staff**)**

4.4.5 Did you receive help and, if so, how helpful was it to you? If you did not receive help, why not? (HQ and field staff**)**

SCALING UP

4.4.6 To what extent have *USAID missions scaled up* YRH/HIV programs? What have been the challenges to scaling up evidence-based models at the country level? (for HQ and field staff; CAs**)**

4.4.7 Can you tell us about *some examples of countries where USAID has scaled up YRH/HIV programs*? Whether you know of examples or not, what have been the challenges to scaling up evidence-based models at the country level? (for HQ and field staff; CAs**)**

4.4.8 Are there *examples* in your country where USAID has scaled up YRH/HIV programs? Either way, what been the challenges to scaling up? (field staff**)**

4.5 Questions about advocating for evidence-based programs (1.d.)

USAID sees an important role for itself as an advocate for implementation of evidence-based YRH/HIV programs. Advocacy is generally understood as a set of targeted actions in support of a specific cause. In the context of this assessment, the specific cause is understood to be the spread of evidence-based YRH/HIV programs. Advocacy includes both USAID/W advocating to its field missions as well as USAID missions advocating to local institutions (host country

government policy makers; CSOs). This set of questions aims to get at understanding of the extent to which USAID has played an effective advocacy role in the past 3 years.

4.5.1 What sorts of targeted advocacy actions have *HQ carried out to inform field missions*? To what extent have actions been adequate? (HQ–Jenny and Debbie specifically; field).

- Worldwide meetings
- Appropriate workshops in countries
- Encouraging field missions
- Policy briefs or others

4.5.2 What sorts of targeted advocacy actions have *missions carried out to advocate to host country officials*? To what extent have actions been adequate? (ask HQ if they know of anything the missions have done; ask missions directly)

- Appropriate workshops in countries
- Meetings with government officials
- Support for policy/advocacy work carried out by CAs
- Other advocacy activities

4.6 Gaps and redundancies in the recent GH YRH/HIV portfolio (1.e.)

4.6.1 Thinking about the GH YRH/HIV portfolio as a whole, what if any have been the main gaps? If there were gaps, how significant were they? (HQ and field staff; CAs; other donors)

4.6.2 Thinking about the GH YRH/HIV portfolio as a whole, what if any have been the redundancies? (HQ and field staff; CAs; other donors)

- For example, overlap among CAs; overlap between USAID and other donors; overlap between USAID and other USG agencies.

5 Questions for FHI specifically relating to the knowledge management activity

FHI managed the $700,000 annual knowledge management activity from 2007 to the present. These questions are specifically for the staff at FHI that managed the activity.

5.1.1 What challenges did you face in managing the knowledge management activity?

5.1.2 What were the advantages and disadvantages?

5.1.3 How would rate the level of collaboration with other CAs?

5.1.4 To what extent did you get the support you needed from USAID HQ?

5.1.5 What were your most successful activities?

5.1.6 What could you have done better [what would you have done differently]?

5.1.7 How did you think it worked over the past 3+ years?

6 Questions relating to Task 2 : Assess integration and linkages across different technical areas within Global Health and to youth program in other sectors within USAID

6.1.1 What is your definition of integration or a linked program? What do you consider to be an integrated or linked youth program?

Various options:

- Would it include join work plan reviews of CAs?
- Joint funding?
- Collaboration between the two offices for designing new programs?
- Review by both offices of proposed youth programs?
- Other

6.2 Integration between youth RH and HIV programs (2 a,b) (GH, Mission and CA staff unless otherwise indicated)

6.2.1 Do you believe that all youth RH-HIV programs should be integrated? Why or why not?

6.2.2 If there is value in RH-HIV integration on youth programs, please describe that value in concrete terms. What specific value added have you observed? Are there circumstances where integration or linking of the programs does not make sense? (USAID, CA and donor staff)

6.2.3 Do you think that there are often missed opportunities for integrating or linking HIV and RH programs that, if addressed explicitly, could result in improved program outcomes? Cite examples if possible.

6.2.4 What challenges do you face when you integrate programs at the GH level but the office at the USAID missions implementing specific country activities are separate? Are you aware of Mission programs where officers managing youth activities for HIV and those working on RH are deliberately working together to achieve better integration? (OHA, PRH staff)

6.2.5 What are the institutional, cultural or political challenges at the country level for integrated RH-HIV programs for youth? How do they affect GH core funded activities within mission programs?

6.2.6 Can you cite specific core funded programs that have an ideal RH-HIV integration strategy and are successful in operationalizing it at the field level? Is there enough evidence from these programs to call them 'best practices'?

6.3 Integrating Youth RH/HIV programs with MCH, Nutrition, and Infectious Disease programs or specific youth activities within programs (2.c,d)

6.3.1 To what extent has there been any attempt to integrate youth programs dealing with RH/HIV with maternal health, maternal or child nutrition or other MCH programs? Are there any components of MCH programs that you know of that are explicitly focused on youth, such as activities focused on adolescent nutrition with special strategies aimed at youth?

6.3.2 What are the specific disadvantages or constraints to integrating youth RH-HIV programs with maternal and child health programs? Do you know of any specific successful examples of successful integration? Cite specific problems or challenges?

6.3.3 Do you think that there are often missed opportunities for integrating or linking RH-HIV programs to MCH that, if addressed explicitly, could result in improved program outcomes? Cite examples if possible.

6.3.4 Do any of the infectious disease programs (malaria, TB, pandemic influenzas, etc.) supported by GH HIDN have explicit youth-focused components or activities? (HIDN staff**)**

6.3.5 What, if any, are the benefits of integrating youth programs for RH-HIV with infectious disease programs? Under what circumstances does this kind of integration or linking programs makes sense? What are the limitations? (HIDN staff)

6.3.6 Has any of the work done by HS 20/20 on health systems strengthening or health sector reform dealt explicitly with youth? Is there any rationale or programmatic benefit from collaborating closely with the RH-HIV youth activities? If so, what are those benefits? (HIDN staff**)**

6.4 Integrating Youth RH/HIV programs into other development sectors (agriculture, education, etc.) (2.e, f)

note: modify question to suit specific sector person interviewed

6.4.1 To what extent has there been any attempt to integrate youth programs dealing with RH/HIV with other development sectors (name sector)? Do you know of any specific successful examples? What has the integration improved implementation or outcomes? (USAID, CA and donor staff)

6.4.2 Do you think that there are often missed opportunities for integrating or linking youth RH-HIV programs to your sector that, if addressed explicitly, could result in improved program outcomes? Cite examples if possible. (GH, Mission and CA staff)

6.4.3 What challenges would you face if you integrated or linked programs at the USAID/W level but the offices dealing with these sectors at the USAID missions implementing these development programs are separate? How would you overcome those challenges? (GH, Mission and CA staff)

6.5 Field experience with integrating RH, HIV, other health and other development programs (2.g,h) (Mission and CA staff)

6.5.1 Has the idea of integrating or linking Youth RH and HIV program to other health or other development programs been discussed at your Mission? Is it something Mission leadership has promoted? How do your colleagues in the host government and ministries feel about such integration? Do they have explicit policies about it?

7 Questions relating to Task 3: Recommendations for future GH investments in YRH/HIV

7.1 Mission Priorities and Needs (3.a, b)

(USAID mission and CA staff)

7.1.1 Within your country program, do you feel that more needs to be done in the area of youth-focused activities in RH and HIV? What are the constraints to doing so? Are there budget, management load, technical or country specific constraints?

7.1.2 What are your priorities with respect to Youth RH-HIV activities? What kind of programs, if any, aimed at improving reproductive health and HIV prevention for youth would be the most helpful at this juncture?

7.1.3 What specifically do you need from GH Bureau, if anything, to help you implement those priorities? Timely technical help for design? Technical or programmatic information? Core funding? (USAID mission and CA staff)

7.1.4 The scale-up of core-funded programs in the field is often problematic. What are the challenges and do you have any ideas for how to address these problems for youth RH-HIV programs? In your view, can GH do something to ensure scale up during early stages of these programs? (Mission staff**)**

7.1.5 Based on past experience, what, if any, are likely to be the problems with accessing what you need from the GH Bureau? (Mission staff**)**

7.2 Missions programs: best practices and barriers (3.c)

(USAID mission and CA staff)

7.2.1 Can you cite specific bilateral and/or core-funded Youth RH-HIV programs or components of programs that have been successful (from your current post or previous postings)? Why have these activities been successful in your view? Is there enough evidence from these programs to call them 'best practices'?

7.2.2 Do you think GH Bureau has done an adequate job of sharing this experience globally as a best practice or made an attempt to apply lessons in other countries? How can it be improved?

7.2.3 What have been some of the challenges and barriers for you to implement Youth RH-HIV programs? Are they specific to the country and local context or to USAID factors? How can they be addressed?

7.3 Overall gaps, needs and priorities for Youth RH-HIV programming (3.d, e)

7.3.1 What are likely to be some future challenges and barriers for you to encourage and support the development of Youth RH-HIV programs? Are these constraints specific to USAID mission circumstances, GH Bureau program flexibility or rigidity issues, resource constraints, lack of interest, etc? Please cite specific examples. (OHA, PRH**)**

7.4 Mechanisms and options for GH core funds (3.f)
(Mission, GH and CA staff)

7.4.1 Since 2006, GH has not had a large 'youth' project but has relied on core PRH funds, the OHA/PRH jointly funded FHI mechanism and otherwise trying to mainstream youth activities into on-going programs with GH CAs. What have been the advantages and disadvantages of this approach?

7.4.2 Do you believe that a new Youth RH-HIV project would produce better results in terms of catalyzing mission programs, testing new models or disseminating best practices?

7.4.3 GH has tried both approaches. What do you think should be done to improve youth-focused RH-HIV programs in the future? Better advocacy with missions? More or better technical info dissemination? More core funding set aside specifically to support Youth RH-HIV activities within on going projects? A major new political initiative directed at youth? Other ideas?

7.4.4 Is there a need to have a flexible mechanism located in the GH Bureau with core funds for certain functions (like global leadership, information dissemination, technical assistance, etc) but with a ceiling and a capacity to include country-specific programs using bilateral or core funds? (USAID only)

7.5 Special initiatives (3.g)

(**GH, CA, donor staff**)

7.5.1 What new opportunities may be presented by virtue of the new Global Health Initiative or the Global Engagement Initiative or the newly authorized PEPFAR II that might strengthen Youth RH-HIV programs?

7.5.2 Do they offer the opportunity for a renewed political impetus for youth particularly to reach young girls and women and reduce gender discrimination?

7.5.3 What are the risks of focusing on youths through one or more of these initiatives? Is there a downside and if so, what?

7.6 Global leadership in RH-HIV (3.h)

GH, CA, donor staff)

7.6.1 How can the GH Bureau's mandate to provide global leadership on behalf of the Agency on various technical and programmatic issues be strengthened in the area of Youth RH-HIV?

7.6.2 Has USAID been able to offer internationally recognized technical expertise in the field of Youth programs? Is USAID seen as a leader in this field by other donors? Do you have suggestions to improve this?

7.6.3 Has USAID been able to share information about best practices or results of research in the area of youth RH-HIV programs in ways that have been useful to field missions and colleagues from other organizations? How can this function be improved?

7.6.4 How can USAID's research function be improved in Youth RH-HIV? How can the topics be more relevant and useful to field programs?

APPENDIX 5: POWER POINT PRESENTATION ON RESULTS

USAID
FROM THE AMERICAN PEOPLE

Youth Reproductive Health and HIV Assessment

Joy Riggs-Perla
James E. Rosen
GH Tech
March 2, 2010
USAID/W

USAID
FROM THE AMERICAN PEOPLE

Purpose and Outcomes

- Assess progress in four objectives (2006 onward)
  - Advocacy
  - Research
  - Evidence base disseminated
  - Countries supported
- Assess integration (health and broader)
- Make recommendations for future

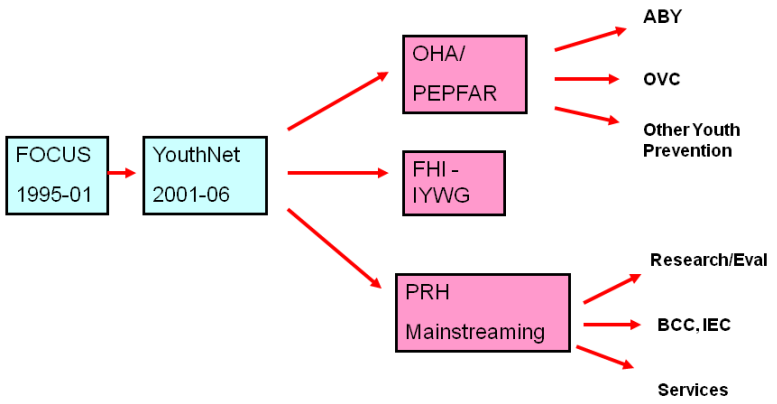
USAID
FROM THE AMERICAN PEOPLE

Methodology

- Review of documents
- Interviews using Structured Question Guide
  - USAID mission staff (25)
  - USAID/W staff (28)
  - Donors and UN Agencies (8)
  - CAs and NGOs (17)
  - Foundations (7)
  - Youth Advocates/Experts (3)

USAID
FROM THE AMERICAN PEOPLE

Lay of the Land



Take Home Message on Findings

- USAID has lost ground on global leadership in youth RH/HIV
- GH research has flagged, with gaps remaining
- Dissemination and support to missions have shown progress but with key weaknesses
- Integration offers promise but constrained by lack of evidence on value-added and funding silos

Key Findings Advocacy

Achievement – Youth advocates, technical priority

Problems/Constraints

- Political/policy environment difficult until recently
- USAID not viewed as leader in global youth RH-HIV and actually set back progress in some ways
- USAID approach to youth sexual and reproductive health does not appear to have changed from previous administration
- Policy status quo due to gap in political leadership

Key Findings Research

- Achievements
  - Small scale research but high quality and relevant
  - Support for research synthesis
- Problems/Constraints/Gaps
  - Lack of prioritized research agenda
  - Decreased volume and budget for research
  - PEPFAR 1 de-emphasized research, problems continue with mechanisms
  - Mission research needs not met, gaps exist

Key Findings Dissemination Best Practices

- Achievements
  - IYWG and other knowledge management activities successful
- Constraints/Problems
  - Difficulty in tracking use of best practices for youth RH bilateral programs
  - Lack of awareness of best practices
  - IYWG mandate too narrow
  - External dissemination better than internal

Key Findings
Country Support

Achievements

- Positive on technical inputs of OHA & PRH
- Evidence of technical help shaping youth programs
- Some core investments scaled up
- Substantial Mission interest in youth

Problems/Constraints

- ABY set back youth HIV prevention efforts
- Mixed messages on youth prevention
- Lack of clear focal organization for technical assistance on youth

Integration
What we know about value-added

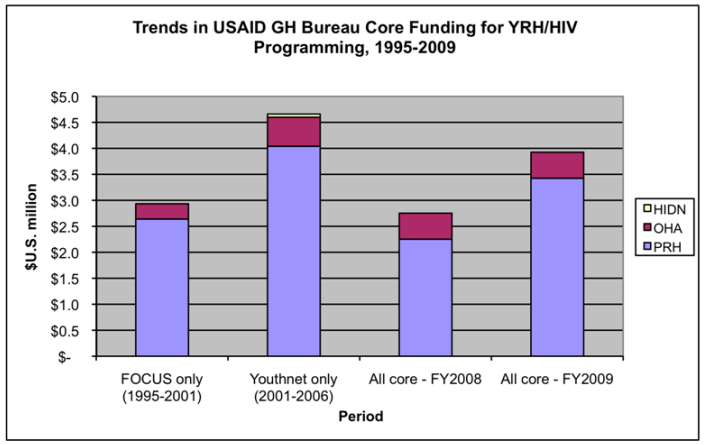
- RH/HIV models exist and should be exploited
- RH/HIV with other health (e.g., maternal, adolescent anemia) less well defined but promising
- Multi-sectoral youth interventions promising but unproven

Integration
Is it happening? Why or why not?

- RH/HIV integration happening to some extent but missed opportunities exist
- RH/HIV jointly-funded activity an achievement
- Wide spread support for integration but difficult to develop
- Push for youth inter-sectoral programming from technical level not senior leadership
- Stove-piped funding situation not conducive

Future Opportunities
Environment

- Strong global partner commitment - demand for USAID action
- Policy/Advocacy/New Initiatives
  - GHI "business model" useful for renewed youth advocacy
  - New PEPFAR strategy – attention to youth prevention, linking to broader health/development context
  - Global Engagement Initiative (?)
- Funding – favorable environment with caveats

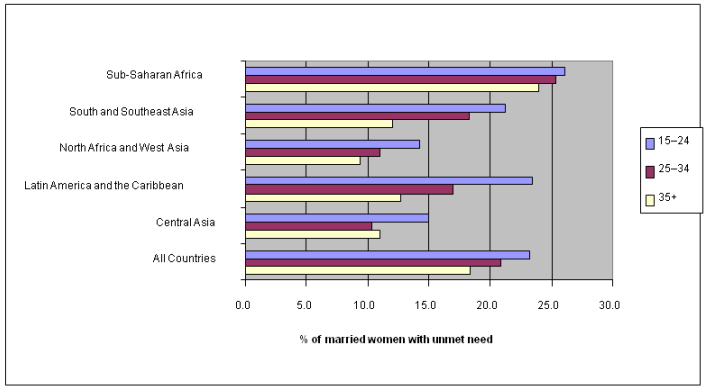


Future Opportunities Technical

Epidemiology and Better Evidence

- Size of youth cohort
- Better data on youth, so better targeting
- Trends positive but youth needs remain high

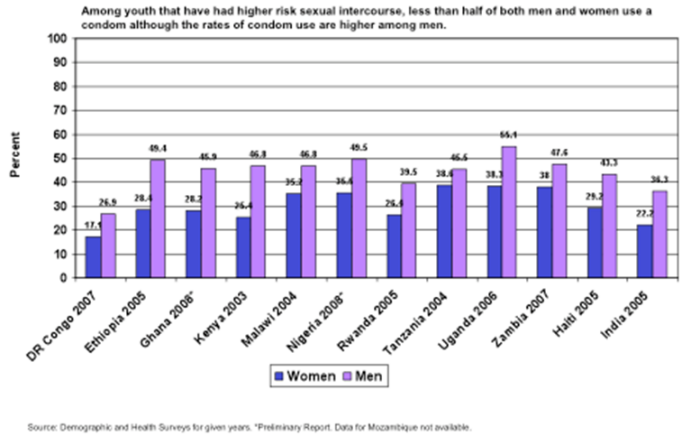
Unmet Need for Contraception by Age Group and Region



Source: (Sedgh *et al.* 2007)

Condom Use among Youth

Percentage of youth who used a condom the last time they had higher-risk sexual intercourse



Source: Demographic and Health Surveys for given years. *Preliminary Report. Data for Mozambique not available.

Future Opportunities Programmatic

Programmatic Trends

- Evidence base exists and growing
- Increasing importance of structural interventions
- Recognition of vulnerable youth (including MARPs, OVCs) for RH & HIV problems
- Recognition of HIV+ youth
- Gender and youth programming convergence

Recommendations Global Leadership

- **Develop a high profile Youth Advocacy Strategy under the GHI**
- For example:
  - Political level Youth Summit linked to roll-out of GHI. Explore GHI principles of girls/women centered approach, integration, country-led
  - Strengthen ties with external community
  - Advocate for Agency-wide youth policy, enlist other agency allies in effort

Recommendations Goals and Priorities

- Research and data
  - Develop new research agenda, priorities & funding, address OHA research problems
  - Develop better youth indicators
  - Build on and continue successful KM effort
- Programming
  - (Go for it) Encourage missions to scale up proven interventions for youth
  - Keep innovating, testing – improve integration where appropriate

Recommendations Goals and Priorities

- Helping field missions
  - Conduct strategic information campaign for missions and partners (country-specific youth disaggregated data, assessments, etc.)
  - Develop tracking of bilateral youth activities
  - Conduct staff training, update E-learning, SOTAs
- Structural and management changes
  - Formalize network of staff working on youth including field missions
  - GH system for proactively helping missions

Recommendations
Youth Implementing Mechanism

- Recommended Option: (1)political advocacy tied to GHI, (2) new focal entity/mechanism, and (3) youth mainstreaming
- Allocate core funds (PRH and OHA) for:
  - Mission technical support, country youth assessments and other analyses, research as needed
  - Pilot projects or components within mission bilateral programs with explicit plans for scale-up,
  - Knowledge management and related activities

Recommendations
Implementing Mechanism

- New Youth specialized entity:
  - Field buy-in not likely in large amounts
  - Explore adding to existing mechanism if possible rather than developing a new project
  - Many Missions want entity specialized in youth
- Also encourage mainstreaming to the extent that it fits with on going programs

Conclusion

THE TIME IS NOW!

Reclaim global leadership role

Work with missions to expand best practices

Research, innovate and integrate

APPENDIX 6: ASSESSMENT SCOPE OF WORK

Scope of Work for a Thematic Assessment:
Youth Reproductive Health and HIV
USAID/Global Health, Office of Population & Reproductive Health and Office of HIV/AIDS

I. PURPOSE

The Office of HIV/AIDS (OHA) and the Office of Population and Reproductive Health (PRH) within USAID/Global Health (GH) intends to conduct an external, independent assessment of the current successes and gaps in youth reproductive health and HIV prevention, care and treatment (YRH/HIV) programming since 2006. The focus will be on Global Health (GH) Bureau-funded activities. Topics in youth reproductive health and HIV can include early marriage, sexual debut, contraception, HIV prevention, care, treatment, orphans and vulnerable children. The results of this assessment will be used by USAID to inform GH strategy for future USAID investments. The three primary purposes are:

1. To assess to what extent Global Health youth-focused activities met the following four objectives:
    b. Research increased and innovative models tested
    b. Evidence base on youth programs disseminated
    c. Needs of country and regional programs met and evidence-based models scaled-up
    d. Evidence-based programs that meet youth's needs advocated to key decision makers and policy makers.
2. To assess integration and linkages across different technical areas within Global Health as well as linkages to youth programs in other sectors within USAID.
3. To make recommendations for a strategic portfolio of future Global Health investments in YRH/HIV, including options for implementing mechanisms.

II. BACKGROUND

Since 1995, USAID/GH has supported a wide range of activities (including research) to promote best practices in youth RH/HIV to USAID Missions. USAID supported two centrally-funded youth projects: FOCUS on Young Adults (1995-2001) and YouthNet (2001-2006) to prepare program tools, conduct research, promote policy change, design interventions and disseminate information for youth reproductive health. Throughout the years, several external assessments have been conducted to guide USAID's investments in youth. An assessment in 2005 was conducted in advance of YouthNet's end. The assessment team recommended that a "lead project assume the role of consensus building, information synthesis and dissemination, research and program support coupled with the specialized focus and strengths of other centrally funded projects". PRH and OHA proceeded with this recommendation and did not continue a large stand alone youth central project. PRH focuses its resources on disseminating

knowledge and develop smaller youth activities into a larger number of programs. OHA focuses a small amount of resources on disseminating knowledge in addition to some PEPFAR central initiatives.

In 2003, the President's Emergency Plan for AIDS Relief (PEPFAR) was created and allocated significant central funding for centrally managed, direct service provision HIV prevention programs targeting youth and children. These agreements, referred to as Track 1.0 Abstinence, Be Faithful for Youth (ABY) and Orphans and Vulnerable Children (OVC) programs, will end in June 2010. These projects were created with the aim to meet specific PEPFAR focus countries needs not to be a global youth project.

The knowledge management component started in 2007, with funds from PRH and OHA jointly investing about $700,000 annually for youth RH/HIV activities through the Contraceptive Research Technology and Utilization (CRTU) project (now the Prevention Technology Agreement – PTA), a project managed by the Research Technology Utilization (RTU) Division of PRH, implemented by Family Health International. This amount of funding was designed to support knowledge management activities to promote best practices for youth reproductive health and HIV. The primary activity was the creation of the Interagency Youth Working Group (IYWG), a network of nongovernmental agencies, donors, and cooperating agencies, in 2006.

The IYWG's mission is to provide global technical leadership in the areas of reproductive health and HIV among young people aged 10-24 in the developing world. The IYWG sponsors a website (www.youthwg.org) which summarizes evidence and provides links to resources by program area and by organization. It organizes technical meetings in Washington, D.C. on topics such as involving parents in youth RH/HIV health programs, monitoring and evaluation, and programming for youth most-at-risk of HIV. It also sponsors a publication series, *YouthLens,* and a monthly digest of youth-related resources, meetings, and events. The IYWG project also produces global guidance and materials and disseminates these. At its start, the IYWG also convened meetings of "IYWG partners", cooperating agencies that had received dedicated youth funds from PRH to discuss topics of upcoming meetings or outline priorities for planned activities. The last meeting was held in March 2008 due to the ceasing of PRH dedicated youth funds.

Meanwhile, following the recommendation of the 2005 assessment, smaller and country specific youth activities, varying in funding amount, duration and geographic location, continued through centrally funded agreements. A complete list of these activities can be found in Annex 1. These activities, as a whole, aim to advance and support improved reproductive health and HIV/AIDS outcomes for young people. PRH also created a special position of Youth Advisor to advocate for youth funds and youth became one of the 10 office-wide Global Leadership Priorities (GLPs).

It has been observed by USAID Youth experts that evidence-based practices for effective youth reproductive health and HIV activities have not been adequately used and scaled up in USAID Mission programs. Three primary reasons why best practices may not be adopted include limited knowledge of the best practice, lack of motivation to use the best practice, and limited knowledge and skills on how to do so.

In 2006, the World Health Organization published "Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries", a document which outlined interventions that were ready for wider replication based on research. This review has since been updated in August 2009 and is considered an authoritative document that describes the latest compilation of evidence for certain youth interventions for HIV prevention, some of which also apply to interventions to prevent unintended pregnancy. This document can be used as a standard to review the components of activities in order to identify program gaps.

As the focus of the Assessment is on core-funded activities, the questions directed to USAID Missions will be restricted to what youth-focused programming and support is needed from USAID/Washington and would USAID Missions buy into a youth-specific project.

An assessment can provide valuable and timely input into USAID's future directions for youth programming. Since the last assessment, USAID is operating under the new political administration, which has shown positive support for youth and family planning efforts. The creation of the Global Health Initiative will result in an important and new addition to the Global Health Bureau. It will affect future investments across all topic areas. In addition, PEPFAR has recently released the new 5 year strategy document which mentions youth as a target population. Youth is also an area of priority under the Global Engagement Initiative, an initiative created to respond to President Obama's speech in Cairo Egypt in July 2009, which called for increased engagement with young people in Muslim-majority countries and other countries. While all of these initiatives are in various stages of development, this assessment can provide concrete guidance on setting youth priorities within the Global Health Bureau and as part of these initiatives.

III. STATEMENT OF WORK

The assessment team will have three tasks and answer the following questions, though exact questions to be answered will be finalized in collaboration with the consultants.

Task 1:

1. To assess to what extent Global Health youth-focused activities met the following four objectives: (50% LOE)

    a. Research increased and innovative models tested

i. Is YRH/HIV research being conducted? If so, what are the current research projects?
ii. What are the gaps and additional needs for YRH/HIV research? On what issues?
iii. How innovative is the YRH/HIV research being conducted by GH partners?

b. Evidence base on youth programs disseminated
   i. How well do GH YRH/HIV activities promote best practices as reflected in the latest findings from the WHO review in 2009 and use tools that are evidence-based?
   ii. Are Headquarters and field staff aware of these best practice models and evidence-based tools?

c. Needs of country and regional programs met and evidence-based models scaled-up
   i. Has research conducted by GH responded to missions needs and informed programming?
   ii. What have been the challenges to scaling up evidence-based models at the country level?
   iii. Has knowledge of evidence-based models and tools reached the field at all levels?

d. Evidence-based programs that meet youth's needs advocated to key decision makers and policy makers.
   i. Are decision makers aware of the evidence for youth programming?
   ii. How is evidence shared with policy makers?

2. What are gaps and redundancies in GH YRH/HIV portfolio?

<u>Task 2: Assess integration and linkages across different technical areas within Global Health and to youth programs in other sectors within USAID. (15% LOE)</u>

2. What are tested and proven models of integration of youth RH and HIV activities?

3. How successful has GH been at integrating youth RH and HIV activities through these proven models?

4. What are strategies that GH could adopt to promote and scale up best practices in integration of RH and HIV among youth for country and regional programs?

5. What are the advantages and disadvantages of integrating RH/HIV into maternal and child health, nutrition, and malaria programming for youth?

6. What are tested and proven models of integration of youth health activities with other sectors such as agriculture, economic growth, or education?

7. What are advantages and disadvantages of integrating youth health with other development sectors?

8. What are strategies that GH could adopt to promote and scale up best practices in integration among youth health and other development sectors when advantageous?

9. Which Missions have attempted major integration efforts related to youth (both RH and HIV integration, RH/HIV into other health areas- nutrition, maternal and child health and malaria, and Youth Health with other sectors)? How successful have these efforts been? What have been the challenges and barriers to this work?

10. To what extent do USAID Missions perceive a need for more integration of RH and HIV youth activities, RH/HIV into other health areas- nutrition, maternal and child health and malaria, and GH youth activities with activities in other USAID sectors?

<u>Task 3: Make recommendations for a strategic portfolio of future Global Health investments in YRH/HIV, including options for implementing mechanisms. (35% LOE, first priority)</u>

11. What is the level of awareness Missions and HQ staff have about HQ resources, services, and TA in youth RH/HIV? How could HQ communicate better with the field and with other HQ staff?

12. What are current priorities in USAID Missions for YRH/HIV programming and how can GH better meet these needs in the future?

13. Which YRH/HIV evidence-based best practices are country and regional programs adopting? What are the barriers to adopting these practices?

14. What are current gaps in youth RH/HIV programming that a new activity could potentially fill?

15. What should be the goals, technical priorities, and high impact activities for GH youth RH/HIV investments over the next three years? What is the minimum level of investment required to achieve these goals?

16. What might be options for implementing mechanisms to help GH realize these goals?

17. How can GH strengthen its global leadership role for YRH/HIV?

IV. SUGGESTED METHODOLOGY

The assessment team is tasked with responding to the assessment questions through analysis of information and data obtained through, but not limited to document review, surveys and interviews with stakeholders. This assessment will be funded by both PRH and OHA. Therefore, time on the three tasks will be roughly equal for reproductive health topics and HIV topics.

Document review

The team will review the following documents:

Technical documents:

a. WHO Preventing HIV/AIDS in Young People in Developing Countries (2006) and the updated report from the London School of Hygiene and Tropical Medicine (2009)
b. World Bank (2007) World Development Report : Youth.
c. Select YouthNet Research Papers such as No. 2 "The Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries". Doug Kirby

Project management documents:

a. PRH Results Framework
b. Youth GLP Strategic Plan and Results Framework, 2005
c. Annual results of PRH youth activities 2006-2009
d. Matrix of PRH Youth activities 2006-2009
e. Simon, C. (2009) Mapping exercise of PEPFAR and PRH activities
f. PEPFAR USG Survey on youth prevention priorities
g. Track 1 ABY and OVC Program Assessment
h. Annual work plans for FHI IYWG activity
i. IYWG Knowledge Management Evaluation
j. List of PRH Priority Countries
k. List of PEPFAR Priority Countries
l. List of PRH Global Leadership Priorities and Technical Priorities
m. List of OHA Priority Pillars

Other resources

a. Kaliel, D and Truong, J. (2009) Global Health Brief
b. USAID Chief Operating Officer (2009) Briefing paper on youth to First Lady
c. USAID Chief Operating Officer (2009). Position paper on FY 2011 Budget Increase for Education and Youth
d. Intra Agency Youth Working Group, USAID (2009). Briefing paper on Youth and Global Engagement
e. Kennedy, et al. (1999), *Assessment of G/PHN Young Adults Reproductive Health Programming Options.*
f. Senderowitz (2000). *A review of Program Approaches to Adolescent Reproductive Health.*
g. Rosen, J. (2000). *Moving the Agenda Forward: A One-Day Forum on Adolescent Health and Development for USAID Staff and External USAID Partners.*
h. FOCUS on Young Adults. (2001), *Advancing Young Adult Reproductive Health: Actions for the Next Decade.*
i. Adamchak SE and Senderowitz J. (2005) *Assessment of Youth Reproductive Health Programming Options.*
j. YouthNet (2006), *Taking Action: Recommendations and Resources*

Documents will be provided to the team in an electronic format whenever possible.

Key informant interviews

The team will conduct semi-structured interviews with key stakeholders, including, but not limited to the following. A final list will be developed in conjunction with the consultants, who may also suggest additional persons who can provide insights useful to this assessment.

USAID interviews:

- PRH staff (those currently or previously working on youth or managing projects that include youth activities). Scott Radloff, Ellen Starbird, Kathryn Panther, Jenny Truong, Sarah Harbison, Mihira Karra, Michal Avni, Patty Alleman
- OHA staff (those currently or previously working on youth or managing projects that include youth activities): John Crowley, Debbie Kaliel, Shanti Conly, Emily Osinoff, Maury Mendenhall, Rebekah Krimmel, Christine Adamczyk; Colette Botinni; Diana Prieto
- Regional Bureau staff with interest and expertise in youth activities: Jennifer Mason, Lindsay Stewart, Ishrat Husain
- USAID/Mission staff that manage PEPFAR programs, PHN officers or other staff managing youth activities: 10-15 countries represented- Stella Akinso (USAID/Nigeria), Sophie Parwon (USAID/Liberia); TBD.

- USAID staff working on youth in non-health bureaus and offices, e.g. Economic Growth, Agriculture and Trade (EGAT), Democracy, Conflict, and Humanitarian Assistance (DCHA), Office of Women in Development: Julie Hanson-Swanson, Clare Ignatowski, Joe Kitts,

External informants

- PEPFAR staff at other agencies (Centers for Disease Control and Prevention, Office of the Global AIDS Coordinator, Department of Defense); Melissa Poulsen; Linda Wright Deaguero
- USAID implementing partners. Headquarters and field staff (e.g. Family Health International, Pathfinder International). : Joy Cunningham (FHI), Karah Fazekas (FHI), Gwyn Hainsworth (Pathfinder), Cate Lane (Pathfinder), Bill Finger (FHI)
- Donor agencies working in the area of youth RH/HIV, e.g., DFID, Gates and Packard Foundations, World Bank, UNFPA, WHO, UNICEF, UNESCO, etc. Wendy Cunningham (World Bank), Laura Laski (UNFPA), Jane Ferguson (WHO); Bruce Dick (WHO);
- Other stakeholders with knowledge of YRH/HIV research and programs, e.g. academic experts, advocacy organizations, IPPF, Marie Stopes International, youth-led organizations, etc. Doug Kirby, ETR Associates, Robert Blum (Johns Hopkins University

On-site interviews with domestic stakeholders will be conducted in Washington D.C. at their respective on-site locations or by telephone, whichever is most expedient and cost effective. Additional telephone interviews with overseas interviewees may be conducted from the U.S.

Others will be added to the list by the team as additional key informants are identified during the course of the assessment.

V. TEAM COMPOSITION

A two-member assessment team is proposed, and one person will be designated as the team leader, who will be in charge of the overall design, data collection and analysis and writing of the assessment It is anticipated that the team will be made up of two consultants, one of whom will be designated as the Team Leader :

a) **Team Leader** who will oversee all aspects of the project, liaise with the other consultant and with USAID/GH/PRH and USAID/GH/OHA, oversee data collection and analysis, write sections of the report and meld contributions of the Technical Consultant into a coherent set of responses, and present conclusions and recommendations to USAID. The team leader should have prior experience and expertise in program evaluation and assessment, understanding of USAID program processes, and experience with FP/RH, HIV/AIDS and, preferably, youth.
b) **Technical Consultant** who has specialized evaluation expertise and programmatic experience in youth RH/HIV. This individual will bring the lens of his/her subject matter expertise and experience to bear on all aspects of the

Scope of Work. S/he will work closely with the Team Leader to assess the quality and relevance of GH youth activities. S/he will work seamlessly with the Team Leader to interview key informants, conduct data collection and analysis, and write sections of the report.

The combined skill sets of the consultants should include, at a minimum:

- Excellent analytical and writing skills
- Longstanding experience and technical expertise in FP/RH and HIV/AIDS
- Expertise in conducting evaluations and assessments of public health interventions
- Experience in youth reproductive health and HIV prevention, care and treatment programs
- Familiarity with USAID systems and way of business

VI. DURATION, TIMING, AND SCHEDULE

USAID/GH anticipates that the period of performance of this assessment will be approximately 63 days to begin on or about January 4, 2009 (the actual start date will depend on consultant availability). No travel to the field will be necessary.

Team Planning Meeting

The full team will have a two-day team planning meeting in Washington, D.C. The team planning meeting is an essential step in organizing the team's efforts. During this meeting, the team will meet with USAID/GH/PRH and USAID/GH/OHA to review the SOW and discuss expectations and deliverables, determine roles and responsibilities of all team members, and agree on a timeline for the assessment effort. In addition, the following will be accomplished:

- clarification of any aspect of the SOW and what is expected
- logistical and administrative procedures for the assignment
- agreement of components of the draft work plan,
- establishment of a team atmosphere, through sharing of individual working styles, and agreement on procedures for resolving differences of opinion,
- development of a preliminary draft outline of the team's report, and
- assignments made regarding drafting responsibilities for the final report.

Within three days following the Team Planning Meeting, the team will develop and submit to USAID/GH/PRH and USAID/GH/OHA a draft work plan that will include the following elements:

- description of each team members' roles and responsibilities,
- list of the final assessment questions or guidelines for questionnaires,

- approach to data collection, methodologies to be used, how data will be analyzed
- data collection instruments (in appendices)
- draft outline of final report (as an appendix)
- assignment timeline

USAID/GH/PRH and USAID/GH/OHA must approve the final work plan before data collection begins.

USAID/GH/PRH and USAID/GH/OHA and the assessment team may request to meet on a periodic basis during the implementation of the evaluation for the purposes of clarification and sharing information.

The following is a sample schedule. The assessment team will finalize a schedule and exact dates for the assessment at the Team Planning Meeting in collaboration with the PRH/OHA assessment team. Proposed level of effort: Total LOE is 63 person days distributed as follows:

Task/Deliverable	Time in days	LOE		
		Team Leader	Team Member	Total LOE (days)
1. Document review	3	3	3	6
2. Team Planning Meeting/Draft Work plan/Draft Data Collection Instruments/Scheduling of Interviews	5	5	5	10
3. Information and data collection. Includes development of data collection tools, interviews with key informants, email survey, and data analysis, continued document review.	15	15	15	30
4. Mid-course meeting with USAID Assessment Team to discuss relevant issues, comments, concerns	1	1	1	2
5. Draft evaluation report and preparation for debrief	5	5	4	9
6. Debrief with USAID/GH and USAID and external stakeholders (2 meetings on different days)	2	1	1	2
7. USAID/GH provide comments on draft report	10	0	0	0
8. Prepare final assessment report	3	3	1	4
Total # of business days	**44**	**33**	**30**	**63**

Consultants will be responsible for coordinating and facilitating assessment-related interviews, surveys and meetings.

The contractor will be responsible for all costs incurred in carrying out this review. The proposed cost may include, but not be limited to: (1) in-country transportation and travel; (2) office space for the team to work and hold meetings; and (3) other office supplies, equipment, computers, copiers, printers, etc.

VII. DELIVERABLES

Work Plan

Within three days of the Team Planning Meeting, the team will submit a draft work plan to USAID/GH via the contractor for approval. Any major changes to the work plan proposed by the assessment team will be discussed with USAID and require approval by USAID prior to implementation. The draft work plan will contain the components listed in Section VI.

Debriefing

After the assessment team conducts the data collection and has time to discuss and reach consensus on the preliminary conclusions and recommendations, but before the draft report is submitted, the assessment team will meet with select members from USAID/GH to discuss the preliminary results. At this time, USAID/GH may provide additional information and provide its perspective, but will not approve the findings per se.

A second debriefing for a larger audience will take place several days after the draft report has been submitted to USAID/GH. The evaluation team will prepare a PowerPoint presentation for the debriefing. Participants in the second debriefing audience may include USAID/GH staff, other interested persons outside of GH as well as other interested stakeholders such as other donors or implementing partners. Attendees shall provide comment at the debriefing or communicate their feedback to the USAID/GH point of contacts.

Draft Report

The assessment team will submit a draft report to USAID/GH via the contractor (if applicable).

Final Report

The evaluation team, via the contractor, shall deliver five printed copies of the final report.

The final report will use the following the format:

- An Executive Summary (5 pages) containing a clear, concise summary of the most critical elements of the report, including the recommendations.
- Table of Contents
- Body of the report (no more than 30 pages), which includes:

    - Purpose of assessment
    - Team composition
    - Methodology
    - Findings based on evidence
    - Conclusions drawn from the findings
    - Recommendations based on the assessment's findings and conclusions, presented with sufficient detail so that USAID can take specific actions to improve program quality and implementation.

The Final Report will also include, but is not limited to, the following appendices:

- Assessment SOW
- List of documents reviewed
- List of key informants interviewed and their contact information (institution or organization)
- Data collection instruments developed;
- More detailed discussions of methodological or technical issues as appropriate
- A Power Point presentation on the results of the assessment.

The body of the report should be no more than 30 pages total, not including the annexes. If necessary, supporting data may be included in appendices, the length of which should be discussed and approved by USAID.

The Team Leader is responsible for the content of the final report. If there is disagreement among the team members conducting the assessment, the Team Leader should have the final decision, with dissenting opinions provided as footnotes or as an appendix. The final report should be completed no more than one week after comments from USAID are received. The contractor will have the report edited, formatted, and printed within approximately 15 days of receiving final USAID approval of the content. Due to procurement-sensitive information, parts of or this entire document may not be distributed outside USAID.

The contractor may prepare a separate Internal USAID Memo that includes Future Directions and any recommendations that are procurement sensitive information so that the main report can be released as a public document. The contractor will make the

main report available through the Development Experience Clearinghouse and its website www.dec.org.

VIII. POINT OF CONTACT

The contacts at USAID/GH include the Youth Health Advisors in PRH and OHA, respectively:

- Jenny Truong, GH/PRH/SDI (**jtruong@usaid.gov**; 202-712-0618) and
- Deborah Kaliel, GH/OHA/ISD (**dkaliel@usaid.gov**, 202-712-0254)

IX. ADDITIONAL DOCUMENTS/ANNEXES

Annex 1: List of youth-specific activities supported by PRH projects

APPENDIX 7: ROLES OF UN AGENCIES IN HIV PREVENTION AMONG YOUNG PEOPLE

Area of prevention activities	ILO	UNAIDS Secr.	UNDP	UNESCO	UNFPA	UNHCR	UNICEF	UNODC	WFP	World Bank	WHO
IDU and prisoners	P	P	P	P	P		P	L			P
MSM		P	L	P	P			P			P
Sex workers	P	P		P	L	P	P	P			P
Vulnerable groups	P			P	L		P	P	P		P
Displaced populations			P	P	P	L	P		P		P
Workplace policy/progs	L		P	P		P					
Health sector interventions	P		P		P	P	P	P		P	L
In-school youth	P			L	P	P	P	P	P	P	P

L = lead agency, P = main partner agency; IDU = injecting drug use, MSM = men who have sex with men

* ILO: International Labour Organization; UNAIDS: Joint United Nations Programme on HIV/AIDS; UNDP: UN Development Programme; UNESCO: UN Educational, Scientific and Cultural Organization; UNFPA: UN Population Fund; UNHCR: UN Refugee Agency; UNICEF: UN Children's Fund; UNODC: UN Office on Drugs and Crime; WFP: UN World Food Program; WHO: World Health Organization.

Source: UN Interagency Task Team on HIV and Young People. *Global Guidance Briefs: HIV Interventions for Young People*. New York: UNFPA, 2008.

APPENDIX 8: LATEST EVIDENCE ON THE EFFECTIVENESS OF YOUTH HIV PREVENTION INTERVENTIONS

SUMMARY OF CURRENT READY AND GO! RECOMMENDATIONS

Recommendation	Setting	Type of intervention
Go! - take this type of intervention to scale NOW!	Schools	Curriculum-based, sexual health education programmes, led by adults, with or without the involvement of peer educators from within the same school (for knowledge and reported sexual risk behaviours goals)
Go! - take this type of intervention to scale NOW!	Mass media	Messages delivered through radio & other media (eg. print media), with or without TV (for knowledge & reported self-efficacy goals)
Ready - implement on a large-scale with evaluation for impact	Schools	Curriculum-based, sexual health education, led by older, well-trained youth with or without the involvement of peer educators from within the same school (for knowledge and reported sexual risk behaviours goals)
Ready - implement on a large-scale with evaluation for impact	Health services	Training service providers and actions in the clinic to make them more 'youth friendly', with activities in the community and involvement of other sectors (for utilisation of services goals)
Ready - implement on a large-scale with evaluation for impact	Geographically defined communities	Targeting youth and delivered using existing organisations, and interventions that target the community and are delivered through traditional networks or delivered through community-wide activities (for knowledge, skills and reported sexual risk behaviours goals)
Ready - implement on a large-scale with evaluation for impact	Young people most at risk	Interventions that provide information and services, through facilities and outreach (for reported sexual behaviours & utilisation goals)

STEADY, READY, GO! TERMINOLOGY

Go!	**Take these interventions to scale NOW!**
	Sufficient evidence to recommend widespread implementation on large scale now, with careful monitoring (coverage & quality & cost)
Ready	**Implement widely but continue to evaluate**
	Evidence suggests interventions are effective, but large-scale implementation must be accompanied by further evaluation to clarify impact and mechanisms of action
Steady	**More research and development still needed**
	Evidence is promising, but further intervention development, pilot testing and evaluation urgently needed before they can move into the "Ready" or the "Do not go" categories
Do not go	**Not the way to go...**

Source: London School of Hygiene and Tropical Medicine 2009

For more information, please visit
http://www.ghtechproject.com/resources.aspx

Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
www.ghtechproject.com