Addressing Youth
within the World Bank's Multi-Country HIV/AIDS Program (MAP)

AFRICA FREE OF HIV/AIDS
DEVELOPMENT AND THE NEXT GENERATION

Health, Nutrition, and Population Unit, Human Development Network and AIDS Campaign Team for Africa (ACTafrica)

HNP

ACTafrica
AIDS Campaign Team for Africa

Front Cover Painting

About the artist:

Mr. Paul Olaja is a 19-year-old AIDS orphan from Uganda. Mr. Olaja passionately shares the stories of his homeland and conveys young people's aspiration towards life through his artistic works. His paintings are vivid and dynamic, revealing his love of movement, harmony and community.

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[1] Responsible for writing the case study on Malawi.

ACRONYMS AND ABBREVIATIONS

ABBEF	Association Burkinabé pour le Bien-Etre Familial, Burkina Faso
ACTafrica	AIDS Campaign Team for Africa (World Bank)
AIDS	Acquired immune deficiency syndrome
ALAVI	Association Laafi La Viim, Burkina Faso
BCC	Behavior change communication
CHAI	Community-led HIV/AIDS Initiatives, Uganda
CBO	Community-based organization
CRAIDS	Community Response to HIV/AIDS, Zambia
CSO	Civil society organization
DACC	District AIDS Coordinating Committee, Malawi
DATF	District AIDS Task Force, Zambia
DFID	Department for International Development, U.K.
DHS	Demographic Health Survey
EAF	Emergency HIV/AIDS Fund, Ethiopia
ESMAP	Ethiopia Multi-Sector HIV-AIDS Project
FGAE	Family Guidance Association of Ethiopia
GAMET	Global HIV/AIDS Monitoring and Evaluation Team (World Bank)
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HAPCO	HIV/AIDS Prevention and Control Office, Ethiopia
HIV	Human immunodeficiency virus
HNP	Health, Nutrition and Population
IDA	International Development Association
IEC	Information, education, and communication
JSDF	Japan Social Development Fund
MAP	Multi-Country HIV/AIDS Program
MEBA	Ministry of Basic Education, Burkina Faso
MESSRS	Ministry of Secondary and Higher Education and Scientific Research, Burkina Faso
NAC	National AIDS Commission
NAS	National AIDS Secretariat
NGO	Nongovernmental organization
OED	Operations Evaluation Department (World Bank)
OVC	Orphans and Other Vulnerable Children
PAD	Project Appraisal Document
PAMAC	Programme d'Appui au Monde Associatif et Communautaire, Burkina Faso

PEPFAR	President's Emergency Program for HIV/AIDS Relief, USA
PLWHA	People living with HIV/AIDS
PROMACO 1	Project de Marketing Social des Condoms, Burkina Faso
PRSP	Poverty Reduction Strategy Paper
RAJS/BF	Réseau Africain des Jeunes contre le Sida, Burkina Faso
SHARP	Sierra Leone HIV/AIDS Response Project
SIDA	Swedish International Development Agency
TAP	Treatment Acceleration Project
TB	Tuberculosis
TTL	Task Team Leader
UACP	Uganda HIV/AIDS Control Program
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary counseling and testing
WHO	World Health Organization
YTSC	Youth Technical Sub-Committee, Malawi
ZANARA	Zambia National Response to HIV/AIDS

EXECUTIVE SUMMARY

Young people are central in the battle against HIV/AIDS. Each day 5,000-6,000 new infections occur among young people age 15-24, representing half of new infections. The disease disproportionately affects young females; rates of infection among girls in the hardest-hit countries of Africa are 1.3 to 12 times higher than for boys of the same age. Young people are also the best hope for fighting the epidemic; where HIV prevalence has fallen, youth have led the way by delaying sex, reducing partners, and increasing condom use.

As one of Africa's largest donors for HIV/AIDS, the World Bank can help ensure that programs to contend with the disease adequately focus on young people. This study, based on six in-depth country case examples,[2] examines the experience of the World Bank in addressing the youth dimension of the HIV/AIDS epidemic through its Multi-Country HIV/AIDS Program (MAP) in Africa. The study hopes to provide further guidance to the Bank on improving the effectiveness of its investments in youth and HIV/AIDS programming.

Key Findings

Government officials and World Bank staff generally recognize the importance of young people in fighting HIV/AIDS. Most national AIDS strategies pay attention to youth, although to varying degrees. Within this context, almost all MAP Project Appraisal Documents (PADs) identify young people as a key target group, and many include project impact indicators that are youth-specific. However, mirroring some of the weakness of national strategies, few PADs mention specific youth programs or put forth a coordinated approach to the concerns of young people.

MAP supports a wide range of youth-specific programming, with most effort focused on the local response component and support to public sector entities such as the Ministries of Education and Youth. Appropriately, given the beneficiary group, youth-oriented projects concentrate on disease prevention, including information, education, and communication (IEC) and services.

MAP is providing at least a small level of support for youth programs. Information from a range of studies and countries show that a small but significant portion of funding is youth-oriented.

Little information is available on the effectiveness of youth initiatives. Although most youth-focused, MAP-funded programs fall within international good practice guidelines, impact evaluation is almost non-existent, which DEC or the office of the Chief Economist in Human Development can assist in developing.

Current programming displays weaknesses that may undermine effectiveness. These include poor links with broader reproductive health concerns, limited duration of activities, lack of coordination, and a lack of attention to rural youth and gender concerns.

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[2] The case study countries are Burkina Faso, Ethiopia, Malawi, Sierra Leone, Uganda, and Zambia

Further constraints limit the reach and effectiveness of youth-focused interventions. These include gaps in the capacity of civil society organizations (CSOs), lack of meaningful youth involvement, lack of coordination and capacity in youth ministries and poor coordination among donors and youth-serving groups. While education ministries, through activities such as curriculum development, have the capacity to address youth prevention issues on a large scale, in many countries these efforts are limited in scope and quality.

Recommendations for *Improving the Effectiveness of Youth HIV Interventions*

Build on the positive policy environment by strengthening existing national policies and plans and supporting multi-sectoral effective policy implementation. Governments, for example, can tap into the donor-funded AIDS Strategy and Action Plan (ASAP) program for specific help in improving the youth focus of AIDS strategies.

Boost expertise on youth issues on national, regional, and local AIDS councils and coordinating committees. Governments can augment this expertise by assigning additional tasks to youth networks and other organizations with comparative advantage on services for young people.

Improve coordination of youth HIV/AIDS activities among different ministries through links with other adolescent reproductive health and youth development concerns and by strengthening ties among key ministries. Coordination should occur at national, regional, and local levels. NACs should assign coordination tasks to youth networks and other appropriate youth-serving groups.

NAS should improve coordination among donors through strengthened partnerships. The NAS should build better coordination and partnerships among the different donors working with youth ensuring, among others, to benefit from respective expertise from organization such as UNICEF and UNFPA.

Increase the external focus of public sector entities for HIV/AIDS activities and explore possibilities to tailor programs to youth beneficiaries.

Concentrate on prevention, particularly the strengthening of HIV education in school systems.

Ensure that MAP supports evidence-based, results-focused programming by incorporating the latest evidence-based findings and emphasizing support for longer-term, multi-pronged programs that aim for sustained behavior change.

Integrate impact evaluations of youth-oriented interventions in program design including consideration of investments in more rigorous randomized trials of common yet under-evaluated approaches.

Include consistent youth-specific indicators for monitoring and evaluation in the national M & E framework and MAP project indicators, drawing on internationally accepted lists such as those produced by the Joint United

Nations Programme on HIV/AIDS (UNAIDS) and the Inter-agency Task Team on Youth and HIV/AIDS.

Improve tracking of youth-oriented activities by upgrading information systems and working towards consistent reporting across countries.

Deepen the community involvement element of the local response component to appropriately and systematically include parents, teachers, women's groups, and religious and traditional leaders in youth HIV/AIDS programs.

Increase targeted programs for difficult to reach young people such as sex workers, young married women, domestic workers, out-of-school youth working in the informal sector, and out-of-school youth in rural areas.

Boost the capacity of youth-serving civil society organizations, with emphasis on improving proposal writing, leadership and management, training, and monitoring and evaluation. This could occur most efficiently through networks of youth-serving organizations acting as intermediaries for small groups.

Make it easier for youth groups to access MAP funds through support of youth networks and consortiums, which in their turn can provide support to smaller groups implementing youth and HIV/AIDS activities.

Improve youth representation and involvement on governance bodies and within youth-serving organizations.

Strengthen youth networks as a way to advocate for policy implementation, improve coordination, and enhance access to funding.

INTRODUCTION

Young people are central in the struggle against HIV/AIDS. Half of the 4.2 million infections that occurred in 2005 were among young people ages 15 to 24. Each day 5,000-6,000 new infections occur among young people (UNAIDS IATT 2006) and over 10 million young people are now living with the virus that causes AIDS (UNAIDS 2004; UNAIDS IATT 2006). The disease disproportionately affects young females; rates of infection among girls in the hardest-hit countries of Africa are 1.3 to 12 times higher than for boys of the same age. Adolescent girls are especially vulnerable to HIV infection. About two thirds of newly infected young people aged 15-19 years in sub-Saharan Africa are female (UNAIDS IATT 2006). HIV/AIDS is one of the top causes of illness and death among young people (WHO 2002).

The AIDS epidemic is a problem for young men and women everywhere, but affects youth very differently depending on the region and the stage of the epidemic. In regions where general rates of HIV infection are typically less than 1 percent, the epidemic is still concentrated in specific groups. In those countries, the young people infected with HIV generally are those engaging in high-risk behaviors such as injecting drug use, commercial sex, and male-to-male sex (UNICEF 2002).

By contrast, in the generalized epidemics of southern and eastern Africa, HIV infects 10 percent or more of youth, with heterosexual transmission by far the most likely route of infection. For the region as a whole in 2005 an estimated 4.6 percent of women and 1.7 percent of men ages 15 to 24 were living with HIV (UNAIDS and WHO 2005). As a result, sub-Saharan Africa contains almost two-thirds of all young people infected with the virus—approximately 6.2 million people. The concentration of new infections among the younger generation creates immense health problems and threatens the economic and social underpinnings of the continent.

On a more hopeful note, as the World Bank's Global HIV/AIDS Program of Action affirms, "Young people also represent the future and biggest hope in fighting the epidemic" (World Bank Global HIV/AIDS Program 2005). Where HIV prevalence has fallen, youth have led the way by delaying sex, reducing partners, and increasing condom use. The few countries where rates have decreased have achieved these gains mostly by encouraging safer behavior choices among young people. In Uganda, Tanzania, and Zambia, HIV prevalence among young people has recently declined by half or more, primarily because of changes in behavior such as delay in first sexual experience and higher condom use (Kiragu 2001; UNICEF 2002; UNAIDS 2004). Countries in other regions also have had success in reducing some risky youth sexual behaviors and promoting safer sex. Brazil, a country promoting information about and encouraging the widespread availability of condoms, reports large increases in the percentage of young men using condoms the first time they have sex (UNICEF 2002). This rise in condom use may be offsetting less encouraging trends such as earlier sexual debut and a greater number of sexual partners (UNAIDS and WHO 2005).

Many youth-focused actions that prevent infection or mitigate the effects of HIV/AIDS also benefit young men and women in other ways. For example, programs to promote abstinence, delay sexual activity, reduce partners, and use of methods such as condoms for disease prevention, inhibit

transmission of other sexually transmitted infections and help to delay childbearing and prevent unwanted pregnancies. Skills that are key to negotiating sex also apply to other spheres of life. In large part because of the synergies between HIV prevention and related areas, recent economic studies have found that youth HIV prevention programs are a sound public investment (World Bank 1999; Knowles and Behrman 2003).

In recognition of how important the younger generation is to anti-AIDS efforts, the international community at the 2001 United Nations Special Session on HIV/AIDS set the target of reducing HIV prevalence among 15 to 24-year-olds by 25 percent in the most affected countries by 2005 and globally by 2010. Similarly, the Millennium Development Goal of halting and reducing the spread of HIV/AIDS by 2015 also focuses on the 15 to 24 age group.

Despite scattered signs of progress, the world is still far from achieving these goals. The number of people living with the virus continues to grow in almost regions. An estimated 2.8 million adults and children became infected with HIV in 2006 in sub-Saharan Africa more than in all other regions of the word combined (UNAIDS 2006). Data from surveys in 20 high-prevalence countries reveals that although most young people have heard of HIV and AIDS, the large majority neither can recognize three common misconceptions about HIV nor identify at least two methods of disease prevention (UNAIDS 2004). Particularly troubling given their higher risk, young women are generally less informed about HIV than are young men. Data from 35 countries in sub-Saharan Africa show that, on average, young men were 20 percent more likely to have correct knowledge of the disease than young women (UNAIDS and WHO 2005). These statistics highlight the need to improve and scale up prevention among young people, starting with providing basic information that leads towards sustained behavior change.

The World Bank, HIV/AIDS, and Youth

The role of the World Bank in helping to achieve these prevention goals is potentially enormous. The Bank is already one of the world's largest donors in the battle against HIV/AIDS. Since 1988, the Bank has provided more than US$ 2.7 billion in grants and credits for anti-AIDS work in over 100 projects (World Bank 2006). Funding increases for AIDS programs in Africa have been particularly impressive, rising from a yearly average of US$ 10 million in the mid-1990s to an estimated US$ 200-250 million in the past three years (ACTafrica 2006). Along with finance, the Bank is also a major provider of implementation support to countries, through direct provision of expertise on technical matters, dissemination of good practices and lessons learned, inter-country learning, and as the seat of the UNAIDS monitoring and evaluation country support team, GAMET. Through these support services, the Bank can play an important role in creating a more supportive environment for countries to address youth issues.

Several of the Bank's key policy statements clearly assign a priority to action on youth and HIV. The Bank's 2005 Global HIV/AIDS Program of Action (World Bank 2005) explicitly recognizes the essential role of young people and stresses the need to "stay the course" on prevention, with an emphasis on the young and uninfected. The Program of Action calls for providing young people with access to youth-friendly and gender-specific information, health services, and counseling on and access

to condoms. It also highlights the need to reach both in-school and out-of-school youth and to involve young people in designing and carrying out programs. Similarly, the Bank's Children and Youth Strategic Framework incorporates reducing risky behaviors, including those that promote the spread of HIV, as a strategic pillar (World Bank Children & Youth Unit 2005). HIV and other health risks of young people is also a focus of the World Development Report 2007, *Development and the Next Generation*. Outside groups also recognize the importance of World Bank funding for youth reproductive health, including HIV/AIDS prevention, and have urged the Bank to boost its efforts in this area.[3] Importantly, beyond the policy pronouncements, many Bank-financed projects support activities that meet the health needs of young people, including HIV prevention. One analysis found that 62 (43 percent) of the 143 HNP and HIV/AIDS operations approved in fiscal years 1999-2004 include support for HIV and youth programs. The Bank has also supported a range of analytical work, policy dialogue, and outreach related to HIV and young people.[4]

Objectives and Methodology of the Study

Much of what was known about the Bank's work on HIV and youth came from informal reviews or examination of policy or planning documents such as the Project Appraisal Documents prepared for each Bank operation. These previous reviews left largely unanswered the question of how the Bank's expressed support translated into concrete actions. Furthermore, little was known about the day-to-day challenges facing Bank-supported HIV and youth efforts.

To answer such questions, this study proposed a more in-depth look at the Bank's experience in dealing with the youth dimension of the epidemic. Although it looks specifically at MAP-supported projects in Africa including the TAP program, its findings and lessons learned are relevant to other regions and other sexual and reproductive health programs that incorporate a youth and HIV concentration.

Specific objectives of the study are to:

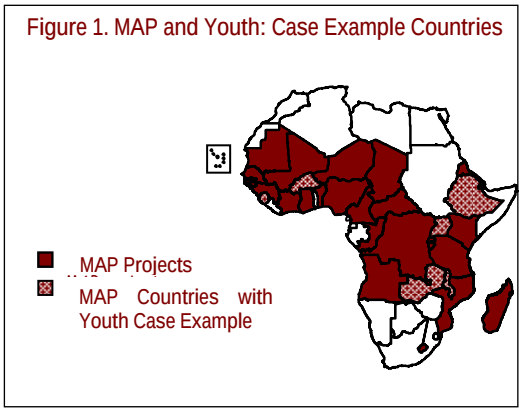
- determine current levels and type of funding for MAP-financed, youth activities;
- determine the effectiveness of current youth-focused efforts;
- determine the factors that may foster or hinder attention to young people in MAP;
- develop recommendations to strengthen the inclusion and implementation of youth-focused MAP interventions.

While many activities supported by MAP reach young men and women as a by-product of some broader strategy, this assessment highlights actions that specifically intend to target youth. Furthermore, the study hopes to identify key areas where the Bank can improve the effectiveness of its investments in HIV prevention for youth.

[3] See the Global Health Council's recent report, *Commitments: Youth Reproductive Health (YRH), the World Bank, and the Millennium Development Goals*. 2004. Global Health Council.
[4] *Taking Stock: The World Bank's Work on Youth and HIV/AIDS,* Draft note, 11-15-2004

The results of this study are primarily for use by World Bank staff and government counterparts designing and carrying out MAP and other HIV/AIDS projects in Africa and elsewhere. Additionally, the study may be of interest to World Bank staff working on broader youth matters, to other international agencies, and to members of civil society groups—in particular to young people and others involved in HIV/AIDS prevention.

Figure 1. MAP and Youth: Case Example Countries



The study is meant to be descriptive and not an exhaustive census or evaluation of all youth-oriented activities supported by MAP. Nor does it pretend to be comprehensive in its scope. The report draws primarily on in-depth case examples based on field visits to six countries[5] and from documents review and interviews with Bank MAP task team leaders (TTLs), ACTafrica staff, government counterparts, young people, and officials of youth-serving organizations. The findings section (Section 2) describes the range of youth-focused actions supported by MAP, amounts of funding, and evidence on effectiveness of current activities. In Section 3, the report discusses important constraints and opportunities and provides concrete recommendations for increasing the effectiveness of Bank investments in HIV efforts directed at young people. Appendix A includes short case examples from six MAP countries. Appendix B summarizes international good practice in youth and HIV programming.

Defining Key Terms

It is useful to review how this report defines the terms youth and youth-focused HIV/AIDS activity. Countries typically define youth in terms of both age and life circumstance, and thus the meaning of the expression varies across countries. For purposes of this study, youth are defined as between 10 and 24 years old. The report uses the terms young people, youth, and adolescents interchangeably to refer to the 10 to 24 age group, unless otherwise specified. This broader use of the term underscores the need for policies and programs to focus less on age and more on recognizing the specific developmental needs of people as they transition from childhood to adulthood.

The report defines youth activities or projects as those that specifically designate young people as beneficiaries. The study does not closely examine the many HIV/AIDS strategies that aim to serve a broad age range that may include 10 to 24-year-olds. Furthermore, the study does not look in depth at programs targeting orphans and other vulnerable children (OVCs). Although such programs may serve youth, OVC programs typically concentrate on care and support, not the core prevention activities that make up the bulk of youth programming.[6]

[5] The case study countries are Burkina Faso, Ethiopia, Malawi, Sierra Leone, Uganda, and Zambia
[6] For detailed information on support to OVCs, see the OVC Toolkit for sub-Saharan Africa at: http://info.worldbank.org/etools/docs/library/164047/index.htm

Overview of MAP

Launched in September 2000, the Africa MAP remains the Bank's primary vehicles for HIV/AIDS support in Africa. Conceived as a response to earlier shortcomings in the Bank's response to the epidemic, the MAP committed substantial International Development Association (IDA) resources. Through mid-2005, the Africa MAP had committed US$ 1.2 billion to 29 African countries and four regional programs (World Bank Global HIV/AIDS Program 2005).[7]

The development objective of the overall MAP is to dramatically increase access to prevention, care, and treatment programs, with emphasis on vulnerable groups such as youth, women of childbearing age, and other groups at high risk. Country-specific national strategic plans are the basis for defining development objectives of individual MAP projects, and where efforts to address youth and HIV issues should begin.

The MAP approach represents the first phase of a long-term World Bank commitment to support the national mobilization of countries in sub-Saharan Africa against the HIV/AIDS epidemic. By design, MAP is unprecedented in its flexibility and coverage, stressing speed, scaling up existing programs, building capacity, and "learning by doing" rather than exhaustive up-front technical analysis of individual projects. This strategy relies on immediate monitoring and evaluation of programs to determine appropriate expansion and need for capacity building.

Individual country MAPs typically have four funding components:[8]

(1) *Capacity building for government agencies and civil society* to enhance the capacity of the public and private sectors and civil society to conduct a broad range of HIV/AIDS activities. This includes a focus on strengthening national AIDS councils and capacity building for nongovernmental organizations (NGOs) and community-based organizations (CBOs).

(2) *Expanding the public sector response* to the epidemic in a broad range of sectors, with particular attention to strengthening health systems. Funds flow to sector ministries and other government agencies to carry out HIV/AIDS plans against agreed targets and timetables.

(3) *Local response fund* to channel grant funds directly to community organizations and groups, NGOs, PLWHA associations, and the private sector for local initiatives. These typically operate from a separate special account and disburse based on plans developed by local actors.[9]

(4) *Project coordination* for effective coordination, facilitation, and monitoring and evaluation. This includes development of country-led common management systems and the development of knowledge sharing networks both within and among countries receiving MAP support.

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[7] The MAP approach has been adapted in other regions. For example, a Caribbean MAP has committed US$ 118 million for nine countries and one regional project, and a MAP-like approach was adopted in Central Asia. Because of its speed and flexibility, MAP was used as the model for the Bank's avian flu program.

[8] For more detail, see *Second Multi-Country HIV/AIDS Program (MAP2) for Africa*, ACT*africa,* AIDS Campaign Team for Africa, Africa Regional Office, World Bank. http://www.worldbank.org/afr/aids/map/mapII_abstract.pdf

[9] For an analysis of the local response component, see Jean Delion, Pia Peeters, and Ann Klofkorn Bloome, December 2004, *Experience in Scaling up Support to Local Response in Multi-Country Aids Programs (MAP) in Africa*, ESSD Regional Program on HIV/AIDS in collaboration with AIDS Campaign Team for Africa (ACTafrica).

The Bank will likely continue to provide substantial levels of funding for HIV/AIDS activities in sub-Saharan Africa for the medium term. Although the specific funding mechanism to support such efforts may change, the basic programmatic design emphasizing a multisectoral, multipronged approach is expected to remain. Likewise, the Bank will continue to endorse the Three Ones Principles: one agreed HIV/AIDS action framework; one national AIDS coordinating authority with a broad based multisectoral mandate; and one agreed country-level monitoring and evaluation system. Some MAP recipient countries are already on their second project[10] and many of the countries currently receiving MAP funds are likely to have follow-on projects. Thus, the findings and recommendations from this study will remain applicable for the near future.

Large-scale funding for care and treatment is a relatively new and increasingly important feature of Bank support. In June 2004, the Bank approved an IDA grant of US$ 59.8 million for the Regional HIV/AIDS Treatment Acceleration Program (TAP) in Burkina Faso, Ghana, and Mozambique.[11] The TAP aims to pilot strategies for strengthening capacity to scale up effective, affordable, and equitable care and treatment. The TAP has three components:

- testing strategies for scaling up service delivery for care and treatment;
- strengthening institutional capacity for care and treatment; and
- facilitating regional learning under the guidance of the World Health Organization (WHO) and the United Nations Economic Commission for Africa.

The TAP opens up additional opportunities to support youth activities through its promotion of voluntary counseling and testing and through its research agenda.

[10] Including Burkina Faso, Eritrea, Ghana, and Madagascar

[11] For a full description of the TAP, see World Bank, *Project Appraisal Document, Regional HIV/AIDS Treatment Acceleration Program*, May 2004; and TAP website at: http://www.uneca.org/tap/

FINDINGS

With young men and women key to halting the epidemic and with the Bank continuing to use MAP as its main support mechanism, it is important to examine how current efforts are addressing this important group. This section starts by looking at how the Project Appraisal Documents (PAD) treat young people, then examines the types of and level of funding for youth programming, and finally looks at the effectiveness of current initiatives.

Youth in the Project Appraisal Documents

As mentioned previously, the country-specific national AIDS strategic plans are the basis for defining development objectives of individual country projects from the World Bank.

For all six countries covered in this assessment, the national AIDS strategies address youth, but are generally weak with respect to specific actions related to youth. Most identify them as a focus group, with no specific interventions/activities and do not include youth-specific monitoring and evaluation.

The PAD is the key project technical report prepared by Bank staff and provides the basis for the grant and credit agreement presented to the Bank's Board during the loan approval process. Thus, appropriate attention to youth concerns in the PAD is an important first step to ensure that funding will eventually go for such purposes. Adding or enhancing a youth emphasis after grant or loan approval is more difficult, especially when the project budget has not allocated resources for youth programs.

What emerges from an analysis of MAP PADs is that they generally reflect the degree to which national strategies pay attention to youth. As shown in Table 1, the PADs for virtually all of the country MAPs identify young people in some way as a key target group, either combined with other groups as being especially vulnerable, or as a specific high-risk group. Moreover, many but not all of the PADs include project impact indicators that are youth specific, such as HIV prevalence in 15 to 24-year-olds. Many of the PADs also describe specific activities for young people, although the degree of detail and emphasis varies widely.

Some of the PADs that have been strong in addressing youth include those of the Gambia, Kenya, Madagascar, and Malawi. The Gambia PAD, for example, has two of three key targets and indicators for monitoring progress related to young people and behavior change such as use of condoms for young people. The PAD also includes HIV/AIDS activities for beneficiaries of ministries, such as expansion of family life education programs through the education system; and mentions the expansion of "Stepping Stones," a program which has been proven to be successful to change behavior among youth. There is also a focus on information, education, and communication (IEC) and on youth-friendly reproductive health services through the Community and Civil Society Initiatives component.[12] In general, however, most PADs do not specify youth activities. Moreover, the PADs rarely put forth a coordinated approach for attending to this important risk group, or how to

[12] For the full report, see World Bank, *Project Appraisal Document, the Gambia HIV/AIDS Rapid Response Project,* December 2000.

coordinate and build upon youth activities of other donors implementing the National AIDS Strategy such as UNICEF and the Global Fund.

Table 1. Youth in MAP Project Appraisal Documents

Extent to which MAP PADs include language specifically addressing youth issues, by youth-specific element, 2000 – 2004.

Youth-specific element of the Project Appraisal Document	Country					
	Burkina Faso	Ethiopia	Malawi	Sierra Leone	Uganda	Zambia
Recognizes youth as a key target group	Y	Y	Y	Y	Y	Y
Includes youth-specific impact indicators	Y	Y		Y	Y	Y
Mentions youth-specific activities	Y	Y	Y	Y		
Local response component	Y		Y			
Ministry component			Y			
Other targeted programs	Y					

Source: World Bank Project Appraisal Documents

The Range of Youth Activities MAP Supports

Given that almost all the project documents address youth issues, it is not surprising that the study found many examples of youth programs. This section summarizes those findings, with special emphasis on the six country case examples.

The study found that support for youth-specific programming is concentrated in the local response and ministry components of MAP projects. All the local response efforts support some degree of youth-oriented activities, and compared with the ministry component, youth programs within the local response component appear to be stronger and more widespread. Support to ministries with a focus on young people include, depending on the country context, Ministries of Education, Health, Youth, Community Development, Science Technology and Vocational Training, and Gender.

Small-scale analyses show that a small yet significant proportion of local response funds go towards youth programming. Table 2 below summarizes information on the volume of and funding for youth projects based on the country case examples as well as on other information the team was able to collect through various sources. Although not comparable across countries and not representative of the total funding amounts per country, these studies show that MAPs are directing some resources towards youth projects. For the samples studied, between 7 percent and 38 percent of projects have a youth focus. Available funding data showed that spending for youth projects ranges from between 9 percent and 54 percent of the total funding within the sample.

Table 2. MAP Support for Youth-focused Civil Society Organizations

Number of projects and funding amounts for civil society organizations through the local response component, by country for various periods.

Projects with a youth focus			Funding for youth		
Country	Number	percent of projects	Amount ($US m)	percent of funding	Sample frame, time period
Burkina Faso	40	7%	n.a.	n.a.	Number of youth-led CBOs formed under the local response component, 2004
Ethiopia	28	n.a.	4.1	54%	National-level CSOs, 2002-2005
Ethiopia	n.a.	n.a.	1.3	16%	Regional-level CSOs, 2002-2005
Malawi	91	37%	0.8	32%	Youth-focused CBOs funded from June 2003-November 2004
Uganda	15	38%	0.15	37%	Local response projects, 1st quarter 2005
Zambia	10	17%	0.07	9%	Local response projects active as March 2005

Source: National AIDS Commissions and World Bank data

These numbers should be interpreted with caution. Definitions of youth and youth-focused activities vary within and across countries. Data is often incomplete. Many projects have youth-specific components as parts of an overall community approach. Other projects that may not be specifically classified as youth-oriented may also benefit young people. For example, many MAPs support programs for OVCs. In Zambia, for example, roughly half of projects supported through the local response component include activities to help OVCs.[13] Moreover, many MAP-supported programs may benefit young people indirectly but not be counted as "youth-specific." For example, programs that help expand VCT services will benefit both older and younger clients, many who fall into the 10 to 24 age group. Similarly, mass media campaigns will reach both older and younger audiences.

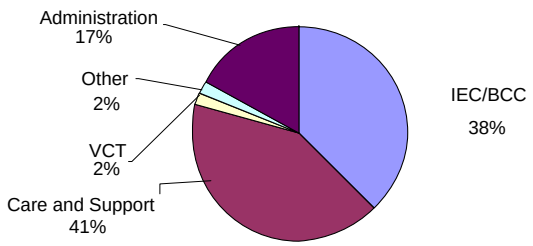
Some MAP projects do include separate and specific components targeting young people. The Burkina Faso MAP, for example, supports counseling centers for youth in two major cities. Other countries with youth-targeted programs include the Gambia, Madagascar, and Senegal.

MAP appears to fund a wide range of youth-specific programming. The local response components fund a variety of efforts from small scale initiatives of community based organization, to regional or national programs carried out by NGOs. Activities range from peer education, behavior change communication, advocacy, life skills training, establishment of youth-friendly health services, social marketing of condoms, and care and support for AIDS-affected persons and their families. In many countries, such as Cape Verde, Cameroon, Ethiopia, and Senegal, youth clubs receive funding for HIV/AIDS prevention. The majority of activities funded under this component are for IEC. For example, in Ethiopia, youth clubs leveraged funding received from MAP to mobilize financing from businesses and provide support to OVCs. Information constraints make it difficult to give a precise breakdown of programs funded, but some information is available. For example, as shown in Figure 2,

[13] For more information on the Bank's work with OVCs, see the *OVC Toolkit for Sub-Saharan Africa* developed in 2005, http://info.worldbank.org/etools/docs/library/108875/toolkit/

MAP funds for youth-specific local response in the Ethiopian capital were equally split between IEC/BCC (behavior change communication) and care and support.

Figure 2. Spending on Youth-Focused Activities, By Component, Addis Ababa HAPCO, 2002-2005



Within public sector entities, the majority of MAP-funded activities have been for internal workshops and sensitization of ministry staff and some support for PLWHA. The study found scattered examples of MAP funds supporting ministries for specific youth-oriented programming aimed at beneficiaries external to the ministry. In Zambia, MAP supports the health ministry to develop youth-friendly health corners in clinic settings. In Ethiopia, MAP is funding the Ministry of Youth to construct 11 youth centers in highly HIV-affected towns. The Ministry of Education in Sierra Leone conducted prevention activities in schools. In Kenya, the Ministry of Education, together with the National AIDS Secretariat, provided AIDS education programs for young people in and out of school, with a special emphasis on young women (15-19 years).

The Effectiveness of Current Youth Efforts

A lack of good evaluation hampers the ability to judge the effectiveness of MAP-financed activities described above.[14] Virtually no rigorous evaluation studies have been carried out of MAP-funded programs that focus on young people. Nonetheless, in many of the countries where MAP operates, other programs have been evaluated from which MAP can learn. Many have found positive impact on key behaviors of young people such as delay of sex, condom use, and partner reduction.[15]

Based on these and many other studies, a consensus is emerging around effective youth and HIV programming.[16] One indirect way to gauge effectiveness is to compare MAP-funded activities with this internationally-accepted good practice list. In Zambia, for example, an analysis found that 82 percent of the youth activities funded through the local response component of MAP are consistent with this good practice list. The study team also attempted to obtain anecdotal information on program effectiveness. In Uganda, 20 of 23 organizations interviewed scored their current efforts as either very effective (5) or effective (15). Informants credited empowerment of young people with life planning skills and school programs particularly, for effectively influencing behavior change. In Ethiopia, the Addis Ababa regional office of the national AIDS commission recently began documenting and disseminating information on some its innovative and promising youth strategies.

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[14] As the recent independent review of the MAP program noted, weak evaluation is a general feature of the MAP and not associated solely with youth-focused programs. Partly this reflects the MAP philosophy of quick disbursement and not waiting for identification and funding of best practices. For more, see World Bank Operations Evaluation Department 2005 and World Bank 2004, *Interim Review of the Multi-Country HIV/AIDS Program for Africa.*

[15] For a recent review of the evidence for policies and program effectiveness to decrease HIV prevalence among young people, see UNAIDS Inter-agency Task Team on Young People, 2006, *Preventing HIV/AIDS in Young People, A systematic review of the evidence from developing countries.*

[16] For a full list of these international good practices, see appendix B.

CONSTRAINTS, OPPORTUNITIES, AND RECOMMENDATIONS

Many informants expressed the view that national HIV/AIDS activities are not doing enough to address youth concerns. In exploring the potential reasons for this perceived gap, several themes emerge related to constraints that limit attention to youth concerns as well as opportunities that present themselves to deepen, improve, and expand on youth-oriented efforts. This section summarizes those key constraints and opportunities in five broad categories: (1) the policy environment; (2) staff expertise and coordination; (3) programming approaches; (4) civil society capacity; and (5) youth involvement. In addition, the section offers recommendations for overcoming the constraints and building on the opportunities.

The Policy Environment

The policy environment is generally supportive of initiatives for young people. The threat posed by the disease has partially helped to overcome taboos on discussion of youth sexuality and helped place youth concerns on the agenda. Currently, most countries in sub-Saharan Africa either have enacted or are in the process of developing national youth policies, almost all of which give specific attention to HIV/AIDS.[17] Such support is further seen in national reproductive health policies, national population policies, and, where they exist, adolescent health policies. Attitudes of key World Bank and government officials are also positive towards youth programming. World Bank, National AIDS Commission (NAC), and other government officials interviewed for this study expressed broad support for placing a specific emphasis on young people in battling the epidemic.

Policy support is not, however, uniform. For example, only a few poverty reduction strategies adequately address youth HIV/AIDS issues.[18] Moreover, in countries such as Sierra Leone the lack of a national policy on adolescent health is an obstacle for action on youth and HIV. Some policies can limit the access to HIV/AIDS services for young people. For example, in Burkina Faso, the national directive adopted in 2003 states that minors (under the age of 18) cannot use VCT services without the specific consent of parents or guardians. Especially for young women in rural areas, such a policy could reduce access to this critical service.

Within this relatively supportive policy context, programming for youth activities has flourished in recent years. Although nongovernmental organizations have generally taken the lead, many government agencies also have initiated HIV programs for young people. Moreover, with the inclusion of religious leaders, faith-based youth and HIV/AIDS efforts have also expanded. Still, linking and systematic coordination of the various policies and interventions for effective programming is not yet well developed.[19]

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[17] See www.youth-policy.com for examples of policies addressing HIV and young people.

[18] A World Bank-UNFPA expert consultation in January 2007 developed a set of draft recommendations to better incorporate youth issues in poverty reduction strategies. Based on these recommendations, an inter-agency resource guide will be developed to implement these recommendations at country level.

[19] World Bank. Assessment, Policy and Institutional Frameworks: Mainstreaming Adolescent Reproductive Health and Gender in HIV/AIDS Programs, Case from Ethiopia and Uganda, (Draft, unpublished, Dec. 2006).

Recommendations to enhance the policy environment

Build on the positive policy environment. The Bank has a comparative advantage in its ability to influence the overall policy environment for youth and HIV. Bank staff and government counterparts can continue to push for strengthening the youth focus of existing national policies and plans and for developing such policies where they do not yet exist. For example, Bank staff can encourage governments to tap into the AIDS Strategy and Action Plan (ASAP), a global technical assistance service that helps countries develop well-prioritized, evidence-based, results-focused, costed national AIDS strategies and action plans, which can strengthen the youth focus of such national AIDS strategy and plans.[20] The Bank and other partners should also pay special attention to ensuring that poverty reduction strategies adequately address HIV/AIDS and other youth issues.[21] Just as important is the need for supporting effective implementation of policies through support for strategic planning, continued high-level political backing, provision of adequate budget support, and systematically aligning the programs of key sectors and stakeholders.

Staff Expertise and Coordination

Despite the generally positive policy environment, there is inadequate expertise to properly address youth programming. Furthermore, knowledge on youth issues at regional and district-levels is often lacking. An exception is in Malawi, where Youth Technical Sub-Committees have worked for over a decade as part of District AIDS Coordinating Committees. Another positive example is in Cape Verde, where the Vice-President of the National AIDS Secretariat is also the Secretary of State for Youth, facilitating stronger youth efforts.

Coordination on youth and HIV/AIDS is weak. While MAP projects may support youth-related activities through their different components, neither the PAD nor the NACs have an overall coordinated strategy for youth and HIV/AIDS. No single entity has responsibility for national-level coordination on HIV and youth matters. In part, this reflects lack of effective youth representation. Even in countries such as Malawi, where the NAC has assigned clear coordination responsibility on HIV and youth matters to the quasi-governmental National Youth Council, in practice communication and coordination among stakeholders has been lacking. Due to the general lack of a coordinated youth strategy within NACs, programs of different ministries are in general also not coordinated.

Many donors are providing considerable financial and technical assistance to youth HIV/AIDS efforts but their coordination is also insufficient. Important partners include multilateral organizations such as the Global Fund for AIDS, TB, and Malaria (GFATM), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF), and bilateral donors such as USAID. In most countries, little coordination exists between MAP-supported activities and the youth HIV/AIDS activities of other donors. While all international partners recognize the need for and potential benefits of greater coordination, they also acknowledge

[20] More information on ASAP is available at www.worldbank.org/hiv.
[21] See World Bank and UNFPA, 2007 (draft), Expert Consultation on Young People in Poverty Reduction Strategies: Investing in the Next Generation, January 24-26, 2007, Key Recommendations and Action Plan.

that time and resource constraints limit coordination. The donor community has recognized the lack of coordination between multinational and international institutions as a general weakness.[22]

Recommendations to improve staff expertise and coordination

Ensure NACs have youth expertise. A step towards better coordination and improved effectiveness would be to ensure that the national AIDS coordinating authority has staff expertise on youth matters. Regional and local levels should ideally also have such expertise. To leverage the limited resources from NACs, governments should assign specific tasks to national and regional youth networks, and organizations that focus on services for young people, including UNFPA and UNICEF, bilateral donors such as USAID, and international NGOs.

NACs should improve coordination of youth HIV/AIDS activities among different ministries, partners, and key stakeholders. To improve the effectiveness of programming, the NACs should coordinate youth activities with other adolescent reproductive health and youth development issues and require coordination among key ministries such as health, education, and youth. One such collaboration model in Mozambique has strengthened the provision of youth reproductive health and HIV/AIDS services throughout the country. MAP should also push for coordination not only at the national level, but also at the regional and local levels, where more and more funding decisions occur. Better coordination would also help to harmonize existing youth materials and other approaches such as peer education and school-based HIV/AIDS curricula. To achieve successful coordination, involvement of youth networks, other donors and NGOs working on youth, is crucial.

NACs should improve coordination with other donors through strengthened partnerships. The Global Task Team (GTT) on improving donor coordination recommended that UNAIDS Cosponsors and the Global Fund establish a more functional and clearer division of labor, based upon their comparative advantages and complementarities (UNAIDS 2005). The GTT recommended that UNFPA should be the lead organization on youth, while UNESCO has lead responsibility for prevention among young people in education institutions. In line with these recommendations, the NAS should build better coordination and partnerships among the different donors working with youth ensuring, among others, to benefit from respective expertise from organization such as UNICEF. This is also a key principle of the World Bank's Global HIV/AIDS Program for Action. UNICEF, for example, has developed in many countries life skills curricula for in- and out-of-school youth for HIV/AIDS prevention but often lacks the funding for scaling-up. Resources from MAP could be used for scaling-up the implementation and use of these life skills curricula.

Strengthen expertise on youth issues at all levels. A further step towards better coordination and improved effectiveness would be encouraging national, regional, and local AIDS councils and coordinating committees to include representatives with expertise on youth matters. Such experts could also work within the umbrella organizations that provide technical assistance to community groups and would

[22] At the "The Global Response to AIDS: 'Making the Money Work', The Three Ones in Action" meeting, held in London on 9 March 2005, leaders from donor and developing country governments, civil society, UN agencies and other multilateral and international institutions met in London, and agreed to form a Global Task Team on improving coordination among multilateral institutions and international donors to further strengthen the AIDS response in countries. Participants asked the Global Task Team to develop a set of recommendations for improving the institutional architecture of the response to HIV/AIDS.

help to coordinate, strengthen current programs, and act as a technical resource for youth-serving groups.

Enhance funding mechanisms and cash flow. Any future MAP or related program should make clear reference to practical ways of attracting projects and sub-grantees that focus on young people. Existing eligibility requirements for MAP funds exclude the bulk of anti-AIDS youth associations and anti-AIDS clubs because they are not registered, lack bank accounts, etc. Even registered youth organizations have received nominal amounts of funding. Governments should facilitate granting of legal status to potentially good youth clubs, raising the funding ceiling approved for youth NGOs, and proportionately earmarking funds that should go to these NGOs, while putting mechanisms in place to ensure program quality. Small clubs and non-registered associations should receive help to attach themselves to larger, registered NGOs or community structures, in addition to help upgrading themselves into registered associations. This could also facilitate capacity building of small youth groups by the larger youth serving organizations. At the same time, MAPs could disburse funds more quickly.

Programming Approaches

Although the study documented a range of program strategies, it was apparent that gaps remain. One important reason is that in the early MAPs, most public sector entities focused HIV activities on their civil servants, not on actions aimed at the beneficiaries of ministry programs.[23] For example, in Burkina Faso, the majority of resources for line ministries covered per diems and transport costs for civil servant workshops. By contrast, in Cape Verde and Sierra Leone, the Ministry of Youth and Sports carries out programs to reach beneficiaries. In Cape Verde, youth centers at the district level are venues for condom distribution. While Ministries of Education, through avenues such as curriculum development, have the capacity to address youth prevention issues on a large scale, in many countries these efforts are limited in scope and quality. More recently, MAP has begun to reorient its support to ministries, aiming to support four to five of the most pro-active ministries, and to increase activities for the beneficiaries of ministries. This change could potentially increase the direct support that MAPs provide to youth.

Another constraint has been the weak link between HIV/AIDS and broader youth reproductive health concerns. While many countries were carrying out reproductive health programs for adolescents before MAP, in most countries linkages between current HIV/AIDS and reproductive health strategies are limited. Young people interviewed in several countries mentioned that learning about HIV/AIDS when one does not understand the fundamentals of reproductive health and sexuality is very difficult.

The limited duration of many youth activities also hampers their effectiveness. Often, they consist of one or two sensitization activities, such as workshops, theater, etc. In addition, training of peer educators is often through short-term projects, with very little systematic follow up and continuous technical support to strengthen HIV/AIDS-related messages. As mentioned by some civil servants during field visits to Burkina Faso and Sierra Leone, knowing about the disease and being able to

[23] Transport and education ministries have been the exception in some countries.

transmit the message to others is a very different matter. Due to inadequate technical assistance, the majority of activities focus on sensitization.

Coordination of prevention messages is likewise insufficient, and message quality needs strengthening. In countries such as Burkina Faso and Sierra Leone, different ministries, international donors, and national and international NGOs often develop their own prevention materials for young people, with varying degrees of quality. Besides, agencies often develop overall messages without distinguishing between urban and rural areas, different ages and genders, in-school and out-of-school youth, marital status, and other key groups.

In many countries, the majority of projects, including those funded by MAP, remain urban focused and thus shortchange rural youth. While infection rates are generally lower in rural than urban areas,[24] rural youth have relatively little access to HIV/AIDS information and services, in part because of service and language barriers. For example, a recent evaluation of IEC programs in Uganda reported that both rural youth and youth in difficult circumstances (i.e., street youth, youth in conflict situations, and youth from poor families) benefited little from HIV initiatives.

HIV/AIDS activities do not sufficiently mainstream gender concerns. Young women and men face different constraints to practice healthy reproductive and sexual health behavior, due to their differentiated social roles and responsibilities in society. However, most youth programming makes no distinction between boys and girls in their messages and strategies. A few CSO projects are directed at young women, but very few specific programs exist for young men—especially those not in school.[25]

Recommendations to improve programming approaches

Increase the external focus of public sector entities for HIV/AIDS activities. In a process already underway, in particular ministries of health, education, agriculture, labor, and youth should explore strategies to reach their beneficiaries outside of the ministries.

Emphasize prevention within the new focus on care and treatment.[26] Although young people have a role in care and treatment, they are also the focal point for new infections and thus youth-oriented efforts must concentrate on prevention. Even in the highest prevalence countries, most people are uninfected and need the information and means to stay so. Prevention should include strengthening HIV education in school systems. Especially in rural areas, teachers are an important, and sometimes the only, source of information for reproductive and sexual health. School programs should link and coordinate with ongoing out-of-school programs (usually peer education). On the other hand, existing IEC programs should also be channels for information on ongoing and future planned care and treatment programs.

[24] In Ethiopia, recent surveillance reports suggest infection rates are stabilizing in cities but increasing in rural areas.
[25] For an overview on gender and HIV/AIDS, see World Bank, 2004, *Integrating Gender Issues into HIV/AIDS Programs: An Operational Guide,* http://www.worldbank.org/afr/aids/map/Gender_and_HIV-AIDS_Guide_Nov-04.pdf?
[26] Many recent international policy documents support greater emphasis on prevention. See for example, World Bank, *Global HIV/AIDS Program of Action,* December 2005; UNAIDS, 2005, *Report on the Global HIV epidemic, December 2005*; and UNAIDS, 2005, *Intensifying HIV prevention policy position paper*, August 2005.

Ensure that MAP supports evidence-based, results-focused programming. As the international evidence base grows for effective youth programming, MAP-supported efforts should incorporate these findings into their policies, ensuring that money is well-spent on proven or—at the very least—promising approaches. MAP should stress support for programs that aim for sustained behavior change among young people and for longer-term, multi-pronged programs.

Strengthen the community involvement element of youth and HIV/AIDS programming. Community involvement is an important element of any program, but is particularly important for youth programming. Parents and other influential adults often serve as gatekeepers who can determine whether young people receive adequate services. MAP should encourage that the community involvement process be deepened and strengthened to appropriately and systematically include parents, teachers, and religious and traditional leaders in youth programs. A survey in Sierra Leone, for example, found that 97 percent of young people listen to religious sermons.

Expand targeted programs for difficult to reach youth such as sex workers (including male sex tourism workers such as in the Gambia), young married women, domestic workers, out-of-school youth working in the informal sector such as young females working in markets, and out-of-school youth in rural areas.

Harmonize existing youth HIV/AIDS materials. Countries should inventory existing materials and, after identifying the best materials, encourage their consistent use. At the same time, countries should improve the quality of materials to ensure differentiated messages according to age, gender, geographical areas, local languages, religion, etc. The materials should also build upon and, where appropriate, be integrated with existing adolescent reproductive health materials.

Capacity of Civil Society Organizations

Efficient use of funds for the local response component requires that civil society organizations have the capacity to tap into and effectively use MAP funds. Currently, however, the capacity of youth-serving organizations to tap into MAP funding is very limited. Almost universally, technical and human resource capacity gaps exist in community organizations and local NGOs. Such gaps are even more pronounced everywhere among youth-focused groups. Important reasons hampering the ability of youth groups to tap into MAP funding include complicated application forms, insufficient capacity in basic proposal writing, and delays in selection of projects and access to allocated resources by the national AIDS secretariats. Additionally, officials in some countries are concerned about the quality of projects and thus are reluctant to fund many of the youth-oriented groups that, while innovative, lack a record of accomplishment and thus credibility.

Moreover, the quality of NGOs and CBOs working with young people varies widely. NGO specialties can change often, depending on availability of resources. For larger-scale projects, a distinction has to be made between short-term and long-term NGOs as implementers. Although many of the larger, well-established groups need greater organizational and technical capacity, capacity needs are the greatest among the small community youth groups and associations.

Recommendations to address capacity gaps

Boost the capacity of youth-serving CSOs. Priority capacity needs include strengthening proposal writing skills to tap into World Bank and other funding, better leadership and management, improved and continuous training for peer educators, training for youth-friendly VCT, and capacity building for evaluation and monitoring by CSOs themselves. Existing governmental or nongovernmental organizations or strengthened youth associations could carry out capacity building. In the Madagascar MAP project, for example, a consortium of three international NGOs provided technical support to the NGOs or CBOs that submitted sub-project proposals under US$ 25,000. In Cape Verde, consultants provided technical assistance to CBOs and NGOs to strengthen their proposals for MAP funding.[27] Furthermore, local response management units should make a special effort to inform youth-serving CSOs, especially in more remote areas, about the availability of funding.

Make it easier for youth groups to access funds while maintaining and improving quality through support of youth networks and consortiums. Local response management units should publicize the availability of funding to youth-serving CSOs. MAPs should facilitate accessing of grants for smaller organizations implementing youth and HIV activities through the support of youth networks and consortiums. Small clubs and non-registered associations should then be able to receive support from the larger, registered NGOs.

Youth Involvement

Meaningful involvement of young people is important to effective programming. This study found that youth representation on policymaking bodies is improving but still inadequate. Countries are moving slowly towards greater and more meaningful youth involvement but are still a long way from adequate levels of involvement of young people. Most countries include a young person to represent the country's youth organizations on national-level policymaking bodies. In Burkina Faso, for example, the Reseau Africain des Jeunes contre le Sida Burkina Faso (RAJS/BF, African Youth Network Against AIDS), created to help coordinate and strengthen activities of youth associations, advises the National AIDS Secretariat. However, key informants interviewed for this study feel that often these individuals are not effective alone as advocates. In Uganda, for example, youth representation on the AIDS Commission is seen as inadequate.

The experience with youth involvement in programming is similarly mixed. Young people generally decry their lack of involvement in program design, implementation and monitoring and evaluation. This is particularly the case for "traditional" ministry programs and for large nongovernmental organizations. On the other hand, examples abound of organizations struggling to meaningfully involve young people. For example, the Family Planning Association of Uganda has youth-specific, youth-led activities in its portfolio.

Recommendations to improve youth involvement

Improve youth representation and involvement. More youth representation on governance bodies in youth-serving organizations and at the intermediary and national levels is essential. The selection processes

[27] Average response time to proposals from small NGOS and CBOs is only 2-3 days.

for youth representatives should be transparent. Such representation should rotate among young people and organizations to maintain fresh perspectives and give voice to a range of youth-serving groups, also enhancing capacity of the participating groups. The NACs should also emphasize youth participation in programming, needs assessment, planning and monitoring and evaluation.

Strengthen youth networks. MAP should also help build the capacity of youth-serving organizations and youth groups to network and advocate for carrying out existing policies. Better networking would also improve coordination and access to funds. MAP should support youth-serving CSOs to share experiences through site visits and other information exchanges with the goal of developing regional and national learning networks.

Monitoring and Evaluation

As noted in the discussion of effectiveness above, monitoring and evaluation of MAP-funded youth programs is weak. While many MAPs include some specific youth indicators, baseline data and ongoing collection of indicators is missing. Besides, very few MAPs specifically evaluate the impact of youth HIV/AIDS activities.

Recommendations to improve monitoring and evaluation

Include consistent youth-specific indicators for monitoring and evaluation in the national M & E framework and MAP project indicators. MAP projects should include consistent youth-specific impact indicators, drawing on internationally accepted lists such as those produced by UNAIDS and the Inter-agency Task Team on Youth and HIV/AIDS.[28] Monitoring systems should disaggregate indicators by age, gender and by urban or rural location. At the community level, projects should develop simplified indicators that the communities themselves can collect. Given the new strategy of one overall national monitoring and evaluation system as part of the Three Ones Principles, these indicators could be collected for overall youth programs, and not only limited to MAP. The Global HIV/AIDS Monitoring and Evaluation Team (GAMET) of the Bank could provide the necessary support to the NACs, which would also be in line with the World Bank's new Global HIV/AIDS Program of Action.

Improve tracking of youth-oriented activities. Information systems within countries should allow tracking of youth-oriented programs, types of projects, and funding amounts. MAP should aim to make such reporting as consistent as possible across countries, in accordance with national needs.

Integrate impact evaluations of youth HIV/AIDS programs in program design. MAP projects should support more in-depth evaluation of youth-specific approaches and consider investing in more rigorous randomized trials of common yet under-evaluated strategies such as peer education. MAP should try to collaborate with the research arm of the Bank to carry out selected evaluations. Projects should plan impact evaluations at the beginning phase, and the technical capacity of NACs should be strengthened to measure program impact. Program officials and researchers should share evaluation findings inside and outside of the country.

[28] For an overview of indicators for youth, see WHO, 2004, *National AIDS Programmes: A Guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people.*

CONCLUSIONS

Young men and women are clearly important to halting to spread of HIV/AIDS. The study set out to examine the experience of MAP in addressing the youth dimension of the epidemic. Very little systematic information existed about how the World Bank, one of the major financial supporters of HIV/AIDS programs in developing countries, was attending to this key risk group. This study is one step towards providing greater understanding of efforts to date and of identifying specific actions the Bank can take to enhance the effectiveness of its investments in this critical area of development.

At least at the planning stage, young people are a priority of World Bank and government officials. Almost all MAP Project Appraisal Documents identify young people as a key target group, and many include project impact indicators that are youth-specific. The PADs make less mention, however, of specific youth activities and rarely put forth a coordinated approach to youth issues. This attention to youth in planning documents reflects to some extent the generally positive policy environment and the recognition by government and World Bank officials of the importance of dealing the needs of the younger generation.

The study found that most of the actual implementation of youth programming in MAP projects is through the local response component, with more scattered initiatives occurring within the ministry component and a few projects aimed directly at young people. This imbalance reflects in part the inward focus of the activities supported under the ministry component of MAP. Although getting an accurate gauge on numbers of youth-oriented projects and levels of funding is difficult because of poor data, it is clear that all MAPs studied in-depth for this study are providing at least a small level of support for youth initiatives. While again data limitations make it difficult to give a precise breakdown, it is clear that MAP supports a wide range of youth strategies. Because of the target group, the majority emphasize disease prevention, including information, services, and mitigating factors that may raise the risk of infection, such as poverty and unemployment.

The effectiveness of the youth programs in terms of changing youth behaviors, preventing new infections, and caring for those already affected by this affliction is an important question, but one that needs much further exploration. Direct evaluation of MAP-supported activities of all types is rare. Most youth-focused, MAP-funded programs fall within international good practice guidelines, thus providing an indirect yet insufficient measure of effectiveness. In contrast, the study uncovered several weaknesses in current programming that may undermine effectiveness, including poor links with broader reproductive health concerns, short duration of activities, lack of coordination, and a lack of attention to rural youth and to gender concerns.

Moreover, the number and quality of youth-oriented programs may be hampered by serious gaps in the capacity of civil society organizations, lack of meaningful youth involvement at all stages or policy and programming, and poor coordination with other donors, and among youth-serving organizations. Encouragingly, although serious gaps are present in all these areas, the trends appear to be moving in the right direction.

The World Bank should work with its partners in government and civil society to ensure that each country is adequately addressing the youth dimension of the epidemic in a way that is appropriate to the particular country setting and to the stage of the epidemic. Recommendations from this study will feed into in-depth guidelines currently being prepared for staff from the Bank and counterparts in national HIV/AIDS efforts.

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APPENDIX A. COUNTRY CASE EXAMPLES

Methodology

This appendix summarizes findings from in-depth studies carried out in six countries: Burkina Faso, Ethiopia, Malawi, Sierra Leone, Uganda, and Zambia. The study team developed common country assessment tools and reviewed relevant background documents. Bank staff and international consultants, in conjunction with local consultants contracted in each country (except Malawi), analyzed project documents, interviewed policy makers and staff members of key organizations, carried out site visits of MAP-funded activities, conducted roundtable discussion with key informants, and organized focus group discussions with youth and community leaders and other stakeholders. Each assessment was carried out under the guidance of an in-country technical committee that included representatives from the national AIDS council, the World Bank country office, and other stakeholder groups. Each case example describes the situation of HIV and youth in the country, the policy and program environment, how the MAP project is addressing youth, constraints and opportunities, and areas for improvement.

Case Example: Burkina Faso 32
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Case Example: Burkina Faso

Country and Project Context

Almost two thirds of Burkina Faso's young, poorly educated, and largely rural population lives below the poverty line (see Box).[29] Girls on average have their first sexual experience and marry at a young age, thus exposing them to risk of HIV infection. Results from the Demographic and Health Survey (DHS) carried out in 2003 showed an adult prevalence rate of 2 percent. Urban rates are significantly higher than rural rates; prevalence rates increase with income and education level; and are higher for people living in monogamy than polygamy.[30] Young women are at a greater risk of contracting HIV and are infected at younger ages than men are. According to DHS 2003 data, prevalence rates for females aged 20-24 are three times higher than for males aged 20-24 (1.8 percent compared to 0.6 percent). Especially in rural areas, young females tend to marry men much older. Young, married women are less mobile, have more limited social networks, and tend to end schooling earlier than unmarried women.[31] An additional challenge is relatively high rates of illegal abortions. According to a study in the three largest cities of the country, 28 percent of young women between 10-25 years old have had an abortion, and 42 percent among them know a friend who has had an abortion.[32]

HIV & Youth in Burkina Faso

Total population, all ages	13.6 million
Rural population	84%
Population ages 10-24	34%
Gross national income in purchasing power parity (GNI PPP) per person	$1,220
Human Development Index rank	175
Adult HIV/AIDS prevalence	2%
Youth HIV/AIDS prevalence rates (M/F)	0.5/1.4%
AIDS Orphans	120,000
HIV Prevention Knowledge (M/F)	23/15%
Condom Use for high-risk sex (M/F)	67/54%
Teen birth rate	159 per 1000
Child death rate	192 per 1000
Secondary school enrollment (M/F)	14/9%
Single, sexually active women 15-19 using modern contraception	47.0%
Median age at first intercourse (M/F)	20.7/17.5 years
Median age at first marriage (M/F)	25.5/17.7 years

Data for 2001-2005 period. See note for definitions and sources

In 2001, the Board of the World Bank approved the Burkina Faso HIV/AIDS Disaster Response Project for US$ 22 million. The main objectives of the project are to: (1) lower the risk of HIV transmission, (2) strengthen the capacity to provide care and treatment to HIV infected/affected persons, and (3) help mitigate the socioeconomic impact of the disease on affected households and communities. The project includes four components: (1) support for multi-sectoral response, including financing Action Plans for government ministries, (2) support for provincial activities and community micro-projects in 13 provinces (out of 45), (3) support of targeted programs for vulnerable groups (e.g. youth, women of reproductive age, commercial sex workers, prisoners, truck drivers, migrant workers) through NGOs, and (4) project coordination, monitoring and evaluation. The Bank approved a supplemental grant for US$ 5 million in May 2005 to ensure continued funding for NGOs to carry out

[29] United Nations, World Youth Report 2003: The Global Situation of Young People.
[30] Demographic Health Survey of 2003, Burkina Faso.
[31] Population Council, Addressing the Needs of Married Adolescent Girls in Burkina Faso, Brief no.9, May 2005
[32] Yaro Yacouba, Sankara Augustin, Analyse Situationnelle des Programmes de Sante Sexuelle et de Lutte contre le VIH/SIDA centres sur la Jeunesse au Burkina Faso, August 2005, background report prepared for the World Bank.

targeted programs, including counseling centers for youth and HIV awareness raising and counseling for pregnant women.[33] In 2006, the Bank approved the *Health Sector Support and Multisectoral AIDS Project* for US$ 33 million. Component B will support the National HIV/AIDS strategy through a pooled fund at the National AIDS council to: (i) improve knowledge of HIV prevention and encourage adoption of lower risk behaviors, among high-risk groups including youth as well as the general population; and (ii) mitigate the socio-economic consequences of the AIDS epidemic through improved coverage of social safety nets.[34]

Existing Policies and Programs On Youth and HIV

The policy environment for HIV and youth in Burkina Faso is relatively well developed. In 1995, the country launched the National Adolescent Reproductive Health Program as part of its 1998-2008 Strategic Plan for Reproductive Health. The first five-year phase of the National Adolescent Reproductive Health Program (1998-2002) aimed to provide reproductive health services including family planning, diagnose and treat sexually transmitted infections (STIs) and HIV/AIDS for 10 to 24-year-olds, and provide IEC and counseling services including sexuality and family life education.[35] The revised National Population Policy of 2000 recognized the specific needs of young people and included an objective to provide integrated youth reproductive health services. The National AIDS Secretariat (NAS) is currently developing the next Strategic HIV/AIDS Plan for 2006-2010. The president of the NAS has emphasized youth involvement in developing the plan and the inclusion of actions specific to young people.

Through a variety of national and international NGOs, a range of youth HIV/AIDS activities have been carried out, including development of IEC materials, mass communication,[36] peer education and outreach, social marketing of condoms,[37] and youth-friendly health clinics. The majority of activities have focused on IEC. The Association Burkinabé pour le Bien-Etre Familial (ABBEF, Burkina Association for Family Well-Being) for example has played a pioneering role in operating youth centers that contain full service health clinics. ABBEF operates a peer education program for reproductive health concerns including HIV/AIDS prevention with in- and out-of-school youth through *centres d'écoutes*, youth-friendly reproductive health centers. Peer educators provide information and distribute contraceptives at events such as debates and theater. A specially trained teacher supervises the peer educators and meets with them at least once a month. The centers refer young men and women for VCT to other clinics. ABBEF currently operates four such centers, in Ouagadougou, Bobo-Dioulasso, Koudougou, and Koupéla.

The creation of the Réseau Africain des Jeunes contre le Sida Burkina Faso (RAJS/BF, African Youth Network against AIDS Burkina Faso) in 2001 helped to coordinate and strengthen activities of youth associations and youth clubs. The RAJS/BF represents more than 270 youth associations in 41 of the country's 45 provinces. Through advocacy, peer education, and condom distribution, RAJS/BF contributes to the fight against HIV/AIDS. Their program strategy focuses on youth clubs assisted by

[33] World Bank, 2005, *Burkina Faso HIV/AIDS Disaster Response Project, Supplemental Grant Document.*
[34] World Bank, 2006, *Burkina Faso Health Sector Support and Multisectoral AIDS Project*, Project Appraisal Document.
[35] Guiella, Georges, *Santé Sexuelle et de la Reproduction des Jeunes au Burkina Faso: Un Etat de Lieux*, Alan Guttmacher Institute, Occasional Report 12, May 2004. The Ministry of Health, through its *Direction de la Santé de la Famille (DSF),* is responsible for implementation.
[36] Media campaigns include NAC's "It's My Life" and "Marcelline and Jojo" by Family Health International.
[37] The most important social marketing effort is the *Project de Marketing Social des Condoms, PROMACO*, carried out with the support of Population Services International. Begun in 1994, the project is an integral part of Burkina's AIDS reduction policy.

a team of two peer educators per club, with five different clubs according to age (from 5-30). RAJS/BF has formed over 1500 such clubs in schools. They collaborated with UNICEF to use the life skills development manual developed by UNICEF for their peer education program. They work with different ministries, NAS, UNFPA, UNAIDS, UNICEF, Africare, Associational and Community Support Program (PAMAC), and Plan International. RAJS/BF has also contributed to the development of the 2006-2010 strategic HIV/AIDS plan.[38]

How MAP is Addressing Youth

How the Project Appraisal Document (PAD) addresses youth. The PAD of MAP recognizes young people, and especially young females, as one of the vulnerable groups that require special attention. To promote behavior change the document mentions the importance of messages from peers and family members, and the combination of preventive messages and condom promotion accompanied by genuine changes in gender dynamics. The Community HIV/AIDS Sub-Projects supports activities such as IEC, peer education and condom promotion and income generation to assist affected families and to empower women economically. The Targeted Intervention component funds NGOs with specialized, proven expertise to carry out activities for different vulnerable groups, including for youth.

Support through government ministries. Most MAP activities under the different ministries of MAP had an internal focus, funding mainly sensitization, training and care and treatment of ministry staff. The majority of resources covered per diem and transport costs for workshops.

Support for provincial and village level HIV/AIDS activities. In 2004, the project financed awareness raising and community care micro-projects in over 3500 villages, covering up to 40 percent of the rural population. Village micro-plans have tended to prioritize awareness raising more than care and support.[39] Of the 600 CBOs the project supported, about 40 were youth led.

Support through Targeted Interventions. The NGO Fondation pour le Développement Communautaire (FDC-Foundation for Community Development) carried out two targeted efforts for young people. The first established counseling centers for youth in the major cities of Ouagadougou and Bobo. The second supported the National Policy on Prevention of Mother to Child HIV Transmission of the Ministry of Health in two districts (Ouahigouya and Kaya), serving young women from 15 to 24 years old and pregnant women. The objectives were to reduce the infection rates of young women and to prevent mother to child transmission through, among others, peer education, mass communication, and VCT services. Together, the programs received about US$ 500,000 in MAP funding.

[38] A recent external review of RAJS/BF found that while the organization needs technical assistance to strengthen the impact of their HIV/AIDS activities, they are a good mechanism to reach youth throughout the country. See Naré, Christine and Compaoré, Cyrille, Evaluation Externe du Réseau Africain des Jeunes Contre le SIDA du Burkina Faso (RAJS/BF), May 2005.
[39] World Bank, 2005, *Burkina Faso HIV/AIDS Disaster Response Project, Supplemental Grant Document.*

How the follow-up project (Component B of the Health Sector Support and Multisectoral AIDS Project) addresses youth. The project recognizes again youth as one of the vulnerable groups requiring special attention. On of the key indicators of the project is the percentage of young adults (age15-24) who report having used a condom during their previous sex with a non-regular partner. Youth will be supported through, among others, HIV prevention programs through NGOs and CBOs, VTC services, improved behavior change communication, and strengthening HIV/AIDS and reproductive health programs for in-and out-of-school youth.

Table A.1. Youth and HIV/AIDS Knowledge and Behavior in Burkina Faso

Percent of males and females 15-24 with specific HIV/AIDS-related knowledge and percent practicing specific risk behaviors, Burkina Faso 2003.

Knowledge or Behavior	M/F
Youth who have heard about HIV	94/94
Knowledge of prevention methods	
Condoms	61/49
Only sexual relationship with one, non-infected partner	66/60
Know of the possibility of mother to child transmission of HIV	40/46
Know a healthy looking person can have HIV	61/56
Know HIV can not be transmitted by mosquito bites	38/30
Reported high-risk sex in the last year with a non-marital and non-cohabiting partner	78/23
Used condom the last time they had higher risk sex, of those who had high-risk sex in the last year	67/54
Urban	91/66
Rural	52/35
Know a place to obtain condoms	
15-19 years	63/44
20-24 years	83/50
Rural	63/35
Urban	94/78
Poorest quintile	53/19
Richest quintile	94/76

Source: Burkina Faso DHS 2003.

The HIV support through ministries under the new project refocused from general awareness towards encouraging VCT, strengthening care and support for infected and affected civil servants and families, and integrating HIV/AIDS into core activities of the ministries. Strengthening HIV/AIDS programs for youth in and out of school will be a major priority, in coordination with UNICEF and UNFPA, with co-financing for school health activities through the World Bank education project.

Evaluation of youth efforts in Burkina is generally weak. Most youth-serving organizations lack the capacity and resources to carry out rigorous evaluations. However, a number of projects have undergone such evaluation, including the Community Participation Project to Improve Adolescent Reproductive and Sexual Health,[40] Project de Marketing Social des Condoms, (PROMACO 1-Social Marketing of Condoms), the Multimedia campaign on reproductive health carried out under the MAP program,[41] the programs of UNFPA, ABBEF and RAJS-BF, and an evaluation of the targeted activities for young people implemented by FDC under the MAP program. Lessons learned from the latter include, among others, (a) the need start youth focused interventions at age 12 instead of 15, (b) the need to strengthen the collaboration with the education system for NGOs implementing youth focused HIV/AIDS activities for in-school youth, and (c) the need to include a gender approach in youth HIV/AIDS prevention efforts.[42] While the contracting approach with large NGOs has helped to reach high-risk

[40]This four-year project, completed in 2002, trained three youth organizations to engage community members in identifying priorities and developing and implementing community-based programs. For more information, see Advocates for Youth, www.advocatesforyouth.org/about/burkina.htm

[41] Evalution de l'impact de la campagne multimédia de sensibilisation sur la santé de la reproduction, Ministère de l'Economie et des Finances, Project Population et Lutte contre le SIDA (PPLS), September 2001

[42] CERAC, Inc, *Évaluation des performances et appréciation des résultats des interventions ciblées exécutées par les organisations non gouvernementales et les associations*, Mai 2006

and vulnerable groups, geographic coverage needs to be increased while reducing administrative costs.[43]

In general, most evaluations have been limited to process evaluations that provide little information about behavioral impact. One evaluation of a program supported by Advocates for Youth showed that behavior change occurs when HIV/AIDS prevention is continuous, combines IEC with access to condoms and youth-friendly services, and involves local communities.[44] Sustainability and cost effectiveness are continuous challenges for most HIV/AIDS youth projects.

*Despite the many HIV/AIDS activities for youth, levels of adequate knowledge are still relatively low and the level of risky sexual behavior remains high (*Table A.1*).* While 94 percent of both male and female youth have heard about the disease, many misconceptions remain. For example, only 49 percent of young females and 61 percent of young males know that condoms can protect against transmission and 30 percent of females and 38 percent of males know that mosquito bites cannot transmit HIV. Given that many girls marry and bear children young, of particular concern is that only 46 percent of young women know that mothers can transmit the virus to their children. Of those who reported high-risk sex over the last year (23 percent for young females versus 78 for young males), only 54 percent of females and 67 percent of males used a condom. Especially in rural areas, condom use remains low for both males and females.

Complementary Role of Other Bank-funded Efforts and Other International Partners

The two Ministries of Education (Ministry of Basic Education, MEBA, and Ministry of Secondary and Higher Education and Scientific Research, MESSRS) participate in the World Bank's Accelerate the Education Sector Response to HIV/AIDS Initiative.[45] The education ministries have focused mainly on internal mainstreaming of HIV/AIDS and have paid little attention to external mainstreaming of HIV/AIDS throughout the education cycle. The existing HIV/AIDS activities in the school system are uncoordinated pilot projects conducted by NGOs using a variety of tools. As a follow-up to an April 2005 workshop, the World Bank recommended that the education ministries: (1) harmonize materials used in primary and secondary schools; (2) roll out prevention education in schools; (3) introduce HIV/AIDS in the training curricula of the vocational and professional training centers for teachers; and (4) increase coordination with NGOs to carry out peer education for in-school and out-of-school youth.[46] MAP does not have sufficient resources to fund these strategies in their entirety. Other possible funding sources include the World Bank Basic Education Sector project and the Education for All Fast Track Initiative.

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[43] World Bank, 2006, *Burkina Faso Health Sector Support and Multisectoral AIDS Project*, Project Appraisal Document

[44] Advocates for Youth, Youth and their Communities Take Charge to Improve Youth Reproductive and Sexual Health in Burkina Faso, http://www.advocatesforyouth.org/about/burkinafaso/summary_eng.htm

[45] This initiative is a multi-partner effort, involving countries, development partners, civil society, and the private sector, which aims to promote better understanding, stronger leadership, and more effective national responses at all levels of the education sector. This effort aims to strengthen the capacity of the education sector to respond with timely actions to prevent HIV infection in learners and teachers. Part of the work of the initiative is to organize demand-driven sub-regional and national workshops.

[46] Back to Office report, Mission of Education Working Group, 18-23 April 2005.

Burkina Faso is one of the pilot countries participating in the Regional HIV/AIDS Treatment Acceleration Project (TAP),[47] whose primary goal is to pilot strategies for strengthening capacity to scale up comprehensive programs providing care and treatment, which is effective, affordable, and equitable. Some of the implementation partners of the NAS have extensive experience working with youth, such as *Association Laafe La Viim (ALAVI)* and *Associations des Jeunes pour la Promotion des Orphelins (AJPS)*. As part of the TAP, the United Nations Economic Commission for Africa will conduct research to enhance project results. The research agenda will include youth concerns. The *Health Sector Support and Multisectoral AIDS project* will continue financing to NGOs and the private sector for treatment after the close of the TAP program.

Other international partners include UNICEF,[48] UNFPA, the Global Fund for AIDS, TB and Malaria,[49] UNDP, and a variety of bilateral donors. UNFPA has made improving sexual and reproductive health rights of young people a central goal since the early 1990s. UNFPA has supported policy development, development of IEC materials, and condom distribution.[50] UNICEF helped develop a life skills manual for peer educators that covers HIV/AIDS prevention. UNDP is supporting a pilot program integrating education, HIV/AIDS, and new information and communication techniques in schools.[51] Nonetheless, donor coordination is lacking.

Constraints and Opportunities

While the government clearly recognizes the importance of youth initiatives, coordination and quality of activities is lacking. As reflected in government policies, the strong support by the leadership of NAS, and some specific emphasis on youth in the World Bank project documents of both MAP and TAP, policy makers recognize young people as a key beneficiary group. While the coordination between NAS and other donors such as UNICEF and UNFPA is stronger in Burkina Faso than in other countries, current efforts still lack coordination and quality control at both the national and provincial levels.

Young people themselves have responded to the HIV/AIDS epidemic through high levels of volunteerism. Youth have involved themselves through initiatives such as national VCT campaigns, peer education, and activities organized by organizations such as RAJS-BF and ALAVI, and at the community level through the establishment of youth clubs or youth-led CBOs using MAP funds.

Communication with parents on sexuality is limited. Young people do not tend to discuss reproductive health with their parents. A study carried out in three major cities revealed that 40 percent of youth feel uncomfortable discussing reproductive and sexual health with their parents and 60 percent of parents do not feel comfortable discussing these concerns with their children. Especially for young women, parental control can reduce access to other sources of information on reproductive health and HIV/AIDS, such as community center services. At the policy level, the national directives adopted in

[47] World Bank, 2004. The US$ 18 million project became effective in March 2005 in Burkina Faso and is implemented by the Ministry of Health. The Bank plans to integrate the project into the subsequent health/AIDS operation, currently under preparation.
[48] UNICEF's activities include: (a) preventing HIV infection in young people ages 10 to 24; (b) preventing mother-to-child transmission of HIV; and (c) supporting orphans and other children made vulnerable by HIV/AIDS.
[49] For more on Global Fund support, see http://www.theglobalfund.org/search/docs/2BURH_203_0_full.pdf
[50] Well Olivier, Munz Monique, Tapsoba Lydia, *Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The Contribution of UNFPA and IPPF, Burkina Faso Country Evaluation Report*, September 2003
[51] Programme Pilote Intégrée Education-VIH/SIDA et NTIC, PPIE

2003 states that minors (under the age of 18) cannot use VCT services without the specific consent of a parent or guardian.

Capacity of youth-serving organizations to tap into funding is limited. Almost universally, technical and human resource capacity gaps exist in community organizations and local NGOs. Such gaps are even more pronounced everywhere among youth-serving groups. Important reasons hampering the ability of youth groups to tap into funding include complicated application forms, the weak capacity in basic proposal writing, and delays in selection of projects and access to allocated resources by the national AIDS secretariats.

The quality of CSOs working with youth on HIV/AIDS varies widely. Government and donor officials note that only a minority of NGOs working with young people have an adequate structure and can carry out quality activities. Moreover, the technical expertise of NGOs and CBOs can change quickly, depending on availability of resources, resulting in limited quality.[52] Training of peer educators is often through short-term projects, with very little systematic follow-up and continuous technical support to strengthen HIV/AIDS related messages. Some civil servants interviewed note that knowing about the disease and being able to transmit messages to others is very different, and that many CSOs lack the latter ability. Due to insufficient technical assistance, the majority of activities focus on sensitization. Although many of the larger, well-established groups need greater organizational and technical capacity, capacity needs are the greatest amongst the small community youth groups and associations, especially in rural areas.

Coordination of HIV/AIDS prevention messages is weak, and their quality varies. Different ministries, international donors, and national and international NGOs each develop their own prevention materials for youth, with varying degree of quality. Besides, agencies often develop overall messages without distinguishing between urban and rural youth, different ages, gender, in-school and out-of-school youth, marital status, etc.

Rural youth are short-changed. Although four out of five people live in rural areas, the majority of HIV/AIDS activities remain urban focused. While prevalence rates are lower in rural than urban areas, rural youth have relatively poorer access to information and services, largely because of language barriers, and health system inadequacies.

Most youth HIV/AIDS activities are short term and focus on IEC. Often, projects consist of one or two sensitization activities, such as workshops, a media campaign, theater, etc. Usually, programs do not link IEC to other services such as VCT and condom distribution, reducing the effectiveness of behavior change efforts.

[52] During a mission in January 2005, government officials in particular expressed this view.

Key Areas for Improvement

NAS should continue to improve coordination among donors through strengthened partnerships. The NAS should build better coordination and partnerships among the different donors working with youth ensuring, among others, to benefit from respective expertise from organization such as UNICEF and UNFPA.

Strengthen HIV/AIDS prevention in the school system. Given the inadequate knowledge of youth, providing continuous information throughout the education cycle, is necessary. Especially in rural areas, teachers are an important, and sometimes the only, source of information for reproductive and sexual health, including HIV/AIDS. Programs should try to link and coordinate school programs with ongoing out-of-school programs (usually peer education).

Include youth expertise inside of NAC and at decentralized levels. While the efforts of the leadership of the NAS in Burkina Faso to supported youth related activities and include youth representatives are stronger than in many other countries, the NAS should assign a person responsible to coordinate the different initiatives by the ministries, different multi- and bilateral donors, and international and national NGOs. Given the importance of community-based initiatives in Burkina, boosting the technical capacity on youth and HIV/AIDS initiatives at the provincial and community level is also necessarily. An institution such as UNICEF and/or PAMAC could provide inputs at the governmental and non-governmental level to ensure quality control of youth-related initiatives.

The NAS should coordinate and strengthen the quality of HIV/AIDS messages for youth. Developing of quality materials is both time and resource intensive. UNICEF and FCI, for example, developed a life skills development manual for both in-school and out-of-school youth.[53] Other donors and NGOs should be encouraged to use these already developed manuals instead of developing their own manuals.

Improve capacity of youth-serving CSOs through support of youth networks and consortiums, which in their turn can provide support to smaller groups implementing youth and HIV/AIDS activities. Priority capacity needs include strengthening proposal writing skills to tap into World Bank and other funding, improved and continuous training for peer educators, training for youth-friendly VCT, and capacity building for monitoring and evaluation.

Work towards a longer-term, multi-pronged approach for youth HIV/AIDS activities. Behavior change results from a multi-pronged strategy that includes continuous and repeated access to information (including peer education) combined with access to condoms and high-quality youth-friendly reproductive health services. The information provided should also include general information on reproductive health and life skills education to hone skills such as negotiation of sexual relations and contraceptive use. Existing youth-serving programs should include information on ongoing and future planned care and treatment programs. In addition, health care workers who provide STI-related and contraceptive services need training in non-judgmental and confidential youth-friendly care. A recent study showed

[53] See http://www.familycareintl.org/countries/pl_AF_Burkina-Faso.php

that young men in particularly view health workers as unfriendly, especially those staffing government health centers.[54]

Expand targeted programs for hard to reach young people such as commercial sex workers, and out-of-school youth working in the informal sector or living in rural areas. In rural areas, programs should pay special attention to young married girls, for example, by providing family planning services.

[54] Amuyunzu-Nyamongo Mary, Biddlecom Ann E., Ouedraogo, Christine, Woog Vanessa, *Qualitative Evidence on Adolescents' Views of Sexual and Reproductive Health in Sub-Saharan Africa,* Alan Guttmacher Institute, Occasional Report 16, January 2005.

Case Example: Ethiopia[55]

Country and Project Context

Ethiopia has the fifth highest number of HIV-infected people in the world, with 1.5 million. The national adult prevalence rate is 0.9-3.5%. UNAIDS estimates that females ages 15 to 24 have infection rates more than twice as high as young males of the same age. Adult deaths from AIDS have left between 280,000 and 780,000 AIDS orphans. Current surveillance reports suggest that the infection rate is stabilizing in urban areas while increasing in rural areas. Young people face a host of other critical reproductive health problems including early sexual debut, high rates of early and unwanted pregnancies, and high prevalence of sexually transmitted infections. Widespread unemployment, low rates of schooling, and generalized poverty exacerbate these reproductive health problems and make Ethiopian youth more vulnerable to infection.

HIV & Youth in Ethiopia

Total population, all ages	74.8 million
Population ages 10-24	33.2%
Gross national income in purchasing power parity (GNI PPP) per person	$1000
Human Development Index rank	170
Adult HIV/AIDS prevalence	0.9-3.5%
HIV/AIDS youth prevalence (M/F)	0.2-0.8/0.5-2.3%
AIDS Orphans	280000-780000
HIV Prevention Knowledge (M/F)	n.a.
Condom Use for high-risk sex (M/F)	30/17%
Teen birth rate	90 per 1000
Child death rate	166 per 1000
Secondary school enrollment (M/F)	28/16%
Single, sexually active women 15-19 using modern contraception	44%
Median age at first intercourse (M/F)	20.3/16.0 years
Median age at first marriage (M/F)	23.3/16.0 years

Data for 2001-2005 period. See note for definitions and sources

The World Bank-funded Ethiopia Multi-Sector HIV-AIDS project (EMSAP) was approved in 2001 with a total budget of $US 63.4 million for a three-year period, and with an extension through December 2005. EMSAP supports the Federal and Regional Multisectoral HIV-AIDS Strategic Plans through prevention, care, and treatment services, with a focus on community-driven initiatives. EMSAP's four components include (1) capacity building for government and civil society; (2) expanding the government's multisectoral response through its ministries; (3) an Emergency HIV/AIDS Fund (EAF) to expand the response of communities, NGOs, and the private sector; and (4) project coordination and management. The National HIV/AIDS Prevention and Control Office (HAPCO) functions as the technical secretariat of the National AIDS Council and directs Ethiopia's national program. HAPCO maintains offices in the country's 11 regions and in 266 of the 550 *woredas* (districts). An unknown number of the several thousand *kebele* (sub-district) administration committees maintain an HIV/AIDS coordination body.

Existing Policies and Programs On Youth and HIV

The Policy Environment. A good institutional and policy framework for addressing youth and HIV activities exists as part of broader government support for youth reproductive health concerns. The 2004 National Youth Policy cites HIV/AIDS as one of ten major policy subjects. The Federal Policy

[55] Unless otherwise specified, the case example draws from the longer report, *Ethiopia Assessment Report: Scaling up Youth-Focused Interventions in the Multi-Country HIV/AIDS Programs (MAP) and Building Capacity of Civil Society Organizations (CSOs)*, Haddas Wolde Giorgis and Mulugeta Gashaw, Unpublished report, July 25, 2005.

and Strategic Framework on HIV/AIDS includes youth empowerment. Ministry of Health guidelines issued in 2002 support youth VCT services and allow young people 14 and older to access VCT services without adult consent. The National Policy on Ethiopian Women supports efforts to meet the special concerns of young women. Furthermore, the revised Ethiopian Family Law raised the minimum age of marriage for girls from 15 to 18 years old and contains several provisions to protect the rights and interests of all women including young females. Other national health, education, and population policies contain supportive language.

Programs for Youth. A large number of programs focus on HIV/AIDS and other reproductive health concerns of young people in Ethiopia. Government ministries and offices that provide youth reproductive health and HIV/AIDS education or services include the Ministry of Health, the National Office of Population, the Ministry of Youth, Sports, and Culture, HAPCO, and the Ministry of Education. Nongovernmental organizations—both international and national—also play a large role in the provision of HIV/AIDS services to young people. At the community level, the number of youth clubs and organizations formed to fight the spread of the disease is rising. A recent assessment supported by UNICEF found about 12,000 registered youth anti-AIDS and reproductive health clubs and associations in the country. Some, such as Hiwot Ethiopia and Eshet Children and Youth Unity, have become registered NGOs. Despite such efforts, serious programming gaps remain. For example, programs for younger adolescents are nearly universally absent. Likewise, services for rural youth are insufficient and scattered.

How MAP is Addressing Youth

How the Project Appraisal Document addresses youth. The PAD classifies young people as a high-risk group, includes youth-specific impact indicators, and lists youth-specific activities that the project will support. The PAD describes the "window of hope" that young people afford for combating the epidemic, noting that if youth "can be taught and empowered to protect themselves from HIV infection before they become sexually active, they could avoid HIV infection." Specific strategies cited in the PAD include youth-friendly STI/TB services, life-skills training for girls, and assistance to youth clubs.[56]

Support through Ministries. With EMSAP funds, HAPCO supports 37 government organizations, including 12 federal ministries. Most of these institutions target their own civil servants without a concentration on external beneficiary groups. A few ministries, however, are using EMSAP funds to carry out youth activities. The Ministry of Youth is constructing 11 multi-purpose youth centers, upgraded 100 libraries/youth information centers throughout the country, and supports youth clubs through training and capacity-building assistance. The Ministry of Education has used EMSAP funds for a variety of activities including curricula revision to incorporate HIV/AIDS subjects; preparation of supplementary booklets for teachers and students; capacity building workshops and teacher trainings; and distribution of IEC materials and other forms of support to school anti-AIDS clubs.

[56] World Bank. Report No: 20727. *Project Appraisal Document for Proposed Credits to the Federal Democratic Republic Of Ethiopia and the Republic of Kenya in Support of the First Phase of the US$500 Million Multi-Country HIV/AIDS Program for the Africa Region.* August 14, 2000. AFRHV, AIDS Campaign Team for Africa (ACTafrica), Africa Regional Office.

Support for Civil Society Organizations. Through its Emergency HIV/AIDS Fund (EAF), EMSAP has supported youth programs by CSOs at the national, regional, and local levels. Through May 2005, EAF had committed about US$ 4.1 million to 28 national-level CSOs for youth activities. This represented slightly more than half the total amount committed at the national level (see Table A.2 below). Among the national groups receiving funds were Dawn of Hope, Mekidim Association of PLWHA and AIDS Orphans, Mary Joy Aid through Development, the Family Guidance Association of Ethiopia, Integrated Services for AIDS Prevention and Support Organization, the Ethiopian Orthodox Church, the Supreme Council of Ethiopian Islamic Affairs, and Hiwot Youth. The EAF also distributed another US$ 8 million to CSOs working at the regional level. Based on an in-depth analysis of the types of activities supported in the Addis Ababa region, it is estimated that about US$ 1.3 million of this amount (16 percent) was destined for young people. The EAF disbursed another US $5.7 million to *woreda*–level programs. Although anecdotal reports suggest that many of the groups receiving this support are youth clubs and other youth-serving organizations, it was not possible to estimate the exact amounts or proportions. With the closure of MAP I in June 2006, most of the activities of the groups supported by EMSAP suffered a major setback.

Table A.2. Funding for Youth Activities in Ethiopia

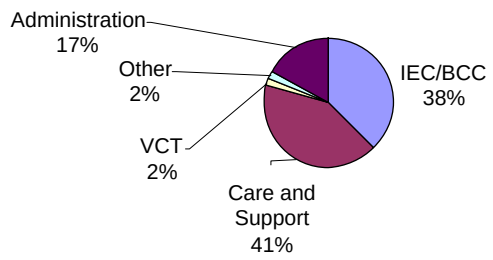
Funding for CSOs to Carry Out Youth Programs through the Emergency HIV/AIDS Fund Component of the Ethiopia MAP, by type of CSO, 2001-2005.

Type of CSO	Total CSO Funding ($ m)	Youth-Serving CSOs	
		Amount ($ m)	percent of Total
National Level	7.6	4.1	54%
Regional Level	8.0	1.3[a]	16% [a]
Woreda Level	5.7	n.a.	n.a.

[a] *Estimate based on figures from Addis Ababa Regional HAPCO*
Source: HAPCO

Programmatically, funding for youth efforts in the Addis Ababa region was about equally split between IEC/BCC and care and support activities (see Figure A.1).

Figure A.1 Spending on Youth-Focused Activities, By Component, Addis Ababa HAPCO, 2002-2005



Very little information is available on the effectiveness of EMSAP-funded, youth programs. Partly, this stems from a traditional lack of documenting good practices in most CSOs.[57] Youth activities supported by the MAP were not systematically designed or targeted, but were part of the community response component. Moreover, HAPCO has typically lacked the

[57] An evaluation of 23 HAPCO-financed CSOs undertaken for Action Aid also documented this tradition of aversion or non-sensitivity to best practices.

mechanisms to support, replicate, and scale up good practices. On the other hand, the Addis Ababa regional HAPCO, recently began documenting and disseminating information of some of its innovative and promising youth strategies. These include:

- *Provision of VCT services to young people within youth centers and clinics*, supported through the Family Guidance Association of Ethiopia (FGAE).
- *The integration of HIV/AIDS activities within existing sexual and reproductive health projects including clinics with a special focus on youth*. Also an FGAE initiative, this includes provision of reproductive health and VCT to young people, together with recreation and information resources.
- *Scaling up AIDS and reproductive health youth clubs into resource centers.* With UNDP support, HAPCO provides material, equipment, and training that use existing facilities.
- *The Ministry of Youth's plan to build 11 multi-purpose youth centers* (described above).
- *Hiwot Ethiopia's support to the establishment and functioning of anti-AIDS youth clubs.*
- *EMSAP's funding for care and support activities to balance prevention efforts.*
- *Involvement of youth and adult women volunteers.* A total of 1,800 women and 1,035 young people volunteered in programs at all 100 *kebele* in the capital, Addis Ababa. Programs effectively retained volunteers, who helped combat stigma and discrimination.
- *Promotion of VCT at high schools, with referral linkages to health facilities providing VCT*. The program, along with anti-AIDS clubs and AIDS information centers, functioned in 15 high schools.

Complementary Role of Other Bank-funded Efforts and of Other International Partners

A small amount of funding from Bank headquarters global programs (including Population and Reproductive Health, Children and Youth, and External Affairs) has supported the development of the youth sector, including the organization of policy dialogues and the development of a national strategic plan for youth development. The Bank is in dialogue with the government over a project to develop civil society capacity. One component of this project would potentially concentrate on youth groups. Efforts were also made to support the development of the national adolescent and youth reproductive health strategy (AYRH) document that was led by the Ministry of Health's Family Health Department.

Several multilateral and bilateral donors, along with private foundations, are supporting youth HIV/AIDS activities in Ethiopia. The main international donors include USAID, UNICEF, and UNFPA. USAID, through its contractors and grantees, directs its support to Oromiya, Amhara, and SNNPR regions. Through Pathfinder and other partners, USAID supports over 150 adolescent service sites. UNFPA funds many youth NGO activities, including those of the FGAE, and is actively involved in policy formulation and advocacy. The Packard Foundation is also a major funder of youth reproductive health and HIV initiatives in Ethiopia, providing funding for many NGO and CSO efforts. Other external donors include UNICEF, Action AID, and DSW.

Constraints and Opportunities

Youth Programming is Still Nascent. Despite the relatively favorable policy environment for youth activities, the number of youth-oriented organizations is limited, and no national consensus exists that young men and women are a valuable asset for nation building. A recent UNICEF study found low levels of youth participation and poor understanding of the concept of youth programs.

Lack of a strong national leader on youth issues. The Ministry of Youth, Sports, and Culture, which could conceivably take more of a lead role, was only established in 2001, has limited influence within the government, and is still creating effective connections with civil society. For example, the ministry set up a national technical working group on HIV/AIDS in January 2005, but lack of resources has impeded action. The government has looked favorably on the ministry's request for a national youth fund that would include support for HIV/AIDS activities, but funding and implementation questions remain unanswered.

Capacity gaps. A major constraint on expanding youth activities is the low technical and managerial capacity of CSOs, particularly those community-based groups and youth associations and clubs. Larger, more experienced NGOs have relatively better organizational, technical, financial and fund raising capacities. Others that recently achieved recognized NGO status are somewhat less capable. However, the bulk of youth clubs and community organizations are small and unregistered.

Key Areas for Improvement

Enhance funding mechanisms and cash flow. Any future MAP or related program should make clear reference to practical ways of attracting youth projects and sub-grantees. Existing eligibility requirements for MAP funds exclude the bulk of anti-AIDS youth associations and anti-AIDS clubs on the ground that they are not registered, lack a bank accounts, etc. Even registered youth organizations have received nominal amounts of funding. Government should facilitate granting of legal status to potentially good youth clubs, raising the funding ceiling approved for youth NGOs, and proportionately earmarking funds for these NGOs. Small clubs and non-registered associations should receive help to attach themselves to larger, registered NGOs or community structures in addition to help in upgrading into registered associations. At the same time, HAPCO could disburse funds more quickly and with more impact under an outsourcing arrangement through better-performing, larger CSOs. Meanwhile, HAPCO should ensure that it funds more than just a few of the better-known, larger organizations and explores funding of smaller, newer groups. These might include some of the many private schools as well as organizations that target hard-to-reach subgroups such as street children, and displaced youth.

Upgrade youth programming. Youth programming should better reflect differences by age, gender, education, residence, status, roles and responsibilities, etc. One way to encourage such an approach is to introduce more flexibility into the types of activities that HAPCO funds and leaving more room for flexibility and innovation to grantees and subgrantees. Programs should do better in tailoring the many IEC/BCC efforts to specific subgroups, for example to currently under-served younger adolescents. Educational activities, although important in their own right, must also be balanced by greater attention to services for young people including VCT, youth-friendly clinical services, and institutional and home-based care. Funding could also be increased for carefully designed strategies that integrate

prevention with income generation and other livelihoods activities. Programming also needs to more strongly emphasize gender and prioritizing the needs of young females. Finally, there needs to be much more concentration on serving young people in rural areas and in hard to reach groups.

Strengthen coordination and linkage of major stakeholders working on integrated reproductive health and HIV/AIDS programs for youth. Although organizations are implementing integrated HIV/AIDS and reproductive health interventions, most activities happen without any visible coordination. Youth programs should be strategic and complementary. One way to improve coordination is through youth task teams established at all levels and involving the relevant ministries, donors, and CSOs, with effective documentation and dissemination that encourages learning. Overall, groups need to coordinate better on youth initiatives of all types, not only for HIV/AIDS. For example, groups should reach consensus on defining what constitutes a "volunteer" and on coordinating stipends and volunteer training.

Enhance monitoring and evaluation. HAPCO bases its monitoring and evaluation system on the UNAIDS indicators. HAPCO should simplify the system, ensure that it includes youth indicators, and work on helping ordinary communities make sense of evaluation standards. HAPCO should also develop simple, appropriate, and practical monitoring and evaluation guidelines and timetables that promote experience sharing and joint review among sub-grantees across localities and projects. As a relatively new HIV/AIDS strategy, youth-oriented programs require robust monitoring and evaluation and consistent standards at all levels.

Build capacity of youth-serving groups. HAPCO should make building capacity of youth and youth-serving associations a priority, particularly in leadership and managerial knowledge and skills. HAPCO could set standards for designating a minimum level of capacity requirements for youth-serving CSOs, in terms of staffing, service packaging, coverage, etc. Funding arrangements should also be more flexible to allow youth groups to employ more young people to carry out programs. Furthermore, HAPCO should make a special effort to inform youth-serving CSOs about the availability of funding that is potentially available to them.

Take stock of lessons learned. The EMSAP (MAP I) was closed in June 2006. Negotiations are underway for HAPCO to carry out a follow-on MAP, which is expected to be operational before mid-2007. To increase the scope and effectiveness of youth HIV programs, it would be useful to reflect on previous initiatives and take stock of the lessons learned from MAP I.

Case Example: Malawi

Country and Project Context

The epidemic in Malawi is among the most severe in the region. About 14% of adults aged 15-49 are infected, which translates to about 1,000,000 adults and children carrying the virus.[58] General awareness of the disease is high, but so are misconceptions about prevention. As a result, high-risk behavior among sexually active youth and adults is common. Prevalence among females ages 15 to 24 is 9.7 percent, more than double the prevalence among men ages 15 to 24 at 3.4 percent. HIV/AIDS is now the leading cause of death in the most productive age group (20-49 years), resulting in an estimated 50,000 to 70,000 adult and child deaths annually.

HIV & Youth in Malawi

Total population, all ages	12.8 million
Population ages 10-24	33.0%
Gross national income in purchasing power parity (GNI PPP) per person	$650
Human Development Index rank	165
Adult HIV/AIDS prevalence	14.1%
Youth HIV/AIDS prevalence (M/F)	3.4/9.7%
AIDS Orphans	550,000
HIV Prevention Knowledge (M/F)	41/34%
Condom Use for high-risk sex (M/F)	47/35%
Teen birth rate	158 per 1000
Child death rate	175 per 1000
Secondary school enrollment (M/F)	37/29%
Single, sexually active women 15-19 using modern contraception	16%
Median age at first intercourse (M/F)	18.6/17.3 years
Median age at first marriage (M/F)	22.9/18.0 years

Data for 2001-2005 period. See note for definitions and sources

In July 2003, the World Bank board approved $US 35 million over five years for the Malawi Multi-Country AIDS Project to support the National HIV/AIDS Strategic Framework, developed in 1999. The AIDS strategy's seven pillars are prevention and advocacy; treatment, care, and support; impact mitigation; sectoral mainstreaming; capacity building and partnerships; monitoring, evaluation and research; and national leadership and coordination. The National AIDS Commission (NAC), established in 2001, coordinates and facilitates the national response but does not direct carry out programs. The NAC Secretariat approves grant proposals that are multi-district, regional, or national in scope. For smaller proposals such as those from CBOs or within a single district, NAC operates through five umbrella organizations responsible for mobilizing local CBOs, reviewing and approving eligible proposals, on granting to approved applicants at the community level, monitoring CBO finances, and regularly reporting to the central NAC.[59] The umbrella groups, chosen through a competitive bidding process, also work with the district assemblies and HIV/AIDS coordinating committees in their areas of expertise, to build local capacity to take over coordination and monitoring functions.

The District Assemblies formed District AIDS Coordinating Committees (DACCs) to coordinate and monitor local initiatives. These committees are composed of government staff, community representatives, and NGO representatives and have developed district plans for implementation by community-based groups and public-private partnerships. DACCs have no allocated staff or operating budget and rely on ad hoc funds from the National Government.

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[58] UNAIDS. *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections*. 2004. www.unaids.org

[59] The umbrella organizations are: Action Aid Malawi; Canadian Physicians for Aid and Relief (CPAR); Plan International Malawi; Save the Children, USA; and World Vision International.

A unique aspect of Malawi's HIV efforts is the basket funding mechanism used by most development partners.[60] Partners provide support congruent to the Strategic Framework based on a combined annual work plan, using joint financial, procurement, and reporting mechanisms. This contrasts with the circumstances in most countries, where external partners fund multiple projects requiring parallel systems for tracking and reporting.

Existing Policies and Programs On Youth and HIV

Policy Environment. The Government of Malawi has taken some important steps to provide a supportive environment for meeting the sexual and reproductive health needs of young people. The 1995 National Youth Policy identifies young as a distinct sector and provides guidelines for development of programs to facilitate youth participation in national development strategies. In 1996, the national Family Planning Policy and Contraceptive Guidelines gave young people the right to access reproductive health services.[61] The government has also introduced family life education in schools and is making special attempts to reach out-of-school youth. The 2003 National AIDS Policy provides a framework for carrying out a multisectoral national response and included attention to youth issues.[62]

Programming. Many HIV/AIDS programs in Malawi are directed at young people. In the public sector, the National Reproductive Health Program headed up by the Ministry of Health and Population provides adolescent reproductive health services, including STI and HIV prevention and management services. Another widespread youth activity are in-school anti–AIDS clubs, popularly known as *Edzi Toto* ("AIDS is not for me") clubs, established with the assistance of UNICEF for girls and boys.[63] These clubs help members develop improved skills in critical thinking and communication. They use interactive, participatory methods to carry out various activities, including dramas, debates, quizzes, role plays, and sports among members and nonmembers. Through these techniques, the clubs try to present HIV/AIDS and sexual health information in interactive ways that can help fellow students identify and change their risky behaviors. Anti–AIDS clubs for out-of-school youth provide access points for peer education and income-generating activities. Another important mechanism for to serve young people are the Youth Technical Sub-Committees (YTSC), established in the early 1990s as subcommittees of the DACCs.[64] Where DACCs are fully functional, the YTSC is also functional. YTSCs draw membership from district offices of the Ministries of Education, Youth, Health and other ministries, as well as from local and international NGOs. YTSCs get mostly government funding, with occasional support from the National AIDS Commission and other agencies. The YTSC are generally responsible for coordination of youth activities, such as training headmasters and patrons of the anti–AIDS clubs in schools; training peer educators; distribution of information, education and

[60] Participants in the basket fund, in addition to the World Bank, include the Global Fund for HIDS, TB and Malaria, UNDP, AfDB, CDC, CIDA, DfID, IDA, NORAD, and SIDA.
[61] Alister C. Munthali, Agnes Chimbiri and Eliya Zulu, *Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence.* Alan Guttmacher Institute, Occasional Report No. 15 December 2004 available at: http://www.guttmacher.net/pubs/2004/12/01/or_no15.pdf
[62] Government of Malawi, Office of the President and Cabinet: National AIDS Commission, National HIV/AIDS Policy A CALL FOR RENEWED ACTION, October 2003
[63] Wansi, E.; Mtango, D.; Maganga, E.; Banda, E.; Msiska, T. Community IMCI Baseline Survey - Household Baseline Survey on Key Community Child Care Practices in Selected Districts of Malawi, UNICEF Evaluation Database, 2000. Accessed 2005 at: http://www.unicef.org/evaldatabase/index_14061.html
[64] The Alan Guttmacher Institute, Adolescents in Malawi: Sexual and Reproductive Health. Research in Brief Series, No. 3, Washington, DC. 2005.

communication materials; counseling; establishing Community AIDS Committees; providing technical support to youth NGOs; and monitoring, evaluating, and registration of all youth NGOs and clubs.

How MAP is Addressing Youth

How the Project Appraisal Document addresses youth. The approach put forth in the PAD closely parallels the action areas of the National HIV/AIDS Strategic Framework. This framework has nine themes, three of which specifically classify young as a beneficiary group, including strengthening dialogue with youth to promote responsible behavior; empowering vulnerable groups to resist behavior harmful to their health status; and increasing accessibility of VCT services for men, women, and youth. Young people fall into two of the seven the pillars of the basket fund: prevention and impact mitigation. As part of the prevention pillar, Malawi is working to promote correct and consistent condom use through social marketing and distribution of quality condoms in all health facilities and retail outlets. To reach the young people in the community, the emphasis is on incorporating safe sex messages, life skills education, and information about HIV/AIDS into primary and secondary schools. Out-of-school youth are also a focus. Activities within the impact mitigation pillar include educational support and training for OVCs, income generation for vulnerable households, community-based and institutional care for orphans, and psychosocial support for affected families.

Support through Ministries. The Ministry of Education has received funding from the NAC to purchasing IEC materials for schools. The Ministry of Youth, Sports, and Culture has received funding to organize some courses to develop the capacity of youth clubs to manage themselves and their finances. Both the Ministry of Education and the Ministry of Youth, Sports, and Culture cite lack of adequate resources from the NAC as a source of their problems. The Ministry of Education has severe shortages in supplies of books and other IEC materials, low number of teachers trained in HIV education, and constraints because of the overall impact the disease has had on the teacher workforce. The education ministry has submitted another proposal to the NAC to support non-teacher counseling services and a referral system into the school system. They would also like to train more teachers to scale up the "Stepping Stones" pilot program.

Support for Community Based Organizations. As shown in Table A.3 below, of the 243 CBOs funded by the NAC between June 2003 and November 2004, 91 (37 percent) were youth focused. Of the total $2.44 million in funding for CBOs, $0.79 million (32 percent) went for youth. Youth activities included prevention, advocacy, impact mitigation, capacity building, and treatment, care and support.

Table A.3. NAC Funding for Youth-Serving Community-Based Organizations in Malawi

Number of CBOs funded and amount, by all CBOs and youth-focused CBOs, June 2003 – November 2004

Type of CBO	Number	Amount ($ million)
All CBOs	243	2.44
Youth-Serving CBOs	91	0.79
Youth as a percent of all CBOs	37%	32%

Sources: National AIDS Commission project data and UNICEF Malawi

The degree to which NAC-supported programming is effective is unclear. NAC has made much progress in developing financial and program monitoring systems. Nonetheless, current systems do not allow for evaluation of the effectiveness of the youth programming in terms of impact on key prevention behaviors.

Evaluation of youth activities in Malawi has been low. Although most of the youth-serving organizations in Malawi lack the resources and the capacity to evaluate their programs, a few evaluations have taken place. UNICEF's impact evaluation of the *Edzi Toto* program (described above) found that the performance of the anti-AIDS clubs depended on resources and on staff and student commitment.[65] Although many students were aware of the existence of clubs, very few participated, particularly in primary schools. The study also found that the participation of teachers in such clubs was a critical factor in the success of the activities. Clubs where teachers attended orientation seminars were stronger and more successful than other clubs. According to the study, young people enrolled in these clubs generally possess a good knowledge of life skills. The in-school and out-of school clubs complement life skills education and have had an impact on young people's lives, as some of the adolescents have reported changes in sexual behavior and adoption of the use of condoms during sexual intercourse. Furthermore, these clubs are helping to break the barriers of communication between the young and older members of the community.

Complementary Role of Other Bank-funded Efforts and of Other International Partners

The Malawi Social Action Fund Project, continuously funded by the Bank since 1996, supports decentralized community-based development activities. Two of its components, sponsored subprojects and community subprojects, help vulnerable groups including youth gain access to health care, education, and employment opportunities by improving schools and health facilities. Sponsored subprojects supports initiatives identified by NGOs/CBOs. Community subprojects finances community demand-driven socio-economic infrastructure (extension and construction of schools, health facilities, etc.) in rural and urban areas.

Aside from the donors that contribute to the National AIDS Framework basket fund, UNICEF and UNFPA are very involved in youth reproductive health and HIV activities in Malawi and are trying to coordinate using a joint program of action. UNICEF has concentrated on life skills education for in-school and out-of-school youth and on youth reproductive health. UNICEF introduced HIV education into all primary schools with the help of NORAD and has used life skills as a vehicle for pregnancy prevention messages. UNICEF also supports outreach with IEC materials, and has supported youth centers, youth festivals, and recreation materials. UNFPA also supports life skills education through development and distribution of materials and in-service and pre-service teacher and staff training. To date, UNFPA has supported distribution of 300,000 life skill textbooks for fifth graders and has oriented at least one teacher from each of the 5000 schools. UNFPA also works with out-of-school youth to integrate HIV information into the sexual and reproductive health information given to young people. UNFPA also supports training of young people as "distributing agents" to give

[65] See Reijer, Piet and Miriam Chalimba. 2000. *Going to Scale: Sustained Risk Reduction Behavior for Youth. Evaluation Report for Government of the Netherlands and UNICEF Malawi.* http://www.unicef.org/evaldatabase/files/MLW_00-056.pdf

out condoms and IEC materials in communities, and training of health workers in youth-friendly services.

Constraints and Opportunities

The government of Malawi has identified youth as an important target group for HIV activities, but coordination and quality control are lacking. As reflected in supportive government policies and the strong interest in young by the leadership of NAC, young people are recognized as a key beneficiary group. Current efforts, however, lack coordination and quality control at both the national and provincial levels. The National Youth Council is a quasi-governmental body that attempts to help youth-led CSOs get registered and qualified for funding. The NAC has also designated the Youth Council as a lead agency for coordinating the youth activities. Although the National Youth Council has a coordination mandate, in practice the communication and coordination among stakeholders has been lacking. Better coordination would help to avoid duplication and improve understanding of how groups are using money for youth-oriented activities, and what gaps may exist. One example is in the area of BCC messages. Young people in Malawi receive inconsistent and often conflicting prevention messages.

Lack of capacity hampers access to funding. One of the factors influencing the number of youth activities funded through NAC is the difficulty in accessing the funds. First, many youth groups are not aware of the various funding sources available within the country. Second, youth groups lack the ability to develop a proposal to meet the standards to receive funds. Third, youth groups do not have the records to show financial stability and lack the capacity to become financially stable. This eliminates their ability to qualify for funding from the umbrella organizations. Funding delays that are a generalized problem for NAC-funded activities also influence the number and quality of youth programs.

Key Areas for Improvement

Better coordinate current activities addressing HIV and Youth. The NAC should designate a body to "map" current youth efforts, identifying program types, beneficiaries, gaps, and potential networks of youth-serving organizations. Better coordination of the activities will help to ensure young receive consistent BCC messages and help to eliminate gaps in coverage. With greater human and financial resources, the National Youth Council can take on this coordination role together with the umbrella organizations and the DACCs. Better coordination will help in developing a coherent package or strategy to sufficiently meet the many needs young men and women have.

Identify people with youth expertise within the umbrella organizations and within the DACCs. Staff with such expertise, placed at the regional level within the umbrella organizations and at the district level in the DACCs, would help to coordinate, strengthen current programs, and act as a technical resource for youth-serving groups. An enhanced role for the District Youth Officers, now deployed in 23 of the country's 26 districts, could further strengthen youth-oriented efforts. The District Youth Officers currently lack visibility at the community level and lack influence at the district level. Some lack expertise in youth issues. As these human resources are strengthened at the regional and district level, better communication and coordination among the District Youth Officers, the National Youth Council and the umbrella organizations should become a focus. These steps could help ensure that strategies and materials are better-adapted for young people.

Develop specific youth-friendly activities. Although the National Strategic Framework identifies youth as an at-risk group, it lacks clear strategies for young people. MAP should support development of messages and strategies that cater to young people, including IEC materials, communication strategies, youth-friendly services, prevention messages, livelihoods programs, etc.

Increase outreach to youth-serving organizations. Many youth-serving groups are in very poor and rural communities. They lack capacity to access funds. Working through existing networks, the NAC should strengthen efforts to build the capacity of these groups and help them access funds and use them effectively.

Case Example: Sierra Leone

Country and Project Context[66]

About one third of the population of Sierra Leone is between the ages of 10 and 24 years, average levels of education are low, and about 70 percent of the population lives below the poverty line.[67] HIV prevalence rates are 1.6 percent nationally, with roughly equal rates among males and females. The age groups with the highest prevalence rates are females 20 to 24 years (2.0 percent) and males 35-39 years (3.5 percent). The low rates suggest that the main problem in HIV/AIDS in Sierra Leone is among specific groups such as commercial sex workers, miners, truck drivers, the police and military.[68]

HIV & Youth in Sierra Leone

Total population, all ages	5.7 million
Population ages 10-24	32%
Gross national income in purchasing power parity (GNI PPP) per person	$780
Human Development Index rank	176
National HIV prevalence rate	1.6%
Urban/Rural HIV prevalence rates	2.1/1.3%
Youth HIV prevalence rate (M/F)	0.4/1.1
AIDS Orphans	31,000
HIV Prevention Knowledge (M/F)	n.a./16%
Condom Use for high-risk sex (M/F)	n.a.
Teen birth rate	179 per 1000
Child death rate	283 per 1000
Secondary school enrollment (M/F)	33/22%
Average age first sexual intercourse	16

Data for 2001-2005 period. See note for definitions and sources

Although rates are still relatively low, many observers believe the ingredients are in place for a rapid spread of the epidemic. Key factors found to facilitate the spread of the disease in other conflict and post-conflict environments are present in Sierra Leone, and include: a brutal and protracted civil conflict with increased levels of rape, sexual violence and abuse, until recently major troop deployments including foreign troops with potentially higher prevalence, high unemployment and chronic poverty, increased commercial sex work and informal exchange of sex for goods and services, massive population movement (internally and refugee populations), and minimal public health infrastructure.[69] New research finding from Uganda cast doubt, however, on the widely held assumption that internally displaced persons and refugees are more likely to be HIV-infected than people in more stable settings. A recent review of HIV literature on displaced persons in eight countries (including Uganda) also failed to find evidence that conflict increases HIV transmission (UNAIDS 2006).

Another factor potentially contributing to the spread of HIV is the relatively low HIV/AIDS awareness. According to a 2001 survey of adolescents from Sierra Leone, levels of HIV/AIDS knowledge and risk perception are among the lowest in sub-Saharan Africa. Although awareness among adolescents has risen in recent years, young people do not seem to be changing their sexual

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[66] This case example draws on a background study commissioned by the World Bank, *Scaling-up of Youth-focused HIV/AIDS intervention in NAS and Assessing the Capacity of Civil Society Organizations (CSO)*, Samuel Weekes, August 2005 draft.
[67] World Bank, Country Assistance Strategy for Sierra Leone, 2005
[68] UNAIDS, *Sierra Leone National Report on the UNGASS Declaration of Commitment on HIV/AIDS*, 2006
[69] The Global Fund for AIDS, TB and Malaria, *Development of a comprehensive national response to HIV/AIDS that includes adequate prevention, treatment, care and support for those affected*, Sierra Leone, 2005. http://www.theglobalfund.org/search/docs/4SLEH_814_0_full.pdf ; and UNICEF, *The impact of conflict on women and girls in West and Central Africa and the UNICEF response*, 2005

behavior.[70] For example, the percentage of youth using condoms at first sexual encounter was 3.7 percent in 2002 and increased only to 4.5 percent in 2004.[71]

The World Bank approved the Sierra Leone HIV/AIDS Response Project (SHARP) in February 2002 for US$ 15 million. The main objectives of the project are to contribute to reducing prevalence and mitigating the impact of the disease. The project includes four components: (1) capacity building, policy and program coordination, (2) multi-sector responses for prevention and care, (3) health sector responses to STI/HIV management, and, (4) community and civil society initiatives.[72]

Existing Policies and Programs On Youth and HIV

Policy Environment. The government of Sierra Leone has put in place an array of policies in recent years to address youth issues. In 2002, the government established the Ministry of Youth and Sports and ratified a National Youth Policy in 2003. One of the policy's key objectives is to aid in the fight against HIV/AIDS and to sensitize youths and their communities on the implications of the disease for national development. The youth policy also mentioned explicitly sex workers and young people living with HIV/AIDS among marginalized youth groups of primary concern.[73] The National HIV/AIDS Policy from 2002 highlights young men and women as beneficiaries from IEC and recognizes youth as explicit partners in various institutions and committees in the struggle against the disease. The National HIV/AIDS Strategic Plan 2005-2009 proposes various strategies on youth and HIV/AIDS, including: (a) mainstreaming activities into the education sector, (b) training of peer educators, and (c) establishment of multi-purpose youth centers at the community level. Other relevant policies include the National Education Policy, which highlights the importance of prevention education. One of the few important policies that fail to openly address youth sexual and reproductive health is the National Health Policy.

Programs. A variety of national and international NGOs have carried out a range of youth HIV/AIDS activities in Sierra Leone, including IEC, social marketing of condoms,[74] peer education, and some counseling services. One such program is the Youth-led Peer Education Program of Student Partnership Worldwide and the Ministry of Youth and Sports. This two and a half year program, launched in September 2005, aims to train 160 peer health educators and reach 50,000 rural youth through weekly classes, life skills education, and participatory awareness-raising events. The program also aims to influence community members and build capacity in the public sector and in civil society to improve health services for young people.[75] The trained peer educators will live for two years in remote communities. The program will also act as a pilot and demonstration model for a potential program of national youth service. A second example of a youth program operating in Sierra Leone is the School and Community Based Peer Health Education. The program, supported by the Ministry of Education and Science and Technology, United Nations Educational, Scientific and Cultural

[70] UNICEF, *HIV/AIDS and Programme*, March 2004
[71] UNAIDS, *Sierra Leone National Report on the UNGASS Declaration of Commitment on HIV/AIDS*, 2006. Data is based upon a National HIV Behavioral Survey from 2004.
[72] World Bank, *Project Appraisal Document Sierra Leone HIV/AIDS Response Project*, February 2002
[73] *Sierra Leone National Youth Policy*, 2003, http://www.daco-sl.org/encyclopedia/6_lib/6_2Agov.htm
[74] Especially through the *Condom Social Marketing Project* from CARE with support from USAID and NAS. The project, begun in 2003, initially targeted the Western Area, especially Freetown, and expanded to the rural provinces with additional resources from KFW and the Global Fund.
[75] Student Partnership Worldwide, *Report of Student Partnership Worldwide/Ministry of Youth & Sports Collaboration*, 2004

Organization (UNESCO), and CIDA, trains peer educators to develop and conduct classroom presentations, to engage their peers, and to encourage healthful behavior and attitudes. Peer educators also develop community outreach programs targeting neighboring schools, out-of-school youth, and the public.

How MAP is Addressing Youth

How the Project Appraisal Document (PAD) addresses youth. The PAD emphasizes prevention among young people, including two key performance indicators related to youth knowledge and behavior. Four project components support youth activities: Capacity Building, Policy and Program Development, supports IEC for youth; Multi Sector Responses for HIV/AIDS Prevention and Care, through the Ministries of Education and Youth and Sports; Health Sector Responses to HIV/AIDS epidemic, especially through social marketing of condoms; and Community and Civil Society Initiatives.[76]

Support through Information, Education and Communication. The project supports CBOs and NGOs to effectively deliver prevention and care messages to their target populations, through mass media, interpersonal communication including peer educators, and participatory community theater, dance and music.

Support through Ministries. In contrast to MAP-funded strategies in other countries, government ministries in Sierra Leone are using MAP funding to go beyond activities for their staff alone, and also budgeting for and carrying out programs for their external clients. The Ministry of Youth and Sports, for example, has trained 50 young men and women as community animators (peer educators) for prevention in the Western Region and produced a newsletter on HIV/AIDS. Other institutions with extended HIV/AIDS activities include, among others, the Sierra Leone Armed Forces and the Sierra Leone Police.

Support through Community and Civil Society Initiatives. The National Commission of Social Action (NaCSA) rather than the NAS managed those initiatives with budgets above US$25,000. Most proposals reviewed by NaCSA had a youth component and/or specify youth as direct program beneficiaries. For example, of the 29 projects approved by NaCSA through December 2004, 7 had an exclusive youth focus. NGO and CBO programs have concentrated on IEC. Lack of information, complicated proposal forms, and lack of proposal writing skills have constrained the ability of youth organizations to access funds through the community and civil society initiative, according to the youth organizations themselves. Since 2006, this component is implemented under a new arrangement with NAS transferring block grants to Local Councils that provided the grants to eligible beneficiaries.

Increased focus on targeted programs As mentioned before, the main problem in HIV/AIDS is Sierra Leone is among high-risk groups such as commercial sex workers, miners, truck drivers, the police, and military. The SHARP project increased over the last year the focus of programs towards these groups, including change in behavior and well-targeted treatment of the infection.

[76] World Bank, *Project Appraisal Document Sierra Leone HIV/AIDS Response Project*, February 2002

Evidence of effectiveness. In general, most of the youth-serving organizations in Sierra Leone lack the resources and capacity to evaluate their programs, including those that MAP funds. A recent national-level survey found that, although young people's knowledge of HIV/AIDS has increased, their sexual and reproductive behavior has not changed significantly. Attributing these improvements to MAP alone is difficult if not impossible, because of the many other HIV and youth programs operating in the country. The survey found several barriers to practicing safe sexual behaviors, including: (a) the lack of appropriate skills, such as to negotiate condom use; (b) lack of trust in the source of information; (c) lack of access to services including to condoms; and (d) lack of continuity of information give the often short-term nature of IEC activities.[77]

Complementary Role of Other Bank-funded Efforts and of Other International Partners

The Ministry of Education and Science and Technology (MEST) participates in the World Bank's Accelerate the Education Sector Response to HIV/AIDS Initiative.[78] As part of this initiative, the World Bank recommended the MEST establish committees to harmonize curricula and coordinate NGO activities; teach life skills at the primary and secondary level; and ensure that all 20 tertiary institutions, including teacher training colleges, have developed and carried out institutional policies on HIV/AIDS. The MEST made significant progress since 2005 including (a) the launching of the Education sector HIV/AIDS policy in 2006, (b) the revision of syllabi for primary and secondary education in collaboration with PLAN, UNICEF and the Population and Family Life Education (POP/LE) Program funded by UNFPA, (c) the development of teacher's guides for primary and secondary education with NAS support, and (d) integration of HIV/AIDS into teachers training with UNICEF.

Other international partners supporting youth-related HIV/AIDS activities include UNICEF, UNFPA, and the Global Fund for AIDS, TB and Malaria,[79] UNDP, and a variety of bilateral donors. For example, UNICEF and CARE have supported the National AIDS Secretariat and the Ministry of Education and Science and Technology to develop a life skill based youth reproductive health tool called *Sissy Aminata*, which the education ministry has formally adopted into its life skills curriculum and uses with both with in-school and out-of-school youth. UNFPA also supports school-based sexuality and HIV/AIDS education and infusion of HIV/AIDS topics in non-formal education settings.[80] Currently, donors supporting youth HIV/AIDS programming are not coordinating effectively.

Constraints and Opportunities

While the government of Sierra Leone clearly recognizes the importance of youth initiatives, coordination of activities is lacking. As reflected in government policies, programs of other donors such as the Global Fund, UNICEF and UNFPA, and specific emphasis on youth in the Project Appraisal Document of MAP,

[77] World Bank, Aide Memoire Mid Term Review Mission SHARP, Jan 2005
[78] See description of this initiative in the Burkina Faso case example.
[79] The Global Fund for AIDS, TB and Malaria, Development of a comprehensive national response to HIV/AIDS that includes adequate prevention, treatment, care, and support for those affected, Sierra Leone, 2005.
http://www.theglobalfund.org/search/docs/4SLEH_814_0_full.pdf
[80] World Bank, October 2005, Aide Mémoire SHARP Sixth Implementation Support Mission, Freetown, October 3-11, 2005.

youth is recognized as a key beneficiary group for HIV/AIDS initiatives. Current efforts, however, lack an overall coordinated strategy both nationally and regionally.

Coordination of HIV/AIDS prevention messages is weak, and their quality varies. International donors and national and international NGOs often develop their own prevention materials for youth, with varying degrees of quality. For example, UNICEF, UNFPA, and UNESCO each have independently supported development of education materials. In addition, national NGOs tend to develop general messages for youth, without distinguishing between subgroups.

Most youth HIV/AIDS activities are through short-term projects and focus on IEC. Activities often comprise just a few sensitization activities, such as workshops, a media campaign, theater, etc. Moreover, programs do not link IEC to other strategies such as VCT or condom distribution, thus reducing the chances for behavior change. Short-IEC campaigns have limited impact. For example, ARC International recently conducted a post-intervention survey in Port Loko to measure changes in HIV/AIDS knowledge and attitudes among soldiers, commercial sex workers, youth, and ex-combatants. The survey found that despite significant increases in levels of knowledge on HIV, young people still have low levels of correct knowledge on HIV,[81] and that while condom use rose, approximately half of the youth interviewed had never used a condom.

Rural youth are short-changed. Although more than 65 percent of the population live in rural areas, the majority of HIV/AIDS efforts remain urban focused and are often limited to the Western Area and the capital, Freetown. In rural areas, youth have inadequate access to HIV/AIDS information and services.

The quality of CSOs working with youth on HIV/AIDS varies widely. According to government and donor officials, only a minority of NGOs working with young people can carry out quality activities. Training of peer educators is often through short-term projects, with little systematic follow-up or technical support to strengthen HIV/AIDS-related messages.

HIV/AIDS programs are not closely linked with other reproductive health activities. Currently, youth HIV programs lack coordination with other reproductive health activities of the Ministry of Health. To achieve programs going beyond IEC and including, for example, youth-friendly VCT, a stronger collaboration is needed.

Key Areas for Improvement

Better coordination of ongoing and future youth HIV/AIDS programs. A possible solution could be to strengthen youth expertise within the National AIDS Secretariat and assign a staff to be responsible for coordinating the different initiatives by the Ministries, different multi- and bilateral donors, and international and national NGOs. Given the pro-active role of the Ministry of Youth and Sports in Sierra Leone, close coordination with this Ministry would be beneficial. The NAS should build better

[81] ARC Sierra Leone, August 2003, *Post-Intervention Survey Report: HIV/AIDS/STI Knowledge, Attitudes, and Practice (KAP) Survey among commercial sex workers, military and youth in Port Loko, Sierra Leone.*

coordination and partnerships among the different donors working with youth ensuring, among others, to benefit from respective expertise from organization such as UNICEF and UNFPA.

Coordinate and strengthen the quality of HIV/AIDS messages for youth and strengthen links between in-school and out-of-school activities. Developing quality materials is both time and resource consuming. Groups could use quality life skills manuals such *Sissy Aminata* as a basic tool for prevention instead of developing their own manuals. Ongoing programs such as *Nova Scotia* could be used to strengthen the links between in-school and out-of-school activities. Special attention should also be paid to reaching unemployed youth and youth working in the informal sector.[82]

Need for a longer term, multi-pronged approach for youth HIV/AIDS activities to ensure behavioral change. To achieve behavior change, a multi-pronged strategy is needed that includes continuous information, access to condoms, and high quality, youth-friendly reproductive health services, preferably at the decentralized level.[83] Information should include general reproductive health information and life skills education such as negotiation of sexual relations and the use of contraceptives. These activities are in line with the Global Fund interventions that include improving access to voluntary Confidential Counseling and Testing, and improving access to condom by the use of social marketing. The Student Partnership Worldwide program represents one possible longer-term approach.

Continue targeted programs. While important to stress prevention for all young people, targeted programs for high-risk subgroups of youth such as commercial sex workers and truck driver remain essential.

Expand geographic coverage of youth HIV/AIDS programming. Rural areas need special attention to ensure that young females can also participate in youth activities. The ongoing decentralization, including the development of District Aids Committees, is a useful mechanism to expand programs in remote regions.

Boost the capacity of youth-serving CSOs through support of youth networks and consortiums, which in their turn can provide support to smaller groups implementing youth and HIV/AIDS activities. Priority capacity needs include improved and continuous training for peer educators; training health care workers in nonjudgmental and confidential youth-friendly VCT; and capacity building for evaluation and monitoring.

Strengthen the inclusion of religious leaders in youth and HIV/AIDS activities. According to a survey, 97 percent of young people in the Western Region listen to religious sermons. Sometimes, religious leaders may spread misinformation on the disease. Programmers should more systematically include religious leaders, building on efforts such as a meeting with religious leaders and the president of Sierra Leone during World AIDS day 2004.

[83] The ongoing process of decentralization through District AIDS Committees aim is to ensure community participation, and active involvement of district coordination bodies, District Councils and individual responsibility in all HIV/AIDS programming. (UNAIDS, 2006)

Develop a national policy on adolescent sexual and reproductive health and strengthen the coordination of activities between the Ministry of Health and others, both at the national and regional level. As noted, Sierra Leone currently does not have an adolescent sexual and reproductive health policy. Improving links with ongoing HIV/AIDS activities and using existing mechanisms of the Ministry of Health would improve use of limited resources and strengthen the overall link between HIV infection and other sexual and reproductive health concerns.

Case Example: Uganda[84]

Country and Project Context

As UNAIDS recently noted, "In Africa, Uganda remains the preeminent example of sustained success [in fighting the epidemic]."[85] By the end of 2005, HIV prevalence in adults was estimated to be 6.7 percent, down significantly from its peak in 1992. Experts attribute much of this decline to behavior change among young people, such as delay in first sexual experience and higher condom use.[86] Although overall prevalence rates for young people have declined, stark differences for males and females remain. Females 15 to 24 years old are more than twice as likely to have the infection as males in the same age group (see box).

HIV & Youth in Uganda

Total population, all ages	27.7 million
Population ages 10-24	33.7%
Gross national income in purchasing power parity (GNI PPP) per person	$1,500
Human Development Index rank	144
Adult HIV/AIDS prevalence	6.7%
Youth HIV/AIDS prevalence (M/F)	2.3/5.0%
AIDS Orphans	1,000,000
HIV Prevention Knowledge (M/F)	40/28%
Condom Use for high-risk sex (M/F)	55/53%
Teen birth rate	208 per 1000
Child death rate	138 per 1000
Secondary school enrollment (M/F)	22/18%
Single, sexually active women 15-19 using modern contraception	22%
Median age at first intercourse (M/F)	18.8/16.6 years
Median age at first marriage (M/F)	22.3/17.8 years

Data for 2001-2005 period. See note for definitions and sources

In 2000, the World Bank approved the $50 million Uganda HIV/AIDS Control Program (UACP), to support national initiatives to accelerate and expand existing programs in prevention, care, treatment, and mitigation, and to build capacity. The Uganda MAP supports the Government of Uganda's National Strategic Framework for HIV/AIDS, which aims to reduce the spread of HIV infection; mitigate the health and socio-economic impact of HIV/AIDS at individual, household and community levels; and strengthen the national capacity to respond to the epidemic. The project has three main components: (1) nationally led initiatives directly carried out by different ministries or central government agencies, or contracted out to civil society organizations or the private sector; (2) district initiatives directly carried out by district authorities, or are contracted out to civil society organizations or to the private sector; and (3) community-led HIV/AIDS initiatives (CHAI), directly carried out, or contracted out, by community-based organizations.

Existing Policies and Programs on Youth and HIV

Policy Environment. The government of Uganda has put in place an array of policies in recent years to address HIV and other youth reproductive health concerns. In addition to the 2001 National Youth Policy, which encourages establishment of youth-friendly health services, other policies promote

[84] Unless otherwise specified, the case example draws from the longer report: *Uganda Assessment Report: Scaling up Youth-Focused Interventions in the Multi-Country HIV/AIDS Programs (MAP) and Building Capacity of Civil Society Organizations (CSOs)*, Ismail Ndifuna, Unpublished report, June 28, 2005.
[85] UNAIDS. 2004. *2004 Report on the global AIDS epidemic*, http://www.unaids.org/bangkok2004/report_pdf.html
[86] UNICEF. 2002. *Young People and HIV/AIDS. Opportunity in Crisis*. New York, NY: UNICEF; [86] UNAIDS. 2004. 2004 *Report on the global AIDS epidemic*, http://www.unaids.org/bangkok2004/report_pdf.html

universal primary education, integration of gender into all aspects of development, and the rights of young people to HIV counseling and testing. Strong political support for prevention has helped reduce some of the cultural taboos against discussing youth sexuality. The National Adolescent Health Policy, approved in October 2004, also provides strong policy support to HIV programs.[87] Nonetheless, the country has not fully put these policies into practice.

Programs for Youth. A large constellation of youth-serving organizations works on HIV/AIDS. These stakeholders include government ministries and departments, the Uganda AIDS Commission, District Youth Councils, District HIV/AIDS Committees, local and international NGOs, faith-based organizations, and community-based organizations. These groups, working from the national level down to the smallest communities, carry out a wide range of programs including prevention, treatment, care and support, and mitigation of the socioeconomic impact of the epidemic. Despite this range of activities, observers still consider funding for youth programs to be inadequate given the needs. Most projects are largely adult driven, and duplication of efforts contributes to the failure to adequately meet youth needs.

How MAP is Addressing Youth

How the Project Appraisal Document addresses Youth. The PAD clearly identifies the younger generation as a high-risk group and part of the target population, includes a youth-specific impact indicator, and mentions various youth-specific projects.[88] Although the consensus is that planned activities have generally been carried out, in practice the absence of a strong monitoring and evaluation component makes it difficult to ascertain whether this in fact was the case.

Support through community initiatives. MAP supported community-led initiatives in 30 of the country's 56 districts. Through the end of March 2005, 3,965 community subprojects were approved. An analysis of disbursements to civil society organizations in the first quarter 2005 showed that 15 of 40 groups (38 percent) receiving funds were youth-serving. Funding for these groups totaled $154,000, or about 37 percent of the total disbursed. One example of a youth program supported by MAP is the Strengthening Uganda Muslim Community Response on HIV/AIDS project of the NGO Islamic Medical Association of Uganda. The project trained young imams (Muslim leaders) in development of work plans, conducted workshops for young Muslim district HIV/AIDS coordinators and trainers in 26 districts, and conducted training for community educators.

Evidence on Effectiveness. Effectiveness of MAP youth programs cannot be established with certainty because community groups are not disaggregated according to the age groups they serve.

Self-scoring of effectiveness. The majority (20 of 23) of the organizations interviewed for this assessment believed their current efforts were either very effective (5) or effective (15). Empowerment of young people with life planning skills, and school programs were particularly credited for effectively

[87] YouthNet, *Uganda: Youth Reproductive Health and HIV Policy Environment,* May 2004; POLICY Project, 2005, Uganda: Networking for Policy Change, Youth Reproductive Health Policy Country Brief Series No. 5.
[88] *Project Appraisal Document on a Proposed Credit in the Amount of SDRD 37.3 Million (US$ 47.5 Million Equivalent) to the Republic of Uganda for an HIV/AIDS Control Project*, December 28, 2000.

influencing behavior change, and transforming in-school youth into competent and conscious individuals. Only three organizations reported that their programs are not effective. Reasons cited for non-effectiveness include poor coordination, little involvement of out-of-school youth, and down playing condom use.

Complementary Role of Other Bank-funded Efforts and of Other International Partners

The Bank is not currently funding any other initiative in Uganda directly related to HIV and youth. However, several other donors currently support youth-serving organizations. These include UNICEF, African Youth Alliance, USAID, CIDA, Global Fund, HIV/AIDS partnership through NAFOPHANU, Steven Lewis Foundation, Japanese Trust Fund, UNESCO, Global Ministries, UNFPA, Action AID, European Union, President's Emergency Program for HIV/AIDS Relief (PEPFAR), Hope for African Children Initiative, SIDA, Department for International Development (DFID), WHO, UNAIDS, UK Scouts. UNFPA, for example, supports peer education, community mobilization, and training health workers and strengthening health facilities to provide youth-friendly services.

Constraints and Opportunities

Capacity gaps. Despite the resolve of the UACP build capacity in local communities and government departments, numerous technical and human resource capacity gaps exist, especially in civil society organizations. Such gaps are even more pronounced among youth groups. The staffing in most youth-serving organizations is inadequate both quantitatively and in terms of expertise. Such groups lack capacity of strategic planning of their programs, proposal writing, monitoring and evaluation of their activities and overall service delivery, staffing and logistical issues. Moreover, youth-led organizations lack credibility or a proven record of accomplishment. Young people are perceived to lack self-confidence and as unable to articulate their needs and problems. Such barriers impede funding to youth programs despite the overwhelming needs of young people.

Lack of coordination. Although young people are seen as a priority in the battle against the epidemic, the general view is that youth-serving organizations are not well coordinated and are therefore unable to fully benefit from existing opportunities. In addition, a number of youth-serving organizations and youth groups are unaware of funding opportunities so they simply do not benefit from available funding opportunities.

Limited Youth Involvement. Youth representation on governance bodies both at the Uganda AIDS Commission and in youth-serving organizations is inadequate. Moreover, involvement in program design, implementation, and monitoring and evaluation is also lacking. An exception is the Family Planning Association of Uganda, which has some youth-led, youth-specific activities. Although the UACP has received general credit for wide consultations of stakeholders and beneficiaries in the project planning phase, young people feel the consultations were not inclusive enough to accommodate their concerns and needs. For example, CHAI included young people as a target group in its design, but youth involvement in assessing needs was ad hoc.

Key Areas for Improvement

Improve youth representation and involvement. More youth representation on governance bodies in youth-serving organizations and at the intermediary and national levels is essential. The selection processes for selection of youth representatives should be transparent. Such representation should rotate among young people and organizations to maintain fresh perspectives and give voice to a range of youth-serving groups. The UACP should also emphasize youth participation in programming, needs assessment, planning and monitoring and evaluation.

Build capacity of youth groups. The UACP effectively contracted relatively experienced CSOs to build the capacity of less-experienced community groups. UACP should scale up these efforts, aiming to increase capacity of youth groups in areas such as planning, supervision, tracking of funds, and monitoring and evaluation.

Strengthen youth networks for advocacy, coordination, and learning. The UACP should also help build the capacity of youth-serving organizations and youth groups to network and advocate for carrying out of existing policies. Networking among youth-serving organizations and youth groups would go a long way to dealing with lack of knowledge of funding sources and the lack of coordination among youth groups. To improve the expertise of youth groups, UACP should support youth-serving CSOs to undertake site visits to established projects, organize internship or placements with skilled staff in order to develop local learning networks. UACP should also develop a training and skills enhancement plan to address weaknesses or key capacity concerns in youth-serving organizations.

Case Example: Zambia

Country and Project Context

UNAIDS estimates that 17.0 percent of adults in Zambia were infected with HIV at the end of 2005. HIV prevalence was 12.7 percent in females ages 15 to 24 and 3.8 percent in males ages 15 to 24. Despite these sobering figures, Zambia has made progress in reducing high rates of infection among young people, lowering the infection rate from 28 percent in 1993 to 15 percent in 1998.[89]

HIV & Youth in Zambia

Total population, all ages	11.9 million
% Urban	35%
Population ages 10-24	35.6%
Gross national income in purchasing power parity (GNI PPP) per person	$950
Human Development Index rank	166
Adult HIV/AIDS prevalence	17.0%
Youth HIV/AIDS prevalence (M/F)	3.8/12.7%
AIDS Orphans	710,000
HIV Prevention Knowledge (M/F)	33/31%
Condom Use for high-risk sex (M/F)	42/33%
Teen birth rate	128 per 1000
Child death rate	182 per 1000
Secondary school enrollment (M/F)	30/25%
Single, sexually active women 15-19 using modern contraception	22%
Median age at first intercourse (M/F)	18.0/16.8 years
Median age at first marriage (M/F)	23.8/17.8 years

Data for 2001-2005 period. See note for definitions and sources

The Bank's board approved the $42 million, 5-year Zambia National Response to HIV/AIDS Project (ZANARA) project on December 30, 2002 and the project became effective on July 8, 2003. ZANARA has four components: (1) support to the National AIDS Council and Secretariat, (2) support for community responses to HIV/AIDS (CRAIDS), (3) support to ministries, and (4) program administration. A unit of the Ministry of Finance and National Planning manages ZANARA directly. The National Aids Council (NAC) of Zambia monitors, evaluates, and coordinates ZANARA's activities as part of its overall national mandate. The Project Administration Unit of ZANARA is responsible for administration of the project components, which includes the financial management, procurement, and disbursement functions of the project and the day-to-day interactions with the World Bank. The Administration Unit is also responsible for the management of the logistical aspects of the project and review and consolidation of progress reports on project activities for all stakeholders on procurement plans, implementation progress and resource use. The CRAIDS component funds subprojects developed at community levels and through civil society and faith-based organizations. In addition to its headquarters staff in Lusaka, CRAIDS has regional coordinators in each of the country's nine regions. Each of Zambia's 72 districts has a District AIDS Task Force (DATF) comprised of representatives from civil society (NGOs, faith-based organizations, PLWHA, traditional healers, and traditional chiefs), private sector, ministries, health boards, and local government. The role of the DATFs is to support the management of CRAIDS and coordinate AIDS activities within the districts.

Existing Policies and Programs On Youth and HIV

The AIDS crisis has catalyzed action at the national policy level on youth. Several policies mention youth as an important population, including the Population Policy, the Gender Policy, the National HIV/AIDS/STI/TB Policy, and the National AIDS Control Program's Strategic Framework. A draft

[89] UNICEF, UNAIDS, WHO. 2002. *Youth and HIV/AIDS: Opportunity in Crisis.* http://www.unicef.org/publications/files/pub_youngpeople_hivaids_en.pdf

National Reproductive Health Policy contains youth-specific objectives.[90] In addition, Zambia's poverty reduction strategy examines the relationship between HIV/AIDS and poverty, notes the centrality of young people in fighting the epidemic, proposes youth policies, and sets targets in terms of key youth-specific indicators including delay of sexual debut and infection rate among 15 to 24-year-olds.[91]

Civil society hosts a rich variety of youth-serving groups that have led in programming to combat HIV/AIDS. Almost all youth-serving groups include an HIV component in their work, and many have been working for several years on HIV and other reproductive health concerns. Traditional youth groups in this category include the Scouts, Girl Guides, YWCA, and YMCA. Other large NGOs with a youth focus include Kara Counseling and Training Trust. National alliances of youth groups include the Forum for Youth Organizations. Many small, relatively informal community youth groups also operate almost everywhere in the country. In addition, a number of larger, established NGOs working broadly on HIV/AIDS and reproductive health also have youth activities. Such groups include the Planned Parenthood Association of Zambia, Zambia Business Coalition on HIV/AIDS, Zambia Alliance of Women, and Zambia Health Education and Communication Trust.

Zambia has been at the forefront among African countries in testing and putting in practice youth-friendly clinical services for young people. First established in 1996 in Lusaka, by 2001 there were 63 youth-friendly clinics across the country. Peer educators work with specially-trained nurses to provide information and services on reproductive health, including HIV/AIDS.[92] A strong national program of life skills education and health services is credited with helping to increase condom use and reduce sexual partners among young people.[93] However, beyond the Ministry of Health, few other ministries have contributed directly to developing youth HIV policies or programs.

No single entity has responsibility for national-level coordination on HIV and youth issues. Among the groups that exist that touch on one or another aspect of youth and HIV and that offer coordination possibilities are: (1) the adolescent task group of the reproductive health subcommittee of the Central Board of Health, which includes representatives of key ministries, NGOs, and UN partners; (2) the OVC working group of the National AIDS Council and Secretariat; and (3) the National Steering Committee on Youth, chaired by the Ministry of Sport, Youth, and Child Development and comprised of representatives of the various ministries, civil society and faith-based groups. The Steering Committee does advocacy, coordination, resource mobilization, and supports research and information sharing.

How MAP is Addressing Youth

How the Project Appraisal Document addresses youth. The PAD for the ZANARA project tends to be more explicit than other MAP PADs in its treatment of youth issues. As outlined in the Project Appraisal Document, the project development objective of the ZANARA emphasizes reaching vulnerable populations, defined as including young people and orphans. The PAD recognizes that youth—and especially young women—are particularly vulnerable to infection. It identifies roles for key ministries

[90] YouthNet, 2004, *Zambia: Youth Reproductive Health And HIV Policy Environment.* Unpublished.
[91] Zambia Ministry of Finance and National Planning. 2002. *Zambia Poverty Reduction Strategy Paper, 2002-2004.* www.worldbank.org/prsp.
[92] UNICEF, UNAIDS, WHO. 2002. *Youth and HIV/AIDS. Opportunity in Crisis.* http://www.unicef.org/publications/files/pub_youngpeople_hivaids_en.pdf
[93] UNICEF, UNAIDS, WHO. 2002. *Youth and HIV/AIDS. Opportunity in Crisis.* http://www.unicef.org/publications/files/pub_youngpeople_hivaids_en.pdf

in combating the epidemic among young people, including the ministries of health, education, and youth, sport, and child development. The PAD designates $11.7 million to the Ministry of Health and specifically notes that a portion of this money will fund strengthening of youth-friendly health services. It also calls for education efforts aimed at both in-school and out-of-school youth. The PAD also recognizes cultural sensitivities associated with prevention services directed towards young people, including education and condom distribution. The PAD assigns a role to the Ministry of Youth, Sport, and Child Development in information dissemination and in developing youth-led initiatives. The PAD specifically directs the community response component to support youth programs, and includes in and out-of-school youth as a priority target group.

ZANARA provides significant levels of support to programs for young people. Through both the civil society and ministry components, ZANARA supports a range of activities that include primary prevention and care and mitigation. Orphans and other vulnerable children are a particular emphasis of ZANARA funding. Many Zambian communities perceive OVCs as particularly vulnerable, and a group whose socioeconomic problems place them at heightened risk of infection.

Activities in ministries have initially had an internal focus. ZANARA's support to ministries with a youth focus include Education; Health; Youth, Sport, and Child Development; Science Technology, and Vocational Training; and Community Development. To date, funding has gone mainly for sensitization and training of ministry staff; relatively few activities benefit young people directly. This strategy is in keeping with the objectives of ZANARA and with the relatively limited amounts of funding available for the ministries. One exception is a large allocation of funding to the health sector to establish youth-friendly corners in clinical facilities. Through October 2006, funding had helped to establish or rehabilitate 87 of these youth-friendly corners and train almost 1,500 peer educators based in these clinics.[94]

ZANARA has provided moderate levels of support for youth efforts in civil society through the CRAIDS local response component.

An analysis of 60 projects active as of March 2005 (see Table A.4) found that 10 of the 60 projects (17 percent) had youth-oriented components. The amount of funding for youth projects, US$ 73,000, represents about 9 percent of the total. If OVC projects are included in the calculation, then the combined proportion of youth and OVC-oriented projects rises substantially, to 65 percent of projects and 59 percent of funding.

[94] Musonda Rosemary Sunkutu, *Making Operations Work for Youth: A Case Study of the Zambia National Response to HIV and AIDS Project*, Presented November 8, 2006 in Washington, DC at World Bank Human Development Learning Week.

Table A.4. Youth Projects Supported through the Community Response Component of the Zambia MAP, Current Projects as of March 2005

	# of Projects	percent of total	Funding (US$)	percent of total
Projects with Youth component	10	17%	72,750	9%
OVC Projects	29	48%	404,236	50%
Projects without a youth or OVC component	21	35%	328,255	41%
Total	60	100%	805,241	100%

Source: CRAIDS Project Profiles

A less in-depth analysis of the 706 subprojects approved by CRAIDS through October 2006, found that 230 or 32.5 percent targeted and/or were implemented by youth.[95] Interventions supported cover a wide range of youth activities including peer education, behavior change communication, advocacy, life skills training, the establishment of youth-friendly corners in clinical settings, condom promotion and distribution, promotion of school health services, counseling, income generation, and support for OVC skill training. Programs help both in-school and out-of-school youth and also target particularly vulnerable youth such as street children and former commercial sex workers.

The degree to which ZANARA-supported youth programming is effective is unclear. The CRAIDS team has made considerable strides in developing financial and program monitoring systems. However, current systems do not allow evaluation of the effectiveness of the youth programming in terms of impact on key prevention behaviors. No analysis has taken place of the impact of other MAP-funded efforts that have focused on young people.

CRAIDS generally supports activities falling within the set of international good practices in youth programming. Analysis of the 10 youth-oriented projects supported by CRAIDS found that 14 of 17 activities are among the list of international good practices in youth and HIV programming.[96] Table A.5 shows the breakdown by type of activity.

[95] Musonda Rosemary Sunkutu, *Making Operations Work for Youth: A Case Study of the Zambia National Response to HIV and AIDS Project*, Presented November 8, 2006 in Washington, DC at World Bank Human Development Learning Week.

[96] For more information on best practices, see World Health Organization. 2004b. *Information brief on the Talloire consultation to review the evidence for policies and programmes to achieve the global goals on young people and HIV/AIDS: Steady, ready GO!* Geneva, WHO. http://www.who.int/child-adolescent-health/publications/ADH/IB_SRG.htm

Table A.5. Extent to which Zambian MAP Funds Good Practices in Youth Programming
Activities classified as good practices according to international standards as a proportion of all funded interventions, Zambia, March 2005.

Interventions supported by MAP	Number of Activities	Effective based on international good practice standards
Good Practice Activities		
Train peer educators	3	Y
Train youth in HIV counseling	1	Y
IEC materials distribution to youth	1	Y
Drama performances	1	Y
Rehab of old building for school for out-of-school youth	2	Y
Psychosocial counseling	3	Y
Resource center development	1	Y
Life skills training	1	Y
Working with adults to reduce transmission amongst young girls	1	Y
Subtotal good practice	14	
Non-good practice activities		
Sports tournaments	1	N
Income-generating activities	2	N
Subtotal non-good practice	3	
Total	17	
Proportion Good Practice	82%	

Source: CRAIDS Project Profiles

Evaluation of other youth HIV programs in Zambia. Zambian organizations have carried out relatively rigorous evaluations of past youth and HIV activities, including experiences with participatory learning and assessment in the design of youth-friendly services, a project looking at the health of adolescent refugees, and an evaluation of youth-friendly health services. The latter study found increases in adolescent contraceptive use and in service use related to community attitudes towards adolescent reproductive health care.[97] A current evaluation is underway to measure the impact of OVC programs in Zambia on socioeconomic outcomes as well as on reproductive health knowledge and behaviors.[98]

Complementary Role of Other Bank-funded Efforts and of Other International Partners

The Bank is supporting the Ministry of Education in Zambia through the *Accelerate the Education Sector Response to HIV/AIDS Initiative.* This effort aims to strengthen the capacity of the education sector to respond with timely actions to prevent infection among learners and teachers. The Ministry of Education hosted an August 2004 national-level workshop involving teams from all nine provinces

[97] FOCUS on Young Adults, 2001, *Advancing Young Adult Reproductive Health: Actions for the Next Decade.*
[98] Minki Chatterji, Futures Group, personal communication

and 72 districts of Zambia.[99] The objective was to accelerate the education sector response to HIV/AIDS and other related issues by developing specific District and Provincial action plans to be integrated into the 2005 activity-based Annual Work plan and Budget, enabling decentralized implementation of activities to the school level.

Other international partners are providing considerable financial and technical assistance to youth HIV/AIDS activities. Important partners include the U.S. government through USAID and PEPFAR, UNICEF, UNFPA, and the Global Fund for AIDS, TB, and Malaria. These partners are also keenly interested in supporting civil society organizations and building capacity of communities; some capacity-building projects on HIV/AIDS already exist. All the international partners recognize the need for and potential benefits of greater coordination, but also acknowledge that time and resource constraints hamper coordination.

Constraints and Opportunities

NAC and ZANARA staff is supportive of youth HIV initiatives but recognize the need for greater knowledge of "what works" and how to conduct specific youth activities. Clearly, ZANARA's program team and the leadership of the NAC recognize that youth are a key beneficiary group. This acknowledgement closely tracks with the emphasis the PAD placed on the younger generation.

The NAC includes a youth representative. The National AIDS Council includes a young person who acts of representative of the country's youth organizations. However, although several technical working groups advise the council and its secretariat, none specifically deals with young people.

Capacity of youth-serving groups is limited. Although many of the larger, well-established groups express need for greater organizational and technical capacity, capacity needs are greatest amongst the small community youth groups and associations. These groups comprise the primary target for CRAIDS support. Although some have been able to tap into CRAIDS funding, questions remain about how effectively they are using the support. Furthermore, many more youth groups have not yet been able to access CRAIDS funding, despite what many informants perceive as strong efforts to publicize the availability of funding.

District AIDS Task Forces lack the capacity to adequately identify and support youth activities. Few DATFs have specialized technical expertise on youth matters, and many lack adequate representation of youth and youth groups. These capacity gaps on youth exist within the broader context of the ability of DATFs to carry out their technical and oversight role.[100]

[99] *Accelerating the Education Response by Mainstreaming HIV/AIDS; Equity and Gender; Special Education Needs; and School Health and Nutrition in Decentralized Planning in Zambia.* Workshop Report. 8 - 13 August 2004, Lusaka, Zambia. Seminar sponsored by the Zambian Ministry of Education with Technical Assistance from the Working Group of the UNAIDS Inter-Agency Task Team (IATT) for Education.
[100] See *Aide Memoire from a World Bank Mission to Strengthen Local Government Response to HIV/AIDS*, November 9-19, 2004.

Key Areas for Improvement

Increase ZANARA/CRAIDS staff expertise on youth issues. To build on its work supporting youth-oriented programs, CRAIDS should consider building its staff expertise on youth to improve its technical oversight on youth activities.

Establish a technical working group on youth at the NAC. The NAC currently lacks a technical working group on youth. To strengthen the national effort, NAC should consider forming such a group. This group could work closely with the proposed youth focal person on the CRAIDS team.

Building capacity of youth groups. The smaller youth groups need help acquiring a range of managerial, organizational, and technical capacities. Although civil society groups of all kinds face many of these same capacity gaps, groups with a youth focus have even more need of capacity building, because of the relative inexperience of their members. This capacity-building effort could be coordinated and implemented by national level NGOs or other civil society groups.

Building capacity among the DATFs. Strengthening the capacity of the DATFs could complement activities aimed more directly at civil society groups.

*SOURCES FOR CASE EXAMPLE HIV AND YOUTH STATISTICS**

Total Population size, mid-year 2006: World Population Data Sheet 2006, Population Reference Bureau.

Percent Urban, 2006: World Population Data Sheet 2006, Population Reference Bureau.

Population ages 10-24 as a percent of the total population (2005): Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2004 Revision and World Urbanization Prospects: The 2003 Revision.

Gross national income (GNI) PPP per person, 2005: World Population Data Sheet 2006, Population Reference Bureau.

Human Development Index rank, 2005 (out of 177): United Nations Development Program *Human Development Report 2005*.

Adult (15-49) HIV/AIDS Prevalence, end of 2005: WHO, UNICEF, and UNAIDS. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections. December 2006 Update.

HIV/AIDS prevalence in youth 15-24 (male/female), 2005: WHO, UNICEF, and UNAIDS. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections. December 2006 Update.

AIDS Orphans 0-17 living in 2005: WHO, UNICEF, and UNAIDS. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections. December 2006 Update.

AIDS Knowledge Indicator (male/female): Percentage of young people 15-24 who both correctly identify two ways of preventing the sexual transmission of HIV and who reject three misconceptions about HIV transmission. WHO, UNICEF, and UNAIDS. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections. 2006 Update.

Condom use indicator: Proportion of young people reporting the use of a condom during sex with a non-regular partner. WHO, UNICEF, and UNAIDS. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections. 2006 Update.

Teen birth rate; births per 1000 women ages 15-19, 2004: World Bank, *World Development Indicators 2006*

Child death rate (under 5 mortality), 2004: World Bank, *World Development Indicators 2006*.

Boys/Girls secondary school enrollment, 2000-2004: PRB. *World's Youth 2006 Data Sheet.*

Youth contraceptive use (percent of single, sexually active women ages 15-19 using a modern method of contraception: DHS. PRB. *World's Youth 2006 Data Sheet.*

Median age at first sexual intercourse for women ages 25-49; men ages 25-54: DHS.

Median age at first marriage for women ages 25-49; men ages 25-54: DHS.

** Source is for all case example countries, unless otherwise noted*

APPENDIX B. INTERNATIONAL GOOD PRACTICE—HIV AND YOUTH

Summary of findings and recommendations from the systematic reviews of interventions to achieve the global goals on HIV and young people in five delivery settings

Setting	Type of intervention	No. of studies meeting inclusion criteria	Threshold of evidence needed to recommend widespread implementation	Strength of evidence for a beneficial impact	Recommendation
Schools	Curriculum-based interventions *with* characteristics that have been found to be effective in developed countries and are led by adults	13	Low	Very strong	Go
	Curriculum-based *with* characteristics found to be effective in developed countries and that are led by peers	1	Low	Weak	Steady
	Curriculum-based *without* the characteristics found to be effective in developed countries and that are led by adults	2	Low	Weak	Steady
	Curriculum-based *without* the characteristics found to be effective in developed countries and led by peers	1	Low	Weak	Steady
	Non-curriculum based *without* characteristics found to be effective in developed countries and led by adults	4	Low	Weak	Steady
	Non-curriculum based *without* characteristics found to be effective in developed countries and led by peers	1	Low	Equivocal	Steady
Health services	Interventions with service providers and in the community	1	Low	Equivocal	Steady (or Do not go)
	Interventions with service providers and in facilities and the community	4	Low	Weak	Go
	Interventions with service providers and involving other sectors	1	Moderate	Equivocal	Steady (or Do not go)

Source: UNAIDS Inter-agency Task Team on Young People, 2006, Preventing HIV/AIDS in Young People, A Systematic Review of the Evidence from Developing Countries.

Setting	Type of intervention	No. of studies meeting inclusion criteria	Threshold of evidence needed to recommend widespread implementation	Strength of evidence for a beneficial impact	Recommendation
	Interventions with service providers and in facilities and involving other sectors	0	Moderate	No data	No data
	Interventions with service providers and in the community and involving other sectors	2	Moderate	Equivocal	Steady (or Do not go)
	Interventions with service providers and in facilities and the community and involving other sectors	8	Moderate	Weak	Ready
Mass media	Radio only	1	Moderate	Equivocal	Steady
	Radio with other media (excluding television)	6	Moderate	Medium	Go
	Radio and television with other media	8	High	Strong	Go
Geographically defined communities	Targeting youths through existing youths-service organizations	11	Moderate	Equivocal	Ready
	Targeting youths through new structures	6	High	Weak	Steady (or Do not go)
	Targeting the community through traditional networks	3	Moderate	Equivocal	Steady
	Targeting the community through community events	2	Moderate	Weak	Steady
Young people most at risk	Information only provided through outreach	1	Moderate	Weak	Steady
	Information and services provided through outreach	0	High	No data	No data
	Facility-based information and services	1	Low	Weak	Steady
	Outreach and facility - based information and services	2	Moderate	Weak	Steady (but Ready if evidence from developing countries among all ages considered)

The "Steady, Ready, Go" continuum for recommending interventions

Recommendation	Criteria
Go	Evidence threshold met
	Sufficient evidence to recommend widespread implementation on large scale now, ideally with careful monitoring of coverage, quality and cost, and operations research to better understand the mechanisms of action
Ready	Evidence threshold partially met
	Evidence suggests interventions are effective but large-scale implementation must be accompanied by further evaluation and operations research to clarify impact and mechanisms of action
Steady	Evidence threshold not met
	Some of the evidence is promising but further development, pilot-testing and evaluation of processes and outcomes are needed before it can be determined whether these interventions should move into the "Ready" category or "Do not go"
Do not go	Strong enough evidence of lack of effectiveness or of harm
	Not the way to go

APPENDIX C. SCOPE OF WORK

Scope of Work:

Evaluation of the Youth Component of the Multi-country AIDS Program

Introduction

This scope of work lays down the parameters for an evaluation of the youth component of the Multi-country AIDS Program (MAP) of the World Bank. An international consultant will carry out the evaluation in four countries in Africa.

The evaluation is being funded under a grant from the Swedish International Development Agency (SIDA) Trust Fund to the Health, Nutrition, and Population Unit of the World Bank's Human Development Network (HDNHE).

Background

Young people are central in the battle against HIV/AIDS. Half of the 14,000 new infections that occur each day are in the 15-24 age group, with young females disproportionately affected. In the generalized epidemics of southern and eastern Africa, HIV infects 10 percent or more of youth, with heterosexual transmission by far the most likely route of infection. The concentration of new infections amongst the young has created immense health problems and threatens the economic and social underpinnings of those countries hit hardest by the epidemic.

The World Bank, through its HNP and MAP lending, is one of the world's largest donors in the areas of reproductive health and HIV/AIDS. Many Bank-financed HNP and MAP projects contain components that focus on the health needs of young people. An evaluation of the youth component in countries currently receiving MAP funding will help to gauge how well MAP is addressing the youth dimension of the epidemic and where the Bank and its counterparts can improve. This evaluation will feed into the development of guidelines for Bank staff on best practices in addressing youth within the HIV epidemic and strengthening the inclusion and implementation of youth-focused MAP components. This evaluation also complements activities under a proposed Japan Social Development Fund grant to strengthen the HIV activities of youth-serving NGOs.

Purpose of the Evaluation

To determine how well MAP is addressing the youth dimension of the HIV/AIDS epidemic and areas for improvement.

Specific Objectives

- Determine current levels and type of funding for MAP-financed, youth-focused activities
- Determine the factors that may foster or hinder attention to youth in MAP
- Determine the effectiveness of current youth-focused efforts

Evaluation Methodology

The evaluation will employ a variety of means to collect information including interviews of policy makers and staff members of key organizations, roundtable discussion with key informants, and focus group discussions with youth and community leaders and other stakeholders. A desk review of relevant documents will provide background and inform the evaluation, including those available in Bank HQ (e.g., the recent Operations Evaluation Department evaluation of MAP) and on web site. All evaluation activities will appropriately address gender issues.

The evaluation will take place in four African countries that are current MAP recipients. These countries will be chosen according to the following criteria: the level of interest of MAP TTL; the degree to which MAP is already supporting youth-focused activities; where MAP is in the project cycle; geographical and linguistic diversity (e.g. one Francophone African country, one Anglophone African country), and complementarity with other Bank efforts to strengthen the youth component of MAP (e.g., the proposed JSDF grant).

The consultant will develop assessment tools in consultation with key Bank staff including MAP officials and TTLs and staff of the Global AIDS Monitoring and Evaluation Team (GAMET).

Key evaluation questions will include:

Levels and Type of Funding

- What is the amount and percentage of MAP funding that goes towards youth-focused activities?
- What proportion of funding for civil society goes toward youth-focused activities?
- What proportion of funding for public sector benefits youth?
- Are funding levels adequate given the needs?

Factors Influencing Attention to Youth Issues

- Is there congruence between the planned youth-focused activities as discussed in the PAD and how things have played out on the ground?
- Does MAP/NAC have adequate staffing and expertise to properly address youth-focused programming?
- Is there a youth representative on the NAC (at the national/subnational level)? If not, why not?
- Is having a youth representative on the NAC sufficient to ensure proper attention to youth issues in funding programming?
- To what extent do national officials view youth as a priority group?
- How supportive is the policy environment?

Effectiveness of Current Efforts

- What is the range of youth-focused activities that MAP currently support?
- To what extent does the current MAP funding support best practices in youth programming?
- What could be done to increase the effectiveness of current efforts?

Integration with other Activities

The evaluation will be carried out in close coordination with a JSDF-funded assessment of capacity-building needs for Civil Society Organizations to carry out youth-focused HIV activities with MAP funding.

To the extent possible, the international consultants carrying out the JSDF assessment and MAP evaluation will coordinate their trip dates and conduct joint interviews and discussions with key stakeholders, where the scope of work overlaps.