Youth Community Involvement Resources

Community Involvement in Youth Reproductive Health and HIV Prevention: A Review and Analysis of the Literature

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A two-day consultation on community involvement in youth reproductive health and HIV programs was held November 8-9, 2005, in Arlington, Virginia, led by CARE USA/YouthNet and Family Health International (FHI)/YouthNet. This literature review and synthesis was done by consultant Alex Maclean, in preparation for the consultation and then expanded as a result of discussions held during the meeting. Maclean has worked for many years with participatory approaches, particularly in reproductive health and HIV prevention. The U.S. Agency for International Development (USAID) funded the consultation and this literature review.

This literature review is part of a package of materials YouthNet produced to help provide global technical leadership on the issue of community involvement and youth RH/HIV prevention. In addition to this review, the package includes:

- a guide to using participatory assessment techniques at the community level, focusing on youth involvement
- a report of the consultation meeting
- an annotated guide to technical resources

The package is available at:
www.fhi.org/en/Youth/YouthNet/Publications/CIresources/index.htm

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Executive Summary

Community involvement in youth reproductive health (YRH) and HIV prevention programming refers to the engagement of the community as a whole, as well as the involvement of young people themselves. The lives of young people are deeply embedded in, and affected by, community norms and expectations and by the behavior of adults around them. Anecdotal evidence and limited evaluation studies indicate that involving communities in YRH/HIV has the potential to reach youth within their social contexts, to reach vulnerable and marginalized youth, and to create a more enabling environment to support and sustain healthy behaviors. A gap remains, though, in terms of systematic analysis and evaluation of the impact of community programming relating to YRH.

In November 2005, YouthNet and its partner CARE convened a technical consultation on community involvement in YRH/HIV prevention. One objective of this meeting was to examine the evidence base for the value of community involvement in YRH/HIV programs. A second objective was to analyze selected promising YRH/HIV models with substantial community involvement components to determine promising practices that could be replicated in other sociocultural contexts. This review synthesizes the information available in the published and unpublished literature to help answer the questions implicit in these objectives.

Communities can be defined by a geographical area or by shared interests or characteristics. They are socially complex, serving a variety of economic, social, and political functions, and vary across space, time, and population. Those outside the community may have very different definitions from those inside.

Community involvement in this report is considered equivalent to community participation. From a program perspective, the goals or purposes of community involvement in health programming can be defined as a means to achieving health-related project objectives efficiently and effectively, or as an empowerment tool that is an end in itself. These two approaches are not contradictory and are likely complementary.

Evidence of Community Involvement Impact

The literature search on YRH/HIV programs with substantial community involvement components in them yielded documentation on 30 programs. Most documents were evaluative in nature. Quantitative and qualitative methods were used – not always together – and a significant number of reviewed interventions were operational research projects using a quasi-experimental design. Participatory involvement by communities implies that one must involve the community in evaluation, but no examples of community members setting and measuring their own indicators were identified.

Most of the interventions reviewed had YRH/HIV-related objectives and did not specify empowerment goals. Few reports of interventions articulated their concept of community involvement in any detail, although expected benefits of community involvement identified in the literature relate to YRH/HIV outcomes, empowerment outcomes, and greater sustainability of community actions related to YRH outcomes. Making empowerment-related objectives explicit in program plans and monitoring frameworks may result in evaluation data that provide more insights into the complex relationship between empowerment, social capital, and YRH/HIV. Evidence from work in health promotion and with sex workers

demonstrates that it is possible to conduct "parallel track" evaluation of community involvement/empowerment objectives and of program-focused objectives, although parallel track evaluation frameworks were seen only very rarely in the programs reviewed for this paper.

Results of the reviewed programs showed mixed YRH/HIV-related outcomes. Knowledge and attitudes were generally easier to change than behavior, although some studies did report positive sexual behavior change. Numerous interventions reported positive changes in the community context and the capacity, confidence, and social relationships of young people. Intensive participatory work with young men demonstrated the feasibility of changing inequitable gender norms among men and indicated some trends toward positive behavior change. Changing adult perceptions of youth capacity were widely reported, and youth involvement was shown to increase the status of youth in their communities.

In some cases self-efficacy and agency were also measured (using indicators such as girls' autonomy and mobility, time use, skill use, social networks, and perspectives of gender norms). Some studies also measured community capacity, using indicators such as organizational capacity and leadership support and involvement. There is some evidence that higher levels of social capital reduces vulnerability and enables uptake of services, although none of the reviewed programs attempted to measure social capital outcomes.

Attribution of program results to community involvement is difficult. However, one study by Mathur et al. used a quasi-experimental design specifically to test the effectiveness of participatory approaches in defining and addressing the reproductive health concerns of adolescents. The evaluation revealed that participatory approaches yielded more positive results than traditional "top-down" reproductive health interventions. The positive effect was marginal when comparing the two approaches in terms of basic indicators of YRH. The effect was substantially more positive in the participatory, community-involved intervention in terms of the broader, more contextual factors that influence youth reproductive health, as well as capacity building, empowerment, and sustainability. This study suggests that while participatory approaches are not a magic bullet, they can help change underlying social attitudes and beliefs, which enable incremental progress in the enabling environment that has some influence on YRH outcomes, which would not otherwise be achieved.

There are some striking limitations in the evaluation data and inherent challenges in measuring YRH/HIV program outcomes. Significant concerns were raised about the reliability of data on reported sexual behavior. Few interventions articulated objectives related to community involvement. Attribution of impact to specific program components or approaches is extremely difficult when program interventions are complex and inter-active. Differences in approaches and intensity of implementation of community interventions, combined with limited available documentation of process and quality monitoring, makes comparison between different interventions difficult, even when interventions implemented nominally used similar strategies.

Promising Programming Practices and Emerging Issues

The review of programs suggests that a minimum package of activities for an YRH/HIV intervention should include activities or interventions that:

- Improve the provision of information and services to young people
- Develop human or social capital among youth

- Mobilize youth and community members to change norms, attitudes, and social systems.

A number of guiding principles, or lessons learned, were identified. The literature highlights the necessity of understanding, and responding to, the local context and to acknowledge the heterogeneous needs, perspectives, and priorities of young people. Participation of key youth and adult stakeholders is critical. Youth participation in designing and implementing programs is identified as a key to success in developing programs relevant to youth in terms of services and information as well as helping empower youth.

Other lessons identified in the review included:

- Different strategies will be necessary to enable meaningful participation by disempowered groups.
- Creating safe spaces for discussion allows young people to talk about issues they confront and to access correct information and services.
- Working through existing community groups and structures that serve or engage youth (like sports clubs and schools) is effective in reaching a greater proportion of youth in communities.
- Ensuring supportive adult roles and engagement from community leadership, parents, and older peers provides access by youth to older people for advice and support; such support also gives permission to communities to address sensitive YRH/HIV issues.
- Programs must be able to manage conflict to achieve success. YRH/HIV programs with strong community involvement raise cultural and socially sensitive issues about sex, sexuality, and gender and thus risk opposition, or at a minimum mistrust, from influential or powerful sectors of the community.

An area requiring further exploration is integrated, multi-sectoral programs designed to address holistic needs, as defined by the youth themselves. There is no specific evidence to demonstrate the relative advantages of different program components in integrated programs. However, programs suggest that the intensity of activities found in integrated programs – i.e., where many types of activities occur simultaneously in a community setting that attract youth in different ways – may be a significant advantage, leading to improved outcomes.

Sustainability and Scaling Up

The literature emphasizes how sustainability relates to community involvement and the ownership and the mobilization of resources. These factors have the potential to sustain changes, whether in demand, supply, or the enabling environment and social norms.

Capacity building of implementing organizations can lead to more sustained YRH/HIV program efforts, particularly when organizations can mobilize resources effectively. The relationship between community involvement and organizational capacity building will depend on the nature of the nongovernmental organization (NGO) and its relationship with the community. YRH/HIV programs often aim to enable community involvement and institutional sustainability by establishing youth-led clubs and networks. Existing local institutions may be more effective and sustainable; however, it may be particularly difficult to find appropriate existing local structures for youth-oriented activities.

Scaling up is used to describe the process of increasing program impact. When scaling up the community involvement/mobilization components of YRH programming, scaling up of services must also occur. A study by Igras and Blacher stressed the importance of ensuring

that equity in participation and access to program benefits is maintained during the process of scaling up. Strategies for technical agencies, such as NGOs, aiming to scale up YRH interventions with a community involvement component include: program expansion/replication, technical or financial support to other organizations to replicate a program, diffusion of concepts, and influencing policy or legislation.

When scale up involves new geographical areas with new and diverse communities, creative and flexible approaches are needed for community participation. Mechanisms for replication and scale up should be identified at the design stage. It is critical for stakeholders who will be involved in the roll-out to be involved in the initial design and decision-making. In the context of community participation, it may be helpful to focus on the attitudinal – as well as programmatic or institutional – aspects of scaling up: for example, within a growing project team or implementing organization/s. Strategic participation is important, rather than all-encompassing participation, as a means to manage the logistical challenge of a potentially large volume of participation.

Conclusion

The available evidence of the role and impact of community involvement in YRH/HIV prevention programming is promising but limited. A body of knowledge exists relating to promising practices, but it is not widely available as much it has not moved from grey literature into peer reviewed journals. While research and evaluation will help clarify what constitutes best practices, utilizing the existing knowledge of program experiences can help move toward developing a more substantial body of knowledge – and eventually evidence – of good program practice.

A recurrent theme in this review is the need to define concepts and terms related to community involvement and the need for better process documentation. Stating how and why youth and community involvement is expected to take place – and how these relate to YRH/HIV and community capacity outcomes – can facilitate the monitoring and evaluating of program impact. Defining concepts of community and community involvement at the outset does not preclude the evolution of community involvement over the life of a project.

There are no standard or widely accepted approaches to assessments of YRH/HIV programs with significant community involvement components. Many challenges to measurement exist, and whether to apply core indicators across different situations is uncertain. In addition, participatory community-based programs imply a level of engagement in evaluation by communities, including youth. How communities define success and indicators of success may differ from donors and implementing organizations.

Mechanisms for replication and scale up should be identified at the design stage and involve critical stakeholders. In scaling up community-based interventions, there may be some tradeoffs in quality of involvement versus geographic expansion.

1. Introduction

1.1 Review Rationale and Objectives

Young people are inherently a part of the larger community in which they live. Parents, families, neighbors, schools, and religious institutions all play a significant role in shaping young people's knowledge, attitudes, and behaviors relating to sex and sexuality. Involving communities in youth reproductive health (YRH) and HIV prevention projects has the potential to reach youth as individuals, members of families, and as a part of their community. Community involvement also has the potential to reach youth who are not in school and more at risk, such as orphans and vulnerable children. Anecdotal evidence from projects and research studies frequently states the importance of involving the community and building an enabling environment to foster positive youth choices and behaviors. The FOCUS on Young Adults end of project report highlighted the need to evaluate the impact of community programming on YRH, and the YouthNet program was charged with providing global technical leadership on community involvement in youth reproductive health and HIV prevention, among other issues.

In November 2005, YouthNet and its partner CARE convened a technical consultation on community involvement in YRH/HIV prevention. One objective of this meeting was to examine the evidence base for the value of community involvement in YRH/HIV programs. A second objective was to analyze selected promising YRH/HIV models with substantial community involvement components to determine promising practices that could be replicated in other sociocultural contexts. This review is intended to synthesize the information available in the published and unpublished literature to help answer the questions implicit in these objectives.

1.2 Methodology, Sources, and Limitations

Literature for this review was identified by a search of Web sites and databases (Sociological Abstracts, Medline, and Google Scholar) and documents located through international development contacts. The search yielded more than 120 documents, about half from the databases (published) and about half from contacts (unpublished gray literature).

Key terms used for Internet search using google.com:

- Community participation youth reproductive health
- Community participation youth sexual health
- Community participation youth adolescent HIV/AIDS
- Community participation adolescent reproductive sexual health
- Community involvement youth reproductive health
- Community involvement youth sexual health
- Community involvement youth adolescent HIV/AIDS
- Community involvement adolescent reproductive sexual health

Key terms used in database/journal searches: Youth OR adolescent AND involvement OR participation OR mobilization AND (sexual health) OR (reproductive health) OR HIV

The review focuses on interventions that are youth-focused, have a significant community involvement component, and have been evaluated. Thirty interventions were identified that meet these criteria. Documents reviewed were mostly published or unpublished project and

evaluation reports produced by implementing agencies. Information about a small number of interventions was obtained from peer-reviewed journals and detailed meeting notes. In some instances, information about the same project was drawn from more than one source. The amount of available detail about each intervention varied widely. The projects were all implemented by NGOs, sometimes in partnership with government agencies.

Most of the interventions reviewed were evaluated using a combination of quantitative and qualitative methodologies. About one-third used quasi-experimental research design, and there is one example of a randomized trial. The amount of available information about evaluation methodologies varied widely; therefore, using the evaluation approach as a criterion for inclusion in the review would have been too limiting.

Community involvement was interpreted as widely as possible during the initial literature search, and all interventions that described youth or community involvement at one or more stages of the project cycle were considered. A small number of interventions whose only community involvement component was a peer education program were not included in the review, as this was considered to be too limited a form of community involvement, and because a specialist body of literature on peer education programs already exists. Likewise, the youth focus of the interventions included in the review varied. The majority of these interventions aimed to reach a wide range of young people in different situations (such as in-school and out-of-school) and of different ages. A few targeted particular groups of young people, such as young married couples, or younger unmarried rural girls, and a few targeted either young women or young men.

This review also evaluated selected non-youth-focused reproductive health (RH) or HIV/AIDS interventions where these provide relevant evidence or insights. Overall, the review revealed the limited amount of evidence available about community involvement and YRH/HIV. The unevenness of the available information about different interventions contributes to the referencing of some interventions and analysis more often than others.

2. Concepts of Community Involvement

2.1 What Is Community?

Communities are defined by a geographical area or by shared interests or characteristics. They are socially complex, serving a variety of economic, social, and political functions, and vary across space, time, and population. The capacity of a community to engage in social or political issues or to support its members will also change over time.

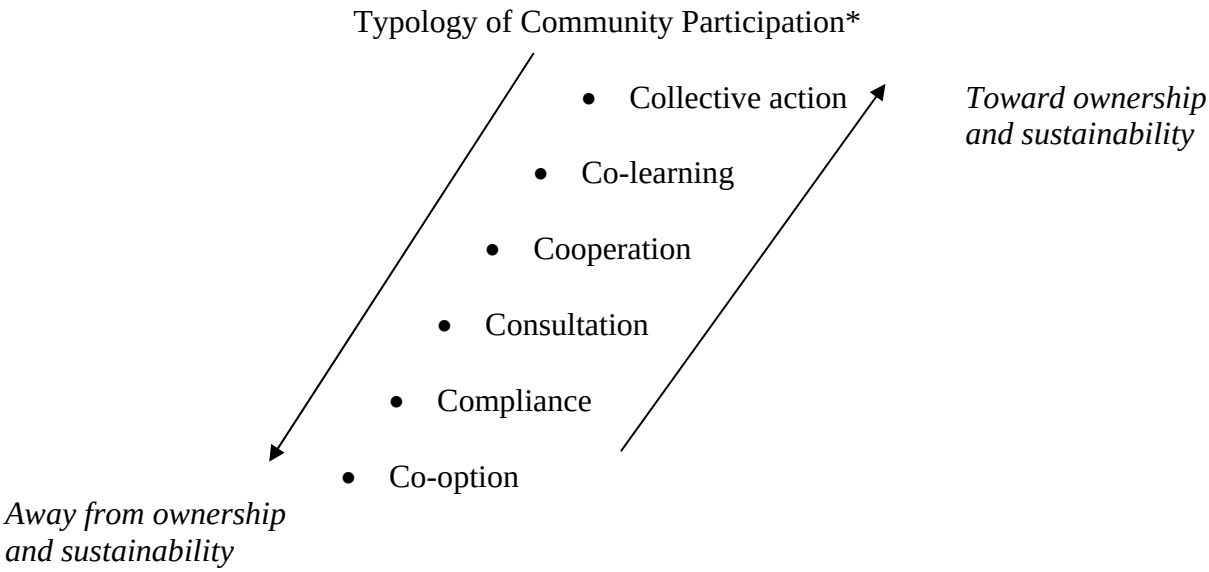
Most of the interventions reviewed during this analysis used a geographically based conceptualization of community. Broadly, this encompasses organizations such as schools, religious institutions, and services, as well as the people who live in a geographic area, such as a village or district. This concept of community is largely implicit, rather than explicit, in the documentation reviewed. For example, interventions take place in defined geographic areas, and quasi-experimental studies use comparable locations for control groups. Some interventions distinguish between institution-based activities (such as activities in schools with students and teachers) and community-based activities (such as activities with out-of-school youth) (e.g., Adamchak, 2003).

Who defines community? Outsiders may see similarities across a group where the members of that group would not. "Until people identify themselves as a community and share some sense of mutual belonging, there is no real community" (UNAIDS, 1997:3). In the context of community involvement in rural and urban areas in Nepal, Mathur et al. (2004) highlight how geographical notions of community do not always correspond with the community identities of the people living in these areas. In Nepal, for example, "[A] sense of community [geographically defined] is prevalent in rural areas, while in urban areas, the boundaries of 'community' are more artificially designed, especially given the greater diversity of residents in urban areas" (Mathur et al., 2004:9).

In the context of YRH/HIV interventions, the youth perspective of community is important to consider. Adult-designed programs are often based on an idealized view of how young people should behave as members of a particular society that is likely to reinforce socially and culturally determined ideals about young people and sex. Failure of adults to recognize and understand youth-defined support systems will limit the effectiveness of YRH/HIV interventions. Youth perceptions of their needs and of solutions to problems often differ from the perceptions of adults (Tipton et al., 2003).

2.2 What Is Community Involvement?

There is no single definition of community involvement. In this review, "community involvement" and "community participation" are used interchangeably. The concept of community involvement spreads along a continuum, according to the degree of control and decision-making that community members have (see diagram, below). Moving up this typology toward collective action increases community ownership and sustainability.



- *Collective Action:* Local people set their own agenda and mobilize to carry it out, in the absence of outside initiators and facilitation.
- *Co-learning:* Local people and outsiders share their knowledge to create new understanding and work together to form action plans with outsider facilitators.
- *Cooperation:* Local people work together with outsiders to determine priorities; responsibility remains with outsiders for directing the process.
- *Consultation:* Local opinions are asked; outsiders analyze and decide a course of action.
- *Compliance:* Tasks are assigned, with incentives; outsiders decide agenda and direct the process.
- *Co-option:* Token involvement of local people; representatives are chosen, but have no real input or power.

*Adapted from Cornwall, 1995, cited in Howard-Grabman and Snetro, 2003

Community mobilization is a related term used to describe a process at the higher end of this continuum. The Joint United Nations Programme on HIV/AIDS (UNAIDS, 1997) defines community mobilization as a process whereby a group of people become aware of a shared concern or common need and decide to take action in order to create shared benefits. Save the Children Federation USA emphasizes how community involvement produces growing autonomy through a process of communication, education, and organizations working together.

Community participation can be a tool for enabling community empowerment, through which communities take responsibility for diagnosing and working to solve their own health and development problems (Morgan, 2001). Community empowerment involves shifts towards greater equality in the social relations of power (who has resources, authority, legitimacy, or influence) (Laverack and Labonte, 2000). Community empowerment may be an explicit goal of community participation or may arise indirectly (or not all). Gibbon et al. (2002) define the term community capacity building in the same way as community empowerment.

A similar term, social mobilization, should be clearly distinguished from community mobilization. Social mobilization refers to the process of bringing together partners or potential allies across a range of sectors to address a particular problem. The initiative may be a one-time event, such as a campaign to raise awareness about YRH and promote safer behavior, or an annual campaign to raise awareness of a particular development objective.

Few of the interventions reviewed during this review defined their conceptualization of community involvement. Those that did concurred with this view of a continuum, with "physical" participation (e.g., attending meetings) at one end, moving towards meaningful involvement in decision-making at the other (e.g., Mathur et al., 2004; Yaro et al., 2003). Community participation can also be a *principle* underlying the development and implementation of YRH interventions – a way of doing that informs each aspect of the intervention, rather than a project component.

Communities can be involved at different stages of an intervention. The stage (or stages) at which communities are involved helps to determine where on the community participation continuum their involvement can be placed. For example, involving community members from the beginning, in planning, implementing, monitoring, and evaluating is likely to increase the influence or control of community members over decision-making, moving their involvement up the typology towards collective action. Mathur et al. highlight how the nature of participation will evolve over the life of a project:

> Given the existing power structures, capabilities and community setup, it is often not realistic to expect a full partnership with youth or a community at the very beginning of a project. Moreover, it may even be unrealistic to assume that a full partnership [in decision-making] can be achieved in the two- to three-year lifespan granted to most projects. (2004:7)

Who is involved is also an important question. Communities are not homogeneous, and community members will not participate equally. External agencies often consider the involvement of particular people or organizations necessary to the success of an intervention – for example, the people who are intended to benefit from the intervention, and those who can influence its success. Social relationships and power dynamics within the community will also influence who is most able to participate. For example, gender relations and norms may hinder the involvement of women. The potential exclusion of poorer or more marginalized people from participatory processes – and the benefits of participation – are well documented in the general development literature.

2.3 Involving Youth and the Wider Community

Community involvement in YRH/HIV refers to the engagement of the community as a whole, as well as the involvement of young people themselves. Mathur et al. explain the importance of involving both youth and the wider community in the context of a YRH intervention in Nepal:

> Although the project focused on the needs of youth, the participatory efforts had a broader emphasis in terms of engaging the community as a whole. This focus was motivated by the conviction that the needs, actions, and options of youth are embedded in their contextual surroundings. The lives of youth everywhere are

> integrally connected to, and affected by, adults, which is especially the case in cultures with strong age-based hierarchies, such as Nepal. Thus, adult approval and buy-in is essential for achieving youth participation or behavioral change. Moreover, altering adult behavior and attitudes is equally, if not more, essential for achieving sustainable change with regard to the fundamental factors affecting young people's reproductive health. (2004:6)

A project in Ghana provides examples of the impact of community context and adult behavior on youth sexual behavior. Formative research for the project identified that adolescents often had sex to generate money to meet basic needs such as food and essential toiletries. Pastors and teachers were reported to cajole young people into having sex. Feedback of the research findings to the community catalyzed a commitment to address this problem (CARE Ghana, n.d.).

While involving the wider community is generally recognized as important in the literature reviewed here, several interventions note the importance of enabling young people to "drive" the process (e.g., Weissman, 2002; Hainsworth, 2002), so that the issues, priorities, and perceptions of young people inform the intervention. Mathur et al. (2004) summarize the benefits of involving youth:

- Research, intervention design, and implementation reflect the ideas, concerns, and colloquial language of youth.
- Planned interventions enable youth to meet their objectives and advocate on their own behalf.
- Projects designed for youth provide them with experience to enhance their own critical thinking skills and increase their ability to make decisions that reflect healthy choices and behaviors.
- Intensive youth involvement provides an opportunity for broader capacity building, leadership development, and empowerment of youth.

Many of the interventions highlighted the fact that "youth" are a diverse group with different issues, priorities, and perspectives (e.g., Hainsworth, 2002). Understanding the particular needs of young people in a specific situation is important for developing relevant interventions. For example, young people in rural areas in Nepal identified teachers as an important source of information and education and actively desired their involvement in the YRH intervention. By contrast, young people in urban areas were reluctant to have their teachers involved in the provision of information and education on sexual and reproductive health (SRH) issues (Mathur et al., 2004). Common ways of differentiating between young people included gender, age, in-school and out-of-school, married, and unmarried. Some projects specifically targeted vulnerable subgroups of youth, such as underprivileged rural girls (Ishraq, 2002) or young married couples (CREHPA, 2004; Mathur et al., 2004).

3. Community Involvement in Youth Reproductive Health (YRH)/HIV Prevention

3.1 Rationales for Community Involvement in Programming

Community participation in health has traditionally been defined according to one of two distinct perspectives: as a means to achieving project objectives more efficiently, effectively, or cheaply; or as a tool for empowering communities to solve their own health and development problems (Morgan, 2001). This can lead to the tension: Is community capacity building (empowerment) a means to an end, or an end in itself? Most agencies or funders have specific mandates or objectives for which they are accountable, and these priorities sometimes overlap completely with the interests of communities and sometimes do not (Gibbon et al. 2002). The authors conclude that the two perspectives are not mutually exclusive and that a "parallel track" approach can create two complementary sets of objectives – one program-focused and the other focused on building community capacity.

Many of the interventions reviewed aim to change social and gender norms affecting young people, which is likely to contribute to both YRH/HIV and empowerment outcomes. For example, the main outcome from an intervention working with adolescent girls in India is an "increase in perceived self-determination regarding ability to decide whether or when to marry, and when to have a first child" (Swaasthya and ICRW, n.d.). Such increased self-determination is likely to result in increased power or control in other areas of a young woman's life.

The documents do not always make explicit the expected benefits of community involvement in a particular intervention. The various rationales for community involvement in YRH/HIV programming identified during this review – whether explicitly or implicitly stated – can be summarized as follows:

- Community involvement is necessary to address social norms, including gender norms, which affect YRH and the broader well-being of young people.
- Adults play significant roles in the lives of young people. Greater understanding of YRH needs, issues, and perspectives will enable them to provide more effective support and will lead to improved communication between adults and young people.
- The support of certain adults, such as parents, is necessary to enable access to young people and their participation in YRH activities.
- Influential adults, such as religious leaders, can have a significant impact on young people and the community context in which they live.
- Increased respect and recognition of the needs, rights, and capacities of young people builds constructive relationships between youth and adults
- Developing youth capacity, including their life skills, decision-making, interpersonal skills, and leadership skills, builds trust and social capital. It also enables young people to realize their objectives and advocate on their own behalf.
- Youth and community involvement increase the relevance of interventions to the needs and priorities of young people and the communities around them.
- Community involvement increases ownership and sustainability of YRH interventions.

Several of these rationales relate to capacity building of youth and adults and to shifts in relationships and social norms that may lead to empowerment outcomes for young people or

adult community members. However, as stated above, these connections are rarely made explicit in the literature reviewed.

3.2 Defining Community Involvement at an Operational Level

This section describes the various approaches to community involvement used by interventions reviewed during this study. Documentation of approaches to community involvement and participatory processes is limited in the literature reviewed. Interventions varied widely in the type of community involvement they enabled. In addition, a stated commitment to community (or youth) involvement in all stages of the intervention is not always reflected in the available documentation or evaluation findings. Mathur et al. (2004) are unusual in presenting a detailed description of their approach to community involvement in a YRH intervention in Nepal. They explain that the intervention:

- Recognized the evolving nature of participation and aimed to deepen community involvement in decision-making over the life of the project.
- Was built on the "practical premise" that not everyone needs to participate all of the time. "Strategic participation" of key people at key points maximizes the use of community and project skills, resources, and time.
- Adopted strategies to enable the adequate participation of disempowered groups within the community.
- Recognized the value of the resources and skills of both the community and the implementing agency, acknowledging that the intervention would not be entirely "owned" by the community.
- Aimed to involve both community members and the project organizers in decision-making.

Save the Children (2005) describes how its YRH/HIV interventions in Bhutan, Malawi, Nepal, and Vietnam were planned on the basis of four basic principles, which provide an overview of its expectations of community involvement:

1. The use of participatory approaches to engage young people, service providers, parents, and other key community members in a dialogue about issues relating to YRH/HIV and to identify leading youth, service providers, parents, and other community members who would be willing to participate in the program.
2. The use of the information from these discussions to design program activities. Participatory approaches would be used to develop or adapt health education and training materials, and training activities would build young people's reproductive health communication and negotiation skills.
3. The provision of sexual and reproductive health services, bringing together service providers, teachers, and youth to improve access to and quality of SRH information and services.
4. Commitment to involving a broad range of parties in establishing clear, measurable objectives to be tracked jointly by young people, service providers, and community members as implementation progressed, including qualitative and quantitative measures of SRH knowledge, attitudes, and practice.

In contrast to these two projects, most interventions reviewed do not clearly articulate guiding principles for community participation. Some interventions describe a process of engaging with the community and enabling community input into intervention design. For example, an

intervention in Burkina Faso held a series of participatory workshops with village committees to identify priority areas in YRH/HIV, focus groups and large assembly gatherings to gather broader input, and meetings with local and provincial administrators to keep them informed and supportive of the project (Yaro et al., 2003). This intervention is also notable for its focus on developing the meaningful participation of a core group of young people by building the capacity of local youth associations.

Other interventions describe similar formative participatory research processes, which aim both to inform the design of the intervention and engage the interest of community members. Like the Save the Children approach described above, many of the interventions pre-defined the types of activities that would be undertaken or the roles that groups would play in the intervention strategies (e.g., Diop, 2004; Njue, 2003; Vernon and Durá, 2004; Bhuiya, 2003; Alford et al., 2005).

The extent to which communities are involved in planning and decision-making following formative research is not always clear in the documentation. For example, participatory action research in Tanzania trained young people in theatre techniques and supported them to use these techniques to conduct research, give feedback on the findings to the communities involved, and discuss solutions with community members (Bagamoyo College of Arts et al., 2002). Several interventions appeared to enable meaningful youth participation and autonomy, with the aim of building capacity and skills, within frameworks such as youth clubs or networks (e.g., Ramella and de la Cruz, 2000). As Mathur et al. (2004) note, the depth of participation may change over time.

Many of the interventions reviewed can be broken down into different components, and community involvement may be greater in some components than others. For example, few interventions describe the active involvement of young and adult community members in the development and delivery of youth-friendly services, although formative research contributing to the design of such services may be participatory. Typical strategies and activities are summarized below.

4. Impact of Community Involvement in YRH/HIV Prevention Programming

4.1 Evaluation Approaches and Methodologies

Of the 30 interventions that form the focus of this review, just over a third used quasi-experimental research designs to test the impact of different components or approaches in YRH programming. These studies either compared the intervention site to a control site with no activities, or controlled for the inclusion of specific program components, such as school-based activities (e.g., Adamchak, 2003). One study, in Nepal, systematically tested the effectiveness of community and social mobilization in meeting the reproductive health needs of married adolescents and youth (Mathur et al., 2004). One example of a community randomized trial from rural Tanzania (Ross and Cleophas-Mazige, 2003) was identified.

Methods used to evaluate the different interventions include quantitative surveys and qualitative tools, such as focus group discussions, in-depth interviews, and observation. Many interventions were evaluated using a variety of these methods. Some report using only quantitative or qualitative methods. Discussions of data derived from combining quantitative and qualitative methods provide a significantly more detailed analysis of results (e.g., Mathur et al., 2004).

Most of the interventions reviewed describe involving young and adult community members in evaluation only as information providers, although some of the qualitative methods used may encourage community members to participate in analysis of information. The review found no detailed descriptions of the involvement of young and adult community members in evaluation teams, but a few mention that community members and young people were engaged in assessment (e.g., Mathur et al., 2004). Some reports mention feedback of evaluation findings to the communities involved, which may also enable community members to participate in analysis of the findings (e.g., Yaro et al., 2003).

None of the documents reviewed explicitly described young people or community members setting and monitoring their own indicators. The staff of one project noted that adding such a component would increase community involvement and potential sustainability (Tipton et al., 2003). The evaluations appear to rely on external definition of indicators for success, although qualitative methods may enable community members to contribute their own assessments of success in some instances.

The interventions reviewed in this study used indicators related to their stated objectives to evaluate results. For example, indicators for YRH/HIV objectives focused on assessing changes in knowledge, attitudes, and practices (KAP) among young people, often including some measure of self-efficacy. The randomized trial in Tanzania was unusual for including biological indicators, including measurements of HIV incidence, genital herpes, other STIs, and pregnancy rates. Indicators of social change and increased capacity of young people are assessed by interventions that state these changes among their objectives or that identify broader normative issues as critically relevant to YRH (e.g., Mathur et al., 2004; Swaasthya and ICRW, n.d). An intervention aiming to increase support for gender equity among young men developed the “Gender Equitable Man Scale” to provide a quantitative measure of changes (Hutchinson and Weiss, 2004).

Most interventions did not state community participation or empowerment objectives and therefore did not develop indicators to evaluate participation. An intervention in Burkina Faso did specify the involvement of community members in developing, implementing, and evaluating the project in its objectives, and therefore developed indicators to assess the achievement of this objective. Its evaluation assessed community participation by looking at accuracy of community perceptions about the project; degree of leadership in project activities; degree of ownership of the project; degree of decision-making and initiative in project activities; and degree of community empowerment to sustain activities (Yaro et al., 2003).

Monitoring data (as well as data from evaluation of objectives) may be used by some interventions to assess different aspects of community participation. For example, Mathur et al. (2004) note the importance of the monitoring data in highlighting the evolution of the nature of community participation during the life of the program, with community members gaining greater decision-making power and numerous signs of youth and community empowerment becoming evident. These examples demonstrate the importance of defining the meaning of community participation and its intended results in order to monitor and evaluate its impact.

Other interventions described a community mobilization approach but do not specify empowerment-related objectives or describe them clearly in the evaluation or monitoring (e.g., Weissman, 2002). Holistic and integrated (multisectoral) interventions developed indicators for the outcomes of different activities, such as literacy and livelihood programs, as well as indicators of girls' autonomy and mobility, time use, skill use, and perspectives of gender roles (e.g., Sebastian et al., 2004).

4.2 Challenges and Limitations in Evaluation

Most of the interventions reviewed are part of complex, multi-component programs, which makes it difficult to attribute impact to specific components. In addition, the lack of stated community involvement objectives for the interventions reviewed is likely to contribute to the general lack of evaluation of community involvement. Attempts to develop “standard” indicators of community involvement have been made in other contexts. For example, Bandyopadhyay et al. (2003) worked with a sex worker-led intervention in India to identify standard indicators of the empowerment of sex workers. USAID's Measure Project (1999) reported some indicators relating to community empowerment. However, the evolutionary nature of community participation compounds the challenges of evaluation. “Participatory processes do not necessarily follow structural pre-determined and linear directions” (Morgan, 2001).

In addition, there is a paradox that the evaluation of participatory programs often lacks community participation (Morgan, 2001). If young and adult community members are enabled to set and evaluate indicators, the indicators they consider important may not match the evaluation priorities of implementing agencies, donors, or other stakeholders.

Laverack and Labonte (2000) have developed a participatory evaluation approach that may have the potential to be adapted and applied in YRH/HIV prevention programming. In the context of integrating community empowerment objectives into health promotion planning, the authors identified nine operational domains: participation, leadership, organizational

structures, problem assessment, resource mobilization, asking why, links with others, role of the outside agents, and program management.

These domains are conceived as the organizational elements of community empowerment and in themselves act as a proxy for social elements such as relationships, trust, and social capital (Laverack and Labonte, 2000). Gibbon et al. (2002) used participatory visual tools to assess changes in these domains and concluded that this was a useful new approach for evaluating community empowerment within the "parallel track" approach to community mobilization.

The documents reviewed provided little information about how involvement of young and adult community members was monitored during the interventions, possibly because the intricacies of enabling community participation are dealt with on a day-to-day basis by field-based staff and are not well documented. Mathur et al. (2004) are notable for monitoring the evolution of the nature of community participation in an intervention in Nepal. Where the nature and purpose of community involvement has not been clearly conceptualized, it will be difficult to monitor and evaluate its impact.

Finally, it should be noted that some of the evaluations occurred after a relatively short implementation period. For example, an operational research study in Kenya developed and implemented interventions over 18 months out of a total study period of 42 months (Askew et al., 2004). This may be considered too short a time to achieve sustained behavior change. Writing of community empowerment, Laverack and Labonte (2000) suggest that two to seven years may be a reasonable amount of time to enable some degree of sustainability.

4.3 Available Evidence of Impact

This section summarizes key evaluation findings reported by the interventions reviewed: changes in standard YRH/HIV indicators; evidence relating to social change, social capital, and increased capacity; and the extent to which it is possible to attribute these results to community participation in the intervention.

YRH/HIV Indicators on Knowledge, Attitudes, and Practices (KAP). Many of the interventions reviewed reported positive changes in knowledge and attitudes relating to sexual and reproductive health among young people (e.g., Sebastian et al., 2004; Ishraq, 2004a). These include changes in attitudes about culturally rooted practices, such as early marriage and female genital cutting. Results regarding sexual behavior are generally more mixed. For example, the evaluation of a youth reproductive health intervention in Burkina Faso reports increased condom use and reductions in numbers of sexual partners. It also reports a greater number of sexually active youth but attributes this increase to increased openness to talking about sex as a result of the intervention (Yaro et al., 2003).

Alford et al. (2005) report generally positive behavior changes from projects in Cameroon, Kenya, Zimbabwe, Uganda, and China that employed a package of activities focused on:

- Increasing access to services (e.g., referrals, youth-friendly services, provision of condoms, and contraceptives)
- Improving knowledge using information, education, and communication approaches (e.g., peer education, mass media)

- Involving and sensitizing community members (e.g., involvement of religious leaders, parents, and teachers)

Largely relying on KAP surveys as part of a quasi-experimental design, reports of these projects focus on positive behavioral indicators, including:

- Delayed initiation of sexual intercourse
- Increased abstinence among sexually experienced youth
- Reduced number of sexual partners
- Increased use of contraception, including condoms
- Increased communication with parents and other adults about sexual health

Note that these reported positive behavior changes do not apply equally to males and females in each setting, and evaluations should be designed to measure behavior changes by sex.

In another example, projects implementing a similar three-pronged package of interventions in Kenya, Bangladesh, Mexico, and Senegal report more mixed results. (Significantly more detailed reports about these projects were available than for the projects reported by Alford et al.) Preliminary findings from these projects showed no clear differences between intervention and control areas regarding changes in behavior, but knowledge and attitudes did change in many settings (Adamchak, 2003). The quasi-experimental design of the projects aimed to assess the impact of including a school-based component alongside community-based interventions and improvements in services. No clear pattern emerged among the four countries to indicate that the interventions including the school-based components outperformed those with only community-based and health service interventions. The intervention sites generally did better than the control sites, but results are mixed depending on the indicator. For example, knowledge of HIV/AIDS increased in all intervention sites in Bangladesh and Mexico but declined in an intervention site and the control site in Kenya.

In addition to predetermined indicators, several studies acknowledge unexpected positive results, such as very high uptake of tetanus toxoid vaccinations among young women who were pregnant or contemplating marriage (e.g., Bhuiya, 2003). Their experience suggests that evaluation methodologies should be designed to enable identification of unanticipated program effects.

*Social Capital and Social Change***.** Social capital (community cohesion associated with positive social norms such as trust and reciprocity) and social networking (social relationships that allow information exchange and mutual support) have been shown to reduce vulnerability and enable uptake of services in some contexts. For example, research with sex workers in Brazil shows a significant correlation between social capital indicators, including social participation and social inclusion, and consistent condom use, greater self-reported capacity to manage drug and alcohol use, and the lack of violent client reactions to condom negotiation (Castle et al., n.d.). Research in rural areas of northern Ghana found that, for most women, the decision to initiate family planning practice is facilitated by informal discussions with social network partners who encourage contraceptive adoption (Feyistan et al., 2003). Research from Zimbabwe found that participation in local community groups is often positively associated with successful avoidance of HIV among young women, which, in turn, is positively associated with psychosocial determinants of safer behavior (Gregson et al., 2004). An operational research project in Nepal that tested the effectiveness of communication-based interventions, using groups of married women and young married

women to reach young married couples with SRH information and services, demonstrated impact in increasing contraceptive use and SRH knowledge (CREHPA, 2004).

A number of other interventions report positive social change and positive changes in the capacity, confidence, and life skills of young people. Some of these seem to contain a community involvement element. For example, girls participating in the Ishraq project in Egypt, which has a strong sports component, were willing to challenge boys' perspectives on girls and sports and to state that they will encourage their daughters to play sports (Ishraq, 2004b). There is evidence that youth involvement in developing and implementing an intervention builds capacity in leadership and organization, including fundraising (Mathur et al., 2004).

Changes in community attitudes and understanding of YRH issues as a result of community involvement were widely reported. For example, the mid-term review of an intervention in Vietnam reports that adults were beginning to recognize the benefits of delaying marriage for their children. The adults also reported feeling more comfortable discussing HIV/AIDS, early marriage, and pregnancy with their children. Activities involving parents in Bhutan resulted in improved parenting skills, increased communication with children, and better relationships with children and the children's schools (Save the Children, 2005). Forming community groups of women and adolescent girls improved communication between girls and their mothers and changed adult gatekeepers' perceptions of adolescent girls' lives and needs (Swaasthya and ICRW, n.d.). The Ishraq project in Egypt reports positive changes among participating girls, parents, and community leaders regarding the benefits and social acceptability of sports for girls, a focus of this integrated program (Ishraq, 2004a). Community participation in Nepal resulted in increased options for schooling and social spaces for girls in particular (Mathur et al., 2004). Operations research from Brazil and India showed that intensive participatory group work with young men, based on formative research and facilitated by trained peer leaders, is effective in diminishing support for inequitable gender norms among young men and shows some indications of increasing condom use (Hutchinson and Weiss, 2004; Verma et al., 2005).

Youth involvement in YRH/HIV programming appeared to increase the status of youth in the community. Parents in Nepal expressed a new recognition of the capabilities of their children as a result of notable increases in youth capacity and leadership (Mathur et al., 2004). Bagamoyo College et al. (2002:338) describe how the leading role taken by youth in an intervention using theatre techniques to carry out participatory action research in a Tanzanian district changed the social position of the young artists, where they were previously “regarded as potential delinquents, they are now seen as serious artists with a major contribution to make to society.” Similarly, “youth zone coordinators” in Malawi who helped oversee, guide, and monitor intervention activities served as important role models and leaders not only for the project but within their communities as well (Save the Children, 2005). In Nepal, young people were aware that they were able to participate in program activities – especially those involving more independence, time, or initiative – because of the legitimacy the program had acquired through participation by adults in the community (Mathur et al., 2004).

The need to build a supportive policy environment is stressed by a number of interventions reviewed during this study (e.g., Save the Children, 2005). The YouthNet experience in Ethiopia provides an example of the feasibility and benefits of enabling young people to contribute in the policy arena at the national level. The iterative consensus-building consultation process drew youth perspectives and input from all regions of the country to

influence national policies and services, enabling young people to agree to a National Youth Charter and Plan of Action and launch them at a high-profile national event. This intervention resulted in increased recognition of YRH/HIV issues among government and other agency representatives and built the capacity of youth to play a leadership role in policy and program development (Attawell, 2004).

Attributing Impact to Community Involvement. It is not possible to attribute greater and lesser impact to subtle differences between the interventions reviewed, given the complexity of the programs, their varied settings, and the significant variation in depth and detail of reporting. For example, a project in Malawi sought to improve knowledge, access to services, and involvement of influential community members. It appears to have a stronger focus on youth empowerment and capacity building of youth leaders (through the establishment of youth clubs) than some of the similar projects, whose results are summarized above. An evaluation found positive behavior change among young people (Save the Children, 2005). However, it is not clear as to the extent to which the focus on youth empowerment and capacity building was related to the reported positive behavior change.

Attribution of results in the documentation reviewed is not always clear, and interventions report different levels of success in implementing the various strategies. For example, the report of the Malawi project notes that "youth-unfriendliness" can still be detected in clinics (as does documentation of several other interventions, e.g., Askew et al., 2004). Nonetheless, an increase in the number of female STI clients is partially attributed to improvements in services (Save the Children, 2005).

The Nepal study discussed throughout this report (Mathur et al., 2004) specifically tested the effectiveness of participatory approaches in defining and addressing the reproductive health concerns of adolescents in Nepal. The project's quasi-experimental study design used participatory approaches for research, intervention, monitoring, and evaluation at two study sites, together with more traditional reproductive health research and interventions at two control sites. The project defined the different programmatic approaches at the study and control sites as follows:

Control sites	**Study sites**
• Standard set of interventions	• Community-determined interventions
• Separate interventions	• Linked and coordinated interventions
• No participant input	• Participant input in design and training
• Didactic training approach	• Interactive program
• Program and training limited	• Participatory training approach
• Focus on RH information and services	• Holistic programming

As a result of the participatory process used in the study sites, a larger number and wider range of interventions were implemented at those sites compared to the control sites.

Control sites	Study sites
1. Adolescent-friendly services 2. Peer education and counseling 3. Teacher training	1. Adolescent-friendly services 2. Peer education and counseling 3. Information and education 4. Adult education 5. Youth development 6. Social norms 7. Economic livelihoods 8. Teacher education

The evaluation revealed that participatory approaches yielded more positive results than traditional reproductive health interventions used at the control sites. The positive effect was marginal in terms of basic KAP indicators of youth reproductive health. The effect was substantially greater in terms of the broader, more contextual factors that influence youth reproductive health, such as norms regarding marriage and childbearing for girls, capacity building and empowerment of youth and adults, and development of potentially autonomous institutions within the community.

These findings illustrate the complexity of achieving behavior change. They show how participatory approaches enable a vital understanding of the ways individual issues and needs are interwoven with the social context. The project successfully addressed social and knowledge barriers to contraceptive use identified in the baseline assessment. The removal of these barriers enabled young people to identify and articulate a further obstacle to contraceptive use: negative perceptions of specific contraceptive methods. Thus, while the evaluation did not show an increase in contraceptive use, it revealed an important "proximate" barrier to contraceptive use among youth. The analysis suggests that while participatory approaches are not a "magic bullet," they enable incremental progress that would not be achieved with a more "top-down" approach.

5. Promising Models and Emerging Themes

This section summarizes lessons and guiding principles identified by evaluated interventions and highlights other themes and issues that have emerged during this review.

5.1 Participatory Project Design

The Nepal study (Mathur et al., 2004) found that a quality needs assessment followed by a well-planned program design – in terms of outcomes and community structure – are the most critical components of effective programming. An effective planning process in a participatory YRH/HIV intervention requires facilitation by people with expertise in such programming to help incorporate lessons learned from elsewhere into activities suggested by the community.

An intervention in Nepal implemented by Save the Children provides an example of the benefits of involving both youth and other key stakeholders in project design. Its Youth Defined Quality program, in which young people and service providers explored barriers to access and provision of SRH services to young people, is reported to have fully bridged the gap between service providers and their young clients. Service delivery improved and youth utilization of the services increased as a result of the intervention. This participatory process may be replicable in other contexts, and it provides an example of how youth-adult partnerships can jointly achieve improved outcomes (Save the Children, 2005).

5.2 Project Components

Most of the interventions reviewed address information and skills among young people, the development of a supportive community environment for YRH/HIV, and increasing access to quality services. A number of interventions, particularly those with a more integrated or holistic approach, place emphasis on developing youth capacity and social capital. Available evidence suggests that such emphasis is likely to be beneficial to both young people and the wider community in which they live. Mathur et al. (2004) summarize the "minimum basket" of YRH/HIV interventions as follows:

- An intervention that improves the provision of information and services to young people
- An intervention that develops human or social capital among youth
- An intervention that mobilizes youth and community members to change norms, attitudes, and social systems

Several reports noted the importance of linking increasing demand for services with increasing provision of, or access to, quality services and commodities (e.g., Mantilla and Antezana, 2004; Hainsworth, 2002). Evaluation of a project in Nepal underscored the importance of peers and social networks as critical sources of service provision for young people (Mathur et al., 2004). While interventions can achieve positive changes in service provider skills and approaches, most YRH/HIV programs cannot remove barriers caused by limitations in the existing health infrastructure, such as buildings, equipment, supplies, and staffing levels.

Programs integrating other components, such as livelihood development, will help to address specific issues faced by young people. Integrated programs provide opportunities to address a greater range of antecedents to YRH/HIV problems, including poverty. This review did not

find sufficient documentation to compare the relative advantages of specific program components, such as sports, livelihood development, or education. One advantage of integrated programs may be that the inclusion of many components increases the intensity of the intervention. The intensity of methods employed is identified as a factor contributing to the success of a multisectoral project in Haiti, along with the ability to engage youth through activities related to the full scope of their interests: cultural, sporting, community, religious, and economic (Tardieu, 2003).

No accounts were found of evaluated interventions focusing on increasing legal definition and respect for the rights of children and young people, including those who are marginalized or otherwise vulnerable, although documentation of a project in Ghana suggests this may be a promising approach.

5.3 Responsiveness to Local Context and Different Needs

Models of community involvement in YRH/HIV programming should be based on the specific objectives of the intervention and the local context and should be responsive to changing needs and environments. Existing tools and methodologies can often be adapted to meet the demands of different situations. However, it is clear that "one size does not fit all." Similarly, young people are a diverse group with different needs and priorities.

This literature review did not find any detailed accounts of the extent to which young people who are particularly marginalized or vulnerable – for example, orphans, street and working children, young people engaged in illegal or socially sanctioned activities such as sex work or drug use – are reached through mainstream YRH/HIV interventions, including those specifically targeting out-of-school youth. More detailed analysis about how successfully different interventions reach marginalized or vulnerable young people is likely to help refine approaches to youth and community involvement.

Evidence from programs with sex workers in India suggests that community mobilization approaches have the potential to be very effective in meeting dual sets of objectives for HIV prevention and empowerment of sex workers, successfully building capacity and collective identity among sex workers, and addressing the broader social and political environment (Bandyopadhyay et al., 2003). In contrast, a different project in Madras was unable to facilitate effective participation of sex workers because it did not address the structural and institutional barriers to their participation (Asthana and Oostvogels, 1996). Such experience may be relevant to community mobilization approaches with vulnerable or marginalized young people.

In addition, complex power relationships between and within different communities and subgroups may result in synergies between interventions targeting young people and those working with adults in similar circumstances. For example, mobilization of sex workers in India resulted in a reduction in the number of underage girls working in the commercial sex industry, as adult sex workers took action against trafficking of girls and women. Over three years, the number of underage girls involved in sex work dropped from one in five to one in 30. The adult sex workers were motivated by a desire to reduce their competition but also because some of them had experienced trafficking themselves and wanted to help prevent it (Dugger, 1999, cited in Trasi, 2005).

5.4 Enabling Participation

The Nepal study (Mathur et al., 2004) found that participation should be strategic, rather than all-encompassing. Maintaining an intensive level of interaction at all times imposes a burden on both the community and project team. Instead, the strategic involvement of stakeholders at key points is more effective, especially initial entry to the community and program design. Participation is a political process that requires constant negotiation among different stakeholders. In many societies, such as the hierarchical context of Nepal, it is essential to ensure the support of gatekeepers and community leaders before anyone else is approached. Meaningful participation also requires strategies to enable the involvement of people who are marginalized or discriminated against in some way. In Nepal, women, young people, members of specific ethnic or caste groups, and the poor are much less likely to be present in public spaces and to be automatically given an opportunity to interact or make decisions, and it is important to find ways to enable their involvement.

Enabling community participation requires thought and consideration about who has defined the community and how. The Nepal report noted that urban boundaries of "community" can be more artificially designed, especially given the greater diversity of residents in urban areas. In addition, urban residents are generally better off than rural populations and may not consider themselves in need of the benefits offered by NGO-initiated programs. They may have less time available to devote to participation in an NGO program and more opportunities for spending their time in other ways.

Heavy youth involvement is identified as a factor for success by several interventions (e.g., Senderowitz et al., 2004; Save the Children, 2005; Tipton et al., 2003). An evaluation of an intervention in Mozambique notes that enabling youth representation on coordinating bodies would be beneficial to both young people and the project (Senderowitz et al., 2004).

5.5 Managing Conflict

YRH and HIV/AIDS interventions involve raising culturally and socially sensitive issues about sex, sexuality, and gender, and thus risk widespread opposition from influential or powerful sectors of the community, such as religious leaders, as well as mistrust from communities targeted by the intervention. A project in Georgia suggested that community involvement may help reduce the risk of such conflict because, for example, it involves taking the time to forge relationships with influential groups and individuals and using interactive methodologies such as theater to foster community dialogue (Bartel and Tavadze, 2004).

Participation may also lead to conflict, both over control of an intervention (for example, strategies, activities, resources) and, more widely, by leading to a shift in the social relations of power. Morgan (2001) points out that struggles over power are not necessarily destructive and can be a creative factor in positive change. However, conflict is unlikely to be productive unless it is anticipated. Participatory programs that cannot cope with disputes over power are likely to fall short of expectations. Monitoring and evaluating the effectiveness of different strategies to mitigate or prevent conflict is likely to provide useful guidance for YRH/HIV prevention programming.

5.6 Safe Spaces

The importance of creating safe spaces for young people is highlighted by several interventions. The Ishraq project in Egypt includes sports for girls in its integrated program. It notes that a safe and supportive environment is particularly important for girls, who have historically been excluded, whether intentionally or unintentionally, from public spaces. In practical terms, the project notes the importance of protecting girls from harassment by men and boys when they are playing sports, of ensuring that the facility is accessible to the girls, and of scheduling activities on appropriate days and times (Ishraq, 2002). A midline evaluation of an integrated intervention in India revealed how the number of girls identifying a safe space to gather had increased from 13 percent at baseline to 95 percent, demonstrating the significance of this issue (Sebastian et al., 2004).

5.7 Adult Roles

Clear strategies for the systematic involvement of community leaders are important (Senderowitz et al., 2004). An intervention in Mozambique identifies training parents as community activists (peer educators for other parents and adults) as an effective strategy to increase support and facilitate communication between parents and children (Hainsworth, 2002). Identifying appropriate adults to fulfill different roles in different contexts emerges as a theme from several interventions. Several interventions highlight the effectiveness of using "promoters" or "friends" who are a little older than the young people themselves in educational and supporting roles (e.g., Alford et al., 2005; Ishraq, 2004b).

The literature suggests that people already performing educational roles are not always best placed to communicate with young people effectively. The evaluation of an intervention in Kenya found that teachers may have instilled negative attitudes toward the use of contraception, including condoms, among young people participating in school-based activities, countering general trends toward approval (Askew et al., 2004). Evaluation of a similar intervention in Senegal noted that a specific program is needed to provide a favorable school environment towards YRH/HIV to facilitate school-based interventions (Diop et al., 2004). Work with young factory workers in Cambodia demonstrated how interventions need to actively support YRH project workers to develop supportive, nonjudgmental attitudes about YRH (Forder, 2000).

5.8 Core Groups and Structures

A number of interventions note increases in the capacity of youth associations and clubs, providing a potentially sustainable resource and structure for continued youth and community development. One intervention set out to build the capacity of local youth associations (Yaro et al., 2003). Other interventions appear to have achieved this outcome with less direct planning, as a result of participatory processes that created opportunities for young people to form groups and develop decision-making autonomy (e.g., Mathur et al., 2004; Tipton et al., 2003). The formation and development of such groups is directly linked to the creation of safe social spaces for young people.

Working with youth groups or local youth associations has been found to be an effective way to reach out-of-school youth, a diverse and heterogeneous group that requires multiple local interventions (Tipton et al., 2003; Hainsworth, 2002). Working with local youth associations allows for a variety of approaches and builds on the trust they have already established

among hard-to-reach groups, such as orphans, street children, and young people involved in sex work. An intervention in Mozambique highlights the importance of realistic expectations of youth associations and an appreciation of their organizational and technical support needs (Hainsworth, 2002).

Experience from interventions in four countries noted the importance of incorporating youth leaders into existing community structures in order to better integrate their activities into the communities' work plans. For example, an intervention in Malawi successfully advocated for the inclusion of youth leaders into community AIDS coordinating committees, giving youth a voice in planning discussions (Save the Children, 2005).

6. Sustainability

6.1 Concepts and Definitions

The sustainability of development initiatives has been an issue of growing concern to policy-makers, donors, and practitioners over recent decades. Given the scale of need in the field of YRH/HIV prevention, and the investment made in the development of effective community-based interventions, ensuring sustainability is a serious concern. An additional issue regarding community involvement is that sudden or inappropriate termination of programs is likely to damage community trust, negatively affecting the level of community support for future programs seeking to involve communities in their activities (Shediac-Rizkallah and Bone, 1998).

YRH/HIV prevention programs enable community and youth involvement for a variety of reasons, including the contribution it is expected to make to sustainability. For example, the evaluation of the initial phase of an HIV/AIDS intervention in Malawi found that the intervention was not sustainable without community participation (Hunter, 2002). The link between community involvement and sustainability is multi-dimensional and may be demonstrated in a number of ways. For example, Mathur et al. (2005) conclude that community involvement will lead to sustainable results by mobilizing local capacity and resources, by diffusing information, and by building structures and mechanisms involving local ownership and authority.

Evaluation of a community-based maternal nutrition program in the Gambia identified a similarly wide range of factors relating community involvement to sustainability, including:

- Involving the community in the planning, implementation, and evaluation to promote community responsibility and ownership
- Creating an intervention compatible with community norms
- Building on existing social units and roles without overburdening community members with new tasks
- Motivating, training, and supervising community members in the performance of clearly defined roles
- Identifying strategies that allow communities to contribute a progressively greater amount of the resources required to sustain the program
- Designing a simple production method that is sparing of time and that depends upon comparatively small production groups
- Eliciting support from key male and female community leaders
- Collaborating with community development agents
- Providing adequate nutrition education in the community
- Helping community members understand that the benefits of an intervention outweigh the costs

(Aubel, 1996)

These cross-cutting factors can similarly be related to community ownership, capacity-building, resource mobilization, and development of community institutions with an additional focus on relevance and appropriateness to the community context. While interventions may conceptualize the mechanisms relating sustainability and community involvement differently, the concepts have become firmly attached and sustainability has become one of the criteria against which participation is evaluated (Morgan, 2001). Each sub-

section below explores one dimenion of the relationship between community involvement and sustainability, concluding with a discussion of challenges in measuring sustainability.

6.2 Community Ownership

Community involvement is widely understood to foster sustainability because it creates a sense of ownership, which in turn stimulates community members to provide support and other contributions towards program sustainability (African Youth Alliance, 2005a). In the context of HIV/AIDS programming, DeJong (2001) identifies strengthening local initiatives and sustaining community ownership as important for sustainable programs. In an intervention supporting community-led orphan support programs in Zimbabwe, the degree of community ownership directly increased project sustainability (Foster, 2000 cited in DeJong, 2001). Evaluation of an intervention in Burkina Faso found that community involvement created community commitment to sustaining activities (Yaro et al., 2003). More literal ownership is sometimes involved. A review of community involvement in health projects states that, in some instances, there may be a transfer of the whole or parts of project assets or resources to community ownership (Shea et al., 1996, cited in Shediac-Rizkallah and Bone, 1998).

Some studies suggest a relationship between community ownership, increased community capacity, and increased likelihood of program continuation. Similarly, community involvement is expected to increase the responsiveness of an intervention to the needs of a community, which is understood to enhance sustainability. For example, Hunter (2002:24) states, “Once empowered, service delivery continues even when external support is removed if services are valuable to the community.” The evaluation of the major intervention in Nepal suggests that actively involving community members in planning how some components would continue after the project ended may contribute towards sustainability (Mathur et al., 2004). Similarly, managing community expectations of the longer-term path of an intervention is likely to be important. For example, an intervention in Ghana formed youth groups that apply to bodies such as local government for funding of their ideas for new initiatives. A failure to secure funds for some of these proposed projects might serve as a disincentive and affect sustainability (CARE Ghana, n.d.).

6.3 Diffusion of Information and Influence

Shediac-Rizkallah and Bone (1998) highlight how continuation of a project’s impact may occur at the individual and network level. Key community members may continue to disseminate program-related information or provide program-related products or services. Also, individuals and organizations may create networks that reinforce program goals and enable coordinated efforts. Lasting shifts in knowledge, attitudes, and practices also represent a form of sustainability of program effort and offer a platform for future YRH improvements.

Many programs hope that information will be diffused through social networks to non-participants in the intervention, although this is often difficult to assess. The Mathur et al. (2004) evaluation of the Nepal project suggests that such diffusion will be a critical mechanism for sustaining program efforts, depending on the extent to which youth and adults who participated in the intervention continue to be seen as reliable sources of information and support. A sports-focused intervention in Egypt found that participating girls stated that the program had affected how they intended to raise their own daughters in the future (Ishraq, 2004), suggesting that impact of the program may diffuse to the next generation.

6.4 Resource Mobilization

The literature emphasizes the relationship between community involvement, ownership, the mobilization of community resources, and the potential contribution that this makes to sustainability (e.g., Japanese Organization for International Cooperation in Family Planning, 2000). Some writers argue that participation results in the provision of health services at a lower cost, as well as the introduction of additional resources into the system, partly due to greater access to fundraising opportunities but more especially to the availability of volunteers (Zakus and Lysack, 1998). Mathur et al. (2004) state that interventions aimed at youth development or social norms or systems are cost-effective when implemented through participatory processes because they allow for the effective mobilization of local resources and initiative. Reviewing a village health care project in rural Cameroon, Eliason (1999) identifies community financial self-reliance as well as adequate fees from patient curative services as key factors enabling sustainability of community-managed health programs.

The potential for mobilizing significant resources from poor communities should be assessed realistically. For example, an HIV/AIDS intervention working with poor communities in Malawi found that resource mobilization was possible but efforts netted small sums and required a relatively large investment of time (Hunter, 2001). Moreover, programs that rely heavily on volunteers often place a significant burden on people in poor communities (Zakus and Lysack, 1998), which militates against program sustainability.

Achieving financial sustainability is a particular challenge. While family planning and other health programs in many areas of the world do generate income through user fees, this approach may be particularly inappropriate to youth. Young people often do not have their own resources, and those who are dependents may find it difficult to discuss their reproductive health with their parents/guardian (Smith and Colvin, 2000). For many poor or vulnerable youth, any cost would be a barrier to accessing services. Newbrander (2002) stresses the importance of ensuring that community financing mechanisms, such as user fees, do not weaken principles of equity in service provision and access. Young people have limited capacity to influence policies and resource priorities and the sustainability of YRH/HIV programs is therefore contingent on the external environment and institutional commitment (World Health Organization, 2004).

One innovative approach relating to mobilizing community resources and scaling up is described in a project report of poverty alleviation and nutrition in Vietnam. Sternin et al. (1999) describe how villagers involved in the pilot phase of the project were able to act as consultants to new villages during scale-up. Communities with experience of implementing the project successfully became “living universities” for communities joining the project during scale-up. This approach is reported to have maximized the use of available resources while also expanding the skills base, encouraging sustainability, and building ownership. In the context of community-based health care, Newbrander (2002) notes the importance of incremental expansion of services, balancing the aim of providing a comprehensive package of services with the resources available, and avoiding overstretching the program.

6.5 Capacity Building

Capacity building is increasingly recognized as a key action to increase chances for long-term sustainability (African Youth Alliance, 2005A). A youth HIV prevention project in

Mozambique reports laying a solid foundation by establishing a cadre of youth and teacher peer educators, developing systems to ensure sustained interventions, and building local capacity (Casey et al., 2004). With youth projects, there are special issues such as the sustainability of the target group as young people grow out of, and into, the targeted age range.

While it is doubtful whether NGOs are likely to become financially sustainable, diversification of funding sources is highlighted as a key action throughout the literature, and there is general agreement that efforts to achieve sustainability benefit NGOs in terms of becoming more independent, efficient, and client-driven (as opposed to donor-driven) (African Youth Alliance, 2005a). The relationship between community involvement and organizational capacity building will depend on the nature of the NGO. For example, building the capacity of community-based organizations, especially membership organizations, or larger NGOs that are very strongly accountable to, or managed by, their community constituents, may be considered a proxy for building the capacity of communities in some contexts.

6.6 Institutional Sustainability

Some youth interventions are integrated into existing structures rather than based on the development of new ones. For example, an HIV/AIDS intervention in Malawi scaled up effectively by integrating its services and functions into the national structure of AIDS committees at district, community, and village levels (Hunter, 2002). Such integration is often expected to contribute to the sustainability of the intervention, particularly when such institutions are considered to represent, or be accountable to, the community.

In the broader context of health, experience from Cambodia found that involving communities through the existing structures of pagodas and pagoda volunteers was more effective and sustainable than newly established community structures with formally elected representatives (Jacobs and Price, 2003). In another example, forming health committees in India with external facilitators significantly improved the representation of women (Foundation for Research in Health Systems, 2004). It may be particularly difficult to find appropriate existing local structures for YRH activities, especially structures that enable youth to play an active and leading role in the intervention.

Mathur et al. (2004) in the Nepal report suggest that newly created structures that serve the interests of their members – such as networks of local service providers – are likely to continue, at least in the immediate future. Many YRH/HIV interventions reviewed formed youth groups, and anticipate that once established with their own space, legitimacy, membership mechanisms – and sometimes fundraising capabilities – these groups will continue to operate. For example, a rural drama group formed by the YRH/HIV project in Nepal has been hired by other organizations to perform plays.

Similarly, work with a newly formed youth organization in Uganda and with an existing youth council in Botswana contributed, in both cases, to the establishment of self-sustaining organizations of young people (African Youth Alliance, 2005a). The longer-term sustainability of such organizations is not reported. The development of structures and organizational systems that enable younger people to emerge as new leaders and provide opportunities for youth to maintain involvement in YRH/HIV as they become adults would

maximize the contribution such organizations make to the sustainability of such interventions.

This review did not find documented examples of the actual long-term sustainability of YRH/HIV interventions established through either existing or newly created institutions. However, the example of the sex worker union formed as a result of the Sonagachi project in India demonstrates how such interventions may lead to the creation of autonomous community-based organizations that sustain over a period of time and continue to contribute to program goals and objectives (Bandyopadhyay et al., 2003). Partnerships may provide the possibility for integration of community-based interventions or their constituent components into partner programs. For example, a YRH/HIV intervention in Nepal found that partnership with the Nepal Red Cross enabled groups of peer educators to become part of the Junior Red Cross and thus maintain access to training and information (Mathur et al., 2004).

6.7 Measuring Sustainability

In general, the push to develop sustainable programs and organizations has not been matched by efforts to measure how effective such interventions have been (African Youth Alliance, 2005a). Shediac-Rizkallah and Bone (1998) suggest that moving sustainability from a latent goal to a planned approach requires the formulation of sustainability goals and objectives as well as the development and implementation of strategies specifically to foster sustainability. In addition, they highlight the importance of monitoring and revision of both objectives and strategies as the project develops, in line with the need for a flexible, organic approach.

Sustainability is a concern common to many community health programs which, having incurred significant start-up costs, often see their funding withdrawn *before activities have reached full fruition* (Shediac-Rizkallah and Bone, 1998, italics in original). An intervention in Malawi established a youth network that has become an integral resource for a number of HIV/AIDS prevention initiatives, including projects funded by the National AIDS Commission. After several years of implementation, the implementing NGO is now working to partner with the government and other NGOs, further building the capacity of youth to organize their own associations to sustain and carry on their work in the project area and beyond (Save the Children, 2005). This example demonstrates that there is no “quick fix” to establishing a sustainable program, and a staged intervention may be required.

Some tools have been developed which measure specific aspects of sustainability mechanisms and can be used to assess progress over time (African Youth Alliance, 2005a). For example, Sarriot et al. (2004) developed a sustainability framework in consultation with NGOs implementing health projects. It should start with a consideration of the local systems that need to develop a common purpose. However, evaluating whether this impact occurs in practice will require revisiting the program in many years’ time. A sex worker-led project in India is said to have taken the best part of a decade for the effects of community mobilization to take root (Castle et al., n.d.). A time-frame such as this extends far beyond most donor funding – and evaluation cycles – and also suggests that establishing evidence about the sustainability may take longer than desirable given the current urgency and extent of YRH/HIV prevention needs.

7. **Scaling Up and Community Involvement**

7.1 Concepts and Definitions of Scaling Up

The World Bank (2004) describes scaling up as a multi-dimensional process to help broaden and deepen a program. Scale may indicate reaching a greater number of people, or it may indicate reaching a particular size of population, activity, or measure of interest (DeJong, 2001). Scaling up may refer to the expansion or replication of existing activities, or to an increase in the types of activities undertaken. DeJong (2001) summarizes definitions of scaling up in this table:

Input	**Output**
• Expanding organizational size • Increasing the scale of activity engaged in • Integrating other activities (*horizontal integration:* addressing unrelated activities; *vertical integration:* addressing different levels of related problems) in order to reach more people	• Reaching more people • Expanding geographic area(s) reached • Reaching other "target groups" • Increasing the volume of outputs (e.g., number of condoms distributed) • Increasing intensity of impact within given geographic area/social group

In the context of YRH/HIV, scaling up usually appears to refer to geographic expansion, either relative to the existing program, or to national coverage. The ultimate objective of scaling up is to increase the impact of a program. However, as DeJong (2001) states, a goal of increasing coverage is insufficient. A program may increase its coverage without a proportionate increase in its impact, as a result of reduced intensity of effort. The relationships between program coverage, impact, cost, and quality are dynamic and change according to both the external situation and the objectives of the scaling up (DeJong, 2001).

7.2 Rationales for Scaling Up

Scaling up programs maximizes the use of resources and investment made in developing the approach. Increasingly, donors express interest in programs that have the potential for scaling up (Cheetham, 2002). There has been a recognized tendency for project designers to plan small-scale pilot interventions, often because they lack funds to initiate a larger scale activity or because there is a perceived need to demonstrate effectiveness or develop program approaches before scaling up. This has led to a “project” mentality, often isolated from a larger program framework (Senderowitz, 2000).

The literature emphasizes the potential that the scaling up of YRH/HIV programs has to influence public debate, creating a more supportive and open climate and demonstrating the extent of YRH-related need to policy-makers (Health Communication Partnership, n.d.; Smith and Colvin, 2000). Scaling up YRH/HIV interventions with a community involvement component may also address some of the underlying causes of health problems as a critical mass of people develop their knowledge and skills and build organizational linkages within and beyond individual communities (Health Communication Partnership, n.d). Thus, scaling up may lead to sustained change on a broader level.

The potential for economies of scale is a widely used justification for scaling up YRH programming (e.g., Smith and Colvin, 2000). In the context of scaling up HIV/AIDS programming, DeJong (2001) notes that, as in other areas of development, organizations often fail to take the cost implications of alternative strategies fully into consideration, and that there is a dearth of evidence about the nature of costs as programs are replicated or expanded.

Smith and Colvin (2000) state that YRH programs can realize economies of scale by using existing research, training programs, supervision systems, resources, and infrastructure as a base for scale-up. The literature reviewed during this study provided no detailed analysis of costs relating to YRH/HIV, community involvement, and economies of scale. However, experience of scaling up a poverty alleviation and nutrition program in Vietnam identified time and cost efficiencies in scaling up, noting that the intensive work is carried out during the initial program development phase. Staggered geographical scale up was also found to increase efficiencies as problems in scaling up the implementation of different program activities, such as training, could be addressed early on, and the solution incorporated into the continued program roll-out (Sternin et al., 1999).

7.3 Scaling Up in YRH/HIV Programming

There is frequent reference in the literature to the danger of sacrificing quality – and therefore impact – to scale. Clearly, careful monitoring of the impact of scaling up on quality is important to track the effect of going to scale on program quality (Smith and Colvin, 2000), although smaller NGOs may not have the capacity to do this (DeJong, 2001). For example, Anti-AIDS Clubs in Zambia grew to national scale quickly but became ineffective. The scaling up efforts of the Family Health Trust therefore initially focused on boosting quality of an initiative already operating at national level. DeJong (2001) suggests that this experience reinforces the view that during scaling up, it may be necessary to concentrate on one aspect – i.e., either quality or coverage – possibly at the expense of the other.

The extent to which such considerations are a concern to YRH/HIV programs is likely to vary according the nature and approach of the intervention, such as the intensity of its activities, including the depth and frequency of community and youth involvement. There may be an optimal point for programs when small-scale replication becomes more effective than continuing to expand (DeJong, 2001).

Scaling up programs whose success is dependent on community involvement is widely considered to be a challenge in the literature (e.g., Bassett and Kaim, 2000). Many of the concerns raised about what will be lost in the process of scaling up relate to youth and community involvement, and the effect this is likely to have on program impact. For example, intensive group work over prolonged periods may have been identified as a key element for program success but may be difficult to sustain when taking the program to scale (Smith and Colvin, 2000). Community participation programs present some obstacles to scaling up due to their deliberately and intensely local nature. A maturing program may even feel the need to reduce the intensity of community participation in order to scale up the project without compromising its participatory nature and results (Cheatham, 2002).

Successful scaling up by The AIDS Support Organization (TASO) in Uganda illustrates that it is possible for a community-based organization, developed by a small group of activists, to develop an effective standardized approach that enables moving to a national scale while

allowing enough flexibility for diversity among different communities. TASO helps local community-based organizations to provide similar clinical and counseling services for people living with HIV/AIDS, which are tailored to the needs of different communities and the local situation (DeJong, 2001). Similarly, essential scaling up of community involvement in HIV/AIDS treatment is stated to be possible if creative mechanisms and programs, capacity building, strong networks, and commitment to the principle and leadership are all in place (Quan, 2004).

In the context of scaling up community-driven SRH programming, Igras and Blacher (2005) note the importance of ensuring that the benefits of the program reach those most in need, enabling meaningful participation by otherwise marginalized groups and increasing equitable access to services and improvements in well-being. Ensuring that any loss of effectiveness and efficiency during scaling up does not extend to less equitable participation and benefit is likely to be a key challenge. For example, even a temporary loss of focus on issues such as gender may result in the institutionalizing of a less gender-sensitive approach and result in decreased access by girls and women to the program and its opportunities and benefits.

Mathur et al. (2005) point out that while the participation of many different community stakeholders has benefits in terms of normative changes, scaling up such an approach may present logistical challenges in managing a large volume of participation. However, participatory approaches are time- and resource-intensive but no more so than other high quality programmatic approaches that yield positive, high-quality returns (Mathur et al., 2004). In one program, communities became involved in the program through a scale-up process that was staggered geographically. Their experiences and contributions were incorporated into the program design through regular communication between communities and staff and between different communities (Sternin et al., 1999).

The ability to scale up quality sustainable service provision must be considered when scaling up the community involvement/mobilization components of YRH programming (Mathur et al., 2005; Mubyazi, 2003). Both youth and community involvement are critical to effective YRH/HIV prevention programming. The challenges inherent in scaling up community involvement identified here relate to community involvement in general.

7.4 Strategies for Scale-Up

The literature reviewed during this study did not detail issues specific to scaling up youth involvement. This appears to be a gap in research and documentation of programming experience. Strategies for scaling up as they relate to community involvement in general are summarized briefly below. For more detailed discussion, which is often theoretical due to the lack of research in the area, refer to the sources cited.

Strategies for technical agencies, such as NGOs, aiming to scale up YRH/HIV interventions with a community involvement component include:

- Program expansion, including replication of an intervention in other geographical locations
- Technical or financial support to other organizations to replicate a program
- Replication of underlying concepts such as community involvement, rather than the intervention activities alone, by other organizations
- Influencing policy or legislation

Most scaling-up efforts require partnership formation. This means new management and operations systems that can continue to support the program's core values and maintain quality. Strategic leadership of the scaling-up process is important, taking into account the program strengths and weaknesses as well as external opportunities and constraints. Factors that sometimes limit the successful expansion of programs include geographic isolation, different interests and priorities of potential partners, and a focus on implementation by program staff (Howard-Grabman, 2003). Therefore it is likely to be important to make a deliberate effort to raise awareness of the programs successes among potential partner and stakeholders in scaling up.

It is critical for stakeholders who will be involved in the roll-out to be involved in the initial design and decision-making (Smith and Colvin, 2000; African Youth Alliance, 2005b). Smith and Colvin (2000) cite the work of Elmore on scaling up successful educational practices, which encourages program developers to pay attention to the attitudinal – as well as programmatic or institutional – aspects of scaling up. Scaling up a participatory approach within the project organization(s) is therefore as important as scaling up community and youth participation. Smith and Colvin (2000) suggest that this is relevant to scaling up YRH programs, and recommend that during scale-up of youth programs, transparent channels are put in place for staff to: learn about what the program hopes to achieve; develop skills in how to work with young people; and participate in the development of strategies that respond to the dynamic needs of youth.

In addition, a number of pre-conditions to scale-up exist. The importance of demonstrating the effectiveness and sustainability of an existing intervention before scaling up is emphasized in the literature, through formal and thorough evaluation where this is possible. In the context of community mobilization programs, the efficiency of the approach, consolidated, defined and refined so that it can be replicated or adapted by others must be demonstrated (Howard-Grabman, 2003). Similarly, plans to scale up an existing intervention must show how the long-term sustainability of the larger program will be enabled. A program must be built with sufficient financial, technical, social, and political support to last over time, including the ability to adapt and respond to changing needs, opportunities, and constraints (DeJong, 2001; Smith and Colvin, 2000). Smith and Colvin (2000) also highlight the importance of focusing on program development and institutionalization during scale-up (as well as at any stage of program implementation). Finally, the political and financial feasibility of scaling up must also be assured (Howard-Grabman, 2003).

Bibliography

Adamchak S, Bond K, MacLaren L, et al. *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs.* Tool Series 5. Washington, DC: FOCUS on Young Adults, 2000.

Adamchak S. Introduction, In: *New Findings from Intervention Research: Youth Reproductive Health and HIV Prevention Meeting Report, September 9, 2003*. Arlington, VA: Family Health International, 2003.

African Youth Alliance. *Sustainability*, Technical Brief. Washington, DC: African Youth Alliance, 2005a

African Youth Alliance. *Scaling up*. Technical Brief. Washington, DC: African Youth Alliance, 2005b.

African Youth Alliance. Advocating Adolescent Reproductive Rights – The Community Paralegals Approach in Ghana (draft). Ghana: African Youth Alliance, 2005.

Alford S, Cheetham N, Hauser D. *Science and Success in Developing Countries: Holistic Programs that Work to Prevent Teen Pregnancy, HIV and Sexually Transmitted Infections*. Washington, DC: Advocates for Youth, 2005.

Askew I, Chege J, Njue C, Radeny S. *A Multi-sectoral Approach to Proving Reproductive Health Information and Services to Young People in Western Kenya: Kenya Adolescent Reproductive Health Project.* Washington DC: Population Council, 2004.

Asthana S, Oostvogels R. Community mobilisation in HIV prevention: problems and prospects for community-based strategies among female sex workers in Madras. *Social Science and Medicine* 1996;43(2):133-48.

Attawell K. *Going to Scale in Ethiopia: Mobilizing Youth Participation in a National HIV/AIDS Program: A Lessons-Learned Case Study.* Washington, DC: The Synergy Project, 2004.

Aubel SN. Lessons on sustainability for community health projects. *World Health Forum* 1996;17(1):52-57.

Bagamoyo College of Arts, Tanzania Theatre Centre, Mabala R, Allen K. Participatory action research on HIV/AIDS through a popular theatre approach in Tanzania. *Evaluation and Program Planning* 2002;25:333-9.

Bandyopadhyay N, Mahendra V. *The Role of Community Development Approaches in Ensuring the Effectiveness and Sustainability of Interventions to Reduce HIV Transmission through Commercial Sex: Case Study of the Sonagachi Project, Kolkata, India, DMSC, Kolkata, India.* New Dehli, India: Horizons/Population Council, 2003.

Bartel D, Tavadze M. *Mitigating Conflict and Public Opposition to an Adolescent Reproductive Health Project Through Building Community Understanding and Dialogue: Guria Adolescent Project*. Draft report. Atlanta, Georgia: CARE USA and CARE Georgia, 2004.

Bassett M, Kaim B. *What They Don't Know Can Hurt Them: How School-based Reproductive Health Programmes Can Help Adolescents Lead Healthy Reproductive Lives.* Harare: Training and Research Support Centre, 2000.

Bhuiya I. Adolescent reproductive health findings from interventions research in Bangladesh. In: *New Findings from Intervention Research: Youth Reproductive Health and HIV Prevention: Meeting Report, September 9, 2003*. Arlington, VA: Family Health International, 2003.

CARE Cambodia. *A midterm evaluation measuring the "Sewing a Healthy Future" project coverage and behavior change outcomes in intervention and non-intervention factories.* Unpublished report. CARE/USA and USAID, 2005.

CARE Ghana. Report of CARE Ghana project using Societal Perspectives Involvement and Action (SPIA) approach. Draft Report. N.d.

Casey L, Pacca J, Badini R. *Scaling Up Youth HIV/AIDS Prevention: The Experience of Pathfinder International and the Foundation for Community Development in Inhambane Province, Mozambique*. Watertown, MA: Pathfinder International, 2004.

Castle C, Overs C, Longo P, et al. The Challenges of Implementing Community Development Approaches among Sex Workers in Brazil to Reduce their Vulnerability to HIV. Unpublished report. N.d.

Center for Research on Environment, Health and Population Activities (CREHPA) (2004). *Determining an Effective and Replicable Communication-Based Mechanism for Improving Young Couples' Access to and Use of Reproductive Health Information and Services in Nepal – An Operations Research Study.* Kathmandu: Center for Research on Environment, Health and Population Activities, 2004.

Cheetham N. Community Participation: What is it? *Transitions.* 2002;14(3): 3-6.

DeJong J. *A Question of Scale? The Challenge of Expanding the Impact of Non-Governmental Organizations' HIV/AIDS Efforts in Developing Countries,* London: International HIV/AIDS Alliance, 2001.

Diop N, Bathidja H, Touré I, et al. *Improving the Reproductive Health of Adolescents in Senegal. FRONTIERS Final Report.* Washington, DC: Population Council, 2004.

Eliason R. Towards sustainability in village health care in rural Cameroon. *Health Promotion International*. 1999;14(4):301-06.

Family Health International. *New Findings from Intervention Research: Youth Reproductive Health and HIV Prevention*: *Meeting Report, September 9, 2003*. Washington, DC: Family Health International, 2003.

Feyistan B, Philips J, Binka F. Social interaction and contraceptive change in Northern Ghana. *African Population Studies* 2003;18(2):47-67.

Forder J. Experience of using a participatory approach in Cambodia: Exposing the needs of sex and good women. *PLA Notes* 2000;37:56-62.

Foundation for Research in Health Systems. *Community Involvement in Reproductive Health: Findings from Research in Karnataka, India*. Washington, DC: Population Council, 2004.

Gibbon M, Labonte R, Laverack G. Evaluating community capacity. *Health and Social Care in the Community* 2002;10(6):485-491.

Gregson S, Terceira N, Mushati P, et al. Community group participation: can it help young women to avoid HIV? An exploratory study of social capital and school education in rural Zimbabwe. *Social Science and Medicine* 2004;58:2119-32.

Hainsworth G. *Providing Reproductive Health and STI/HIV Information and Services to this Generation: Insights from the Geração Biz Experience*. Mozambique: Pathfinder Mozambique, 2002.

Howard-Grabman L, Snetro G. *How to Mobilize Communities for Health and Social Change.* Health Communication Partnership. Baltimore: Health Communication Partnership, 2003.

Hunter S. *Supporting and Expanding Community-Based HIV/AIDS Prevention and Care Responses: A Report on Save the Children (US) Malawi COPE Project, Social Protection Discussion Paper Series.* Washington, DC: The World Bank, 2002.

Hutchinson S, Weiss E. Brazil's Program H. In *Involving Young Men in HIV Prevention Programs: Operations Research on Gender-based Approaches in Brazil, Tanzania and India*. Horizons Report, December 2004, pp. 2-6.

Igras S, Blacher R. *Scaling Up Sexual Health and Reproductive Health Programs to Increase Impact: An Overview of Concepts and Processes*. Atlanta, GA: CARE-USA, 2005.

Ishraq. *Briefing Sheet No 2*, Egypt: Population Council, Caritas, CEDPA, and Save the Children, 2002.

Ishraq. *Briefing Sheet No. 5*, Egypt: Population Council, Caritas, CEDPA, and Save the Children, 2004a.

Ishraq. *Briefing Sheet No. 6*, Egypt: Population Council, Caritas, CEDPA, and Save the Children, 2004b.

Jacobs B, Price N. Community participation in externally funded health projects: lessons from Cambodia. *Health Policy and Planning* 2003;18(4):399-410.

Japanese Organization for International Cooperation in Family Planning. *A Guidebook for the Development of Sustainable CBD/CBS Programs*. Tokyo: Japanese Organization for International Cooperation in Family Planning, 2000.

Laverack G, Labonte R. A planning framework for community empowerment goals within health promotion. *Health Policy and Planning* 2000;15(3):255-62.

Levene J, MacLean A. *Reviewing community mobilization and HIV/AIDS: what works? what next?* Unpublished report. London: International HIV/AIDS Alliance, 2006.

Mantilla M, Antezana M. *Evaluation of Community Education Interventions in Sexual and Reproductive Health Services in Urban-Marginal Areas of La Paz, Bolivia.* Washington, DC: Population Council, 2004

Mathur S, Mehta M, Malhotra A. *Youth Reproductive Health in Nepal: Is Participation the Answer?* New York: EngenderHealth and International Center for Research on Women, 2004.

Mathur S, Pande R, Barua A, et al. *Community Mobilization and the Reproductive Health Needs of Married Adolescents in South Asia*. Paper prepared for presentation at the Annual Meetings of the Population Association of America, March 31-April 2, 2005, Philadelphia.

Morgan L. Community participation in health: perpetual allure, persistent challenge. *Health Policy and Planning* 2001;16(3):221-30.

Morgan R. Pathfinder's Community-Based Projects Address Barriers to Reproductive Health Services. *Pathpapers*, 2000;1(1).

Mubyazi G. *Understanding Mechanisms for Integrating Community Priorities in Health Planning, Resource Allocation and Service Delivery: Results of a Literature Review*. Harare: EQUINET: Network for Equity in Health in Southern Africa, 2003.

Newbrander W. Resources to Get the Job Done: The Sustainability of Community-Based Health Care. In Rohde J, Wyon J, eds. *Community-Based Health Care: Lessons from Bangladesh to Boston*. Management Sciences for Health, Boston, 2002.

Njue C. Innovative Project Delivers Reproductive Health Information and Services to Young People in Western Kenya. In: *New Findings from Intervention Research: Youth Reproductive Health and HIV Prevention Meeting Report, September 9, 2003*. Arlington, VA: Family Health International, 2003.

Quan A. Community Involvement Critical to Treatment Scale-Up. *TREAT Asia Report*. New York: American Foundation for AIDS Research (AMFAR), 2004.

Ramella M, de la Cruz RB. Taking part in adolescent sexual health promotion in Peru: community participation from a social psychological perspective. *Journal of Community and Applied Social Psychology* 2000;10:271-84.

Ross D, Cleophas-Mazige B. Results from a Community Randomized Trial in Rural Tanzania: the MEMA kwa Vijana Project. In: *New Findings from Intervention Research: Youth Reproductive Health and HIV Prevention Meeting Report, September 9, 2003*. Arlington, VA: Family Health International, 2003.

Sarriot E, Winch P, Ryan L, et al. Qualitative research to make practical sense of sustainability in primary health care projects implemented by non-governmental organizations. *International Journal of Health, Planning and Management* 2004; 19(1):3-22.

Save the Children. *Working to Improve the Reproductive and Sexual Health of Young People: Save the Children's Experience in Bhutan, Malawi, Nepal and Viet Nam.* Westport, CT: Save the Children, 2005.

Sebastian MP, Huntington D, Singh AN. *Integrating Adolescent Livelihood Activities within a Reproductive Health Program for Urban Slum Dwellers in India*. Washington, DC: Population Council, 2004.

Senderowitz J. *A Review of Program Approaches to Adolescent Reproductive Health.* Arlington, VA: Population Technical Assistance Project, 2000.

Senderowitz J, Alban A, Taela K, Matsinhe C. *Evaluation of Geração Biz Program,Mozambique.* Unpublished Report. Pathfinder International, 2004.

Shediac-Rizkallah M, Bone L. Planning the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research* 1998;13(1)87-108.

Smith J, Colvin C. *Going to Scale in Young Adult Reproductive Health Programs, FOCUS Tool Series.* Washington, DC: Pathfinder International, 2000.

Sternin M, Sternin J, Marsh D. Scaling Up a Poverty Alleviation and Nutrition Program in Vietnam. In Marchione T, ed. *Scaling Up, Scaling Down: Capacities for Overcoming Malnutrition in Developing Countries*. Gordon and Breach, Amsterdam, 1999.

Swaasthya and International Center for Research on Women. The Roadmap to Increased Self Determination. In *Addressing Adolescent Girls' Reproductive & Sexual Health Concerns, Update 1*. Available at: *http://www.swaasthya.net/pdf/Evaluation%20of%20ARSH%20prog.pdf*

Taylor C, Taylor H. Scaling Up Community-Based Primary Health Care. In Rohde J, Wyon J, eds. *Community-Based Health Care: Lessons from Bangladesh to Boston*. Management Sciences for Health, Boston, 2002.

Tardieu C. *CARE-Haiti Bassin-Bleu Youth Development Initiative, Final Evaluation.* Atlanta, GA: CARE International, 2003.

Tipton P, Igras S, Zambezi R, Ashley M. *Examining Multisectoral Approaches to Youth: Case Study of the Youth Development Initiative in Bassin Bleu, Haiti.* Arlington, VA: Family Health International, 2003.

Trasi R. *Sonagachi*. Unpublished report. Yale/(Center for Interdisciplinary Research on AIDS (CIRA), 2005.

UNAIDS. *Community Mobilization and AIDS.* Technical update. Geneva, Switzerland: UNAIDS, 1997.

USAID. *Health and Family Planning Indicators: Measuring Sustainability, Volume II.* Washington, DC: U.S. Agency for International Development, 1999.

Verma R, Pulerwitz J, Mahendra A, et al. Promoting gender equity among young men: Positive experience of the "Yari-dosti" project in India. *Sexual Health Exchange* 2005;2.

Vernon R, Durá M. *Improving the Reproductive Health of Youth in Mexico*. Washington, DC: Population Council, 2004.

Weissman A. Mobilizing communities for change – the youth to youth for healthy life project. *Transitions* 2002;14(3).

World Bank. Scaling-Up a Community-Driven HIV/AIDS Program in Malawi. *Social Development Notes* 2004;96.

World Health Organization. *Key Issues in the Implementation of Programmes for Adolescent Sexual and Reproductive Health.* Geneva: World Health Organization, 2004

Yaro Y, Mukenge M, Calvès A. *A Final Evaluation of a Collaborative Program on Community Participation to Improve Adolescent Sexual and Reproductive Health in Burkina Faso*. Los Angeles, CA: Pacific Institute for Women's Health, 2003.

Zakus D, Lysack C. Revisiting community participation. *Health Policy and Planning* 1998;13(1):1-12.

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