Youth Community Involvement Resources

The Role of Community Involvement in Improving Reproductive Health and Preventing HIV among Young People

Report of a Technical Consultation

November 8-9, 2005

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Acknowledgements

Introduction

Community involvement is considered an important element of most health and development programs. Local knowledge can inform program design when community members are involved from the beginning, and community action extends the reach and scope of interventions.

Experience with programs in many sectors has shown that behavior change to improve people's health and well being requires changes in knowledge and attitudes not only at the individual level, but also at the community level. Community-level shifts in attitudes and social norms create a more supportive environment that enables individual to adopt and maintain new behaviors. Community involvement can also create the sense of ownership necessary to sustain behavior change beyond the life of an externally funded program.

Involving both youth and adults in communities is particularly important for youth reproductive health (YRH) and HIV programs. Some degree of youth involvement is essential for such programs to function. Greater levels of youth participation may also increase the impact of reproductive health and HIV prevention interventions. Programs for youth that are designed only by adults tend to be based on an idealized view of how young people should behave. Young people's participation in planning, implementation and evaluation is expected to ground programs in the real needs of youth and the support systems they actually use, making interventions more relevant to their intended beneficiaries.

Beyond youth participation, the involvement of the larger community is also considered critical to the success of youth HIV and reproductive health programs. Such programs cannot work with young people in isolation. In fact, in most societies it would be impossible to reach young people without at least the cooperation of the adults responsible for their physical and social development. Moreover, because young people and adults in a community often have different perspectives, involving only young people and not adults in YRH/HIV programs can be controversial. Conversely, adult involvement in such programs can enable adults to provide more effective support for youth, improve communication between adults and young people, and increase community ownership and sustainability of YRH efforts.

Although the need for community involvement in youth programs seems clear, only a handful of studies have actually attempted to measure the added value of incorporating such participation into an YRH program. Program experience in community involvement for youth reproductive health and HIV prevention – though extensive – is poorly documented. Thus, to understand the value of community involvement in youth reproductive health and HIV programs requires more research. Questions remain about the most effective ways to encourage, support, and sustain community members' participation in such programs.

To advance the field of community involvement in YRH programs, YouthNet brought together experts from a wide range of international organizations working with youth. The U.S. Agency for International Development funded this effort, and many other organizations contributed staff time, resources, talents, and ideas (see Acknowledgements). Together, they developed a process to help close the gaps in our understanding of community involvement for YRH and begin strengthening the evidence base. Participants in the consultation were charged with two inter-related tasks:

- **Examine the existing research** on the value of community involvement interventions in YRH and HIV programs, the gaps in empirical evidence, and suggest ways to build on and strengthen impact research and program evaluation of YRH/HIV programs that involve communities; and,

- **Examine the state-of-the art of YRH/HIV programs** with substantial community involvement interventions, including promising practices and emerging issues that require more experimentation and documentation, and suggest ways to expand the knowledge base and practices related to effective YRH/HIV programs that involve communities.

As a result of this meeting, participants generally agreed that future research and program efforts should focus on:

- Developing conceptual frameworks that more clearly define the relationships between community involvement and RH and other program outcomes.
- Defining standardized yet flexible indicators of the impact of community involvement.
- Ensuring strategic community participation at critical points throughout the life of the project. Strategic participation in the context of working with youth implies more conscious youth-adult partnerships, and specific strategies which may be required to include marginalized youth in communities.
- Conducting additional research and rigorous program evaluation which are critical to strengthen the evidence base and address knowledge gaps regarding the role of community involvement in youth reproductive health and HIV prevention.
- Improving program/process documentation about community involvement in youth reproductive health/HIV projects.
- Furthering interagency collaboration and donor support of process and evaluation documentation.

This report of the consultation is part of a package of materials YouthNet has produced to help provide global technical leadership on the issue of community involvement and youth RH/HIV prevention. Besides this report, the package of materials includes:
- a guide to using participatory assessment techniques at the community level, focusing on youth involvement
- a review of the literature on the topic
- an annotated guide to technical resources

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Some material in this meeting report is taken from the literature review. That review includes a more in-depth discussion of many of the ideas and projects discussed in this report as well as a full bibliography of sources, which readers of this report may want to consult. Please note that the programs described in the sidebars are placed to illustrate particular themes. However, these programs are multidimensional and relate to other themes in the report as well and should not be viewed as only addressing the particular issue emphasized.

Defining Community Involvement

Because all participants would come to the consultation with different understandings of what constituted community involvement, the consultation began with a presentation and discussion about definitions of community involvement and related terms. The starting point is the word "community." Typically, communities are defined either geographically or socially. A geographical community is recognized by attributes tied to physical appearance or location, such as natural boundaries, a recognized history, demographic composition, or the presence of certain industries or organizations. A socially defined community consists of people who share common social attributes and interests, such as language, customs, class, or ethnicity, regardless of geographical proximity.

Who defines community is also important to the design and eventual impact of an intervention. Community "insiders" and technical expert "outsiders" often have different views of community needs and how to address them. Programs involving communities may be externally rather than community-driven. Ideally, however, outsiders serve as catalysts for community action. Issues, such as the threat of HIV, may be used as entry points to involve communities.

Communities are often idealized as benevolent entities. In reality, all members of a community do not have equal access to goods and services. Moreover, community power structures are not always altruistic or inclusive, particularly for women and youth. The "capacity" or "competency" of a community refers to physical and social attributes such as resources, goods and services, the environment, the organizational infrastructure, and social and political connectedness. Community capacity helps determine what kind of community involvement can be expected.

In the literature on community involvement in youth RH and HIV programs, the terms "community involvement" and "community participation" are often used interchangeably. Both are seen as occurring along a continuum, according to the degree of control and decision-making that community members have, as shown in Figure 1.

Figure 1. Typology of Community Participation[1]

- Collective action   *Toward*
                                        ownership and
- Co-learning   *sustainability*

- Cooperation

- Consultation

- Compliance

- Co-option

Away from ownership
and sustainability
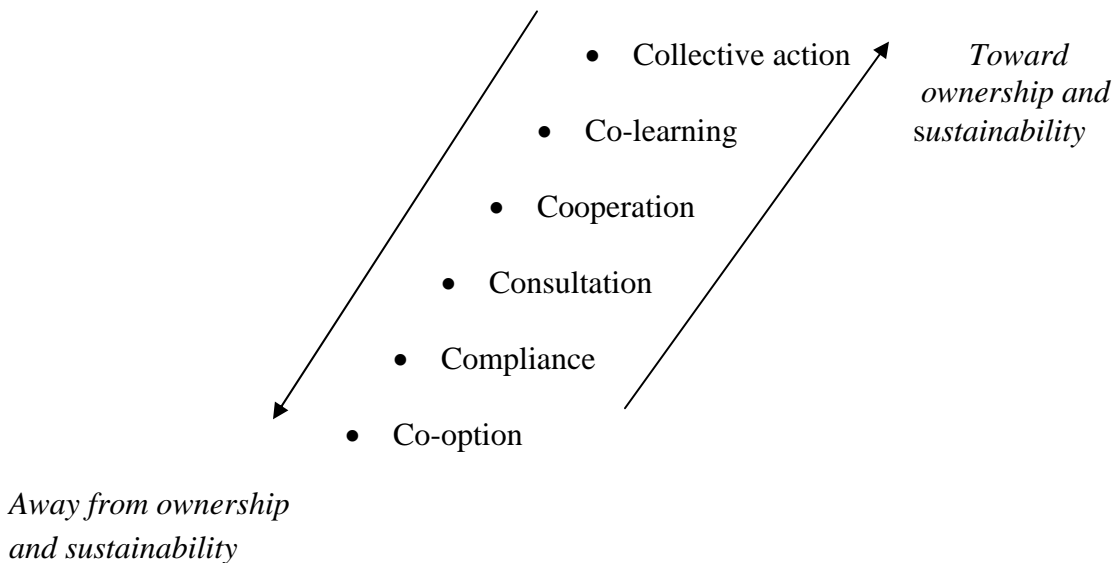
"Community mobilization," a related term, is used to describe a process at the higher end of this continuum. Community mobilization has been defined by the Joint United Nations Programme on HIV/AIDS as a process whereby a group of people become aware of a shared concern or common need and decide to take action in order to create shared benefits. Save the Children Federation has described community mobilization as a continual and cumulative process that involves communication, education, and organizations, which together lead to more autonomy and conscience. Another way to look at the range of community involvement is as a cyclical rather than linear or sequential process, recognizing that the degree and intensity of community participation in any project varies over time, depending on the context, timing, and circumstances.

Meeting participants agreed that context dictates appropriate levels of community involvement and those levels may fluctuate during a project. Many factors affect the level of involvement. For example, gender and social norms can hinder or support placement on the continuum. Also, the level of community preparedness to participate will influence the appropriate level of community involvement at a given time.

Three different types of goals are usually stated for involving communities in YRH and HIV prevention. Community involvement is seen as:
- **A means to an end,** or a tool for achieving project outcomes more efficiently and effectively, and with less expense, than without such involvement.

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[1] Adapted from Cornwall, 1995, cited in Howard-Grabman L, Snetro G. *How to Mobilize Communities for Health and Social Change.* Baltimore, Maryland, USA: Health Communication Partnership, 2003.

- **An end in and of itself,** because the transformational, empowering effect of participation leads to greater equality in social power relations and greater community capacity to manage resources in pursuit of better health or other desired benefits.
- **A principle** of engagement and of good development practice (this is more an aim that is not directly goal-related), which informs all interventions rather than being a project component.

Participants noted that these reasons for involving community members often overlap and are not mutually exclusive. While underlying principles or programmatic approaches are not necessarily designed to be measured, objectives and indicators are needed to measure and describe the impact of community involvement.

Youth involvement adds complexity to community involvement efforts. Young people's access to community forums and ability to participate are often limited by adults' perceptions of them and by social norms. But young people *are* members of their communities, and their involvement in youth HIV and reproductive health interventions is essential.

Community involvement plays a variety of roles in YRH and HIV interventions. Consultation participants identified the following roles:
- Creating a supportive community environment that enables individual behavior change
- Facilitating changes in gender norms that affect young people's risk of HIV infection and other adverse RH effects
- Generating demand for interventions or services for youth
- Providing access to youth through adult gatekeepers
- Implementing programs
- Empowering community members, including youth
- Promoting sustainability and a sense of community ownership of programs

Research and Evaluation Issues

Findings from Program Research

In preparation for the technical consultation, YouthNet commissioned a background paper that synthesized and analyzed published, evaluated YRH and community involvement programs and related research (referred to as "the meeting review paper").[2] Highlights of this review were summarized at the meeting. The review identified 30 evaluated programs or interventions that substantially involved communities in youth RH and HIV prevention. Only one of those evaluations was designed explicitly to measure the added value of involving communities. Most measured progress toward youth RH objectives, usually through indicators of changes in knowledge, attitudes, and practices (KAP). The use of rigorous research designs was limited; only one-third of the reviewed studies used a quasi-experimental research design with a comparison group; most relied on cross-sectional KAP-type surveys applied before and after an intervention without any comparison group.

The one completed research study that did explicitly measure the effectiveness of participatory approaches was an intervention study conducted by the International Center for Research on Women (ICRW) and its partners in Nepal – EngenderHealth, New Era, and BP Memorial Health Foundation. Mathur and colleagues described this study in a 2004 ICRW report. This study in Nepal was the only example found of using a quasi-experimental design to test the effectiveness of participatory approaches (see page 12). A community involvement approach in one village was compared to a traditional "top-down" health education approach in another village. Differences in positive effects on most YRH knowledge, attitude, and practice indicators were marginal between the two approaches. However, the study found substantially more positive changes in contextual factors that influence YRH in the villages reached by the community involvement intervention. These changes in contextual factors included norms relating to marriage and childbearing, capacity building, and empowerment of youth. No increase in contraceptive use was detected, but the intervention did result in youth identifying a barrier to contraceptive use (beliefs about specific contraceptive methods).

This community involvement intervention appeared to be more effective than traditional top-down education interventions in addressing deeply entrenched attitudes about maternal care services, such as acceptance of the need for postnatal care, which challenged strong cultural beliefs about the importance of a period of confinement after giving birth. Results from in-depth interviews and group discussions suggest that involving communities helped give young women the confidence to broach what had been a taboo subject and voice their maternal care needs to their elders. This involvement also helped increase support for maternal care services among husbands and mothers-in-law.

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[2] Maclean A. *Community Involvement in Youth Reproductive Health: A Two-Part Review and Analysis of the Literature.* Arlington, Virginia: YouthNet/Family Health International, 2006.

Nepal and India Studies Examine Impact of Community Involvement on Youth Reproductive Health

The ICRW conducted studies in Nepal and India that explicitly examined the impact of community involvement on YRH. The Nepal study compared two approaches to improving maternal care knowledge, attitudes, and practices among female and male youth − married and unmarried − ages 14 to 21 years. In one urban and one rural site, community members were mobilized to participate in every phase of the intervention, from design to evaluation. Seminars, interactive discussions, theater, and other methods were used to improve RH knowledge and life skills; increase support for maternal care services among male partners, parents, and in-laws; and encourage changes in social norms. Communities in two other sites, also one urban and one rural, received more traditional health education and services, with limited community engagement and predetermined interventions. ICRW, Engenderhealth, and two Nepali organizations − New Era and the B.P. Memorial Health Foundation − administered the study.

Likewise, a study in India compared different interventions for improving understanding and use of maternal care services. This study targeted married women ages 16 to 22 years and their husbands in rural areas of the state Maharashtra. The strategies tested were: 1) community mobilization to increase demand for maternal care services, including delivery in a formal healthcare setting; 2) improving the quality of maternal care at government health services; 3) a combination of both strategies; and 4) existing services. ICRW and the Ahmedabad-based Foundation for Research in Health Systems conducted this study.

The studies found that community mobilization and more traditional approaches were equally successful at improving knowledge of maternal care issues, such as complications during pregnancy and childbirth. Findings on use of services were mixed. Increases in the proportion of young married women reporting delivery in a formal setting were seen in both the study and comparison sites in Nepal, but the improvement was greater in the community mobilization sites.

Qualitative results suggest that community mobilization was more effective than more traditional approaches in addressing deeply entrenched attitudes about maternal care, such as awareness of the need for postnatal care. To suggest that women in these communities need postnatal care challenged strong cultural beliefs about the importance of a period of confinement after giving birth. Therefore, it was essential to work with the community to raise awareness of the need for women to seek postnatal care. Information on less controversial subjects such as pregnancy complications, on the other hand, seemed to be conveyed with equal success through more traditional health education.

Results from in-depth interviews and group discussions suggest that community mobilization approaches helped give young women the confidence to broach what had

been a taboo subject and voice their maternal care needs to their elders. They also helped increase support for maternal care among husbands and mothers-in-law.

Before the project began, community members viewed the risks associated with childbearing as negligible and considered prenatal care unnecessary unless a problem occurred. "We did not have this care," said an Indian mother-in-law, in a typical response. "We did heavy work during pregnancy and never had any problems." The change in attitudes that occurred over the next two years is illustrated by a comment from another Indian mother-in-law: "I think this new system of care is good for the health of the mother and the child," she said. "This generation is lucky – we did not have such a system."

Findings from Program Evaluations

As noted earlier, the background paper to the consultation found that most research relied on cross-sectional KAP-type surveys applied before and after an intervention without any comparison group. These evaluations provide useful findings in terms of types of indicators that are being used or could be used to measure community involvement interventions and link them to YRH outcomes as well as collective, community outcomes that create an enabling environment.

Findings from these program evaluations indicated that social change and social networking were shown to reduce vulnerability of youth and increase their uptake of services in some cases. Changes in perceptions of socially ideal behaviors or in normative behaviors (indicators of social change) were also reported in programs with substantial community involvement.

For example, a number of interventions:
- increased girls' perceived self determination and positive perspectives
- improved youth decision-making and leadership skills, which increased their sense of self-worth and value to the community
- helped girls be more willing to challenge gender norms

Other interventions reported social change, such as:
- improved parenting skills and increased communication between parents and their children in Bhutan
- changed perceptions among adult women of adolescent girls' lives and needs in India
- positive changes among parents and community leaders about the benefits and social acceptability of girls playing sports in Egypt
- diminished support for inequitable gender norms among young men in Brazil

Some interventions increased the status of youth, through:
- increased parental recognition of youth capabilities
- increased community recognition that youth peer educators served as role models and leaders in communities

Conceptually, programs can consider two complementary sets of objectives: one focused on program-specific objectives and the other focused on community empowerment. One such approach identified nine operational domains that focus on the organizational elements of community empowerment: participation, leadership, organizational structures, problem assessment, resource mobilization, "asking why," links with others, role of the outside agents, and program management.[3]

Research testing these domains found that community members used a variety of participatory tools to identify and evaluate indicators of change in these domains. The researchers concluded that this was a useful approach to evaluating community empowerment within the parallel track approach to community mobilization.[4] This approach could be adapted and applied by YRH interventions seeking to involve youth and other community members in evaluating empowerment-related objectives.

Research and Evaluation Challenges in Measuring Impact

The meeting review paper also identified challenges involved in research.

- **Community involvement-related objectives are rarely stated and therefore not evaluated.** Most interventions have youth RH-focused objectives, so they assess progress towards those objectives. They usually do not assess the role community involvement played in that progress. Most projects do not articulate goals regarding involving communities, the processes they use to do so, or the expected outcomes.

- **Standard indicators of community involvement do not exist**, making it difficult to compare results of those studies that do attempt to assess the value of CI interventions. Questions remain as to whether indicators can be standardized. Can a set of standard indicators be applied to different communities, in different contexts? Alternatively, can standard indicators be developed for particular types of communities, such as people engaged in commercial sex, urban communities, or communities experiencing high levels of mobility and migration?

- **Clear monitoring and evaluation frameworks for community involvement are lacking.** Despite recognition that community involvement is a critical component of many types of programs, in most cases concepts of community involvement and how it will contribute to YRH outcomes are not clearly documented.

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

[4] Gibbon M, Labonte R, Laverack G. Evaluating community capacity. *Health and Social Care in the Community* 2002;10(6):485-91.

- **The evolutionary nature of community involvement compounds challenges of evaluation**. Participatory processes do not necessarily develop in linear directions. Their evolutionary nature complicates expectations that results can be predicted, and therefore evaluated against pre-determined objectives and measures of success. Projects can, however, monitor the nature of participation over time.

- **Community members rarely participate in evaluating community involvement**. Programs appear to rely on externally determined indicators. The meeting review paper found no examples of community members developing their own indicators to evaluate youth RH interventions or assisting with data collection or analysis. Also, the paper noted that while indicators set by community members may help the community itself, these indicators may not address the evaluation priorities of implementing agencies, a donor, or other stakeholders. Moreover, different sectors of the community – such as young men, young women, or adults – are likely to have different perspective about how to measure a project's success.

- **Attributing results to community involvement is difficult**. Linking cause and effect is always difficult in programs that focus on prevention (ie, prevention implies the *absence* of an outcome, like unintended pregnancies, which is not observable). Attribution may be even more challenging for impact evaluations of community involvement in youth RH because the types and depth of community involvement vary and are often not made explicit. In addition, interventions that involve communities are usually complex, and the depth of available documentation varies widely, making comparisons difficult.

Responding to These Challenges

One of the reasons for paucity of data on the impact of community involvement, consultation participants suggested, is the widespread belief among program implementers that community involvement is a critical program element to achieving health and development goals. Many do not question the need to evaluate it, as involving communities is good program practice and a development principle.

But given limited resources, not everyone is convinced of the value of community involvement or agrees that it is worth the time and cost entailed, compared to other types of YRH program interventions. Donors, in particular, may need stronger evidence before they are willing to fund long-term programs with intensive community involvement. In addition, participants suggested that well-planned monitoring and evaluation, as well as rigorous evaluation research, offer important lessons about how to improve efforts to involve communities in youth RH/HIV programs and make such programs more effective. Monitoring and evaluation can also provide insights about which activities are most critical (and when) − information that program planners need to make the best use of limited resources or to plan program scale-up.

In discussions about these challenges and how best to address them, consultation participants pointed out that theoretical models or conceptual frameworks are needed that more clearly define the relationships between community involvement and program outcomes. A stronger conceptual basis would make it easier to understand and evaluate the role of community involvement in youth RH and HIV prevention for youth. One suggestion was to develop a parallel track concept to explain and measure how community involvement affects collective, as well as individual, behavior change. Some cautioned that a single model or "blueprint" might lack the necessary flexibility to assess community involvement in different contexts. Participants also recognized the **need for standardized indicators of the impact of community involvement**, but again stressed the need for flexibility to adapt standard indicators for different types of communities and situations.

Program Issues: Community Involvement in Practice

Many of the interventions discussed in the meeting review paper used three strategies to improve YRH and protect young people from HIV, and essentially represent the state of YRH program models:

- Building youth knowledge and skills
- Creating an enabling environment by, for example, addressing social norms, developing supportive social and peer networks, or sensitizing adults
- Providing or strengthening youth-friendly services

While the majority of interventions reviewed in the background paper had traditional YRH objectives, some also focused on building youth capacity or changing social norms. One intervention in Burkina Faso also aimed to build local organizational capacity to involve youth and other community members. For most of the interventions reviewed, descriptions of participatory processes or approach to community involvement and expected benefits of community involvement are not explicit in the documentation.

The review found some examples of interventions that take a more holistic approach, addressing social and economic issues that affect youth, and particularly girls and young women. Examples include integrating YRH into broader literacy and education support, developing sports programs for girls, establishing savings and vocational or livelihood programs, and building youth capacity and networks by establishing youth clubs.

Consultation participants focused on several major thematic areas that related to good program practice and emerging program issues. These themes were reflected in the meeting review paper, the presentations on individual program experiences, and key YRH/HIV and community involvement issues identified prior to the consultation in interviews with key stakeholders. Discussions focused on the following themes: enabling and strategic participation, managing conflict, multi-sectoral programs with YRH/HIV prevention components, challenging gender and other social norms, scaling up programs, and reaching vulnerable youth

Enabling and Strategic Participation

Consultation participants agreed that all *programs that seek to involve community members must enable them to participate in meaningful ways*. This requires not only 1) providing opportunities for community participation in program design, implementation, and evaluation but also 2) strengthening the ability of community members to participate effectively. 3) Programs for youth have the additional challenge of helping adults and youth communicate and work together, despite differences in perspectives and experience.

Consultation participants agreed that *capacity building for community involvement should start with project staff*, to give them a true understanding of participation and its practical application. Strengthening staff skills in facilitating community involvement was

considered essential for moving beyond awareness raising and knowledge-building of individuals to individual and community behavior change for improved reproductive health. Organizations also need to *help staff challenge their own assumptions and biases* about working with members of communities that can be different from their own communities.

How a project positions itself in targeted communities may be critical for effective YRH interventions. The ICRW study by Mathur and colleagues suggests that an effective planning process must begin with a quality needs assessment facilitated by people with expertise in YRH programming, so that they can help incorporate lessons learned elsewhere into activities suggested by the community.

Discussion also focused on *strategic participation* and the need to be more *selective of which community stakeholders or community institutions to focus on in terms of building capacity and enabling participation.* Which community stakeholders are most critical in achieving a specified program outcome? The Nepal project studied by ICRW chose to engage in strategic rather than all-encompassing participation of community members. Maintaining everyone's participation throughout a project is often too much of a burden on community and project staff, and strategic involvement of key stakeholders at appropriate times can be even more effective. The most critical points for stakeholder engagement are during initial entry to the community and program design.

Strategic participation implies specific strategies are needed to involve marginalized segments of the community. Women, young people, members of specific ethnic or caste groups, and the poor are much less likely to be present in public spaces or to be automatically given an opportunity to interact or make decisions. Youth associations and clubs can be a good mechanism for involving hard-to-reach youth, particularly the more vulnerable groups such as orphans, street children and young sex workers.

Strategic participation also *implies* more conscious youth-adult partnerships to improve YRH/HIV interventions. A program implemented by Save the Children in Nepal provides an example of the benefits of involving key stakeholders, including youth and service providers, in project design. As a result of youth and service providers working together to identify and address barriers to access and provision of YRH services, service delivery was improved and young people's use of services increased. This example also illustrates how youth-adult partnerships can improve YRH/HIV interventions. In another example in Malawi, young people were better able to integrate their activities into their communities' work plans when youth leaders were included in community AIDS coordinating committees.

Adults who play key roles in the lives of youth in a given community should be identified and engaged appropriately to facilitate youth access to YRH/HIV information and services. One intervention in Mozambique found that providing parents and other adults with training as community activists increased support for YRH activities and facilitated communication between parents and children. Several other interventions describe the importance of involving slightly older youth, or young adults, in educational and supportive roles. Teachers also need community support and education to facilitate effective school-based interventions.

Developing Community Institutional Capacity in Burkina Faso

A consultation presentation on a project in Burkina Faso illustrated important themes regarding how to enable community participation. Sustained efforts were needed to build the capacity of youth associations and a local non-project organization, as well as members of the targeted communities. Advocates for Youth implemented the project, working with a local nongovernmental organization (NGO) called Mwangaza Action and three local youth associations.

An organizational needs assessment helped Advocates for Youth determine the capacity building needed to prepare Mwangaza Action and the youth associations to lead a community-driven process of diagnosing and addressing priorities for youth. Then, Advocates for Youth and Mwangaza Action trained members of the youth associations in youth RH, community participation, and each step of the "autodiagnostic" process. This process helps to identify community priorities and develop action plans, through local village committees.

After training, the youth associations established and facilitated discussions among village committees of 10 people representing each of the 20 villages in the project. They also held focus group discussions with community members and conducted village assemblies at which the village committees shared their conclusions and received feedback from the larger community.

Based on this feedback from the community, the youth associations and village committees developed action plans for their three project areas. Their plans were similar, centered around peer education and information, education, and communication for parents and the community as a whole, but each had distinctive features. One placed more emphasis on encouraging parent-child communication, another on discouraging the practice of female genital cutting, and a third on addressing limited use of reproductive health services by youth.

As the communities moved through the autodiagnostic process and began carrying out these action plans, Advocates for Youth and Mwangaza Action continued to build the capacity of youth and adult community members to lead and participate in the project. They also ensured that the structures and processes developed for facilitating participation, such as the village committees, were inclusive not only of the community, but specifically of sufficient numbers of youth to enable them to play leadership roles.

Developing the community action plans in a highly participatory way took about a year. Results of a project evaluation conducted by the Pacific Institute for Women's Health after a year and half of project implementation suggest that this time was well spent, building a high degree of participation and a sense of ownership among community members.

By the end of the project, 69 percent of community members surveyed reported participating in at least one project activity, such as home visits or group talks with

project peer educators, video showings, and theater presentations. More than three out of four viewed youth as key actors in the process, and six out of 10 considered the youth associations the principal implementers. Parents said that they wanted peer educators to continue their work. The peer educators had become a resource not only for the young people in their communities, but also for adults and residents of neighboring communities.

Managing Conflict

Youth RH and HIV interventions raise culturally and socially sensitive issues, such as sex, sexuality and gender. In most societies, the sexuality of young unmarried people is particularly controversial. Widespread community opposition to YRH/HIV activities may arise because:

- Adults feel threatened
- Adults want to protect youth
- Adults fear that educating youth about preventing pregnancy and sexually transmitted infections, including HIV, will increase promiscuity
- YRH-related interventions and participatory processes may challenge deeply entrenched cultural norms, including expectations about gender roles

The literature shows that such power struggles are not necessarily destructive. In fact, they may be essential to creating opportunities for positive change. As conflict arises, though, it must be managed. Consultation participants discussed the importance of youth RH/HIV projects forging relationships with influential leaders and engaging communities from the outset to gain their trust and buy-in to YRH interventions.

The importance of such relationships was evident in the two presentations at the meeting that addressed conflict management: Guria Adolescent Health Project (GAP) in the Ozurgeti district of the Republic of Georgia, coordinated by CARE, and the Knowledge Attitude Improvement of Sexual Health for Adolescents' Responsibility (KAISHAR) project in Nasirnagar, Bangladesh, coordinated by Save the Children (see page 22).

Based on the lessons from the GAP and KAISHAR projects and some of their own experiences, consultation participants identified the following strategies as critical to overcoming resistance to YRH programs:

- **Identify common ground.** Community members can move beyond fixed and opposing positions on an issue to consider youth and community needs and common interests. The obvious interest they have in common is meeting the needs of youth. Meeting those needs can also be considered an investment in a community's future. Projects should not, however, agree to compromises that fail to meet youth needs.

- **Ensure a broad spectrum of stakeholders.** Stakeholder analysis is critical to help anticipate and prevent community resistance to a program. But the experiences of Save the Children in Bangladesh and CARE in Georgia illustrate that stakeholder

analysis must be revisited; analysis and outreach to stakeholders are needed at strategic points throughout a program, and particularly when sensitive issues, materials or activities are introduced.

- **Involve youth in meaningful ways.** Consultation participants emphasized the need for a *meaningful* ways to involve youth. Youth participation is often only a token involvement. Even when young people are asked to be involved, they may not feel comfortable doing so. Youth are not supposed to speak up in the presence of adults in many cultures. They may need opportunities to express themselves when adult community members are not present.

- **Build the skills needed to overcome resistance.** Program staff should expect resistance and be prepared to overcome it. Their organizations should equip them with the skills they need to manage resistance from community members. Leadership and conflict resolution skills are particularly important. In the examples from Bangladesh and Georgia, staff initially panicked when opposition to youth RH activities emerged. Such reactions are understandable, because conflict makes most people uncomfortable. But fear of conflict can prevent staff from taking timely action to defuse a crisis. Program staff members need training and practice in dealing with tensions and criticism.

- **Build good communication skills within implementing organizations and among community members involved**. In addition to good interpersonal communication, skills are needed to depersonalize issues, define terms clearly, and tailor language and messages to the audience. Effective communicators are also mindful of culture, engage community members in communication activities, and use different communication methods.

Projects Address Conflict in Georgia and Bangladesh

In 2004, CARE began introducing youth RH interventions to conservative, geographically and culturally isolated communities in the Republic of Georgia. Accustomed to living under strong hierarchical governments, first under Soviet rule and then under post-communist governments, these communities had no experience of civil society challenging authority to improve people's health and well-being.

Religious leaders viewed with suspicion CARE's effort to improve young people's RH knowledge and life skills and to establish a local model of youth-friendly reproductive health services. Even more sensitive, however, was the project's third objective, which was to reduce the community's tolerance of abductions and rape of girls or young women who are then forced to marry the perpetrators.

Shortly after GAP began in 2004, an article in the December 2 issue of *The Georgian Times* accused the project of "contributing to the depravity of youth." Other early warnings of potential conflicts included resistance from religious leaders, community protests against other nongovernmental organization (NGO) projects for youth, and a school headmaster's decision to block GAP activities in one village.

CARE staff and its local NGO partners moved quickly to identify and address key stakeholders' interests, needs, and positions. They also made a concerted effort to build relationships with potential allies, including Orthodox priests sympathetic to the project's goals; adolescents from families who are highly ranked politically or socially; and sympathetic teachers, doctors, and nurses.

Another conflict prevention strategy that proved effective was to design an "entry point" and progression of activities for target villages. In each village, CARE introduced the project to gatekeepers and then assessed the needs and interests of both youth and adults. This assessment guided the phased introduction of activities, moving from less controversial to more contentious issues. Interventions most likely to encounter resistance were pre-tested to identify potential problems, and highly sensitive issues were addressed through community "forum" theater. At these events, actors performed open-ended plays about a social practice that affects the health of adolescents, then asked audience members to role-play options for resolving the challenges portrayed in the plays.

Despite growing acceptance of the project, CARE staff members recognize the need for continuing conflict assessment and response. They currently hold monthly meetings with local NGO staff, volunteers, community stakeholders, and youth participants to keep them informed about the project's progress and address any concerns that might arise.

In Bangladesh, Save the Children expected some opposition to the KAISHAR project's efforts to improve the sexual and reproductive health (SRH) of adolescents in the area's conservative Muslim communities. To prevent conflict, project staff members first

discussed their plans with religious leaders, parents, extended family members, and other community members and enlisted their support.

Nevertheless, opposition to the project emerged two years later, when religious leaders objected to the content of SRH/HIV materials. Imams and other religious leaders told their communities that adolescent SRH was "anti-religious" – a message that was reinforced by an inaccurate newspaper article about the project – and asked Save the Children to halt all project activities.

Activities were temporarily suspended, to show respect for religious leaders. But instead of ending the project, KAISHAR staff improved relations with key stakeholders by holding individual meetings with religious, political, and community leaders and advocating for SRH with government officials. They prepared advocacy packages for different audiences and held a series of community meetings to explain the benefits of adolescent SRH information and services. Workshops for media personnel helped clarify adolescent SRH issues and established communication between journalists and project staff, resulting in more accurate media coverage of the project.

Save the Children also facilitated alliance building with local partners to help reduce resistance to the project. National religious leaders and Ministry of Health officials provided orientation to imams and other community stakeholders.

A particularly important strategy for overcoming resistance was the formation of local advisory committees involving community and religious stakeholders. One of these committees made minor revisions to the controversial SRH materials and involved community members in developing program implementation guidelines.

As a result of all these activities, KAISHAR was able to resume. Parental support increased, and some former opponents of the project became community-level trainers and advocates. A few imams even held discussions about HIV and other SRH issues at their mosques before Friday prayer.

A key lesson from Save the Children's experience is the importance of periodic assessment of community support for youth RH activities. Mechanisms for encouraging strategic but continuing community involvement, such as the KAISHAR advisory committees and regular community meetings, can help project staff identify and respond to any concerns as they emerge.

Multi-Sectoral Programs with YRH/HIV Components

This program area requires much more experimentation and related research. Some programs have found that encouraging multi-sectoral youth programs (education, livelihoods, etc.) to integrate YRH/HIV interventions can result in more youth being engaged in issues related to pregnancy and HIV prevention and good sexual and reproductive health choices. Yet there is little documentation or research to test this assumption.

Participants at the consultation discussed multi-sectoral work and evaluations done in Haiti. A study there suggests that integrated programs may increase the intensity of interventions, along with their ability to engage youth by addressing a range of cultural, sporting, community, religious, and economic needs and resources. Another case study from Haiti suggests that youth view their needs and their world differently than adults, in a more integrated and less segmented manner. Hence, offering information and services through only one sector (i.e., the health sector) is of less interest or relevance to youth in terms of addressing their needs holistically.

The meeting review paper and presentations during the consultation did not offer sufficient documentation to compare the effectiveness of different project components, a research issue that could help guide development of multi-sectoral programs that focus on youth. A pre-occupation with livelihoods is a reality facing young people, and participants noted the need for open and in-depth discussions about transactional sex among youth and ways of providing realistic livelihood options.

Challenging Gender and Other Social Norms

Changing gender and other social norms is a particularly important challenge for those seeking to involve communities in youth RH/HIV. Societal expectations about male and female gender roles as well as norms around marriage and other social institutions are at the core of much of the resistance to such interventions. Young people, in particular, are scrutinized regarding adherence to norms. Young women may be expected to be virginal and uninformed about sex, while prevailing definitions of masculinity may accept and even encourage early sexual initiation and sexual promiscuity among young men. Young girls are sometimes forced to marry early because of values around childbearing, fears of bringing dishonor to the family, and economic motivations of poorer families.

Cultural leaders rarely challenge existing gender norms or advocate on healthy approaches to RH/HIV issues for youth. Leaders from government, religion, and other areas can help or hinder the ability of both young women and young men to obtain information and make safe choices regarding their reproductive health. Involving communities in YRH issues can create new possibilities for challenging norms that impede young women and men from making safer reproductive health choices and can create public spaces for new, more supportive norms to be discussed and to evolve from prevailing norms.

A promising project that challenges prevailing gender norms in Al-Minya, Egypt, called Ishraq was presented at the consultation (see below) While the impact of community involvement in this project has not been evaluated, the Ishraq midterm evaluation suggested the importance of using non-confrontational ways of challenging gender norms such as creating safe spaces, particularly for girls who have been excluded from public spaces for historical and cultural reasons. The project provides safe spaces by creating a supportive environment with involved communities and ensuring access to services or activities. It protects girls from harassment by men and boys when they are playing sports, ensuring that facilities are accessible to the girls and scheduling activities on appropriate days and times. The midterm evaluation found that the number of girls identifying a safe space to gather had increased significantly from the baseline. Ishraq staff members believe the community's participation has enabled the project to operate in a conservative environment and has created the support necessary for girls to take advantage of new educational, recreational, and vocational opportunities offered by the project.

Community Helps Change Gender Norms in Egypt

In Al-Minya, a rural, impoverished governate in Upper Egypt -- as in many parts of the world -- girls' schooling opportunities and mobility are limited. Early marriage is so common that 20 percent of girls ages 16 to 19 years are married. Opportunities begin to narrow at an early age for girls in such communities. A national survey found that 53 percent of Al-Minya's girls ages 16 to 19 had been circumcised, and only 31 percent could name the legal age for marriage. Less than half of the girls had ever played sports.

To address such issues, the Ishraq project seeks to increase adolescent girls' mobility, skills, knowledge, and confidence through education in literacy, numbers, and life skills, as well as sports and other physical activities. At the same time, the program works with parents, boys, community leaders and health promoters to influence social norms about girls' roles in their families and communities.

Community support was nurtured from the outset of the program, beginning with extensive orientation of various community leaders, parents, and other adults. Ishraq staff also opened participation in the project's classes for girls to all community members, including parents, to reassure them of their value. Village committees were formed and convened for regular meetings to address any concerns and keep the community informed and involved in the project.

A collaboration among the international organizations Caritas, the Centre for Development and Population Activities (CEDPA), the Population Council, Save the Children, and local governmental and nongovernmental organizations, the Ishraq project includes life skills classes that emphasize awareness of health issues, citizenship, and individual rights. The girls, generally ages 13 to 15 also learn to read and write in Arabic, play team sports, and participate in recreational activities, vocational training, and savings clubs. The aim is to increase adolescent girls' mobility, skills, knowledge, and

confidence, while working with parents, boys, community leaders, and health promoters to influence the gender norms that limit girls' opportunities. Eighty-four percent of those in the Ishraq project's target group had never been to school, and less than half had ever played sports

After completing the Ishraq program, the girls can take an adult education qualifying examination to qualify to return to formal schooling. More than 90 percent of Ishraq participants who took this government literacy exam passed, and more than half received a score of "excellent." Educational aspirations of program participants have increased dramatically, with almost all expressing a desire to attend school. "For the first time in my life I learned that girls have equal rights to education as boys," said an Ishraq graduate named Wafaa. "In the past my understanding was that girls did not need to be educated because they were going to marry."

Positive changes in project participants' attitudes toward early marriage and female genital cutting were also reported. Whether families' and communities' support for Ishraq activities reflects shifts in prevailing gender norms remains to be seen. The impact of the project on girls' lives and community norms will be assessed as ISHRAQ evaluations follow participants through the transition to adulthood.

Scaling Up Programs

Consultation participants identified scaling up of community involvement programs as another area requiring further exploration, documentation, and evaluation. While donor and government pressure exists to scale up community-based interventions in order to achieve greater impact in HIV/YRH, participants expressed concern about the risk of losing the value of community involvement when programs are expanded to reach larger populations. More operations and evaluation research is needed to identify the types of interventions appropriate for scaling up and how to scale up using processes that ensure the continued impact of key interventions. *How much community involvement must be retained to achieve the desired results, and at what cost?* Participants called for cost-benefit analyses of programs that involve communities. They emphasized that such analyses should separate the start-up costs of developing programs from the cost of continuing to implementing them at scale.

Scaling up means not only replicating an intervention but also building or supporting the infrastructure and system capacity to support it on a larger scale. Program participants discussed the importance of program planners identifying the minimum requirements for maintaining the quality and impact of community involvement in expanded programs and determining which civil society and governmental structures can support them. Issues of community compensation must also be addressed when scaling up interventions.

One example of a youth RH/HIV program involving communities that was expanded to a national scale was presented at the consultation. Geração Biz, a RH/HIV prevention program for youth in Mozambique, began in 1999 as a pilot project in two provinces,

with a plan for gradual expansion into a national program. It has used three interconnected approaches in its expansion - more youth-friendly health services, community-based peer education, and school-based education. The pilot project was designed with future scaling up in mind and conscious choices were made of which institutions to work with and through in order to take the program to scale. During the consultation, some participants queried the extent communities were involved in pilot efforts (this was not defined), and how the initial level of community involvement may have shifted as the program went to scale.

Pilot Project Expands to National Program

Geração Biz, a reproductive health and HIV prevention program for youth in Mozambique, began in 1999 as a pilot project. But project implementers had always intended to gradually expand pilot interventions into a national program.

Young people − who gave the project its name, which means "Busy Youth" − are at the center of all the project activities, as peer educators and organizers of activities in schools, health centers, and communities. Peer educators participate in community events, perform dramas to communicate program messages, and show health education videos. They also visit churches, nightclubs, and homes; counsel individuals and groups; refer youth to health services; and distribute educational materials and condoms. Young people's participation is organized through local youth associations created through the Geração Biz program. A National Youth Council represents these associations in discussions with the government, partner organizations, and donors.

To make expansion and sustained intervention possible, the project was established within existing government programs and structures. The Mozambican government was involved from the beginning, with the Ministry of Health conducting the initial needs assessment and working with Pathfinder and the United Nations Population Fund (UNFPA) to establish more youth-friendly RH services in selected maternal-child health clinics.

As the project expanded to other provinces, each of its approaches was supported by a government ministry at the national and provincial levels. Today, the Ministry of Health works with its provincial directorates to help clinics throughout the country offer RH/HIV services that are sensitive to the needs of youth. The Ministry of Youth and Sports supports community-based peer education and youth-targeted events and activities, while school-based programs are led by the Ministry of Education and Culture.

By 2005, the youth RH/HIV effort was recognized as national program, working in eight of 11 provinces. Under an agreement among UNFPA, Pathfinder, and the Government of Mozambique, it will expand to all the provinces and continue through 2007. The project, now firmly established in local institutions, is emphasizing strengthening institutional capacity to enable the government, youth associations, and communities to sustain interventions beyond the end of project.

Reaching Vulnerable Groups

Community involvement with particularly vulnerable youth, such as urban street children, those affected by conflict, and young sex workers, is another critical gap in youth RH/HIV programs that needs more documentation and evaluation of program approaches. The most vulnerable youth are often seen as marginal members of their communities. The very reasons for their vulnerability − poverty, family violence, the death of a parent to AIDS – may be associated with a stigma that cuts them off from sources of community support. The challenge is how to engage the mainstream community to work with people that it consciously or unconsciously marginalizes. Related to this challenge: how to not further marginalize the most vulnerable young people through the process of helping them?

The stigma associated with HIV/AIDS can make people reluctant to participate in a project offering support to orphans and other vulnerable children. A presentation about such a project in four urban areas of Kabwe, Zambia, explained that to avoid adding to that stigma, the project does not single out individuals or families affected by HIV. Instead, it casts a wider net, helping all orphans and families coping with chronic illnesses to meet some of their immediate needs and to help lay a foundation for a more secure future (see page 30).

Stigma was the focus of much of consultation participants' discussion about the challenges of community involvement in youth RH interventions targeting particularly vulnerable youth. To help frame their discussion, participants developed a partial list of groups of vulnerable youth, which ranged from orphans and vulnerable children, youth with disabilities, sex workers, to sexually active youth (e.g. boys with money, truck drivers). This very exercise raised the question of how to avoid a risk inherent in targeting such groups: How do you reach vulnerable youth without further stigmatizing them? For example, trying to reach young sex workers through community involvement poses a real risk of further stigmatizing the young women.

Other challenges to improving the reproductive health of vulnerable youth were identified, including the following:
- Achieving strategic representation and participation of vulnerable groups in community-wide actions.
- Understanding vulnerability in more complex ways by looking at not only proximate but also distal factors for vulnerability.
- Determining which specific barriers and supportive conditions will work in a given community.
- Re-defining "community" as a common interest group, and not solely by geography.
- Determining which alliances to build with which influential adversaries, such as religious and traditional leaders.
- Reaching youth where there is no system or infrastructure for doing so
- Finding appropriate entry points to engage vulnerable youth and the larger community.

Group members noted that interventions with vulnerable youth are often similar to those undertaken with other young people, but they take more time, for a number of reasons. Vulnerable youth may be harder to identify when they are not in school or living with families. They may be less trusting of outsiders than other youth are, and may require additional services, such as HIV care and pregnancy care. Vulnerable youth may also require additional protection − for example, to avoid disclosing their HIV status or that they are engage in commercial sex − and those efforts may in turn take more time.

Implementing organizations should help donors understand the need for longer project cycles. Also, although all youth are vulnerable to an extent, it is necessary to be even *more* protective when working with vulnerable youth.

The group concluded that programs should be more strategic in defining which members of the geographical community need to be involved for the protection of the most vulnerable. Some tools that might be useful for strategic identification of community participants include a tool called "force-field analysis" from the United Kingdom's Department for International Development (DfID), social mapping, and other forms of community analysis. Group members also identified some steps that could be taken in program design to reduce vulnerability and stigma.

Some program approaches to address vulnerability and marginalization are shown below:
- Work with field teams to identify their own biases that may cause or exacerbate stigmatization.
- Be careful not to raise controversial issues in ways that force disclosure or jeopardize the safety of individuals.
- Consider in advance how an intervention could effect or even perpetuate the problem (or drive it underground). Find strategies to keep the vulnerable safe.
- Test ideas to ensure they would do no harm before implementing them in public settings.
- Involve the most vulnerable and at risk in defining the approach.
- Conduct a systematic community analysis of how community dynamics and social norms actually perpetuate the behaviors an intervention is designed to address, so that community members can develop strategies to begin changing those dynamics and norms.

Program approaches to address stigma and decrease vulnerability:
- Consider stages or sequenced actions for addressing stigma, linked with community involvement. Assess community readiness and meet people where they are.
- Avoid labeling in defining groups that might increase stigma (for example, instead of "commercial sex worker" use "high-risk youth").

Community Key Link in Zambian Program Assisting Orphans

The Zambian project, implemented by the Adventist Development Relief Association (ADRA) and World Emergency Relief, has provided psychological and social support, HIV prevention information and counseling, vocational training, and life skills education to more than 385 orphans since 1996. Graduates are registered with the Trades Council of Zambia, for examination under the Examination Council of Zambia. This enables them to receive a recognizable certificate in carpentry or tailoring, which increases the graduates' chances of employment and makes them more competitive among self-employed workers.

Support from the community is an essential part of this project. At each site, a community-based organization helped identify young people and families in need of assistance and community volunteers, whom ADRA trains to provide that assistance. About 80 home-based care providers visit homes to care for the chronically ill, while more than 25 community counselors/educators help sensitize the community about HIV prevention, care, and support, and how to live with HIV. The educators also disseminate HIV messages through educational materials and community drama performances.

Obtaining consistent support for the project from desperately poor families is sometimes a challenge. Many project participants have lost both parents and live with foster or extended family members, while others are caring for sick parents and other family members. In some cases, family members pressure the youth to go make money or find food for their siblings instead of attending classes.

Project staff identified irregular attendance and attrition as problems during the first year of intervention. They found that some of the young people had to walk as far as 14 kilometers to the training center every day. Along the way, they were likely to seize any opportunity they came across to earn money. Then ADRA began providing a simple daily lunch consisting of a carbohydrate, a protein, and a vegetable. All the young people eagerly took turns helping prepare the meals, and attendance improved markedly.

Still, the short-term sacrifices required to participate in the project represent a burden to most of the families. Foregoing income now so that young people can receive training that will provide greater and more reliable economic benefits in the future may mean going without food or other basic needs. ADRA hopes to provide food supplements to families and is exploring other community-based strategies to facilitate young people's participation in the project.

Next Steps

Discussions throughout the consultation highlighted the need for theoretical and conceptual frameworks of community involvement that show how such interventions link to program outcomes. The related need for standardized indicators for research and program and evaluation was also discussed throughout. Specific suggestions on next steps from a research perspective and from a program perspective are below.

Research to Build the Evidence Base

Participants agreed that more research, including operations research and more rigorous program evaluation, is critical to strengthen the evidence base and address knowledge gaps to increase an understanding of the contribution of community involvement in improving young people's reproductive health. Consultation participants developed the following list of research questions that should be addressed (not in any particular order):

- What frameworks and evidence of the value of community involvement already exists that YRH/HIV prevention researchers and practitioners can learn from and possibly adapt (such as child health, primary health care, community development, and health promotion)?
- What is the level of community involvement that is critical for success in terms of youth RH outcomes (timing, sequencing, place on the continuum of participation)?
- How does community involvement lead to more supportive environments?
- How do communities build their own pathways of community involvement, and how can researchers document that process?
- What standard indicators would allow researchers to capture the added value of community involvement in youth RH?
- Which community involvement interventions are most useful when working with youth?
- What is the cost of meaningful community involvement? What is the cost-benefit of involving communities in youth RH/ HIV prevention in different settings?
- Does community involvement lead to *sustained* supportive environments?
- Which types of community involvement interventions are appropriate for scaling up, and how can such interventions be expanded to ensure their continued impact?

Program Experiences to Build the Knowledge Base

Discussions throughout the consultation highlighted areas where there is insufficient program knowledge and related documentation. These included scaling up community involvement interventions, involving communities in working with vulnerable or marginalized youth, and multi-sectoral programs that are community-based and include YRH/HIV prevention components.

Better documentation is needed of approaches and processes used with and by communities in matters related to YRH/HIV. With more documentation, one can begin managing a collective knowledge base. The group acknowledged that documentation of community involvement presents an enormous challenge, requiring inter-organizational approaches to building and sharing the knowledge base.

- Participants thought that a critical first step would be to review existing process documentation to compile a more complete list of lessons learned and promising practices that exist in community involvement interventions around YRH/HIV prevention.
- Explore ways to share community involvement information through existing electronic "clearinghouses," such as the Implementing Best Practices forum, the Maximizing Access and Quality Web site, and the Institute of Development Studies participation database.
- Build on the review paper prepared for the consultation, particularly reviewing the literature on scaling up and multi-sectoral programming.
- Promote among YRH program planners the use of standardized indicators of CI outcomes across programs. This would include simple indicators of normative change.
- Involve communities in documentation and program evaluation and include community members' own assessments of what happened and why.
- Identify existing community involvement approaches and tools. Develop tools to address areas not currently being addressed.

Suggestions for Donors

Advancing the field of community involvement in youth RH/HIV programs will require more interagency collaboration, rigorous research and program evaluation, and sharing of lessons learned and promising practices. Donors could help by supporting efforts to mine the existing process documentation, as well as by supporting evaluation and documentation of ongoing projects and post-project impact evaluations to assess sustainability. Specifically, donors could:

- Identify inter-organizational partnership possibilities and encourage work to build the evidence and knowledge bases
- Encourage multi-sectoral programming partnerships and innovation.
- Include community involvement in results frameworks and strategies. Promote among YRH program planners the use of standardized indicators of CI outcomes across programs. This would include simple indicators of normative change.
- Support documentation of case studies of community involvement in youth RH and HIV prevention.
- Support systematization of the information about what is being done to involve communities in youth RH/HIV and how and why it is being done.
- Support efforts to utilize existing process documentation, evaluate and document ongoing projects, and conduct post-project impact evaluations to assess sustainability.

Appendix 1. List of Participants

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Appendix 2. Agenda

Tuesday, November 8, 2005	
9:00-9:30 am	Welcome, Introductions, and Consultation Objectives
9:30-10:30 am	SESSION 1: Defining and contrasting key terms **SPEAKER: Susan Igras, Senior Program Advisor, Sexual & Reproductive Health, CARE-USA** **Overview of key concepts guiding this consultation: definitions, perspectives, challenges.** Distinctions between concepts of community involvement, participation, mobilization. Range of definitions. Continuum of participation/involvement. Why this consultation will not seek a consensus on any one definition of CI. Discussion.
10:30-11:00 am	**Tea/Coffee Break**
11:00 am-12:00 pm	SESSION 2: What is the evidence-base of the added value of involving communities in YRH/HIV programming? **SPEAKER: Alexandra Maclean, Community Participation Consultant** What evidence exists for the value added by CI? Findings from the literature review on the research base that exists. Discussion.
12:00-1:00	**LUNCH**
1:00-1:45pm	SESSION 3: Current CI programming efforts around YRH/HIV issues **SPEAKER: Usha Vatsia, Senior Technical Advisor, Community Involvement, YouthNet/CARE-USA** Where are we with CI interventions in YRH/HIV programs? Findings from the literature review and key informant interviews on main types of interventions that involve communities. Program gaps that exist. Discussion.
1:45-3:15pm	SESSION 4: Promising program examples: Involving communities in integrated youth programs addressing RH and HIV issues **MODERATOR: Akinyele Dairo, UNFPA** *Geração Biz* **SPEAKER: Julio Pacca, Country Representative** **Pathfinder International/Mozambique Office** Pathfinder will share experience with an integrated multisectoral SRH/HIV youth program in Mozambique, recently cited by the World Bank as a "best practice"

	among YRH programs. Issues to be presented include: the centrality of community involvement, sustainability challenges, community ownership, parental involvement to address gender with peer educators, and the use of HIV as an entry point to engaging the community.
	Burkina Faso **SPEAKER: Nicole Cheetham, International Division Director Advocates for Youth** Advocates for Youth will present its work with youth and communities in Burkina Faso. This presentation will discuss the community mobilization methodology used in the project, elements that contributed to its successes, challenges and lessons learned, and the results of their work on organizational capacity, knowledge, attitudes and practices, and degree of community participation. Discussion
3:15-3:45pm	Tea/Coffee Break
3:45-5:00pm	SESSION 5: Promising program examples: Involving communities in multisectoral programs addressing livelihood, YRH/HIV prevention, other issues **MODERATOR: Gill Gordon, Senior Programme Officer: Prevention International HIV/AIDS Alliance** *Nepal & India Projects* **SPEAKER: Rohini P. Pande, Sc.D., Social Demographer, Population and Social Transitions, International Center for Research on Women** ICRW will present evidence from intervention research programs on the positive effects of community mobilization in improving reproductive health awareness and use of maternal care services for young, married women. The presenter will discuss the extent to which approaches with comprehensive community mobilization efforts are more successful in changing the systemic and contextual barriers to good reproductive health for young married women when compared with more traditional reproductive health program approaches. *ISHRAQ Project:* **SPEAKER: Kathrin Tegenfeldt, Operations Manager, Asia & Near East CEDPA** This presentation will describe a project that seeks to improve the life trajectory for adolescent girls through a holistic program of literacy, health awareness, skills building, physical activity, and civic engagement. Discussion
5:00pm	Adjourn the day

Wednesday, November 9, 2005	
8:30-9:00am	Recap of first day
9:00-10:00am	*SESSION 6: Emerging Program Issues: Managing community conflict and working with vulnerable youth*

Georgia

SPEAKER: Doris Bartel, Senior Program Advisor, Sexual and Reproductive Health, CARE-USA

The Guria Adolescent Project is a reproductive health project implemented by CARE to improve adolescent reproductive health. Due to the conservative nature of this isolated and rural area, project staff and implementing partners have faced significant pressure to ignore issues of adolescent reproductive health from suspicious community members, religious and educational leaders, and the press. In order to mitigate conflict, minimize opposition and maximize community support, GAP staff have proactively used specific community mobilization techniques to engage stakeholder and community support.

Bangladesh

SPEAKER: Kazi Amdadul Hoque, Deputy Program Manager, Save The Children-USA, Bangladesh Field Office

Save the Children will present their work with an adolescent RSH program in a conservative Muslim community in Bangladesh. KAISHAR is working with adolescents, parents, community, and religious leaders towards a common goal based on community identified needs. Areas to be discussed include the necessity for continuous community involvement, sociocultural traditions and religious beliefs, and the importance of working with all stakeholders.

Zambia and Peru

SPEAKER: Erin Anastasi, MHS, Technical Advisor for Family Planning/Population Leadership Program Fellow
ADRA International

This presentation will highlight two of ADRA's many community-based programs working with youth around the world. ADRA will discuss their work in Zambia with orphans and vulnerable children (operating a day center, teaching life skills, etc.) and in Peru with street children. Discussion |