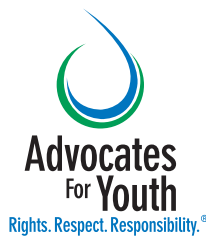
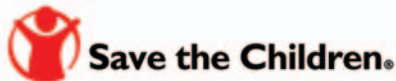


**COMMUNITY PATHWAYS TO
IMPROVED ADOLESCENT SEXUAL
AND REPRODUCTIVE HEALTH:**

**[A Conceptual Framework and
Suggested Outcome Indicators]**

December 2007



CONTRIBUTORS

Core IAWG members who played major roles in developing the framework include: Dairo Akinyele (UNFPA), Meena Cabral de Mello (WHO), Nicole Cheetham (Advocates for Youth), Ugo Daniels (UNFPA, IAWG co-chairperson), Gwyn Hainsworth (Pathfinder International), Irit Houvras (UNFPA consultant), Susan Igras (CARE, IAWG co-chairperson), Brad Kerner (Save the Children), Cate Lane (Pathfinder International/ Expanding Service Delivery project), Rose Amolo (CEDPA), Peggy Tipton (CARE), Reshma Trasi (consultant), and Usha Vatsia (consultant).

Irit Houvras conducted a literature review of community-involvement frameworks in other disciplines as well as indicators of social change, which informed the thinking of the IAWG. Several people helped write and edit this working paper, including Irit Houvras, who drafted the first version, and Susan Igras and Cate Lane, who revised, reworked, and edited later versions. Reviewers of various drafts included Dairo Akinyele, Ian Askew, Nicole Cheetham, Ugo Daniels, Gwyn Hainsworth, Brad Kerner, Ilene Speizer, and Reshma Trasi.

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Community Pathways

INTRODUCTION

Involving communities in development is good practice, because community members know their own needs and understand issues that influence their health. For more than 35 years, community involvement has been seen as essential to the success and sustainability of development programs, including public health. Yet as resources for health programs become more limited and, indeed, even more restricted, in the case of reproductive health and family-planning programs some may question if community-driven interventions are worth the time, effort, and resources.

One recent inquiry on evidence, commissioned by the WHO Health Evidence Network (HEN), involved an extensive literature review focusing on empowering approaches to health, including community-wide participation. A wide range of outcomes were identified - at psychological, organizational, and community levels, and within families, programs and services, and other spheres. While very few researchers used designs ranked as 'strong' in the traditional evidence grading system, the author concludes that evidence exists "based on multi-level research designs that empowering initiatives can lead to health outcomes and that empowerment is a viable public health strategy" (Wallerstein, 2006).

There remains a need for more rigorous research designs to establish better empirical evidence of the contribution of community involvement to health outcomes, including evaluation research of adolescent sexual and reproductive health (ASRH) programs, which address socially-sensitive adolescent issues, and need to involve youth, adults, and the larger community to gain support and be sustainable. At the end of the YouthNet¹/CARE technical consultation on the role of community involvement in ASRH, participants affirmed the need to articulate more clearly relationships between community-involvement processes and adolescent sexual and reproductive health (ASRH) outcomes, and the impact of participation on individual behaviors. Recognizing the wide range of community involvement outcomes, ASRH programs need to measure social-change effects that result from involved communities (e.g., girls allowed to stay in school instead of marrying early) as systematically as are individual and structural changes. To further thinking on these program and measurement issues, the Inter-Agency Working Group on the Role of Community Involvement in ASRH was formed at the end of the 2005 YouthNet/CARE technical consultation, with a mandate to develop a conceptual framework and propose outcome level indicators that articulate and measure the full impact of community involvement in improving ASRH.

IMPROVING ASRH: WHAT DO WE KNOW?

As health and development practitioners, our experiences tell us that communities need to be substantially involved in programs in order to create supportive environments for and participation in tackling sensitive issues, such as ASRH.

The Inter-Agency Working Group (IAWG) on the Role of Community Involvement in ASRH was created at the end of a YouthNet /CARE technical consultation in 2005.

Co-chaired by UNFPA and CARE, the group's active organizational members include: Advocates for Youth, CARE, Pathfinder, Save the Children-USA, and UNFPA.

The group advocates for a better articulation of community-involvement processes and for more comprehensive measures of outcomes of community-involvement interventions.

The IAWG's first task was to develop a conceptual framework and illustrative outcome indicators to better measure the benefit of community involvement in achieving ASRH outcomes. The framework and indicators may be used as program design tools as well as to provide guidance on developing program evaluations.

Please contact members of the IAWG for more information.

¹ YouthNet was a five-year (2001-2006) global USAID-funded project led by Family Health International. CARE, a partner organization in YouthNet, provided technical leadership for community YRH programs.

Adults influence young people's access to sexual and reproductive health (SRH) information and services, as well as their ability to make healthful decisions. To ensure sustained positive behaviors among adolescents, the community must view these behaviors as beneficial, and community members must support change. Most organizations operating at the community level, however, lack measurement tools or financial resources for studies linking community involvement with social-behavior outcomes. For that reason, ASRH programs to date have mainly focused on achieving and measuring individual behavior change among targeted youth. Such programs have included:

- Family life and sexual education in schools, clubs and churches;
- Peer education and outreach;
- Behavior-change communication and mass media;
- Social marketing;
- Efforts to make providers of reproductive health services more youth-friendly;
- Development of policies that specifically address ASRH; and
- Advocacy by social service institutions and influential community leaders to support ASRH programs.

“WHILE MOST YOUTH PROGRAMS ACKNOWLEDGE THE IMPORTANCE OF COMMUNITY INVOLVEMENT AND PARTICIPATION IN THEIR ACTIVITIES, THE LITERATURE ALSO SHOWS THAT VERY FEW PROGRAMS FOCUS ON MEASURING SOCIAL CHANGES THAT RESULT FROM ASRH PROGRAMS.”

In addition, while most youth programs acknowledge the importance of community involvement and participation in their activities, community-involvement efforts seem to have focused more on ensuring community support for a program, rather than building community capacity to more effectively enable and sustain positive behavior change.

The literature shows that many youth programs are able to achieve statistically significant changes in SRH *knowledge and attitudes* (Maclean, 2006). The literature also shows that very few programs focus on measuring social changes that result from ASRH programs. Sustainability of knowledge and behavior gains can be short-lived; after a program ends, they can essentially revert back to near pre-program levels. The IAWG suggests that this is due in part to limited community support in terms of social norms and values supporting individual adolescent change.

This belief is supported by a 2004 study from Nepal (Mather et al., 2004) that highlights the unique contributions of community-involvement interventions in ASRH programs. The quasi-experimental study, one of very few published rigorous studies of ASRH programs, tested the hypothesis that involving communities (particularly youth and adult gatekeepers) would enhance service-delivery choices for youth and result in better health outcomes, when compared to more traditional approaches that focus primarily on behavior-change communication and improvements in service delivery.

The findings clearly demonstrated that the intervention with significant community participation yielded more positive results than the control sites; the most apparent results were changes in community norms and values that influence ASRH. In the intervention communities, researchers recorded positive shifts in opinion on the appropriate ages for girls to marry and bear children; the importance of providing youth with opportunities to develop skills that empower both youth and adults; and the need to strengthen community structures and institutions that serve youth. While there was a marginal difference between intervention and control sites in basic ASRH knowledge, attitudes and practice indicators, the authors suggest that behavior change is more likely to be sustained in the communities that underwent normative change.

This working paper aims to enhance efforts to improve ASRH program outcomes by presenting an intervention framework for changing community norms and practices as well as enhancing even amplifying individual and structural interventions. It is intended as a resource for program planners, evaluators, donors, and policymakers who want to strengthen their understanding of how community involvement contributes to ASRH program outcomes, and as a way to encourage greater application and measurement of interventions that focus on community involvement and change.

DEVELOPING THE FRAMEWORK FOR COMMUNITY INVOLVEMENT

Concepts underlying the framework

The IAWG began its conceptualization of the framework by agreeing that ASRH programming should be approached from an ecological perspective, with the belief that individual behaviors and decisions are not made or practiced in a vacuum, and that social norms and institutions often determine the choices available to most individuals. The concepts represented in the framework draw on several theories of change, including ecological-systems theory and individual- and social-change theory (also called an empowerment model).² These theories of change recognize the importance of addressing health at multiple levels and through a social empowerment lens.

Individual, structural and social changes are necessary for improving the health of communities, and involving community members in issues that affect their health will lead to more sustained positive health impacts. It is at the community level that social issues are discussed, and norms are formed and enforced. Through community dialogue and collective action, social issues that are beyond the mandate of public institutions can be addressed.

Community involvement is an essential strategy and must be grounded in a community's inherent ability to engage in (that is, recognize, discuss and act upon collectively) issues of common concern. Involving young people as community members is also an essential strategy; programs need to recognize that young people, by virtue of their age and position in society, experience unique barriers to access and choice.

While the framework is based primarily on the IAWG's efforts to design and evaluate programs with significant community-involvement components, it also incorporates the work of numerous researchers and practitioners. (The work of Figueroa, Chaskin, Laverack, Labonte and their colleagues are cited in the references.) These papers contributed to the IAWG's thinking on community dialogue and collective action in social-change processes; community capacity as an organizing construct for community-involvement interventions; and capacity-building approaches as defined by individuals, institutional structures, social systems and other community resources.

“ASRH PROGRAMMING SHOULD BE APPROACHED FROM AN ECOLOGICAL PERSPECTIVE, WITH THE BELIEF THAT INDIVIDUAL BEHAVIORS AND DECISIONS ARE NOT MADE OR PRACTICED IN A VACUUM, AND THAT SOCIAL NORMS AND INSTITUTIONS OFTEN DETERMINE THE CHOICES AVAILABLE TO MOST INDIVIDUALS.”

² The ecological-system theory recognizes that successful activities to promote health not only aim to change individual behavior, but also to address multiple social levels that affect the individual, such as families, communities, institutions and policies. The individual and social-change, or empowerment, theory asserts that, through dialogue, social change can take action against forces that are oppressive, thus building a critical perception of the social, cultural, political and economic forces that structure reality. (Source: AIDSQUEST: The HIV/AIDS Survey Library — www.popcouncil.org/horizons/AIDSQUEST/; accessed 21 September 2007)

What do we mean by community involvement?

Community involvement in the IAWG framework is comprised of two key elements: dialogue (which implies two-way communication) and collective action. Since communication and eventual collective action occur within a community context, defining community involvement in ASRH and its relation to health and other outcomes first requires a common understanding of community and all its complexities.

A community can be defined either geographically or socially. “A geographic 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.” (Chaskin et al., 2001)

“DEFINING COMMUNITY INVOLVEMENT IN ASRH AND ITS RELATION TO HEALTH AND OTHER OUTCOMES REQUIRES A COMMON UNDERSTANDING OF COMMUNITY AND ALL ITS COMPLEXITIES.”

In addition, in many developing countries, a significant subset of a community is its youth population. Despite the size and complexity of this subset, youth are often defined by external programs as a homogenous group (perhaps with some differentiation based on age and gender). Yet the youth subset can also be further stratified, based on development stage, school enrollment status, level of education, life experience, sexual orientation, social employment and/or marital status.

Underlying these definitions are the social, economic and political realities facing a community, which defines its capacity to act collectively around an issue. Communities are complex and heterogeneous, and members have varying needs, interests and social affiliations. Communities are endowed with varying levels of resources and access to external resources. Power, class and gender define individuals and institutions, and not all of them share equal access to resources. Conflict can be an outcome of such differences.

Focusing on youth within communities adds another layer of social, economic and political realities. In many cases, youth behavior is controlled to different extents by adults, including parents and others who interact with youth on a regular basis. The capacity of young people to act as full members of the larger community is influenced by these realities.

Involving communities in strategic efforts to foster dialogue and collective action – this includes making maximum use of available resources, yet not harming young people in the process – means that ASRH programs must first understand the communities where programs are being implemented. Since social communities play a significant role in influencing youth behavior (and thus behavior change), no intervention to reach youth can be complete without considering how best to encourage dialogue and involvement of these gatekeepers in promoting positive SRH practices.

THE CONCEPTUAL FRAMEWORK

While it has long been observed that individual, structural and social changes result from community participation, ASRH programs lack empirical evidence of how community involvement impacts individual adolescent health behaviors and outcomes, let alone a way to measure changes in the enabling environment of adults, institutions and societal norms. The framework, found on the following page, specifically links community involvement interventions to desired adolescent health outcomes. The framework also captures outcomes of community-involvement processes that go beyond the realm of more typical ASRH

programs with regard to structural and social changes in other words, the enabling environment that influences choices available to youth and related decision-making.

The framework begins by examining community capacity around ASRH issues (Existing State or Baseline in the framework diagram). One of the base measures of community capacity is its level of ASRH awareness. Awareness may be catalyzed by a specific event (e.g., the death of an adolescent due to an unsafe abortion) or by an accumulation of ASRH-related observations, such as a rise in school dropouts due to pregnancy. With awareness and subsequent discussions, communities may take their own actions, independent of an external catalyst. In many cases, though, communities are hesitant to take on sensitive, sexually related issues. Thus, external catalysts such as ASRH programs can often build awareness of ASRH issues, facilitate community dialogue and collective action, and build the capacity of local organizations and individuals to play catalytic and support roles, which will allow the community to take action on ASRH issues.

Program catalysts often lead to community controversy. While some people may view externally supported ASRH programs as positive catalysts for community involvement, others may perceive them as negative or foreign to community norms and values. Community involvement in this instance may even be confrontational, and may lead to unanticipated and unwanted outcomes that are challenging for external programs to manage. External programs may also be considered negative because the community becomes dependent on external inputs and support for development, effectively negating or precluding the community's own internal development processes and ability to take collective action.

In any event, catalytic events will, in turn, lead individuals to begin addressing the issue as a *community* concern, rather than as an *individual* or *family* problem. This public dialogue then leads to collective action to address the identified issue of concern (Processes or Outputs in the framework diagram). Collective (and individual) actions lead to a wide spectrum of change, which will occur at the individual, structural and/or social level (Results or Outcomes in the framework diagram). These activities and changes lead to the creation of an *enabling environment* of community support for positive changes in ASRH knowledge, agency and behaviors (Goal or Impact in the framework diagram).

The framework attempts to capture the dynamic nature of community involvement i.e., that collective action is likely to improve the capacity of a community to address other pressing issues. As individuals, institutions and social-support networks become more skilled in addressing community concerns, they are increasingly able to take on new issues. This, in turn, further improves community capacity.

“THE FRAMEWORK SPECIFICALLY LINKS COMMUNITY INVOLVEMENT INTERVENTIONS TO DESIRED ADOLESCENT HEALTH OUTCOMES. THE FRAMEWORK ALSO CAPTURES OUTCOMES OF COMMUNITY-INVOLVEMENT PROCESSES THAT GO BEYOND THE REALM OF MANY ASRH PROGRAMS WITH REGARD TO STRUCTURAL AND SOCIAL CHANGES IN OTHER WORDS, THE ENABLING ENVIRONMENT THAT INFLUENCES CHOICES AVAILABLE TO YOUTH AND RELATED DECISION-MAKING.”

The African Youth Alliance (AYA) in Uganda: A Program Brief Highlighting the Use of the Framework to Understand the Role of Community Involvement in Achieving Individual ASRH, and Related Structural and Social Outcomes.

The African Youth Alliance was a comprehensive, multi-sectoral program implemented from 2000-2005 by UNFPA, PATH, and Pathfinder. AYA aimed to improve ASRH and the prevention of HIV/AIDS among young people ages 10-24 in Botswana, Ghana, Tanzania and Uganda.

In Uganda, several macro-factors supported communities' capacity to engage in ASRH-focused efforts, including the recent adoption of a national ASRH strategy, the active involvement of Ugandan society in a variety religious institutions as well as Kingdoms, social-cultural institutions.

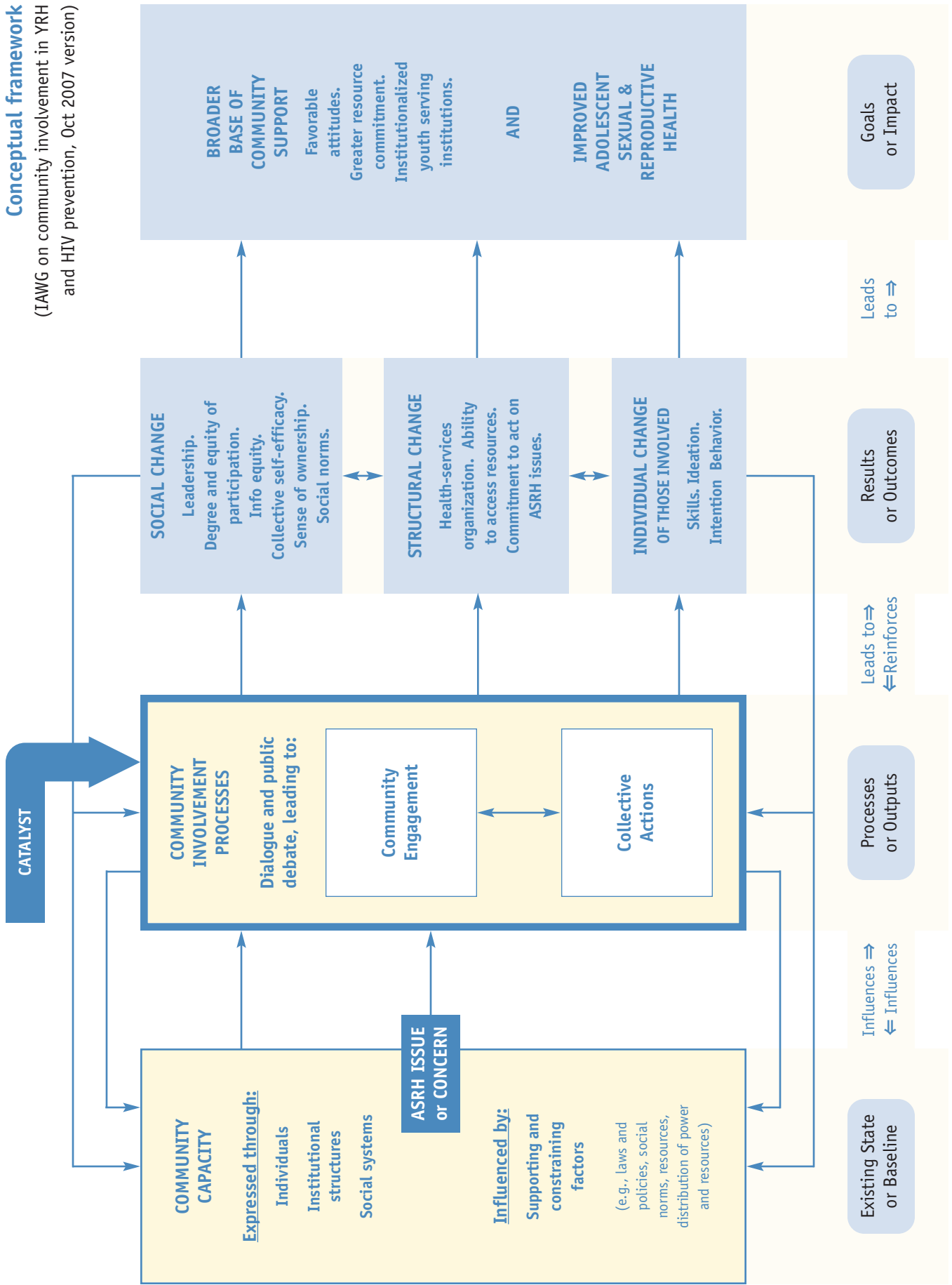
Community involvement was fundamental to the success and sustainability of the AYA program. Through a range of integrated interventions, communities participated during all stages of programming. Key stakeholder groups in government, non-governmental organizations, community-based organizations - including youth, parents, religious leaders, the media and policy makers – were involved in participatory learning and action activities to identify ASRH issues locally, plan interventions, and implement a wide range of activities.

AYA-Uganda served as a catalyst to involve communities and build their capacity to analyze and act upon ASRH issues. For example, AYA resources helped to build institutional capacity of selected NGOs and government health services, to foster leadership on ASRH issues among influential people, and to support ASRH activities planned and implemented by community groups.

A wide range of outcomes resulted - at the *individual level* of youth, adults, and community leaders, at the *structural level* in leadership, new organizational networks, and new policies and bylaws, and at the *social level* in intergenerational relations and normative community institutions having more favorable, supportive youth environments. To note only a few results:

- *Responsible health behavior as "Cool"*: The youth-based organization, Ma-PLAY (Making Positive Living Attractive to Youth), focused on improving ASRH behaviors by promoting and organizing young people to become role models for successful lives – and still have fun. While Ma-PLAY was youth-led, a major strategy was to engage adult stakeholders (parents, teachers and others) to support these positive decisions. This youth-adult partnership implemented after-school youth clubs that helped students develop a group culture supporting positive behaviors. Young people also became involved in enter-education activities, using drama and talk shows to reach a wider audience. In addition to resulting in significant changes in participating students' attitudes, behaviors and intentions, the project influenced adults' commitment to ASRH issues in school and beyond, positively affecting the community environment.
- *Uganda Kingdoms influence policy and norms*: Kingdoms are cultural institutions in Uganda that have significant influence over traditions and social norms, and on the formulation and implementation of laws and policies. AYA's partnerships with four Kingdoms, covering 50 % of the Ugandans, were designed to further HIV/AIDS prevention among young people. As a result, ASRH and HIV/AIDS prevention initiatives have been deemed critical concerns within the Kingdoms' development agendas, for which Toro and Busoga Kingdoms have secured funding. The Busoga Kingdom set up a by-law prescribing 18 as the earliest age of marriage; this has now been taken on by all the other Kingdoms, leading to harmonization with national age of consent in Uganda.
- *AYA's partnership with Christian and Muslim denominations in Uganda resulted in policy change related to age of marriage, contraceptive use and school continuation*: Sensitization of religious leaders led to ASRH issues being incorporated into religious pronouncements and sermons. The Anglican Church signed a declaration supporting ASRH and revised pre-nuptial counseling guidelines to include VCT. His Eminence Mufti of Uganda announced that Muslim couples should use condoms in marriage to prevent HIV/AIDS and other STIs. Educational institutions have added ASRH into seminary school curriculums.
- Institutional capacity building activities of NGOs and CBOs led to the formation of the Uganda Youth Alliance Network (UYANET). At a June 2004 workshop on sustainability held by AYA, participants acknowledged that although AYA had built their institutional and technical capacities to implement ASRH programming, more work was needed. Twelve organizations decided to form a coalition (UYANET) to synergize organizational capacities and work towards the promotion and protection of rights of young Ugandans. The group has now received funding from the World Bank. UYANET hopes to assist in operationalizing the National Adolescent Health Policy and improving coordination between ASRH stakeholders at all levels.

Conceptual framework
(IAWG on community involvement in YRH
and HIV prevention, Oct 2007 version)



Community capacity provides the basis for community involvement

All communities have existing capacity;³ the success of projects implemented by youth-serving NGOs or other organizations to address ASRH will very much depend on the capacity of the community to engage around this and other issues. Factors such as how community leaders interact with community members, whether or not community leaders ensure broad community representation, and how communities are organized socially will influence project results. Community involvement will also depend on how committed a community decides to become vis-à-vis an ASRH issue as well as the more intangible elements of external ASRH programs, such as program staff attitudes toward communities and approaches to working with communities.

Four main characteristics define community capacity (Chaskin et al.) and, consequently, help define the realm of inquiry for project baseline assessments:

- Cohesive sense of community that includes a degree of connectedness, as indicated by social networks, and a sense of trust and reciprocity;
- Sense of commitment and active participation among community members, who possess a strong sense of ownership and a belief in collective self-efficacy;
- Ability to translate commitment into action to solve problems, including the ability to interpret and use information and data for critical reflection, action planning, managing activities, addressing conflict and evaluating efforts; and
- Ability to access resources (economic, human, physical and/or political) inside and outside the community.

While communities may not have much experience addressing ASRH-related issues prior to an external organizations' involvement – although they will have experience addressing other issues of common concern – communities can develop ASRH capacity over time. It is just as important to assess a community's capacity to address ASRH and other health issues, as it is to survey adolescent knowledge, attitudes and practices, and to document the availability of youth services. A capable community that supports an enabling environment for youth will foster both individual and institutional change.

Strategies for building community capacity for ASRH

Developing a community's capacity to solve problems related to ASRH requires action at the individual, institutional and social level. Chaskin et al. recommend four strategies to build community capacity (the frequent use of some of the first three strategies was corroborated in Maclean's 2006 review of ASRH programs):

- Develop the *leadership* skills of individuals in the community;
- Strengthen *existing organizations*, or create new ones that can more effectively engage in community-focused activities;
- Strengthen community *governance*, ensure equity in representation and mobilize individuals for collective action; and
- Promote *collaborative partnerships* and inter-organizational collaboration.

Every community has internal and external factors that will either constrain or support change. Internal community factors include socio-cultural norms and the community's own prioritization of ASRH issues. Other factors are external and thus beyond the community's direct control, such as national laws and policies, and environmental conditions. All these factors

³ According to Chaskin et al., community capacity is the interaction of human capital, organizational resources and social capital within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of that community. It may operate through informal social processes and/or organized efforts by individuals, organizations and the social networks that exist in their communities and beyond.

can create or prevent problems, affect the community's ability to address problems, and enable or deter community involvement. External programs need to understand these supports and constraints, and consider how best to maximize support and minimize constraints to ensure success.

From capacity to involvement

Community involvement is defined as a process by which a community acts collectively to address a condition or issue affecting it and its members. The process of community involvement has been documented extensively. It is initiated by internal and external catalysts, with varying degrees of participation. Community participation is also a dynamic and cyclical process: Participation builds community capacity and creates greater potential for even more participation and related actions. At times, collective action occurs quickly and unexpectedly, because communities can and do organize without external assistance or catalyst. There are many pathways to community involvement, with common core elements being dialogue and collective action.

Levels of community involvement can vary and are often presented as a continuum of participation that ranges from tokenism to cooperation to collective action (Cornwall, A., cited in Maclean, 2006). External programs increasingly use participatory, action-centered processes, such as Participatory Learning and Action, to facilitate ASRH dialogue and analysis, and to improve opportunities for communities to get actively involved in addressing those issues.

It is difficult to determine *a threshold level of participation* that is required to lead to social and other changes – community contexts and ASRH issues will influence levels of involvement and thresholds of collective action. We believe that wide participation of adults and of youth are necessary to lead to sustained changes in knowledge and attitudes that support behavior change. An HIV prevention program working in the only secondary school in the area, that targets youth and teachers, for example, will likely lead to more knowledgeable students and more supportive teachers, but will not necessarily lead to community-wide changes in norms supportive of adolescent ASRH. A higher level of community participation, involving members in the larger community, would more likely influence socially normative changes.

The *quality of facilitation of community interventions by external ASRH programs* also influences participation. Community interventions supported by external programs may seem similar, but, in fact, they can differ greatly. There are many intangible factors that affect the level of community-participation in interventions, such as the attitudes of program staff toward the community, their belief in the power of group process, and their willingness to listen to and learn from community members. Say, for example, two ASRH programs believe they are significantly involving communities. Both train peer educators, both support behavior-change communication efforts and both coordinate their efforts with community leaders. Yet, by comparing the quality of processes used by each program, it will become apparent that there are differences. Communities will be more involved in processes that focus on community empowerment and decision-making. The IAWG believes that for a program to create sustained change, it must approach community involvement as the development of collective action. This means engaging in dialogue with community members; encouraging them to analyze and act on issues of concern; treating them as partners; and engaging community leaders as active advocates.

There is no established model for community involvement in ASRH, although, at a minimum, programs must understand and respond to specific needs, perspectives, and priorities of young people. Programs should be built on substantive adolescent involvement, underlying issues of gender equality, and adolescent rights to SRH information and services. Program approaches to ASRH themes should be culturally sensitive, using cultural knowledge, awareness, and engagement of local communities to make change effective and sustainable. Community involvement means the participation of not only youth, but also adult gatekeepers and institutions that are affected by ASRH. Collaborating with these gatekeepers (e.g., traditional leaders, religious leaders, school principals, and influential parents) can provide general entry points to engaging communities and youth.

Results of community-involvement processes: individual, structural, and social change

Making information and services available to adolescents is a critical component of ASRH programs. To create an enabling environment for ASRH, programs must recognize and address the influence of community norms and expectations as well as the behavior of both adults and youth. Well-designed and supported community-involvement interventions will lead to changes in community attitudes toward ASRH. For example, a program in Vietnam that involved the community in dialogue and debate about early-marriage issues helped adults better understand the benefits of delaying marriage for young women and men. Parents also reported feeling more comfortable discussing HIV/AIDS, early marriage and pregnancy with their children (Maclean, 2006).

Well-designed and supported community-involvement interventions can also lead to structural changes, such as schools and religious-based programs incorporating ASRH information for adolescents. When youth are involved in ASRH programs, their status in the community can change, since youth with new skills and capacities will demonstrate to adults what young people can bring to community development. Within this more enabling environment, young people's ASRH-related choices will increase, and ASRH-related decisions can be supported.

Given the broad range of changes that result from community involvement, the framework attempts to articulate and promote more systematic measurement of outcomes at individual, structural and social levels. The text boxes in this section illustrate ASRH-related outcomes of community involvement. Additional indicators of ASRH-related social change outcomes are included in Appendix A. In addition, two case studies of ASRH programs, found in Appendix B, highlight how the conceptual framework can be used to organize and analyze the wider range of ASRH outcomes.

Individual change

Individuals involved in community-based interventions do change. Individual outcomes are described as changes to skills, ideation, intention and behavior (Figueroa et al., 2002), and may include some of the changes listed in the box to the right.

Dimensions of Measurement of Individual Change (of those who participate in community involvement processes)

- Ideation
- knowledge, attitudes, perceived risk
- subjective norms
- self-image
- emotion
- self-efficacy
- social influence
- personal autonomy
- Skills
- Intention
- Behavior (including use of health services)

Illustrative Outcome Indicators for ASRH Programs

Adolescents

- Knowledge of ways to prevent pregnancy and HIV infection (**ideation**)
- Perceived risk of HIV, STIs and pregnancy (**ideation**)
- Confidence to resist peer pressure (**ideation**)
- Level of self-efficacy in SRH "social" situations (**ideation**)
- Existence of skills to negotiate condom use (**skills**)
- Intention to abstain from sex until marriage (**intention**)
- Level of sexual activity (**behavior**)
- Use of condom in last sexual encounter (**behavior**)

Adult gatekeepers

- Knowledge of ways to prevent pregnancy and HIV infection (**ideation**)
- Level of awareness of SRH in adolescent 'social situations' (**ideation**)
- Improved parent-child communication on SRH-related issues (**skills**)
- Intention to grant adolescents rights to SRH information and services (**intention**)
- Improved economic support for family adolescent seeking SRH services (**behavior**)

Dimensions of Individual Change – Community Engagement

- See social-change box for dimensions and outcome indicators, as individuals contribute to social change outcomes

(List of dimensions adapted from Figueroa et al., 2002.)

ASRH programs most often aim for changes in knowledge, attitudes, perceptions, skills and behavior. They use standardized indicators of sexual behavior, such as level of sexual activity, number of partners in previous 12 months and use of contraceptives.

Through their active involvement in community ASRH activities, adolescents may also contribute to social change. For example, communities may begin to view adolescents as contributors on equal footing with adults. Some adolescents will be recognized as youth leaders, whose advice is sought on community issues.

Individual behavior change among adolescents also requires individual behavior change among adults, including parents, healthcare providers, religious leaders and teachers. Before an adolescent can access and use contraception, for example, a healthcare provider may need to change her attitude about providing contraception to young people. Change among adults is often measured as increased understanding of ASRH, improved awareness of adolescents' needs and increased support for comprehensive SRH education and services.

Structural change

Structural change refers to changes in the capacity of community institutions, organizations and social networks (Chaskin et al., 2002), including health facilities, schools, faith-based organizations, workplaces and youth groups. Structural changes that result from community involvement include those that support individual behavior change, social change and/or community participation and involvement. For example, when external ASRH programs facilitate community discussions between youth, adults and service providers, communities can work with health facilities and schools to offer youth-friendly services and monitor the quality of information and services provided.

Community involvement can lead to structural changes at the regional or national level; for example, citizen advocacy on certain issues can lead to local government enacting bylaws and policies that positively address those issues. Some communities have mobilized to improve roads and build bridges in order to improve access to health services.

Structural changes can include the development of health and education laws or policies, both local and national, supporting the SRH rights of young people; improved enforcement of such laws and policies; institutionalization of ASRH programs, such as family-life education or youth-friendly services; and improved inter-sectoral collaboration on youth and ASRH issues.

Dimensions of Measurement of Structural Change

- Program management asset base
- Inter-organizational connections
- Inclusiveness of social networks
- Effective functioning of social-service systems
- Collective efficacy
- Organizational commitment to common issues
- Access to resources

Illustrative Outcome Indicators for ASRH Programs

- Organizational capacity to design and implement ASRH programs (**asset base**)
- Existence of laws and policies supportive of ASRH rights (**asset base**)
- Extent of inter-organizational collaboration on specific ASRH issues (**inter-organizational connections**)
- Extent of gender equity in youth club participation (**social networks**)
- Health services have institutionalized ASRH-friendly services (**systems' effective functioning**)
- Health services and citizens/youth have governance systems in place (**systems' effective functioning**)
- MOH has an institutional commitment to ensuring that all eligible adolescents are served by health facilities (**collective efficacy**)
- Increased resources for ASRH-related activities in an organizations' health program (**resource access**)

(List of dimensions adapted from Chaskin et al., 2002.)

Social change

Like individual and structural changes, social changes can be monitored and measured, although this kind of measurement is complex. Important social changes resulting from community involvement may include changes in: leadership capacity, the quality of community participation, access to information, collective self-efficacy and communitywide ownership of key issues. Less-visible changes perhaps more difficult to measure, but no less important may include changes in community social cohesion and social norms.

Specific social changes that relate to ASRH can include changes in social norms and values that support the SRH rights of young people. Public discussion about normative behaviors that influence ASRH, and support for these debates from community leaders, can lead to changes in norms, such as views on: early marriage, family-planning services or the right of pregnant, unmarried adolescents to continue school. Shifts in normative behaviors will lead to greater access to information, education and services for adolescents.

Overall impact

The interplay of individual, structural and social changes will lead to improved and sustained adolescent health at a societal level, including decreases in:

- Prevalence of HIV and STIs,
- Adolescent maternal morbidity and mortality,
- Infant morbidity and mortality,
- Adolescent birth rates, and
- Abortion rates.

Societal-level impact will also be seen in terms of broader community support for improvements in ASRH at the structural and social level, including:

- More ASRH-supportive social attitudes and norms,
- Increased allocation of resources for ASRH programs,
- Institutionalized youth-friendly services available to more young people, and
- Better, more responsive policies.

Dimensions for Measurement of Social Change

- Leadership
- Degree and equity of participation
- Information equity
- Collective self-efficacy/empowerment
- Sense of ownership
- Social cohesion
- Social norms

Illustrative Outcome Indicators for ASRH Programs

- Changes in perception of how leadership acknowledges ASRH issues as community issues (**leadership**)
- Changes in leadership seeking representation by youth in ASRH discussions (**leadership**)
- Improved communication between parents and adolescents on ASRH issues (**equity of participation**)
- Observed equity in participation and information: adolescent (girls and boys) inclusion in community ASRH-related discussions and related actions; parental inclusion in community discussions and related actions (**equity in participation, information equity**)
- Number of ASRH-related issues identified by the community that have been resolved (**collective self-efficacy**)
- Perception that ASRH issues are community issues (**sense of ownership**)
- Perception that neighbors agree with ASRH-related community actions (**social cohesion**)
- Number of young people (girls and boys) in leadership roles for SRH and/or the community in general (**social norms**)
- Changes in beliefs that girls should delay marriage until age 18 (**social norms**)
- Changes in values that support healthful timing and spacing of pregnancies (**social norms**)

(List of dimensions adapted from Figueroa et al., 2002.)

MEASUREMENT OF COMMUNITY INVOLVEMENT OUTCOMES

The IAWG framework is intended to provide greater clarity on 1) how community involvement leads to a range of health and non-health outcomes and 2) the interrelationships between community capacity, participation, and outcomes. By more clearly explaining desired outcomes and related concepts, and definitions of processes leading to ASRH and other outcomes, the IAWG hopes to contribute to the equally important issue of defining measures of ASRH program outcomes. While the conceptual framework is not an evaluation framework and does not have a temporal element that would show sequencing of community involvement activities, which is important in community engagement work, it could guide the development of a logical framework, with expected individual, structural, and social outcomes. A related program action plan could provide the initial ordering of community involvement activities. Appendix A provides illustrative outcomes and indicators for ASRH programs to help readers think practically of ways to measure social and structural changes.

This section highlights some of the more general measurement issues, beginning first by acknowledging that measurement of community capacity, involvement, and social and structural outcomes is complex. The process of community participation itself is not static during a project's lifecycle. There can be a multiplier effect; for example, as more individuals become knowledgeable and feel empowered to address ASRH or other issues, the dynamic in the collective community will shift. The interrelated nature of social systems with individual outcomes influencing social-change outcomes, and unique relationships between adolescents and adults also contributes to this complexity. Communities are "open systems," for which it is often difficult to establish comparisons to support causal attributions.

There is a need for commonly accepted indicators and measurement methodologies that can be applied in general ASRH program settings. Figueroa *et al.* have put great thought into how to measure social-change outcomes and related processes; their paper includes many useful methods (mostly qualitative) for measuring process and social changes. The Health Communications Partnership Working Group on Measuring Community Capacity is compiling indicators to measure community capacity to address health and other issues.⁴ Some efforts are also underway to create quantitative indicators to help measure related social/psychological dimensions of community capacity or participation, such as collective efficacy, by adapting individual indicators of efficacy from psychology disciplines (Chaskin, *et al.*). Clearly, more work is needed in this area to provide empirical evidence of the benefit of community involvement, and specifically for ASRH programs, in measuring changes in youth-adult dynamics at social and structural levels.

Communities also need to evaluate their processes and outcomes. The Communication for Social Change Consortium has developed tools and guidelines for use by and with communities to evaluate social change. Story-based methodologies such as "most significant change"⁵ can help guide community evaluation.

"MEASUREMENT OF COMMUNITY CAPACITY, INVOLVEMENT, AND SOCIAL AND STRUCTURAL OUTCOMES IS COMPLEX. THERE IS A NEED FOR COMMONLY ACCEPTED INDICATORS AND MEASUREMENT METHODOLOGIES THAT CAN BE APPLIED IN GENERAL ASRH PROGRAM SETTINGS (VERSUS RESEARCH-INTENSIVE SETTINGS WITH SIGNIFICANT RESOURCES DEDICATED TO MEASUREMENT)."

⁴ Personal communication with Gail Snetro-Plewman, Save the Children-US, November 2006, member of the Health Communication Partnership Working Group on Measuring Community Capacity.

⁵ For an overview of the Most Significant Change method, read "Using narrative methods to link program evaluation and organizational development," in *The Evaluation Exchange*, volume IX, no. 4, winter 2003/2004 (<http://www.gse.harvard.edu/hfrp/eval/issue24/pp3.html>. Accessed 19 November 2007).

Donors and program staff also can contribute to development of standardized indicators and methodologies, by explicitly defining upfront the expected outcomes of community involvement. Consequently, program evaluators will focus more systematically on assessing social and structural changes as well as individual changes in ASRH knowledge, attitudes, and behaviors.

SUMMARY

ASRH programs that focus solely on individual behavior change among adolescents will not likely effect changes in socio-cultural norms and structural barriers that directly influence individual health behaviors. This is particularly true for young people, whose access to SRH information and services, and even their ability to make healthful decisions, is influenced (and, in some respects, controlled) by adults in the community. To ensure sustained and positive behavior change among adolescents, a significant proportion of the community must view these behaviors as beneficial, and support efforts to achieve change.

The IAWG developed the framework and illustrative indicators to more explicitly articulate the multiple roles that communities can play in addressing ASRH issues. Community engagement, discussion and actions beyond clinic walls can lead to the removal or reduction of social and structural barriers that limit young people's choices. This, in turn, creates environments that support behavior changes favorable to ASRH and to the general development of youth.

Community-driven interventions are critical compliments of service delivery and behavior change community-focused interventions. External ASRH programs can play critical support roles in catalyzing communities by offering information and public spaces for dialogue on sensitive, often unspoken, issues and by working with influential local leaders. They can also support communities as they address ASRH-related issues.

We hope that the framework and its more precise definitions of individual, structural and social outcomes of community involvement will contribute to better-designed and -evaluated ASRH programs. As an international health community, we need to advocate for better definitions of the aims and processes of community-involvement interventions as well as for more comprehensive measurement of community-involvement outcomes.

REFERENCES

Byrne, Ailish, Gray-Felder, D, and Hunt, J (eds). *Communities Measure Change: A Reference Guide to Monitoring Communication for Social Change*. Communication for Social Change Consortium.

<http://www.communicationforsocialchange.org/publications-resources.php?id=281>

Chaskin , R., Brown, P., Venkatesh, S. and Vidal, A. "Community Capacity and Capacity Building: A Definitional Framework" in *Building Community Capacity*. New York: Walter de Gruyter, 2001.

Figueroa, M.E., Kincaid, D.L., Rani, M. and Lewis, G. *Communication for Social Change: An Integrated Model for Measuring the Process and its Outcomes*, Communication for Social Change Working Paper Series No 1. Rockefeller Foundation, 2002.

<http://www.communicationforsocialchange.org/publications-resources.php?id=107>

Houvras, Irit. Main findings of the literature on community involvement in public health and other development disciplines. Presentation to the IAWG, New York City, November 2006.

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

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

<http://www.fhi.org/en/Youth/YouthNet/Publications/CIresources/index.htm>

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

http://www.icrw.org/docs/nepal_0104.pdf

Wallerstein, N. *What is the evidence on effectiveness of empowerment to improve health?* Health Evidence Network report. WHO Regional Office for Europe, 2006.

<http://www.euro.who.int/Document/E88086.pdf>

APPENDIX A: ILLUSTRATIVE OUTCOME MEASURES OF SOCIAL AND STRUCTURAL CHANGE RESULTING FROM COMMUNITY INVOLVEMENT

A1. Beginnings of a logical framework: Community-involvement pathways to social and structural outcomes

<p>STRATEGIES TO INCREASE COMMUNITY INVOLVEMENT IN ASRH ISSUES AND PROGRAMS</p> <p>Organizational capacity building</p> <ul style="list-style-type: none"> • Strengthen leadership skills • Strengthen organizations to more effectively engage in community activities • Strengthen community governance • Promote collaborative partnerships and inter-organizational collaboration <p>Information provision and advocacy</p> <p>Public spaces for dialogue and debates of identified issues</p> <p>Facilitation by external programs that maximizes substantive participation</p> <ul style="list-style-type: none"> • Participatory, egalitarian interactions between communities and external programs 	<p>Social / Psychological Outcomes (Source: Figueroa, et al, 2002)</p> <p>Effective leadership</p> <ul style="list-style-type: none"> • Extent of leadership • Equity and diversity • Flexibility • Competence in encouraging and securing dialogue and action • Vision and innovation • Trustworthiness and popularity <p>Improved equity of participation</p> <ul style="list-style-type: none"> • Access to participation • Extent and level of participation <p>Improved information equity</p> <ul style="list-style-type: none"> • Awareness and correct knowledge of an issue or program • Enhanced free-flow of information <p>Greater collective self efficacy</p> <ul style="list-style-type: none"> • Perceived efficacy to take action as a group • Perceived capability of other community members • Perceived efficacy to solve problems as a group <p>Increased sense of community ownership</p> <ul style="list-style-type: none"> • Importance of an issue or program to participants • Responsibility for the issues/program • Contribution to the program • Perceived benefit from the program • Perceived accountability from the program results • Perceived personal identification with the program <p>Increased social cohesion</p> <ul style="list-style-type: none"> • Sense of belonging • Feelings of morale • Goal consensus • Social trust • Social reciprocity • Network cohesion <p>Positive shifts in social norms in specific ASRH issues regarding:</p> <ul style="list-style-type: none"> • Participation • Leadership
	<p>Structural / Organizational Outcomes (Source: adapted from Wallerstein, 2006; Chaskin et al, 2002)</p> <p>Well-functioning services</p> <ul style="list-style-type: none"> • Public accountability • Equitable distribution of services • Equitable use of services • Efficient • Culturally appropriate <p>Organizational/institutional effectiveness and capacity</p> <ul style="list-style-type: none"> • Good governance • Accountability • Sustainability • Effective leadership • Equity of member participation • Skills in group facilitation, strategic planning, problem solving, conflict resolution, coalition building, policy advocacy <p>Effective inter-organizational networks/partnerships</p> <ul style="list-style-type: none"> • Commitment to common issues • Increased social capital <p>Increased access to resources</p> <ul style="list-style-type: none"> • New linkages with organizations and resources outside the community

A.2. Outcome indicators of social change resulting from ASRH programs and sources of measurement

In this section, we suggest some measures and indicators that can be used for each of the ASRH social change outcomes. Note that these indicators have not been validated yet in field settings. Indicators and measurement found in this section have been adapted from a set of generalized social change indicators from Figueroa et al in their paper “Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes.”

The desired social change outcomes to improve ASRH include the following:

- **Leadership** around ASRH
- **Degree and Equity of Participation** of individuals and organizations affected by ASRH
- **Information Equity** about ASRH, among adults and youth
- **Collective Self-Efficacy** to be able to solve ASRH problems
- **Sense of Ownership** of ASRH issues and concerns
- **Social Cohesion** around addressing ASRH issues
- **Social Norms** on improving ASRH

Within each outcome, indicators will vary by level of difficulty and type of data collection method. Some are quantitative, and others are qualitative. It is not feasible to think that any program would be able to use all of the indicators for each outcome. We include here a variety of basic indicators so that program developers and evaluators can choose the ones that best fit the purpose, abilities, and resources of their program.

Leadership

One of the main objectives of a social change program for ASRH is to strengthen or develop leadership to recognize and address the needs of youth and adolescents. Sustained and effective leadership for improved adolescent health and well-being is a foundation for community involvement and participation and is an important outcome for social change related to ASRH. When measuring change of youth programs, however, we must be sure to look both at changes in leadership among youth as well as leadership among adult gatekeepers.

As suggested by Figueroa et al, leadership is made up of six dimensions:

- Extent of leadership
- Equity and diversity of leadership
- Flexibility
- Competence
- Vision and innovation
- Trustworthiness and popularity

An index of leadership can be developed from these dimensions, which can be measured over time. The dimensions are described more fully below:

Extent of leadership refers to the number of formal and informal leaders in the community and to the degree community members, especially youth, serve as a leader on ASRH.

This can be measured by assessing:

- > Who are the main leaders in the community (both formal and informal)
- > Who are the leaders in the community with respect to ASRH?
- > Have youth been given an opportunity to play a leadership role in addressing ASRH issues? Is yes, what roles?

Equity and Diversity of Leadership refers to the make up of the leadership. Leadership may be narrow, representing only a few sections or groups in the community. In the case of ASRH, leadership may come from the health sector, which sees the effect of unwanted pregnancy or HIV/AIDS. To enhance community involvement in ASRH, leadership must change from an elite model to a more broadly based leadership model to facilitate greater representation and inclusion, especially of youth.

This can be measured by assessing:

- > The proportion of leaders (people or groups) on ASRH that belong to different interest groups in the community.⁶

The matrix (below) can help describe the characteristics of leaders on ASRH.

Leaders can be individuals or groups. If the leaders are groups, the group can be described in terms of the proportion of members with the characteristics listed in the matrix.

Matrix 1: Characteristics of Leaders on ASRH

Characteristic	Leader 1	Leader 2	Leader 3
Gender			
Age			
Ethnicity			
Economic status			
Religion			
Occupation			
Other relevant characteristic			

Selection and flexibility in leadership refers to the process of selecting leaders on ASRH and to opportunities for others in the community to become leaders (especially youth).

To assess the selection process and proportion of leaders selected by the community, and the degree to which community members are able to play a leadership role, **you may collect the following information from program records, key informant interviews, focus groups, and household surveys:**

- > How are leaders selected in the community? How are youth leaders selected in the community?
- > Who in the community decides on leaders on ASRH? Is it the whole community, other people or groups within the community, other people or groups outside the community? Or does the government or an external agent, such as a donor, choose them?

⁶ It is particularly important to measure the participation of female adolescents in leadership positions since young women are not often encouraged to take leadership roles.

- > From the total number of leaders on ASRH, how many were selected by the community?
- > Is anyone involved in ASRH able to be a leader if they want to?

Leadership competency in encouraging dialogue and action on ASRH refers to the importance of building broad based and sustained community support for improvements in ASRH. To assess overall leadership competency, you can use the matrix (below) to determine how well individual leaders and groups implement leadership activities. The information can be collected through key informant interviews or through a survey.

Matrix: Leadership competency in community dialogue and action for ASRH

Activity	Leader or Group 1	Leader or Group 2	Leader or Group 3
Identification of ASRH problems in the community			
Initiating community dialogue around ASRH			
Encouraging wide participation of stakeholders on ASRH			
Encouraging participation of youth on ASRH			
Facilitating opportunities to seek input from all community members, especially youth, and those who are disadvantaged or disenfranchised.			
Implementing an agreed upon plan of action on ASRH			
Mobilizing resources to address ASRH			
Ensuring resources of ASRH program are fairly distributed			
Ensuring benefits of ASRH program are fairly distributed among youth			

Another aspect of leadership competency is to assess the degree to which leaders accept conflict or dissatisfaction as “normal” and see it as an opportunity for change (versus something that is bad and needs to be controlled).

Through program records, key informant interviews, or household surveys, you can determine how leaders deal with conflict/dissatisfaction/disagreement of community members when discussing ASRH.

- > Do leader(s) respect differences, try to enrich the view of the issue, ignore those with a different opinion, manipulate those with a different opinion, prevent dissidents from becoming involved, etc. To what extent do leaders incorporate the views of youth?

The mechanism for reaching community consensus on ASRH is a useful measure of leadership competency.

- > Do leader(s) dictate the decision, allow discussion until a consensus emerges, state a decision and ask if there are any objections, state the options and ask for votes, etc. Is decision-making consensual and inclusive or top-down and non-participatory? Does the decision-making process significantly involve and incorporate youth perspective?

Vision and Innovativeness look at the degree to which a leader articulates a vision for ASRH and enhances community spirit.

Using program records, the mission statements of community groups, statement of program long-term objectives or plans, interviews with community members and other key informants you can assess the following:

- > Do leader(s) have a clear goal or direction for the community on ASRH? Do they have any innovative solutions to the problems around ASRH?
- > How would you describe each leader’s enthusiasm or passion for strengthening or motivating communities to address ASRH? Are they very enthusiastic and involving or are they very apathetic?

Trustworthiness and Popularity refers to the community’s (including youth’s) trust in their leaders for keeping their promises and managing their resources effectively.

Through program records, key informants and representative sample surveys, you can collect the following information, using a four-point scale (very, somewhat, not very, not at all).

When thinking about (leader or group’s name), you may recall things he/she said and did related to ASRH. Thinking about all of his/her attributes, please tell me:

- > How credible would you say (leader or group’s name) is on the things she/he says or promises on ASRH?
- > Does she/he keep her/his promises?
- > How trustworthy is this leader/group in managing the community’s resources?
- > How courageous is this leader or group in standing up for ASRH and youth and dealing with conflicts constructively?
- > How likable is this leader or group among community members? Among youth?
- > How sensitive is this leader/group to the needs of the community? To the needs of youth?
- > How accessible is this leader/group to community members? To youth?
- > How respectful is this leader/group about others’ opinions? Of youth’s opinions?
- > How much do you like this leader or group?

Degree and Equity of Participation

This dimension of social change measures the range of community participation to ensure that traditionally disenfranchised members of the community (women, the poor, certain ethnic or tribal groups, youth, and certain occupations) are encouraged to participate in addressing ASRH. It also measures whether community members are involved in a diverse range of activities to improve ASRH including planning of programs, selecting leaders, mobilizing and managing resources, and evaluating outcomes.

The dimensions of participation include:

- > Access to participation
- > Extent and level of participation

Using key informant interviews, program records and direct observation, you can collect the following information.

Access to participation

How many community groups exist that deal with ASRH?

Are there any committees, community organizations, or groups that are dedicated to ASRH?

How many of these groups address ASRH?

How accessible are these community groups to community members who are affected by ASRH?

Do these groups offer and encourage opportunities for people in the community (especially youth, and those who interact with youth, such as teachers, coaches, the business community, parents, youth organizations, youth clubs, to actively participate?

How do these groups encourage participation?

Extent and Level of Participation

What proportion of traditionally excluded or more disadvantaged members of the community participate in meetings and get involved in ASRH programs?

Do any of the following people/groups participate in any of the following activities related to ASRH? Use the matrix below.

Matrix: Participation in ASRH activities by selected members of the community

Activity	Women	Men	Youth	Other relevant interest group	Outside organizations	Government
Accepting or starting an ASRH program						
Attending meetings or discussions on ASRH						
Speaking up at meetings that concern youth						
Selecting leaders and resource persons						
Setting ASRH program objectives						
Decision-making on actions						
Implementing ASRH programs						
Assessing or evaluating ASRH programs						
Initiating new activities related to ASRH						

NB: the local situation will determine the actual groups that are assessed in this matrix. Similarly, activities can be adapted to the specific characteristics of the ASRH program.

Information Equity

There are two main dimensions of information equity:

- > Awareness and correct knowledge about ASRH
- > A free flow of information about ASRH

To assess awareness and knowledge about ASRH, you can conduct in-depth interviews with representatives of different groups who have a stake in improved ASRH or conduct representative sample surveys that look at:

- > Percentage of community members who have correct knowledge about ASRH. (Distribution should be about the same by gender and other individual or group characteristics). Alternatively, you can assess the average level of knowledge about ASRH in the community. (If specific knowledge items are identified, a knowledge index can be constructed to assess overall community knowledge of ASRH.)
- > Percentage of community members who are aware of community activities that are being implemented related to ASRH. (You may wish to create a matrix of individually listed program activities to assess specific awareness by different individuals and groups in the community.)
- > Percentage of community members who are aware of community sites or other sources of information related to the ASRH program
- > Percentage of community members who are aware of mechanisms for participation in the ASRH program
- > Percentage of community members who are aware of other ASRH programs in their community

To assess the free flow of information, you may look at the following:

- > Proportion of community members who have access to various sources of information (TV, radio, newspapers, telephone, internet, town crier, etc)
- > Frequency of use of local media and other information mechanisms by community members to learn about ASRH and ASRH programs
- > Degree of media participation/involvement in ASRH
- > Percentage of media time devoted to ASRH
- > Number of media reports related to community activities and accomplishments related to ASRH (e.g. news articles, radio/TV interviews)
- > Percentage of community members who have discussed ASRH with other community members in the last (X) months.

Collective Self-Efficacy

Collective self-efficacy describes a group's shared belief in its collective abilities to attain goals and accomplish desired tasks (Bandura, 1986). It is the belief or perception that effective collective action is possible to address a social or public health problem, such as the need to improve ASRH. Beliefs of collective self-efficacy may be a predictor of group performance, and influences dialogue, goal setting, collective effort, and persistence in the face of barriers.

There are two different approaches to the measurement and evaluation of collective self-efficacy (Bandura, 1995):

- > Aggregate appraisals (by members) of their personal capabilities for the functions they perform in the group
- > Aggregate appraisals by members of the group's capabilities as a whole

Perceptions of self-efficacy will vary with the task and contextual factors. Questions about perceived self-efficacy (whether for individuals or communities) should be precise and refer to specific circumstances.

Dimensions of collective self-efficacy include:

- > Perceived efficacy to take action as a group
- > Perceived capability of other community members
- > Perceived efficacy to solve problems as a group.

Data sources may include analysis of statements of community leaders in community meetings, media, key informant interviews and representative sample surveys.

Perceived self-efficacy as a group refers to the confidence of the community to work together as a group to take collective action to address problems, not just ASRH. This may be affected by contextual factors, such as experiences, or a history of factionalism or conflict in the community. Use the following statements to assess this dimension, using a standard Likert-type format (strongly agree, agree, unsure, disagree, strongly disagree).

- > People in this community are always able to discuss problems that affect everyone.
- > If a problem arises that people cannot solve by themselves, the community as a whole will be able to solve it.
- > People in this community usually have trouble dealing with conflict.
- > Whenever our community undertakes a project together, we know we will work hard until it is accomplished.
- > Whenever our leaders ask us to work on projects together, almost everyone is willing to join in and do their share of the work.
- > Whenever a community problem arises, I have very little confidence that we will be able to solve it.

Perceived capability of other community members refers to members' perceptions of other community members' talents and abilities to do their work within the group or community. **The following items (adapted from Riggs et al, 1994) help assess these perceptions:**

- > The community members I work with have the ability to tackle ASRH.
- > People in this community have poor skills and resources to improve ASRH compared to other communities I know of.
- > I have plenty of confidence that people in this community can perform the tasks that are assigned to them to address ASRH.
- > The people in this community have excellent skills to tackle ASRH.
- > The community is not effective in addressing the problems related to ASRH.

Perceived efficacy to solve problems as a group refers to the perceived confidence in problem solving around ASRH at the community level by working together. This dimension is problem specific. A community may feel confident working together on some issues, but not confident about resolving ASRH issues because they are controversial or opinions are divided. **The following items can be used to assess perceived group efficacy for ASRH, using standard Likert scale format:**

- > I believe our community is capable of using innovative approaches to address ASRH, even when we face barriers and setbacks.
- > As members of this community, we are able to take on ASRH, because we are all committed to the same collective goal(s).
- > Our community can come up with creative ways to improve the health of adolescents, even without outside support.
- > Our community has the internal skills, knowledge, and ability to implement actions to improve ASRH.
- > Our community can sustain ASRH project activities once external support is no longer available.
- > Our community can mobilize resources to change ASRH.

- > I am confident that we as community members can develop and carry out ASRH initiatives in a cooperative way, even when difficulties arise.
- > Our community as a group can influence the ASRH initiatives that affect them because we are a cohesive and competent community.
- > We can deal effectively with even the most critical events, because we can draw upon the social networks that exist in our community.

Two other related questions can also be asked:

- > To what extent does this community or organization have the skills, knowledge, and abilities to implement a plan to address ASRH?
 - 0 Not at all. Members do not have the skills, knowledge, and abilities and cannot implement a plan to address ASRH
 - 1 Somewhat. Members may have some skills, knowledge, and abilities but cannot use them collectively to address ASRH.
 - 2 Pretty well. Members have the skills, knowledge and abilities, and are taking steps to use them to address ASRH.
 - 3 Very well. Members have all the skills, knowledge and abilities and the community can implement a plan to address ASRH.

- > Does your community feel more, the same, or less confidence as you did five years ago to address ASRH?
 - 0 Less confident
 - 1 Same level of confidence
 - 2 More confident

Sense of Ownership

This is the community's feeling/belief that ASRH and/or ASRH programs belong to them and that they have a commitment to the issue and/or the program. The sense of ownership will be affected by how intensively and extensively people are involved in defining the issues around ASRH and developing ASRH programs.

An external agent may help determine needs and program goals and guide the implementation process; however, the community must be heavily involved so that a sense of ownership can develop. Creating a sense of ownership reinforces what people learn and encourages them to apply learning to other issues.

Six dimensions for sense of ownership are identified:

- > Importance of ASRH and/or ASRH program to participants
- > Sense of responsibility for ASRH and/or ASRH programs
- > Contribution to ASRH programs
- > Benefit from ASRH programs
- > Participant sense of ownership of either credit or blame in ASRH program outcomes
- > Personal identification with ASRH and/or ASRH programs

Importance of ASRH and/or ASRH programs refers to the level of importance of ASRH and/or ASRH programs for members of the community. **This can be assessed through key informant interviews, surveys or focus groups that examine the following:**

- > What are the main ASRH related problems that affect you, your family, and your community? Rank them in order of importance.
- > How important is ASRH for you (youth/the community) compared to other issues affecting (youth/the community)? This can be measured using a five point scale or by comparing the relevance of ASRH in relation to other concerns as more, less or of equal importance.
- > What do you think you (youth/your community) should be doing about ASRH?

Responsibility for ASRH and/or ASRH programs refers to the percentage of community members that identify themselves as having responsibility for ASRH and/or ASRH programs. This information can be collected from key informant interviews, surveys, or focus groups.

- > Who is responsible for solving ASRH problems/making this ASRH program successful? Outsiders? Some members of the community? Youth? The entire community?

Contribution to the program addresses the degree to which community members contribute to ASRH and/or ASRH programs.

- > How much would you say you (youth/the community) have/has contributed to ASRH/ASRH programs as a whole: Very much, slightly, not much, not at all.
- > If not much or not at all, has anything/anyone prevented you (youth/ the community) from contributing to ASRH/ASRH programs?

Perceived benefits from the program refer to the degree to which community members believe the community benefits from improved ASRH/ASRH programs.

- > How much did you (youth/ the community) benefit from this ASRH program? Very much, slightly, not much, not at all.
- > Who in the community benefits from ASRH programs?
- > What are the reasons why you (youth/the community) participate in the program? For money? Because you feel the program is important? Because you were asked by community leaders to participate? For the sake of curiosity?
- > What are the reasons why you (youth/the community) did not participate in the ASRH program? Not aware of ASRH/ the ASRH program? Did not know how to participate? Were not allowed to participate? Did not see any benefits to participation?

Perceived accountability from program results refers to the degree to which community members recognize their accountability in the outcome of the program.

- > Who do you think deserves the credit/blame for making this ASRH program a success/failure? Outsiders? Some members of the community? The youth? The community as a whole?

Perceived personal identification with the program assesses the degree to which community members report they (the youth/the community) own the ASRH problem/ASRH program.

- > Whose ASRH program is this: Outsiders? Some members of the community? The youth? The community as a whole? Others?

Social Cohesion

Social cohesion is the forces that act on members of a group or community to remain in and actively contribute to the group. In cohesive groups, members want to be part of the group; they generally like one another, get along well, and are loyal and united in pursuit of group goals, as improved ASRH. Social cohesion is an important antecedent as well as a consequence of successful collective action. It mediates group formation, maintenance, and productivity.

The dimensions of social cohesion related to ASRH include:

- > Sense of belonging
- > Feelings of morale
- > Goal consensus

Sense of belonging refers to the extent to which individuals feel that they are an important part of the group or community. The group's level of belonging can be measured through focus group discussions, in-depth interviews, and sample surveys of community members. For ASRH, it is particularly important to assess the extent to which youth feel that they are important and valued members of the community. **Using a standard Likert scale, you may wish to ask the following questions:**

- > I feel that I belong to this community.
- > I see myself as part of this community.
- > I feel that I am a member of this community.
- > I would rather live in a different community.
- > I would rather live in this community than any others that I know of.
- > I would like to move out of this community as soon as possible.
- > People in this community are all striving for the same goals.
- > Everyone here wants to pursue their own goals rather than working for the good of the community.

Feelings of morale refer to the extent that members of a group or community are happy and proud to be a member of the community. It is important to look at whether or not youth feel happy living in this community. Level of belongingness can be measured through focus group discussions, in-depth interviews, and sample surveys. The following questions can be asked, using a standard Likert-scale.

- > I am happy to be part of this community.
- > I am content to be part of this community.
- > This community is one of the best anywhere.
- > Youth are encouraged to take part in community projects.
- > Most of the people in this community genuinely like youth.
- > Most of the people here are willing to share responsibility to make our community a better place for youth.

Goal consensus examines the degree to which members of the community agree on the importance of ASRH issues that face the community and on the objectives to be achieved by the community or group. Before a community can reach consensus on priorities and goals for improving ASRH, they must first understand the issues and what objectives have been set.

During baseline or project planning, focus group discussions may be held to define the community and identify leaders. This is also an important time to elicit the most important issues/concerns that the community may have related to ASRH. This consensus list of problems can then be used in a survey of community members to measure goal consensus. Each respondent should be presented with this list of ASRH priority issues/concerns and then should be asked to prioritize which issue/concern is most important, which is the second most important, and so on.

Social Norms

Social norms are people’s beliefs about attitudes and behaviors that are considered normal, acceptable, and even expected within groups and communities. People’s perceptions of social norms greatly influence their behavior.

The dimensions of social norms include:

- > Norms on participation
- > Norms about leadership
- > Norms about ASRH

Norms on participation refers to the community’s beliefs and rules about behaviors that are acceptable for participation, such as who should attend meetings, speak up in meetings, or share in decision-making. It also addresses “fairness” regarding contribution to ASRH solutions and sharing of benefits. This can be further assessed by examining the extent of perceived approval about community member’s participation in addressing ASRH problems. Using the following table, ask respondents to identify who should participate in specific activities related to improving ASRH.

People/Group	Attend meetings & discussions	Speak out at meetings	Be involved & contribute to addressing ASRH concerns	Benefit from ASRH programs	Elect or act as leader for ASRH programs
Women					
Men					
Youth					
Parents					
Teachers					
Health care providers					
Religious leaders					
Youth serving NGOs					
Business community					
Other					

To assess the proportion of community members/groups that believe the community will voluntarily participate in addressing ASRH, ask under what circumstances should members of the community participate in problem solving for ASRH: Every time they are asked/voluntarily? If the community gets outside resources/money? If they think there will be negative repercussions if they do not participate? Only if they are paid?

To assess perceived potential of personal risk for becoming involved in ASRH programs, ask if becoming involved in ASRH program might result in some type of personal risk, including economic, physical, and/or social risk.

Norms about leadership refer to the community's systems, rules, and beliefs about the attributes and responsibilities of a leader and the ways leaders are selected.

- > Perceived role of community leaders: What is the role of the community leader(s) in ASRH? Who in the community can become a leader on ASRH? Can youth be ASRH leaders?
- > Perceived attributes of a good leader: What are the characteristics of a good leader for ASRH?

Norms about ASRH refer to the community's beliefs and rules about how acceptable it is to talk about and participate in activities related to ASRH, especially who should/can deal with it, who is traditionally excluded from the discussion, and the level of personal risk for addressing ASRH.

- > Extent of perceived relevance of ASRH for community involvement: Who in this community are the people who should act to address ASRH? Only men? Only women? Youth? All the community?
- > Extent to which ASRH can be discussed freely in the community: Who are the people you would talk to about ASRH/ASRH programs: Nobody? Immediate family members? Other relatives? Same sex friends? All friends? Acquaintances? Teachers? Health care providers? Religious leaders? Elected officials? Other people in the community? Others outside the community? Anybody else?
For each person that you can talk to: Do you think that they are advocating for solutions to problems related to ASRH? Is it acceptable to address ASRH in the media?
- > Degree and level of support that other community members have in solving ASRH problems: How many people do you think support solutions to ASRH problems? The majority? Most? More than half? Less than half? Few? None? How strong do you think people feel in their support of ASRH solutions: Very strongly? Somewhat strongly? Not very? Weakly? Not at all?

APPENDIX B:

Case Studies Of Evaluated ASRH Projects, With Processes And Outcomes Organized According To The IAWG Framework

We include two case studies to demonstrate how ASRH projects with significant community involvement / empowerment components do report a range of individual, organizational, and social change outcomes.

Each case study summarizes main community involvement approaches and outcomes reported in project evaluation reports and process documentation. Advocates for Youth and Mwangaza Action supported the Burkina Faso project. CARE International supported the Georgia project. Using the IAWG framework as an organizing reference, the case studies highlight the wide realm of individual, structural, and social outcomes that were documented at the end of each ASRH project.

Of interest, also, is how each evaluation focused on measuring the challenging, less tangible processes and outcomes of community-based programs. The evaluators of the Burkina Faso project, for example, assessed levels of community participation as well as individual, organizational, and social outcomes. The evaluators of the Georgia project looked quantitatively at changing perceptions of gender and social traditions / norms that influence ASRH.

Youth and their Communities Take Charge to Improve Youth Reproductive and Sexual Health in Burkina Faso

Advocates for Youth, based in Washington, DC, and Mwangaza Action, based in Burkina Faso, implemented a project from 1999 – 2003 promoting the participation of communities (specifically youth and adults) to improve adolescent reproductive and sexual health (ARSH), including mitigating HIV/AIDS. The objectives were to improve adult and youth knowledge, attitudes and practices related to the sexual and reproductive health needs of young people; to engage community members, especially youth, in developing and implementing interventions; and to build capacity among participating partners to work on ARSH issues through a variety of strategies, including strengthening youth-adult partnerships. The project operated in 20 villages in three provinces, with an estimated population of 158,000.

Community participation, with a focus on inter-generational participation and leadership, was the basis for the program. The creation of ‘intergenerational teams’ with eight youth and two adult members under the guidance of three Youth Associations – one in each province - linked with community-based village committees comprised of girls, boys, women and men, were responsible for facilitating many community level activities. These groups worked in all 20 villages, and conducted an ASRH needs assessment, facilitated community prioritization of ASRH issues to address, assisted in refining the project designs, and oversaw activities at the village level. Activities designed to increase participation and discussion of ASRH issues included a series of participatory workshops, village assemblies, regular meetings with local authorities, focus group research, and action planning.

Through an early community mobilization process by village committees, with boys and girls taking the lead, the following priorities were identified:

- Lack of information on sexually transmitted infections (STIs), including HIV, family planning, and female genital cutting;
- Infrequent use of reproductive health services; and,
- Lack of parent-child communication.

The strategies that communities identified to address these priority concerns included:

- Peer education;
- Activities to improve parent child communication;
- Information, education and communication (IEC) activities, including theatre, dance, and public video showings and discussions; and
- Implementation of youth-friendly reproductive health services.

As a result, communities launched interventions that ran for the remaining year and a half of the project. [Many of the activities continue today.]

Community networks and institutions catalyzed awareness of ASRH issues

IEC activities were essential to the success of the project as they created an enabling and empowering environment. Use of multiple media and tools such as street theater and video presentations helped convey sensitive issues to community members across sex and age.

Youth Association and village committees trained 47 female and male peer educators aged 15 to 24. Peer educators led about 80 group talks and made 160 home visits each month, focusing on topics that communities had identified as priorities. Peer educators also sold about 330 condom packets (each packet contained four condoms) and reached about 1,760 youth per month.

Youth association and village committee members led about 45 topic-specific discussions in each village each month. These discussions were open to all villagers and usually featured a video or theatre performance, often accompanied by music and dance. Members of the youth associations also made about 90 home visits each month, meeting with village adults and focusing on parent-child communication around sexual health and sexuality issues. Because of the IEC activities and home visits, the project reached about 3,780 youth and 2,070 adults each month across the sites.

Improvements in health facility capacity to deliver youth-friendly services

In response to the need for more youth-friendly services, Advocates and Mwangaza led a five-day training workshop for health center personnel from the three sites on how to make their services friendly and welcoming to young people. Two sites thereafter designated one person whose special focus was to oversee youth services. All three sites adjusted their operating hours to better suit youth's needs. Two of the sites designated a space just for youth. The third site rearranged counseling space to maximize confidentiality.

Noteworthy Social and Organizational Elements of the Project

- Youth and community members actively participated in designing the program;
- Youth worked in partnership with adults;
- Local organizations developed and increased their capacities;
- Local knowledge and expertise converged with research-based, effective reproductive and sexual health strategies;
- Communities harnessed their own technology and other assets;
- Youth organizations involved entire communities in group discussions;
- Focus was on the gender- and age-specific needs of youth;

- Consistent focus placed on achieving gender parity in youth’s and adults’ involvement;
- Focus also put on achieving multi-sector community buy-in;
- Transparency and trust existed between community entities, Mwangaza, and Advocates for Youth; and,
- Flexibility of project to make adjustments occurred as the program and community involvement evolved and grew.

Results From The End-Of-Project Evaluation

Highlights below are drawn from the project evaluation, conducted by the Pacific Institute for Women’s Health. The evaluation plan sought information at various levels.

- 1) A baseline and end line cross-sectional household survey of youth measured changes in ASRH knowledge and behaviors after the 18-month intervention period. In addition, a second survey was used at end line to gather information from a smaller sample of parents and service providers.
- 2) At end line, interviews with 100 purposively selected community representatives – adults and youth – measured how much (levels) and the scope (how) of participation. Discussions focused on indicators of community participation, including accuracy of community perceptions about the project, leadership ownership, decision-making, and empowerment.
- 3) Organizational capacity of the main organizations working with communities – Mwangaza and the three Youth Associations – was measured at baseline and end line through an in-depth interview guide that assessed changes in organizational capacity around ASRH, use of community participatory strategies, and organizational development.

Improvements in Knowledge, Attitudes, and Behaviors

Knowledge and attitudes	Base	End line
Felt able to talk to parents about sexuality issues	36%	55%
Improved knowledge about HIV	70%	86%
Knew how to use a condom correctly	52%	84%
Not intending to excise future girl children	72%	86%
Aware of where to obtain health services	62%	78%
Reported behaviors	Base	End line
Increased proportion of sexually active youth reporting only one partner (increase in 2 of 3 communes)	47%	67%
Increased proportion of sexually active youth reporting current condom use	51%	73%

“IN ANY CASE, BEFORE WE WERE SCARED OF GOING TO THE HEALTH CENTERS BECAUSE WE FELT ASHAMED BUT ALSO BECAUSE OF THE RECEPTION OF THE HEALTH CENTER STAFF. BUT NOW IT’S EVEN BECOME OUR NUMBER ONE PLACE TO SEEK ALL THAT WE WANT TO KNOW ABOUT SEXUALITY AND HEALTH.”

A YOUNG PERSON DURING A FOCUS GROUP

FOR ME, THE CONDOM IS NOT JUST SOMETHING FOR THE BOYS. WITH THESE DISEASES THAT WE HAVE NOW, I ALWAYS HAVE MY CONDOM IN MY PURSE. THIS WAY, IF MY BOYFRIEND SAYS THAT HE DOES NOT HAVE A CONDOM WHEN WE ARE GOING TO MAKE LOVE AND THAT WE HAVE TO DO IT WITHOUT IT, I JUST SAY NO, BECAUSE I HAVE ONE.

A YOUNG WOMAN IN PAMA

There was no change in age at first intercourse. The evaluation did show, however, that a larger proportion of young women reported being sexually active (up from 24% to 38%). Qualitative research later demonstrated that this apparent increase in sexual activity arose from a greater openness in admitting to sexual activity.

Increased Organizational Capacity

The three youth associations developed capacity in community participation and facilitation techniques, organizational development, and reproductive and sexual health. The youth associations have become well known for their work on youth reproductive and sexual health issues and are often asked to assist local and some national organizations.

Mwangaza developed capacity in youth reproductive and sexual health. [Mwangaza already had a great deal of expertise in community mobilization.] Mwangaza has also gained recognition at the national and international level for its capacity to implement reproductive and sexual health programs for youth—an asset that Mwangaza previously lacked.

THE ADMINISTRATIVE REPRESENTATIVE OF A NEIGHBORING VILLAGE [15 KM AWAY] PARTICIPATED IN ONE OF THE HIV PREVENTION VIDEO SHOWINGS AND DISCUSSIONS IN PAMA. AT THE EVENT'S END, HE APPROACHED YOUTH ASSOCIATION MEMBERS AND SAID, "WHY CAN'T YOU COME DO A SESSION LIKE THIS IN MY VILLAGE? OR, DO YOU THINK THAT WE DON'T HAVE ANY PROBLEMS?"

HEALTH CENTER STAFF AT ONE PROJECT SITE REPLICATED THE TRAINING FOR OTHER HEALTH PERSONNEL IN THAT VILLAGE. THE TRAINING HAS SINCE BEEN REPLICATED IN THE OTHER TWO SITES OUTSIDE THE PROJECT AREA.

High levels of Community Participation

The project achieved high levels of participation by community members, including participation from a wide range of leaders, service providers, community members, parents, and youth. Perhaps even more important, youth achieved meaningful participation.

Of those interviewed – percent who had participated in some project activity.	70%
Percent who perceived young people aged 16 through 21 as key actors in the project.	78%
Percent who indicated that parents and other adults played consultative or observational roles.	70%

Mwangaza & AFY inputs support CI

COMMUNITY CAPACITY to address ASRH issues

Defined as:

- A strong sense of community, of knowledge of ASRH-related problems, and ability of youth, adults, leaders, NGOs, CBOs, and health services to address ASRH problems

Modified by:

- Low ASRH knowledge levels among adolescents and youth
- Limited parent-child communication
- Infrequent youth use of health services

Supported by:

- Existence of dynamic community youth associations
- Existence of local NGO with strong CI capacity yet no ASRH experience (as project began)

COMMUNITY INVOLVEMENT

- Youth and adults conduct ASRH needs assessment
- Action research by youth and adults to develop and implement plans to address youth issues
- Identification and development of leadership skills of selected youth
- Linking youth association with community development committees, to train and oversee peer educators
- Awareness raising by peer educators and facilitated discussion linked to popular theater and videos
- Systematic community-wide discussions of specific ASRH themes

OUTCOMES

Social Changes

- Youth viewed by adults as important community development agents
- Adults prioritize youth ASRH issues
- Improved parent-child communication
- Girls empowered to take leadership role
- Sense that ASRH activities are of the community

Structural Changes

- Increased capacity of youth association to engage communities and manage ASRH related issues
- Increased capacity of Mwangaza NGO to address ASRH through its CI efforts
- More youth-friendly services

INDIVIDUAL CHANGES (of those involved adols)

- Improved adolescent RH knowledge
- Increased knowledge of where to access health services
- Reduced number of sexual partners (of sexually active youth)
- Increased rates of youth using condoms
- Increased youth leadership skills
- Improved ability to talk to parents about sexual issues

BROADENED BASE OF COMMUNITY SUPPORT

- Improved youth-adult perceptions of each other as community actors
- Heightened awareness of youth ASRH issues and roles and responsibilities of adults and leaders vis-à-vis youth

AND

IMPROVED ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (Assumed)

- Reduction in HIV transmission
- Reduction in unintended pregnancies among youth

Workshop to sensitize service providers of ASRH issues and services needs (informed by needs assessment, above)

Youth friendlier services (eg, confidential places to consult, youth-serving providers identified)

ENGAGING AND CHALLENGING COMMUNITIES IN ASRH, GENDER, AND SOCIAL EQUITY ISSUES: CARE – GEORGIA’S ADOLESCENT HEALTH PROJECT (GAHP)

In the Republic of Georgia, adolescents face considerable SRH risks, including those associated with abortions, early pregnancy, STIs and HIV. They are unable to speak openly about sexual health, and do not have reliable and accurate sources for information, services, and treatment. Traditional attitudes and ways of thinking are the norm and are closely tied in with the Orthodox Church. The vast majority of Georgians are Orthodox Christians, and their beliefs are often shaped by the church’s conservative teachings. Furthermore, adolescents are not empowered to demand information from adults or healthcare professionals about SRH because they are perceived to have a low-status with limited rights. Instead, they tend to seek information from their peers who are often very misinformed and pass on commonly held myths around sex. Social norms also influence the decisions that adolescents make. Boys are expected to be sexually experienced, while girls are expected to remain virgins until marriage, though they are often pressured or forced into sex and/or marriage. The Guria region in western Georgia was selected as the target area for this three-year intervention that began in 2004, because of its high level of poverty, unemployment, reproductive health problems, and low level of attention it received from international organizations. In addition, the area included populations facing different physical and social access challenges, such as populations living in villages in extremely mountainous areas versus those living in seaside villages.

The project’s baseline qualitative research included a social analysis (a participatory needs assessment that focuses on social factors that influence health outcomes). The findings, described above, helped CARE determine which community-based approaches would be necessary, ones that targeted all members of the community including boys and girls, adults and parents, teachers, church leaders and health care providers. The project sought not only to change knowledge, attitudes and beliefs of individuals, but to create a sense of agency and address the social factors that make it difficult for young people to act on knowledge, and adopt healthy behaviors (e.g. adult/parent-child dialog, gender inequality, poor health care infrastructure).

The project interventions were strongly community-based, engaging Guria youth and the adults in the community, helping mobilize efforts that left communities better equipped to address the reproductive health needs of its adolescents. Approaches to inform and engage communities in discussions and planned actions varied. They included youth and adults participating in initial assessment activities, training youth and adult change agents to inform members of the community about RH and HIV prevention practices, using social marketing tools for information dissemination, using forum theatre to challenge adults and youth in communities on social issues that influence health. Finally, providing micro-grants to develop and implement a project on RH allowed a practical application of intergenerational partnership.

The GAHP initiative also focused on the need to improve health care services by upgrading facilities and training health care providers on how to provide youth-friendly services. Community involvement in this component was relatively more limited. A group of particularly interested adults and youth formed a Youth-Friendly RH Service Support Group who were involved in selecting facilities to upgrade and participated in facility assessments.

COMMUNITY INVOLVEMENT APPROACHES TO ASRH, GENDER, AND OTHER SOCIAL NORMS

In many ways, the GAHP project served as a **catalyst** for community involvement in ARSH issues. Residents of Guria were involved in the initiative through various community approaches aimed at engaging them around ARSH related issues that are best addressed within the community. Providing ASRH information, and creating spaces for dialog between adults and adolescents, formed the basis of the community approaches.

Change Agents.

The project trained 77 adolescent and adult Change Agents of both genders on the core themes of the project (intergenerational communication, gender-based violence, conflict mitigation, STIs/HIV, family planning, and puberty). They learned important life-skills such as decision-making, negotiation, and assertiveness. They collaborated in the intervention design and testing, and engaged in peer support and community health education. Change Agents were instrumental to the success of the project because they helped to instill trust from the community by being the liaison between the community members and the project.

Health education and social marketing.

Change Agents and project staff disseminated IEC/BCC/life skills materials (video, calendars, brochures, and posters) within the community, to individual households and to healthcare facilities. The materials addressed central SRH themes such as intergenerational relations, gender-based violence, and kidnapping, STIs and HIV, family planning and puberty. Information about where to access youth-friendly services was also supplied. For the healthcare facilities, doctors and nurses received social marketing materials that detailed the importance of their patients' rights to private and confidential services, as well as information about the nature, location, and costs of services for adolescents.

Theatre for development/forum theatre.

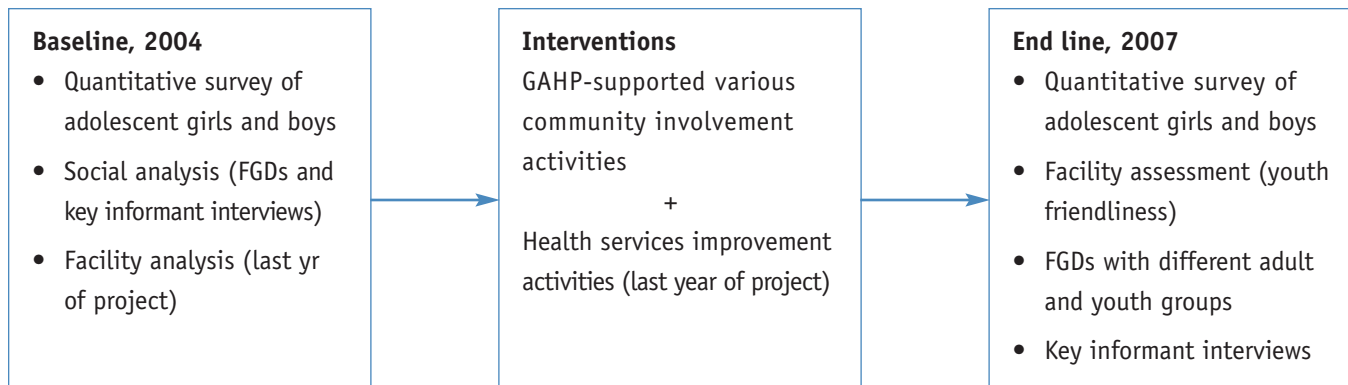
Theatre was also used as a vehicle for educating the public around issues of ASRH and engaging them in discussions of ASRH-related issues. The performances discussed adolescent choices and behaviors, and raised awareness about the core project themes, especially social equity. The group of actors included professionals and amateur volunteers from the community that performed short and long dramas. Theatre performances included video documentary and participatory post-drama dialogue with audiences to discuss the issues that had been addressed. The theatre intervention was particularly successful because it encouraged people to start talking about their opinions, at which point people realized that there is not just one normative opinion, but several. Once people realized that others shared their same opinions, they were less intimidated and more empowered to voice them. The debates that ensued after the theatre encouraged the public to discuss possible solutions to the problems they had just seen. Each theatre performance reached between 50 and 100 people.

Micro-grants.

Micro-grants were funded by GAHP and gave adolescents and adults the autonomy to develop their own proposals for projects around RH in the community, thus furthering community involvement by reaching even more people. Micro-project groups consisting of adults and adolescents interested in the same project did RH trainings leading to scale-up of the project, and communication with community members of all ages and categories (e.g. kidnapping video and health education drama, developing youth-friendly information for pharmacists). Besides furthering community involvement, the grants also focused on furthering the youth-adult participation, and intergenerational relations components of the project.

RESULTS FROM THE END-OF-PROJECT EVALUATION

The project used a non-experimental evaluation design, summarized below:



The community involvement approach led to a range of outcomes at the individual, structural, and social levels, documented in an end-of-project evaluation report by a team of external consultants commissioned by CARE-USA.

Individual Change

Individual change was achieved through empowering individuals and providing them with information about SRH and improving their communication and social skills. Individuals such as adolescents, adults, teachers, and service providers achieved greater knowledge of RH, FP, HIV/STI, and GBV issues. Ideas around SRH changed, and many adolescents became much more comfortable speaking about SRH issues with their parents and doctors, a great accomplishment given the taboo nature of the topic, and the conservative environment in which they live. Life skills were taught to improve communication and decision-making ability, which led to greater self-esteem and self-confidence among adolescents. They became empowered and developed a sense of accountability to seek out their own health care, and to make better choices regarding their reproductive health. Furthermore, there is evidence that the initiative led to the uptake of more preventive behaviors, decreased rates of abortion, and increased use of contraceptive methods.

Knowledge, beliefs, self efficacy, and service use

	Baseline	End line
Knowledge: Know STI symptoms	3%	27%
Belief: Do not believe girl can get pregnant at first sexual encounter	12%	5%
Self efficacy: Able to share personal problems with peer group	78%	94%
Proportion of adolescents seeking FP services	Seven-fold increase over baseline	

NB: Information on behavior change to prevent STIs and pregnancy was not collected during the survey, given extreme sensitivities within target communities. Instead, time-series service data documented trends in the proportion of adolescents seeking services in one maternity/FP room serving a target community.

I WAS SHY TO TALK ABOUT RH TOPICS AND WORDS; NOW I AM ABLE TO TALK FREELY ABOUT IT IN PUBLIC AND EVEN NON-PROJECT SETTINGS. NOW INTERGENERATIONAL RELATIONS ARE BETTER WITH MY RELATIVES; AND FOR LIFE SKILLS – I THINK MORE DEEPLY IN TERMS OF DECISION MAKING AND I AM MORE ASSERTIVE.
ADULT WOMAN AND GYRC FACILITATOR

AMONG ADOLESCENTS, THE GENERAL LEVEL OF AWARENESS HAS INCREASED AS SEEN IN CONVERSATIONS ON THE STREETS, AND OTHER ADOLESCENT DISCUSSIONS – AND THEY REMIND EACH OTHER ABOUT WHAT THEY HAVE SEEN AND HEARD IN THE EARLIER DRAMAS AND TRAININGS – THEY HAVE PERMANENTLY LEARNED SOMETHING ON THESE ISSUES. CHANGE AGENT, 16 Y/O, GIRL, AND LEADER OF VILLAGE INITIATIVE GROUP

Structural Changes

Although church leaders were difficult to collaborate with and there had been a previous rejection of another reproductive health project with another agency, the GAHP project did manage to work within the constraints of the religion. The key to working with them was through individual and informal contact with the project staff to make sure that they were not being marginalized. The project staff met with the bishop and village priests, some of the latter having more liberal ideations than others do. Although the priests did not participate in any training, they did contribute by suggesting themes that should be addressed in the forum theatre. Schools were not targeted for the intervention because the Ministry of Education would not have approved addressing RH in that setting. However, some teachers who were interested in the topic presented themselves as volunteer Change Agents, which may be important to them becoming more involved in ASRH in the future. Within the conservative social context of Georgia, this sort of involvement of influential adults equates to great gains for the project, as it means that religious leaders and teachers did contribute to creating structural change, albeit in an indirect way.

Qualitative finding: The project promoted close relations of parents, teachers, and adolescents. Because of the program, a dialogue has started between teachers and parents. So far, this is only informal, but planning for more local meetings. Women teachers, members of a village initiative group

Social Change

Social change was achieved by increasing participation among community members and developing social cohesion. Changes in social and gender norms were also identified. The relationship between adults and adolescents began to improve and they learned better strategies for communicating with each other about sensitive topics. The project addressed the issue of adolescent discrimination by building a foundation upon which youth and adolescents could work together and make joint decisions. This resulted in a critical barrier being broken down and adults no longer being the only ones who had a right to access information. The combination of community-based interventions led to an increase in community knowledge and awareness about the core RH issues. Not only were people empowered with knowledge but they also knew where to go to access services and additional information. Overall, the project led to greater support from the community. Participants also recounted that after the interventions, ASRH was more talked about within households, and considered less taboo than it used to be.

	Baseline	End line
Community participation by adolescents: Respondent participated in a community activity for sake of community well being	19%	22%
Normative behaviors: Adolescent respondent has tried to stop kidnapping in last year	n/a	33%
Normative behaviors: Older family member has talked about pregnancy to adolescent	11%	35%

EARLIER, HE WAS THINKING ONLY FROM THE POINT OF VIEW OF THE BOY AND NOT FOR THE GIRL. NOW HE THINKS OF CONSEQUENCES FOR THE GIRL – AND I HAVE SEEN HIM ARGUING WITH OTHERS AND TRYING TO CHANGE THEIR VIEWS ABOUT KIDNAPPING.

WOMAN, PARENT

AT THE BEGINNING, I DID NOT EXPECT AS MUCH RH INVOLVEMENT FROM THE COMMUNITY AS WE HAVE NOW. I DID NOT EXPECT AS MUCH UNDERSTANDING FROM ADOLESCENTS TOWARD THIS TOPIC AS AN ISSUE.

FACILITATOR, GYRC

THE COMMUNITY STARTED TO TALK OPENLY ABOUT THESE ISSUES. RELATIONS BETWEEN ADULTS AND ADOLESCENTS ARE BETTER AND WE MORE ABLE TO TALK ABOUT CONTRACEPTION, FP, STDs. THOSE ISSUES WERE TABOO BEFORE.

ADOLESCENT CHANGE AGENT

CONCLUSION

The GAHP initiative showed many signs of success. As demonstrated in the final evaluation of the project, there is good evidence to support involving communities around issues of adolescent health, social factors, and traditions that affect health outcomes within a community. Community approaches to SRH are necessary. Engaging communities, encouraging their participation, and increasing their knowledge, can improve a community's capacity and commitment to solve their own issues and create lasting changes that can lead to improved ASRH. Similarly, once individuals are empowered with knowledge and their awareness has been raised, they are more likely to want to be involved in the issues facing their community and make positive behavior changes for their individual health, and the health of the greater community.

The diagram on the next page (adapted from the conceptual framework developed by the Inter-Agency Working Group on Community Involvement in ASRH) summarizes the GAHP Initiative's wide-ranging community involvement approaches and realm of social and individual outcomes that led to a supportive community environment as well as improved youth SRH outcomes. Note that GAHP's structural outcome (more youth-friendly services) was due mainly to a parallel intervention to the community involvement intervention. Services improvement activities were introduced significantly after the community involvement interventions because community awareness of and support ASRH needed to be built before engaging the health care system in ASRH-specific efforts.

GAHP Summary Diagram

GAHP Inputs

