Promoting Young People's Sexual and Reproductive Health

Dynamic Contextual Analysis

A context specific approach to understanding barriers to and opportunities for change

Second Edition

January 2006

ISBN 085432 846 7

Safe Passages to Adulthood

The UK Department for International Development (DfID) has funded a major programme of research into young people's sexual and reproductive health in poorer country settings.

Coordinated jointly by the Centre for Sexual Health Research at the University of Southampton, the Thomas Coram Research Unit at the Institute of Education, University of London and the Centre for Population Studies at the London School of Hygiene and Tropical Medicine, the principal objectives of the Safe Passages to Adulthood programme are to:

- fill key knowledge gaps relating to the nature, magnitude and consequences of reproductive and sexual health problems amongst young people;
- identify situation-specific key determinants of young people's sexual behaviour;
- identify culturally appropriate means by which barriers to good sexual and reproductive health can be overcome;
- identify new opportunities to introduce and evaluate innovative programme interventions; and
- develop concepts and methods appropriate to the investigation of young people's sexual and reproductive health.

Work adopts a life course perspective in which the focus of interest is on individuals in the period prior to the transition to first sex, and up to the point of entry into marriage or a regular partnership. This spans the key transitional events of 'adolescence', and captures a period of high sexual health risk and distinctive service needs. Sexual and reproductive health includes physical and physiological processes and functions in addition to psychological and emotional aspects. It encompasses young people's capacity to decide if and when to have children; the ability to remain free from disease and unplanned pregnancies; freedom to express one's own sexual identity and feelings in the absence of repression, coercion and sexual violence; and the presence of mutuality and fulfilment in relationships.

Beyond young people themselves, the **Safe Passages to Adulthood** programme focuses on policy makers and practitioners as 'gatekeepers' to the promotion of young people's sexual and reproductive health.

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Acknowledgements

The authors would like to thank the following who contributed their time, information, experiences and advice during the preparation of this resource.

Mary Crewe
- Centre for the Study of AIDS, University of Pretoria, South Africa

Robert Dubrow
- Department of Epidemiology and Public Health, Yale University School of Medicine, USA (with particular thanks for input and advice in relation to the analysis of relevant quantitative data)

Gethwana Makhaye
- Targeted AIDS Interventions, KwaZulu/Natal, South Africa

Macdonald Maswabi
- Men, Sex and AIDS programme, Botswana

Zethu Matebeni
- Department of Sociology, University of Pretoria, South Africa

Salim Mohamed
- Carolina for Kibera Kenya, Nairobi, Kenya

Rakgadi Mohlahlane
- Centre for the Study of AIDS, University of Pretoria, South Africa

Helen Schneider
- School of Public Health, University of Witwatersrand, Johannesburg, South Africa

The consultation which led to the development of this revised guide was supported by NIH Training Grant # D43 TW05808 funded by the Fogarty International Center and the National Institute of Mental Health, awarded to Yale University and affiliated with the Center for Interdisciplinary Research on AIDS.

Held in South Africa in 2004, the meeting was organised jointly by the Centre for the Study of AIDS, University of Pretoria, the Centre for Interdisciplinary Research on AIDS, Yale University and the **Safe Passages to Adulthood** programme

Contents

Introduction

Internationally, there is growing recognition of the importance of young people's sexual and reproductive health. The increasing numbers of young people infected with HIV and the large numbers of children and people between 15 and 24 years of age living with HIV pose a considerable challenge to public health if prevalence worldwide is to be reduced. Recent international conferences and meetings[1] have agreed the pressing need to reduce the prevalence of HIV in young people by 25% in the worst affected areas by 2005, and globally by 2010.

Young people are also at risk of other sexually transmitted infections (STIs) such as gonorrhoea, syphilis and chlamydia, which if left untreated can cause longer term problems. Some may experience forced sex and/or coercion to behave in particular ways. In many countries, inadequate information and prevailing social attitudes cause young people to feel ashamed or guilty about their sexual development and associated behaviours, feelings and desires.

Sound information is therefore needed regarding young people's sexual development, behaviours and relationships to inform the design of appropriate and acceptable programmes to promote sexual and reproductive health. Such programmes and services need to be tailored to the contexts in which young people live, and to the health and education infrastructures that are already in place and/or that could be developed.

Whilst all young people may face difficulties in finding out what they need to know and do in order to minimise risks to their sexual health, certain groups of young people may be especially vulnerable. They include young refugees and asylum seekers, young people who sell sex and young people who inject drugs. Not only is it harder for them to obtain relevant information, they are also disadvantaged when it comes to accessing the resources and services they need. It has become increasingly clear that when young people are provided with accurate information about sexual health and are provided with appropriate resources to act on this information, the likelihood of acquiring an STI is reduced. This is particularly the case when policy programmes establish supportive environments in which young people's vulnerability to sexual health risks can be reduced.

During the early years of the HIV epidemic, prevention strategies focused largely on individual risk but paid little attention to the broader contexts influencing young people's lives and behaviours. More recently, as understanding of the epidemic has improved, it has become clear that a variety of influences impact on young people's sexual activities. These go beyond individual risk factors. They include the various contextual factors that make some young people more vulnerable than others to threats to their sexual well-being.

To date, research and programmes of relevance to young people's sexual and reproductive health have been relatively narrow in focus, ignoring many of these wider contextual factors. Typical research approaches have included studies of the epidemiology of STIs and HIV, KABP (knowledge, attitudes, beliefs, practices) surveys, and secondary analyses of Demographic and Health Surveys (DHS) data sets. Typical programmatic responses have focused on enhancing risk perception and promoting individual behaviour change.

Such work has been successful in identifying many of the demographic and socio-economic and other factors associated with young people's sexual behaviour and its consequences. It has led to a deeper understanding of areas that demand greater attention. However, it has often failed to reveal

[1]For example: Cairo International Conference on Population and Development, the Millennium Summit, 2001 UN General Assembly Special Session on HIV/AIDS, 2002 UN General Assembly Special Session on Children

much about the contexts and settings in which behaviour takes place, including the many factors that impact upon, and contribute to, sexual risk.

> The development and health of a young person is dependent not only upon the individual, but also upon the social environment that informs the decision making process. WHO Technical Report Series 886, Geneva, WHO, 1999

A number of approaches have been developed to enable a relatively speedy understanding of one or more aspects of sexual and reproductive health (originally, in the field of women's reproductive health and family planning). They include rapid epidemiological assessments, rapid assessment procedures, focused ethnographic studies and situation analyses. Furthermore, a range of approaches to the general field of policy analysis has been developed, with an emphasis on both health policy reform and on improving ways of involving local communities in planning health care delivery.

Each of these, and other related approaches, have contributed to an extension of the more traditional research paradigms, and many of them incorporate both qualitative and quantitative approaches as integral components. Their aim is to help develop a sound understanding of an area within a relatively short time frame, so that appropriate policy responses can be introduced. The emphasis of much of this work has been on the mainstream aspects of health structures, organisation and service provision (such as family planning), which may be of little relevance to the specific needs of young people.

> The gender inequities and differences that characterise social and economic life are reflected in the socialisation of young people and influence their health and development. WHO Technical Report Series 886, Geneva, WHO, 1999

Whilst each of these approaches has certain strengths, a dedicated form of systematic exploration is needed to examine the particular contexts in which young people's early sexual activity takes place.

Five key elements of context are:

- the political context including legal and policy issues of relevance to the health and education of young people
- the socio-economic context including demographic patterns, patterns of employment and unemployment, and educational opportunities
- the community context including cultural, religious and traditional influences on young people
- the interpersonal context in which young people live their lives and negotiate relationships, and
- the programmatic context in which responses to young people's sexual health needs take place.

The approach to Dynamic Contextual Analysis (DCA) described in this guide has been developed specifically to generate understandings about the importance of these contextual influences on young people's sexual and reproductive health, and to explore the interplay between them.

The following chapters consider current understandings about sexual and reproductive health and look in detail at how a DCA takes place and, in particular, how it maintains a focus on the contexts in which young people live and develop. They also provide guidance on reporting and disseminating the findings and recommendations of a DCA study.

The guidance offered here has been informed by a series of pilot DCA assessments carried out in Brazil, Kazakhstan, Mali, Mexico, Peru and Zimbabwe and also draws on a DfID sub-regional consultation held in South Africa in 2004.

Understanding sexual health

There have been many attempts at defining sexual health. These have evolved alongside increasing understanding of the wider political and social influences affecting sexual relationships. Many current definitions owe something to the WHO (1946)[1] overall definition of health, in particular in their focus away from disease processes and on well-being.

In the United Kingdom (UK), a recent government definition of sexual health points to the importance of access to information and services:

> *'Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life, and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.'*
> Department of Health 2001[2]

WHO's[3] most recent definition maintains a focus on well-being whilst at the same time referring to ways in which the risks of disease and disability related to sexual activities and reproduction can be minimised. It also recognises people's right to be free from harmful behaviours and practices:

> *'[Sexual health is] a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled'.*

Implied in these definitions of sexual health, is government and society's responsibility to create an enabling environment (through, for example, appropriate legislation, policies and services) in which healthy sexual development can take place. However, this responsibility is often not recognised nor made fully explicit.

In order to make a difference to young people's lives, conceptual definitions such as those above need to be linked to concrete actions to promote young people's sexual health. There is also a need for local and contextual influences on sexual health to find expression in future definitions. A 1987 WHO regional consultation on sexuality and sexual health concluded:

- there is variety and uniqueness in individual sexuality
- people have the right to be free from sexual exploitation and abuse
- sex education is needed and must reflect individual values, beliefs and feelings
- contextual factors such as culture, sexual preference and socio-economic factors impact on sexual health (WHO, 1987[4])

A further operational definition of sexual health is offered below. Developed as part of the DfID sub-regional consultation held in South Africa in 2004, it seeks to make explicit dimensions of sexual health relevant to young people and their circumstances.

An operational definition of sexual health

Sexuality and sexual development are life-long processes. Young people have the right to healthy sexual development as well as the responsibilities associated with that right. In this context, sexual and reproductive health encompass the following four rights:

[1]World Health Oganisation (1946) Official Records of the World Health Organisation. Geneva, WHO
[2]Department of Health (2001) The National Strategy for Sexual Health and HIV. London, Department of Health.
[3]http://www.who.int/reproductive-health/gender/sexual_health.html#1
[4]World Health Organisation Regional Office for Europe (1987) Concepts on Sexual Health: Report on a working group. Copenhagen, WHO.

1. Freedom to express one's own sexual preferences, feelings and practices in the absence of repression, coercion and sexual violence
2. Respect, equality and fulfilment in relationships
3. Protection from HIV, other STIs and unplanned pregnancies
4. Freedom to make responsible choices about if, and when, to have children.

Ultimately, it is the responsibility of society to create an enabling environment, through appropriate legislation, policies, education, and services, so that healthy sexual development takes place.

Inherent in the aspirations within this operational definition are a number of important inter-related themes. These are elaborated briefly below, together with some examples of how they might apply to young people.

Access to support and services

In order to protect their health and that of others, young people are entitled to access high quality and relevant sexual and reproductive health education and services. Good quality sex and relationships education has been shown to promote healthy development, delay pregnancy and prevent STIs (see, for example Kirby 1994[1]; 2001[2]). Young people who attend health services for sexual and reproductive health concerns should be treated with dignity, respect and confidentiality. Access to condoms is essential, as well as choices regarding contraceptive methods.

The disproportionate share of new HIV infections, pregnancy risks, unsafe abortions and other sexual and reproductive health problems faced by young people demonstrates the failure to make serious headway in ensuring that all young people can access good quality and accurate information and services. Sex, pregnancy and young people are sensitive issues. But they cannot be swept under the carpet; the consequence of doing this would be to deny young people the opportunity to flourish and fulfil their potential. Beyond ICPD + 5; Action on Reproductive Health, DfID, 2000

Quality of relationships

Good quality interpersonal relationships can be nurtured through appropriate forms of sex and relationships education and family support. In this way, sexual health amongst young people, with particular emphasis on mutuality and respect, can be promoted. All young people should be empowered to make informed, responsible decisions about their sexual lives, free from peer or cultural pressure, and to have the option to abstain or be sexually active, either with their chosen partners or through self stimulation. Through appropriate education, all young people should be freed from the harmful influence of sexual myths and misconceptions and should be helped towards the achievement of fulfilling sexual lives.

Coercive practices and norms

The quality of relationships varies and can range from mutual respect and equality to coercion and extreme violation. Government and civil society need to create and foster supportive environments by challenging cultural practices that deny young people respect and equality. Examples include taking away young women's dignity (for example, through virginity testing), endangering young men's health (for example, through medically unsafe circumcision) and

[1]Kirby, D., Short, L., Collins, J., Rugg, D. et al. (1994) 'School-based Programs to Reduce Sexual Risk Behaviours: A review of effectiveness.' Public Health Reports, 109(3): 339-361 and available through www.unesco.org/education/fresh

[2]Kirby, D. (2001) 'Emerging answers: research findings on programs to reduce teen pregnancy.' The National Campaign to Prevent Teen Pregnancy, Washington, USA

allowing sexual decisions to be made on the basis of unfair economic and emotional pressures. Rape and other forms of sexual violence are crimes whether they occur within or outside marriage and other relationships. Social norms that narrowly dictate what constitutes sexual beauty, attractiveness and acceptability also need to be challenged.

Acceptance of diversity

Integral to the concept of the right to express one's sexuality is freedom from harassment. In many cultures, young people who do not display a conventional pattern of heterosexual interest and relationships are subject to discrimination and rejection and, sometimes, abuse and violence. Of concern from a contextual point of view, is the extent to which such harassment is tolerated and condoned by those in authority, be these school authorities, policy makers, legal enforcers, or others. Similarly, discrimination can stem from society's attitudes toward the legality and acceptance of stable same-sex relationships. Such discrimination is not only a violation of individuals' rights to live without fear of abuse, but may also encourage unsafe sexual activity on the part of those being discriminated against.

Marriage

Young people have the right to decide if, when and whom to marry, as well as the right to enter into long-term committed relationships other than marriage or not to enter into long-term relationships at all. The four sexual and reproductive health rights listed in the operational definition are just as important within the context of marriage, including freedom from sexual coercion and violence, respect, equality and fulfilment within the marriage relationship, protection from HIV, other STIs and unplanned pregnancies, and the right to choose whether or not, and when, to have children without coercion.

Rights

The recent WHO definition and the operational definition used in this guide have their origins in a rights based approach to sexual and reproductive health. The importance of such an approach to health is increasingly recognised (see, for example, Petchesky, 2003[1]) and the notion of sexual rights as an essential component of sexual health was first included in a UN sponsored definition of sexual health in 2001[2]. Such an approach has the legitimacy of being founded in a more general acknowledgement of the importance of the human rights of individuals worldwide.

[1]Petchesky, R. P. (2003) Global Prescriptions: Gendering Health and Human Rights. London, Zed Books
[2]Pan American Health Organisation (2001) Promotion of Sexual Health. Proceedings of a Regional Consultation convened by PAHO, WHO in collaboration with the World Association for Sexology, Antigua, Guatemala.

What is a DCA?

A Dynamic Contextual Analysis offers a means of developing sound information about young people's sexual and reproductive health. It is an approach that pays attention to the multiplicity of contexts in which young people grow and develop, in which they learn about sexual health matters, and in which they engage in sexual activities.

DCAs aim to be respectful of young people and the circumstances and difficulties that many of them face. DCAs recognise the importance of the contribution to data gathering that young people themselves can make. The understandings gained through such an approach ensure that health and education programmes are effective in responding to the particular concerns of young people, and in promoting sexual and reproductive health.

DCAs make a significant contribution to the understanding of contextual influences on young people, and to identifying barriers to, and opportunities for, improving their sexual and reproductive health. A successfully completed DCA provides insights into the ways in which contextual influences interact, including the identification of gaps in policy, service provision and relevant information regarding sexual health and the extent to, and ways in which, existing policies are being implemented.

Crucially, DCAs aim to make use of existing information so as to reduce the time, effort and, therefore cost, of carrying out a study. This existing information is complemented with new data wherever these are relevant.

The main aims of a DCA are therefore to:

- consolidate what is known within a particular country/region/locality (or occasionally within a particular ethnic group) regarding young people's sexual and reproductive health;
- add to existing data by gathering new information, such that understandings are as sensitive as possible to young people's current concerns and to the contextual influences on their daily lives; and
- use insights gained to influence decisions about the development of sexual and reproductive health policies and programmes specifically for young people.

These aims can be achieved by bringing together insights drawn from different sectors of society, including the views of government officials, non-governmental organisations (NGOs), community and youth representatives, teachers, health care providers, parents and young people themselves. In each case, the contexts within which individuals are living and working constitute important information to consider alongside the views they express.

Barriers to improved sexual health outcomes among young people can be found at a variety of levels. At an individual level, there may be lack of knowledge about sexual and reproductive health, inappropriate attitudes to risk, poor self-esteem and economic dependence. In some communities, negative attitudes to the discussion of sexual health matters are found amongst parents and other gatekeepers. At an institutional level, legislative structures, attitudes of religious organisations, financial constraints and programmatic limitations all impact on young people's sexual lives, affecting what they can and cannot do. They are therefore key areas to explore within a DCA.

The nature and importance of these and other obstacles vary from context to context and, while barriers will always be encountered, opportunities for making a positive impact also exist. A DCA offers a particularly sensitive approach to exploring and understanding the opportunities and constraints associated with key contextual influences. As such, the findings of a DCA should be fundamental in contributing to policy and programme development.

DCAs move beyond reliance on a single research methodology. Important as they are, there are considerable pitfalls in developing programmes and services based solely on the findings of large-scale surveys or alternatively on detailed ethnographic studies conducted in one small community. The complexity of young people's lives and the contexts in which they gain understandings about sexual and reproductive health demand an in-depth and multi-method approach.

In a nutshell, a DCA:

- places emphasis on young people's perspectives, situations and circumstances;
- aims to capture the dynamism and change associated with young people's sexual socialisation in a rapidly globalising and evolving world;
- is respectful of young people's sexuality, sexual relationships and rights.

Underpinning the DCA approach is a recognition that the resources for conducting a fully comprehensive study of all the factors influencing young people's sexual and reproductive health are not available everywhere. Despite this, important progress can be made in more resource constrained contexts where there are groups of individuals with expertise and commitment to working collaboratively with, and on behalf of, young people.

Key contextual influences

DCAs combine a traditional focus on individual activity and beliefs with recognition that wider contextual factors impact upon young people's sexual and reproductive lives. In other words, whilst acknowledging that young people have varying desires, attitudes, knowledge, skills and abilities, a DCA explicitly recognises that there are, in all societies, forces that determine whether, how, when, with whom and where young people engage in sexual activity. The challenge for those conducting a DCA is to understand these various contextual elements, the interplay between them, and their influence on young people's lives. Only in this way do young people's actions become meaningful and ways of responding appropriately to their needs become clearer.

Studying individuals within their wider social context means that progress is made in not only understanding sexual activities, but also in identifying the barriers and constraints that inhibit potential improvements in physical and psychological outcomes, as well as identifying opportunities for change. People live in social and cultural contexts and are influenced by a range of ideas and material resources regarding sexuality and gender relations. They engage in sexual relations for different reasons with varying levels of volition, coercion and need.

For clarity, key contextual influences will be described separately, but in reality there is much interplay between them. For example, in some societies girls, in particular, may suffer sexual abuse at the hands of authority figures including teachers (community context) and it may be difficult, if not impossible, for them to do anything other than absent themselves from school. This disadvantages them both in terms of their education and their subsequent employment prospects (socio-economic consequences). The extent to which the media (community context) engage with young people and include items of relevance to their need for, and rights to, information about sexual activities and safe practices, in turn reflects the political context within which journalists and broadcasters operate.

Interplay and overlap between various elements of context are further complicated when (as is often the case) the contextual influences on young girls differ from those that impact on young boys. The involvement of young girls in decisions about relationships that lead to marriage may be, and often are, very different to that of young boys. Within marriage, young men usually retain greater sexual freedom than do their wives, and sexual relationships outside marriage are more frequently overlooked or encouraged for men than they are for women. At the same time, programmes may respond to such differences by paying more attention to the needs of young women and this, in turn, may disempower young men.

The political context

Young people's sexual and reproductive lives are influenced by legislation and policy decisions about their sexual behaviour. Such issues may, or may not, be seen as politically important by those in positions of power, despite the potential to positively influence young people's sexual health. Some governments also take the view that restricting young people's access to sexual health information, including information about ways of minimising risk, is an effective means of limiting their sexual activity.

> Sexual and reproductive health programmes (as administered by teachers) in schools hardly make reference to abortion, contraception and condom use '… because children should not know such things …'. Zimbabwe pilot DCA

Laws and policy frameworks also influence future opportunities and life chances. Policies and laws may reinforce inequities between young girls and young boys, particularly when sanctions are more stringent against girls as, for example, when a girl is excluded from school when she is pregnant but the boy involved is not.

Very often such legislative and policy concerns are seen as the responsibility of adults who may have little understanding of, or rapport with, young people themselves and may be poorly informed about sexual and reproductive health. Older people may operate with erroneous views about, for example, modes of transmission of STIs, may be unaware of sexual diversity and may be out of touch with the ways in which young people express their sexuality. Same-sex relationships remain illegal in some countries. Even when legislation appears to be liberal, traditional values and beliefs may maintain restrictions on young people.

> In terms of sexuality, Mexico is characterised from the legal and political standpoint by a lack of restrictions. The general population as a whole, however, has more traditional moral codes than are implied by the government actions. In the society there appears to be resistance to change and there is considerable conservatism in the sexual arena. Mexico pilot DCA

Despite the influence of laws and policies on their lives, young people are often unable to vote on, or be involved in debate about, the issues that concern them. For example, the age at which young people are legally entitled to leave school or engage in sex with someone of the same sex is rarely determined through consultation with young people themselves. This leaves some young people with feelings of ambiguity about who is responsible for their behaviour. However, when sexual and reproductive health is low on the political agenda, those keen to raise the importance of young people's sexual health may be active in a variety of ways. Sometimes such groups offer opportunities for young people's views to be heard.

The socio-economic context

In many developing countries, young people's socio-economic position restricts opportunities for them to be well informed and supported. In countries with a high prevalence of AIDS, young people may be infected with HIV or orphaned, and there may be many child-headed households. Such circumstances create considerable tensions for young people who are maturing and needing to take decisions about their own sexual relationships and sexual health. They may have to make choices that can be challenging for all young people, but that can be especially so against a background of socio-economic distress, sometimes exacerbated by personal sexual health problems or even family bereavement. Such young people are particularly vulnerable because their circumstances are likely to exclude them from mainstream social groupings and support, such as close family and older relatives, and they face responsibilities beyond the norm. If a young person is caring for other children, s/he may be absent from school and miss out on educational opportunities and peer support.

Young people who become parents at an early age are also vulnerable to social and economic disadvantage. For young girls in particular, pregnancy and motherhood may signal the end of formal education and to prospects of paid employment. There is evidence that good sexual health for girls is associated with school attendance and completion, in part through improved literacy and employment prospects (UNFPA, 2003[1]).

Inequalities in gender also render some young people more vulnerable to sexual health problems. In most societies, girls and boys experience different forms of socialisation even within the same

[1]UNFPA (2003) State of the World Population 2003: investing in adolescents' health and rights. New York: UNFPA

household. Young women are frequently regarded as of lower social status and are therefore more likely to be coerced into relationships over which they are unable to exert any control. There are more ambiguities in what are considered acceptable behaviours for young women, with many societies valuing submission to men's wishes whilst at the same time ostracising women who become infected with, for example, HIV. Globally, young women are numerically more affected by HIV/AIDS, especially in Africa, but are more often denied educational opportunities, including sex education, and/or they leave school at an earlier age than young men. They have more limited employment opportunities with available jobs paying a lower wage and so remain more susceptible to involvement in transactional sex and sexual coercion for money and/or gifts.

> But (sex) is also a tool to generate money and other material rewards and (in rural areas especially) a means for negotiating marriage. These are the aspects of (hetero) sexuality that are rarely talked about in public. Zimbabwe pilot DCA

Young men can also be disempowered by gender stereotypes and differences in physiology. Boys may be excluded from conversations about sexual activities and sexual health that take place between girls and older female relations or female family friends. The start of menstruation often provides an opportunity for discussion about relationships, sex and pregnancy with young girls, but no such obvious milestone exists for young boys. The higher status afforded to men in many societies can deter young men from asking for information or advice about sexual health matters for fear of being seen as lacking in knowledge and 'know-how'.

Other socially and economically disadvantaged and vulnerable groups include young immigrants and the children of migrant workers, young people from minority ethnic groups and 'street' children. Their access to education and health services is variable but usually less good than other young people and there may be language difficulties. They are more likely to be poor and poverty is linked to poor sexual health. Young people without adequate means of financial support need alternative sources of income and become more vulnerable to exploitation both in terms of employment and transactional and/or coercive sex. As developing countries take on more of the characteristics of the Western world, there may be an increasing number of environments in which sex work can take place, such as clubs and bars.

The community context

Young people live in communities in which cultural, religious and traditional influences are important motivators of behaviour for people of all ages. In many communities, the response to such influences varies between generations, and young people often feel particular tensions about activities they choose to engage in, and the way in which, for example, their parents would wish them to behave. Consumerism has become an additional challenge to traditional values, with young people's access to the global media changing their expectations and desires.

> To many young people, economic advantage, consumer products and the chance of a good future are more important than 'our ancestors'. Zimbabwe pilot DCA

Individual behaviour does not take place in isolation but is promoted, sanctioned, penalised or evaluated by adults whose actions affect young people's lives. Beliefs and practices influencing young people's sexual decision-making are reinforced by authority figures in the community, such as religious leaders, village elders, teachers and parents. These socially

powerful individuals often control the acquisition and transmission of sexual health knowledge by young people while reinforcing gender norms and other community standards.

In all societies, sexual activities are subject to moral constraint. For instance, sexual relations outside marriage are rarely explicitly encouraged; indeed, they are frequently condemned. In some places, regular sexual activity between married people is seen as important for good health, whereas in other places moderation is advocated. The proscription of sexual activities has many and varied implications particularly for young people. There are often powerful, traditional attitudes to contraception and abortion, mediated through church or other community leaders, although there may be adaptation of these by the lay population. Such traditional understandings affect young people directly and indirectly. They may deny them access to appropriate resources for contraception and, through their influence on others, hamper parents' ability to accurately respond to their needs for information about sexual and reproductive health matters.

In many societies, if young people do not take notice of the advice of authority figures such as parents, teachers and health care workers, they become subject to certain sanctions. These can range from disapproval, the withdrawal of privileges and freedoms, to physical force. Increasing exposure to a more liberal media and the activities of some NGOs pose challenges to the traditional influence of village elders and other adults in some countries.

Culture is a major influencing factor on young people's sexual health. Composed of values, norms and ideologies, culture reflects religious beliefs as well as social class and economic status. Cultural beliefs about sex, for example, can influence the development of sexual identity in young people and may encourage certain sexual health practices and discourage others. Some cultural practices are promoters of sexual health while others are barriers to it. In any one area, there may be intersecting, competing and complementary cultures and some may be more dominant than others.

Some impacts of culture on sexual health

- In cultures where respect for others is valued, there is more respect within sexual partnerships
- In cultures where young people are respected and listened to, they are more confident seeking advice and information about sexual health and in making informed choices
- In cultures where men are dominant, women are less able to make sexual health choices

Some cultural practices are ambiguous in terms of their capacity to promote or limit young people's sexual health. In some cultures, circumcision of boys is seen as an important contributor to sexual health through improved penile hygiene which is seen as protective against STIs, whilst others regard the practice as enforced mutilation with the potential to cause urethral strictures due to scar tissue and adhesions. Female genital mutilation (FGM) is also a controversial practice that in some societies is seen as essential for successful marriage but is associated both with immediate (e.g. pain, infection) and long-term (e.g. deformity, painful vaginal sex) health risks.

Local and national media play an increasing role in shaping and influencing young people's sexuality and sexual health knowledge. They provide an important source of sexual health information although what they provide may not always be accurate or contextually relevant. For instance, young people may develop their self-image in relation to what they read in magazine articles or newspapers, or what they see on television or at the cinema. Such sources of information are frequently set in, or derived from, contexts other than young people's own.

In many societies, religion and religious leaders are important influences on young people's sexual health and on their access to information and services. Religious influence may be positive when, for example, religious leaders encourage tolerance to sexual expression and sexual diversity or demonstrate understanding for those affected by HIV/AIDS by engaging in caring activities. However, some religious leaders reinforce stereotypical views about those who have contracted HIV, portraying them as reaping 'the rewards of promiscuity' or relationships outside marriage or with people of the same sex. Religious doctrine may also limit the availability of information and resources to young people that would assist them in minimising risk such as, for instance, the availability of condoms.

The campaign against the legislation of abortion and emergency contraception promoted by the Catholic Church has effectively reduced the strength of NGOs. Mexico pilot DCA

The interpersonal context

Young people live in an interpersonal context in which relationships are negotiated and renegotiated. They operate with certain expectations of the roles and relationships open to them. In most societies, the expectations young people have of adults differ from those they have of their peer group. Conflict is not unusual between different generations and sexual diversity is a particular area of challenge for older people brought up with limited views about sexual preference and about the ways in which sexual expression can take place.

Young people form relationships with a variety of others with greater or lesser degrees of influence on them. What has been considered the traditional pattern of family relationships, for example parents, siblings, aunts, uncles, cousins etc., is changing in many areas due to modernisation and the impact of HIV and AIDS. This has left some young people as heads of households at a time in their development when they would more usually have access to parental advice and care. Their relationships with younger siblings and with their peers are open to continual renegotiation as roles and responsibilities change.

Peer groups have an important role to play in defining the kinds of sexual behaviour that are expected of members…Sexual activity can gain one entry and acceptance into one group, and result in expulsion from another. Zimbabwe pilot DCA

In the same way that sexual diversity is not taken into account in the national policies, there is a lack of awareness of cultural diversity between urban and rural populations and between different ethnic groups. Programmes are homogeneous for the whole country and do not consider the multiple contexts of sexuality in different groups. Mexico pilot DCA

Youth subcultures exist all over the world and peer relationships are particularly influential determinants of sexual subjectivity and behaviour. While many such relationships are supportive of young people, a few may enhance vulnerability to sexual ill-health. Some youth subcultures may encourage belief in myths or involvement in drug and substance use, posing additional risks to young people's physical, mental and sexual health. In some youth groups there may be little equity, particularly between young women and young men or between those of different ethnic status. Such power relationships may encourage a lack of respect more generally for those who are less valued.

The programmatic context

Few societies have implemented comprehensive programmes to promote young people's sexual and reproductive health. That said, much is now known about how to promote safety, mutuality, respect and responsibility. Effective programmes to minimise sexual health risks range from small scale, individual counselling

to mass media campaigns. Most go beyond individual advice to engage with the contextual factors that either encourage or hinder young people's ability to act in certain ways. For example, advice to young women about how to minimise their risk of HIV is unlikely to be successful if the culture in which they live either denies them access to education and resources, or limits their ability to take any control in their relationships. In this kind of context, broad-based initiatives are needed alongside individual support to challenge gender inequalities and to promote more gender equitable norms.

Programmes for young people can incorporate mass media work, sex and relationships education classes in school, and group or individual discussions outside formal education settings. The issues addressed and the young people included will vary from one context to another. Even when suitable programmes do exist, some young people are more likely to be denied access than others. Those marginalised through poverty, low levels of literacy, ethnic status and homelessness find gaining entry especially difficult.

Sexual health services may be offered from a health centre or comparable setting, or may be available through designated outreach services. Outreach services are particularly valuable for contacting hard to reach young people such as injecting drug users or others who face stigma or harassment. Levels of service provision available for young people, the extent of education regarding relationships and sexual matters (both within the home and in school) and media coverage of sexual issues are all influenced by the contexts within which they are developed. Where cultural sanctions seek to keep young people ignorant of sexual knowledge, service providers face difficult challenges.

There is therefore an urgent need to increase education and prevention programming within the out of school context and across a variety of settings. Zimbabwe pilot DCA

Preparing to carry out a DCA

A DCA aims to improve understanding about young people's sexual lives and the contextual influences that shape them. In the area of sexual and reproductive health, young people are subject to many kinds of pressures including, on the one hand, encouragement to behave in certain ways and, on the other, sanctions against engaging in specific activities.

A DCA does not assume that every young person's experience is the same. Instead, it acknowledges that even within countries there may be significant differences between what happens in one particular area and another, and between different categories of people. There is therefore a need to explore, in a sensitive way, the different contextual influences and values that impact on young people's sexual and reproductive activities and health in a given locality. In this way, the development of programmes and services for young people can be tailored to their particular circumstances and concerns.

Those best equipped to carry out a DCA are people who already have knowledge of a particular culture but who remain open to the diversity and possible uniqueness of the data that might be gathered about it.

In this chapter, some of the steps needed to set up a DCA are described.

DCA team

A DCA team numbering between three and six people with experience in different areas of work with young people, including sexual health and HIV/AIDS work, is helpful. The skills, characteristics and values of individual workers are important and it is usually helpful to have both female and male personnel involved. In many situations, having team members who are indigenous to a particular area and therefore have appropriate language skills may be advantageous to ensure that data gathered are potentially more reliable.

Individuals with established access to, and contact with, local, national and international organisations can significantly enhance the strengths of a DCA team, notably in terms of raising funds, facilitating access to key individuals and groups, and mobilising support. Personal contact with influential people such as youth policy makers and practitioners is also of value.

Those who already have experience of working with young people and who are already involved in sexual and reproductive health work may be well suited to be included in the DCA team. Ideally, the team will also include people who have worked with a variety of research methods such as qualitative approaches and statistical methods. Some people may bring experience of research related to biomedical concerns and some may bring a more social science or health education slant. The richness of experience gained by recruiting a team from different backgrounds helps to ensure effective access to the breadth and depth of data required for a good quality study. Involving young people directly in aspects of the work helps to ensure that issues and concerns of importance to young people themselves are taken into account.

The sensitive nature of some of the data gathered, and the individuals who provide them, make it important that the people carrying out a DCA are up to the challenges of the work. They need to adopt an approach that is non-threatening to, and supportive of, informants and that reassures them about confidentiality.

Additionally, DCA team members need to accept the diversity of views, practices and concerns that come to light. They will have to evaluate individual evidence in the knowledge that personal accounts are influenced by a number of factors including memory and context and, sometimes, by a desire to

please or to shock. A careful and sensitive study produces a sound analysis and unbiased mapping of the different contexts influencing young people's sexual behaviour and their responses to them.

Respecting confidentiality

Confidentiality is a right for all young people. If respondents are confident that confidentiality will be respected, they are more likely to:

- talk about sensitive issues, such as sexual activities, HIV
- talk about activities that are sanctioned or proscribed
- talk about concerns related to authority figures/organisations
- access health services
- report situations of coercion or force
- put members of a DCA team in touch with other young people

Gaining support

Each DCA is different, and the time required to carry out the work is likely to vary but is usually between three and six months. Before beginning, it is important to identify appropriate sources of support. Support takes many forms and includes agreement for the team to have dedicated time for the work. Whenever possible, teams should seek to gain support for planned activities locally, nationally and internationally. The team may need permission to contact certain groups and organisations. In most situations, it will need individuals, including young people themselves, to consent to give information.

Consent[1]

Because sex, sexuality and sexual relationships are sensitive and potentially stigmatising topics, talking about them openly raises a number of ethical as well as practical concerns.

It is vital that informed consent is gained from respondents.

In order to achieve this, the purpose of the study should be explained in a way that is understandable. The likely benefits and any possible harms should be discussed. A respondent's understanding should be checked at the beginning of the study. Furthermore, all questions asked before and during the study should be answered honestly.

When working with young people, particular efforts may need to be made to ensure they understand the adults' phrases and terms. In addition, and in some communities, the consent of parents may need to be sought.

Every respondent has the right not to take part. This right extends throughout the work, including the right to withdraw from the study at any time after it has commenced, without explanation. Not taking part can mean either complete withdrawal, or the decision not to answer one or more questions.

[1]Warwick, I. and Aggleton, P. (2001) Learning from what young people say…about sex, relationships and health. Southampton, University of Southampton Safe Passages to Adulthood Programme.

The best means of gaining access to individuals, groups and organisations is through communication and negotiation with key people and gatekeepers. Often, an advisory group to the DCA team can be helpful in facilitating access. Previous good relationships between team members and officials from government and non-governmental organisations make gaining access easier.

Dedicated financial support is likely to be necessary in order to carry out a DCA. Whilst there may be only limited funds available in the area to be studied, it may be possible to encourage local NGOs and businesses, for example, to support the research. The number of employable young people in some areas is seriously threatened by high levels of AIDS, and local businesses and community groups may value funding work that aims to improve the sexual and reproductive health of young people.

Time planning

Whilst support is being gained and access to individuals and groups negotiated, drawing up a time line for the projected work is useful. A time line that indicates the various stages of the study and their likely duration can provide a helpful guide for the team and offers a visual plan and time scale to those from whom support is being sought. Some teams may find it useful to add to the plan each team member's particular responsibilities.

Table 1 provides an example of a time line for a six month study illustrating the kinds of activities likely to take place and their planned duration.

Table 1
Example of a DCA time line for a six month study

Activities	Month 1	2	3	4	5	6
1 Review relevant literature (academic, legal, political, statistical, journals and media)	■	■	■			
2 Review legislation related to young people's sexual and reproductive health	■	■				
3 Identify key individuals (including young people) and organisations for interview and group discussions (local, national, international)	■	■	■			
4 Prepare questionnaires /interview schedules			■			
5 Carry out interviews and group discussions			■	■	■	
6 Transcribe interviews Analyse data from interviews and group discussions			■	■	■	
7 Analyse and synthesise data					■	■
8 Prepare report(s)					■	■
9 Disseminate findings						■

Note: Shaded cells represent allocated time

Carrying out a DCA (1) - using existing information

There are three major elements to a DCA: collecting existing data; collecting new data; and bringing the data sets together to make sense of the different contextual influences impacting upon young people's sexual and reproductive health.

This chapter offers guidance on collecting and evaluating existing information. The aim is to explore existing data to paint an overall picture of the circumstances in which young people live and in which they make decisions and act in relation to their sexual and reproductive health. This includes developing understandings about the problems young people face and the influence of factors such as where they live, what age they are and their ethnic background.

Existing data, from both formal and informal sources, may be in the form of documents about, for example, health and educational strategies, policies related to service provision and large and small scale studies carried out by other workers in the field. In most countries and in many regions, there will also be data about demographic structures and information about illness and disease patterns.

Accessing relevant documents will be helped by good relationships with gatekeepers and can be influenced by their prevailing view about young people in general, and the value of work on young people's sexual and reproductive health in particular. Some of the difficulties that might be encountered include:

- key people not being available at all, or not at the right time;
- sexual and reproductive health being seen as unimportant; and
- access to existing data being restricted (possibly due to suspicion about the research itself).

Quantitative methods, such as surveys, are valuable for measuring the prevalence of knowledge, attitudes, beliefs, and practices, as well as for exploring the relationships among variables. However, while providing important background information, numerical data alone usually reveal very little about more sensitive issues associated with sexual and reproductive health. By contrast, good qualitative research allows a richness and depth of analysis often not available in quantitative enquiry. Comparability between different numerical data sets may also be difficult to establish when definitions (of sexual activities, for instance) are unclear. In some circumstances, for example, sensitive data such as those on patterns of contraceptive use may be gathered from all sexually active young people, whereas other official figures may only include married young people.

However, many of the data gathered at this stage in a DCA are likely to be quantitative in nature and may be predominantly of the survey type. While professional quantitative researchers spend many years honing their skills, DCA teams will need to evaluate existing survey studies by asking a number of simple but pertinent questions. The evaluation will be enhanced when the person carrying it out has knowledge and expertise about the subject of the study.

Below are some example questions that someone involved in a DCA study might ask about surveys.

Evaluating surveys

1. Who paid for and conducted the survey? If the sponsors or researchers have a financial or ideological interest in the outcome of the survey, their conscious or subconscious biases may influence the survey design, implementation, data analysis, and/or interpretation of results.

2. When was the survey conducted? A study conducted several years ago may not be relevant to current conditions. DCA team members will need to be familiar with local circumstances to decide on the value of research that is not very recent.

3. Where was the survey conducted? The results of a national survey may not apply to a local region populated by an ethnic minority group, or groups, who might have different sexual traditions and taboos.

4. Who were the survey participants and how were they selected? A survey of students misses young people who have dropped out of school. If the students were selected for the survey by the school principal or were volunteers, they may not have the same sexual behaviours as the general student population.

5. What was the participation rate? People who decline to participate in surveys often differ in significant ways from those who agree to participate. Their views may be of equal if not more importance than those who take part. The lower the participation rate, the more likely non-participation could bias the results. Be wary of surveys with low participation rates as well as surveys that do not report participation rates.

6. Under what circumstances was the questionnaire administered to the survey participants? Interviews with young people at home, in the presence of their parents, may not yield valid estimates of sexual behaviour. Young women may not give honest answers to questions about sexual behaviour if interviewed by a mature man.

7. What was the wording and sequence of questions? Local terms that young people understand should be used in the wording of questions. For example, in Nicaragua the popular term for genital warts is crista de galo. The results of a survey that asks have you ever had genital warts, will be very different from one that asks have you ever had cristo de galo. Furthermore, young people are more likely to be honest about sexual matters after the interviewer has gained their trust. If the first question asked by an interviewer is, "How many times in the last three months have you had sexual intercourse," the answer given by the young person may be less than truthful.

8. Are there reasons to believe that the survey participants would not answer the questions truthfully? Young men living in a culture in which they are expected to have many sexual "conquests" may over-state their sexual experience and vice versa.

9. Could variables not considered in the analysis explain the results? A survey may find that young people who smoke cigarettes are more likely than non-smokers to engage in risky sexual behaviour. This does not necessarily mean that smoking causes risky behaviour. Smokers are generally more likely than non-smokers to use alcohol and illicit drugs and these may influence sexual risk-taking.

10. To what degree were the results influenced by chance? In a survey, a sample is selected from a population to make inferences about that population. Surveys are subject to chance variability – the smaller the sample size, the larger the uncertainty in the inference. Conversely, the larger the sample size, the less likely the results occurred by chance.

Similarly, there are questions to ask about qualitative studies. Below are some examples.

Evaluating qualitative studies

- How typical were the samples?
- How complete were the data (especially with respect to depth of data)?
- Were the data gathered in settings where participants usually live and/or work?
- How close did the study get to the understandings of those involved?
- How much note was taken of the context within which the data were gathered?
- Were the data accurately recorded and transcribed? Were suitable checks made for translation and back-translation? (Some studies and analyses may benefit from checking data and interpretations with original participants.)
- Were the data searched for competing explanations e.g. deviant case analysis?
- To what degree did the study move from description to analysis?
- Was there a system for assessing inter-researcher reliability?
- Does the study report include some reflection about possible influences/biases?

The political context

A DCA team will find it useful to identify and examine the substance of official policies, laws, and regulations that influence young people's sexual and reproductive health, as well as evidence about how effectively such laws and regulations operate. Examples include legislation pertaining to children's rights, the legal age of consent and marriage, contraceptive use, abortion and same-sex relations.

While many different kinds of data concerning political influences on young people's lives are likely to exist, the initial task is to identify and obtain copies or sight of relevant documents. To do this, access will be needed to government officials, universities and libraries in order to obtain relevant academic, political, legal and statistical material. The search for material should be driven by the focus of the DCA. For example, if the goal of the work is to develop better sexual and reproductive health programmes for young women who have sex with women, then particular attention will be paid to legislation and policies about same-sex relationships, and to women's rights. Alternatively, if the focus is on sex and relationships education in schools, the search for material will look especially at national policies and guidance to teachers about the curriculum and at the content and resources of any dedicated training programmes.

Sometimes contradictions may be discovered between official policies and local actions. For example, non-attendance at school may be overlooked in some rural communities where the economic contribution of young people to agricultural work is seen as essential. Here, as with other data, it may be important to ascertain why variation exists (the reasons may be political, economic or logistical), and what the sexual health consequences (both positive and negative) for young people are likely to be.

Efforts need to be made to find out the extent to which relevant laws are enforced, and, if they are, how this is done and what the penalties are for non-compliance. It may be helpful to find out about the budgets that enable laws and policies to be implemented.

DCA teams are also likely to want to trace the development of policies over time and find out what future changes are planned. In particular, efforts will need to be made to identify key factors, and sometimes key people, influencing policy development and changes in the law with

regard to young people's sexual and reproductive health. Sometimes, detailed information about policy development can be found in workshop and meeting minutes and reports that have focused particularly on young people's sexual and reproductive health. Sometimes, public opinion may have created pressure for change.

Concerns over sexual abuse, particularly when it occurs within the family, has begun recently to be reflected in Peruvian law and in programmes designed to tackle the issue. Peru pilot DCA

Important sources of data on laws, policies and regulations are the local Ministry of Health and the Ministry of Education. Information obtained from a Ministry of Health might include:

- policies related to young people's sexual and reproductive health;
- relevant service provision and the availability of treatments for STIs;
- legal age for first intercourse and marriage;
- laws regarding homosexuality, prostitution and abortion;
- policies and laws related to female genital mutilation (where relevant); and
- staff training for work associated with young people and sexual and reproductive health issues.

Information obtained from a Ministry of Education might include:

- whether or not sex and relationships education takes place in schools;
- the context within which sex and relationships education in schools takes place (e.g. whether or not it has an emphasis on family life);
- the status and content of sex and relationships education and the ages at which it is provided;
- national directives affecting the curriculum and the extent of local influence;
- consultation about sex and relationships education with young people, parents and teachers;
- specialist teacher training for sex and relationships education;
- barriers to sex and relationships education;
- the monitoring of programmes of sex and relationships education and evaluation of outcomes; and
- policies with respect to school age pregnancy, school attendance and teacher/pupil relationships.

Other important government departments to consult include ministries of youth, ministries of labour, ministries of culture and sport, ministries of women and/or ministries of justice.

Each may be able to provide information on the political, economic and social climate within which young people are growing up, and its potential impact on sexual and reproductive health and behaviour.

Of particular significance in this respect are recent, or current, political developments relevant to social, educational or health activities and policies. Some of these may signal positive changes for young people. For example, in several countries, major transformations in the size and scope of the media have enhanced opportunities for young people to be more aware of sexual health issues.

The socio-economic context

Gaining access to a full range of sources relevant to the socio-economic context in which young people grow up and develop can be difficult and time consuming. In some countries or regions, there may be only limited data available on factors such as the demographic and reproductive health

characteristics of young people, particularly if culture and tradition mean that certain groups of young people are 'missed' when, for example, data are collected from those attending school, or when terms such as 'sexual activity' are narrowly defined.

In rural areas girls not infrequently left school to work on the fields. Zimbabwe pilot DCA

Information regarding the sexual activity of young people in Kazakhstan remains sparse and where it does exist consists mainly of data pertaining to first penetrative intercourse. Kazakhstan pilot DCA

Available descriptive data about the area under study may be found in censuses and surveys. These may provide information about, for example, overall population numbers, density and geographical spread, together with current and projected rates of youth mortality, morbidity, fertility and marriage. Data may also be available on sexual and reproductive health indicators such as contraceptive use and abortion rates. Most countries have carried out a Demographic and Health Survey, although the lower age limit of those included in some surveys restricts their direct applicability to young people. Similarly, the value of existing data may be difficult to determine when they concern illegal, proscribed or taboo activities.

Actual numbers of abortions occurring in the country are difficult to determine due to the incidence of illegal and private abortions (privateers can perform mini-abortions for a fee) being omitted from official counts. Kazakhstan pilot DCA

The real incidence of abortion-related death is unknown because many cases never arrive at hospital. Peru pilot DCA

Other sources of socio-economic data include sociological, anthropological and ethnographic accounts that may add value to the largely quantitative data described above. Gathering information of this kind during a DCA is vital if the team's subsequent analysis is to move beyond simple description. Valuable information may be located in the archives of academic institutions and in national libraries.

Individual researchers may also be able to supply useful data from their own published or unpublished work. Often contact with one individual will facilitate access to other informants. Particular topics to be explored include:

- the changing biological and social context of sexual behaviour - for example, with particular reference to attitudes to pre-marital sexual activity; changes in the extent and acceptability of pre-marital sexual activity over time; young people's sources of information about sexuality and sexual behaviour.
- gender – for example, with particular reference to the place and status of women; the impact of this on girls' ability to make choices about relationships and sexual activity; their education and health opportunities compared with boys.
- same-sex relationships – for example, with particular reference to social and cultural responses to same-sex relationships and the organisation and support of those in homosexual and lesbian relationships.

Despite the political will existing at the highest levels to improve women's position, in reality there is still a long way to go. Improvements in reproductive health cannot occur so long as there are inequalities in gender relations and opportunities. Mali pilot DCA

In particular, there has been a rapid decline in the importance of virginity upon marriage for girls in urban areas. Mali pilot DCA

Special attention will need to be paid to the social dimensions of sexual and reproductive behaviour among young people from different ethnic groups or different social classes. In addition to gender variations, there may be differences according to where young people live, and their degree of contact with people who are active in condoning, sanctioning or encouraging particular sexual behaviours.

The community context

Beyond official laws and regulations affecting young people's sexual and reproductive health, there are other, less formal, sources of influence. Accessing information about the policies and strategies adopted by NGOs, community and religious groups necessitates rather different data gathering techniques from those cited above. While there may be some documented data, much information is likely to come through contact with a range of key informants and individuals.

There are challenges for a DCA team when trying to assess the cultural and community contexts in which young people live. It is not easy to access the determinants of a given culture, the factors that cause cultures to change, or the impacts that cultures have. Team members who are indigenous to the area of study may be able to comment more authoritatively on what they perceive as existing cultural aspects. Conversely, however, they may find it difficult to look beyond conventional frames of reference to be surprised by the diversity that may exist within their own culture and community.

Two key concerns are relevant to most DCAs:

- sexuality – with particular reference to meanings ascribed to intercourse and motivations for sexual activity; the factors guiding sexual decision-making and perceptions of risk; rape, pain and violence; 'rights' to intercourse and the 'right' to say 'no'; cultural perceptions of sexual pleasure and autonomy.
- sexual behaviour – with particular reference to sexual norms and expectations for young men and women; the groups or individuals who uphold, set or sanction standards of sexual behaviour associated with health risk (such as multiple partners or early intercourse).

Among the Ndebele people, it is still commonly understood that a man marries to have a child. In this kind of context, girls and young women may engage in premarital sex in trying to demonstrate their fertility. Zimbabwe pilot DCA

DCA teams are also likely to visit NGOs and other groups in order to identify patterns of service provision and civil society priorities related to young people's sexual and reproductive health. Using this and more 'official' sources of information, the relationships between the work of government and non-governmental organisations can be explored to see how far their policies and activities complement and support each other or, alternatively, where they are at odds.

One aim can be to establish whether NGOs fill gaps in sexual health provision and, if so, what the gaps are. The particular characteristics of the populations targeted by the various organisations

may be relevant to ascertain whether certain groups are more or less likely to gain access to government or non-government services. For example, interviews with NGO representatives may highlight that school-based courses on sexual and reproductive health fail to adequately take account of the ethnic and cultural backgrounds of the young people for whom they are provided.

A DCA team may also seek information about the provision of information and help for those groups of young people known to be especially vulnerable and marginalised. Some individuals or groups may be excluded from all sources of help.

All too frequently, policies are developed in central government offices, by consultants following guidelines derived from resolutions from international meetings, without adequate appreciation of young people's sexual and cultural realities and diversities. Zimbabwe pilot DCA

Local NGOs can play a significant role in determining young people's access to services and in encouraging behaviour change and better sexual health outcomes. While local NGOs may have a lower profile and smaller budget than some of their international counterparts, they may have objectives that are more socially and culturally appropriate, and therefore have more of an impact on sexual and reproductive health.

A DCA is also likely to assess the quality of NGOs' own evaluations of the impact of their activities. The rigour with which these have been conducted may vary, together with individual organisations' overall commitment to the need for evaluation. It is key, therefore, to determine whether systematic evaluation activities form part of NGO programmes and whether or not significant biases exist in their evaluation methodologies or programme priorities.

A general problem is the lack of a culture of evaluation making it difficult to correct the course of policies and activities. Mexico pilot DCA

A DCA is also likely to explore the role of community gatekeepers, with particular reference to traditional routes of sex education (initiation ceremonies/schools), and the degree to which they persist. Some gatekeepers may encourage or support high risk practices (such as multiple sexual partners; sexual initiation with sex workers) and family gatekeepers may restrict young people's freedom to enter into relationships of their choice and may monitor sanctioned relationships. For instance, older female family members, such as grandmothers and aunts (and sometimes mothers), may be involved in establishing a young girl's virginity both by physically examining young women and by preparing and then inspecting the marital bed.

Virginity testing is a violation of a young girl's privacy. It is expected that mothers will be involved but this sets up all sorts of tensions. There is nothing really similar to it for young boys. DCA consultation in South Africa.

Whenever possible, a DCA should incorporate an analysis of newspaper and magazine articles related to young people's sexuality and sexual behaviour, and/or to perceptions of young people more generally. Articles offering sexual health information and/or advice are helpful in understanding the broader cultural and community context in which young people live, and the kinds of advice publicly available to them. Reviews of magazine problem pages that focus on young people and their sexual and/or reproductive health issues, can add to the information available. Critical accounts of similar presentations on television or in radio broadcasts may also be useful.

The interpersonal context

Finding relevant existing information about the interpersonal context in which young people grow and develop may prove a particular challenge to a DCA team, both because of the often intimate and sensitive nature of the information and because roles and relationships adapt more rapidly to changing circumstances than do, say, laws or traditions. This is an area that particularly lends itself to the gathering of new and up to date data through less formal channels of enquiry (see chapter 7).

However, there will usually be some useful data available including statistics on relevant concerns such as sexual preference, domestic violence and sexual abuse. Health workers in various service provisions and NGO officials, for example, may keep records of the numbers of young people they see who report incidents of abuse or violence. There may also be information about the numbers, and age and gender characteristics, of young people involved in youth subcultures, together with data about sanctioned and encouraged activities within the groups.

Teachers and youth workers may also have information about the role of peer groups in the maturation and development of young people. For instance, they may be able to cite examples of how information about sexual health is transmitted to both young men and young women by their peers. They may also be able to provide information about whether or not characteristics that foster good interpersonal relationships are promoted in the work they do. For example, they may have strategies and policies that demonstrate the importance of mutuality and respect in their contact with young people. Some may have conducted their own small scale studies to evaluate the effect of such activities.

The programmatic context

Finally, a DCA team will want to pay particular attention to existing programmes and services for young people. These will vary from one setting to another but there remain some common concerns applicable to many circumstances. Table 2 identifies some of the key questions to ask about the characteristics of existing programmes, about the settings in which they take place and about the focus of the work they do. A DCA team will want to tailor, and add to, such questions according to local circumstances and the particular focus of study.

Table 2: Policies and programmes – suggested example questions

Characteristics of young people's sexual and reproductive health programmes	Are the targeted groups young men and/or young women? What ages of young people does the programme include? Is the programme for married and/or unmarried young people? Does the programme operate in urban and/or rural areas? What are the key elements of the programme? Does it provide information, education and /or communication training? Does it offer service provision? How is the programme being implemented (through schools, health services, peer education, youth associations)? Has the programme been evaluated and, if so, when and by whom? What was the focus of the evaluation? What were the results? What was the quality of the evaluation? Were young people involved? How and by whom is the programme funded? Does the source of funding have any influence on policy or programme content and delivery? Does the programme operate in collaboration with, or separately from, government health services? What is the nature of any collaboration? Are costs shared? How are staff selected, trained and supported? Are young people involved in managing and/or evaluating programmes?
Setting: in school	What are the organisation's policies/views about school attendance, education for girls, sex and relationships education in schools? Do their programmes include activities related to education for girls and young women, education for vulnerable and marginalised groups? Do their programmes reflect national or NGO school sex education curricula?
Setting: out of school	What provision is there for out of school activities? Do these activities reach those children and young people not attending school, including young people heading up households? What efforts are made to include hard to reach young people and how successful are they? Is provision made to include orphaned young people?
Setting: health services	Where is the service located? What are its opening hours? Is the location welcoming to all young people? What are the organisations policies/views about confidentiality? What provision is made to ensure that guidelines about confidentiality are followed? How do young people get to know about the services available? Does such information reach those who are most vulnerable and marginalised? Are young people given the opportunity to comment, in confidence, on the service provided?
Focus: sexual behaviour	What are the organisations policies/views about sex between unmarried people, same-sex relationships, sex work?
Focus: adulthood and marriage	What are the organisation's policies/views about age at first marriage, early marriage, forced marriage, polygamous and leviratic marriage? Do their programmes address issues associated with female genital mutilation and male circumcision?
Focus: contraceptive use	What are the organisation's policies/views about providing contraceptives for those under a particular age, for those who are unmarried, for young men? What kinds of service are provided? Which types of contraceptive are available and promoted? Are contraceptive users offered any follow-up? Does tracking of users take place? Is there a pricing policy and, if so, how does it operate?
Focus: abortion	What are the organisation's policies/views about abortion, abortion after rape, abortion when the mother's health is at serious risk? Does abortion form part of their reproductive health service? What forms of abortion (if any) are available? Is there provision for support before and after abortion?
Focus: sexual violence	What are the organisations policies/views about sexual violence and do their programmes include activities to support young women at risk of, or subjected to, violence? Do their programmes work with young men to challenge violent behaviour patterns?
Focus: sexually transmitted infections and HIV	What are the organisations policies/views about support and treatment for those with a sexually transmitted infection? What kind of services and treatments are provided? Does contact tracing take place? Is confidentiality assured for service users?

Carrying out a DCA (2) – gathering new information

Adding to existing data involves gathering new information from sources not previously accessed. These can include young people themselves and can take in those who are particularly vulnerable or hard to reach. Other people of importance include adults working with young people, and key informants such as youth workers, night club managers and NGO workers.

Much of the data gathered at this stage in a DCA will be qualitative in nature. A number of approaches to data gathering are possible, but it is likely that interviews, focus group discussions and observation will be the techniques most often used. Interviews, in particular, can provide a DCA team with opportunities to verify existing data about young people's sexual health and to gain an up to date understanding of their lives and their responses to the contextual influences impacting on them.

The importance of gaining an understanding of the five key contextual elements continues during the gathering of new information. This stage of a DCA should enable the team to learn more about the relative impact of each context on young people's sexual and reproductive health.

Throughout, the team is likely to be searching for information to confirm or challenge what has already been learned, but should also remain alert to completely new or unusual findings.

Observation

Much can be learned by observing settings and facilities and by seeing how interactions take place between young people themselves and others. For example, when visiting a health clinic, note can be taken of the accessibility and appropriateness of the location and the relationship and atmosphere between health workers and young people.

Judgements can then be made about how welcoming to young people a clinic seems, how user-friendly and relevant displays and information leaflets are, and how the approach of the staff affects the young people attending. Observation can also help identify some of the characteristics of the young people, such as their age and gender and how at ease they seem in the clinic setting. Observation may also identify those groups of young people who are excluded from a particular service or project.

> On the whole, the areas where the health services were provided tended to be small, not very comfortable, poorly lit and ventilated, inadequately furnished, and the walls were plastered with posters and information about programmes dealing with the problems of other target groups, or that of other programmes with which they shared the space. Peru pilot DCA

For clarity and to save time, the observations conducted as part of a DCA can be carried out using a checklist. When visiting a health centre, for example, the following might be noted:

- the location and type of buildings
- accessibility of location
- age and gender of young people attending
- cleanliness of centre
- atmosphere and general ambience
- lighting
- sources of water
- presence/absence of posters and leaflets and relevance of content

In schools and during sex and relationship education classes, for example, the following might be noted:

- who is teaching – role in school; gender; age; knowledge base; at ease or not with subject matter; health workers involved or not
- age and sex of pupils
- topics discussed – relevance; knowledge, skills and/or values; appropriateness to age/gender group; up to date or out-dated information
- teaching methods – didactic or interactive; pupil involvement or not
- materials used
- nature of language - formal/informal/slang
- student behaviour - e.g. attentive, laughing, disruptive

In most schools, sexual health education is limited to a lesson on the biology of human reproduction assigned by the national curriculum. Like most teaching in Malian schools, this is done by dictation with very little teacher-student interaction. In addition, most teachers are male and probably unable or unwilling to address specific sexual health questions among young girls. Mali pilot DCA

Interviews and focus group discussions

Interviews can be conducted on a one-to-one basis and with small groups. The overall number of interviews carried out during a DCA will depend on the resources available and on the degree of ethnic, religious, cultural or regional diversity in the area or community being studied. The greater the diversity, the more interviews will be needed to gain a sufficient understanding of the influence of contextual factors on different groups.

Some sexual health workers have found that young men in particular may prefer to be interviewed in small groups but that young women may be more open, and able to talk about sensitive issues, in one-to-one settings. With individuals or small groups, a DCA interviewer needs to be as non-judgmental as possible to encourage young people to talk freely.

Focus groups can be helpful when a specific area of concern requires further exploration. For instance, a DCA team may want to find out how young people evaluate a new radio programme about sexual health matters. A small group of young men and women, known to have heard the programme, may be brought together to discuss their views.

Interviews can also be used to investigate how health and education policies and programmes operate in practice. Groups accessed may include:

- officials from government ministries;
- key personnel from NGOs and from community groups, including staff putting programmes into practice;
- local health and education staff;
- young people.

Most important, they (health personnel) need to separate personal experiences and ideologies from professional obligations in delivering services to young people. Zimbabwe pilot DCA

In Bore, the matronne responsible for all family planning provision and STI identifications and treatment had not been retrained since "the time of Moussa " (ie before the presidential rule of Moussa Traore before the coup d'Etat in 1992). … her knowledge of contraceptive side-effects was extremely limited and … her knowledge of STIs was extremely sketchy – for example, she asked if syphilis was an STI or not. Mali pilot DCA

Gathering new and up to date information allows a DCA team to identify gaps between the ways in

which programmes are officially implemented and what happens in practice. In addition, it offers the chance to explore the reasons behind such discrepancies.

Even if the country has a tradition of decades of work on sexual and reproductive health through NGOs, most of the interviewed organisations referred to obstacles for the operation of their programmes. Mexico pilot DCA

It is generally best to interview officials from different organisations on their own. Consent should be obtained not only to the interview but also to the method of recording the data. Keeping accurate notes, and sometimes recording speech verbatim, or using a tape recorder, can help ensure that data are complete and meaningful. The use of direct quotes can enliven a DCA report.

Even the peer educators themselves admitted to not being totally convinced as to the existence of the illness. In our discussions, they said one of their collective wishes was "to see someone who had AIDS" just to be able to prove to themselves that it existed. Mali pilot DCA

In health centres, group discussions and interviews can be carried out with staff working at different levels and in different capacities, as well as with young people accessing the service. In schools, focus groups and interviews may take place with teachers, members of the governing body and/or parent-teacher association and young people. Attention should be paid to discrepancies between the responses of those in authority and those of the young people themselves, and efforts made to understand what is really happening.

Interviews are key to gathering information from young people but carrying them out successfully can present a number of challenges both in terms of whom to interview and how the conversation should take place. For example, leaders of young people's groups may not reflect the perspectives of all the young people they claim to represent. A group's chosen or elected leader is often better educated, or wealthier, than those who elected him or her. Young people who offer to be interviewed are sometimes more confident and articulate than those who appear reluctant to take part. Vulnerable young people are not readily accessible but a DCA team may need to hear their views and concerns to reflect the diversity of opinions among a country's or region's young people.

Young people who move from the rural areas in search of work, being faced with the lack of employment opportunities in the urban centres, may join the underground economy exposing themselves to the risk of abuse, HIV, STIs, and unwanted pregnancy. Kazakhstan pilot DCA

Given the limited time usually available for a DCA, interviewees will need to be selected purposively. It is relatively easy to identify those individuals from recognised organisations who are most suitable to be key informants. Such people are often gatekeepers to information, or the people mainly responsible for policies or programmes. Sometimes, individuals may be put forward for interview by others, and their contribution has to be carefully evaluated. A head teacher, for example, might select pupils seen as good advertisements for the school or who will give 'correct' answers to the interviewer's questions.

Inviting people for interview and setting the tone for the dialogue that might take place is an important step in gathering useful, in-depth information. The suggestions in the following text box were developed as part of the DCA sub-regional consultation in South Africa and reflect direct experience of trying to gain access to young people's views.

Drawing up an invitation

- seek voluntary participation
- explain consent and confidentiality
- use young people's own language and mode of address
- demonstrate knowledge of, and sensitivity to, young people's experiences and concerns
- identify areas for discussion that are relevant
- identify safe, neutral setting where confidentiality is guaranteed
- explain options for record taking
- consider how to access marginalised, vulnerable and/ or illiterate young people

The text boxes that follow highlight some of the issues that need to be responded to when interviewing young people who live in very different circumstances and are subject to a variety of contextual influences.

Remember, young people

- do not form an homogenous group e.g. different genders, ages, levels of maturity, access to resources
- may live alone; with one or more other young people; in own family; as orphans in a ' new' family
- may be caring for younger sibs/orphans
- may be non-attenders at school; in school; in employment; unemployed; in trouble with authority figures
- may be sexually active; not sexually active; married; not married; in a same-sex relationship
- may be illiterate

DCA consultation in South Africa

Talking to young people about sexual health

- show respect; be non-judgemental; ensure confidentiality
- offer choice of male/female interviewer
- consider value of one-to-one versus small group
- allow sufficient time
- gain trust and confidence; consider appropriate dress code
- ice-breakers useful
- offer refreshments
- listen; avoid completing sentences for interviewee; avoid 'taking over'
- have strategies to encourage discussion e.g. case studies; role play; use of personal experience
- use of 'what if' scenarios or imaginary 'agony aunt' letters
- be prepared to introduce particularly sensitive topics yourself
- be open-minded

DCA consultation in South Africa

The topics included in an interview with young people will be determined largely by the focus of a particular DCA study. However, it is likely that they will range from those that seek to understand young people's preparation for adulthood to those that involve disclosure about sexual behaviour and sexual risk-taking.

Some interviews may be concerned with what adults tell young people when the bodily changes associated with sexual maturity take place, and how much of this information is accurate and/or complete. Interviewers may ask how what is said differs from, or is similar to, the way in which adults behave towards young people, and what part, if any,

initiation rituals play in local practices. In some studies it will be important to explore differences in the way young men and young women are treated. For example, young women may be given less information of relevance to sexual and reproductive health, or the information provided may be shrouded in mysticism or associated with threats.

Young people may be influenced by a variety of adult authority figures such as family members, village elders, teachers and religious leaders. Many young people will also gain information and support from their peers. Some DCA interviews are likely to discuss with young people how they make sense of information from a number of different and, sometimes competing, sources. The experiences and responses of young men and young women may vary and can be explored through sensitive interviewing. For instance, some young women may trust explanations given to them by adult female family members while young men may prefer to believe what other young men tell them.

Some DCA interviews may seek to understand young people's sexual activity and their knowledge about STIs and modes of transmission. The availability of resources to assist young people in minimising the risk of acquiring an STI may also be a topic for discussion. Yet other interviews may ask about the use young people make of sexual health services and their view about how helpful and accessible these are.

A DCA will be interested to find out about health and education provision for young people and the local circumstances in which services and teaching take place. Information may be gathered from a variety of individuals including health workers, teachers, and young people. The following table offers suggestions about issues that might be worthy of exploration at interview or in small group discussions. Some of the topics are appropriate for health workers or teachers, such as questions about policies, links with other agencies and funding. Others are important to explore with young people themselves, in particular those that seek to understand how a service, or a school, is meeting the sexual health needs and aspirations of young men and women.

Table 3: Suggested interview and group discussion topics

1. Health-related issues

- Confidentiality (in general; in relation to pregnancy, abortion, STIs) and related issues of permission seeking and partner tracing
- Services available e.g. medical; educational; counselling; follow-up; referral
- Range of contraceptives available
- Gender related issues e.g. separate clinics for young women and for young men
- Issues of sexuality (attitudes towards lesbian and gay young people; availability of specialist services)
- Materials available e.g. posters; leaflets
- Involvement in advertising/publicity (style; extent; key messages)
- Links with other services e.g. education; outreach work
- Integration with other services e.g. contraception/STI treatment
- Information on help seeking patterns and social networks of help seeking
- Fieldwork/outreach e.g. with schools; marginal groups
- Relevant policies and their implementation e.g. under age sex; contact tracing
- Quality control and monitoring and evaluation of services e.g. building infrastructure; hygiene; quality of medical staff; staff training and updating; knowledge and awareness of service among different groups; number of users; types of users; user satisfaction; number of returners
- Funding e.g. public/private; charges to users
- General ambience e.g. welcoming, young people friendly, comfort, waiting times
- Personal experiences of users

2. Education-related issues

- Culture within the school
- Surveys of needs carried out e.g. with young people; staff; parents
- Parental information and consultation
- Curriculum and place of sex and relationships education within it now/future possibilities
- Image of sex and relationships education (among young people; staff; parents; governors)
- Support/non support for sex and relationships education and from whom does it come
- Barriers to/concerns about sex and relationships education
- Mandatory or voluntary; withdrawal policy/rights
- Topics included in sex and relationships education and age delivered e.g. gender issues; sexual orientation; abortion; pregnancy
- Language used within sex and relationships education programmes
- Respect for young people's views
- Expected/ideal outcome from sex and relationships education; monitoring and evaluation
- Staff involved in sex and relationships education (gender; power; status; specialisms; training; updating)
- Teaching materials available e.g. books; videos; contraceptives
- Teaching methods e.g. drama; role play; debates; discussions; lectures
- Comparison between approaches to sex and relationships education and teaching methods for other subjects
- Liaison with other agencies/services
- Experience of recipients

Charting innovative, effective and ineffective programmatic responses

A DCA team should endeavour to document innovative and effective approaches to promoting young people's sexual and reproductive health. Evaluation against established criteria may be helpful. For example, FRESH Tools for Effective School Health[1], a programming guide developed by a number of UN system agencies, drew on reviews by Kirby et al[2] and UNAIDS[3 4] to identify some of the characteristics of successful school HIV/AIDS programmes. The criteria highlight the importance of training for teachers and other workers if they are to be knowledgeable about HIV/AIDS and have sufficient confidence to make use of skills-based teaching methods.

Several characteristics of success relate to key contextual influences on young people. It is important, for example, that programmes:

- are age appropriate and gender sensitive (i.e. relevant to the demographic and socio-economic context);
- address social influences on sexual behaviour such as the media and peers (relevant to the community context); and
- offer practice in communication and negotiation skills (relevant to the interpersonal context).

Innovative programmes go beyond traditional service provision in health and formal education settings. Some examples include new forms of:

- teacher/health worker-led school programmes;
- peer-led programmes in or out of school;
- youth health clinics;
- targeted media campaigns;
- telephone help lines;
- visits and visitors;
- role play and drama; and
- parent-led initiatives in and out of school.

During the course of a DCA, some ineffective programmatic responses are almost certain to be noted. Given the limited resources likely to be available, data gathering should however concentrate on those activities that have been or are being successful, and the reasons for their success. Each DCA team should attempt to identify and visit at least two or three successful, innovative programmes that have improved young people's sexual health.

Some local radio stations have initiated round table discussions on adolescent reproductive health issues. Mali pilot DCA

Interviews and group discussions will need to take place with those who organise and participate in a project, service or programme to gather contextual information and elicit the perspectives of fieldworkers, health workers and young people themselves.

To be successful, programme activities need to go beyond providing information. They need to help young people develop specific skills such as the ability to plan ahead, to seek appropriate help, to negotiate, to form positive relationships and to communicate effectively. Young people's ability to develop these skills is likely to be influenced by their immediate environment including their family, friends and wider community.

Attention will need to be paid to the role of community gatekeepers and their influence on access to a service, programme or project. Similarly, the role of other key stakeholders, such as teachers, clinic personnel and voluntary workers, will need to be explored, usually through interviews and observation.

An important part of a DCA is to find out what, if any, local evaluation has taken place and to determine how rigorous such an evaluation has been. Questions may need to be asked about the size and make-up of the sample used and, in particular, the indicators selected as markers of change.

[1] FRESH tools for Effective School Health' (2004) available on www.freshschools.org/education or www.unesco.org/education/fresh
[2] Kirby, D., Short, L., Collins, J., Rugg, D. et al (1994) 'School-based Programs to Reduce Sexual Risk Behaviours: A review of effectiveness.' Public Health Reports, 109(3): 339-361 and available on www.unesco.org/education/fresh
[3] UNAIDS (1999) Sexual Behavioral Change for HIV: Where have all the theories taken us?
[4] UNAIDS (1997a) Impact of HIV and Sexual Health Education on the Sexual Behavior of Young People: A review update.

Carrying out a DCA (3) – analysing the data, drawing conclusions, making recommendations, writing the report

Prior to any form of data collection, the DCA team will need to think carefully about analysis and, later, drawing conclusions and making recommendations.

Analysing the data

The aim of data analysis is to generate understandings concerning the importance of different kinds of political, socio-economic, community, interpersonal and programmatic influences on young people's sexual and reproductive health, and to explore the interplay between these different factors. Without an understanding of local contextual influences, recommendations for the development of services and programmes tend to focus on narrow, often impractical solutions.

Data elicited are likely to include:

- political context – laws and policies relevant to young people's sexual health; institutional responses to laws and policies; effects of policy change and development;
- socio-economic context – numbers and social distribution of young people including percentage of young people who are married; school enrolment; percentage of young people in paid employment; number of child-headed households; number of orphans; levels of household income;
- community context – cultural influences on young people's sexual health; role and influence of organised religion; status of young people and power relations; media messages both implicit and explicit; role of NGOs; gender differences such as in the legal, and actual, school leaving age;
- interpersonal context - key relationships inside and outside the family; how such relationships are negotiated and develop; what they mean to young people; age-related gender/power relations; percentage of young people sexually active; use of contraception; prevalence of STIs; abortion rates; youth sub-cultures; patterns of substance misuse; and
- programmatic context - formal and informal modes of education and their consequences; levels of sexual health knowledge and awareness; provision of health services specifically for young people; accessibility of education and services especially for marginalised and vulnerable groups; variations in provision for different groups of young people (e.g. young women/young men).

Typically, the analysis associated with a DCA will occur in three stages.

Stage one

This initial stage will involve searching individual datasets and sources of information to develop understandings about specific issues of relevance to young people's sexual and reproductive health. The aim is to identify major contextual influences in each of the five domains, of relevance to young people's sexual well-being. This will involve analysing existing, probably largely quantitative, information and using the new data gathered during a DCA to support or challenge the findings.

Types of analyses required during stage one will depend on the sorts of data collected during the fieldwork. Some secondary data sources, for example, may require quantitative analysis to render them relevant. Young people's responses in DHS

data, for instance, may not have been analysed separately from the entire dataset, and these analyses may need to take place as part of a DCA.

Thematic analysis of interview and focus group data will be needed to identify the main contextual influences on local young people and to develop an in-depth understanding of their significance. Observational data may need to be searched to support or refute the emergent findings.

Much of the qualitative data will have been gathered during the DCA study itself. Some suggestions about how to evaluate qualitative studies can be found on page 19.

Stage two

Once the data from different sources have been individually analysed, a second stage of analysis can commence. During this stage, the team can begin to develop some preliminary conclusions and start to formulate a range of explanations that can be tested. For example, national guidelines for sex and relationships education in schools (political context) may advocate the same curricula for young women and young men. Focus group discussions with young people in a local area may have raised doubts about how far such guidance is followed. In searching for possible explanations, the team may wonder about the appropriateness and adequacy of teachers' training and preparation for sex and relationships education classes (political/socio-economic context), and question whether local pressure, perhaps from parents, teachers themselves and/or religious leaders (community context) might result in more limited, or different, curricula for girls.

The process of exploring these possibilities makes use of data already collected but sometimes it may highlight when further data collection is required. In the example cited above, a DCA team may decide that further one-to-one interviews with young women are needed, or may decide that an additional visit to a school or schools for observation would be helpful. At times, the process may highlight the need for a specialised study. For instance, within a local area there may be considerable variation in the content of sex and relationships teaching in schools. The team may feel that their data to date do not adequately explore the complexity and possible range of contextual influences.

Stage three

The third and most important stage of a DCA analysis takes the form of a relationship or link analysis. Here the goal is to examine the relationship between the core issues and the contextual factors identified during stages one and two. The aim is to examine the relative effects of political, socio-economic, community, interpersonal and programmatic factors on young people's perceptions, attitudes and priorities in order to begin drawing conclusions about the central questions: 'Why are things like this?' and 'What can be done to improve the situation?'

Examples of questions pilot research teams have asked during stage three are included below. These are not meant to represent the best, or only, way of examining the issues but may offer a useful starting point for future work.

- Who or what are the main sources of information for young men and women; how do young people synthesise the knowledge they gain; how do they translate this knowledge into action?
- What are the dominant discourses about sex and sexuality that young people have to deal with; when are particular discourses acted upon or suppressed?
- Who provides health services to young people; how are they delivered; what are the barriers facing young people in accessing these services; why are there these hurdles?

- Do services/activities acknowledge and adequately respond to diversities in the interpersonal, community and other contextual factors that influence young people's behaviour?
- Why are certain laws/policies not acted upon; what are the barriers to their implementation; what accounts for the shortcomings in implementation; how does this impact upon young people's lives?
- Is the social, economic and political climate conducive to improving young people's sexual and reproductive health?
- What are the pressures on young people to engage in particular sexual practices; who exerts these pressures; why do they exist?

Drawing conclusions, making recommendations

Drawing conclusions from a DCA requires the team to look beyond the analysis itself to consider the implications of the findings for future action to benefit young people's sexual and reproductive health. The conclusions provide the basis for making specific recommendations. As recommendations are likely to be actioned by a variety of individuals or groups (with different agendas, resources and expertise), the ways in which they are explained and disseminated need to be carefully considered and reflected in the wording of the final report.

The need to ensure that recommendations are appropriate, and worded in an accessible way, means the team may wish to involve a range of lay and professional people in discussions and report development. Such people may be from inside or outside the research arena, and may or may not have previously been included in the DCA process. For example, policy makers, programme managers, independent consultants, sexual health workers and young people may all have useful contributions to make at this important stage. They may provide valuable advice about the conclusions drawn and the best way to put recommendations forward to an audience likely to be varied in its commitment to improving sexual and reproductive health.

Conclusions and recommendations aimed at policy makers will be very different from those aimed at local youth workers, which in turn may vary considerably from those aimed at researchers in the field of sexual and reproductive health. The significance of different contextual influences on young people's sexual health, and on opportunities for change, may need to be explained and justified. For example, some policy makers may be unfamiliar with an approach that goes beyond apparently simple cause and effect relationships to consider, for example, how roles and relationships within the interpersonal context can influence policy implementation.

Writing the report

Although the report is likely to be one of several outputs produced from a DCA (see next section), it will probably be the only one to include a detailed account of the entire process, the conclusions and the recommendations. Consequently, it should be accessible, both in language and availability, to all those with an interest in young people's sexual and reproductive health. Technical terms need to be accompanied by definitions, and charts and tables can often usefully supplement narrative text. Annexes and appendices may be helpful to document relevant material not essential to the main body of the text but of interest to those able to spend more time examining additional information.

Each DCA report will differ in its content and style and will be tailored to the place of study and to the audiences for whom it is intended. However, there are likely to be some commonalities and Table 4 offers some guidance to possible sections, and examples of content, for inclusion.

Table 4: Suggested section headings for a DCA report

Executive summary

Introduction

- Overall purpose of the DCA
- Objectives
- List of institutions involved in work
- Sources of funding
- Background
- Brief description of country, region or locality of study – geography, current political, social, economic concerns and any recent changes. Young people – numbers, status, overview of main sexual health concerns

Methods used

- Description of key methods used to gain information. Evaluation of success of methods used. Description of analysis.

Findings:

- Political context
  Key actors and institutions involved in young people's sexual health. The role of national and local government. Laws and regulations of relevance to young people's sexual health including those generated by Ministries of Health, Education, Labour, Culture, Justice, Women, Youth and Sport. Penalties for non-compliance.
- Socio-economic context
  Data and statistics about the sexual health of young people – sexual activity, contraceptive use, pregnancy, abortion, STIs, HIV/AIDS. Numbers of young people attending school/not attending school. Training of teachers, health workers. Quality and content of sex and relationships education. Identification of particularly vulnerable groups and assessment of their social status and economic concerns. Commercial sex, young people as sex workers.
- Community context
  The role of NGOs (including their policies), voluntary groups, youth groups, church/religious groups, women's groups. The role of community leaders, gatekeepers, the media and family members. Accessibility of sex and relationships education for young men, young women, marginalised groups. Cultural influences on young people's sexual activities and health. Rites of passage, initiation practices.
- Interpersonal context
  Peer groups, youth sub-cultures. Relationship issues and role of family and others in negotiation of marriage and same-sex relationships.
- Programmatic context
  Details of available services and programmes. Evaluations of impact on young people's sexual health. Young people's utilisation of services and programmes, barriers to access, examples of effective and innovative projects.

Discussion

- Gaps and omissions in data, contradictions and inconsistencies in findings, barriers and constraints to improvements in young people's sexual health, opportunities for improvements in regulations, programmes and services.

Conclusions and recommendations

- Strength of findings, specific detailed recommendations for improvements to regulations, programmes and services related to young people's sexual and reproductive health. Anticipated benefits if improvements implemented with suggested priorities and time scales. Guidance on further research needed.

Appendices

References

A good DCA report is likely to be 40-50 pages in length. A 2-3 page executive summary can be important to provide an overview and may be crucial in engaging those with limited time to read the whole report. It may also be helpful to produce some focused summaries for specific groups.

Making good use of DCA findings

One aim of a DCA is to use insights gained to influence decisions about the development of sexual and reproductive health policies and programmes specifically for young people. The findings from a DCA will therefore be of interest to all those involved in young people's sexual and reproductive health, from policy makers, stakeholders and donors, to young people themselves, workers at grass-roots level and researchers in the field. The results and recommendations that most interest one group may differ from those of interest to another. This chapter provides guidance on how best to disseminate the results to people in positions of power and influence, and to those who can more locally make the required changes for improvements to take place in young people's sexual and reproductive health.

Whilst this chapter necessarily comes at the end of this booklet, dissemination of the findings needs to be thought about throughout the whole DCA process. Only if this is done will dissemination be sensitive to the needs of different groups and individuals, and effective in making sure understandings gained reach key people and organisations. Team members are likely to learn about the particular concerns of policy makers, for example, during the course of gathering data.

Similarly, dissemination of preliminary findings and information about the progress of the project are likely to occur periodically during a DCA as the team makes contact with stakeholders and key players as part of the fieldwork and data collection phases. There may also be value in developing links with journalists sympathetic to the study aims, who can disseminate information about the progress of the work. Progress reports may highlight key issues and prepare the ground for the final report.

A DCA provides a dynamic 'snap-shot' of the status of young people's sexual and reproductive health at a particular point in time and under particular, often local, circumstances. The findings therefore need to be disseminated quickly to ensure that local communities, local programmes, governments, NGOs, international organisations and individuals respond swiftly and appropriately to the present needs of young people. Possible target audiences include:

- government and NGO workers
- programme planners/managers
- service providers
- donor and funding agencies
- youth and community leaders
- religious leaders
- parents/carers
- health and education professionals
- young people
- general public
- academics and researchers
- the media

The information needs of the target audiences are also likely to differ. For example, government agencies are likely to take more notice of quantitative data about young people's sexual and reproductive health together with findings about the impact of political and socio-economic influences. Those providing confidential services for young people about, say, contraception, may be more interested in the influence of village leaders and family members on young people's decisions about contraception and on factors that affect how young people negotiate relationships with each other.

Just as the information needs and interests of different groups are important, so too are the ways in which they are informed about the findings and recommendations. Whilst the written report will be the major document from the work, there may also need to be several focused summaries for different audiences. For instance, it may be helpful to produce a summary specifically for donors, focusing on the funding issues highlighted in the study. Some groups may need something between a summary and the whole report. For example, a modified, shortened report for teachers may be needed to detail the recommendations, and the findings on which they are based, for sex and relationships education in schools.

In addition to written reports and summaries, DCA findings and recommendations can be disseminated through other written and verbal channels. Table 5 below gives some examples of such methods.

A DCA team will need to think carefully about who are the most appropriate groups or individuals for dissemination of the study findings. Sometimes individuals and organisations with past experience of dealing with particular target audiences will be important. Using publishers respected for their work with young people, for example, may help to ensure that key messages are disseminated effectively through articles and papers. Radio and television can be useful in raising awareness of DCA findings among the general population and, in particular, among certain hard to reach groups including those who are illiterate. A team may consider assistance from experienced advocacy groups practiced in lobbying and raising awareness about young people's health among politicians and those in positions of power.

Table 5: Possible modes of dissemination

Written	DCA reports	Magazines
	Executive summaries	Information and training packs
	Journal articles and papers	Posters
	Newsletters	Wall charts
	Books	Web-sites
	Monographs	Electronic mailing lists
	Press releases	CDs
	Policy memos	Floppy discs
	Fact sheets	
	Data sheets	
	Newspapers	
Verbal	Lectures and talks	Informal policy briefings
	Seminars	Radio announcements, call shows and interviews
	Workshops	
	Conferences	Television programmes
	Briefing sessions	Videos/DVDs
	Press conferences	Tape/CD recordings

Ongoing activities – short term

For the results of a DCA to have impact on the sexual and reproductive health of young people, targeted activities will need to be take place during and after dissemination. Maintaining a focus on the key issues and keeping them in the media spotlight and on the agendas of individuals with influence is important if changes are to take place. For example, the team might consider approaching different media outlets in the months following the study with ideas for relevant articles and updates on the recommendations made.

An advocacy strategy to modify and influence policy might also be developed. This could be arranged in conjunction with other key players and organisations with specific interest in young people's sexual and reproductive health. Individuals and groups known for their positive connections with young people could be encouraged to take part. The team may also be able to involve young people in advocacy work. Different people and organisations may be effective in different ways. A health worker may be more successful in talking to donors about findings related to clinic facilities and the need for improvement if young people are to attend, whereas a group of parents may have more influence on policy decisions about equality of sex and relationships education for girls and boys in schools.

Ongoing activities – longer term

The findings from a DCA may be suitable for use as baseline data to monitor and record change. They may point to a range of indicators relevant to young people's sexual and reproductive health. These include:

- input indicators - policies, strategies, finances, staffing levels, other resources;
- process indicators - delivery and provision of services, ways of collaborative working;
- short-term outcome indicators – knowledge, behaviour, attitudes;
- long-term outcome indicators – reduction in STIs, unwanted pregnancies, abortions, coercive sexual activity, increase in levels of mutuality and respect.

Monitoring change locally may also be something in which team members can usefully become involved after the completion of the main study. This might include monitoring changes to existing projects, services and programmes and assessing the impact of the developments made.

Replicating the DCA process in its entirety or on a smaller scale in the future should enable improvements in young people's sexual and reproductive health to be measured, tracked over time, and celebrated.

Selected internet resources

- ***Department for International Development, UK (DFID)***
  www.dfid.gov.uk
  DFID manages Britain's international assistance programmes and works to eradicate extreme poverty.

- ***Eldis***
  www.eldis.org
  Eldis is an internet-based development information service.

- ***Futures Group***
  www.futuresgroup.com
  Futures Group specialises in the design and implementation of public health and social programmes for developing countries. Internet resources include various computer modelling programmes to analyse existing information and assist policy makers determine the impact of specific programmatic responses.

- ***Global Reproductive Health Forum (GRHF)***
  www.hsph.harvard.edu/organizations/healthnet
  GRHF provides interactive electronic forums, global discussions, distributes reproductive health and rights materials from a variety of perspectives as well as maintains an extensive, up-to-date research library.

- ***ID21***
  www.id21.org
  ID21 aims to communicate international development research to policy makers and practitioners worldwide.

- ***International Planned Parenthood Federation (IPPF)***
  www.ippf.org
  IPPF is a voluntary, non-governmental provider and advocate of sexual and reproductive health and rights. Resources include medical information, and HIV and youth focused publications.

- ***John Snow, Inc. (JSI)***
  www.jsi.com
  The International Division at JSI provides management assistance, information and training designed to enhance the effectiveness and quality of public health programmes.

- ***Marie Stopes International (MSI)***
  www.mariestopes.org.uk
  Working to fulfil the ICPD Programme of Action, the MSI Global Partnership has developed comprehensive sexual and reproductive health programmes for young people and produces a range of publications on a number of sexual and reproductive health issues.

- ***MEASURE***
  www.measureprogram.org/
  Includes the Demographic and Health Surveys, which provide national and sub-national data on family planning, maternal and child health, child survival, HIV/AIDS, STIs, reproductive health and nutrition.

- ***National Library of Medicine (NLM) Gateway***
  gateway.nlm.nih.gov
  The NLM Gateway allows users to search in multiple retrieval systems at the US National Library of Medicine. The current Gateway searches MEDLINE/PubMed, OLDMEDLINE, LOCATORplus, AIDS Meetings, HSR Meetings, HSRProj, MEDLINEplus and DIRLINE.

- ***Oxfam International***
  www.oxfam.org
  Oxfam International is a confederation of 12 organisations working together with over 3000 partners in more than 100 countries to find lasting solutions to poverty, suffering and injustice.

- ***Pathfinder International***
  www.pathfind.org
  Pathfinder International works to improve the reproductive health of women, men, and adolescents throughout the developing world. Publications include a tool for rapid assessment and improving reproductive health for youth.

- ***POPLINE***
  db.jhuccp.org/popinform/basic.html
  POPLINE (POPulation information onLINE), is the world's largest bibliographic database on reproductive health.

- ***Population Council***
  www.popcouncil.org
  Directing programmes such as Frontiers and Horizons, the Population Council conducts biomedical, social science and public health research for the development of sustainable approaches to enhancing people's health and well-being. Research tools include situation analysis methodology aimed at pinpointing service delivery problems (www.popcouncil.org/slr/sitanly.html)

- ***Population Reference Bureau (PRB)***
  www.prb.org/datafind/datafinder6.htm
  PRB's 'datafinder' and country pages provide quick access to essential information on population, health, and the environment for over 200 countries.

- ***Safe Passages to Adulthood (SPA)***
  www.socstats.soton.ac.uk/cshr/safepassages.htm
  The SPA web site contains details of research activities, example research instruments and relevant publications.

- ***Save the Children***
  www.savethechildren.net
  Save the Children fights to improve children's rights. Publications cover education, exploitation and abuse, conflict and disaster, and HIV/AIDS.

- ***Source***
  www.asksource.info
  Source is an international information support centre designed to strengthen the management, use and impact of information on health and disability.

- ***Synergy HIV/AIDS Resource Center***
  www.synergyaids.com
  The Synergy HIV/AIDS Resource Center contains documents that are relevant to HIV/AIDS project management and research. Resources include the APDIME Toolkit; Module 1 outlines how to undertake an HIV/AIDS epidemic situation and response assessment. (www.synergyaids.com/apdime/index.htm).

- ***US Census Bureau, International Data Base (IDB)***
  www.census.gov/ipc/www/idbnew.html
  IDB is a computerised data bank containing statistical tables of demographic, and socio-economic data for 227 countries and areas of the world.

- ***UNAIDS***
  www.unaids.org
  UNAIDS' HIV/AIDS information and data pages contain the latest country-specific data on HIV/AIDS prevalence and incidence.

- ***UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction***
  www.who.int/reproductive-health/index.htm
  Includes links to the adolescent reproductive health programme web pages which contain a synopsis of on-going research and example instruments on aspects of young people's sexual and reproductive behaviour.

- ***UNICEF***
  www.unicef.org
  Priority areas cover girls' education, HIV/AIDS, child protection and early childhood. Internet resources include UNICEF publications, working papers, guidance notes and links to the UNICEF Innocenti Research Centre (www.unicef-icdc.org).

- ***United Nations Population Information Network (POPIN)***
  www.un.org/popin
  POPIN includes an extensive electronic library, population trends database and regional population information and networking.

- ***World Bank Data Base***
  www.worldbank.org/data
  The World Bank Data Base contains data profiles drawn from official statistical systems organised and financed by national governments.

- ***World Health Organisation – Technical Guide to Rapid Assessment and Response (TG-RAR)***
  www.who.int/docstore/hiv/Core/Index.html
  The TG-RAR provides a detailed introduction into all aspects of planning and implementing rapid situation assessments. Although generic in nature it is best used in conjunction with the associated Adaptation Guides, which provide

brief guidance on how to use the RAR approach with specific health issues: 'HIV/AIDS Prevention among Especially Vulnerable Young People' (www.who.int/hiv/pub/prev_care/en/youngpeoplerar.pdf); and 'HIV/AIDS Prevention and Male-to-Male Sex' (www.who.int/hiv/pub/prev_care/en/msmrar.pdf).

- ***YouthNet***
  www.fhi.org/en/Youth/YouthNet/index.htm
  Part of Family Health International (FHI, www.fhi.org), YouthNet is a global, USAID-sponsored programme to improve reproductive health and prevent the spread of HIV/AIDS among people aged 10 to 24 years-old. Internet resources include: key issue research briefings; in-depth reviews of critical topics; and the 'Youth InfoNet' an electronic source containing programme resources and peer-reviewed research papers.

Other publications by Safe Passages to Adulthood

www.socstats.soton.ac.uk/cshr/safepassages.htm

Guides to Good Practice

www.socstats.soton.ac.uk/cshr/guidestogood.htm

- Working with young men to promote sexual and reproductive health
  ISBN 0 85432 781 9
- The role of education in promoting young people's sexual and reproductive health
  ISBN 0 85432 782 7
- Preventing HIV/AIDS and promoting sexual health among especially vulnerable young people
  ISBN 0 85432 783 5
- Stigma, discrimination and human rights in relation to young people's sexual health
  ISBN 0 85432 806 8

Guides to Programme Development

www.socstats.soton.ac.uk/cshr/guidestoprogramme.htm

- HIV/AIDS prevention and care among especially vulnerable young people
  ISBN 0 85432 807 6

Research Tools

www.socstats.soton.ac.uk/cshr/research01.htm

- Learning from what young people say… about sex, relationships and health
  ISBN 0 85432 780 0
- Rapid assessment and response - adaptation guide for work with especially vulnerable young people
  www.who.int/hiv/pub/prev_care/guide/en/
- Rapid assessment and response - adaptation guide on HIV and men who have sex with men
  www.who.int/hiv/pub/prev_care/rar/en/
- Annotated bibliography of young people's sexual and reproductive health
  www.who.int/reproductive-health/adolescent/annotated_bibliography/index.htm
- Qualitative and quantitative research instruments
  www.who.int/reproductive-health/adolescent/questionnaire.html

All available for free download, or by request to

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Email: cshr@socsci.soton.ac.uk
http://www.socstats.soton.ac.uk/cshr/SafePassages.htm

ISBN 0 85432 846 7

The Safe Passages to Adulthood Programme is a collaborative activity between the Centre for Sexual Health Research, University of Southampton, the Thomas Coram Research Unit, Institute of Education, University of London and the Centre for Population Studies, London School of Hygiene and Tropical Medicine

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