

*safe passages*

*to adulthood*

*Dynamic Contextual  
Analysis of Young  
People's Sexual Health*

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

***August 2001***

## ***Safe Passages to Adulthood***

In 1999, the UK Government's Department for International Development (DfID) funded a five-year programme of research into young people's sexual and reproductive health in poorer country settings. The ***Safe Passages to Adulthood*** programme aims to conduct and support research to enable young people to improve their sexual and reproductive health. In order to achieve this goal the programme is working to increase the research capacity of developing country partners and generate new knowledge that will lead to the development of clear, systematic guidelines for action at programme and policy levels. An underlying assumption of the ***Safe Passages*** programme is that variations within and across different settings are identified, so that culturally relevant and sensitive programmes can be devised.

The five main 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 among young people;
- to identify situation-specific key determinants of young people's sexual behaviour;
- to identify culturally-appropriate means by which barriers to good sexual and reproductive health can be overcome;
- to identify new opportunities to introduce and evaluate innovative programme interventions;
- to develop concepts and methods appropriate to the investigation of young people's sexual and reproductive health.

The ***Safe Passages*** programme does not define young people through the use of specific age boundaries. Rather, it adopts a life course perspective in which the domain of interest is young people in the period prior to the transition to first sex and up to the point of entry into marriage or stable partnership (although it is recognised that in some countries, age at marriage is very young). 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.

Young people themselves are not the only focus of the ***Safe Passages*** programme. Other extremely important groups include policy makers, practitioners and other 'gatekeepers' to effective work.

# *Dynamic Contextual Analysis of Young People's Sexual Health*

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barriers to, and opportunities for, change**

This booklet was prepared for the *Safe Passages to Adulthood* Programme by Helen Chalmers, Nicole Stone and Roger Ingham with contributions from Peter Aggleton, John Cleland, Rachel Partridge and Sarah Castle.

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# Section One

## Introduction



Young people's sexual and reproductive health has increasingly become a priority area since the 1994 Cairo International Conference on Population and Development (ICPD) declared that

*“...countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies.”<sup>1</sup>*

In poorer countries, it has been estimated that 60 percent of all teenage conceptions are unintended. Furthermore, about two million teenage women are thought to undergo unsafe abortions every year, with unsafe abortive practices being linked to maternal morbidity and mortality.<sup>2</sup>

The World Health Organisation and UNAIDS estimate that globally one in twenty young people have contracted a sexually transmitted infection (STI) before they reach the age of 21 and an estimated half of all HIV infections occur in the 15-24 age group, with young women out-numbering young men by a ratio of two to one.<sup>3</sup> In 1999, the ICPD +5 recommended that at least 90 percent of young women and men should have access to preventative methods such as condoms, voluntary testing, counselling, and follow-up, in order to reduce vulnerability to HIV/AIDS infection.<sup>4</sup>

In Africa the HIV rates among teenage girls and especially among women under 25 defy belief: in 7 of the 11 studies, more than one woman in five in her early 20s was infected with the virus; a large proportion of them will not live to see their 30th birthday. *Report on the Global HIV/AIDS Epidemic, Geneva, UNAIDS, 2000*

In many instances, early sexual initiation and unprotected sexual activity lead to negative social and economic consequences in addition to adverse health outcomes. For example, early parenthood can interrupt schooling which, in turn, can lead to fewer job possibilities and lower income. Negative psychological reactions may occur; for example, lowered self-esteem, discrimination, prejudice, and other similarly harmful outcomes. Young people who choose to express their sexuality in socially proscribed ways may also face strong negative reactions from others.

Both internationally and within many countries, there is increasing recognition of the importance of young people's sexual and reproductive health. Because of this, there is a need for sound information regarding young people's sexual development, behaviours, relationships and attitudes so as to inform the design of culturally appropriate and acceptable health and education services.

To date, much research of relevance to young people's sexual and reproductive health has been relatively narrow in focus. Typical approaches have included studies of the epidemiology of STIs and HIV, KABP (knowledge, attitudes, beliefs, practices) surveys, and secondary analyses of DHS (Demographic and Health Surveys) data sets.

Such work has been successful in identifying many of the demographic, socio-economic and other background factors associated with young people's sexual behaviour and its consequences and, indeed, has led to a deeper understanding of areas that demand greater attention. However, it has often failed to reveal the context in which behaviour takes place, including the many factors that impact upon, and contribute to, sexual risk-taking. Further, relatively little recognition is conventionally paid to the social, cultural and economic forces that result in different sexual experiences, expectations and behaviours.

The development and health of an adolescent 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 other approaches have been developed to enable a relatively quick understanding of one or more aspects of sexual and reproductive health (originally, in the field of women's reproductive health and family planning). Many of these are grouped under the generic heading of rapid appraisal procedures, and include rapid rural appraisal, participatory rural appraisal, rapid epidemiological assessments, rapid assessment procedures, focussed ethnographic studies and situation analyses. Further, various approaches to the general field of policy analysis have been developed, with an emphasis on both health policy reform and improving ways of involving local communities in planning health care delivery.

Each of these and other related approaches has contributed to an extension of the more traditional research paradigms, and many of them incorporate qualitative approaches as integral components. Their aim is to develop a more complete understanding of an area within a relatively short time frame so that appropriate policy responses can be devised and introduced. The emphasis of much of this work has, however, been on the mainstream aspects of health structures, organisation and service provision that 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 adolescents and influence their health and development. *WHO Technical Report series 886, Geneva, WHO, 1999*

Whilst each of these approaches has its uses for specific purposes, a new and dedicated form of systematic exploration is needed concerning the contexts in which young people's early sexual activity takes place. Dynamic Contextual Analysis (DCA) has been developed to meet this need.

### **1.1 Why a new approach?**

The primary aim of a DCA is to consolidate, within available resources, what is known within a particular country regarding young people's sexual and reproductive health in order to obtain a more **comprehensive** understanding of the complex array of factors that affect young people's sexual lives. By bringing together insights drawn from different levels and sectors of society, including the views of government officials, non-governmental organisations, community and youth representatives, teachers, health care providers, parents and young people themselves, barriers and opportunities can be identified and priorities for further actions can be agreed upon.

Barriers to improved sexual health outcomes among young people operate at the level of individuals (lack of knowledge, inappropriate attitudes to risk, poor self-esteem, economic dependence), communities (negative attitudes of parents and other gatekeepers) and institutions (legislative structures, opposition of religious organisations, financial constraints and programmatic limitations). The nature and importance of these obstacles varies from context to context and, while barriers will always be encountered, opportunities for making a positive impact also exist. To date, however, relatively few attempts have been made to assess the opportunities and constraints associated with each of these levels in order to assist in programme development.

The key components of a DCA include:

- its emphasis on young people's perspectives, interpretations and accounts;
- its concern to situate these accounts within the local and/or national context;
- its sensitivity to the multi-levelled nature of young people's lives and experiences;
- its commitment to capturing the dynamism and change associated with young people's sexual socialisation in a rapidly globalising and evolving world.

This booklet has been developed to guide programme and project leaders through the process of carrying out a DCA focusing on young people's sexual and reproductive health. It includes sections on planning, conducting the fieldwork, analysing and disseminating the findings and finally using the findings to influence best practice. A variety of methodologies and procedures are proposed that can be freely adapted to suit individual research contexts and the resources available.

It is recognised that the likely readership of this booklet will vary considerably in experience and training. An attempt has therefore been made to strike a balance between providing too much and too little information. Readers who find insufficient detail are encouraged to explore further resources available within their own countries whilst more general sources of information, available via the internet, are listed at the end of the manual.

<sup>1</sup> United Nations (1994) Report of the International Conference on Population and Development, Cairo 5-13 September 1994.

United Nations publications, sales no. E95.XIII.18

<sup>2</sup> Noble, J. et al. *The World's Youth* 1996. Washington, D.C., Population Reference Bureau, Inc. (1996).

<sup>3</sup> UNAIDS and WHO. Report on the Global HIV/AIDS Epidemic: December 1998. Available online at [www.unaids.org/publications/](http://www.unaids.org/publications/)

<sup>4</sup> Report of the Ad Hoc Committee of the Whole of the 21st Special Session of the General Assembly, July 1999. Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development. Issued as United Nations Document A/S-21/5/Add.1. Available online at [www.unfpa.org/ICPD/ICPD.HTM](http://www.unfpa.org/ICPD/ICPD.HTM)



# Section Two

## *Why DCAs?*



Dynamic contextual analyses combine a traditional focus on individual sexuality with a recognition that wider contextual factors affect young people's sexual and reproductive lives. In other words, whilst acknowledging that young people have varying desires, attitudes, knowledge, skills and abilities, it is recognised that, in all societies, forces exist that determine whether, how, when, with whom and where young people engage in sexual activity.

In all societies, sexual activities are subject to moral constraint. For instance, sexual relations outside marriage are rarely encouraged; indeed they are frequently condemned. The proscription of sexual activities has many and varied implications particularly for young people. Legal, social and cultural sanctions may exist, with important consequences for the 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.

There is a compelling need to study individuals within their wider social context so that progress can be made, not only in understanding sexual activity, but also in identifying the barriers and constraints that inhibit potential improvements in physical and psychological outcomes and identifying opportunities for change. People live in social and cultural contexts and are influenced by a range of discourses regarding sexuality and gender relations. They engage in sexual relations for different reasons with varying levels of volition and coercion.

### **2.1 What is a DCA?**

DCAs are intended to make a significant start in the process of exploring these wider contexts. A successfully completed DCA aims to provide insights into the many ways in which individual and societal/cultural aspects interact, including the identification of gaps in policy, service provision and information regarding sexual health and how any relevant central policies are, or are not, implemented.

An in-depth situation assessment of all these factors would, of course, require the involvement of a number of full-time researchers drawn from a variety of relevant disciplines, including psychology, sociology, anthropology, public health, political science, policy analysis, and others. The DCA approach has been developed on the assumption that the necessary resources for such a fully comprehensive study are unlikely to be available, while recognising that important progress can still be made in more resource constrained contexts.

DCAs also attempt to move beyond reliance on a single research methodology. Important though they are, there are considerable dangers in developing programmes solely on the basis of findings from large-scale surveys or on detailed ethnographic studies in, perhaps, one small community. The complexity of young people's sexual activity demands recognition in the research approaches adopted.

A successful DCA aims to provide insights at a number of levels, demonstrating how different factors influence patterns of sexual activity. In this way, DCA outputs add to the accumulating global understanding of the many and varied factors that affect sexual conduct amongst young people. DCAs will also identify tangible outcomes in the form of recommendations. Sometimes these may suggest urgent research priorities or they may focus on, for example, the need for improved monitoring of statistical information, the benefits to be gained from better staff training, or the need to extend identified innovative and successful programmes.

## **2.2 Using a DCA**

Findings from a DCA are likely to be of great interest to all those involved in young people's sexual and reproductive health, from the highest levels of government through to those working in the field.

### **2.2.1 Government responses**

Many governments are in the process of formulating or rewriting national policies concerning young people's sexual health. A DCA is a useful tool in the development of many of these policies and can be used to inform strategic policy change in priority areas. Where legislation aimed at improving the sexual health of young people is already in place, the DCA can be used to investigate the possible existence of political, religious, economic, programmatic and logistical barriers to full implementation. Providing evidence-based research to both policy makers and stakeholders about the negative consequences of these barriers can help to raise awareness and to enhance the potential for change.

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*

### **2.2.2 Civil society responses**

As the value of taking action to promote young people's sexual and reproductive health has been recognised in many countries, so the number of players involved in the field has increased. The results of a DCA analysis can be used to identify how voluntary or international and local NGO (Non Governmental Organisation) activities can work to complement national government policies and services, or to fill the gaps in existing sexual health care provision.

Findings of a DCA can also be used to assist international and local NGOs strengthen their work with young people. This may occur through the dissemination of new information on issues such as social and gender norms, knowledge, relationships, perceived barriers and risk-taking. Such information can help NGOs define their priorities and design and strengthen socially and culturally appropriate activities to improve young people's sexual health.

### **2.2.3 The responses of health and other professionals**

Information from a DCA is also helpful to individual professionals and volunteers working with young people at grass-roots level in schools, in the community and in the health sector. Greater understanding about young people and the wider social context in which they are growing up will help ensure that professionals and volunteers provide the best and most appropriate education, support, services, and care.

The category 'young people' represents a highly complex and variable group with diverse needs. A comprehensive DCA will explore the nature of this complexity and in doing so will highlight those young people who are marginalised by current service provision. A DCA will seek to recognise and report opportunities for strategic action and to inform the design of new programmes likely to make a difference to young people's sexual health and well being.

#### 2.2.4 The broader context

Individual behaviour does not take place in isolation but is promoted, sanctioned, penalised or evaluated by others whose actions affect young people's lives. Beliefs and practices influencing young people's sexual decision-making are formed and reinforced by peers, religious leaders, village elders and parents. These socially powerful individuals often control the gaining and transmission of sexual health knowledge by young people and impart norms relating to gender roles in their societies. If the sexual health of young people is to be improved, the role of such individuals needs to be understood. Findings from a DCA can help to raise awareness among key individuals and gatekeepers of the need for sensitive action to improve young people's sexual and reproductive health.

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

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 that may not always be accurate. 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. Using the media to disseminate the findings of a DCA can help to ensure that journalists and others have access to accurate information regarding young people's sexual health. It will also improve the likelihood of findings being available to young people themselves as well as to the wider public.

Finally, one of the key aims of the DCA process is to identify priority areas for future research. In many developing countries, sound information is lacking about young people's sexual and reproductive health. Whatever the gaps, a DCA is a useful tool for development agencies, donors and researchers alike in setting and clarifying future research objectives

# Section Three

## *Planning a DCA*



A critical feature of a DCA is its ability to access knowledge of the variations inherent in different cultural settings. Nowhere is this more important than in the arena of sexual and reproductive health. A DCA does not assume that every developing country is the same; rather it acknowledges that even within countries there may be significant differences between one particular area and another. There is therefore a need to explore the differences and values in a given locality to ensure that the data gathered are situationally specific and sensitive.

Those best equipped to carry out a DCA will be 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 section, some of the steps that need to be gone through in setting up a DCA will be described.

Six DCAs have already been carried out as part of the SPA (Safe Passages to Adulthood) programme - in Brazil, Kazakhstan, Mali, Mexico, Peru and Zimbabwe - and the experiences of the research teams involved in those studies will be used where appropriate to illustrate some of the points that follow.

### **3.1 Laying the groundwork**

#### **3.1.1 *Is it appropriate to carry out a DCA?***

In reaching a decision whether or not to conduct a DCA, a number of factors need to be taken into account. Firstly, is a DCA the best form of assessment for the circumstances or might a different kind of appraisal be appropriate? Secondly, is the timing right and is it sensitive to other work taking place? Thirdly, is there a suitable research team available with sufficient resources to carry out a good quality study?

### **3.1.2 Research team**

If the decision to proceed is taken, it will be crucial to bring together a suitable research team. A research team numbering between three and six with pre-existing experience in different areas is probably best. The skills, characteristics and values of individual workers will need to be identified alongside the agreed and specific aims of the DCA, so that the team is clear that it has the necessary expertise or can acquire it reasonably easily. For example, it is likely to be helpful to have both female and male researchers available to gather data. In some situations, researchers with particular language skills may be essential, and so on.

Sometimes individuals with established access to, or contact with, local, national or international organisations will significantly enhance the strengths of a research team, notably in terms of raising funds, gaining access to key individuals or groups, or in mobilising support. The value of personal contacts, including those with influential people such as youth policy makers and practitioners, has been identified as useful by those researchers who have already worked on a DCA.

The sensitive nature of much of the data to be gathered and the individuals who will provide them make it important that the people carrying out a DCA are carefully chosen. They need an approach to the work that is non-threatening to, and supportive of, informants and that reassures them about confidentiality. Additionally, they need to be accepting of the diversity of views, practices and concerns that may come to light so that the analysis produces a realistic and unbiased mapping of the context in which it takes place.

It is likely, therefore, that researchers who already have experience of working with young people and who are already involved in matters concerning sexual and reproductive health will be the most suitable to form the team for a DCA. Ideally, the team will also include people with experience of statistical research and others who have worked with a variety of research methods. Some of these people may have experience linked primarily to biomedical concerns, some may come from a more social science or health education background. Careful thought needs to be given to developing a team that will work effectively to gain access to the breadth and depth of data required. Having one or more young people involved in aspects of the work would also be extremely helpful in ensuring that important issues and concerns are taken into account.

### **3.1.3 Aims of the DCA**

All over the world there is a pressing need to develop new and more effective programmes to promote the sexual and reproductive health of young people. Programmes and interventions need to be tailored to the culture and the health and educational infrastructures that are already in place. Despite a great deal of work, much remains to be learned about the best approaches to be used in specific circumstances.

Thus, a DCA will provide a sound and well-researched knowledge base about particular regions within a developing country against which interventions can be planned, implemented and evaluated. It will gather detailed information about the nature and consequences of sexual and reproductive health problems among young people, and will identify key determinants of young people's sexual behaviour. Alongside these concerns, a DCA will identify how barriers to good sexual and reproductive health can be overcome, and will point to new opportunities for intervention to improve young people's sexual and reproductive health.

Beyond this, however, and more substantively, a DCA will highlight concepts and methods appropriate to the further investigation of young people's sexual and reproductive health in the country.

#### **3.1.4 Gaining support**

Before beginning a DCA, it is important to identify appropriate sources of support. Each DCA will be different, but the time required is likely to be not less than three months and more usually about six. For the majority of research teams, it will be necessary to secure agreement from their employer/department/organisation for dedicated work time.

When planning a DCA, it is important to identify those individuals, groups and organisations (in addition to the researchers' employers) that can offer support to the project. The team will need to negotiate this support locally, nationally and internationally. Support takes many forms. In particular, the research team will need permission to contact certain groups and organisations and in many situations will need individuals, including young people themselves, to consent to give information.

The best means of gaining access to individuals, groups and organisations will be through negotiation with key people and gatekeepers. In some circumstances, an advisory group may be helpful in facilitating access and has the advantage of including key individuals throughout the process. Sometimes, previous good relationships between researchers and officials from government and non-government organisations can make gaining access easier, but always the benefits of carrying out the DCA should be made clear so that the value of the research can be its own advocate for co-operation and support. Results from previously completed DCAs can sometimes be helpful in persuading officials of the value of the work to the sexual and reproductive health of the country's young people. Access to the information contained within this booklet may also be helpful in convincing key people of the credibility of the research.

Support in the form of funding will be essential for all DCAs. Efforts should be made to seek funding internationally, nationally and locally. Whilst there may be only limited funds available in the area to be studied, there may well be local circumstances that can be used to encourage

businesses to support the research. It may be, for instance, that the number of employable young people is seriously threatened by high levels of HIV/AIDS. In these circumstances, local businesses may see the value of contributing financially to work that aims to improve the sexual and reproductive health of young people.

Additional training and preparation in the use of suitable and culturally sensitive research methods can assist a team in carrying out a DCA. Early DCAs benefited from a training workshop for the researchers run by the SPA Programme. Equivalent activities are best planned and carried out locally or regionally.

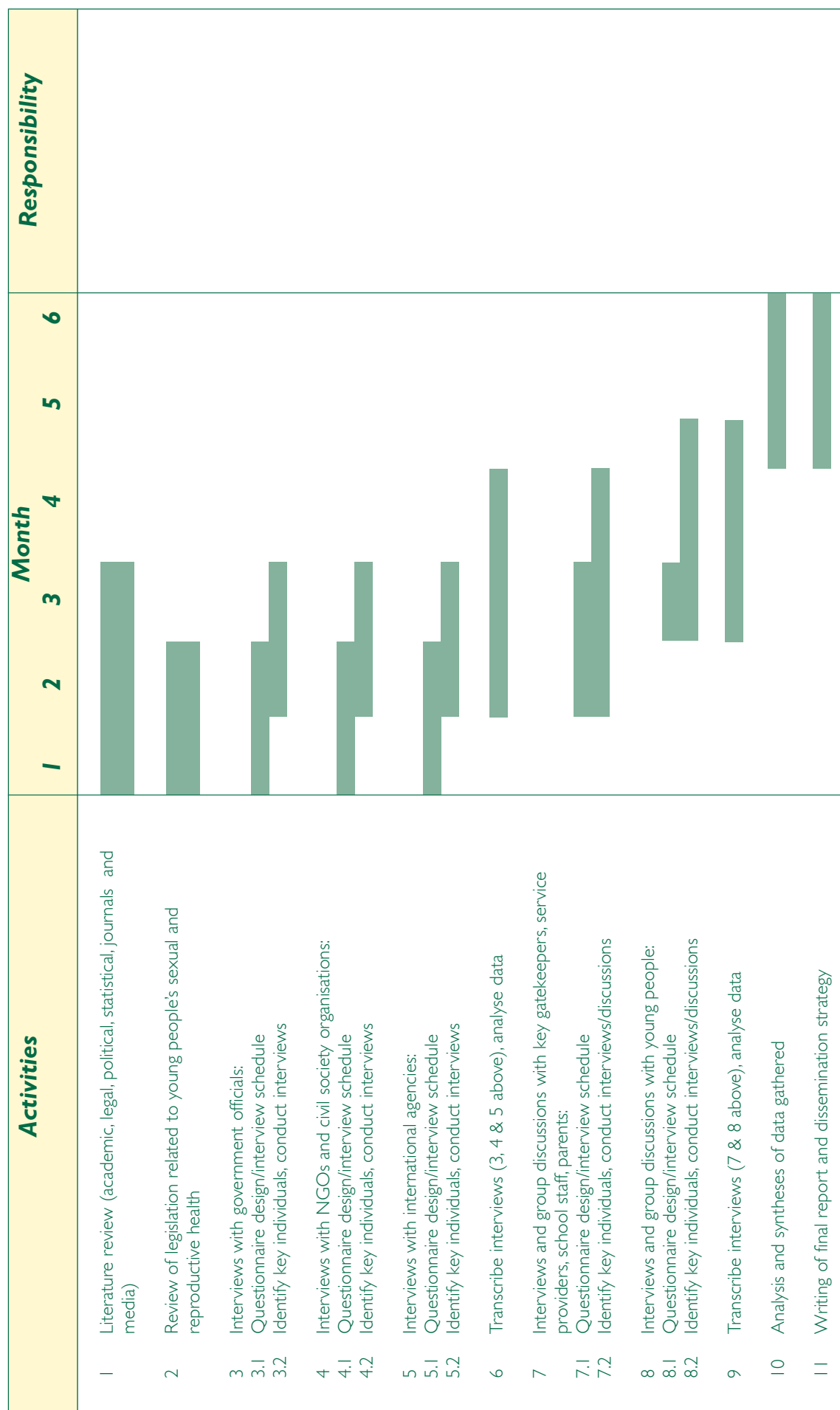
### ***3.1.5 Time planning***

Concurrent with efforts to secure permission, access, funding and training, a time line for the DCA needs to be drawn up. A time line is not only useful for researchers themselves, but also for those from whom support is being sought. A time line indicates the stages of the research and their likely duration together with the responsibilities of each team member.

Figure 1 is an example of a possible time line for a six month study to illustrate the time scales and the kinds of activities in which the team will be engaged.



**Figure 1: DCA activity plan and time line**



Note: Shaded cells represent allocated time

## *Section Four*

# *Conducting a DCA*



This section offers guidance on collecting information to paint an overall picture of the country or region; its demographic structure, its cultural heritage and ideologies, its patterns of ill-health and disease, and its educational and health provision.

Throughout the research process, there will be a sustained need to gather information that might have a bearing on young people's sexual and reproductive health. The research team will therefore need to remain open to any documents, policies, or papers about, for example, health and educational strategies, as they bear on sexual and reproductive health. Usually, such information will come from both formal and informal sources. An important part of the DCA involves the research team going beyond the face value of any such documents to explore the reality in practice of current policies or strategies.

Additional information should be collected from interviews with key informants, either individually or in groups. The particular challenges associated with gathering reliable data from young people themselves need also to be addressed. In many countries, knowledge about sexual health outcomes such as HIV/STIs, unsafe abortion, sexual coercion and violence is very limited. A successful DCA will add significantly to this knowledge base.

Throughout the DCA it will be important to identify those strategies, both familiar and novel, that are most effective in promoting young people's sexual and reproductive health. During the research process, the team will need to keep this aim in mind so that opportunities for successful interventions are identified and noted, and so that any ineffective interventions can also be commented upon and recommendations made. In many poorer countries, attention will need to be paid to those interventions that do not assume well-developed educational or health infrastructures for their likely success. Similarly, in some parts of the world, it will be important for interventions to take note of variations in literacy levels among young people.

## 4.1 Using existing information

A review of existing information is the logical first step in a DCA. While many different kinds of data are likely to exist already, the initial task will be to identify and obtain copies or sight of relevant documents. To do this, access will be needed to government officials, universities, libraries and to personnel working in NGOs in order to obtain relevant academic, political, legal and statistical material.

Gaining access to a full range of relevant sources may sometimes prove difficult and time consuming. In addition, in some countries there may be only limited data on the socio-economic, demographic and reproductive health characteristics of young people.

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

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

These are issues that all DCA research teams will need to consider and plan for at an early stage.

Descriptive data about the country under study will be readily available in printed and written sources such as censuses and surveys. These will 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 more specific sexual and reproductive health indicators such as contraceptive use and abortion rates. Most countries will have already carried out a demographic and health survey (DHS) containing relevant information, although the lower age limit in some of these surveys may restrict their direct applicability.

*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 DCA*

It is important to remain sensitive to the limitations of such quantitative data. While providing important background information, recorded numbers alone usually say very little about the sensitive issues associated with sexual and reproductive health. Furthermore, comparability may be difficult to

establish when definitions (of sexual behaviours, for example) are unclear. In some circumstances, 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 refer to *married* young people.

Throughout the DCA process, researchers will need to ensure that the definitions used in official documents, in relevant literature and in face-to-face contacts are consistent. Terms such as 'young people', 'adolescents', 'sex work' and 'prostitution' may vary according to the data source and the values or prejudices of the writer or informant. Those providing services for young people need to be especially sensitive to the different meanings of various concepts, and to the meanings adopted by young people themselves. To ignore such differences may hinder the establishment of good working relationships, as well as limiting the value of the data collected.

*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 DCA

Additional background data may provide information about the political and economic climate within which young people are growing up, and its potential impact on their sexual and reproductive health behaviours. Some of this information will be readily accessible, such as known political groupings and well-documented political and social tensions in the country. Of particular significance will be any recent or current political and economic 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.

Whilst much of the secondary data gathered at an early stage in the DCA may have considerable face validity and may be regarded as 'official' evidence, researchers will need to be vigilant in evaluating the information to decide whether it is out-dated, inaccurate or incomplete. Any concerns identified or ambiguities and contradictions noted can then followed up as the project progresses, perhaps through interviews with key individuals.

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

Table 1 lists some of the data sources common in many developing countries. The table also identifies some potential weaknesses in the available data.

## 4.2 Existing information of relevance to young people

The next step in the DCA is to collect existing information and literature that will contribute to a more in-depth understanding of:

- the social and cultural dimensions of young people's sexual and reproductive health;
- official policies, laws, regulations and programmes that influence young people's sexual and reproductive health;
- the policies and strategies of international and local NGOs, women's groups, religious groups and community youth groups of relevance to young people's sexual and reproductive health.

### 4.2.1 Social and cultural dimensions

Suitable sources of data here include up-to-date sociological, anthropological and ethnographic accounts that add value to the largely quantitative data described above. The importance of gathering data of this kind during a DCA cannot be overstated if efforts are to be made to move beyond a purely descriptive level.

Important sources of information are likely to 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. Very often contact with one individual will lead to knowledge of other informants. The research team will need to remain vigilant in asking about possible new contacts, and in following them up, so that data gathered are as comprehensive as possible.

As before, it will be important to ensure that local definitions of 'sex', 'sexuality' and 'young people' are adequately explored and understood. For example, there is confusion in many published studies between sexuality and sexual behaviour. The general issue, as noted above, is for the research team to be as certain as possible of the operational definitions in any source material that is used.

*Many of the meanings that male and female adolescents attach to different words or concepts relating to sexuality do not match the concepts that health professionals and school teachers have in mind when they use them. Peru DCA*

Particular attention needs to be paid to the social and cultural dimensions of sexual and reproductive behaviour among young people from different ethnic groups or different social classes. There may be important gender variations in sexual and reproductive behaviour as well as differences according to where young people live, and their degree of contact with people of influence who are active in condoning, sanctioning or encouraging particular sexual behaviours.

**Table 1: Data sources and potential problems**

| <b>Indicator</b>   | <b>Likely source of data</b>  | <b>Possible weakness or bias</b>  |
|--|---|---|
| <b>Socio-economic/demographic</b>  |   |   |
| Number and distribution of young people  | Census  | Age may be incorrectly estimated. Marginal groups likely to be excluded                               |
| Percentage of young people married or cohabiting                                 | Census; Demographic and Health Survey   | Definition of marriage may be difficult in societies where it is a process rather than a single event |
| Percentage of young people in paid or unpaid work                                | Ministry of Labour; International Labour Organisation statistics  | Unpaid work may not be included   |
| Percentage of young people currently (and ever) in school                        | Ministry of Education statistics  | Private and NGO-run schools may not be included. Reasons for drop-out rarely collected                |
| <b>Sexual behaviour</b>  |   |   |
| Percentage of sexually active young people                                       | National AIDS Programme data, academic research, Demographic and Health Survey                          | Age coverage and biases associated with willingness to report sexual activity                         |
| Percentage of young people with multiple partners                                | National AIDS Programme data, Demographic and Health Survey; academic research, NGO surveys/evaluations | Risk of under-reporting (by women) and over-reporting (by men)  |
| Percentage of young people having sexual relations for cash and/or other favours | National AIDS Programme data, Demographic and Health Survey; academic research, NGO surveys/evaluations | Definition of prostitution in societies where sexual encounters often involve cash or gift exchanges  |
| Percentage of young men visiting sex workers                                     | National AIDS Programme data, academic research, NGO surveys/evaluations                                | Very little data likely to be available   |
| Percentage of young people in same-sex relationships                             | National AIDS Programme data, academic research, NGO surveys/evaluations                                | Little data likely to be available  |

Adapted from WHO (1997) *Coming of Age – From Facts to Action for Adolescent Sexual and Reproductive Health*. Geneva: World Health Organisation

| <b>Indicator</b>   | <b>Likely source of data</b>   | <b>Possible weakness or bias</b>   |
|--|--|--|
| <b>Health and family planning</b>  |  |  |
| Percentage of young people using any form of contraception                     | Ministry of Health, Family Planning Association, IPPF and Population Council data.   | Data may only exist for married women. Data may not be age specific.   |
| Percentage of young people using condoms                                       | Ministry of Health, Family Planning Associations, IPPF and Population Council data. Demographic and Health Surveys. Condom social marketing projects | Data may only exist for men. Limited information on correct use, or on condom quality  |
| Young people's fertility rates   | Demographic and Health Surveys. Ministry of Health data.   | Age mis-reporting. Under-reporting of pre or extra-marital fertility   |
| Percentage of young people who have experienced a sexually transmitted disease | Ministry of Health and National AIDS Programme data. Demographic and Health Survey   | Under-reporting by symptom-free individuals. Under-reporting by people treating themselves or being treated by traditional practitioners |
| Percentage of young women who have experienced abortion                        | Ministry of Health data. academic research.  | Difficult to obtain data where abortion is illegal.  |
| Percentage of young women who have experienced genital mutilation              | Some Demographic and Health Surveys, NGO surveys   | Sensitive topic that may not be seen as a 'problem'  |
| Prevalence of vesico-vaginal fistulae in young women                           | Ministry of Health data. NGO surveys   | Under-reporting due to social stigma   |
| Numbers of young people using intravenous drugs                                | Ministry of Justice data, police records.  | People not in contact with the police will not be included.  |

Sensitivity to what may sometimes be subtle social and/or cultural variations within a country is crucial in order to avoid unwarranted generalisations.

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

Topics likely to be explored during this stage of the fieldwork include:

- **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 (for men) and the 'right' to say 'no' (for women); 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).
- **same sex relationships** - with particular reference to social and cultural responses to same sex relationships; the organisation and support of those in homosexual and lesbian relationships.
- **the changing biological and social context of sexual behaviour** - 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.
- **the role of community gatekeepers** - with particular reference to traditional routes of sex education (initiation ceremonies/schools), and the degree to which they persist; societal gatekeepers who encourage or support high risk practices (such as multiple sexual partners, sexual initiation with sex workers); traditional attitudes to contraception and abortion, and the perception and/or adaptation of these by the lay population.
- **the media** - with particular reference to the analysis of newspaper and magazine articles related to young people's sexuality and sexual behaviour; or to perceptions of young people more generally. For example, an analysis of newspaper and magazine articles offering sexual health information and/or advice; a review of magazine 'problem pages' which focus on young people and their sexual and/or reproductive health issues; a critical account of similar presentations in television or radio broadcasts; the impact of increasing globalisation of media.



#### 4.2.2 *Policies, laws, regulations and programmes influencing young people's sexual and reproductive health*

Much of the work during this stage of the DCA aims to identify national policies, laws, regulations and programmes impacting on young people's sexual and reproductive health. Examples may include legislation pertaining to children's rights, the legal age of marriage, contraceptive use and abortion.

*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 DCA

An important source of data will be officials from government ministries who should be questioned about the existence, implementation and efficacy of the various policies, laws, regulations and programmes. Sometimes important contradictions and inadequacies may be discovered between official policies and local actions. For example, non-attendance at school may be over-looked in some rural communities where the economic contribution of young people to agricultural work is seen as essential. Here, as in other cases, it may be important to ascertain why the 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.

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

Efforts should also be made to find out the extent to which laws are enforced and, if so, what the penalties for non-compliance are. It may also be relevant to ask about the budgets that enable laws and policies to be implemented.

Tracing the development of policies over time and finding out what future changes are planned is important. In particular, efforts should be made to identify key factors influencing policy development and changes in the law with regard to young people's sexual and reproductive health. Sometimes, detailed information will be available about policy development in workshop and meeting reports focussing on young people's sexual and reproductive health.

*The lack of institutionalisation has its pros and cons. On one hand, it is a problem that policies are not continuous through time due to changes in government. They are linked to individuals in key positions, and shifts of personnel bring changes in policies and in the government-NGO relationship.* Mexico DCA

It may also be useful to explore the impact of religious doctrines on social health policy and laws. In Zimbabwe, for example, conflict has been identified between the traditional rights of parents and the UN Convention on the Rights of the Child to which the government was a signatory.

Important sources of data to learn about laws, policies and regulations are likely to be the Ministry of Health and the Ministry of Education. For example, 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 appropriate);
- staff training for work associated with young people and sexual and reproductive health issues.

Information obtained from a Ministry of Education might include:

- the context within which sex education in schools takes place
- the status and content of sex education and the ages at which it is provided;
- national directives affecting the curriculum;
- consultation about sex education with young people, parents and teachers;
- specialist teacher training for sex education;
- barriers to sex education;
- the monitoring of programmes of sex education and evaluation of outcomes;
- policies with respect to school age pregnancy, school attendance and teacher/pupil relationships.

Other government departments from which it will be important to gather data include ministries of youth, ministries of labour, ministries of culture and sport, ministries of women and/or ministries of justice.

Throughout all of the above, it is important for a DCA to seek out relevant information from those sources appropriate to the country under study, including information on especially sensitive topics including homo/bisexuality, domestic violence and sexual abuse. Researchers will need to remain sensitive to the variations that occur between and within countries, including traditional laws and customs which may only be discovered through less formal channels of enquiry.

*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 DCA

#### 4.2.3 NGO, religious and community influence

Beyond the 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 and community groups with respect to young people's sexual and reproductive health is likely to necessitate rather different data gathering techniques from those cited above. While there may be some documented data, much information is likely to come through personal contact with key individuals. Visits to NGOs and other community groups should be carried out in order to elicit their priorities related to young people's sexual and reproductive health. Drawing on the 'official' information collected, the analysis should explore the relationships between government and non-government organisations and how far their policies and activities complement and support each other and, alternatively, where they are at odds.

The aim should be to establish whether these organisations fill gaps in sexual health provision and, if so, what these gaps are. Some of this work will be to discover the particular characteristics of the different populations targeted by the various organisations and 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 do not consider the ethnic and cultural specificities of the young people for whom they are designed. Such a perspective will of course require checking against other available evidence. At the same time researchers will need to determine if there are some groups of young people who are so marginalised that they are 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 DCA

By talking with international NGOs, it will be possible to assess how their in-country activities reflect their overall policy on sexual health or on the welfare of young people. Many large NGOs have sites on the World Wide Web which can be accessed easily over the internet and which offer a statement of their overall vision or goals. Their policies on, for example, child labour, female genital mutilation or children in war may however be modified at the local level to fit in with

cultural norms and realities. Differences between policies conceived in the head offices of these organisations and the way in which they are implemented at a local level will constitute an important part of any DCA findings.

Local NGOs (ie NGOs run and managed in-country) can play a significant role in determining young people's access to services and in seeking to bring about behaviour change and better sexual health outcomes. While local NGOs may have a lower profile and smaller budget than their international counterparts, they may have objectives that are more socially and culturally appropriate, and therefore have a significant impact on sexual and reproductive health. Where appropriate, interviews with local NGO co-ordinators should aim to elicit how they view their role in relation to international NGOs and to government initiatives, as well as to gather details of their activities and service provision.

It is especially important to assess the quality of NGOs' evaluations of the impact of their activities, as the rigour with which they are conducted may vary together with the overall commitment to the need for evaluation. It is crucial, therefore, to determine whether systematic research and evaluation activities form an integral part of NGO programmes and to identify possible biases in their evaluation methodologies or intervention priorities.

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

Table 2 indicates the kind of information that will be sought during this stage of the DCA and during interviews with key informants.

### **4.3 Operational realities: the importance of interviews and observation**

Some time will need to be given to assessing the operational realities of the programme and project data gathered thus far. In addition, efforts will need to be made to develop an understanding of events from the perspective of young people themselves. To do this, members of the DCA team will need to visit relevant organisations in places where young people meet and/or come into contact with service providers.

*By and large, 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 DCA*

In most locations, there will be opportunities both for interviews and for informal observations. For example, when visiting a health clinic the researcher will have the opportunity to note the accessibility and appropriateness of the location and will gain some sense of the prevailing atmosphere within it. Specifically, it will be important to record how welcoming to young people the clinic seems and whether the staff are non-judgemental and non-threatening in their dealings with young people. The researcher will also be able to ascertain some information about the characteristics of the young people attending the clinic.

It is expected that a significant number of individuals will be interviewed at various stages throughout the course of the DCA. One aim of carrying out interviews will be to investigate how health and education policies and programmes operate in practice. It will be important to explore this with different groups. For example:

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

It will also be crucial to hear from young people about their knowledge, activities and concerns with regard to sexual and reproductive health and their views about intervention policies and programmes and their actual or likely effectiveness. Important disparities between different perspectives may thereby be highlighted.

*In Bore, the matrone 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 DCA*

**Table 2: Policies and programmes; example questions**

|   |  |
|---|--|
| <p><b>Characteristics of the organisation’s young people’s sexual and reproductive health programme</b></p> | <p>Are the targeted groups men and/or 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?</p> <p>What are the key elements of the programme? For example does it provide information, education and/or communication training? Is it involved with service provision?</p> <p>How is the programme implemented (e.g. through schools, health services, peer education, youth associations)?</p> <p>Has the programme been evaluated and, if so, when and by whom? What were the results? What was the quality of the evaluation?</p> <p>How and by whom is the programme funded? Does the source of funding have any influence on policy or programme content and delivery?</p> <p>Does the programme operate in collaboration with, or separately from, government health services? What is the nature of any collaboration? Are costs shared?</p> |
| <p><b>Sexual behaviour</b></p>  | <p>What are the organisation’s policies/views about, for example, sex between unmarried people, same sex sexual relationships, sexual activity for money?</p>  |
| <p><b>Marriage</b></p>  | <p>What are the organisation’s policies/views about, for example, age at first marriage, early marriage, forced marriage, polygamous and leviratic marriage (where applicable)?</p>  |
| <p><b>Contraceptive use</b></p>   | <p>What are the organisation’s policies/views about, for example, providing contraceptives for those who are young or under a particular age, for those who are unmarried, for men? What kinds of service are provided? For example, which types of contraceptives are offered, are users followed up, does tracking of clients take place? What is the quality of the service? For example, is it confidential? Where is the clinic(s) located, what are the opening hours, is it welcoming for young people? Is there a pricing policy?</p>  |

**Table 2: Policies and programmes; example questions**

|                        |  |
|------------------------|--|
| <b>Abortion</b>        | What are the organisation's policies/views about abortion, abortion after rape, abortion when the mother's health is at serious risk? Is abortion included in their reproductive health services?  |
| <b>Employment</b>      | What are the organisation's policies/views about child labour and in particular hours of work, pay and exploitation? Does their programme address young people's working conditions, pay, rights to join unions/syndicates, conditions of urban/rural migration?                   |
| <b>Education</b>       | What are the organisation's policies/views about school attendance, female education, sex education in schools? Does their programme include activities concerning female schooling, education for marginal groups, the content of national or NGO school sex education curricula? |
| <b>Out of school</b>   | What provision is there for out of school activities, particularly those to reach children not attending school? How are hard to reach groups included?  |
| <b>Sexual violence</b> | What are the organisation's policies/views about sexual violence and does their programme include activities to support young women at risk of or subjected to violence and/or work with young men?  |

Interviews may be conducted on a one-to-one basis or may take the form of a group discussion or focus group. The optimum number will depend upon, on the one hand, the resources available and, on the other, the level of variation that needs to be accommodated; for example, in settings with ethnic, religious, cultural and regional diversity.

Generally, it will be best to interview officials from various organisations on their own whereas young people might be more at ease in a group situation. Often such meetings will take place while the researcher is visiting a particular organisation (for example, a school, youth centre or health facility). Keeping accurate notes, and sometimes recording speech verbatim, will be helpful to ensure that data are complete and meaningful. There will be times when direct quotes from individual interviews (maybe unattributed) and/or focus groups will be appropriate in the final 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 DCA

Depending on the scope and nature of the DCA, interviews and focus group discussions may need to be conducted in both urban and rural settings. In health centres, group discussions and interviews could be carried out with staff working at different levels as well as with the young people accessing the service. In schools, focus groups and interviews could take place with teachers, members of the governing body and/or parent-teacher association and young people. Particular attention should be paid to discrepancies between the responses of those in authority and of the young people themselves. There may also be opportunities to observe what is taking place at the visit location and such observations can be used to cross-check both documented and interview findings.

Given the limited time and resources likely to be available for a DCA, it is important to make the most of this opportunity for gathering qualitative data. It is one of the main chances for young people's voices to be heard and therefore included in the final report. Emphasis should be placed on assessing young people's own perceptions of the barriers to better sexual health, and on the ways in which they think these could be overcome. It is important to be aware, however, that the leaders of young people's groups may have points of view that do not necessarily reflect the perspectives of all the young people they claim to represent. A group's chosen or elected leader may be, for example, better educated or wealthier than those who elected him or her.



A particular challenge for researchers working on a DCA will be to find ways of talking to marginalised young people who may not be readily accessible through the usual channels of contact. Their views and concerns will be essential if the DCA is to reflect the diversity of opinions likely to exist among a country's or a 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 DCA

Difficulties may arise in selecting individuals for interview or discussion. Given time constraints, it is acceptable for participants to be selected purposively by the researcher. Within the various organisations that provide documented information for a DCA, it may be relatively easy to identify those individuals most suitable to be key informants. Such people will often be gatekeepers to the information, or may sometimes be the person mainly responsible for the policy or programme. There will be a need to guard against the selection of only those individuals put forward by those in authority. For example, a head teacher might select those pupils who are seen as a good advertisement for the school or those who it is thought will give 'correct' answers to the interviewer's questions.

As indicated above, this part of the DCA provides the best opportunity for the researcher to be able to identify any gaps between the ways in which programmes are said to be implemented and what actually happens *in practice*. In addition, it offers the chance to explore in some depth the reasons that might lie behind such discrepancies. Researchers at this stage of the analysis will need to be particularly sensitive to the diversity of data available to them so that they remain open to discovering the unexpected.

*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 the operational obstacles of their programmes.* Mexico DCA

The use of interview and observational methods together should help to minimise reporting errors due to recall bias, to participants feeling unable to talk freely about subjects that may be embarrassing or taboo, or to discrepancies between what reportedly takes place and what actually happens. Observation is also likely to be important in accessing data unattainable in other ways. Such data may prove to be the only way to gather information about shortcomings in the

implementation of programmes and policies of which the people involved (both organiser and recipient) may be unaware.

Observation, whilst very valuable, is time consuming and labour intensive. Its inclusion in any DCA will therefore need to be carefully thought about so that it is used to good effect. The team should decide on those areas where it is thought to be essential for high quality work. It may be that social interaction during, for example, a family planning provider's consultation is worthy of observation to help access data about the relationship between the provider and the client. A researcher may sit in on a consultation to observe eye contact, sitting positions, physical proximity and tone and nature of the conversation. Such data however are not only time consuming to collect but also require careful analysis if interpretation is to be meaningful.

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

In many DCAs, observation may be carried out using a checklist to note specific elements of interest. Such observations require the researcher to create a list of issues that are then verified with or without the help of the informants from the setting under study. When visiting a health centre, for example, it may be important to note the location and type of buildings and various aspects of the physical environment such as cleanliness, atmosphere, lighting, sources of water and the presence/absence of posters. In schools during sex education classes, observations may be made of who was teaching, the age and sex of the pupils, the topics discussed, the teaching methods, materials used, the nature of the language (formal/informal/slang), and the general atmosphere amongst the students (e.g. attentive, giggly, 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 DCA

The use of observational methods is not without difficulty. Observation may cause people to change their behaviours, and there are important ethical dilemmas associated with covert or unannounced observation. Each DCA team will need to decide on the appropriate course of action within the context in which it is working.

Some suggested topics for interviews and focus group discussions at different locations are listed in Table 3.

#### 4.4 ***Innovative, effective and ineffective interventions***

Throughout the DCA process the research team should endeavour to identify and document innovative approaches to promoting young people's sexual and reproductive health for inclusion in the final report. Innovative interventions include activities that go beyond traditional service provision in health and formal education settings. Some examples, recently reviewed by UNAIDS<sup>6</sup> 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;
- theatre based activities;
- parent-led initiatives in and out of school.

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

During the course of a DCA some ineffective interventions will be noted. However with the limited resources likely to be available, data gathering should concentrate on finding out more about those interventions that have been or are being successful, and the reasons for this. It is suggested that each research team attempts to identify and visit at least two successful, innovative interventions that have affected young people's sexual behaviour and improved their sexual health.

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

During a field visit, detailed interviews and group discussions should be carried out with those who run and participate in a project or intervention. In this way, information and opinions can be accessed from fieldworkers, health workers and, importantly, young people themselves. Existing research confirms that, to be successful, interventions need to go beyond just providing information about sexual health. Rather they need to help young people develop specific skills such as the ability to plan ahead, to seek appropriate help, to form positive relationships and to communicate effectively.

Young people's ability to develop these skills will be influenced by their immediate environment including their family, friends and wider community. Data gathering techniques must be chosen that will allow access to all the elements required for interventions to be successful, as well as to how they operate within the social, economic and cultural context in which young people make sexual health decisions.

Attention will need to be paid to the role of community gatekeepers and their influence on access to any project. Similarly, the role of other key stakeholders, such as teachers, clinic personnel and voluntary workers, should be explored.

*In general terms, providers were in favour of delaying sexual initiation. One woman provider in Ayacucho said males could initiate their sex lives earlier than females because they had "certain needs, which they had to fulfil". Peru DCA*

An important part of the DCA will be to find out what, if any, local evaluation has taken place of the impact of interventions and to determine how rigorous such an evaluation was. There may be questions to ask about the size and make-up of the sample used and, in particular, about the indicators selected as markers of change.

**Table 3: Suggested interview and focus group discussion topics**

| <b>Health Settings</b>   |
|--|
| <ul style="list-style-type: none"> <li>• Confidentiality (in general; in relation to pregnancy, abortion, STIs) and related issues of permission seeking and partner tracing</li> <li>• Services available e.g. medical; educational; counselling; follow-up; referral</li> <li>• Range of contraceptives available</li> <li>• Gender related issues e.g. separate clinics for young women and for young men</li> <li>• Issues of sexuality (attitudes towards lesbian and gay young people; availability of specialist services)</li> <li>• Materials available e.g. posters; leaflets</li> <li>• Involvement in advertising/publicity (style; extent; key messages)</li> <li>• Links with other services e.g. education; outreach work</li> <li>• Integration with other services e.g. contraception/STI treatment</li> <li>• Information on help seeking patterns and social networks of help seeking</li> <li>• Fieldwork/outreach e.g. with schools; marginal groups</li> <li>• Relevant policies and their implementation e.g. under age sex; contact tracing</li> <li>• 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</li> <li>• Funding e.g. public/private; charges to users</li> <li>• General ambience e.g. welcoming; young people friendly; comfort; waiting times</li> <li>• Personal experiences of users</li> </ul> |
| <b>School Settings</b>   |
| <ul style="list-style-type: none"> <li>• Overall culture within the school</li> <li>• Surveys of needs carried out e.g. with young people; staff; parents</li> <li>• Parental information and consultation</li> <li>• Curriculum and place of sex education within it now/future possibilities</li> <li>• Image of sex education (young people; parents; governors)</li> <li>• Support/non support for sex education and from whom does it come</li> <li>• Barriers to/concerns about sex education</li> <li>• Mandatory or voluntary; withdrawal policy/rights</li> <li>• Topics included in sex education and age delivered e.g. gender issues; sexual orientation; abortion; pregnancy</li> <li>• Language used within sex education programme</li> <li>• Respect for students' views</li> <li>• Expected/ideal outcome from sex education; monitoring and evaluation</li> <li>• Staff involved in sex education (gender; power; status; specialisms; training; updating)</li> <li>• Teaching materials available e.g. books; videos; contraceptives</li> <li>• Teaching methods e.g. drama; role play; debates; discussions; lectures</li> <li>• Comparison between approaches to sex education and teaching methods for other subjects</li> <li>• Liaison with other agencies/services</li> <li>• Experience of recipients</li> </ul>   |

<sup>6</sup> See UNAIDS Best Practice Collection. Available online at: [www.unesco.org/education/educprog/pead/GB/AIDSGB/AIDSGBtx/BestPrac/CadBesPr.html](http://www.unesco.org/education/educprog/pead/GB/AIDSGB/AIDSGBtx/BestPrac/CadBesPr.html)

## Section Five

# *Drawing conclusions & recommendations*



Once data collection for the DCA is underway, it is essential for the research team to begin to think about data analysis and the drawing of conclusions. Often this will be the most challenging stage. Throughout the DCA process, data analysis should be an ongoing activity since this allows the early identification of omissions and / or problems, and will enable adjustments to be made to the subsequent fieldwork. It is strongly recommended that time be set aside at regular intervals for such reflection, either individually or as a team. Where an advisory group is involved, it should also contribute to the ongoing analysis.

### **5.1 Analysing the material**

The aim of data analysis is to highlight and generate insight, understanding and new knowledge of the relationship between local, cultural and interpersonal factors, and how these mutually influence young people's sexuality, sexual and reproductive health. Recommendations on how best to approach and engage in the issues identified can then be made drawing upon the evidence collected. It is essential that any analysis provides a complete and accurate a picture as possible, taking into account the diverse range of factors impacting upon a young person's development as an individual and sexual being. Failure to do this will result in narrow and often impractical solutions.

*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 DCA*

Typically, the analyses associated with a DCA occur in two phases. The first phase involves a focus on individual datasets and information collected during the study. The second is more complex and involves bringing together a diverse range of information to identify and delineate major themes.

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

The types of analyses required during phase one will be strongly guided by the sorts of data and information collected during the fieldwork. Secondary data sources may require extensive quantitative analyses. For example, if young people's responses in DHS (Demographic and Health Survey data) have not been analysed separately from the entire dataset, then there will be a need to do this. Policy analysis can be used to examine the effects of policy change and development over time and thematic analysis will need to be applied to any interviews and focus group discussions conducted with key informants. Literature and expertise on the qualitative and quantitative data analysis techniques used to undertake such tasks is both widespread and diverse and should be drawn upon at every opportunity. It is strongly recommended that, if necessary, the research team consult local analytical texts and local experts for guidance before commencing any analysis.

Once the different data sources have been collated and individually analysed, the second more complex phase of analysis can commence. During this phase, the team can begin to derive some preliminary conclusions from the DCA process and start to formulate a series of hypotheses that may be able to be tested using the data already collected, or which may require further data collection as part of a specialised study. Although every phase two analysis will vary depending on the sort and quality of data gathered, it is likely to involve each of the following stages.

### **5.1.1 Stage one**

The first stage of analysis should aim to identify the major themes concerning young people's sexual health, summarise current knowledge, outline the present situation and describe any variations, trends or changes that have occurred in recent years. Any gaps in knowledge and information should also be highlighted at this point. Examples of data suitable for stage one include:

- socio-economic and demographic factors that relate to young people's status in the country, e.g. number and distribution, percent married, school enrolment figures, percent in paid employment, household income;
- information regarding the sexual health status and behaviour of young people, e.g. percent sexually active, use of contraception, prevalence of STIs, abortion rates, patterns of illicit substance use, percent engaging in sex work or compensated sex;
- laws and policies impacting upon young people and their health, including institutional responses;

- formal and informal modes of education and their consequences, including levels of sexual health knowledge and awareness;
- provision of health services for the general population and specifically for young people, e.g. nature of services, accessibility, variations in provision, costs.

*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 DCA*

### 5.1.2 Stage two

The second stage of analysis should define and describe the role of other more contextual factors impacting on the lives and behaviour of young people. For example,

- norms (social, cultural and gender) and their impact on the construction of young people's identity;
- personal relationships and networks - key relationships inside and outside the family, how they are developed and what they mean to young people;
- the role of the media and the delivery of implicit and explicit messages;
- the role and influence of organised religions.

*There is a need to use methodologies of study that allow for the exploration of the contexts of sexual activity, that is, sexual identities interfaced with the various socio-cultural identities and meanings that relate to the sexual and reproductive health of youth. Brazil DCA*

### 5.1.3 Stage three

The third and most important stage 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 structural, local, cultural and interpersonal factors on behaviour in an attempt to understand the changing dynamics of young people's sexual health and to answer the central question *‘Why are things like this?’*. Examples of questions past research team have asked during stage three are included below. Again, these are not meant to represent the best or only way of examining the issues but to serve as a guide to future DCA 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 behaviour?



- What are the sexual discourses 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 personal, family, 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 sexual practices; who exerts these pressures; why do they exist?

*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 DCA

*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 DCA

## 5.2 Preparing the report

Before starting to write up the findings of the DCA in the form of a report, it is strongly recommended that all members of the DCA team, including those involved in both the planning and data collection stages, hold a meeting to discuss the main findings emerging from the phase two analysis. This not only gives everyone involved the opportunity to go through the findings fully, but can also be used to stimulate ideas for future action.

Although a report is only one of many outputs produced from a DCA (see Section Six), it is likely to be the only one to include a detailed account of the entire process and the data and information sources utilised. Consequently, it should be accessible to all those with an interest in young people's sexual and reproductive health, and be written using clear and simple language. All technical terms

should be accompanied by a definition the first time they are used. Uncomplicated charts and tables should be used liberally to illustrate points and full use should be made of annexes and appendices to document, for future reference, relevant material not included in the main body of the text.

Final report writing often takes longer than first imagined, so it is recommended that when developing a time plan and budget for the project at least four complete weeks are set aside for this task

While every DCA final report will differ in its content and style given the huge variations between the types and quality of data available, the time given to the process and the professional orientations of the research teams, the headings displayed in Table 4 have been developed to guide the process.

*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 DCA

*There is a need to deconstruct the concepts of adolescents and youth by stepping beyond the limits laid down by the medical/biological point of view.* Brazil DCA

The optimum length for a DCA report is perhaps 40-50 pages (excluding appendices), together with a 2-3 page executive summary. Section six describes how these documents can be transformed into more digestible reading material for different target audiences.

### **5.3 Drawing conclusions**

Drawing conclusions from the findings of a DCA requires a somewhat different approach to that used in analysis. The conclusions the research team arrive at provide the basis for future action. Consequently, conclusions and recommendations aimed at policy makers will be very different from those for local youth workers, which in turn may vary considerably from those aimed at researchers. Conclusions and recommendations therefore need to be considered carefully and tailored towards specific audiences.

At this stage, the research team may wish to consider the involvement of other lay people and professionals from both inside and beyond the research arena who may or may not have previously been directly involved in the DCA process. For example, policy makers, programme managers, independent consultants and young people may all have important contributions to make. Such people may be in a better position to make judgements and decisions as to the best way forward.

When developing the final recommendations and conclusions it may be useful to bear in the mind the following principles and questions to help guide the process:

- ***Who are the target audiences of the report?***
- ***What are the key issues of importance to the target group(s)?***  
Do the ideas developed at the start of the study still hold true?  
Have new hypotheses and ideas emerged?
- ***What is the current situation regarding each of the key issues?***  
What are the existing sources of information about the issue?  
Are the sources of information sound?  
What are the current gaps and omissions?  
Is more research required?  
Has this issue been tackled in the past?  
What laws and policies are currently in place to tackle this issue?  
Who is involved?  
Do these policies reflect what is happening on the ground?
- ***What can be done?***  
What suggested changes are to be made in the long and short term?  
What will these changes involve?  
Who will be involved in these changes?  
How easily can these changes be made?
- ***What are the current barriers and constraints to change?***  
Is there general agreement for change?  
What are the potential objections?  
Is the social, economic and political climate conducive to change?

- ***What are the opportunities for overcoming these barriers?***

Is further research required?

What approach should be considered?

What activities are required?

Are the barriers ones that can realistically be overcome?

- ***What potential impact will the changes have?***

How, and in what ways, are the changes likely to make a difference to the lives of young people?

How, and in what ways, are the changes likely to have a positive effect on the physical and psychological sexual and reproductive health of young people?

**Table 4: Suggested headings for the final DCA report**

|  |
|--|
| <ul style="list-style-type: none"> <li>• <b>Introduction</b></li> </ul>  |
| <p>To include an executive summary, a description of the overall purpose of the DCA, the objectives, a description of the institutions involved in the study and who funded it.</p>  |
| <ul style="list-style-type: none"> <li>• <b>Background</b></li> </ul>  |
| <p>The country (or region) - a brief description of the geography, the current political and economic scene (including changes over the last few decades), recent social transformations.</p> <p>Young people - their status in the country, norms and other contextual information.</p> <p>Sexual health of young people - sexual activity, pregnancy, abortion, STIs, HIV/AIDs, social and cultural dimensions, the role of gatekeepers and the media, narrative descriptions and discourses</p>   |
| <ul style="list-style-type: none"> <li>• <b>Legal and policy framework</b></li> </ul>  |
| <p>Key actors and institutions involved in young people's sexual health - the role of national and local government, international and local NGOs, voluntary groups, youth groups, church groups, women's groups.</p> <p>Laws of relevance to young people's sexual health - a description of the laws from the Ministries of Health, Education, Labour, Culture, Justice, Women, Youth and Sport, including penalties for breaches.</p> <p>Programmes and policies - an outline of official and NGO policies and programmes aimed at improving the sexual health of young people, organisational structures, funding and implementation mechanisms.</p> |
| <ul style="list-style-type: none"> <li>• <b>Sources of support and services</b></li> </ul>   |
| <p>Health sector services - a description of the health services provided for young people, including public and private, NGO and community programmes, traditional healers and other informal health providers. Young people's utilisation of services, barriers to access, examples of innovative activities, evaluations conducted, inappropriate activities</p>  |

Education sector - a description of sources of sexual/reproductive education for young people, including public and private education, NGO and community programmes, traditional/ritual sources, gatekeepers, parents, relations, friends, peers, the media and other informal providers of education. Quality of education, issues discussed/not discussed, young people's utilisation, barriers to education, innovative educational programmes, evaluations conducted, inappropriate activities.

• **Discussion and analysis**

Gaps and omissions - including silences (neglected issues), marginalised groups, policy gaps, knowledge (missing data sources).

Contradictions and inconsistencies - instances where policy does not reflect reality (all sectors and organisations), where different agencies' objectives are incompatible.

Barriers and constraints - barriers to the improvement of young people's sexual and reproductive health e.g. financial, conflicting discourses, personal, political and religious.

Opportunities and challenges - where opportunities for the improvement of young people's sexual health lie, new innovative activities, strengthened programmes, policy changes / developments, future research needs.

• **Conclusion and recommendations**

• **References & appendices**

# *Section Six*

## *Using the results of a DCA*



As previously mentioned, the aim of a DCA is to generate new knowledge to inform policy and programme development to promote the sexual and reproductive health of young people. The findings of 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 workers at grass-roots level and researchers in the field. As has already been highlighted, the results and recommendations that most interest policy makers may sometimes differ from those of greatest interest to researchers. Careful planning of the strategy for dissemination is therefore required.

Dissemination of preliminary findings and information about the progress of the project will occur periodically during a DCA as the research team makes contact with stakeholders and key players as part of the fieldwork and data collection phases. The purpose of this section is to provide guidance on how best to disseminate the final results to people in positions of power and influence, and to those who can move forward the recommendations, respond effectively to the findings and make the required changes for improvements in young people's sexual and reproductive health.

### **6.1 Dissemination for optimum impact**

A DCA provides a dynamic but 'snap-shot' picture of the status of young people's sexual and reproductive health at a particular point in time. The findings therefore need to be disseminated as soon as they are available to ensure that local communities, local programmes, governments, NGOs and international organisations respond swiftly and appropriately to the present needs of young people.

To use a DCA to best effect, all potential users need to know what has been learned and what action is now required. The development of final reports, presented in a variety of formats and lengths for different audiences is essential. However, reports frequently fail to reach all those for whom they are intended. Moreover, written summaries are not always sufficient to make a

difference. Other ways must therefore be found to disseminate and reinforce the messages and to stimulate and inspire action.

The first step in the development of a dissemination strategy begins at the outset of the DCA process, with a stakeholder analysis and the identification of the groups of individuals with whom the results of the study will be shared. The audience should include:

- those who have decision-making powers to act on the recommendations;
- those who are directly affected by the recommendations;
- those who were directly involved in the DCA process.

Specific groups who fit these criteria include: government and NGO policy makers, programme planners and managers, service providers, donor and funding agencies, youth and community leaders, religious leaders, parent, carers, health and education professionals, young people, the general public, academics and other researchers and the media

The second step is to identify the information needs of the key audiences. These may include some or all of the following:

- current prevalence statistics;
- patterns of behaviour;
- health needs;
- responses to existing service provision;
- cost assessments;
- gaps and opportunities for service provision;
- barriers to improved sexual and reproductive health;
- innovative and successful activities;
- details of the DCA process.

The third and final step involves the identification of the most useful and appropriate channels of communication for the dissemination of results. Alternative routes for dissemination that ought to be considered are listed in Table 5.



**Table 5: Modes of dissemination**

|                                    |  |  |
|------------------------------------|--|--|
| <b>Verbal communication</b>        | Lectures and talks<br>Seminars<br>Workshops<br>Conferences<br>Briefing sessions<br>Press conferences   | Informal policy briefings<br>Radio announcements, interviews & call-in shows<br>Television programmes<br>Videos<br>Tape / CD-recordings                                  |
| <b>Written and visual material</b> | Full reports<br>Executive summaries<br>Journal articles & papers<br>Newsletters<br>Books<br>Monographs<br>Press releases<br>Policy memos<br>Fact sheets<br>Wall charts | Data sheets<br>Newspapers<br>Magazines<br>Interviews in print<br>Information & training packs<br>Posters<br>Web-sites<br>Electronic mailing lists<br>CDs<br>Floppy disks |

Structured and well-executed dissemination is crucial if the results of the DCA are to have the desired impact. The final outputs should therefore be written so that they enable readers at all levels to understand the social and political context of young people's service provision and the factors that facilitate or hinder optimal sexual health. (See Tables 6 and 7 for possible report formats).

The use of technical jargon should be avoided wherever possible or, if used, fully explained. Print media should be uncluttered, simple and attractive. Length should also be carefully considered. In some instances, summing up using three or four key points may be very effective. In all instances, however, the message that is being delivered should be accompanied by a series of implications and/or feasible recommendations for action.

**Table 6: Report formats for suggested users**

| <b>Format</b>                  | <b>Audience/users</b>  | <b>Recommended length</b> |
|--------------------------------|--|---------------------------|
| Executive summary/short report | Fieldworkers, practitioners, general public, press, summary for planners, donors                     | 1-4 pages                 |
| Medium length report           | Government, voluntary sector, international & local NGO programme and policy developers, researchers | 10-25 pages               |
| Longer report                  | Libraries, researchers and other specialised interest groups   | 50-75 pages               |

**Table 7: Example layout for one page executive summary**

| <b>Domain</b>    | <b>Major barriers</b> | <b>Major opportunities</b> | <b>Priorities for action</b> |
|------------------|-----------------------|----------------------------|------------------------------|
| <b>Education</b> |                       |                            |                              |
| <b>Health</b>    |                       |                            |                              |
| <b>Policy</b>    |                       |                            |                              |
| <b>Research</b>  |                       |                            |                              |

The research team will need to think carefully about who are the most appropriate groups or individuals for inclusion in some of the dissemination activities. It might be appropriate, for example, to consider the involvement of individuals and organisations with past experience of dealing with particular target audiences, since credibility is fundamental if the findings of a DCA are to be taken seriously. Using credible publishers and outlets for dissemination is crucial if a research team is to have the impact it desires. Moreover, if a team wishes to move further towards bridging the gap between policy and research, it may be worth considering recruiting the assistance of high status advocacy groups who are practiced in lobbying and raising awareness among politicians and those in positions of power.

It is also strongly recommended that the team cultivates a good relationship with the media at an early stage. Radio and television can be extremely useful in raising awareness among the general population and, in particular, among certain hard-to-reach groups including those who are illiterate. Through the development of a network of journalists to whom information can be sent on a regular basis, the public can be continuously reminded of the importance of such work and the negative implications of ignoring change. This kind of partnership can have the added benefit of sensitising people to key issues prior to the publication of the final report, thus reducing or even preventing the possibility of a media backlash and negative reporting.

## **6.2 Follow-up action**

Work does not stop with the completion of the final report and the production of executive summaries. If DCA results are to have an impact on the lives of young people, targeted activities need to be sustained in the months following completion.

Awareness of the issues facing young people should be sustained by taking every opportunity to disseminate the findings of the DCA. Maintaining a focus on the key issues and keeping them in the media spotlight is vitally important if appropriate changes are to occur. For example, the research team might consider approaching different media outlets in the following months with ideas for relevant stories to ensure that interest does not wane.

An advocacy strategy to modify and influence policy should also be developed. To enhance impact, this could be implemented in conjunction with other players and organisations with specific interests in the field of young people's sexual and reproductive health. High profile individuals known for their connections with young people could be recruited to assist. Further, the research team could consider involving the voice of young people themselves in its advocacy work.

Involving policy makers, stakeholders, gatekeepers, parents, teachers, practitioners and young people in all stages of the DCA process (design, collection of data, development of recommendations, dissemination of results) will build ownership and acceptance of the results, whilst at the same time providing a good basis for follow-up work and actions. Furthermore, the bringing together of individuals and professionals from a variety of sectors throughout a DCA is an important strategy for developing complementary activities following the completion of the study.

### **6.3 Monitoring change**

As mentioned previously, the findings of a DCA provide a 'snap-shot' in time. The information collected is therefore eminently suitable for later use as baseline data. It may offer a range of indicators relevant to young people's sexual and reproductive health. For example:

- 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 and levels of regret. Increase in levels of mutuality and respect.

This baseline information is important because it is against this that the success or otherwise of future interventions, particularly those that result from a DCA itself, can be measured and evaluated. Replicating the DCA process in its entirety, or on a much smaller scale in future years, will enable monitoring of targets and tracking the progress of improvement. It is this long-term commitment to research and to the implementation of culturally and socially acceptable interventions that offers the best chance of improving the sexual and reproductive health of young people throughout the world.

# *Further Information Resources on the Internet*



## ***Centers for Disease Control and Prevention, Division of Reproductive Health (DRH)***

[www.cdc.gov/nccdphp/drh/logistics/global\\_rhs.htm](http://www.cdc.gov/nccdphp/drh/logistics/global_rhs.htm)

The CDC's Division of Reproductive Health (DRH) surveys collect information in the areas of family planning, fertility, infant and child health, maternal morbidity and mortality, young adult sexual behaviour, sex education and attitudes toward sexuality and gender issues, reproductive health care issues, HIV and STIs, intimate partner violence, and evaluation of specific programmes.

## ***Center for International Health Information***

[www.cihi.com/hthpub.htm](http://www.cihi.com/hthpub.htm)

CIHI's Country Health Profile Series includes Health Statistics Reports (HSRs), which present basic national-level demographic and health data for most developing countries, and Country Health Profiles (CHPs), which provide a more comprehensive analysis of health conditions and trends in selected countries.

## ***Demographic and Health Surveys***

[www.measuredhs.com/](http://www.measuredhs.com/)

Demographic and health surveys provide information on family planning, maternal and child health, child survival, HIV/AIDS/STIs and reproductive health.

## ***Global reproductive health forum***

[www.hsph.harvard.edu/Organizations/healthnet/](http://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.

***Healthlink worldwide***

[www.healthlink.org.uk/](http://www.healthlink.org.uk/)

Healthlink Worldwide's bibliographic database provides access to more than 16,000 records of materials focusing on the management and practice of primary health care and disability in developing countries.

***ID21***

[www.id21.org/](http://www.id21.org/)

Aims to make policymakers and on-the-ground development managers aware of the latest development research findings.

***National Library of Medicine Gateway***

[gateway.nlm.nih.gov/gw/Cmd](http://gateway.nlm.nih.gov/gw/Cmd)

The NLM Gateway allows users to search in multiple retrieval systems at the U.S. National Library of Medicine (NLM). The current Gateway searches MEDLINE/PubMed, OLDMEDLINE, LOCATORplus, AIDS Meetings, HSR Meetings, HSRProj, MEDLINEplus and DIRLINE

***POPLINE***

[www.jhuccp.org/popline/](http://www.jhuccp.org/popline/)

POPLINE is the world's largest bibliographic database on population, family planning, and related health issues.

***PopNet***

[www.popnet.org/](http://www.popnet.org/)

Presents information on population topics such as demographic statistics, economics, education, environment, gender, policy and reproductive health. Its resources include Web sites produced by Government and International Organisations, Non-governmental Organisations, University Centres, and Associations.

***Population Reference Bureau, Population and Health Database***

[www.worldpop.org/prbdata.htm](http://www.worldpop.org/prbdata.htm)

The population and health database contains data on 85 demographic variables for 221 countries in the world, for 28 world regions and sub-regions.

***Safe Passages to Adulthood***

[www.socstats.soton.ac.uk/cshr/safepassages.htm](http://www.socstats.soton.ac.uk/cshr/safepassages.htm)

Present information on current research activities, example research instruments and relevant publications.

***US Census Bureau, International Data Base (IDB)***

[www.census.gov/ipc/www/idbnew.html](http://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 HIV/AIDS Information and Data***

[www.unaids.org/hivaidsinfo/](http://www.unaids.org/hivaidsinfo/)

Includes most recent 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](http://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 research instruments on aspects of adolescent sexual and reproductive behaviour.

***United Nations Population Information Network (POPIN)***

[www.undp.org/popin/](http://www.undp.org/popin/)

Includes an extensive electronic library, population trends database and regional population information and networking.

***World Bank Data Base***

[www.worldbank.org/data/](http://www.worldbank.org/data/)

Contains data profiles drawn from the World Development Indicators database.





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