Learning from what young people say... about sex, relationships and health

safe passages

to adulthood

December 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.

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 themselves in the period prior to the transition to first sex, and up to the point of entry to marriage or regular partnership. This spans the key transitional events of 'adolescence', and captures a period of relatively 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 fulfillment 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.

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Acknowledgments

Many people assisted in the development of this resource, and we are grateful to all for their input, comments, ideas and suggestions.

Special thanks go to

Terri Collins, DFID-UNFPA Youth and Adolescent Reproductive Health Programme, South Africa
Aruna Lakhani, Deepak Charitable Trust, India
Agnes Runganga, Human Behaviour Research Centre, Zimbabwe
Jojo Sescon, Remedios AIDS Foundation, Inc, Philippines
Jacobo Schifter, ILPES, Costa Rica

We would also like to thank Sarah Castle and Roger Ingham (both of the Safe Passages to Adulthood Programme) for their insightful comments on earlier drafts of this text, and Fiona Thirlwell and Helen Thomas (at the Thomas Coram Research Unit, Institute of Education, University of London) for secretarial and administrative support.

If any errors or inconsistencies remain, they are of course our own.

Table of Contents

Section One
Background

All over the world, concern has been expressed about high rates of teenage conception and young people's vulnerability to sexually transmitted infections (STIs) including HIV and AIDS. Numerous programmes have been developed to provide the knowledge and skills young people need to avoid becoming parents early in life, and to help reduce the likelihood of acquiring an STI. Yet until relatively recently, efforts to promote awareness of contraception among young people have often taken place independently of those linked to the prevention of sexually transmitted infection.

HIV and AIDS, together with increased recognition of the value of sexual and reproductive health, has changed all this. It is increasingly accepted that in order to address young people's needs, we must do so holistically. Young people (like many adults) do not care much about the differences between medical specialities and their respective spheres of influence.[1] Nor do bacterial and viral infections differentiate between potentially procreative and non-procreative sexual acts. Unprotected vaginal sex can result in both pregnancy and the transmission of STIs, and it is vitally important to take this into account when developing existing programmes and creating new ones.

Assessing needs

The starting point for much work with young people is a local 'needs assessment'. This usually involves finding out what young people believe and feel about a particular issue, as well as what they do. However, too often in the past young people's sexual and reproductive health needs have been unproblematically 'read-off' from the international literature on adolescence and adolescent health.[2] Because some young people take risks, *all* young people are assumed to do so. Because for some young people the present matters more than the future, *all* young people are assumed to live in the here and now. And because some young people seek pleasure and thrills, *all* are assumed to be hedonistic.

But young people are not all the same, and recognising both the similarities and differences between them should be the starting point for programme and project development. To some extent, international public health discourse already does this when it talks of the special needs of the 'girl child' and when it talks of young people living in 'especially vulnerable circumstances'. But far too rarely though are such insights acted upon in sexual and reproductive health programming. All too often, there is a tendency to fall back on stereotypes and

oversimplifications about what young people are like. In our view, young people themselves, and not the adults around them, should have the biggest say in defining what their needs are, and what might be done to address them.

Learning about what young people believe and do can be enlightening and challenging. It may cause us to question our own assumptions. It can lead to new forms of collaboration in which young people are not only the recipients of sexual and reproductive health services, but also genuine partners in their creation and delivery. And it can enable adults to share some of their own anxieties about issues such as 'What is the best age at which to have a child?', 'Are all forms of contraception safe?', 'How is it possible to practise abstinence in a world where sexual activity is promoted widely in the media?', 'Is there genuinely safe behaviour when it comes to HIV and AIDS?' and 'How do men's and women's experiences of sex differ?' These are far from trivial matters, and they are questions to which there exist few, if any, clear-cut answers. Recognising that *we* as adults share many of the same preoccupations as young people should be the starting point for future work.

Learning from partnership

Across the world, policy makers, programme planners and practitioners are striving to combat illness and disease, as well as to enhance the health and well-being of individuals, families, communities and societies. They are increasingly aware of the need to work *with* local people and to find out about, utilise and build upon local health-related knowledge, values and practices. When people fail to take such beliefs and ideas as their starting point things can go badly wrong, as the following examples show.

- In Pakistan, programme planners failed to identify mothers' beliefs about causes of diarrhoea among their children. Mothers thought of severe diarrhoea as an almost natural part of children's lives and were anxious about taking action to stop it lest their child was harmed. Despite a national campaign to promote the use of Oral Rehydration Therapy (ORT), mothers either did not know about ORT, or rejected its use because it clashed with their own ideas about the causes and treatment of sickness (Mull and Mull, 1988).

- Men growing crops in Southern Mexico have high levels of knowledge about the importance of using equipment and protective clothing to guard against the harmful effects of pesticides. However, the meanings attached to symptoms lead them to believe the effects of pesticides are transitory. Strong local views about who is most vulnerable to pesticides – not 'real men', but the weak and infirm – led workers not to bother with protection (Hunt et al., 1999).

- In Israel, efforts were made to reduce the number of children born to Ethiopian Jewish immigrants, a group thought to have traditionally high fertility rates. Programme planners believed that lack of access to contraception was the chief problem. However, studies of local beliefs showed that improving access alone would have little effect on rates of fertility. Although women did use contraception, their chief concern was not to limit the absolute numbers of children they had. Having many children was an important symbol of stature. Mothers could, however, be persuaded to use contraception to space births on the understanding it would improve

their own, and their children's, well-being (Davids, 2000).

The purpose of this guide

This guide has been designed to help find out more about young people's ideas, beliefs and feelings about sex, relationships and health. It makes the assumption that what young people think and say really matters. It recognises, however, that the way in which people think about particular issues is linked to their background and past socialization. None of us can escape our past, and it is in relation to the 'cultural baggage' we carry with us that what we say (and do) must be understood.

Importantly, modern day 'scientific' understandings of sex, relationships, viruses, bacteria and human reproduction are only part of the picture. They serve some people fairly well, but others less so. How many people continue to believe, for example, that you can tell an HIV infected person by the way they look, and how many people all over the world say that pregnancy is the result of good or bad luck? People have a remarkable capacity to 'switch logics' from, for example, the biomedical to the spiritual depending on circumstances and needs. We need to take this into account when listening to what young people (and adults) say, and when attempting to identify their needs.

This guide has been developed for policy makers, programme planners and practitioners interested in young people's sexual and reproductive health. It aims to generate knowledge that will lead to better and stronger sexual and reproductive health programmes. It aims to demystify what young people say and believe about sex and sexual relationships, and complements the guide to conducting ***Dynamic Contextual Analysis*** already developed by the Safe Passages to Adulthood Programme.

Learning from What Young People Say... is divided into seven sections:

- section one – Background. Who this guide is for, and why it has been written;
- section two – Beliefs about health. Professional and lay understandings of health and illness;
- section three - Understanding young people and sex. Images of young people. The cultural dimensions of sex. Sexual health cultures among young people;
- section four - Working with and involving others. How best to involve other people. Some practical and ethical issues;
- section five - Preparing and planning the study. The value of case studies. Finding suitable research questions;
- section six - Collecting information. Where, how and from whom information can be gathered;
- section seven - Analysing and using findings. Analysing what young people say about sex, relationships and health. Maximising the likelihood that findings will be used.

Section Two
Beliefs about health

Medicine promotes the idea that diseases have specific causes (such as bacteria and viruses), which contribute to the biological breakdown of the body. Diseases often need to be treated in a medical setting and/or with drugs of one kind or another. Once they have been cured a person is said to be well again. Over time, some diseases have become associated with either particular personal characteristics, or with specific ways of living (Helman, 2001). STIs, for example, are often associated with risk taking and/or sexual 'promiscuity'.

There is a sharp contrast between the idea that bacteria and viruses cause illness and disease, and more *traditional* beliefs about health. In many parts of the world, for example, people continue to believe that evil spirits or bad luck are responsible for illness. Sometimes their ideas may blend together elements of the old and the new in making sense of personal misfortune (Box 1).

There is often a discrepancy between people's physical state of health and more subjective feelings of pain, discomfort and disability. Indeed,

Box 1

Among Shona speaking people in ***Zimbabwe,*** the course of illness is said to be affected by the ability of the body to resist illness. If one fails to recover after taking medicines, however, the cause of sickness may be attributed to witchcraft or ancestors or other spirits wishing to communicate their concerns and needs through the sick person.

Among some Bambara young people in ***Mali,*** it is believed that TB, bilharzia, haemorrhoids and a traditional illness called 'koko' (which comprises stomach ache and diarrhoea) are sexually transmitted. [3]

In the state of Gujarat, ***India,*** young men believe that masturbation and the excessive loss of semen makes men weak. As one man recently interviewed put it, 'First it (masturbation) would feel good, but afterwards I would worry that by doing this, (the) body would become weak and may affect my work. (The) glow on (my) face disappears, (my) body strength reduces. (My) body becomes thin.

In the Northern Province of ***South Africa,*** gonorrhoea (or 'drop') is said to be caused by a man having sex with a woman who is using hormonal contraception. This is because hormonal contraception is considered to prevent menstruation and lead to the build-up of blood in the woman's body. This blood is thought to be dirty or polluting and may be absorbed by the male sexual partner.

some people with disease may not feel 'ill' at all. This is important because it is people's feelings of illness, rather than the presence of organic disease, that usually leads them to seek treatment. In contrast, some people may say they feel ill or unwell, yet not be taken seriously by professionals. Women's reports of distress during pregnancy or middle age, and young people's feelings of anxiety about starting school or leaving home, have often been responded to in this way.

Yet another approach to understanding health is the more holistic vision endorsed by the World Health Organisation (WHO, 1946). This equates health with a state of complete physical, mental and social well-being. Here, well-being is seen as influenced not only by factors related to individuals (such as their biology or subjective feelings), but also by society (such as having an adequate income), the settings people find themselves (such as good housing) and relationships with others. Promoting health is therefore as much about building on the positive influences in people's lives as it is about eliminating those aspects that are negative.

Professional and local knowledges

Professionals – be they medical doctors or traditional healers – often use a technical vocabulary to talk about health. They go about their work in special settings such as clinics, temples, shrines or rooms set aside in houses. Ordinary people, on the other hand, tend to make sense of health and illness using everyday words and phrases Looking after their health usually takes place in settings used for a range of other purposes – at home and in the community.

As highlighted in the above examples from Zimbabwe, Mali, India and South Africa (Box 1), everyday knowledge about health and illness frequently co-exists with professional understandings, and there is often an overlap between the knowledge of medical professionals and people without such training. While ordinary people's ideas about health may be influenced by the advances in medical knowledge that are more popularly known about, doctors and health professionals' judgments can be swayed by popular or everyday beliefs about health.[6]

Indigenous or local knowledge operates to help people make sense of their own or another's illness or well-being. Such knowledge is often made up of ideas from a number of different sources – including religion, medicine and popular belief. As people talk and consult with others in their social network about their health or illness, they often revise, reject or confirm their own ideas. Because of this, everyday knowledge may sometimes come across as being inconsistent or contradictory (Box 2).

While it might be expected that people with some sort of formal education would be more knowledgeable than those without formal education, familiarity with an illness can also be gained through travelling, meeting and talking with others. In Bamako, Mali, for example, and until relatively recently, highly educated individuals tended to be sceptical of the existence of HIV/AIDS. In contrast, unskilled men and women with no little or no formal education, but who had travelled to Côte d'Ivoire, know about the condition. They had seen people who were sick, who had been treated for the illness by doctors, and who had eventually died from the disease. Among some educated people on the other hand, the view was often expressed that AIDS

Box 2

An example of one such seeming contradiction arose in a recent study of young people's responses to HIV and AIDS in **Costa Rica.** Its authors, Jacobo Schifter and Johnny Madrigal (2000), describe the experiences of a young woman called Maria. She stated that she had strong Christian values and believed in pre-marital abstinence. However, after going out with her present boyfriend for a short time, she agreed to have sex with him. Although this seemed to be contradictory, further discussion with Maria, and her disclosure of being sexually abused by her stepfather, helped explain things.

> *'I don't really know why I did it. I guess when you fall in love you lose your head and do things to prove your affection. I had such a terrible experience with my stepfather that I wanted to do it on my own with someone I love.' (Schifter and Madrigal, 2000. p.156)*

Such incongruities highlight how people not only adjust their aspirations to their current circumstances and needs, but also how their accounts of their lives make use of different ways of thinking – such as the competing ideas offered by religion and romance.

was either an invention of the West to sell condoms, or a policy to put the brake on the growth of the African population (Castle, 2001).

Health and the body

Linked to beliefs about health are ideas about healthiness and the body. These can be important in understanding the sexual judgments people make. In many countries in Africa and South Asia, for example, having a large body and ample body fat is seen as desirable since it signifies higher status and wealth. However, in many Western societies, somebody with the same level of body fat might be termed obese, with their appearance being thought to be due to laziness. Sexual desirability lies very much in the eye of the beholder, and ideas about physical attractiveness vary from one time, place and person to another.

Local beliefs about the human body can lead people to categorise themselves, and others, in particular ways. Certain features may be taken as marking out types of bodies as strong or weak, healthy or ill, and young or old. Culture and tradition also dictate local systems of dress and adornment, what constitute public and private bodily parts, and what are acceptable and unacceptable public bodily functions. Different ideas about the body can influence:

- beliefs about appropriate shape and size;
- beliefs related to the boundaries of a body, including appropriate inter-personal distance, clothing and decoration;
- beliefs about the body's inner structure (such as whether there are organs and where they are positioned in the body);
- beliefs about the body's functions (such as whether there are imbalances of heat or energy, whether there are 'blockages' or flows, or whether the body functions mechanically like a car, like a computer, or in some other way).

Ways of understanding the health and the body are constantly changing. Television and the Internet provide new opportunities to learn about other communities. The international

Box 3

In a recent study in **Mali,** Guéye et al. (2001) report the following comments from young people participating in focus group discussions.

> *'Now girls watch films and in wanting to imitate the actresses they have their first sexual relations before marriage.' (Focus groups of urban girls with formal education).*

> *'Before people did not travel around much, but now young men and women travel a lot. They go into towns where there is television and videos, and this is what pushes them to have sexual relations early.' (Focus group of rural boys without formal education).*

In focus group discussions among young people in the Northern Province of **South Africa,** one male discussant explained how physical desire can be strongly linked to ideas about romantic love:

> *'It can happen that you are at home listening to Celine Dion, and she may be singing about love. This song can push you to leave your home to find someone and discuss with her about love.'*

The authors comment: 'Again, the individual is considered to be driven by forces out of his (or her) control' (Adolescent Health Programme, 1997).

youth media affects the choice of popular music, clothing (e.g. footwear) and language. Young people, in particular, may be much influenced by what they see, listen to and read (Box 3).

The perceived 'causes' of ill health

Causes of ill-health may be seen as internal or external to the body. Internal causes can include hot and cold energies or 'humours', genetic defects, or the lifestyle choices a person makes. They tend to make illness seem a personal thing. External causes include vapours, spirits, germs, bad air, forces from the past, contagion and magic. Examples of local beliefs about the causes of ill health can be seen in the following examples from Thailand and Pakistan (Box 4).

Ill-health is often linked to personal responsibility. When people fall ill, they may be seen as having broken a moral or social code. The all too frequent division of people with HIV/AIDS into those who are 'innocent' (e.g. babies and children) and those who are 'guilty' (e.g. sex workers and homosexually active men) offers one example of this.

The course of illness can be influenced by a variety of factors, including spirit forces beyond an individual's control. Once again, both old and new ideas may be mixed together, particularly among those who have had greatest contact with Western medicine (Box 5).

Where illness is seen as punishment for past mistakes, healing may be hastened by participation in rituals such as exorcism, prayer, fasting and the laying on of hands, to provide the faithful with the benefit of God's powers.

Popular ideas about health exist everywhere. The common cold is the result of a viral infection, yet people believe that a sudden change of temperature or sitting in a draught can cause a cold. Moreover, in countries such as the USA and UK, and despite the widespread dissemination of modern biomedical knowledge, people continue to consume, with no physiological need for them whatsoever, significant quantities of herbs, vitamins and mineral supplements (Maclean, 1971).

Box 4

Internal and external factors are sometimes said to interact to produce illness. In North Eastern **Thailand,** villagers, for example, may talk about how working too hard or thinking too much can leave a person vulnerable to the actions of phii (spirits), so leading to illness. Furthermore, khawn (souls) positioned in various organs of the body may need to be secured to the body lest they flee and result in ill-health. As a curative and preventive measure, a skilled soul specialist (mor khawni) calls back and secures the lost soul to the body by way of fastening white cotton to the wrist (Adapted from Whittaker, (2000))

In the Northern Areas of **Pakistan,** mothers frequently paint the eyes and cheeks of their babies with charcoal or black 'kak-shak'. This is intended to deter the evil eye ('chezhum kak') of jealous onlookers who may admire the health and beauty of the child. If not deterred, the evil eye can lead to misfortune, illness, or even death, of the child (Collins 1996).

Sex, sexuality and health

The mixing together of old and new ideas, and of traditional and more modern forms of knowledge, is nowhere more obvious than in relation to beliefs about sex. In some parts of the world it is believed, for example, that regular sexual activity (between married partners at least) is essential for good health, whereas in others moderation is preached. In each case, there is a clear local rationale for the activities concerned.

Among the Shona people of Zimbabwe, for example, regular penile-vaginal sex within marriage, along with pleasure for both sexes, is believed to be essential for the mental and physical well being of both women and men. Similarly, young men in the Northern Province of South Africa maintain that failure to drain the body of semen through sexual intercourse or wet dreams (regarded as 'help from the ancestors') can lead to acne and even insanity.[7] In India, however, semen loss through masturbation or nocturnal emissions is a cause of major anxiety among men and is believed to lead to bodily weakness and spiritual malaise (Deepak Charitable Trust, 2000).

Popular ideas like these, which vary geographically and regionally, form the backcloth against which to make sense of what young people (or adults for that matter) say about sex, sexual relationships and health. They need to be taken seriously by programme and project developers. But how can we access such ideas and how can we make sense of them?

Box 5

In **Zimbabwe,** traditional Shona religious practices involve asking God and the ancestors for good health. It is believed that ancestors can influence one's responses to treatment, course of the disease and prognosis (i.e. whether one recovers promptly, deteriorates, or becomes chronically ill).

On the other hand, migratory and urban young men in **Zambia,** the **Democratic Republic of Congo** and neighbouring countries have been reported as depending more on herbs, luck and modern health education rather than on the ancestors to prevent illnesses.

Section Three
Understanding young people and sex

Before looking at some of the ways in which young people's beliefs and ideas about sex can be analysed, we will set the scene by looking at research more generally within the field of 'adolescent sexuality'. We do this because the approach we offer differs in some significant ways from much of work in the international literature. We also want to be explicit about the assumptions underpinning the techniques and ways of working that are being advocated.

While categories such as 'young people' and 'adolescents' are often useful in grouping together a number of people of the same age, when used inappropriately they can encourage us to mis-read the nature of young people's experience, and variations within it. Not only do words like 'adolescent' homogenize young people's experiences - making them all seem the same - but they also focus attention on the abnormal, the deviant and the spectacular. Thus, young people and adolescents quickly become seen as some kind of a 'problem' - individuals whose lives and outlooks need to be corrected through adult intervention (Box 6).

In developing sexual and reproductive health programmes, it is important to recognise that young people *always* have their own reasons for doing things which, at the time (if not always later), 'make sense'.[8] These personal perspectives should be the starting point for local programme and project development.

Young people and sex

Internationally, there have been numerous studies of young people and sex. Many of these are studies of Knowledge, Attitudes, Behaviours and Practices, or KABP studies for short. These generally involve collecting data from hundreds or even thousands of young people who are asked to respond to pre-set questions in a questionnaire or interview schedule.

Findings from these surveys can be valuable in

Box 6

Few approaches engage either with young people's sexual desires, motivations and behaviours in ways that are likely to be meaningful to the individuals concerned ...This emphasis is unfortunate in two respects: not only does it provide a limited understanding of young people ... it also encourages us to see young people's sexuality in negative terms - as something that needs to be restrained and controlled, not as a creative force capable of offering pleasure, fulfilment and growth.' (Aggleton and Warwick, 1990. p.81).

Box 7

Some key definitions

Sexuality - aspects of the body and desire that are linked to a sense of the erotic [9]
Sexual meanings - ideas about the characteristics and significance of particular sexual activities and settings.
Sexual identity - the sense of sexual self that enables young people to identify their needs, expectations and sense of appropriate behaviour, in particular situations and in relation to other people
Sexual cultures - the combination of beliefs, values, knowledge and practices that make up sexual lives.

identifying broad patterns of levels of knowledge, attitudes and behaviour. These can help programme planners identify whether problems exist, and in what geographical areas and with which groups work should be prioritised.

Findings from KAPB surveys are considerably less useful, however, in helping us know how best to work with young people. Responses to even the best designed surveys tell us little about what young people mean when they use particular phrases and ideas. They tell us little about the contexts in which young people talk about sex and to whom. And they rarely if ever question young people about their intimate feelings and desires with particular partners and in different kinds of relationships.

A rather different style of research is needed if we are to understand these concerns.

The meaning of sex varies from society to society, as well as across time (Maines, 1999). In some parts of the world, great importance is given to chastity before, and fidelity within, marriage. Elsewhere, young people (particularly young men) may be expected to gain sexual experience before entering into marriage. In some countries, there may be much discussion of sex and sexual relationships in the media, on television and in the home. In others, there may be none.

Together, the beliefs, values and practices that make up sexual life in a particular society comprise its sexual culture. *Sexual cultures* can be liberal or conservative, or even both at the same time such as in the USA where a deeply conservative political climate forbids open discussion of sex in many schools, but where sexually explicit videos can be purchased openly in the majority of states.

The dominant sexual culture within a society provides the resources from which young people can construct understandings of the self, others, and sexual relationships. Sexual identity emerges in relation to the powerful ideas about sex that circulate in a society. For example, in some countries 'gay' identities have been built, in part, as a response to discrimination and prejudice directed towards men who have sex with men. Just as important, however, are the sorts of personal and social identities that heterosexual women and men develop so as to help them live fulfilling lives.

A recent major study of young people's sexual health in relation to HIV and AIDS looked at young people's sexual culture in seven developing countries.[11] Key findings included:

- religion, the state and its laws, medicine and public health influence adults' and young people's sexual beliefs and cultures;

Box 8

In **South Africa,** recent focus group discussions with young people on gender identitiestriggered the following contributions: [10]

'My mother says that I am a girl...I must learn to cook and clean so that when I am married I will know how to do that.' (W. Cape, township, coloured, female, 10-11).

'...As a girl to be proud of yourself, trust yourself, stand up for your rights and be unique...' (Gauteng, Metropolotan, African, female, 16-20).

Meanwhile, boys tended to describe themselves as tough and not displaying their emotions:

'...boys are crooks, girls are honest. Girls are pretty, boys are strong and cool.

Source: National Progressive Primary Health Care Network (1995)

- new ideas about sex among young people often challenge traditional beliefs (e.g. by questioning whether men's sexual needs are beyond their control, and really do require immediate gratification);

- there are important differences between young men and young women in relation to appropriate ways of acting, talking, thinking and feeling;

- processes of 'modernization' (social and economic development) affect sexual cultures leading, for example, to the development of new commercial social spaces, such as bars and discothèques;

- migration between and within countries leads to new relationships being formed, and can cause ties to existing family members to be weakened;

- adults and young people attach great importance to the onset of sexual activity. There is considerable variation within and across countries in the age at which sexual intercourse or other sexual activity begins;

- there is a general lack of opportunities for young people to think and talk about sexual arousal, and how their bodies respond to sex (Dowsett and Aggleton, 2000).

Local knowledge: local practice

But why do ideas such as these matter, and why should programme developers take them into account? First, they matter because they affect beliefs, hopes and aspirations, and the ways in which young people lead their lives. Second, by taking into account history and context, we can better understand what young people say about sex and sexual relationships. Third, the best sexual and reproductive health programmes and interventions are those that build on local circumstances.

When conducting needs assessments with young people, several issues need to be kept in mind.

- Be open-minded. Rather than pretending all young people are the same, try actively to find evidence of similarities and differences between them. Rather than talking about the problems of adolescence, think more positively about young people's own reasons for doing what they do.

- Allow yourself to be surprised. Rather than thinking there are one or two 'truths' about

sex and health to which all groups and societies conform, expect to find a range of experiences and allow yourself to change your mind. What may be extraordinary to one person is an everyday matter of fact to another.

- Listen carefully to what young people have to say. Don't be afraid to ask questions that trigger detailed discussion or a long response. These are the kinds of approaches that really get to the heart of the matter; by highlighting differences in what people say in different contexts, by pointing to discrepancies between what people say and what they do, and by challenging double standards.

Box 9

The following example, drawn from recent in-dept interviews with young men in India,[12] demonstrates how with trust, skill and a degree of persisyence, young people (in this case young men) can be encouraged to talk openly about even the most intimate matters.

Interviewer: *'How did you feel after masturbating?'*

S: I masturbate very rarely because by doing it I feel weak. Instead of (doing) that, it is better to go out sometimes. Then these worries will not arise. And see, if one gets into the habit of masturbation then our body will not grow and the penis will become long and loose.

Interviewer: *' So what do you consider good?'*

S: I feel doing sex is good. But when I don't get sex, the heat needs to be removed!

Interviewer: *'Do you have any worries regarding your semen?'*

S: Yes, if too much of it comes out, then it is considered an illness and one should consult the doctor. But I haven't gone up till now.

Source: Deepak Charitable Trust/Deepak Medical Foundation (2000)

Section Four
Working with and involving others

There are two main groups of individuals from whom information needs to be collected in accessing beliefs about sex, sexuality and reproduction:

- *young people* or *respondents* from whom information is collected directly, and
- *others* involved in the development of the work and who use its findings

Before collecting any information, it is important to think carefully about how each of these groups might best be involved in the study.

Involving respondents

In survey work, the emphasis is often on statistically *representative* forms of sampling. In close focus studies of particular groups or communities, the emphasis is different - on accessing the *diversity* of views present within a locality, for example. Yet other forms of sampling aim to access *unique* accounts and perspectives (the views of sex workers and marginalized groups for example). Whichever approach is taken, it is important to be aware of its strengths and limitations. Strengths usually include depth of understanding in the case of close focus work and statistical representativeness in survey based enquiry.

Consent to participate

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

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

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

The right not to take part

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

withdrawal, or the decision not to answer one or more questions.

Confidentiality

Confidentiality means much more than saying that information will be kept secret. It means thinking about how information will be stored, how statements can be deleted by respondents after data have been collected, how feedback will be given, and so on. When working on sexual health issues, it also means having an explicit plan of the steps that will be taken when serious need or serious harm is revealed. No hard and fast rules can be given, since different procedures may need to be followed in different countries and in different settings.

Special codes and pseudonyms can be invaluable in helping maintain confidentiality and anonymity. When sending out questionnaires, for example, rather than using the name of a person or agency, each can be given a code. A respondent does not have to identify her/himself, yet a record can be completed of which questionnaires have been returned against the list that has been kept in a secure place. Changing the names of people or organisations when reporting on fieldwork is a helpful way to maintain anonymity.

It is important to discuss what is understood by the terms 'confidentiality' and/or 'anonymity'. In certain instances, there will be limits to the kind of confidentiality that can be offered. For example, if a child or young person talks about harm that has happened to them or others, this information might have to be provided to other professionals. At all times, and in accordance with principles enshrined in the UN Convention on the Rights of the Child (http://www.unicef.org/crc/crc.htm), the best interests of the child or young person should be taken into account. What is in the best interests of the child should be based on national and local policy guidance.

Working with colleagues

Generally speaking, a range of others will be involved in any assessment work with young people. They may include the funders of the study, NGO representatives, government officials, community leaders, professionals and practitioners, as well as research colleagues. Furthermore, young people themselves should be consulted and involved in the planning and implementation of a study. Too often, they are viewed simply as 'subjects' from whom information is collected (Box 10).

Box 10

In the Philippines, the success of the Remedios AIDS Foundation's Youthzone (a shopping mall based youth centre) has been due, at least in part, to ongoing consultation with young people about the design of the centre, appropriate health-related activities, and the sorts of staff with whom young people would best communicate. To ensure as wide a range of young people as possible were consulted, five months were set aside for this element of preparatory work.

In South Africa, the DFID-UNFPA Youth and Adolescent Reproductive Health Programme (2001) has been supporting cross-sector partnerships to provide accessible, youth-friendly health services. Rapid assessment techniques were used to determine the perspectives of young people with respect to programme planning and location of service facilities. Subsequently, elected youth committees have played a key role in the management of the facility and implementation of programme activities.[13]

Management groups

A Management Group may be valuable in some studies, especially when funders and other key stakeholders want to maintain control over the pace and focus of the work. Members of such a group can meet regularly throughout the study. Before the work starts, they may discuss and agree the scope of the study and consider what sorts of findings they might expect. Ethical issues should also be discussed and agreed. Each member of the steering or management group should be provided with a written plan of the study, together with a timetable.

As the study progresses, such a group may assume responsibility for monitoring progress. If work goes off track, corrective actions should be discussed, agreed and written down. The study team might be asked to work harder, or more human and/or financial resources might be made available. Alternatively, if things are not going according to plan, this may mean that the original plan was unrealistic. If this is the case, modifications should be made and, as always, agreements written down as meeting notes or minutes. If things are going according to plan (or exceeding expectations) then those involved might find ways to celebrate their achievements. This could take the form of a meal together or some other shared social activity.

Advisory groups

An Advisory Group does not have a formal role in managing the work. It exists to assist the study team as a kind of 'critical friend.' Such a group enables study members to talk about what is happening in the field, the dilemmas they are facing, and the sorts of needs they have. Members of an Advisory Group may be able to offer information about what happened in other studies of this kind. They may make suggestions about ways of handling dilemmas.

Those carrying out the study are likely to have restricted choice in determining the membership of a Management Group. Funders may well decide that. However, they may have greater control over the composition of any Advisory Group. Ideally, the latter should consist of people who are trusted, whose ideas and opinions are valued, and who understand the nature of the work. As well as researchers, such a group should contain policy-makers and young people themselves. To help ensure the latter's involvement, resources should be made available to pay for travel and similar expenses. In addition, an honorarium or fee should be considered.

Training and support

The training and support needs of those carrying out the study should be identified early on. These may include training in equality and ethical issues (Gosling with Edwards, 1995). They also include issues of support. Some fieldworkers, for example, may find that listening to descriptions of sex and physical and mental harm has an impact on their own sense of well-being. Opportunities should be made available to discuss these feelings and if necessary seek support.

Section Five
Preparing and planning the study

Thinking about assumptions

We all take certain things for granted. As professionals, we may assume, for example, that with commitment and effort young people's sexual and reproductive health can be improved. Some parents take it for granted that they are more mature and knowledgeable than their children. Some young people take it for granted that they know more about 'real life' than their parents. Taken for granted assumptions permeate all aspects of life, influencing the way we see things and what we do.

In research too, there are a number of ideas that are taken for granted. Some sexual and reproductive health researchers seem to assume that, just as there are laws governing the properties of matter, so there are universal principles governing people's sexual and reproductive behaviour. For them, the challenge lies in identifying these principles and developing appropriate interventions. This view of people and social reality generally underpins intervention trials and certain types of survey research. However, work of the type outlined in this guide starts with three different sets of assumptions.

So what are our assumptions?

A first set of assumptions relates to what it is that is being studied. *Learning from What Young People Say* .... is based on the idea that social life is created by people acting together in meaningful ways. The patterning and regularities of people's lives are not the effects of simple 'causes', but are the result of the choices people make (or are not able to make) and the meanings they share.

With regard to sex, relationships and health, such a view suggests that young people themselves are actively involved in the creation of sexual meanings, beliefs, identities and cultures. They do so by making use of existing ideas, as well as the values and resources available to them.

A second set of assumptions relates to how best to study young people's beliefs and understandings. If social life is built up by people acting together in meaningful ways, then research needs to focus on this action, and the meanings to which it gives rise. But actions and behaviours should always be viewed in context. What people can think and what they do are influenced by their circumstances and the opportunities that are open to them.

A final set of assumptions relates to the purpose of research. The starting point here is that findings will be used to develop policies or local activities to improve the sexual health of young people. This is important because not all research has this as its goal. Indeed, some researchers feel more comfortable when they do *not* have to conduct studies of immediate policy and practice-relevance. We do not share this point of view.

Cases and contexts

The kind of study outlined below can be seen as a kind of 'case study' focusing in on what a group of young people know, understand and believe. Here, a case could be a group, a class, a school, a set of young people meeting in a bar or in the community, a tribe, a clan or even a village.

Of particular interest are both the views and opinions that young people express and the characteristics, qualities and elements that contribute to young people's experiences. The latter may include:

- individuals' biographies and experiences;
- their interactions and activities with adults, other young people and children;
- the immediate setting in which people interact; and
- the broad contextual factors that influence people's lives.

These four elements each have an immediate and historical dimension. They are both present in the here and now, and they change in particular ways over time (Layder, 1993).

Two principal kinds of information are likely to be collected during any case study:

- information about young people's views, perceptions, perspectives and experiences; and

Box 11

The importance of context

A study [14] that, among other things, explored reproductive failure and values that young men and women residing in rural and urban settings in **Zimbabwe** place upon reproduction, revealed the following views. In a rural area, it was suggested,

> T- 'Impregnating a girl frightens me because I cannot handle the responsibilities of being a father. But it makes me feel good because it's proof that I am a man and can reproduce'.

Whereas young urban graduates generally took a quite different view

> M- 'Think of the money that I will lose in child maintenance if I become a father today! That would ruin my life. I want to buy a car and a house before becoming a parent'

Differences such as these are perhaps best explained by the different contexts and experiences confronting rural and urban youth.

- information relating to 'context' as defined in the four points listed above.

As information is collected, it can be analysed and used to inform subsequent work. This helps influence from where and from whom, about what, and even how, further information is collected. Right from the start in this kind of work, ideas are developed about both the nature of young people's views, and the factors influencing them (Box 11).

The final report from a study is likely to contain detailed description both of what young people talked about and the context. At the very least, it should provide a sense of the topics and issues discussed and the social interactions in which young people were engaged. Ideally though, this should be complemented by information on broader historical and social factors influencing what young people say.

Examples of research using such an approach have been published by UNAIDS (2000), but other instances include recent studies in Uganda (Bohmer and Kirumira, 2000), Mexico (Casteñada et al., 2001) and Costa Rica (Schifter and Madrigal, 2000).

The text in Box 12 comes from a summary of studies designed to examine sexual risk-taking among young people. In each country, the two or three study sites can each be thought of as 'cases'. Information was collected about young people's sexual beliefs, identities and cultures in each site, and the findings were compared. Here, the reasons for the selection of cases are outlined.

Bias, reliability and authenticity

Although no study can be completely objective, it is important to try to minimise bias. *Bias* in a study means that a particular perspective (or set of hidden assumptions) skews the design, collection and analysis of information, and the presentation of findings.

Bias can arise, for example, when adult researchers fail to recognise the privilege and power they hold in their negotiations with younger people. Adults may blame young people for not being involved, seeing what is essentially the result of a power imbalance as 'lack of interest', for example. They may also believe that there are 'correct' and 'incorrect' perspectives on events rather than different interpretations of the same phenomena.

In research of the kind described here, *reliability* means consistency. Reliability can be maximised by carrying out interviews or observations in broadly similar ways. This can be difficult, however, when the issues focused on are in a state of change. For example, a young man may one day want to be interviewed by himself, and on another with friends. A group of young women may consent to being observed in a shopping mall, but not in their school. Reliability is therefore as much about consistency in the use of a range of methods, as about using exactly the same methods across different situations.

Authenticity means giving as honest and balanced view of a situation as is possible from the standpoint of the individuals concerned (Neuman, 1999). Both bias and reliability set limits on authenticity. Thus, no study can reach authentic conclusions if sources of potential bias have not been recognised and taken account of, and if reliability is low.[16]

Box 12

UNAIDS Studies of Contextual Factors Affecting Risk-Related Sexual Behaviour Among Young People

In this cross-site study [15], local research teams were asked to nominate at least two sites in which to undertake their research. The purpose of having at least two sites in each country was to encourage possibilities for comparison or contrast, thereby preventing an artificially narrow view of young people from unwittingly emerging. Various combinations of site-selection criteria were used. Some teams chose three sites (Papua New Guinea, Zimbabwe). Some drew a rural-urban distinction (Cambodia, Papua New Guinea, Cameroon), and two selected contrasting sectors of the same cities using social class and socio-economic status as the distinguishing factor (Chile, Philippines). Still others chose a capital city/provincial town difference (Costa Rica, Philippines, Papua New Guinea, Zimbabwe). The attempt here at contrast and comparison was not one that argued that complete coverage of all young people could thereby be achieved. Rather, the aim was for high contrast, which would maximize the capacity for clear comparison so that social processes could be uncovered.'

Triangulation

One way to enhance authenticity lies in examining the same situation in a number of different ways. The term 'triangulation' is sometimes used to describe this process.

One common way of triangulating upon issues involves taking different 'measures' of the same phenomenon. For example, a young person's knowledge of sexually transmitted infections could be assessed first using a questionnaire, second during an individual in-depth interview and third during a focus group discussion.

A different kind of triangulation occurs when more than one person collects information in the same situation. Team research of this kind can be valuable in accessing the range of meanings and interpretations that can be attached to a single phenomenon since observers' opinions and interpretations may differ on some issues but coincide on others

Regardless of the kind of triangulation used, different responses may be obtained. This is not to say that a young person is being untruthful. It shows that different ways of collecting data produce somewhat different findings. Moreover, by taking part in an interview, a person may begin to clarify her or his views about an issue. What it is important to focus in on during triangulation are elements of consistency, and significant variations in these.

Section Six
Collecting information

It is not uncommon for more information to be collected than can be analysed and reported on. In research with a practical purpose, two principles are important to keep in mind: knowing the degree of accuracy required (so that the right sort of information is collected), and knowing what it is not worth knowing (so that just enough information is collected).[17]

The broad scope of a study will help identify what is not worth knowing, and the sorts of information needed. To some extent, this may be determined by those who are funding the work (Box 13). However, just as important are the information needs of those who will be using findings. Meeting and sharing ideas with the potential users of findings can help build a shared understanding of topics and the issues to be explored.

Choosing settings and respondents

Early in a study it is important to decide whether information from one or a number of sites is needed. When two or more contrasting sites are chosen, work within each may sometimes best be planned and conducted separately. Similarities and differences between these sites can be identified later.

Box 13

The views of funders

Funders often have strong views about how a study is conducted. These may include the overall design, ways of collecting and analysing information, and how to make best use of findings. No matter how skilled a researcher, others will have their own views about appropriate methods. For example, a funder may be convinced that a twenty question KABP survey of 2,500 pupils will produce useful findings to help focus a local educational initiative in school. Even if such a view is incorrect, there will be annoyance if findings from an in-depth study of 30 pupils involved in high risk sexual activity are presented. Reaching agreement about from whom and in what ways information is to be collected can help focus later work.

Being explicit

Reasons for site selection, and for respondent selection within sites, should always be made explicit. They should relate to the kinds of programmes or interventions planned later. In accessing young people's views and perspectives, it is important to focus on those young people to whom sexual and reproductive health services and programmes will be offered. Obvious as it may seem, there is no point in collecting data from young people in school, if an out of school initiative is to take place involving a different group!

Accessing young people

Useful points of access include schools, workplaces, universities, colleges, sports facilities, bars, discothèques and clubs, youth groups, shopping malls, markets, family homes, as well as specialist clinics and health services. Exactly where information is collected depends on the kind of work being planned.

It can be important to take into account seasonal and other kinds of variations in young people's accessibility (Box 14).

Selecting young people

The goal in survey work is usually to elicit views that are representative of a larger population of people or settings. In case study work, the aim is often rather different. In-depth understanding of a situation is sought after. To facilitate this, 'high contrast' groups are often selected.

For example, when developing a sexual health project appealing to a wide variety of young men, preliminary assessment may involve data collection from young men who regularly have sexual intercourse, young men who have only had intercourse a few times, and young men who have not yet had sexual intercourse. By doing this, it should be possible to identify something of the *range of views* expressed, while also gaining an *in-depth understanding* of the perspectives of particular groups.

Different kinds of sampling can be used to do this, and each has its own strengths and limitations.

1. Random (or probability) sampling - here young people are chosen at random (using random number tables or other means) from within the total population of interest. Random samples may be stratified so as to ensure, for

Box 14

Issues of access

In a recent study of young people's sexual beliefs and cultures in **Zimbabwe,**[18] it was observed that migratory patterns, and a community's and individual's patterns of using time, can affect ease of data collection. It is not uncommon to find rural boys and girls visiting parents and relatives in urban centres during the August and September school holiday. During the rainy season, young people work in the fields after school. Both of these factors needed to be taken into account when making arrangements to talk with young people and elicit their perspectives and views.

example, that the proportions of young men and young women in the final sample match those in the population as a whole.

- Random sampling is good at achieving a representative group of people. It suffers from the disadvantage, however, that it is necessary to identify the whole population first in order to draw a random sample from within it.

2. Quota sampling - choosing a pre-set number of cases in each of several pre-determined categories to reflect the diversity of a population (for example, if the sample size is 100, then 49 men and 51 women might be selected to reflect the fact that they make up 49% and 51% of the population more generally). The cases are obtained in any way that is convenient.
    - Quota sampling can be useful to help ensure that there is some diversity among the people chosen. If the person carrying out the study only selects people who are easiest or most convenient to get access to, she or he may end up with a sample of all women, or a single ethnic group.

3. Purposive sampling - choosing some or all possible cases that fit one or more criteria (such as all young women engaged in sex work in a local area, or all young men under a certain age in a local police force, or all religious youth groups in a local area)
    - Purposive sampling can be useful in three ways. First, it can be used to select cases that are especially informative among a potential range of others (for example, to examine why one clinic (rather than others in the same area) is well attended by sex workers). Second, it can help select specialised populations (such as sex workers in a local area by asking at clinics, talking with other sex workers, reading magazines and papers with personal columns). Third, it can be used to select particular cases for in-depth investigation.

4. Deviant case sampling - (a special type of purposive sampling) choosing cases that substantially differ from the dominant range.
    - Deviant case sampling can be useful in selecting a collection of unusual or 'peculiar' cases. As with purposive sampling, various means may be used to try and select relevant cases that, for this type of sampling, are exceptional. If, for example, certain types of young people have been found to engage in sex work, such as those with no other discernible income, then unusual cases here might here include young people with other income and who are also sex workers.

5. Snowball sampling - choosing cases made by referrals from a few initial cases
    - Snowball sampling can be useful to find out more about people's social networks (for example, what kind of people make up a friendship or sexual network, and why this network takes the form it does). By asking an initial contact to nominate others known to them, snowballing can be used to build up a larger group.

6. Theoretical sampling - choosing cases that help reveal features that are theoretically important. Choice of cases may relate to a particular topic (such as finding out about reasons for condom use and non-use) or

setting (such as finding out why some leisure settings are more popular than others among young people).

- In theoretical sampling, cases (such as people, situations, settings or time periods) are chosen because they help to illuminate certain features of phenomena as the study progresses. For example, a study of condom use among young people may initially find that condoms are less likely to be used if a young person believes her or himself to be in 'a relationship' with the other person. A second phase of the study might select all young people who think themselves to be in a relationship to identify whether there is a range of condom use. If there is, and non-condom use is found to be related to feelings of love and trust, a further phase of study might be to select some young people who say they are 'in love' and others who do not feel this, and examine condom use and non-use.

Beyond young people themselves, it may be valuable to collect additional data from key informants including, for example, teachers, parents, community leaders, youth leaders and so on. While the views expressed by these individuals (many of whom will be adults) can never substitute for those of young people themselves, the opinions voiced and the issues talked about offer additional contextual information against which to evaluate young people's own accounts and perspectives.

Key issues and themes

A number of themes related to sexual and reproductive health may be explored in work with young people. The starting point for the selection of these themes should be sensitivity to the overall context within which work is taking place. In most cases, it is *not* appropriate to begin with explicit questioning on sexual matters.

Within a particular setting, there will be particular topics and areas of content that young people are likely to make reference to when talking about sexual matters. Being aware of these may make it easier to talk with respondents and follow up what young people have to say. In talk about sex,

Box 15

To help develop **Mali's** National HIV/AIDS Control Programme, researchers wanted to interview female domestic servants.[19] These young women had little or no formal education, and had left their villages to work in urban areas to gain money to pay for their wedding trousseaux. Researchers were unsure exactly how vulnerable to HIV these young women were. Yet no list or register of their details or whereabouts existed. To get in touch with them, contact was first made with njatiguis (host families who were usually relatives from the young women's villages of origin and who looked after them). Each njatiguis was asked for a list of young women she or he looked after, and often came up with 40-50 individuals. Njatiguis were also able to name other njatiguis who had hitherto been unknown to researchers. Despite all these new contacts, researchers realised that the sample tended to include only those people familiar to njatiguis. Anyone out of their social circle could get left out of the study.

relationships and health, a number of themes often recur. They include:

- reference to professional and technical forms of knowledge; e.g. those of bio-medicine and biology (talk of the 'penis' and 'vagina' for example), psychiatry and psychology (talk of 'homo-' and 'bi-sexuality' for example), economics (talk of 'missed opportunities' and 'investments for the future') and so on;
- reference to 'social movements'; e.g. those of feminism (talk of 'women's rights') and ethnic and sexual minorities;
- reference to religious and spiritual understanding; e.g. Christianity (talk of 'God's gift', 'sinful behaviour' and punishment for wrong doing) and other world religions, as well as ideas related to animism, evil and good spirits and ancestral forces;

Box 16

Being holistic

In the Mopti region of Mali, young people's definitions of reproductive health were recently found to be much broader than those concurrently used by many health professionals or international agencies.[20] Young people referred to overall well-being, and made particular reference not only to cleanliness and hygiene, but also to social and marital relations.

> '[Reproductive health means] to be well, to feel comfortable in your skin and to be clean and eat well. Sexuality means sex, sexual relations between a man and a woman, it means love. Reproduction is the fact of having children. It starts at the beginning of a pregnancy until birth.' (15-year old married woman)

In the **Philippines,** workers on an HIV prevention project recently found that young people's most pressing sexual and reproductive health concerns were not necessarily about HIV and AIDS. Instead, young people were much more concerned about day-to-day problems such as getting on with people and finding ways of earning money.

Similarly, focus group discussions in **South Africa** suggest that young people's priorities may relate to growing up in an environment characterised by crime and broken families (Richter, 1996):

> 'It's a struggle for my mother because I don't have a father. I'd like to go to tech [college], but we have financial problems.'
>
> 'The reason I am saying this is because I am doing many wrong things with no one to tell me this is wrong or right. I didn't think my life would turn out this way because my dream was always to have my family next to me.'
>
> 'I don't know what the future holds. Things I didn't expect to happen are happening, like my friend was killed.'

- reference to the environment, population density and public hygiene, as well as to too hot, cold, wet and/or dry weather, and unusual seasonal variations; e.g. 'AIDS is nature's way of keeping the population under control', 'Diseases like AIDS come from messing with the environment';

- reference to technology, often by way of metaphors; e.g. in which thinking processes are likened to computers, and genito-urinary functioning to household plumbing.

More specifically, and in conversation with young people, it can be important to focus on four sets of issues: those pertaining to individuals, those to do with interactions, those to do with settings, and those to do with broad social influences structuring sexual beliefs, interactions and relationships.

Issues that could be explored under each of these headings include:

1. Individuals

- Personal sexual biographies (including ideas and views about sex, bodily responses to sex, sexual relationships and first intercourse, sexual (in) experience, sexual risk behaviours, aspirations regarding sexual relationships; perceived transitions (physical, emotional and psychological) - such as, sexual debut/loss of virginity; rites and rituals (such as initiation, circumcision).

- Ideas about the body (its appearance, internal structure and functions); (gendered) experiences of the body in different sexual situations (fantasy, masturbation, sexual intercourse). Emotions - love, passion, desire, loss, rejection. Explanations of sexual health/illness.

- Factors which help and hinder learning (including sources of information)

- Use of, and views about, sexual health services.

- Reasons people give for the things they do (e.g. having sex, seeking help, ending relationships). Other (non-sexual) aspirations and priorities.

2. Interactions

- Sexual relationships (including, consensual and non-consensual sexual activity) - perceptions of violence, abuse, sex work, 'sugar daddies'.

- When and how people meet for socialising, dating and sex. Sex in institutions - social environments associated with school, tertiary institutions, prison, church, sports and social clubs etc.

- Ways in which people have sex, and why they have sex in these ways.

- Whether, what, and with whom, sex-related topics are discussed (and topics not discussed).

- Relationships between lay people and health (and/or other) professionals.

- Factors that help and hinder groups and communities in learning about sexual and reproductive health issues (including sources of information).

- People identified as authorities on sexual issues (and those not seen as authorities).

3. Settings

- Where people meet to socialise, date and have sex (including how far they travel and from where).
- Physical conditions within these settings (including whether there are specific spaces in which sexual activity can take place).
- Rules, policies and norms within these settings (e.g. in schools, youth groups, shopping malls and bars).
- Availability of and access to treatment, care and welfare services (e.g. in clinics, hospitals and schools). Perceptions relating to the quality, range, appropriateness and effectiveness of services.

4. Factors shaping social relations

- Geographical location and the environment.
- Gender, ethnic and class relations as well as access to resources.
- Impact of modernization.
- Dominant beliefs and understandings about sexuality (often linked to religion or 'tradition').
- Health, education and leisure facilities.
- Migration (seasonal or long term).

It is important to emphasise, however, that the lists above describe topics that could be explored. They do not identify the specific questions that may need to be asked to examine these concerns.

Collecting information

Information about young people's beliefs about sex, relationships and health can be accessed in three main ways: by reading other people's reports and publications, by collecting new information directly, and through observation.

Reports and publications

Numerous reports and publications have been written about young people's sexual health. These can often be found in international journals or reports produced by international agencies. While some provide useful insights and information, few adopt the close focus necessary to access what young people really think and do.

Having said this, existing reports may provide important contextual information that can help us make sense of what young people say in a more in-depth study. They may tell us, for example, whether sex education is taught in schools. They may reveal whether or not parents feel competent to teach, or talk to, young people about sexual matters. And they may provide insight into the services available locally.

By building and maintaining relationships with local NGOs, university and government departments, and health and education services, one can keep abreast of such work and stay up to date with recently completed or ongoing studies.

Making first contact with young people

It can be emotionally challenging to make first contact with young people and ask if they would like to take part in a study. Several things can help

in this respect. Hanging around beforehand in the places where young people meet, making light-hearted remarks and becoming the 'acceptable incompetent', or adult who has to be taught, are some of the different strategies that have been reported as being successful. Young people often appreciate having an adult listen to them, especially if they know that their views are to be taken seriously.

There may be people you need to talk with first about the study. They may include parents, teachers, managers, older brothers and sisters. Initial conversations with young people should be conducted in an appropriate way - for example, a whole class of young people could be addressed together in a school, but in a bar or club, approaching individuals, pairs, or small groups may be more appropriate.

Have a concise explanation of the study prepared in advance. In an informal setting, delivering this should take no longer than a few seconds; in more formal settings it can perhaps last a minute or so. Any explanation should cover five points: the main issues focused on, why the study is being done, why you have chosen these particular young people, ethical issues, and anonymity and confidentiality. If interest is expressed, further details of what you hope to do can then be provided.

Before beginning work, it is useful to think carefully about what might motivate young people to participate. Often this is not just one thing. Being able to talk about an issue, feeling that the study will help others, learning new skills and gaining new ideas are often as important to young people as perhaps more tangible rewards such as money or useful everyday items (such as cooking utensils, toiletries, condiments or other foodstuffs).

Means and methods of collecting information from young people

The most commonly used methods of gathering information are self-completion questionnaires and interviews. Which are used depends on a number of factors. Some young people, for

Box 17

Some lessons from the field

In recent research with young people in **Zimbabwe,**[21] it was found that meetings tended to be most productive when the young people felt relaxed and comfortable. Afternoons were generally convenient, when free from domestic chores and school lessons. However, the young people tended to be restless and less willing to participate in discussions if anxious or under pressure to fulfil other obligations.

In recent work conducted by the Remedios AIDS Foundation in the **Philippines,** it was found that young people were more likely to share personal information about themselves when interviews were conducted in an environment in which they felt safe. When consulting young people about the development of a new youth service, workers also noted that interviews were most productive when they were led by a young person who had been trained in interview techniques, rather than when led by an adult.

example, may not be able to write, while others may feel uncomfortable talking in-depth about issues related to sex, and sexual relationships. In addition to difficulties with writing, self-completion questionnaire rarely provide the depth of detail needed in close focus studies.

Games and other activities can sometimes be used to gather information. They can include:

- face-to-face interviews - Young people may be asked to respond to a series of questions on sexual health;

- short questionnaires - Young people may be asked to answer a series of questions, either by ticking boxes, or by writing out a response in their own words;

- collages - Young people may be asked to make a collage about issues related to aspects sexual health, and to talk about their collages together;

- maps - Young people may be asked to draw a map of their local area and identify the places important to them in relation to socialising, dating and forming sexual relationships, and places to go for help and assistance;

- sociograms - Young people may be asked to draw a picture of the range of people around them and to identify those who are important in helping them (or making life difficult) in relation to sex and relationships;

- timelines - Young people may be asked to draw a line on a piece of paper and mark periods of time on it (the marks could represent the passing of hours, weeks, months or years). On the time-line, they can then identify and talk about when important incidents related to sex and relationships occurred;

- run-arounds and continuums - Young people may be asked to move into certain areas of a room (marked with 'yes', 'no', 'disagree', 'not sure' etc.) to indicate their responses to a questions;

- building a character - Young people may be asked to build a fictional character (writing down key characteristics, or drawing a person) and asked to say what the character would do in certain situations;

- picture prompts - Young people may be asked to talk about one (or a series of) pictures selected by the interviewer. These could be images of issues related to sexual health and relationships (visiting a clinic, two people kissing or holding hands in a street, an adult handing money to a young person);

- film and/or video discussions - Young people may be asked to comment on particular issues (such as those related to poverty, gender, sexuality or ethnicity) contained in a film or video;

- 'problem page' letters - Young people may be asked to comment on the topics and issues contained in letters to problem pages in adult and young people's magazines. They might be asked to state what the problem is, what contributes to it, and what answers they would give to the person who has written the letter;

- diaries and journals -Young people are asked to chronicle their thoughts and experiences in relation to particular themes. Most effective when regularly reviewed with a 'mentor' whilst

Box 18

In **South Africa,** the Adolescent Health Programme (1997) of the Health Systems Development Unit at the University of Witwatersrand made use of a technique known as the 'River of Life' to generate discussion about the 'gaps' between moral discourse and real experience. A river was drawn on a flip chart or on the ground. In the course of group discussions, young people were asked to mark key life events such as sexual debut, first serious relationship, marriage and first pregnancy. On one bank of the river, the discussants were asked to mark the age at which these events should occur. On the other bank, they were asked to suggest when these events actually do occur. The discussion associated with the exercise was recorded and proved a rich source of qualitative data on young people's values, dilemmas and experiences:

'If a person is 21, it is his time on earth to do what we are here for - to make known his family name, he needs to have a baby.' (School-boy, Northern Province)

'She wants to start having sex at a young age (...) and you find she is too scared to go to the clinic for contraception.' (School-girl, Northern Province)

forming the basis of in-depth interviews. May also provide core material for longitudinal case studies;

- body mapping - used to elicit understandings of the body, its anatomy and physiology. Most effective when used to generate representations and discussion about bodily experiences, illness, emotions and sensations (such as desire, arousal, excitement).

Whatever method is used, it must be appropriate to the skills and interests of young people themselves. To achieve this, watch young people and ask other adults (such as youth workers, teachers, parents and siblings) about the sorts of activities that young people enjoy and get them talking and communicating. No matter which activity is used, make sure a careful note is kept of young people's responses.

Recording young people's responses can be done on audio-tape (with permission granted beforehand), or by writing down responses. The former approach, although perhaps more intrusive, is often to be recommended since there is a tendency in preparing written notes to write down only the points that are clearly understood. This can sometimes lead to the loss of new insights. To facilitate later data analysis, a record should always be kept of from whom, when and where the information was gathered. When tape-recording what young people say, it is likely that the tape will need to be transcribed. As a general rule, one hour of recorded tape takes about 5 - 7 hours to transcribe, depending on the quality of the recording and whether it recorded an individual, a pair, or a small group discussion.

Useful and less useful questions

Closed questions provide those who are responding to them with pre-set answers (such as, 'agree', 'disagree', 'not sure', or 'male', female'). They can often be answered quickly and responses to them easily added up. Having said this, they are less useful for the kind of work we have been describing here. They severely limit what people have to say, for example, and they offer only a limited number of options. Open-

ended questions, on the other hand, enable young people to respond in their own words. There are at least three types of open-ended questions.

- *Descriptive questions,* often asked at the beginning of a study, encourage people to describe people and situations. They can invite responses about times, places and objects (e.g. 'Where do young people go to socialise?' 'What time is the clinic busy?' 'Where did you have sex with your girlfriend and what led to having sex in that place?' 'When and from where did you get condoms?') They can also be used to ask people to describe their experiences (e.g. What happened after the boys had finished playing around (masturbating together)?' 'What did it feel like the first time you had sex?' 'Could you describe the different sorts of boys and girls that come to the bar?')

- *Structural questions*, build on answers to descriptive questions and are used when there is greater familiarity with the features that make up situation (e.g. 'You said there were two types of boys, macho and wimps. Can you tell me more about each of these two types?' 'Are there any other types of girls, apart from those you described as 'madonnas' and 'whores'?')

- Finally, *contrast questions* build on the answers to structural questions. They elicit additional information about similarities and differences (e.g. 'In what ways are vamps and virgins different?' 'You've said something about the differences between macho and wimpy boys, are there any things they have in common?')

Some kinds of questions can actually hinder conversation. 'Why' questions, for example, sometimes seem threatening in that they require people to explain their personal reasons for doing something (e.g. 'Why did you have sex with her?'). Often, it may be better to re-phrase them using the word 'What' instead (e.g. 'At the time, what sorts of things, would you say, led you to have sex with her?')

Other questions may encourage respondents to answer in particular ways. They should only be used to trigger a helpful line of discussion. Such questions include: *hypothetical questions* (e.g. 'If you were 15 years-old again and knew then what you know now, would you still have had sex?'), *assuming questions* (e.g. 'When was the last time you had sex?') and *leading questions* (e.g. 'I've heard it said that young people have unsafe sex because they like taking risks. So, what led you to have unsafe sex'?).

Finally, there are two other sorts of questions that should never be used. These offensive or judgmental questions (e.g. 'Are you normal or homosexual?') and double questions which ask for two kinds of information at the same time (e.g. 'What times was the clinic open and what did you think of the staff?').

Observing what is happening

Observation is an often under-used way of gathering information. When carried out with an explicit purpose in mind, however, it can provide much useful data. Events can be observed in a structured (such as when counting the numbers of people or events in a setting), or less structured (such as when gaining an overall impression of a situation) way. Initial impressions can be explored in greater depth by asking people questions about what they believe to be happening.

Examples of events that might be observed include:

- ways in which young men and women use space in a nightclub;
- numbers of young people reading posters and leaflets in a clinic;
- friendship pairs and groups among young men and women;
- interactions between young people and staff in a clinic;
- sex-related topics of discussion at a bar;
- times at which particular venues (clinics, bars, clubs) are popular and unpopular;
- whether used condoms (and condom packets) litter the ground in an outside setting used for sex.

Regardless of the way in which information is gathered, always make a confidential and anonymous note of the date and time, as well as from where and whom it was collected. This record of events is essential when it comes to later analysis.

Section Seven
Analysing and using findings

There are many ways of analysing the stories, accounts and observations. Being able to carry out an analysis of interview data can require little more than paper, coloured pens and a pair of scissors. While computer software packages such as Ethnograph or NVivo can be used to analyse qualitative data, it is essential to understand the principles at work. Here, we will outline the basic steps to take when carrying out any analysis of qualitative data.

In making sense of the information collected, it is important to bear in mind the original purpose of the study. For example, if the focus of the work was on young men's perceptions of women, then the data should be analysed with this in mind, searching for different descriptions of women, the context in which these descriptions are used and what they signify.

If, on the other hand, the focus is on what young people as a whole think about sexual relationships, then an initial search might focus on all descriptions of sexual activity, with later analysis focusing on perceptions of specific kinds of relationships (e.g. married versus unmarried partnerships), or sex in different settings (e.g. at home, in the fields, in and around shebeens and drinking places)

Remember though, data never speak for themselves. They have to be analysed to extract significant points. There are a series of steps to be gone through when analysing information collected in open-ended interviews and focus group discussions. Although computer software can help, much can be achieved using paper, highlighter pens, scissors, and 'Blu-tack'.

A three-step approach is often used to analyse interview data (Box 19).

Preliminary analysis

Throughout the course of a study, initial ideas about the important issues will emerge. It is important to write down these initial ideas since they may well provide clues about where, or from whom, further information should be collected as the study develops. It can also be useful to share these ideas with others (e.g. members of an advisory group). They can then be returned to when more formal analysis takes place.

Some of the information gathered (such as that from interviews) will need to be transcribed. Transcriptions provide a written record of people's views and understandings. If other material has been collected during a workshop,

for example, this may need to be typed out for later reference. Written records produced during data collection need to be marked with a note about where, from whom and when the information was collected. Each interview transcript or set of field notes should be given a code. For example, information from one of three focus groups with young women might be referred to 'YW, FG 01'. Or, as information from a fourth observation of a youth group could be given the code 'YG, Obs 04'. Create a written index of codes to help remember what they mean.

Before beginning the analysis make a copy of everything. That way, there will be an original set of materials, and another set to use for the analysis. Then, if a mistake is made during the analysis or accidentally lose some records, there is always the original set to refer back to.

Looking for themes

Becoming familiar with the themes and topics in young people's accounts is best achieved by reading them through several times. In reading, there may be some themes it is particularly important to look out for. For example, if the study has set out to examine one group's experiences of sexual discrimination, try to keep this at the forefront of your mind.

Box 19

Analysing interview data - a three-step approach

1. Preparation and preliminary analysis
   a. Transcribe the interviews and make a paper copy of the original on which to work
   b. Give each transcript its own code
   c. Read through each transcript once or twice to become familiar with the data

2. Looking for and identifying the main themes
   a. Look for data that relate to main themes asked about during interviews
   b. Using a 'highlighter' pen, mark the lines of text that relate to each main theme with a colour of your choice
   c. Write the interview transcript code next to the highlighted text
   d. Cut out the marked sections (with the code) and put those with the same colours into a pile
   e. For each pile, read through the sections and arrange them into a sequence that makes sense of the data. 'Blu-tack' the different sections onto a larger bit of paper so that you have a rough 'running order' of quotes.

3. Identifying other themes
   a. Go back to the transcripts (that have had the main themes cut out of them)
   b. Read through the transcripts once more. As you have done this, think about whether there are any common themes that you had not at first noticed or considered
   c. If there are new themes, mark and cut out the data that relate to each, and put these into new piles, and work out a possible running order of quotes for each.
   d. If a segment of data appears to relate to more than one theme, make multiple copies and allocate one copy to each relevant theme
   e. Think about whether there are any absences. That is, were there themes about an issue that you had expected to come up, but about which respondents said little or nothing?

Once familiar with all the materials, it is possible to begin to mark or highlight where particular issues are addressed in the text. Mark, in pencil at the side of the text, where these themes are. Next, highlight areas of the text in which a theme appears. A useful technique can be to assign a different colour to each theme and to colour sections of the text with highlighter pens or crayons.

At the end of this process, the written materials will offer a colourful representation of the different themes that relate to the research question. Certain colours may appear more regularly than others. This provides a sense of the number of times a particular theme arose.

Finding patterns

A way needs to be found of viewing all the themes together, so that similarities and differences between them can be identified. This can be done by first marking each highlighted section with the summary code for that interview or observation (for example, 'YW, FG 01'). Then, all themes sharing the same colour should be cut out and placed in a pile, making several small piles of similar coloured slips of paper. There will also be a number of sheets of paper (the interview transcripts or other materials) that have had bits cut out of them. These should be put to one side as they will be needed later.

The slips of paper in each pile can then be sorted and put into a sequence. Some of the themes will be more similar than others and can be grouped together. Others may more or less stand alone. Yet others may appear not to fit that theme at all and can be put to one side. As the slips are arranged, a storyline can be developed that links them together via a common issue or topic, and which fits in with the overall research question. For example, if one overall theme focuses on perceptions of the causes of sexually transmitted infections, some slips of paper within this theme may make reference to 'germs', others to levels of sexual activity (for example 'promiscuity'), and yet others, say, to 'divine retribution'. Once the slips of paper have been clustered into these three areas, stick them onto backing paper using non-permanent adhesive such as Blu-tack. Using Blu-tack rather than glue means that the slips can be re-arranged if it is later decided that they make better sense if placed into a different sequence.

After organising the slips of paper into an order, the written materials with parts cut out of them can be returned to. By re-reading the data that are left over other, perhaps unexpected, themes will become noticeable. The left over transcripts can also be re-read from a different point of view. Thus, if the original intention was to focus on gender, and all the references to gender have now been cut out, the remaining material could be re-read looking at, say, issues of sexuality, or poverty, or ethnicity. Again, new issues can be highlighted, cut out, and grouped into sections.

At this stage, it can also be helpful to consider any 'missing' themes. There may have been issues expected that have not have arisen. For example, it might have been expected that young people would make reference to a national mass media campaign on prevention of STIs. Or, perhaps it was expected that they would talk about sexual abuse. If anticipated themes do not arise, this needs to be reported on. Such a finding may provide clues that different questions should have been asked. Alternatively, it could suggest that adults' images of what influences young people

are not the influences that young people themselves see as important.

Building a storyline

The themes (and absences) about sexual health and illness can now be built up into a series of storylines. These storylines should be clearly linked to the focus of the enquiry.

When writing up the findings, a number of phrases indicating general trends are useful to keep in mind. These include, 'On the whole, young people felt that ...', 'A clear majority of young men stated that ...', 'Overall, young women thought ...', and 'A recurrent theme among young women's responses was ...'.

Useful phrases indicating minority or unusual points of view include: 'A minority perspective among young people was...', 'It was observed that young men only occasionally ...', 'Young women only infrequently stated that ...'. These sorts of phrases can be useful in providing an indication of what happened, without suggesting that findings are representative in any way and without stereotyping young people's experiences.

Storylines can then be put together into an order so that they offer an overall account that provides insights into the key issues the study is addressing.

While storylines using phrases like these can make up the final report, it is important to remember that the overall story that is created is not a work of fiction. Everything written must be justifiable from the data, and constructed from the accounts young people and others have offered.

Making best use of findings

Sound data collection and good analysis leads to a set of findings grounded in the experiences of young people themselves. The content of any report from this work is likely to contain rich and valuable information about young people's perspectives on sex, relationships and health.

However relevant, content alone will not ensure that findings are used. Steps must therefore be taken to help maximise the likelihood that findings are acted upon. If dissemination is only considered at the end of the study, the chances are it will already be too late. The potential users of findings should be involved early on, perhaps via inclusion in a management or advisory group (see section 4.2). As work progresses they must also be kept informed, encouraged to feel the work is trustworthy, and encouraged to develop a sense of ownership of it.

During the study itself, it may be useful to think about setting up a dissemination and/or implementation task group. Such a group may be given the responsibility for creating an action plan to promote young people's sexual and reproductive health based on the findings. Members can decide priorities, identify a strategy to meet these, identify markers of success, clarify responsibilities and identify resources.

Findings may also need to be reported in a number of ways. The most appropriate form of reporting will depend on the needs of those who are going to use them. The key question to ask here is, 'What sorts of findings, reported in what ways, will enable potential users to take action to promote the sexual and reproductive health of young people?' While funders and the management group may want a written report,

oral presentations and discussions of findings are also likely to be useful.

It may also be important to disseminate findings wider than this - to local community members, including young people who took part in the study, for example. There are many ways in which this can take place and involving young people directly in the process of dissemination may also be a form of health education. Different sorts of dissemination activities include:

- posters, leaflets, flyers and booklets;
- comics and photo stories;
- articles in local and school newspapers, church newsletters and teenage magazines;
- workshops;
- video and audiotape presentations;
- health stalls in markets and shopping malls;
- street theatre performances;
- information on websites or sent by e-mail;
- local radio and television;
- articles in academic and practitioner journals;

Reviewing the study process

A final set of activities can help the research team and others plan for the future. A few weeks after the study has been completed, try to set time aside with others to reflect on how it went. Questions to focus on here might include:

- What worked well? What led to these things working well?
- What was not useful? What led to these things not being useful?
- What sorts of research on young people's sexual and reproductive health is needed in the future?
- What do the answers to the above questions imply for future work?

The topic areas outlined in this guide could be thought about in turn. For example, were people acquainted sufficiently with the existing literature on professional and local understandings of health and illness? Were young people's ideas really valued? How did it feel studying sexual meanings and beliefs? Was the management of the study adequate? Were ethical issues addressed appropriately? Were data collection and analysis competently carried out? Were the findings reported well? Have the findings actually been used?

Notes

1. See Kane and Wellings (1999) for a discussion of the historical and cultural differences between reproductive health and STI medicine, and the difficulties these can create for service access and use.

2. It is important to recognise that perhaps the majority of published studies in these fields have been based on research among North American and European 'adolescents'. The extent to which findings generated in this very specific context have more general applicability must be open to question. See Aggleton & Warwick (1997) for a discussion of some of these issues.

3. See Castle (1999).

4. Deepak Charitable Trust/Deepak Medical Foundation (2000) *Male Semen Loss Concerns.* Baroda, Deepak Charitable Trust (India) p. 16

5. Adolescent Health Programme (1997). *Adolescent Sexuality and Reproductive Health Issues: Final Report of a Three District Study on Adolescent Reproductive and Sexual Health in the Northern Province.* Johannesburg: University of Witwatersrand, Health Systems Development Unit. p. 58.

6. See Helman (1978) for an example of the way that doctors and patients talk together about 'colds', 'fevers', 'germs' and 'bugs'.

7. Adolescent Health Programme (1997). *Adolescent Sexuality and Reproductive Health Issues: Final Report of a Three District Study on Adolescent Reproductive and Sexual Health in the Northern Province.* Johannesburg: University of Witwatersrand, Health Systems Development Unit. p. 52.

8. See Becker (1998, p. 24-28) for a fuller discussion of this point.

9. From Macionis and Plummer, 1998, p. 369.

10. National Progressive Primary Health Care Network (1995) *Youth Speak Out for a Healthy Future.* Johannesburg: NPPHCN/UNICEF

11. The seven countries involved in the study were: Cambodia, Cameroon, Chile, Costa Rica, Papua New Guinea, the Philippines and Zimbabwe.

12. Deepak Charitable Trust/Deepak Medical Foundation (2000) *Male Semen Loss Concerns.* Baroda, Deepak Charitable Trust (India) p. 16

13. DFID-UNFPA Youth and Adolescent Reproductive Health Programme (2001) *Making Connections: Achievements, Challenges and Lessons Learned from the DFID-UNFPA Youth & Adolescent Reproductive Health Programme.* Pretoria: UNFPA

14. Runganga *et al.* (2001)

15. Dowsett and Aggleton (2000). p. 23

16. People who carry out studies that are chiefly quantitative in nature often use the term *validity* here. Among other things, validity involves providing an 'objective' representation of people and the world in which they live. This assumes there to be a single reality that can be illuminated if only the right measure is used. People who carry out studies that are more qualitative in their approach, often understand the world to be a more complex social place in which people may subscribe to a number of different realities.

17. Chambers (1981) calls the former 'proportionate accuracy', and the latter 'optimal ignorance'

18. See Runganga (1998)

19. From Castle (1999)

20. From Castle (1999)

21. See Runganga (1998)

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

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