



INVESTING WHEN IT COUNTS

Generating the evidence base
for policies and programmes
for very young adolescents

Guide and tool kit

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The Population Council is an international, nonprofit, nongovernmental organization that seeks to improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health research and helps build research capacities in developing countries. Established in 1952, the Council is governed by an international board of trustees. Its New York headquarters supports a global network of regional and country offices.

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Investing When it Counts

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Very young adolescents, children aged 10-14, undergo tremendous physical, emotional, social, and intellectual changes. During this period, many very young adolescents experience puberty, their first sexual experiences, and in the case of girls, premature marriage. For a majority of children, early adolescence is marked by good health and stable family circumstances, but it can also be a period of vulnerability because of intense and rapid transitions to new roles and responsibilities as caretakers, workers, spouses, and parents. In many countries, the impact of HIV, poverty, and political and social conflict on families and communities has eroded traditional safety nets and increased the vulnerability of young adolescents. It is therefore critical for policy and programmes to understand very young adolescents' special opportunities as well as their vulnerabilities. In most countries, there are policies for children to be in school at this age, and one finds a higher proportion of this age group in school compared to older adolescents. Capitalizing on this is critical. However, it is also important to note that there are many who are not in school and therefore may be at higher risk for many negative outcomes. Aside from the education sector, very young adolescents have been particularly neglected by policymakers in that they fall out of the reach of most conventional child health, maternal health, and women's empowerment programmes.

We must learn more about the timing, nature, and consequences of the key transitions young adolescents undergo, and in particular how these

play out amongst the most vulnerable groups. Initiating programmes at or around this age is an acknowledgement of young people's evolving capacity. Strategic timing of interventions allows for positive outcomes before the architecture of young adolescents lives are set. If the Millennium Development Goals are to be met, substantial, focused, and thoughtful investments in the social, health, financial, and personal assets of young people in the poorest parts of the globe are required. Such investments are also essential if governments are to uphold their obligations under international agreements such as the Convention on the Rights of the Child, which reaffirms the rights of children to learn, to be healthy, to be able to play, and to be protected from exploitation and abuse.

The Population Council, UNFPA, UNICEF and UNAIDS are committed to evidence-based programming and policy development to address the important issues facing very young adolescents. New research and interventions directed at 10-14-year olds are urgently needed. As we look towards the future, we envision a stronger, bolder, and more dynamic strategy of research and action to support innovative policies and programmes that will provide adolescent girls and boys with a safe, healthy, and productive transition to adulthood. The bridge linking childhood and young adulthood is far too precarious for many children in the developing world. Strengthening this passage to ensure that it leads to a brighter future deserves much more of our attention.



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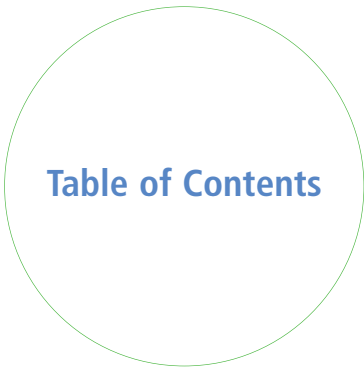
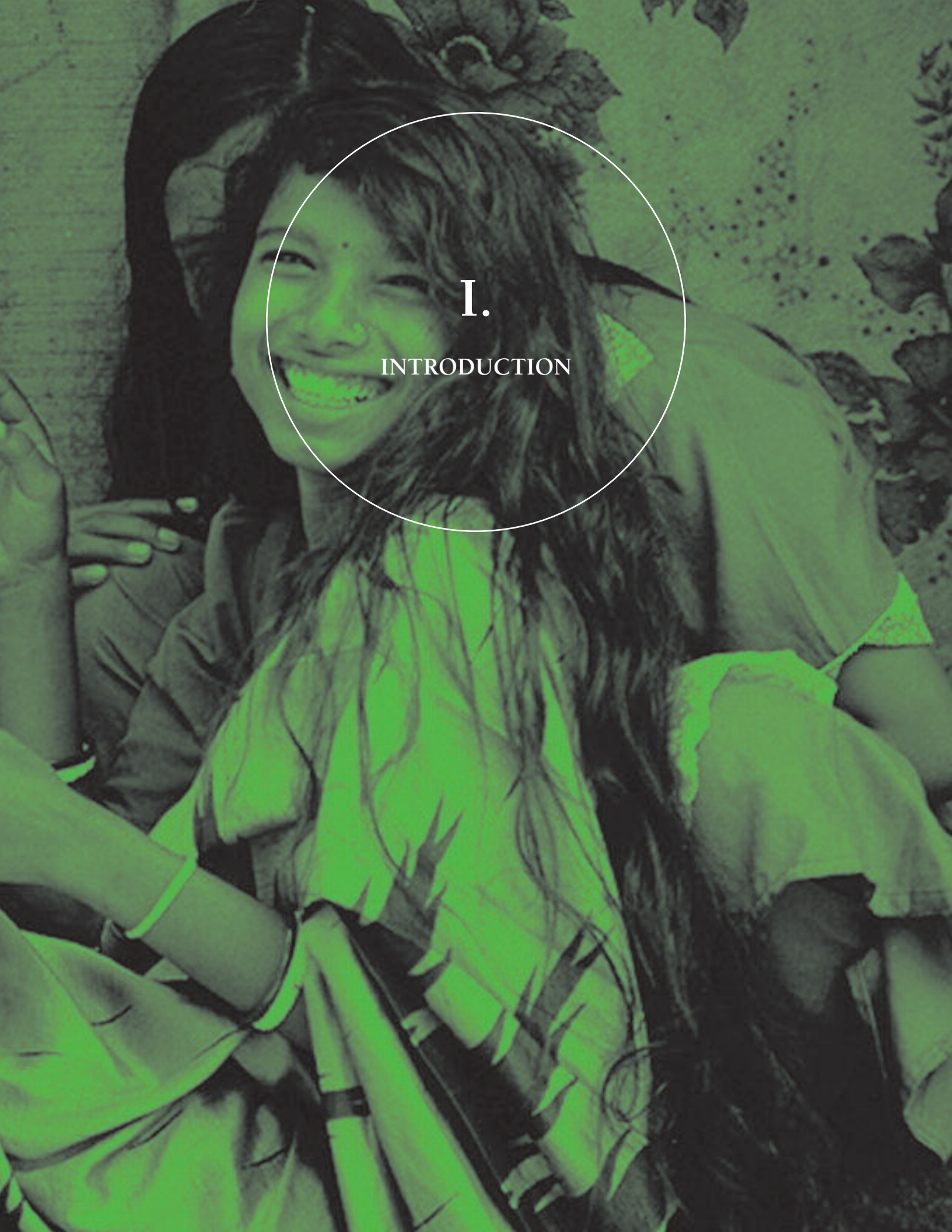


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I.

INTRODUCTION

Very young adolescents— a neglected group

In developing countries, the adolescent population has reached unprecedented numbers—more than 1 billion in 2005. Those aged 10–19 make up one-fifth of the population of these countries. The catchall term “adolescent” encompasses an extremely diverse group; adolescents’ experiences differ dramatically depending on their age, sex, living arrangements, area of residence, and on their schooling, marital, childbearing, and work status.

One subgroup of adolescents that has received minimal attention is “very young adolescents” (VYAs), those who are 10 to 14 years old. Younger children may be reached by immunisation and other child health initiatives and efforts to register children for school, and older adolescents may be targeted for peer education or youth-centre activities, but VYAs tend to fall through the cracks. Early adolescence may be marked by relatively good health and stable family circumstances, but it can also be a period of vulnerability and intense transition. Ten-to-14-year-olds progress from being clearly “children” at age 10, through the onset of puberty, to being perceived in some societies either as young women old enough to begin sexual relations, marriage, and childbearing or as young men who are expected to help support their families and, possibly, serve in the military.

Little research has been conducted concerning the factors that contribute to VYAs’ vulnerability and poor health outcomes. Fifteen-year-olds are typically the youngest adolescents included in national demographic and health surveys and seroprevalence studies. Information about schooling and general well-being has long been collected on young adolescents, but most researchers have shied away from covering

sensitive topics, either because of social norms concerning age-appropriate behaviours, ethical concerns regarding potentially harmful effects of the research, or doubts about the validity of young adolescents’ responses.

Some researchers question whether VYAs have the cognitive ability to answer questions requiring a thoughtful assessment of the barriers they face or of potential consequences of future actions. Others believe that the stigma surrounding premarital sexual activity for girls is too high to obtain accurate information and that researchers are better served by relying on retrospective reporting of sensitive issues, even though some recall bias may be present. Logistically, the sample sizes required for research with very young adolescents can be prohibitively large, because certain risky behaviours of interest are likely to be relatively uncommon in this age group. These are all valid concerns, but they are not insurmountable. Research with VYAs may be conducted successfully, albeit with certain modifications of current methods and approaches.

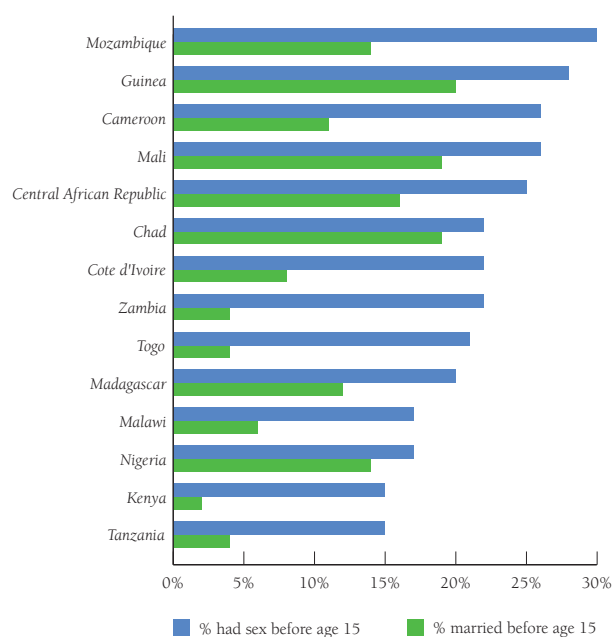
Developing HIV/AIDS programmes targeting very young adolescents

The need to learn more about very young adolescents is critical in light of the HIV/AIDS pandemic, in which half of all new cases of HIV infection are occurring among young people aged 15–24. Girls are particularly vulnerable. In sub-Saharan Africa, where almost two-thirds of all young people living with HIV (6.2 million) reside, 75 percent of infections are found among girls and young women (UNAIDS 2004a). Documenting a precise and accurate picture of the lives of VYAs is the first step in constructing programmes that can begin to improve these daunting statistics.

Intervening during early adolescence can help shape behaviours as they are being formed, rather than during late adolescence, when they are already established and more difficult to change. Intervening early can also help address the effects of structural factors such as gender-role norms and poverty that put VYAs at risk.

Very young adolescents are deeply affected by the AIDS epidemic, either by losing their parents and other family members to the disease or by being infected themselves, either as babies or during sexual encounters. An estimated 640,000 children younger than 15 were newly infected with HIV in 2004, and about 510,000 died from AIDS (UNAIDS 2004b). Sexual activity among very young adolescents is more common than many policymakers and community members

Figure 1 Percentage of girls aged 15–19 who reported that they had had sex or were married before reaching age 15, 14 sub-Saharan African countries



Source: Population Council analyses of Demographic and Health Survey data.

acknowledge. In 14 sub-Saharan African countries, 15 percent or more of girls reported having sex before their fifteenth birthday (see Figure 1).

A substantial proportion of sexual encounters involving VYAs are forced or coerced (Jejeebhoy and Bott 2003). In some countries, the prevalence of child marriage is the predominant cause of early sexual debut (for example, see Chad and Nigeria in Figure 1). Frequently, young people do not possess the information and knowledge they need to protect themselves against HIV/AIDS. Even when they are aware, however, many face social, economic, and cultural factors in their daily lives—often gendered in nature—that hinder their ability to protect themselves. Young girls are at especially high risk of acquiring HIV infection through sexual contact, because their partners tend to be many years older (and hence more likely than younger men to be infected with HIV or other STIs), and girls' genital tracts are immature and vulnerable to infection.

Other vulnerable populations that merit special attention include refugees (approximately two million refugees are 10 to 14 years old), street children, and children involved in sex work (as many as 10 million young people aged 10–17 are exploited by the sex industry) (UNAIDS et al. forthcoming). Many of these children have lost one or both parents, are not in school, begin sexual activity at a very early age with little or no protection, and may begin substance abuse and injecting drug use. These subpopulations are also extremely difficult to collect information from and to reach with programmes and services.

Objectives of this guide

This guide builds on the momentum generated from an international meeting on very young adolescents held in Geneva in 2003.¹ Experts from

The guide's objectives include:

- consideration of the cognitive and developmental changes that occur during early adolescence and what impact they may have on the design of a research study;
- review of ethical issues to be considered before research with VYAs is conducted;
- exploration of the breadth and limitations of information that can be gleaned from existing data sets such as the Demographic and Health Surveys;
- introduction of a number of research methodologies that have been tested already with younger adolescents or that might be expected to be useful in some settings, with discussion of their advantages and limitations;
- description of research results on VYAs that have been achieved using these methodologies; and
- provision of illustrative prototype tools and basic instructions for using them.

a range of disciplines and regions (including active partners such as the Population Council and the United Nations Children's Fund [UNICEF]) met to review the programming experience and research evidence for work on very young adolescents. At the meeting, the dearth of data generated concerning this population was made clear. Little was known about what tools and methodologies were best suited for collecting information from very young adolescents, and debate ensued as to whether and how to gather information about this group.

In an effort to propel the field forward, The United Nations Population Fund (UNFPA) and the Population Council convened a smaller consultative meeting focused on research issues and methods, bringing together experts and colleagues in the adolescent field who were either currently engaged in or planning to conduct

research on very young adolescents. Numerous organisations were represented at the consultative meeting, including the Alan Guttmacher Institute, the Futures Group, PAHO, Save the Children, UNICEF, and YouthNet, among others. This guide is a result of the discussions and deliberations engendered by the meeting.

The methodologies described in the guide are useful primarily for discovering which VYAs are most vulnerable, what their needs are, and whether they are being reached by existing programmes. Young people are better able to take responsible decisions about their health if they are given the information, skills, services, and support required for adopting safe behaviours. Although including parents, service providers, and other gatekeepers in research and programme activities is important, such an effort falls outside the scope of this guide, which focuses on the primary source of

¹ The meeting, "Very Young Adolescents: The Hidden Young People" was sponsored by the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Population Council, and the United Nations Population Fund (UNFPA).

information about VYAs' lives, the adolescents themselves. A gender lens is incorporated throughout this document, because girls' lives typically begin to differ dramatically from boys' lives during this period in terms of schooling, mobility, domestic responsibilities, media access, and marital status.

This guide is intended to be helpful to anyone who plans, manages, implements, monitors, or funds research or programmes that involve gathering information about adolescents aged 10–14. Although no consensus on “good practises” in research methodologies and information-gathering techniques has been reached, we hope that this guide will provide information of practical use in building the knowledge base and continuing the dialogue. Research methodologies must be tailored to particular communities and cultural sensitivities, and researchers must work closely with community members in planning and executing

the research, disseminating results, and developing responses based on results. Although this guide was written with the development of HIV/AIDS programmes for young adolescents in mind, the approaches described below can be used for programmes designed to address any number of issues that threaten the health and well-being of this group, including early and unwanted pregnancy, violence, substance abuse, and female genital cutting.

Note: The guide does not provide training on the methodologies it describes; rather it offers a selection of possibilities. Training is required in order to use the tools described adequately. Furthermore, the guide does not offer direction concerning how the information gleaned from these approaches can be used to inform, improve, or evaluate projects, which requires a close tailoring to context and project objectives.²

² Readers looking for specific program monitoring and evaluation indicators are referred to *National AIDS Programmes: A Guide to Indicators for Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People*, a publication produced by WHO and its partner organisations (2004, hereinafter referred to as “the interagency monitoring and evaluation guide for young people’s AIDS programmes”). It complements indicators already included in the UNAIDS document *National AIDS Programmes: A Guide to Monitoring and Evaluation* (2000) and proposes new indicators that are in early phases of development and use. Because these indicators are designed for large national surveys, they will have to be adapted for monitoring and evaluating community-based HIV-prevention programs for young people, but they can serve as a valuable starting point.



II.

WHAT DO WE KNOW ABOUT
THE LIVES OF VERY YOUNG
ADOLESCENTS?

Recent findings

The nature and quality of young people's future lives depend on how successfully they negotiate the transitions to the roles of citizen, spouse, parent, and worker. The National Research Council and the Institute of Medicine recently convened a panel of experts to examine the current situation of young people in developing countries; to identify and explain recent changes in the nature, timing, and sequencing of the various transitions to adulthood; and to determine priorities for future research. The panel's findings are presented in *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries* (2005). Young people are spending more of their adolescence in school, and the gender gap, where it still exists, is closing rapidly as a result of improvements in girls' education. Although school participation and grade attainment have experienced unprecedented growth, large differentials in attendance by wealth and residence persist.

The health of young people is improving overall, except in areas hardest hit by HIV/AIDS (with girls being more affected than boys in most regions). Although girls and young women continue to face significant risks of maternal mortality and morbidity, boys and young men are disproportionately affected by traffic accidents, violence, war, and suicide. Mental health problems are an emerging issue, comprising a substantial and possibly increasing share of illness in this age group. The age of marriage is rising in nearly all settings; 38 percent of young women aged 20–24 married before age 18, compared with 52 percent 20 years ago. (These percentages are based on survey data representing 60 percent of the developing world population.) School enrolment has a protective effect on reproductive health: students, in comparison with nonstudents, are less likely to have had sex, and are more likely, if they are sexually active, to practise contraception.

The development of the young adolescent

Adolescence is a period that may span ten years or more, and in light of the significant growth and development that takes place during these years, most social scientists and practitioners view adolescence as a series of distinct stages rather than one homogeneous stage. Programme managers must understand these stages as well, so that they can tailor interventions accordingly, craft appropriate messages, set suitable goals, and provide the level of support that young people need. Although experts in the field describe the various stages of adolescence, little agreement is found concerning what ages correspond with which stages.

The Pan American Health Organization (PAHO) recently published *Youth: Choices and Change* in which the authors summarise existing developmental classifications and the theoretical frameworks within which they were developed. They discuss, to name a few, psychodynamic theories on emotional development, the work of Harry Stack Sullivan on interpersonal development, Jean Piaget's studies of cognitive development, and Carol Gillberg's work on gender differences and female development (PAHO 2005). In an effort to create a comprehensive model of adolescent development that integrates these disparate theories and incorporates recent research findings on the impact of the environment, neuropsychological functioning, and information processing, PAHO proposes a new classification of the stages of adolescence, as shown in Figure 2.

Starting with preadolescence and ending with young adulthood, changes are grouped into five developmental domains: body, brain, sexual, emotional, and social. Although the age ranges given in the PAHO classification are the average

Figure 2 The stages of adolescence (PAHO classification)

Age	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Girls		Preadolescence			Early Adolescence		Middle Adolescence		Late Adolescence		Youth			Young Adulthood		
Boys		Preadolescence			Early Adolescence		Middle Adolescence		Late Adolescence	Youth			Young Adulthood			

ages at which developmental changes occur in the five domains, there will always be exceptions to these boundaries, with precocious adolescents at one extreme and late-maturing adolescents at the other. The rapidity with which a young person progresses through these stages depends upon numerous endogenous and environmental factors, including biological differences, cognitive abilities, educational, emotional, and life experiences, and cultural and social contexts. Adolescents who grow up under adverse conditions (extreme poverty, in AIDS-affected households, armed conflict, domestic violence) are thrust into adult roles and behaviours prematurely; little is known about the long-term effects of such accelerated transitions on individuals' development or on their capacity to fulfill their adult roles successfully.

The main changes in each of the five domains are summarised in Table 1. Because this guide focuses on the very young adolescent, only those changes pertaining to preadolescence and early adolescence are included here.

Extracting information from nationally representative surveys

The Demographic and Health Surveys (DHS), although focused on issues of fertility, family planning, and more recently HIV, are an important source of information about very young adolescents. These nationally representative

surveys have been conducted in more than 60 developing countries in every region. Most information about very young adolescents is gleaned from the household surveys of the DHS, in which the head of the household answers questions about all of the individuals who reside in the household. Data can also be obtained retrospectively, using the women's individual questionnaire. Although young adolescents do not respond directly to the DHS, a fairly accurate picture of their lives can be obtained from the survey, including their area of residence, schooling status, parental residence, and information about their experience of early marriage, sex, and childbearing (see the summary table of data from 49 countries presented in Table 2 on pages 14–15).³ Such analyses can suggest fruitful areas for further investigation. For instance, a surprisingly high proportion of 10–14-year-olds in some sub-Saharan African countries are neither in school nor living with either parent. Some of these young people may live with their extended families or in positive fostering arrangements, but many may be vulnerable to sexual exploitation, unsafe work, and substance abuse.

Mensch and her colleagues (2005) have analysed results from Demographic and Health Surveys conducted in 27 sub-Saharan countries in order to investigate the links between trends in age at marriage and premarital sexual behaviour. In comparing 20–24-year-olds with 40–44-year-olds,

³ Population Council. 2003a. For a full listing of available reports, see www.popcouncil.org/gfd/gfdcountries.html.

Table 1 Developmental stages of very young adolescents

Developmental domains	Preadolescence 9–12 years (girls) 10–13 years (boys)	Early adolescence 12–14 years (girls) 13–15 years (boys)
Body	The growth spurt starts, and the body gradually acquires secondary sex characteristics. There is an increase in body fat and weight, as well as a redistribution of these to reflect secondary sexual characteristics. There is a gradual increase in sensation-seeking.	Girls acquire menstruation (mean age=12.4 years), and boys ejaculation (mean age=13.4 years). There is a significant growth spurt and a marked increase in sensation-seeking, particularly among boys.
Brain	A gradual shift occurs from egocentric to sociocentric thought, with more concrete logical thinking. Conservation tasks are in the process of being acquired. There is an increased craving for new information, but language is still concrete. There is still little development of prefrontal lobe and executive functions.	More abstract thinking (formal operations) and less concrete thinking are used. Most adolescents will acquire all conservation tasks during this stage. There is still little development of prefrontal lobe and executive functions, particularly among boys.
Sexual	Boys and girls explore more differentiated masculine and feminine roles compared to previous years. For girls, androgyny is a viable alternative to exclusive femininity, while for boys exclusive masculinity is still the alternative that is socially most expected.	Sexual arousal increases, and so does the need for masturbation. Other autoerotic behaviours, such as sexual fantasies and wet dreams occur. While gender identity is developed in the first years of life, its stability becomes increasingly challenged with the development of sexual orientation, preference, and exploration involving another person during this age period, including at times the emergence of confusing homosexual feelings.
Emotional	A gradual increase in self-consciousness occurs, with fluctuations in self-image and increasing feelings of embarrassment. There is an emerging need for greater privacy, individuation, and more emotional autonomy from parents. Fluctuations occur in verbal and non-verbal expression (facial gestures) of intense emotions. The ability emerges to explore multiple reasons for a feeling, to compare feelings, and to understand triadic interactions among feeling states. This is accompanied by the capacity to differentiate shades and gradations among feeling states. There is a gradual shift from preconventional morality (rewards and punishments) to conventional morality (society's rules).	A high level of self-consciousness and fluctuations in self-image are present. The level of stress increases, particularly among girls. The need for more emotional autonomy from parents continues, fueled by a stronger de-idealisation of one's parents and increased defining of the adolescent's own opinions. At the same time, there is an increase in emotional dependency on one's friends. Intimacy, loyalty, and shared values and attitudes assume a greater weight in friendship. There is an increase in empathy and responsiveness towards close friends and an emerging ability to reflect on feelings in relationships with an internalised sense of self. A conventional morality is assumed.
Social	The need emerges for a same-sex best (or similar) friend with whom to have fun and share secrets. Academic and social demands and expectations increase. Time is still spent with parents, and parental supervision is still present, but these start to gradually decrease, accompanied by a gradual increase in conflicts between the preadolescent and parents. Susceptibility to peer pressure increases.	More time is spent with social subgroups (cliques) and/or alone. There is an emerging interest in opposite-sex ("different") friends. Less time is spent with parents, parental supervision decreases, and conflicts about independence increase. New social privileges are expected. Susceptibility to peer pressure reaches its peak.

Source: Excerpted from PAHO (2005). Pp. 262-264.

the authors found that the prevalence of marriage by age 18 has declined significantly in 24 of 27 countries, the prevalence of having had premarital sex by age 18 has increased significantly in 19 countries, and the prevalence of having experienced sexual initiation by age 18 (either before or at marriage) has declined significantly in 12 countries, increased significantly in four, and not changed in 11. The authors note that “while the age of first sexual activity has either remained the same or increased, a shift in the context of sexual debut from marriage to premarital sexual activity has taken place in many countries” (page 12).

Other major survey programmes include:

Health Behaviour in School-aged Children (HBSC).⁴ HBSC collects data on school-going young people aged 11, 13, and 15 using self-completed questionnaires administered in the classroom. Membership is currently restricted to countries within the European region; 36 countries participated in the 2001–02 round of data collection. The core set of questions looks at background factors, individual and social resources, health behaviours, and health outcomes.

HIV/AIDS/STD Behavioral Surveillance Surveys (BSS). UNAIDS, WHO, Family Health International, and other agencies have worked to develop a framework for HIV surveillance that is appropriate to the stage of the epidemic within a country. BSS are a monitoring and evaluation methodology designed to track trends in HIV/AIDS knowledge, attitudes, and risk behaviour in subpopulations at particular risk of HIV infection, such as female sex

workers, injecting drug users, migrant men, and young people. BSS have been implemented in 15 African and Asian countries. Although the populations of young people surveyed typically do not include those younger than 15, the retrospective questions in the BSS yield important data concerning behaviour in early adolescence.⁵

The Global School-based Student Health Survey (GSHS).⁶ The GSHS, a collaboration between WHO and the Centers for Disease Control (CDC), is a surveillance project designed to help countries measure and assess the behavioural risk factors and protective factors in ten key areas among young people aged 13–15. The ten areas considered are: alcohol and other drug use; dietary behaviours; hygiene; mental health; physical activity; protective factors; background demographics; sexual behaviours; tobacco use; and violence and unintentional injury. Twenty-two countries from all regions have either implemented the GSHS or are in the process of doing so.

The Multiple Indicator Cluster Survey (MICS).⁷ MICS is a household survey programme developed by UNICEF to assist countries in filling data gaps for monitoring the situation of children and women. The first round of MICS was conducted in 1995 in more than 60 countries; the second round took place in 2000 in 65 countries; the next round of surveys, currently underway, is being conducted in more than 50 countries. MICS consists of three questionnaires: a household questionnaire, a questionnaire for women aged 15–49, and a questionnaire concerning the situation of children younger than five (answered by the caretaker). Although the MICS does not survey very young

⁴ For more information, see www.hbsc.org.

⁵ For more information, see www.fhi.org or Amon, Brown et al. (2000).

⁶ For more information, country fact sheets, and questionnaires, see www.who.int/school_youth_health/assessment/gshs/en/.

⁷ See the MICS website at www.childinfo.org.

Table 2 A Summary of Selected DHS Data on Very Young Adolescents, 49 Developing Countries

Country	Survey year	Percent of population aged 10–14	Percent living in rural areas	Percent for whom one or both parents deceased	Percent who live with neither parent (girls/boys)	Percent not enrolled in school (girls/boys)	Percent who live with neither parent and who are not enrolled in school (girls/boys)	Percent of 15–19-year-old girls who reported ^a :		
								Having sex before age 15	Having sex before age 15	Giving birth before age 15
West and Central Africa										
Benin	1996	14	60	12	32 / 18	68 / 41	26 / 8	14	14	1
Burkina Faso	1998-99	15	86	13 ^b	21 / 15 ^b	79 / 70	16 / 10 ^b	12	12	2
Cameroon	1998	14	67	16	24 / 21	24 / 19	6 / 4	26	26	4
Central African Republic	1994-95	13	55	18	28 / 25	50 / 28	17 / 8	25	25	5
Chad	1996-97	13	77	13	19 / 19	71 / 50	13 / 9	22	22	4
Côte d'Ivoire	1998-99	14	65	11 ^b	34 / 24 ^b	53 / 35	23 / 11 ^b	22	22	6
Ghana	1998	14	69	9	29 / 21	20 / 18	7 / 4	7	7	0
Guinea	1999	14	68	13	26 / 20	75 / 62	19 / 13	28	28	7
Mali	2001	14	73	9	19 / 14	68 / 54	14 / 7	26	26	5
Niger	1998	13	78	11	22 / 17	78 / 68	18 / 12	na	na	4
Nigeria	1999	12	70	10	21 / 17	30 / 26	7 / 5	17	17	7
Rwanda	2000	17	87	41	26 / 22	59 / 59	17 / 15	3	3	0
Senegal	1997	14	63	11 ^b	22 / 21 ^b	69 / 58 ^b	16 / 12 ^b	10	10	2
Togo	1998	15	70	16	29 / 23	34 / 16	12 / 4	21	21	2
Comoros	1996	14	74	8	29 / 23	40 / 29	13 / 7	6	6	2
East and Southern Africa										
Ethiopia	2000	13	86	19	18 / 18	64 / 55	13 / 12	14	14	1
Kenya	1998	16	88	14	20 / 14	9 / 7	4 / 2	15	15	1
Madagascar	1997	12	76	16	20 / 19	43 / 41	11 / 9	20	20	6
Malawi	2000	13	87	21	31 / 25	16 / 16	7 / 5	17	17	1
Mozambique	1997	14	77	22	28 / 22	42 / 29	16 / 9	30	30	4
Namibia	1992	12	75	13	41 / 35	7 / 9	3 / 4	8	8	1
South Africa	1998	14	54	15	34 / 34	3 / 4	1 / 2	9	9	1
Tanzania	1999	13	80	16	23 / 24	31 / 31	9 / 9	15	15	1
Uganda	2000-01	15	88	23	30 / 25	10 / 9	4 / 3	14	14	2
Zambia	1996	14	61	20	28 / 25	25 / 24	9 / 7	22	22	2
Zimbabwe	1999	15	77	22	30 / 28	8 / 7	4 / 4	3	3	1

adolescents directly, it yields rich retrospective data and is an important source of information on out-of-school adolescents.

The Centers for Disease Control International Reproductive Health Surveys.⁸ The CDC provides technical assistance with population-based surveys that help the United States Agency for International Development (USAID), Ministries of Health, international donor organisations, and nongovernmental organisations (NGOs) to assess

programme needs and monitor programme performance and impact over time. The CDC's reproductive health surveys have collected information in 20 countries on numerous topics, including young adult sexual behaviour, sex education, and opinions and attitudes towards sexuality and gender issues, reproductive health care, HIV and STDs, and intimate partner violence. These surveys are conducted with men and women aged 15 and older.

Country	Survey year	Percent of population aged 10–14	Percent living in rural areas	Percent for whom one or both parents deceased	Percent who live with neither parent (girls/boys)	Percent not enrolled in school (girls/boys)	Percent who live with neither parent and who are not enrolled in school (girls/boys)	Percent of 15–19-year-old girls who reported ^a :		
								Having sex before age 15	Having sex before age 15	Giving birth before age 15
Latin America and Caribbean										
Bolivia	1998	13	39	8	11 / 10	10 / 6	2 / 1	5	3	1
Brazil	1996	12	24	8	12 / 9	10 / 13	2 / 2	12	4	1
Colombia	2000	10	33	9	14 / 11	12 / 14	2 / 3	10	4	1
Dominican Republic	1996	11	42	7	25 / 20	9 / 12	3 / 3	12	10	2
Guatemala	1998-99	13	62	9	11 / 9	26 / 17	4 / 2	8	7	2
Haiti	1994-95	14	64	18	34 / 26	22 / 21	10 / 8	8	3	1
Nicaragua	1997-98	14	43	8	14 / 13	20 / 25	3 / 3	12	13	3
Paraguay	1990	12	55	na	15 / 12	17 / 11	3 / 1	6	3	1
Peru	2000	12	43	8	11 / 9	8 / 5	2 / 1	5	2	1
South and Southeast Asia										
Bangladesh ^c	1999-00	13	82	na	na	24 / 28	na	na	27	7
India ^c	1998-99	12	75	na	na	31 / 18	na	na	17 ^b	3 ^b
Indonesia ^c	1997	12	74	8	7 / 7	12 / 12	1 / 1	3	3	1
Nepal ^c	2001	13	90	na	na	35 / 18	na	na	14 ^b	1 ^b
Pakistan ^c	1990-91	13	68	na	4 / 3	55 / 31	2 / 1	na	7	2
Philippines	1998	12	55	na	na	8 / 12	na	1	1	0
South and Southeast Asia										
Egypt ^c	2000	13	61	9	2 / 1	18 / 12	1 / 0	na	1	0
Jordan ^c	1997	13	19	5	3 / 2	3 / 3	0 / 0	na	1	0
Morocco	1992	13	59	8	10 / 7	59 / 40	7 / 3	na	2	0
Turkey ^c	1998	11	41	6	5 / 3	39 / 18	2 / 0	na	2	0
South and Southeast Asia										
Armenia	2000	10	45	6	1 / 1	1 / 3	0 / 0	1	1	0
Kazakhstan	1999	12	59	9	5 / 6	1 / 1	0 / 0	1	0	0
Kyrgyzstan	1997	13	75	6	6 / 5	3 / 3	0 / 0	0	0	0
Uzbekistan	1996	12	65	5	1 / 1	1 / 2	0 / 0	1	1	0

Note: All analyses are based on data from the Demographic and Health Surveys. na = Data for indicator not collected.

^a Data abstracted from the household survey, except for the retrospective reporting of 15–19-year-olds from the individual survey.

^b Data for these indicators were taken from earlier DHS (years noted as follows) because the information was not captured in the DHS listed in the table: Burkina Faso, 1992–93; Côte d'Ivoire, 1994; Senegal, 1992–93; India, 1992–93; Nepal, 1996.

^c These countries surveyed ever-married women. Retrospective data presented in the final reports were mathematically adjusted so that they are representative of all women. Never-married women are presumed not to have given birth.

Source: Population Council (2003a).

⁸ For more information, see www.cdc.gov/reproductivehealth/Surveys/SurveyOverview.htm.



III.

ETHICAL CONSIDERATIONS

Maintaining high ethical standards is crucial in conducting information-gathering activities. Children and adolescents require special protections, both because they are vulnerable to exploitation, abuse, and other harmful outcomes, and because they have less power than adults. Investigators should be sensitive to pressures young adolescents may feel to participate in research, such as not wanting to say “no” to gatekeepers (parents, teachers, spouses, or in-laws) or researchers. Thus, some researchers recommend obtaining consent from the young adolescent on several occasions—before the research begins, at the beginning of an interview, and during the research. Adolescents must feel free to withdraw their cooperation at any time or decline to respond to a particular question or element of the research (Miers and Murphy 2004).

In the newly published *Ethical Approaches to Gathering Information from Children and Adolescents in International Settings: Guidelines and Resources* (Schenk and Williamson 2005), two important principles are recommended to guide all activities: (1) always put the best interests of children first by promoting and protecting their rights (at a minimum, investigators must do no harm); and (2) children’s participation must be fostered and respected. Children are often the best sources of accurate information about their own lives, and they have a right to express their views about decisions affecting their lives and those of their families or communities. These principles are in accordance with articles 3 and 12 in the Convention on the Rights of the Child (CRC) (see box).⁹ Implementing both of these principles may require a delicate balancing act that involves maximising children’s participation while minimising their exposure to harm. Schenk and Williamson (2005) establish a series of six topics

Guiding principles in gathering information from children:

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration (Article 3).

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child (Article 12).

—The Convention on the Rights of the Child, 1989

that every investigator should think through carefully before beginning data collection (see summary box on page 19).

Community consultation should occur early and often, and activities should be sensitive to community norms concerning children and sexuality. Some researchers develop a “children’s” questionnaire and an “adolescents’ ” questionnaire, so that younger children are not asked questions about sexuality. One study of orphans and vulnerable children in Rwanda and Zambia used one tool for 6–12-year-olds and another tool for 13–19-year-olds (Chatterjee et al. 2005). The National Household HIV Prevalence and Risk Survey of South African Children used three different questionnaires: one for the parents/guardians of children aged 2–11; one for children aged 12–14 that included a limited number of

⁹ The full text of the CRC can be accessed at <http://www.unicef.org/crc/crc.htm>.



Guatemala - Photo: Jennifer Catino/Population Council

questions on sexual experience; and one for adolescents aged 15–24 that covered sexual experiences and practises extensively (Brookes et al. 2004). Pattman and Chege (2003) emphasise, however, that researchers should not assume that the very youngest adolescents (aged 10–12) have not had sexual experiences. A study in Zambia found that children as young as six years old were familiar with sexual activity, whether or not they engaged in penetrative sex or simply “played” at it, and that they enjoyed talking about it (Pattman, personal communication 2005).

The interagency monitoring and evaluation guide for young people’s AIDS programmes recommends that in settings where sexuality-related questions cannot be asked of very young adolescents, research should focus on their relevant knowledge of HIV prevention, their perceptions of peers’ sexual activity, and the context in which young adolescents take sexuality-related decisions. Proxy behavioural questions (for example, whether they think their peers have already had sex) assume that the respondent is answering about a group similar to him or herself. Research has shown, however, that adolescents often believe their friends are engaging in risk behaviours at a much higher rate than they actually are (Robinson et al. 1999).

The Council for International Organizations of Medical Sciences (CIOMS) has issued and

periodically updates “International Ethical Guidelines for Biomedical Research Involving Human Subjects” (CIOMS 2002). These 21 guidelines include direction for those conducting research with children and suggestions concerning issues of assent and obtaining parental permission. CIOMS recommends that the willing cooperation of the child should be obtained, after the child has been informed to the extent that his or her maturity and intelligence permit. In some settings, children who have not yet reached the legally established age of consent can understand the implications of the research and knowingly agree to participate; however this “knowing agreement” (or assent) must be supplemented by the permission of a parent or legal guardian. Some children who may be too immature to give their assent may be able to register a “deliberate objection”, an expression of disapproval of or refusal to take part in the research procedures. In these situations, CIOMS advises that “a deliberate objection by a child to taking part in research should always be respected even if the parents have given permission, unless the child needs treatment that is not available outside the context of research, the investigational intervention shows promise of therapeutic benefit, and there is no acceptable alternative therapy” (Guideline 14).

Information-gathering activities should proceed only if functional support systems are in place to address possible consequences. Interviewers must

be trained to manage situations in which children are upset by a line of questioning and to make referrals if necessary. If situations of abuse or neglect are discovered, staff must be conversant with the local legal issues, regulations, and guidelines surrounding physical and sexual abuse,

and must be prepared to address the situation, at least to a standard considered appropriate and acceptable by local community members. In settings where the local infrastructure is weak, the scope of work may have to be reduced.

Guidelines for the implementation of ethical standards: Summary

A. Make sure the information-gathering activity is necessary and justified.

- Before starting the activity, clearly define its intended purpose and audience, and make sure that there is sufficient staff and money to conduct it in an ethical manner.
- Only use direct methods with children if the required information is not otherwise available.
- If the information-gathering activity will not directly benefit the children and adolescents involved or their community, do not proceed.

B. Design the activity to get valid information.

- Develop a protocol to clarify aims and procedures for collecting, analysing, and using the information that all partners agree to.
- Apply community definitions to set clear criteria for inclusion. Use existing records when possible, and recognise social and cultural barriers to participation. For surveys, use a minimum number of respondents to achieve demonstrable results.
- All tools, such as questionnaires, should be developed through discussions with experts. These tools should then be translated locally, back-translated, and field-tested.
- The use of a comparison group totally deprived of services is inappropriate with vulnerable children. Alternative approaches should be explored to strengthen research findings. Comparison groups should be used only under careful ethical supervision.

C. Consult with community groups.

- Consult locally to determine who must give permission for the activity to proceed.
- Interviewers must be sensitive that they may be highly visible and a source of local interest. Clarify roles and expectations through community meetings and honour commitments.
- An independent local community stakeholder group should monitor activities.

D. Anticipate adverse consequences.

- In partnership with the community, anticipate all possible consequences for the children and adolescents involved. Do not proceed unless appropriate responses to potentially harmful consequences can be provided.
- Avoid stigma by holding community sensitisation meetings and using community terminology.
- If the safety and security of children and adolescents cannot be assured, do not proceed.
- Interviewers should have experience working with children. They should be trained to respond to children's needs, and require ongoing supervision and support. If appropriately skilled interviewers are unavailable, do not proceed.

- In partnership with the community, determine what kind of follow-up is appropriate to respond to children's needs, recognising age, gender, ethnicity, and so on. If appropriate support cannot be assured to meet the children's needs, do not proceed.
- Prepare a reaction plan to anticipate serious needs. If support for the child cannot be assured, do not proceed.
- Confidentiality should be breached to provide immediate protection to the child or adolescent. Staff should make sure that participants are aware of this before asking for any information.

E. Conduct consent and interviewing procedures with sensitivity to children's specific needs.

- Children must give their agreement to participate, but consent is required from appropriate adults.
- Interviewers should make sure that children know they can stop or withdraw at any time.
- Investigators must provide children and adolescents and their parent or guardian with information about the activity in a manner appropriate to their culture and education. Consent forms and informational tools should be developed with community members and field-tested.
- Use an independent advocate to represent the views of children if there is any doubt about the protection provided by their guardian.
- Avoid efforts to unduly influence participation by the use of incentives. If incentives are used, they should be in line with local living standards.
- Interview procedures should reflect the need to protect the children and adolescents' best interests. Consult with community members to determine appropriate practises.

F. Confirm that all stakeholders understand the limits to the activity and next steps.

- Use appropriate procedures to maintain the safety and security of participants.
- Share findings with community members in an accessible, appropriate format.

Key take-home messages

1. **Consider the following cross-cutting themes** while planning and implementing the information-gathering activity: basic ethical principles; children's participation; legal and professional requirements, including ethical supervision; culture and gender; and especially vulnerable children.
2. **Balance** the need to *maximise* children's participation by hearing their own opinions on the issues affecting their lives with the need to minimise their exposure to harm.
3. **Careful advance planning is crucial.** Investigators are responsible for thinking through all possible consequences, both intentional and unintentional, of the information-gathering activity and for anticipating the effect of the activity on young people and their families. If appropriate safeguards cannot be put into place, the activity should not proceed.
4. **Discussions should be held with local community members, including children and adolescents,** whenever possible. Community meetings at different stages of the information-gathering activity can serve a variety of purposes, including sensitisation, review, and interpretation. These discussions can serve the dual purpose of improving adherence to ethical standards and improving the quality of the information gathered.
5. If there is any question about whether the data collection could be harmful to children, **only begin the activity if services are in place** to address possible consequences. If the information-gathering activity is not associated with a service, prepare referral information for children to reach the required support. Do not conduct the activity without functional support systems in place.

Source: Excerpted from Schenk and Williamson (2005). Pp. ix–xi.

A group of young people, likely students, are shown from the chest up, smiling broadly with their arms raised in the air. The image is overlaid with a semi-transparent green filter. A white circle is centered on the page, containing the text. The overall mood is positive and energetic.

IV.

DATA-COLLECTION
APPROACHES AND METHODS
TO INFORM PROGRAMMES
FOR VERY YOUNG
ADOLESCENTS

Setting a research agenda to initiate or improve programmes for very young adolescents

United Nations country teams in collaboration with key partners (government, researchers, academic and policy institutions, and nongovernmental organisations [NGOs]) can play a critical role in building evidence-based programmes for VYAs. Ideally, information-gathering activities will illuminate the diversity of young adolescents' experiences, highlight which subsets of this population are most vulnerable and which are not being reached by current programming efforts, and allow the requirements of these young people to shape new programme content and design.

Bruce (2003) suggests the following five steps to build effective, grounded programmes:

- (1) Gather and analyse data on adolescents grouped by age, gender, marital and schooling status, residence, and other relevant variables through careful situation analyses and other research methodologies.
- (2) Conduct stakeholder review/insight gathering/planning based on as much comprehensive, coherent data as are available.
- (3) Estimate the number and determine the characteristics of adolescents reached and not reached by governmental and nongovernmental policies and programmes.
- (4) Review the relevance and scope of programme content with respect to various subgroups of adolescents (differentiated by age, gender, marital and schooling status, residence, and other relevant categories).
- (5) Implement an information-gathering process that yields insights into the differential needs and aspirations of various subgroups of adolescents (again, differentiated by age, gender, marital and schooling status, residence, and other relevant categories).

Designing a research agenda and results framework is best accomplished by collaboration. One common practise is the use of working groups, which can be useful for defining critical gaps in knowledge and for identifying feasible and relevant research questions, interventions to be tested, and the associated methodology for evaluation. Engaging key stakeholders such as policymakers, programme managers, researchers, service providers, youth leaders, and influential community members is helpful for building political support to increase attention to the needs of very young adolescents.

A context-specific research agenda should be generated locally, depending on the perceived needs and interests of the country team. The type of data to be gathered and methodologies to be pursued will depend on the particular issues to be addressed. As in any research process, cultural and gender sensitivity is essential both in terms of the types of research questions asked and the way in which the research is conducted.



Ghana - Photo: Melissa May/Population Council

¹⁰ This chapter is adapted from Freudenberg (1999).

Information that researchers, policymakers, and programme managers need can be collected in many ways. The research methods described in this guide are those that participants in the consultative meeting either discussed or have used in their research on very young adolescents.¹⁰

Thus the guide includes those methods that are most commonly utilised, but does not provide a catalog of every possible method that could be used with VYAs. Each of these methods has its own advantages, and the reader should consider developing a strategy that combines the use of multiple methods because such an approach may paint a more accurate and complete picture than that produced by one method alone.

The different methodologies can be characterised along two dimensions. The first is the qualitative/quantitative dimension. The second is the participatory/top-down dimension.

The quantitative / qualitative dimension

Quantitative methods, such as surveys, anthropometric studies, and some types of spatial analysis, generate information that can be captured numerically. They yield summary statistics such as frequency distributions, means, medians, ranges, and other measures of variation that describe a population in aggregate terms. They are, therefore, particularly useful for describing the scope of a problem, and depending on the nature of the sample, the information collected can be used to describe the status of similar populations who, for example, were not survey respondents.

Qualitative methods, on the other hand, do not generate information that is generalisable. Rather, they explore meanings, processes, reasons, and explanations—concepts that are either not easily captured in a structured survey or that are

necessary in order to formulate questions for structured surveys. The data are often captured visually in text or diagrammes. Examples of qualitative methods include focus-group discussions and in-depth individual interviews.¹¹

Practitioners of qualitative and quantitative methods sometimes appear to be at odds with one another. This type of debate is counterproductive, however, especially when one considers the general lack of good information from all sources about very young adolescents. The key, therefore, is to match the type of methodology with the kind of information that is needed. As noted above, in many cases, the best approach involves combining several different methods to obtain the most complete picture possible of a given situation. A survey using face-to-face interviewing techniques, for example, is often the best choice for gathering straightforward information from large numbers of people in a way that permits broad comparisons across a large sample. A survey could be conducted in several regions of a country, for example, to determine basic differences in the proportion of young people who have ever had sex or who used a condom at last sex. Surveys are generally less effective tools for obtaining information about complex or sensitive issues (although the development of methods such as audio computer-assisted self-interviewing [ACASI] may facilitate the gathering of such data). Using qualitative methods, interviewers can create a rapport with young people so that they are encouraged to respond more frankly. They can ask probing questions to find out why people take certain decisions or engage in certain behaviours and can use a variety of tools to cross-check sensitive information. A project would use qualitative methods when it wanted to capture the complexity of a situation by looking at a few cases

¹¹ See Freudenberg (1999) for a comprehensive guide to methods.

in considerably greater depth than what is possible on most surveys. Rather than competing, these two kinds of methods are complementary.

The top-down / participatory dimension

Another way of categorising research methodologies is to assess whether they use a more “top-down” or participatory approach. Top-down methods are those in which most of the essential decisions about what issues will be addressed and how the information will be used are taken by specialists rather than by community members. The role of local people is generally limited to answering questions formulated by outsiders. Methods become more participatory as local people play a greater and more active role in the information-gathering process. Responding to a questionnaire is one of the most limited, passive forms of participation. More active participation might involve map drawing or taking part in open-ended discussions. Both of these types of interaction allow community members to express their concerns directly rather than respond to survey questions. An even higher level of participation is attained when local participants set the agenda for the study, determine the questions, gather the information, and become integrally involved in the analysis and use of the information.

As Freudenberger points out, a project’s use of a more participatory or a more top-down approach depends on what it is trying to accomplish. If the purpose of the research is simply to gather information, it may not require greater local participation than a survey provides. Indeed, the participatory route may be a poor choice in such a situation because it imposes a considerable burden of time and effort on the community members who are involved. If, however, the objective of the research is some combination of information gathering and encouraging the local population to become involved in enacting change based on the

findings, then the participatory aspect becomes vitally important. The greater community members’ participation in the research, the greater their stake in the process will be. The greater that stake becomes, the more they will be motivated to take on responsibilities of decision-taking and leadership.

One family of participatory methods and approaches that merits individual mention is Participatory Learning and Action (PLA). PLA enables community members to analyse, share, and enhance their knowledge, and to plan, set priorities, act, and monitor and evaluate programmes and policies. The three key features of PLA as described by Chambers (1997) are: (1) the behaviour and attitudes of outsiders who facilitate rather than dominate; (2) the methods, which shift the normal balance from closed to open, from individual to group, from verbal to visual, and from measuring to comparing; and (3) the partnership and sharing of information and experience between insiders and outsiders and between organisations.

This kind of methodology is also known by several other labels, the most common among them being Participatory Rural Appraisal (PRA). PRA methodology evolved during the late 1980s to help local people play a more active role in the development projects being implemented in their communities. The acronym PLA is used more frequently in the literature as a result of its broader applicability in both rural and urban contexts and because the term indicates its continued use during the ‘action’, or implementation phases of the project cycle. A wide variety of verbal and visual methods are employed in PLA that include: social mapping, transect walks, time lines, ranking and scoring, Venn diagrams, focus-group discussions, case studies, stories, and portraits (Shah et al. 1999).

Both the qualitative/quantitative and top-down/participatory characteristics are best represented as continuums. Asserting categorically that a given methodology is or is not participatory or quantitative is difficult. It makes better sense to think of a method as being applied in a more or less participatory way or gathering more or less quantitative information. Although quantitative methods are associated with top-down approaches and qualitative methods are assumed to be participatory, this is not necessarily true. We can compare, for example, the case of a focus group in which the research team is comprised entirely of

outsiders and the report is to be used for academic purposes with one that includes members of the local community on the team and includes sharing information with the community.

Table 3 summarises the advantages and disadvantages of the methodologies discussed in this guide and includes rationales for their use. Although the tool kit is representative of the most common research methods currently used with very young adolescents, it is not intended to be a comprehensive list of all options.

Table 3 Research methodologies to gather information about very young adolescents

(Blue denotes methods that tend to be comparatively qualitative in nature; green denotes methods that tend to be more quantitative)

Method	Rationale	Strengths/advantages	Weaknesses/disadvantages
For obtaining information about programmes targeting VYAs			
Programme-coverage exercise	<p>Informs programme managers about those whom programme is serving</p> <p>Indicates characteristics of programme users</p>	<p>Easy to use</p> <p>Provides quick results</p> <p>Builds research capacity of programme staff</p>	<p>Provides no data about those whom programme does not serve</p>
For obtaining information from and about VYAs			
Focus-group discussion	<p>Provides information at formative stage of project</p> <p>Aids in designing question guides for individual in-depth and structured interviews</p>	<p>Participatory method</p> <p>Relatively easy to implement</p>	<p>Requires well-trained group facilitators</p> <p>Requires training for data analysis; analysis may be time-consuming</p> <p>Lack of individual-level information</p> <p>Small numbers of participants may produce nonrepresentative results</p>
Community mapping	<p>Useful for learning about a community quickly</p>	<p>Participatory method</p> <p>Nonthreatening</p> <p>Good icebreaker with community</p> <p>Maps are easy for participants to prepare</p> <p>Potentially captures important local contextual factors</p>	<p>Requires well-trained group facilitators</p> <p>Requires training for data analysis; analysis may be time-consuming</p> <p>Lack of individual-level information</p> <p>Small numbers of participants may produce nonrepresentative results</p>

Continued on next page

Method	Rationale	Strengths/advantages	Weaknesses/disadvantages
Individual in-depth (semistructured) interviews with key informants	Potentially fills gaps in knowledge about crucial issues Aids in designing question guides for individual in-depth and structured interviews	Participatory method Provides individual-level information	Requires training for data analysis; analysis may be time-consuming Small numbers of participants may produce nonrepresentative results
Visual methodologies	Engage very young adolescents as active participants and agents of change	Participatory method Creative Fun Open-ended Nonthreatening	Lack of guidance on best practises with VYAs
Diary-keeping	Allows adolescents to share thoughts and opinions that might not surface in group or face-to-face interviews	Self-paced Allows for self-expression	Requires literate population
Household survey: structured individual interviews (verbal, face-to-face interview method)	Provides information about trends within a very young adolescent population	Individual-level information Allows disaggregation of data by age, sex, school attendance, marital status, and socioeconomic status	Validity/reliability of VYA responses on sensitive topics may be questionable Lack of guidance on best practises with VYAs Expensive Time-consuming Requires training for data analysis; analysis may be time-consuming
School-based survey: structured individual interviews (verbal, face-to-face interview method)	Provides information about trends among school-going young people	Provides individual-level information Allows disaggregation of data by age, sex, school attendance, marital status, and socioeconomic status Respondents found easily Less expensive and less time-consuming than a household survey	Nonrepresentative sample (misses nonenrolled young people—who may be at higher risk) Validity/reliability of VYA responses on sensitive topics may be questionable Lack of guidance on best practises with VYAs Requires training for data analysis; analysis may be time-consuming
Audio computer-assisted self-interviewing (ACASI)	Allows collection of accurate information about sensitive behaviours	Reduces interviewer bias May reduce social desirability bias	Standard software not yet available (programming required) Little data available on method's cost Lack of guidance on best practises with VYAs

Programme-coverage exercise

Insufficient attention has been paid to differentiating purposefully the intended and actual audiences of programmes for young people, or to gathering reliable data on participation in, and entitlement to, government-sponsored programmes. Even officially reported schooling data is not always accurate, because enrolment figures reported for the purpose of collecting revenues often differ greatly from actual attendance. Reporting and evaluation of the four most popular

types of programmes for young people (youth centres, school-based programmes, “youth-friendly” services, and peer education) rarely define which subsets of young people are most engaged in—and which are left out of—these programmes. Nor do they describe the relative effectiveness of each type of programme for different subgroups of young people.¹² A multicountry study of youth centres in sub-Saharan Africa found that these programmes may not be as effective as people generally believe (see box).

Popular, but effective? A review of youth centres in four countries¹³

From 1996 to 2000, the Population Council in collaboration with local family planning associations carried out assessments of youth centres in four sub-Saharan African countries.¹⁴ Twenty-six youth centres were included in the assessments: two in Kenya, three in Zimbabwe, nine in Ghana, and 12 in South Africa. Facilities varied enormously from centre to centre. Some centres were well-funded and well-equipped; others were more modest, having limited recreational and vocational resources. Some centres had been running for many years, whereas others (especially those in South Africa) were relatively new.

The evaluation team reported ten principal findings:

1. Coverage, that is, the number of young people served by a centre, is often low.
2. Youth centres are often stigmatised by the community and by young people.
3. Youth centres that integrate recreational activities and reproductive health services tend to be dominated by boys.
4. People who make use of youth centres tend to be older youths or even adults.
5. At centres that integrate recreational activities and reproductive health services, a low proportion of clients are seeking the latter.
6. Stand-alone reproductive health clinics for young people reach a relatively large number of girls.
7. Condom provision should be strengthened.
8. Youth-centre staff are highly knowledgeable, but often judgemental.
9. Preservation of confidentiality and providers' judgemental attitudes are the main concerns of young people who receive counselling.
10. Young people who visit the centres are not necessarily more knowledgeable than others concerning reproductive health, nor are they more likely than others to practise abstinence.

¹² PAHO and WHO have defined adolescents as those individuals between 10 and 19 years of age, youth as those between 15 and 24, and young people as those between 10 and 24. The authors note that the term “youth” in this section is used more loosely to include 10–24-year-olds, because popular terms such as “youth centres” and “youth-serving organisations” do not adhere to the PAHO/WHO definitions. Very young adolescents are not excluded from youth centres, and indeed, some youth-serving organisations specifically target them.

¹³ Excerpted from Population Council (2003b). For evaluation reports, see Erulkar and Mensch (1997); Phiri and Erulkar (1997); Glover et al. (1998); and Erulkar et al. (2001).

¹⁴ The youth centres in this study were designed to serve young people ranging in age from 10 to 24.

Where programmes for young people are widely used, the question remains: Who uses them? Are those being served, in fact, young people? If so, are they the neediest young people? What subgroups of adolescents are not being served by these programmes? Even fairly superficial inquiries may reveal excessive programmatic attention being paid to the needs of a specific group (for example, older boys) and neglect of other important groups of adolescents (for example, younger girls). Programmes may fail to reach certain groups of adolescents because they operate from incorrect assumptions about where adolescents can be found and, therefore, where efforts to reach them should be directed. The belief is widespread that adolescents can be found in school and/or living



India - Photo: Population Council

with one or both parents, but this assumption is often inaccurate. As a result of marriage, migration for work, or family breakdown, many young people do not live in their natal homes, or they have left school before their adolescent years are over. Developing strategies for identifying and reaching this internally diverse population of young people should be a priority.

School-based programmes are popular, yet often they are fielded without an analysis of who is actually in school—to say nothing of the effectiveness of programmes in schools of variable quality which are often staffed by overworked teachers grappling to provide sometimes controversial content. A majority of 10–14-year-olds, particularly girls, may not be attending school. Population Council analyses of DHS data revealed that only 21 percent of 10–14-year-old girls in Burkina Faso, 22 percent of those in Niger, 36 percent in Ethiopia, and 41 percent in Rwanda were enrolled in school. More useful information like this will come to light as programme planners and policymakers evaluate which adolescents are or are not being reached by existing programmes.

Appendix A of this guide describes the steps involved in conducting a coverage exercise. The worksheet included in the appendix is an example of a tool designed to capture, over the course of several weeks, the characteristics of individuals served by a programme. Ideally, this information should be collected by alert observers or programme staff, who record information about every person who accesses programme services or information. Comparing these results with information obtained from programme directors about whom they aim to serve and whom they think they actually serve can be illuminating. Many youth programmes are unintentionally devoting major resources to serving older males, who may come to dominate programmes. Although these

Example from the field: Results of a programme-coverage exercise with Ethiopian youth-serving organisations

To generate a picture of the reach of existing efforts, a recent exercise was undertaken in Ethiopia with 15 youth-serving organisations, many of which were coordinated by an umbrella group administered by PACT Ethiopia and the German Foundation for Population (Mekbib et al. 2005). Participating organisations listed young people aged 10–24 as their target group, with a few focusing on specific subgroups, including commercial sex workers and HIV-positive adolescents. The organisations used peer educators, forming HIV clubs, and mounting reproductive health information campaigns. Jointly, a simple recording matrix was developed for the peer educators to use as they conducted their daily activities, which enabled them to collect information on contacts' age; school, work, and marital status; living arrangement; and the content of the information provided during the session.

A study of the contacts of these organisations during a six-week period of found that:

- Programmes reached more males than females; nearly 60 percent of those served were boys or men.
- Older boys and men dominated the programmes; 45 percent of contacts were boys aged 15 and older, and one out of five were men aged 20 and older. Fourteen percent of contacts were older than the upper age limit of 24; three organisations reported 30 percent of contacts who were outside their targeted age range.
- A disproportionate number of adolescents reached were attending school (90 percent among contacts aged 10–19), whereas the vast majority of Ethiopian adolescents do not attend school.
- Although 68 percent of contacts received information about HIV/AIDS, only 19 percent of contacts received information about condoms.
- Only 3 percent of female contacts were married, although the majority of girls in Ethiopia are married during adolescence, and nearly all of girls' sexual activity during adolescence (94 percent) takes place in the context of marriage.
- Twenty-two percent of the programmes' beneficiaries were aged 10–14.
- Less than half a percent of all contacts were with girls aged 10–14 living apart from their parents, although in Addis Ababa (where most of the programmes are concentrated), 37 percent of girls in this age range live apart from both parents.
- Eighty-five percent of Ethiopian adolescents live in rural areas; all the programmes were operating exclusively in urban areas.

young men undoubtedly have needs, they are likely not as vulnerable and needy as other (notably young female) adolescents. Moreover, their presence may discourage young girls from participating in the programmes.

Because little knowledge of who uses programmes for young people is currently

available, even these rudimentary approaches can provide useful insights. The roughest determination is likely to reveal a lack of attention to large vulnerable groups such as married girls, out-of-school adolescents, those employed in domestic service, and those living in unstable and unsafe environments, including young refugees (see box above).

Qualitative methods

Focus-group discussions¹⁵

Focus-group discussions are useful for gaining information at the beginning of a project because they can indicate the range of a community's beliefs, ideas, and opinions. Moreover, they are a useful tool for designing question guides for individual in-depth interviews and questions for structured interviews. They are particularly helpful to organisations planning to generate ideas for programmes, campaigns or materials; to pretest educational or promotional concepts, messages, and materials; to improve a product or service by clarifying young people's attitudes and needs; or to identify issues for quantitative research or to clarify (or build upon) quantitative findings.

A focus group is an organised discussion group involving six to ten participants convened to collect information on a particular subject. A trained moderator guides the group through a discussion about the topic. A trained note-taker records the discussion in detail. Group discussions are often tape-recorded to be transcribed later for analysis. The length of a discussion is generally one to two hours. A 15-minute debriefing, involving all participants, should follow each discussion immediately. A complete debriefing should be conducted later with the team. This debriefing session may last for as long as two hours. Therefore, conducting one focus-group discussion will require a minimum of two hours and a maximum of four hours. An average focus-group study will include six to eight focus-group discussions, so that two to four days will be required for conducting all discussions. The analysis and write-up of a six-to-eight focus-group study requires one to two weeks, depending on the training and expertise of the research team.

Numerous books and manuals about this method are available. Many discuss how to conduct focus-group discussions for market research. In the 1950s, the method gained popularity as a means of identifying people's opinions and feelings about certain products in the marketplace. Today in the developing country context it is widely used as a means to gain insight into health, social, and economic development issues. Appendix B of this guide contains a list of resources for information on how to conduct focus-group discussions.

For the method to work effectively, careful attention must be given to the group's composition and the training of moderators. Particularly with adolescents, gender roles are often exaggerated in mixed-sex groups; boys can be boastful and denigrate girls, silencing girls' voices. Single-sex groups may mitigate this problem, but they lose the benefit of learning from members of the other sex by hearing their point of view. A UNICEF-funded study in Zambia developed an innovative approach wherein group interviews were organised in two stages. First, same-sex group interviews were held on the topic of problems they and people of the opposite sex experienced (see Pattman and Chege 2003). The confidence and support that girls gained in the first stage allowed them to hold their own during the second stage, in which boys and girls came together to present and discuss their findings. Indeed, the girls challenged the boys to become more reflective and critical, increasing the boys' awareness of problems that being perceived as "tough" and "strong" generate (for example, being expected to fight, smoke, and drink, and conceal their emotions).

Skilled moderators are critical to negotiate these gender dynamics, elicit participation from all focus group members, and create a nonjudgemental safe

¹⁵ This discussion of focus groups draws on Winch et al. (2000).

space for young people to share their opinions and experiences. Girls may be particularly concerned to present themselves in focus groups as “good”, that is, not having boyfriends, not having sex, and not going out to bars. Pattman (2005) advocates a young-person-centred approach, where interviewers address participants as active subjects and hear from them what boys’ and girls’ lives are like. This approach involves inverting the usual power relations between adults and children, so that young people are encouraged to set the agenda and pursue issues that they deem significant.

*Community mapping*¹⁶

In *The History of Cartography* (1987:xvi), Harley and Woodward define maps as “graphic representations that facilitate a spatial understanding of things, concepts, conditions, processes, or events in the human world”. Mapmaking is a form of communication that allows people to identify those aspects of their society and environment they consider important and to represent the spatial elements between those elements to others.

A community map is a visual representation of the local area created by local programme participants and is, therefore, inherently participatory. This type of mapping aims to empower community members by involving them in collecting, managing, and inputting data to produce the maps, and in taking decisions regarding the use and representation of the data. The maps are subsequently used as vehicles for discussion, information exchange, analysis, and support for decision-taking and advocacy.

Community mapping is an efficient mechanism for gathering abundant information quickly, and is well-suited for use with young people. Because the

method is participatory, it is fun and engaging for young people, values their knowledge, and generates enthusiasm. It can act as a good icebreaker, and, therefore, it is often introduced in the early stages of a project. The visual nature of maps also lends itself well to conveying information to young people, especially those who may be semiliterate or illiterate.



Eritrea / Photo: M. Grant

Community mapping can provide a number of different types of information that are important for understanding the nature of a community: it can show safe and unsafe spaces for different types of people; the physical and social boundaries of the community; physical infrastructure (such as roads, water-supply points, schools, and clinics); social infrastructure (public halls, playgrounds, places of worship, and other public spaces); economic infrastructure (formal and informal places of employment, retail establishments, and formal and informal sources for savings and credit); and if pursued in detail, housing patterns and the relative well-being of neighborhoods or even of specific households.

¹⁶ This discussion of mapping draws from Shah et al. (1999).

Example from the field: Venn diagrammes of public spaces in Burkina Faso

The Population Council conducted a mapping exercise in two rural villages in Burkina Faso with three groups of adolescents aged 10–19: married girls, unmarried girls, and unmarried boys (Population Council 2003c). Participants identified acceptable places for adolescents to gather. They discussed what activities are currently available at each venue and proposed additional services that could be introduced, and they considered where future activities could be placed to make them accessible to the majority of local adolescents. Venn diagrammes were created to represent their findings; participants designed the symbols and drawings used to represent the spaces on the map, symbolising the borders of the village with an oval (Figure 3).

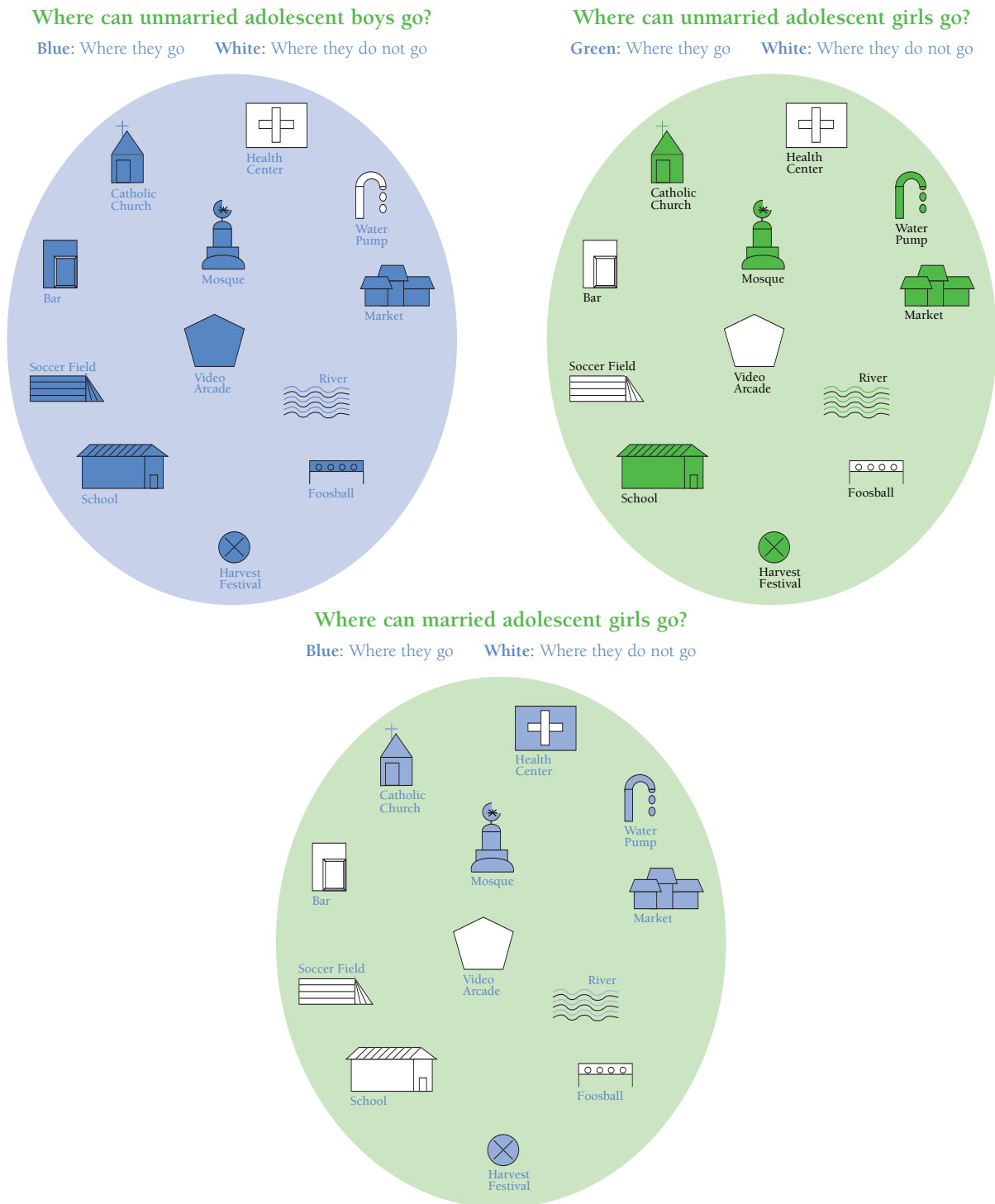
Findings from mapping exercises

- The organisations and collectives that exist in the surveyed communities primarily serve males. The few women's organisations available serve adult women only.
- Girls engaged in the mapping exercise generally identified places of work and religious institutions as safe, whereas boys identified a wider variety of locations and events, reflecting their greater mobility and participation in community life.
- Married adolescent girls have much less free time for accessing services or participating in reproductive health training. They can be reached either in their homes or while visiting the health centre in vaccinations and prenatal consultations at the health centre.
- Existing government administrative facilities in the villages concentrate on agricultural and livestock training and activities. Health services are limited to the health centre and pharmacy, which is frequented primarily by married women for prenatal care and vaccines.
- Because the community is focused on agricultural production, engaging adolescents in training activities in the autumn for anything other than agriculture, including reproductive health activities, is difficult.
- Spaces for leisure activities are considered essential for boys' development to help them become well-rounded and happy individuals; these spaces are considered hazardous and inappropriate for married or unmarried adolescent girls, however.
- Girls need private and accessible spaces where their privacy and anonymity will be protected and respected. According to the adolescents surveyed, general information can be disseminated at local celebrations and festivals. All village residents are present at such occasions, however, and such spaces offer little privacy to allow individuals to discuss their specific problems. Therefore, more private spaces at another venue are also required for girls.
- Married adolescent girls might be provided with reproductive health information at health centres (promotions could be designed to encourage girls to attend) or at religious centres. Using religious centres would require the permission and support of religious leaders.

The mapping methodology normally entails conducting focus-group discussions with particular groups of local community members whose knowledge about and perspectives on an issue are sought. Questions put forward by a trained facilitator elicit information that is discussed

collectively and displayed graphically. Within each group exercise, the completed map can be used to explore specific aspects of a topic in greater depth. Such maps are a good starting point for learning about local issues that can be addressed specifically by means of other methodologies (see Appendix C.)

Figure 3 Community mapping by married and unmarried girls aged 10–19 and unmarried boys aged 10–19, Natiaboani and Koaré, Burkina Faso



*Individual in-depth semistructured interviews with key informants*¹⁷

Individual in-depth semistructured interviewing has been defined as: “Guided conversation in which only the topics are predetermined and new questions or insights arise as a result of the discussion” (Shah et al. 1999: 3.68). This method is intended to complement the findings from group-based methods such as focus-group discussions or community mapping. Semistructured interviews are useful for discussing sensitive topics such as sexual behaviour and attitudes. Very young adolescents may be more

comfortable disclosing information in an individual rather than in a group interview. A semistructured format also allows time for the interviewer to build rapport with the adolescent. The selection of key informants will depend on the nature of the research question; for example, to learn about the levels of reproductive health knowledge of children attending school, a researcher might interview a girl who is popular at school and whose opinions influence her peers. To better understand the pressures that burden orphans and other vulnerable children, a researcher might choose to interview a boy who is head of his household and who is providing for his siblings.

Core components of semistructured interviews:

1. *Preparation:* An interview guide or checklist of issues to be discussed must be prepared.
2. *Interview context:* The interviewer must be aware of the importance of the interview's timing, duration, and setting, and of his or her body language and biases, which might influence the comfort of the respondent.
3. *Sensitive interviewing:* The interviewer must listen carefully and maintain an open attitude.
4. *Sensitive questioning:* The interviewer should ask open-ended and nondirective questions, probing responses carefully.
5. *Evaluating, cross-checking, and verifying responses.*
6. *Recording the interview:* Notes should be taken, and if appropriate, the interview should be tape-recorded.
7. *Self-critical review:* The interviewer should conduct a critical review to assess the effectiveness of the questions and whether the interview was influenced by his or her behaviour in any way.

Some of the issues that have been explored fruitfully using semistructured interviews with very young adolescents include:

- **Sexual behaviour:** Questions may cover age at which she/he first had sex; with whom; reasons for doing so; frequency of sex and number of partners; why partners were changed; whether she/he receives or gives any gifts or payments in exchange for sex; whether contraceptives are used; which partner decides about the use of contraceptives.
- **Sources of information about sex:** Questions may include where she/he obtains information about reproduction and sexually transmitted infections (STIs) and where and from whom does she/he seek help regarding reproductive health.
- **Attitudes towards sex:** Questions may cover her/his view of peers who do or do not have sex, about normative attitudes concerning ideal age at first sex and age at marriage, and about the perceived relative safety of various sexual practises.

¹⁷ Discussion of in-depth interviews draws from Shah et al. (1999) and Pretty et. al. (1995:73–76).

Sensitive questioning is crucial to semistructured interviewing (and to all good participatory research). The interview that lacks sensitive questioning will yield poor information and limited understanding no matter what other methods are employed or applied. Developing effective interviewing skills is difficult because it depends on self-critical awareness, perceptive listening, and careful observation. These qualities take time and effort to acquire. (Appendix D offers guidelines for conducting individual in-depth semistructured interviews with key informants.)

*Photo-voice techniques*¹⁸

Photo-voice techniques belong to a broad group of visual methodologies such as drawing, collage, performance, and video documentary that are used to gain understanding of how community members view the pressures and challenges in their lives. The photo-voice concept was developed by Wang and Burris (see Wang and Redwood-Jones 2001) and is based on three main theoretical understandings: Paulo Freire's approach to critical education, which contends that every human-being is capable of thinking critically about his or her personal and social reality; feminist theory, which acknowledges the domination of women by men and seeks to bring new ideas and voices into the public forum; and a community-based approach to photography that considers how the camera can be used as a tool for social change.

The main goals of photo-voice methods are: to enable people to record and reflect their community's strengths and problems; to promote dialogue about important issues through group discussion and photographs; and to engage policymakers. By allowing community members to shape the

agenda, photo-voice methods circumvent the disconnect that can occur between what government officials and researchers think is important and what the community considers important. Photo-voice techniques are highly adaptable and can be tailored to specific participatory goals (such as needs assessment, asset mapping, and evaluation), specific groups and communities, and distinct policy and public health issues.

Participants in photo-voice activities typically analyse the pictures they have taken in a three-step process:

1. *Selecting*: They choose those photographs that most accurately reflect the community's concerns and assets.
2. *Contextualising*: They tell stories about what the photographs mean.
3. *Codifying*: They identify the issues, themes, or theories that emerge.

Key questions to consider are set around the mnemonic "SHOWeD":

What do you **S**ee here?

What is really **H**appening?

How does this relate to **O**ur lives?

Why does this problem or strength exist?

What can we **D**o about it?

Photo-voice techniques have been used successfully with younger and with older adolescents. Actively composing and taking photographs (rather than being subjects of photographs, as they are accustomed to being) foster adolescents' sense of agency and develop their voices during a period where their opinions are rarely sought or considered. The creative aspect of photo-voice is particularly fun and engaging for

¹⁸ For more information about visual methodologies, visit <http://www.photovoice.com> and the International Visual Methodologies for Social Change Project website at <http://www.ivmproject.ca>.

Example from the field: “Feeling safe and not so safe” in Swaziland

In one project in Mbabane, Swaziland, 30 seventh-grade students were asked to make photographs expressing the ideas of “feeling safe and not so safe” in their school environment. Divided into small same-sex groups, the children were given 45 minutes to take pictures on the school grounds. To represent feeling safe, one group photographed a girl sitting at a desk in front of a chalkboard upon which was written “now safe”, indicating that school was viewed as a safe haven. Pictures representing feeling vulnerable included images of staged rape scenes in the bushes, areas with polluted water, and numerous shots of toilets. Girls deemed the toilet cubicles unsafe because they could be raped there where no privacy exists (the toilets lack doors and are dangerous and dirty). The teachers and researchers were surprised that so many students considered the toilet cubicles dangerous spaces, and this finding led to a re-examination of policies concerning safety in the school environment by the Child Protection Unit of UNICEF.

young adolescents, and absorbs them in ways that more commonly used research techniques and HIV/AIDS interventions may not. Mitchell and colleagues (2005) conducted photo-voice projects involving very young adolescents aged 12 and 13 in South Africa and Swaziland as part of a larger “Youth, Gender, and Sexuality” project that focuses on visual methodologies and social change (Mitchell et al. 2005). As part of a study of sexual abuse in and around schools, a project in Mbabane, Swaziland, asked seventh-grade students to photograph images to illuminate the concepts “feeling safe” and “feeling not so safe” (see box above for more details). In another project in Durban that was studying young people’s participation and HIV/AIDS, seventh-grade students were asked to take pictures of “feeling strong” and “feeling not so strong”. The third project, in KwaZulu-Natal, sought to understand and document the reasons why so many students missed school on Fridays. These sixth-grade students found their absent classmates in the market, trying to make enough money to cover their necessities, and took pictures of their working conditions.

Mitchell notes that the creative process and entertainment content of photo-voice methods can have an impact upon the evidence, evaluation, and

sustainability of HIV/AIDS interventions targeting young people, but that these impacts are difficult to measure and interpret. It is important to conceptualise photo-voice techniques as not just a “one-off” activity or product, but to view it as a development of critical thinking abilities and a stimulus to action. More research is necessary in order to assess the impact of photo-voice projects



South Africa - Photo: Claudia Mitchell

over time, to see whether very young adolescents engaged in such projects became involved in other types of taking action once the initial photo-voice activity has ended. The costs of materials and film developing may be prohibitive to longer-term adoption of photo-voice approaches in some low resource settings.

The use of photo-voice techniques requires a careful examination of ethical issues in order to minimise participants' risks and the loss of privacy to the young photographers and their communities. Before cameras are distributed, the group should discuss cameras and power relationships, potential risks to photographers and how to minimise those risks, and the practise of giving prints of the images to community members to express appreciation and respect. Specific questions to ask the photographers include:

- What is an acceptable way to approach someone in order to take his or her picture?
- Should you take pictures of other people without their knowledge?
- What kind of responsibility does carrying a camera confer?
- What would you not want to be photographed doing?
- To whom might you wish to give photographs, and what might be the implications of such a gift?

Other issues concerning ownership of the photos, confidentiality, and situations in which publication or display of photos is acceptable should also be worked out before the photographers start snapping. (Appendix E provides additional guidelines concerning photo-voice projects involving very young adolescents.)

Diary-keeping

Diary-keeping is a method that can glean rich data from literate adolescents. Participants are typically asked to write in their diaries at the end of every day for a given period of time and are asked to respond to specific questions. Questions are open-ended and ask about significant events, emotions, and relationships. They encourage the diary-keeper to elaborate and to provide illustrative details. Diary-keeping can generate material that is not obtainable through group or face-to-face interviews.

A study in South Africa that used diary-keeping and focus-group discussions found that girls who in group interviews tended to criticise other girls who had boyfriends admitted in their diaries that they have boyfriends themselves and enjoy their attractiveness to boys (Pattman 2005). Whereas boys tended to present themselves as physically, emotionally, and sexually tough in group interviews, diary entries revealed their vulnerabilities, fears, and anxieties about heterosexual rejection and physical violence. Many of the boys, far from boasting about sleeping with and dumping girls, wrote romanticised accounts of their girlfriends and heartfelt pieces about being discarded by them. Two examples extracted from Pattman (2005) illustrate such diary entries:

Mpumelele: I was disappointed by the bad news she told me. She told me that she did not love me anymore. I thought of slapping her, but I did not see any use in hurting her, so I left her and went home. She is the only girl I truly love. She has all the qualities I need in my dream girl (page 8).

Hector: I was so happy [but] I ended up being sad. I was with other guys taking a stroll/walk until we find a snooker shop, then

we played that game. Certain guys approached us, telling us that we have to buy cigarettes for them. We refused to provide them with their request – they beat us – we ended up running away. It was late afternoon, one of our friends got injured – I felt bored and sad (page 10).

Pattman observes that:

It is important not only for understanding but also for working with boys and girls not to iron out their contradictory accounts in diaries and group interviews. The diaries do not provide insights into what boys and girls were really like, in contrast to the group interviews; rather these radically different ways of presenting themselves by the same boys and girls, in the different modes of research suggest that contemporary young masculinities and femininities in the countries where we conducted our research may be lived and experienced in quite contradictory ways (page 10).

Quantitative methods

Structured survey interviews

Quantitative surveys generate information that can be captured numerically. A survey with sufficient sample size yields summary statistics such as frequency distributions, means, medians, ranges, and other measures of variation that describe a population or subpopulations in an aggregate manner. This methodology is particularly useful for describing the scope of a set of issues or problems.

The choice of appropriate indicators to collect within a survey varies with the goals of the programme. Since the diversity of HIV epidemics has grown, two sets of core indicators are

suggested by the World Health Organization, one for low-level and concentrated epidemics, the other for generalised epidemics (see WHO et al. 2004). Attention must be paid to prevention of HIV infection and care for those infected among young people in both scenarios. The indicators capture measures of impact at the population level, i.e. epidemiological measures, most notably HIV-prevalence rates among young people and among specific subgroups of young people. Core indicators can be supplemented with additional indicators as they are deemed appropriate to the goals of the particular programme being designed or evaluated.

Population Council research reveals that the analysis of indicators by age, sex, school attendance, marital status, and such other background characteristics of young people as orphanhood, poverty, and degree of social support is highly instructive (Population Council 2001–02). The age breakdown is especially important because sexual behaviour varies widely among age groups. In general, adolescents aged 10–14 years are probably much less sexually active than are those aged 15–19, who in turn differ from people aged 20–24. Data breakdown by age groups allows researchers, policymakers, and programme managers to look for cohort trends that occur over time. For example, if respondents aged 15–19 report lower proportions of sexual initiation before the age of 15 than do respondents aged 20–24, this finding may suggest a decline in early sexual debut.

Whenever possible, data should be disaggregated at least by the age groups 10–14, 15–19, and 20–24. Some researchers argue that even the five-year cohort of 10–14-year-olds homogenises too much of early adolescence and its rapid transitions. Depending upon the context, the key periods for intervention may best be detected using six-month, one-year, or three-year age

cohorts. In addition to age, the disaggregation of data by background characteristics (for example, urban versus rural residence, school attendance, and marital status) allows policymakers to determine which populations may be at increased risk. It also allows them to take better-informed programmatic decisions, for instance, concerning the inclusion of HIV/AIDS education based on life skills for those in the earlier grades of school. Indicators of interest can be broadly grouped into two main categories:

Risk factors and protective factors. Certain indicators are not causally related to HIV infection among young people but either contribute to risk-taking behaviour and vulnerability or provide some protection against HIV infection. They include young people's knowledge, attitudes, and perceptions; their access to health information, and measures of the quality of the relationship between young people and their primary caregivers. They also include more distal factors that are still potentially important for shaping risk, such as living situation, orphanhood status, school attendance, marital status, social connectedness, and economic status.

Behavioural outcomes. Some indicators measure individual young people's actions that directly affect biological outcomes. They include measures of condom use, injecting drug use, commercial sex, the proportion of young people who have had sex by the age of 15, and numbers of lifetime and current sexual partners of young people. In addition, several indicators are included that are not causally related to HIV infection, but which contribute to young people's vulnerability, such as forced sexual relations and cross-generational sexual partnerships (especially among young women).



Cambodia - Photo: P. Sudhakaran/UN

Implications of developmental stages for questionnaire design

Borgers and her colleagues (2000) consider Piaget's description of developmental stages and their implications for conducting research with young adolescents.¹⁹ During the period labeled development of concrete operations (at roughly 8–11 years), language develops and reading skills are acquired. Children at this stage start to distinguish different points of view (one's own versus those of others), but have problems with logical forms (such as negations) and depersonalised or indirect questions (for example, with questions that start with "Most people . . ."). They also have difficulty with ambiguous speech, and often fail to distinguish between what is said and what is meant. Contrary to general practise in adult surveys, where roughly equal numbers of positive and negative statements are used in ratings to avoid response sets, Borgers and her colleagues advise that negatively phrased items should not be used with this age group. Researchers should also be aware of "satisficing" (reducing the amount of cognitive effort a respondent spends in answering

¹⁹ According to Piaget's theory of cognitive growth, children's intellectual development evolves according to a fixed sequence of stages. As with the PAHO distinctions, Borgers and her colleagues (2000) note that the stages tend to overlap and that abilities vary according to heredity, learning, experience, and socioenvironmental factors.

a question) and other problems that suggest a lack of concentration or motivation, especially with long questionnaires.

Cognitive functioning and social skills are well developed in adolescents in the stage of development of formal thought (typically 11–15 or 16 years). Their behaviours are sensitive to context, however; the same child may be shy and quiet at school yet boisterous and talkative at home. Context, therefore, is an important influence on data quality. Researchers should be sensitive to the presence of parents, siblings, and classmates, and respondents' concerns about confidentiality.

Conducting surveys with very young adolescents

Structured survey interviews have been conducted with very young adolescents in their households and in schools. Each of these settings has its benefits and disadvantages, and the decision to select one or the other should take into consideration available resources and manpower, the desired target population and their literacy level, and the potential effect of those who may be present (parents, teachers, peers) during the interview. (Appendix F provides guidelines concerning the construction of questionnaires for structured survey interviews.)

Surveying students in school is an efficient way to reach a large sample in a short period of time. One project in Ghana collected data using a self-administered questionnaire that was read aloud by a researcher to keep the entire group on pace.²⁰ The classes were sex-segregated while they filled out the questionnaire, which took about one hour to complete. To enhance the privacy of students as they answered sensitive questions, skip patterns were eliminated (since children who would be

filling out certain questions would flag their behaviour to others in the room), and a response category included so that everyone would proceed through the section regardless of behaviour.



Vietnam - Photo: Chieko Ishikawa

School surveys tend to be much less expensive than household surveys to implement. This lower cost is largely due to a more accessible sample (the advantage of having a group of young people in a school, rather than having to find each young person in his/her household), and because most school surveys employ self-administered questionnaires. Some obvious limitations of school-based self-administered surveys is that children who do not attend school (the majority of young people in some settings) are left out. This method may not be appropriate for populations of low literacy. One study in Jamaica of 698 adolescents aged 11–14 noted that the low literacy levels of the study population limited the quantity and complexity of information that could be collected. A 30-item scale for measuring self-esteem had to be modified to a six-item scale with dichotomous responses. Results from the Jamaica study also raise concerns about the accuracy of self-reported information about sexual behaviours: the longitudinal study included three rounds of data collection, and found that 12 percent of girls

²⁰ Adamchak, Susan. 2005. Personal communication regarding SHAPE 2 HIV/AIDS Peer Education Program.

and 65 percent of boys responded inconsistently about their sexual experience between rounds (Eggleston et al. 2000). Multivariate logistic regression analysis indicated that boys were nearly 14 times more likely than girls to report their sexual experience inconsistently.

Surveys of young adolescents are also frequently conducted in their homes as well as in school. Advantages of individual interviews include allowing time to ensure that the respondent fully understands the questions and a greater degree of privacy for the respondent (which plausibly enhances the accuracy of responses). Individual interviews are much more expensive and time-consuming than group surveys to conduct, however. Organisations such as the Alan Guttmacher Institute (AGI) have included young adolescents in their household surveys. For its “Protecting the Next Generation” study, 12–19-year-olds were interviewed in Burkina Faso, Ghana, Malawi, and Uganda. Although the importance of interviewers’ characteristics has not been well-studied, AGI explicitly used same-sex interviewers aged 18–25 to facilitate rapport between the respondent and the interviewer. Other studies have found that repeated visits are successful in building trust: a girl who may deny having had any sexual experience during a first interview may feel comfortable enough to respond with greater frankness on the second or third visit (Erulkar et al. 2004).

Researchers conducting interviews in the homes of very young adolescents likely will need to navigate relationships with parents or other relatives or in-laws and spouses for those adolescents who are married as well as with respondents. In socially conservative settings, special attention may have to be paid to these others to allay their fears and to

provide the respondent with some privacy. The Ishraq project in Upper Egypt, which involved out-of-school girls aged 13–15, found that parents were often distrustful and reluctant to leave the interviewers alone with their daughters.²¹ Despite the interviewers’ efforts (for example, reading questions to parents before the interview or allowing parents to be present for a while before requesting privacy), some interviews were conducted in the presence of parents who tended to interfere and answer questions on behalf of their daughters. Not surprisingly, girls in these cases provided answers that conformed with their parents’ expectations. Some of this resistance can be lessened by working closely with community leaders and parents in the early planning stages of the study.

Audio computer-assisted self-interviewing (ACASI)

The computerised administration of questionnaires, developed in part to address concerns about the influence of interviewers on survey results, works on the assumption that the more private and standardised the interview, the better the quality of the data. The advantage of ACASI over face-to-face interviews is that neither the investigator nor anyone else in the area where the interview is being conducted hears the question or the response, thus reducing any bias that may arise from respondents’ giving what they perceive as socially acceptable answers. Respondents hear the question and the response options through headphones and use an external numeric keypad to record their answers. Colour-keyed buttons may be used to repeat a question and responses or to move on to the next question. Unlike self-administered interviews, which require that the respondent be literate and able to fill out a questionnaire, ACASI can be used without the

²¹ Salem, Rania. 2005. Personal communication.

respondent's having read the questions on a computer screen. Moreover, the researcher does not have to be concerned about differences in the interviewers' characteristics or styles of questioning (Tourangeau et al. 2000).

In the United States, a wide range of sensitive topics has been examined in analyses using computerised self-administration, including sexual behaviour, drug and alcohol use, and induced abortion (Aquilino 1994; Tourangeau and Smith 1996; Fu et al 1998; Turner et al. 1998). Additionally, results from other studies have shown that randomised assignment of respondents to ACASI or face-to-face interviews revealed greater reporting of HIV-related risk behaviours when the computer was used (Des Jarlais et al. 1999); larger

differences were observed among HIV-positive than HIV-negative respondents (Macalino et al 2002). The consistency of these findings suggests that such techniques can provide more valid and reliable data in developing countries than can other methods, even among populations of low literacy or among those who are unfamiliar with computers. Indeed, a commentary in *Science*, summarising the results of an experiment in the United States comparing ACASI with self-administered questionnaires, argued that ACASI may be especially suited to collecting data in developing countries, "where overcrowded living conditions typically prevail, where literacy is relatively low, and where some of the behaviours in question may be particularly pronounced" (Bloom 1998:847).



Egypt - Photo: © 2000 Mohsen Allam, Courtesy of Photoshare

Only a few studies have evaluated the use of ACASI in developing countries (see the Rumakom et al. [1999] study of sexual behaviour among college students in Thailand; the van de Wijgert et al. [2000] feasibility study in Zimbabwe; and the Lara et al. [2001] study of induced abortion in Mexico). A large experiment with interview modes was conducted in Kenya in which researchers sought to determine whether ACASI produces more valid reporting of sexual activity and related behaviours than do face-to-face interviews or self-administered interviews among more than 6,000 unmarried adolescents in two districts, Nyeri and Kisumu. The ACASI performed well during approximately ten months of interviewing, despite arduous working conditions in a largely rural, sub-Saharan African setting. Few problems arose with the software or computer hardware; indeed the computer malfunctioned in only 3 percent of more than 6,000 surveys. Moreover, respondents using the ACASI mode were no more likely than other respondents to ask for assistance during the interview (Hewett et al. 2004). The analysis indicated substantial and significant differences in

Example from the field: ACASI with very young adolescents in the Netherlands

A study conducted in the Netherlands tested audio computer-assisted self-interviewing with 6,428 primary-school students aged 8–12 (Van Hattum and de Leeuw 1999). The questionnaire consisted of 99 questions on attitudes regarding bullying, handling of bullying by teachers and parents, and the experience of bullying, either as a victim or as a bully. Compared with results from the paper questionnaire, the computer version had a lower average amount of missing data (5.7 percent versus 14.1 percent missing values; $p = 0.00$) and less individual variability (3.4 versus 25.0 standard deviation). Presumably children who are not concentrating or who are careless can easily skip a question or even a whole page of the paper questionnaire by mistake (de Leeuw et al. 2003). The computer programme prevents skipping mistakes and keeps children motivated by giving them positive feedback (for example, it tells them “You’re doing fine!” or “Great, thank you”). In terms of greater disclosure, significantly more children using the computer version reported that they were actively involved in bullying than did the children in the paper version, and more victimisation of this sort was reported as well.

reported rates of sexual activity across interview modes, although not always in the expected direction. On one hand, the assumption that girls underreport sexual activity in face-to-face interviews by comparison with ACASI was not confirmed by the Nyeri data. On the other hand, the results from Kisumu—for which the survey instrument was modified to ask respondents the full set of questions about sexual behaviour regardless of their response to the question of whether they had ever had sex—were considerably more promising. ACASI generated significantly higher levels of reporting of sensitive behaviour among girls, including having had sex with a relative or a stranger or with a man ten or more years older and having experienced coerced sex.

For example, 21 percent of girls interviewed with ACASI compared with 1 percent of girls interviewed face-to-face reported ever having had sex with a relative (Mensch et al. 2003; Hewett et al. 2004).

To date, ACASI has been used only with adolescents aged 15 and older in developing-country settings. Speculating as to whether ACASI is appropriate to use with 10–14-year-olds, Mensch (personal communication, 2005) believed that they would be able to master the technical aspects and might find the process novel and fun. Use of this technique with this age group is an area that deserves greater attention. (Appendix G provides a more detailed description of how ACASI was used in the Kenya study.)



V.

CONCLUSION /
THE WAY FORWARD

The paucity of research on very young adolescents is striking, and has resulted in serious gaps in knowledge about the critical factors that shape the contours of young lives. To improve our understanding of the challenges facing young people, we need to widen the lens through which we view young adolescents and deepen our analyses of their risk and protective factors. We must define the key transitions in their paths towards adulthood. We advocate obtaining more data on very young adolescents through the use of a variety of methodologies discussed in this document in at least the following domains:

- the onset of puberty and its consequences in terms of mobility, schooling, and marriage
- living arrangements
- schooling experience
- time use, mobility, and social networks
- health status, health knowledge, and access to health services
- transition to marriage, including the individual's degree of say in the timing of marriage and the selection of a spouse
- sexual activity and the context in which it occurs
- economic status and livelihood opportunities
- participation and membership in social and civic groups

Clearly, the relative priority of these subjects will vary in different settings. However, we argue that all research needs to distinguish the gender and age-specific dimensions of adolescent experience. Furthermore, the social and economic circumstances of very young adolescents must be better understood so that appropriate and meaningful programme interventions can be designed and implemented.

In light of the rapid transition of early adolescence, we recommend that researchers resist the temptation to draw conclusions based on analysis of data using five-year cohorts, because such analyses homogenise extremely diverse experiences. Researchers must acknowledge that the key transitions in the lives of young adolescents are likely played out not over five-year intervals but rather in much shorter periods of time: one-, two-, or three-year intervals. As research progresses, a more detailed picture of threshold periods of change will emerge.

The way forward

The purpose of this guide is to provide a sampling of research methodologies and tools that can be used by programme managers and researchers to gather information about very young adolescents. No one methodology or approach will work in all settings or with all subgroups of very young adolescents. Therefore, experimentation is necessary. By gathering data on the capacities, risks, and opportunities of very young adolescents, programmes can be devised that target this group effectively and provide them with vital information, skills and services.

Recommendations for next steps to advance understanding of very young adolescents' lives include the following:

- Stakeholders should conduct research and gather data on very young adolescents with a focus to determining risk and protective factors in the area of HIV/AIDS and reproductive health.
- Guidance and tools should be developed for programme managers seeking to design and implement programmes and services that reach very young adolescents and that are appropriate and relevant to their needs.

We believe that the time is right for a new generation of research and programme interventions dedicated to very young adolescents. We hope that researchers will foster a new wave of quantitative and qualitative inquiry into these young peoples' lives. The participation of very young adolescents and their communities in the design, implementation, and use of all research

activities should be vigorously encouraged. Furthermore, we hope that their partners—policymakers, service providers, and programme managers—will draw on the information gleaned from this research to create new programmes designed to protect and support very young adolescents, assisting them in making a safe and successful transition to adulthood.



References

Adamchak, Susan, Katherine Bond, Laurel MacLaren, Robert Magnani, Kristin Nelson, and Judith Seltzer. 2000. *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs, Tool Series 5*. Washington, DC: FOCUS on Young Adults.

Amon, J. et al. 2000. *Behavioral Surveillance Surveys: Guidelines for repeated behavioral surveys in populations at risk of HIV*. Research Triangle Park, NC: Family Health International.

Aquilino, W.S. 1994. "Interviewer mode effects in surveys of drug and alcohol use: A field experiment." *Public Opinion Quarterly* 58: 210–240.

Bernard, H. 1995. *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Second edition. Thousand Oaks, CA: Sage Publications.

Bloom, D.E. 1998. "Technology, experimentation, and the quality of survey data." *Science* 280: 847–848.

Borgers, Natacha, Edith de Leeuw, and Joop Hox. 2000. "Children as respondents in survey research: Cognitive development and response quality." *Bulletin de Méthodologie Sociologique* 66: 60–75.

Brookes, Heather, Olive Shisana, and Linda Richter. 2004. *The National Household HIV Prevalence and Risk Survey of South African Children*. Capetown, South Africa: Human Sciences Research Council.

Bruce, Judith. 2003. "Steps in building evidence-based programs for adolescents." In *Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second Generation of Programming*. New York: Population Council.

Chambers, Robert. 1997. *Whose Reality Counts? Putting the First Last*. London: Intermediate Technology Publications.

Chatterjee, Minki, Leanne Dougherty et al. 2005. "The Well-being of Children Affected by HIV/AIDS in Gitarama Province, Rwanda, and Lusaka, Zambia: Findings from a Study." *Community REACH Working Paper No.2*. Washington, DC: Community REACH Program, Pact.

The Council for International Organizations of Medical Sciences (CIOMS). 2002. *International Ethical Guidelines for Biomedical Research Involving Human Subjects*. Geneva: CIOMS.

de Leeuw, E., J. Hox, and S. Kef. 2003. "Computer-assisted self-interviewing tailored for special populations and topics." *Field Methods* 15(3): 223–251.

Des Jarlais, D.C.D.P. et al. 1999. "Audio-computer interviewing to measure risk behavior for HIV among injecting drug users: A quasi-randomized trial." *The Lancet* 353: 1,657–1,661.

Eggleston, Elizabeth, Joan Leitch, and Jean Jackson. 2000. "Consistency of self-reports of sexual activity among young adolescents in Jamaica." *International Family Planning Perspectives* 26(2): 79–83.

Erulkar, Annabel and Barbara S. Mensch. 1997. *Youth Centers in Kenya: Evaluation of the Family Planning Association of Kenya Program*. Nairobi: Population Council.

Erulkar, Annabel, Mags Beksinska, and Queen Cebokhulu. 2001. *An Assessment of Youth Centers in South Africa*. Nairobi: Population Council Frontiers Program.

- Erulkar, Annabel, Tekle Ab Mekbib, Negussie Simie, and Tsehai Gulema. 2004. *The Experience of Adolescence in Rural Amhara Region, Ethiopia*. Accra: Population Council.
- Freudenberger, Karen Schoonmaker. 1999. *RRA and PRA: A Manual for CRS Field Workers and Partners*. Baltimore: Catholic Relief Services. http://catholicrelief.org/publications/pdf/Gen1199_e.pdf.
- Fu, H. et al. 1998. "Measuring the extent of abortion under-reporting in the 1995 National Survey of Family Growth." *Family Planning Perspectives* 30: 128–133, 138.
- Glover, Evam Kofi, Annabel Erulkar, and Joana Nerquaye-Tetteh. 1998. *Youth Centers in Ghana: Assessment of the Planned Parenthood Association of Ghana Program*. Nairobi: Population Council.
- Green, L.W. and M.W. Kreuter. 1999. *Health Promotion Planning: An Educational and Ecological Approach*. Third edition. Mountain View, CA: Mayfield Publishing.
- Hallman, Kelly. 2005. "Gendered socioeconomic conditions and HIV risk behaviours among young people in South Africa." *African Journal of AIDS Research* 4(1): 37–50.
- Harley, J. Brian and David Woodward. 1987. *The History of Cartography*. Volume 1. Chicago: University of Chicago Press.
- Hewett, Paul, Barbara S. Mensch, and Annabel S. Erulkar. 2004. "Consistency in the reporting of sexual behaviour by adolescent girls in Kenya: A comparison of interviewing methods." *Sexually Transmitted Infections* 80(supplement 2): ii43–ii48.
- Jejeebhoy, Shireen and Sarah Bott. 2003. "Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries." *Regional Working Paper* No.16. New Delhi: Population Council.
- Lara, D., C. Ellertson, C. Diaz, and J. Strickler. 2001. "Measuring the prevalence of induced abortion in Mexico City: Comparison of four methodologies." Paper presented at the 24th Population Conference of the International Union for the Scientific Study of Population, Salvador de Bahia, Brazil, 18–24 August.
- Linking Complex Emergency Response and Transition Initiative. 2000. *Rapid Assessment Procedures (RAP): Addressing the Perceived Needs of Refugees & Internally Displaced Persons Through Participatory Learning and Action*. Crisis in Transitions Toolkit. Center for Refugee and Disaster Studies, The Johns Hopkins University School of Public Health. This document is accessible at http://www.certi.org/publications/manuals/rap-16_section2.pdf.
- Macalino, G.E. et al. 2002. "Risk behaviors by audio computer-assisted self-interviews among HIV-seropositive and HIV-seronegative injection drug users." *AIDS Education Prevention* 14(5): 367–378.
- Mekbib, T., A. Erulkar, and F. Belete. 2005. "Who are the targets of youth programs: Results of a capacity building exercise in Ethiopia." *Ethiopian Journal of Health Development* 19(1): 60–62.
- Mensch, Barbara S., Paul C. Hewett, and Annabel Erulkar. 2003. "The reporting of sensitive behavior by adolescents: A methodological experiment in Kenya." *Demography* 40(2): 247–268.

- Mensch, Barbara S., Monica J. Grant, and Ann K. Blanc. 2005. "The Changing Context of Sexual Initiation in Sub-Saharan Africa." *Policy Research Division Working Paper* No. 206. New York: Population Council.
- Miers, Anne and Julieanne Murphy. 2004. "Giving kids a voice: Methodological and practical considerations in conducting research with children and young people." *Survey Methods Newsletter* 22 (Spring): 6–18.
- Mitchell, C., L. Moletsane, J. Stuart, T. Buthelezi, and N. Delange. 2005. "Taking pictures, taking action! Using photo-voice techniques with children." *ChildrenFIRST* 9:(60): 27–31.
- National Research Council and Institute of Medicine. 2005. *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*. Ed. Cynthia B. Lloyd, Committee on Population and Board on Children, Youth and Families. Washington, DC: National Academies Press.
- Pan American Health Organization (PAHO). 2005. *Youth: Choices and Change*. Washington, DC: PAHO.
- Pattman, Rob. 2005. "Young-person-centered methods and researching and working with teenage boys and girls in Africa in the context of HIV/AIDS." Paper presented at the Population Council and UNFPA workshop on Very Young Adolescents, 15 March.
- Pattman, Rob and Fatuma Chege. 2003. *Finding Our Voices: Gendered and Sexual Identities and HIV/AIDS in Education*. Nairobi: UNICEF.
- Phiri, Alford and Annabel Erulkar. 1997. *A Situation Analysis of the Zimbabwe National Family Planning Council's Youth Centers*. Nairobi: Population Council.
- Population Council. 2001–02. "Facts about adolescents from the Demographic and Health Survey: Statistical tables for program planning." New York: Population Council.
- Population Council. 2003a. "Selected DHS data on 10–14-year-olds: Annex to 'Facts about adolescents from the Demographic and Health Survey: Statistical tables for program planning.'" New York: Population Council.
- . 2003b. *Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second Generation of Programming*. Background document for a UNFPA workshop, New York, 1–3 May 2002.
- Population Council. 2003c. "Venn diagrams of public spaces for adolescents." Unpublished.
- Population Council and Crime Reduction in Schools Project. 2005. "Guidance for mapping safer schools and communities." Donor report to UNICEF, South Africa. New York: Population Council.
- Pretty, Jules, Irene Guijt, John Thompson and Ian Scoones. 1995. *Participatory Learning and Action: A Trainer's Guide*. London: International Institute for Environment and Development.
- Robinson, K.Lynne, Susan Telljohann, and James Price. 1999. "Predictors of sixth-graders engaging in sexual intercourse." *Journal of School Health* 69: 369–375.
- Rumakom, P., P. Guest, W. Chinvarasopak, W. Utmarat, and J. Sontanakit. 1999. "Obtaining accurate responses to sensitive questions: A comparison of two data collection techniques." Bangkok: Population Council. Unpublished.

- Schenk, Katie and Jan Williamson. 2005. *Ethical Approaches to Gathering Information from Children and Adolescents in International Settings: Guidelines and Resources*. Washington, DC: Population Council.
- Shah, Meera Kaul, Sarah Degnan Kambou, and Barbara Monahan. 1999. *Embracing Participation in Development: Worldwide Experience from CARE's Reproductive Health Programs with a Step-by-step Field Guide to Participatory Tools and Techniques*. Atlanta: CARE.
- Tourangeau, R. and T.W. Smith. 1996. "Asking sensitive questions: The impact of data collection mode, question format and question content." *Public Opinion Quarterly* 60: 275–304.
- Tourangeau, R., L.J. Rips, and K. Rasinski. 2000. *The Psychology of Survey Response*. Cambridge, England: Cambridge University Press.
- Turner, C.F. et al. 1998. "Adolescent sexual behavior, drug use, and violence: Increased reporting with computer survey technology." *Science* 280: 867–873.
- UNAIDS (Joint United Nations Programme on HIV/AIDS). 2000. *National AIDS Programmes: A Guide to Monitoring and Evaluation*. Geneva: UNAIDS.
- . 2004a. *2004 Report on the Global AIDS Epidemic*. Geneva: UNAIDS.
- . 2004b. *AIDS Epidemic Update: December 2004*. Geneva: UNAIDS.
- UNAIDS, WHO (World Health Organization), and UNFPA (United Nations Population Fund). Forthcoming. *Seen But Not Heard . . . Very Young Adolescents Aged 10–14*. Geneva: UNAIDS.
- Van de Wijgert, J., N. Padian, S. Shiboski, and C. Turner. 2000. "Is audio computer-assisted self-interviewing a feasible method of surveying in Zimbabwe?" *International Journal of Epidemiology* 29: 885–890.
- Van Hattum, M.J.C. and E.D. de Leeuw. 1999. "A disk-by-mail survey of pupils in primary schools: Data quality and logistics." *Journal of Official Statistics* 15: 413–429.
- Wang, Caroline C. and Yanique A. Redwood-Jones. 2001. "Photovoice ethics: Perspectives from Flint Photovoice." *Health Education and Behavior* 28(5): 560–572.
- Winch, Peter J., Jennifer A. Wagman, Rebecca A. Malouin, and Garrett L. Mehl. 2000. *Qualitative Research for Improved Health Programs: A Guide to Manuals for Qualitative and Participatory Research on Child Health, Nutrition, and Reproductive Health*. http://sara.aed.org/publications/cross_cutting/qualitative/qualitative.pdf.
- World Health Organization (WHO), Family Health International, MEASURE DHS, UNAIDS, UNESCO, UNFPA, UNICEF, USAID, and the World Bank. 2004. *National AIDS Programmes: A Guide to Indicators for Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People*. Geneva: WHO.



APPENDICES

Appendix A: Conducting a programme-coverage exercise²²

The four main steps in conducting a programme-coverage exercise are:

1. planning, which includes selecting the organisations that will participate and training the staff who will be responsible for implementing the exercise;
2. fielding the exercise;
3. analysing the data collected; and
4. disseminating the information obtained to programme managers, counterpart organisations, interested donors, and government ministries.

Planning and training staff

Determine which youth-serving organisations will be included in the coverage exercise. Any organisation that targets adolescent boys or girls would benefit from participating in the coverage exercise, including peer-education programmes, and youth-friendly health services. Ideally, participating organisations will have asked to participate and, therefore, will understand the programmatic value of the data being collected.

Copy the data-collection tools (the activity register [at the back of this guide] and the supplementary sheet for collecting information from large groups [featured on right of the inside spread]) so that each workshop participant will be able to review them and mark their edits.

Hold a one-day training for those who provide services to young people directly. For peer-education programmes, these are peer educators or youth-club leaders. In the training, go over

objectives of the activity, review the activity register with providers, and obtain their input so that the form reflects their activities.

Outline of training workshop

- (1) Self-introductions.
- (2) Introduction to the exercise—how it works, why it is important, and how it will help improve services.
- (3) Introduction of the activity register. Review the form column by column, and discuss how to fill it out.
 - Write codes in the spaces provided (using codes at the bottom).
 - Develop codes for topics covered.
 - Discuss data collection for large groups using the supplementary sheet.
 - Discuss problem-shooting such as answering a young person's questions about what is being done with the information gathered, or handling situations in which a topic is reported that is not covered in the list, or responding to someone who does not want to be recorded.
- (4) Discuss data collection.

Who is recorded in the register?

- Those included are anyone who receives information or services from you, personally, either in a group or individually, regardless of age, including young people who are given referrals and those attending drama performances or group discussions. Those who are not recorded include casual or friendly contacts that do not involve programmatic messages, or contacts made to arrange for programmatic activities (for example, head teachers from whom you seek permission to hold a lecture).

²² Source: Meyers, Carey and Annabel Erulkar. 2005. Population Council. Personal communication.

Guidelines for recording in the register:

- Carry the register with you at all times.
 - Record the information received from a client at the time of contact with him or her.
 - Do not assume that you already know the information you are seeking; ask the client all of the questions.
 - Remember that recording names is optional. If a client does not want his/her name written down, that is acceptable, but try to record other details about the client.
 - Record only one response per column, except in columns 14 and 15 where more than one response is possible.
 - If a response is coded “other, specify”, write the response in the register.
 - Write clearly, circling only the response code. If you make a mistake and have to change the response, put an X through the code that is incorrect and circle the correct code.
 - Some participants may decline to be recorded. Explain politely the reason for collecting the information. Remind each client that all information collected is confidential and that giving her/his name is voluntary. If the client continues to refuse to provide the information, record the client’s sex only and leave the rest blank.
- (5) Role-play the form in the large group and in pairs. Return to the large group for discussion of difficulties that arose, changes that should be made to the form, and observations on interviewing techniques.

After the training, revise the form so that it is easy for the peer educators to use, employing idiomatic or other local terms agreed upon during the training. Reproduce the form in bulk and load it into binders with a “Guidelines for data collection” sheet taped into the inside cover of the binder.

Fielding the exercise

Peer educators and service providers receive a binder so that they can begin collecting data. Data is collected for an agreed-upon length of time. Supervisors should ensure that forms are filled out accurately and consistently during the data-collection period. If possible, supervisors should also visit the sites to make certain that data is being collected and to answer any questions that may arise. All activity registers are collected when interviewing has concluded.

Analysis of data

Draft data-entry screen and enter data. Special care should be taken in developing the data-entry screen so that it is clear, easy to use, and captures the relevant information. Supervisors should thoroughly train staff who will enter the data and check periodically that they are being entered correctly. Because of the significant time and technical requirements of the analysis, some organisations may need to request technical assistance from partner organisations.

Analyse data, disaggregating contacts by sex, age, living arrangements, and marital status. Dummy tables are available from the Population Council. Determine whether certain groups are underrepresented and whether the programme’s intended beneficiaries are the actual beneficiaries.

Discuss findings with peer educators and their supervisors and obtain their ideas for additional analysis.

Dissemination

Schedule a dissemination workshop at a venue convenient for all interested parties. Alert the relevant media about the workshop. Develop a summary of key findings, and photocopy it for distribution.

ACTIVITY REGISTER

Name of Service Provider / Peer Educator

Organisation

Record each person contacted on one line. Recording the client's name is optional.

(1) Date	(2) Name (optional)	(3) Age	(4) Sex	(5) In or out of school	(6) Educational attainment	(7) With whom do you live?	(8) Marital status	(9) Have you worked for pay in the last month?	(10) Is this your first contact with the programme?	(11) Recorded in register before? group contact?	(12) Individual or group contact?	(13) Location of contact (Use codes)	(14) Type of services (Use codes; more than one code allowed)	(15) Topics covered (Use codes; more than one code allowed)
			1 = M 2 = F	1 = In 2 = Out		1=Both parents 2=Mother only 3=Father only 4=Other relatives 5=No relatives	1=Never married 2=Married 3=Separated 4=Divorced 5=Widowed	1 = Yes 2 = No	1 = Yes 2 = No	1 = Yes 2 = No	1 = Individual 2 = Group			
			1 = M 2 = F	1 = In 2 = Out		1=Both parents 2=Mother only 3=Father only 4=Other relatives 5=No relatives	1=Never married 2=Married 3=Separated 4=Divorced 5=Widowed	1 = Yes 2 = No	1 = Yes 2 = No	1 = Yes 2 = No	1 = Individual 2 = Group			
			1 = M 2 = F	1 = In 2 = Out		1=Both parents 2=Mother only 3=Father only 4=Other relatives 5=No relatives	1=Never married 2=Married 3=Separated 4=Divorced 5=Widowed	1 = Yes 2 = No	1 = Yes 2 = No	1 = Yes 2 = No	1 = Individual 2 = Group			
			1 = M 2 = F	1 = In 2 = Out		1=Both parents 2=Mother only 3=Father only 4=Other relatives 5=No relatives	1=Never married 2=Married 3=Separated 4=Divorced 5=Widowed	1 = Yes 2 = No	1 = Yes 2 = No	1 = Yes 2 = No	1 = Individual 2 = Group			
			1 = M 2 = F	1 = In 2 = Out		1=Both parents 2=Mother only 3=Father only 4=Other relatives 5=No relatives	1=Never married 2=Married 3=Separated 4=Divorced 5=Widowed	1 = Yes 2 = No	1 = Yes 2 = No	1 = Yes 2 = No	1 = Individual 2 = Group			

LOCATION CODES:

1 = Centre
2 = Clinic
3 = School
4 = Neighborhood
5 = My house
6 = Young person's house
7 = Marketplace
8 = Coffee ceremony
9 = Stadium
10 = Community association
11 = Other
(specify in register)

TYPE OF SERVICE:

1 = Lecture
2 = Small-group discussion
3 = One-on-one discussion
4 = Question and answer
5 = Drama
6 = Video show
7 = Sports
8 = Condoms provided
9 = Pill distribution
10 = Counselling
11 = Referrals
12 = Medical treatment
13 = Other
(specify in register)

TOPIC CODES:

1 = HIV/AIDS
2 = Family Planning
3 = Sexually transmitted infections
4 = Pregnancy
5 = Abortion
6 = Female genital cutting
7 = Condoms
8 = Hygiene/sanitisation
9 = Life skills
10 = Family/social problems
11 = Drug abuse
12 = Delinquency
13 = Gender issues
14 = Population issues
15 = Other
(specify in register)

Appendix B: Focus-group resources²³

- (1) *A Manual for the Use of Focus Groups* by Susan Dawson, Lenore Manderson, and Veronica L. Tallo. 1993, 96 pages.

Who would benefit from using this manual?

Use of this manual would benefit researchers, members of disease-control programmes, and members of departments of health who are working on qualitative research projects. Although the guidelines in this manual are applicable to focus groups in a variety of settings, the examples and techniques are based on the authors' experience in conducting focus-group discussions about malaria in Africa and acute respiratory infections in the Philippines. Although these research areas are mentioned, the manual does not provide complete question guides for any particular disease. Therefore, researchers should know which issues are most important to their study and develop a list of topics. This manual can be used by people already familiar with focus-group research and by those without such prior experience.

Organisation of the manual

The manual provides a brief, thorough discussion of focus groups—what they are, when to use them, and who is involved. It offers simple, step-by-step instructions on how to conduct focus-group discussions. It is divided into two parts: Part I—Team Leader Focus-group Training begins with a definition of focus groups and a discussion of what types of research projects they can benefit. The structure and conduct of focus-group discussions

are described, including guidelines for selecting and training staff and study participants and developing the question line. A section on the management of information collected during focus groups and analysis of the results concludes Part I. Part II—Staff Training for Focus-group Discussions includes a series of training sessions for staff members involved in the research. It identifies the main points to be covered in training field staff, including (but not limited to) the skills required, language differences, stimulation of discussion, and dealing with unforeseen problems.

Ordering information

A full-text version of the manual is available in English and French at:

<http://www.unu.edu/unupress/food/foodnutrition.html>.

- (2) *Qualitative Research for Improved Health Program Design* by Judi Aubel. 1993, 58 pages, available in English, French, and Spanish.

Who would benefit from using this manual?

This manual was written explicitly for health and development workers in developing countries who are involved in implementing health and nutrition programmes and for researchers who are providing support to such programmes. The guidelines are designed to be used in situations in which a health or nutrition programme already exists or in which plans to implement such a programme have been formulated.

The manual describes how programme stakeholders can be involved in all steps of planning, implementing, and completing a qualitative study using group interviews. This

²³ This appendix is drawn from Winch et al. (2000).

approach, based on principles of adult and organisational learning, is intended to increase the relevance of research to programme implementers and their sense of ownership of research results.

Organisation of the manual

The opening chapter describes a group interview and discusses the situations in which this sort of research can be used; it presents a brief discussion of the differences between qualitative and quantitative research methods, criteria to consider when deciding which approach is appropriate, and the advantages of involving programme staff in group-interview research.

The major part of the manual presents 17 steps of focus-group methodology and explains the purpose and the approach to be followed for each step. The 17 steps are:

- (1) Define the topic.
- (2) Review existing literature.
- (3) Constitute the study team.
- (4) Identify the information needs of programme managers.
- (5) Develop a topic map.
- (6) Conduct social influence analysis.
- (7) Choose respondents to be interviewed.
- (8) Define specific data-collection objectives.
- (9) Develop group-interview guides.
- (10) Select and train facilitators.
- (11) Conduct group interviews.
- (12) Analyse the data.
- (13) Summarise findings.
- (14) Hold working session with stakeholders to formulate recommendations.
- (15) Plan dissemination of results.
- (16) Finalise reports.

- (17) Evaluate implementation. (For this last step, the research team members provide feedback on analysis and on the research methodology and implementation processes. They are asked to formulate lessons learnt regarding the implementation process that may be useful to those conducting similar studies in the future.)

The manual also provides an activity calendar and a list of materials and resources required to carry out such a study. Although working with experienced qualitative researchers is an undeniable benefit to the conduct of focus-group studies, this manual's approach is useful for those who have no previous experience with focus-group or other qualitative research.

Ordering Information

The manual is available free of charge from:
Christine Sutton
Development Policy Department
International Labour Office (ILO)
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(3) *Getting It In Focus: A Learner's Kit for Focus-group Research*

Getting It in Focus: A Learner's Kit for Focus Group Research is a comprehensive collection of manuals, worksheets, examples, and visual aids. Extensive instructions are offered for training people to perform all of the roles necessary for focus-group research. Guidelines for conducting a four-day workshop are included. Although the kit may be useful to those who are interested in learning more

about focus groups, it is an excellent tool for those who seek guidance on how to employ them in existing or new research projects.

The kit is a three-component package designed to help researchers use focus groups effectively. It includes:

- *The Handbook for Excellence in Focus Group Research* (1988) by Mary Debus;
- *A Skill-building Guide for Making Focus Groups Work* (1995) by Anne Roberts, Mary Debus, Elizabeth Younger, Valerie Uccellani, and Sylvia Lopez Gaona; and
- *A Training Video for Moderating Focus Groups* (1995) by Lynda Bardfield van Over.

The Handbook was written for the Academy for Educational Development in 1988. The guide and the video were developed as training materials to complement and build on the ideas that were introduced in the *Handbook*. The two manuals with the video provide an overview of qualitative research, descriptions of the in-depth interview method and the focus-group method, and guidelines for selecting and integrating each technique into the researcher's own study. The main purpose of *Getting It in Focus: A Learner's Kit for Focus Group Research* is to provide step-by-

step guidelines for conducting your own focus-group study. Included are instructions on how to design a workshop for training others to prepare for their own focus-group research. The video was designed to be used as part of this training workshop, but can be used on its own.

Ordering information

The kit is available from either:
 BASICS Information Center
 1600 Wilson Boulevard, Suite 300
 Arlington, VA 22209
 Telephone: 1(703)312-6800
 Fax: 1(703)312-6900
 E-mail: wwwinfo@basics.org
 Website: <http://www.basics.org>.

OR

Support for Analysis and Research in Africa (SARA)
 (Price \$10 including shipping and handling)
 Academy for Educational Development
 1825 Connecticut Avenue NW
 Washington, DC 20009
 Telephone: 1(202)884-8700
 Fax: 1(202)884-8701
 E-mail: saramail@aed.org
 Website: <http://www.info.usaid.gov/regions/afr/hhraa/child.htm#subtopics>.

Appendix C: A facilitator guide to mapping safer schools and communities²⁴

This exercise was conducted with very young and middle adolescents in KwaZulu-Natal, South Africa, as part of an action-oriented research initiative designed to improve the safety of young people attending school. Mapping groups were convened in two types of communities, a rural village and a poor urban neighborhood. In each location, the exercise included focus-group discussions with fifth-grade girls, fifth-grade boys, eighth- and ninth-grade girls, and eighth- and ninth-grade boys. Differences were found by sex and by age with regard to what were considered safe and unsafe spaces. Boys were more likely than girls to consider clinics and the school and its surroundings as safe spaces. Although both sexes reported bridges as unsafe locations where gangs exacted fees for crossing, the fees took the form of money or goods for boys, but for girls included sexual favours. Another important finding was the different way boys and girls depicted the same community. Maps drawn by girls presented spatially limited areas such as subneighborhoods in which social institutions featured prominently, whereas boys presented larger geographic areas with roads and highways dominating the space. The information about safe and unsafe spaces from the mapping exercises has been shared with local school principals, economic development committees, and police in an effort to reduce danger in these areas and to learn more about what spaces girls and boys consider safe. Below is the facilitator guide that was used for the KwaZulu-Natal study.

Workshop agenda

Welcoming remarks

Framing and objectives

Describe the objectives of the study to the group in a clear, friendly manner. Objectives of the mapping effort are: to identify safe and unsafe spaces in the community; to understand what makes these spaces safe or unsafe; to explore how people cope with the dangerous situations in these spaces; and to learn how people in the community identify their own solutions.

The data gathered during the study will be shared with key stakeholders (for example, the Department of Education, Metropolitan Police, and the Community Presidential Project Office) with the intention that they will use their resources and work with communities to improve safety. Inform the participants that the confidentiality of their identities will be ensured.

Background for “Mapping for Safe Schools and Communities” exercise

The Department of Education, the South African Council of Educators, and UNICEF are working in partnership with the Crime Reduction in Schools Project (CRISP) and the Population Council to respond to the issues of violence and lack of safe places in schools and communities in KwaZulu-Natal. CRISP is a South African research, facilitation, and training organisation focusing on young people. The Population Council is an international research and capacity-building organisation focusing on improving health and

²⁴ This appendix is drawn from the Population Council and Crime Reduction in Schools Project (2005).

development. Facilitators for the exercise include community members who have undergone training to conduct community mapping. The mapping process will enable the community to better understand issues related to young peoples' safety and provide an opportunity for the facilitators and field researchers to gain a deeper understanding of these issues in the community. The information gleaned will contribute an essential basis for future planning with the community.

Personal introductions

Consent forms

For an adult group, distribute and review consent forms. Collect signed versions. Leave a copy with participants. For a group of young people, collect consent forms presigned by their parents (if they have not already been collected).

Mapping instructions

In a space appropriate for the exercise, ask the group to prepare a visual representation of their community that will help us understand it. Encourage participants by reminding them that they are the experts. Make supplies freely available for the group to use to make the map. Ask the group to think of a prominent landmark in their community that they would like to use to “anchor” the map; other facilities and resources within the community will be drawn in relation to this landmark. (For young people attending the same school, the appropriate landmark might be their school. In a group where they attend different schools or for out-of-school adolescents, some

other landmark in the community might be more appropriate.) Ask participants to draw the other features of their community in relation to that central landmark so that outsiders can understand how their environment looks to them. Leave the group to prepare the map by themselves, and observe the process. The facilitator, content note-taker, and process observer should note carefully what is drawn and in what order. The whole exercise can be videotaped if a video camera is available and using it is acceptable. Labels or symbols may be used to identify community facilities, features, or infrastructure. Allow the participants to select the symbols. Be sure to note what each symbol means.

Questions for participants when the map is completed

For each place on the map, ask the participants if they feel safe going there and safe being there. Ask them to label the unsafe spaces with red stars and the safe spaces with blue stars, varying the number of stars to indicate the degree to which they consider the space safe or dangerous. Ask the what makes going to or being in these places feel safe or dangerous. If there is no school on the map, ask the participants if one exists in the community. If a school exists in the community, ask why it was not put on the map. Ask whether they feel safe or unsafe at the school and why. If there is no clinic or health facility on the map, ask the participants if one exists. If there is a clinic or health facility, ask why it was not drawn on the map and whether participants feel safe there or not and why.

Appendix D: Conducting in-depth semistructured interviews with key informants²⁵

Purpose

To eliminate gaps in our knowledge about high-priority problems.

Preparations

Develop an ethnographic field guide

The team decides which gaps in information about high-priority problems are the most relevant and which demographic groups the data should be collected from. The team then develops an ethnographic field guide that will be used as an aid for conducting the interview. The guide provides ideas about opening questions and topics that the interviewer plans to address. Common topics include the causes and effects of problems faced by very young adolescents, particularly vulnerable groups, coping strategies, and suggested solutions.

Materials needed

- Paper and pens for taking notes;
- Tape-recorder, if available and acceptable to informants; and
- Ethnographic field guide.

Selecting informants

Key-informant interviews are sometimes conducted after other qualitative data-collection activities have concluded, giving the team more time to identify the groups most affected by a problem and identify, from within these groups, those who can

speak with authority about how the problem is experienced. A key informant should be knowledgeable about or be a stakeholder in the problems to be discussed. Potential stakeholders include people who are most seriously affected by the problem or at greatest risk of having the problem; those considered by affected individuals to be responsible for addressing the problem (perhaps according to tradition); and those who are already working on the problem in some capacity.

Steps in data collection

The interview begins with greetings, casual introductions, an explanation of the project and proper consent procedures. (Demographic data about the informant are best collected at the end of the interview.)

Bernard (1995) describes important steps for initial interviews: Ensure the anonymity of all informants. Explain that you want to hear what they think and what their observations are, not what other people believe. Explain to the informants why they were chosen and emphasise that you need to learn their opinions because you are an outsider and, therefore, are ignorant about their situations.

The interview should begin with a general question to encourage them to talk about the topic of interest. One way to open the conversation is to say: *“I would like to learn from you about the situations that young people your age in this community face. Please tell me about your typical day”*.

The interview

Allow the informant to lead the discussion as

²⁵ Adapted from the Linking Complex Emergency Response and Transition Initiative. 2000. An interviewer guide to accompany this manual is also available: Linking Complex Emergency Response and Transition Initiative. 2000. *Interviewers Guide Rapid Assessment Procedures (RAP): Addressing the Perceived Needs of Refugees & Internally Displaced Persons Through Participatory Learning and Action*. Crisis in Transitions Toolkit. Center for Refugee and Disaster Studies, The Johns Hopkins University School of Public Health. <http://www.cert.org/publications/manuals/rap-interview-17.pdf>

much as possible. Bear in mind that you are trying to obtain her or his story. Allow the informant ample time to consider your questions and respond completely. Encourage the informant to interrupt you during the interview if he or she has something important to say. Ask appropriate probing questions about specific issues that come up, such as those suggested in the sample ethnographic guide. Such questions help the informant continue a train of thought. Focus follow-up questions on the topics that help describe in depth high-priority problems in the informant's situation. Such questions should elicit a description of the problem; the time the problems occur (during the day, on special days, during particular seasons); who the most vulnerable groups are who experience the problem; where the problems occur most frequently; what coping strategies are currently being used, especially by vulnerable groups; the perceived causes and effects of the problem; and suggested solutions to the problems.

The interviewer should be careful not to switch topic areas too quickly. Because the range of issues to be covered is wide, a single interview will not suffice for collecting desired data. Arrange to return to conduct a follow-up interview with the same informant in order to clarify issues that emerged in the first interview and to pursue other

subjects of interest. During the second interview, the respondent is usually more at ease because he or she knows the interviewer and understands the purpose and type of the questions.

Avoid probing about sensitive issues, since recalling violent or traumatic events can cause distress among informants. (If the interviewer is a psychosocial professional who can arrange for professional assistance, or if all informants are linked with a functioning counselling service that is qualified to assist those who have witnessed or experienced violence or trauma, sensitive issues or events can be addressed during the interview.) Interviewers should take into consideration very young adolescents' comprehension of questions and their attention span.

Understanding and using this information

Key-informant interviews provide a greater understanding about the dimensions of high-priority problems. The information gleaned in this manner may help community members devise an appropriate strategy to address such problems. For example, a strategy is more likely to address the root causes of a problem rather than its superficial symptoms if knowledgeable informants are able to voice their perceptions of the problems' causes. A strategy is likely to have the greatest possible benefit when it targets those most affected by the problem.

Appendix E: Photo-voice techniques²⁶

Photo-voice techniques use cameras as a “voice” to explore particular issues, topics that may be more effectively explored both visually and verbally than with words alone.

What kind of cameras should be used?

Many researchers who use photo-voice techniques work with point-and-shoot disposable cameras. These are simple to use, and the quality of the photos is adequate for the work. Digital cameras allow participants to view their pictures as they take them and dispose of development costs, but use of a computer and printer is required in order to make copies of the images.

Tips for using photo-voice

Keep the prompt simple and focused (for example, instruct participants to take pictures of “feeling strong” and “feeling not so strong”, of “feeling safe” and “feeling unsafe”, and of “challenges and solutions in addressing HIV/AIDS”). Work in a group setting, so that group members share a camera and interpret the pictures together. Conduct a “seeing and looking” activity at the beginning of the project; study some examples of pictures that include objects (not only people), and different angles (e.g. standing up on a chair



South Africa - Photo: Kathleen Pithouse

looking down, lying down looking up). As the group takes pictures, encourage participants to take notes about each picture: Who took it? Why? Make duplicates of the pictures, keeping one set as a backup. Store the negatives in a safe place. Number all the pictures in a set and note which individual or group took them.

Working with the photos

Participants should be actively involved in selecting, commenting on, and deciding how their views can best be represented visually.

A Walkabout. A good ice-breaker is to simply enlarge a few pictures and put them up on a wall; give participants time to walk around and look at them. Place a paper and marker close by so that participants can also write comments about the pictures.

Close Viewing 1—Selecting. Build time into the session for groups or individuals to look at their whole collection. Ask them to pick three or four pictures that they particularly like and ask them to explain why they like the ones they chose.

Close Viewing 2—Categorising. If photographers have been working in groups in their initial picture-taking phase, ask them to create photo narratives using posterboard. These narratives can relate “stories that your pictures tell”, and photographers can be encouraged to “pick several pictures that you think best explain the challenges in addressing HIV/AIDS”. If you supply markers, ask participants if they want to add titles and captions.

Display. Displaying the photographs in a public exhibition can be particularly important for coming to a deeper understanding of what the photos mean to the photographers. Moreover, once the photos are exhibited, they invite wider community participation.

²⁶ This appendix draws from Mitchell and Walsh. Accessed online at www.ivmproject.ca/tools/photovoice.pdf 3/15/05.

Appendix F: Structured survey interviews

Rather than glossing over the numerous and complex steps involved in carrying out a structured survey (which include sampling schemes, questionnaire development and pretesting, recruitment and training of interviewers, entering and cleaning the data, and so forth), we concentrate here on the important domains to include in the structured survey questionnaire. Readers looking for information about how to conduct structured surveys are referred to the following resources:

Bulmer, Martin and Donald Warwick. 1983. *Social Research in Developing Countries: Surveys and Censuses in the Third World*. New York: John Wiley.

Grosh, Margaret and Paul Glewwe (eds.). 2000. *Designing Household Survey Questionnaires for Developing Countries: Lessons from Ten Years of LSMS Experience*. Geneva: World Bank.

A good general reference is *Evaluating the Impact of Development Projects on Poverty: A Handbook for Practitioners*. It can be accessed at <http://siteresources.worldbank.org/INTISPM/Resources/handbook.pdf>.

The International Labour Organization has published resource materials for practitioners with a child-labour focus. They can be accessed at http://www.ilo.org/public/english/standards/ipecc/themes/timebound/downloads/pp3_3en.pdf and at http://www.ilo.org/public/english/standards/ipecc/themes/timebound/downloads/pp3_4en.pdf.

A guide on sampling can be accessed at <http://www.fantaproject.org/downloads/pdfs/sampling.pdf>.

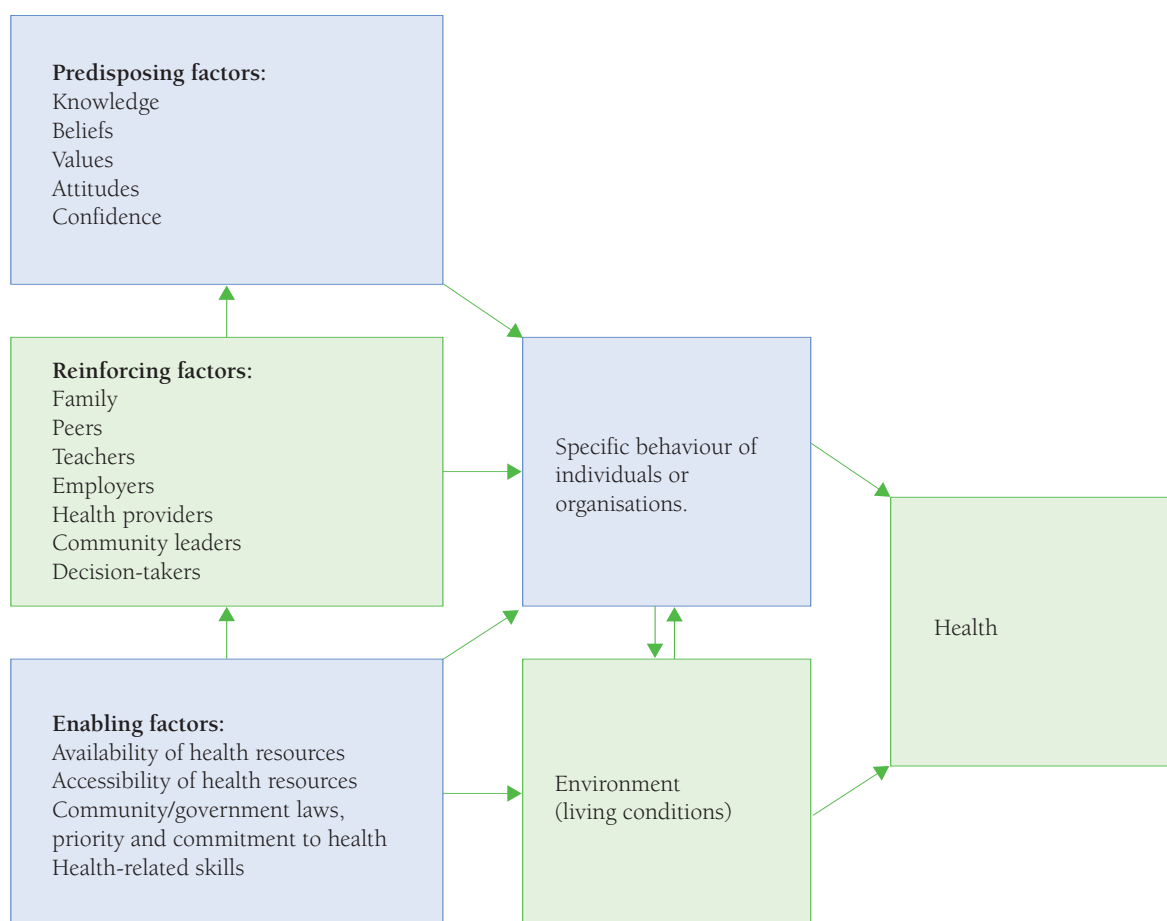
Useful frameworks

Health is a function of individuals and the environments in which they are embedded, including the family, social networks, organisations, communities, and societies as a whole. Conceptual frameworks which illustrate these relationships can be helpful in thinking through what are the critical questions to incorporate in a survey, which will naturally vary depending upon the specific sub-population and health problem a researcher seeks to address. Three frameworks are included here to illustrate some of the different ways the pathways to health have been elaborated; no single framework is the “right” one to use, and readers are encouraged to adapt these or other frameworks to fit the characteristics of their inquiries.

In the PAHO volume *Youth: Choices and Change*, Green and Kreuter's PRECEDE-PROCEED model for health-promotion planning and evaluation is presented (see Figure 1). Green and Kreuter (1999) emphasise the identification of pertinent health determinants in designing health-promotion interventions; these health determinants are forces or factors that predispose, enable, and reinforce individual lifestyles or shape environmental living conditions in ways that affect the health of populations.

The PRECEDE-PROCEED model is helpful for identifying determinants of health at different levels of influence, but has no particular focus on young people and how these factors might differentially impact them. Adamchak et al. (2000) constructed a framework of factors that influence the reproductive health of young people, after synthesising research findings from more than 350 studies, about 250 of which were conducted in the United States and about 100 of which were undertaken in Asia, Africa, Latin America and the Caribbean (see Figure 2).

Figure 1 The predisposing, enabling, and reinforcing factors of the PRECEDE-PROCEED model (Phase 4: Educational and ecological assessment)

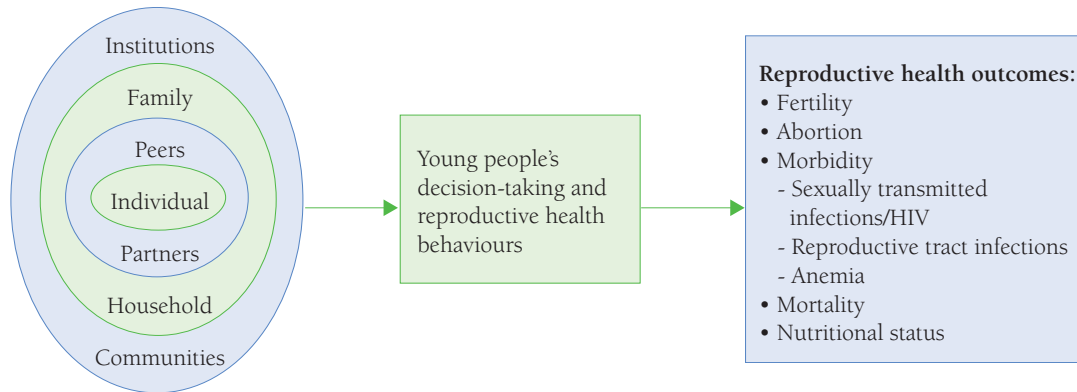


Source: Adapted from Green and Kreuler (1999), as in PAHO (2005).

The authors chose to group the social factors that influence young people's reproductive health into five realms of influence:

- Individual characteristics, including knowledge, attitudes, beliefs, values, motivations, and experiences
- Sexual partners and peers
- Families and adults in the community
- Institutions that support young people and provide opportunities, such as schools, workplaces, and religious organisations
- Communities, through which social expectations about gender norms, sexual behaviour, marriage, and childbearing, are transmitted.

Figure 2 Factors that influence young people's reproductive health



Individual

- Age and gender
- Place of residence
- Knowledge, attitudes, and beliefs
- Religiosity
- Self-efficacy
- Skills:
 - Motivation to do well in school
 - Being actively engaged in learning
- Alcohol and drug use
- Other related risky behaviour
 - Depression, stress
 - Running away from home
- Sexual and physical abuse

Peers and partners

- Perception of peer behaviours
 - Perception that peers are sexually active
 - Perception that peers are using alcohol or drugs
- Relationship with partner(s)
 - Age and income differentials
- Exchange of money or goods for sex
- Sense of commitment to partner

Family and household

- Low educational and economic levels
- Harmful family attitudes
 - Devaluing education
 - Supporting early marriage and childbearing
 - Discouraging young people's access to information and services
- Harmonious relationship with family
 - High-quality interaction with family
 - Family's values are communicated to young people
 - Supervision by adult family members

Institutions

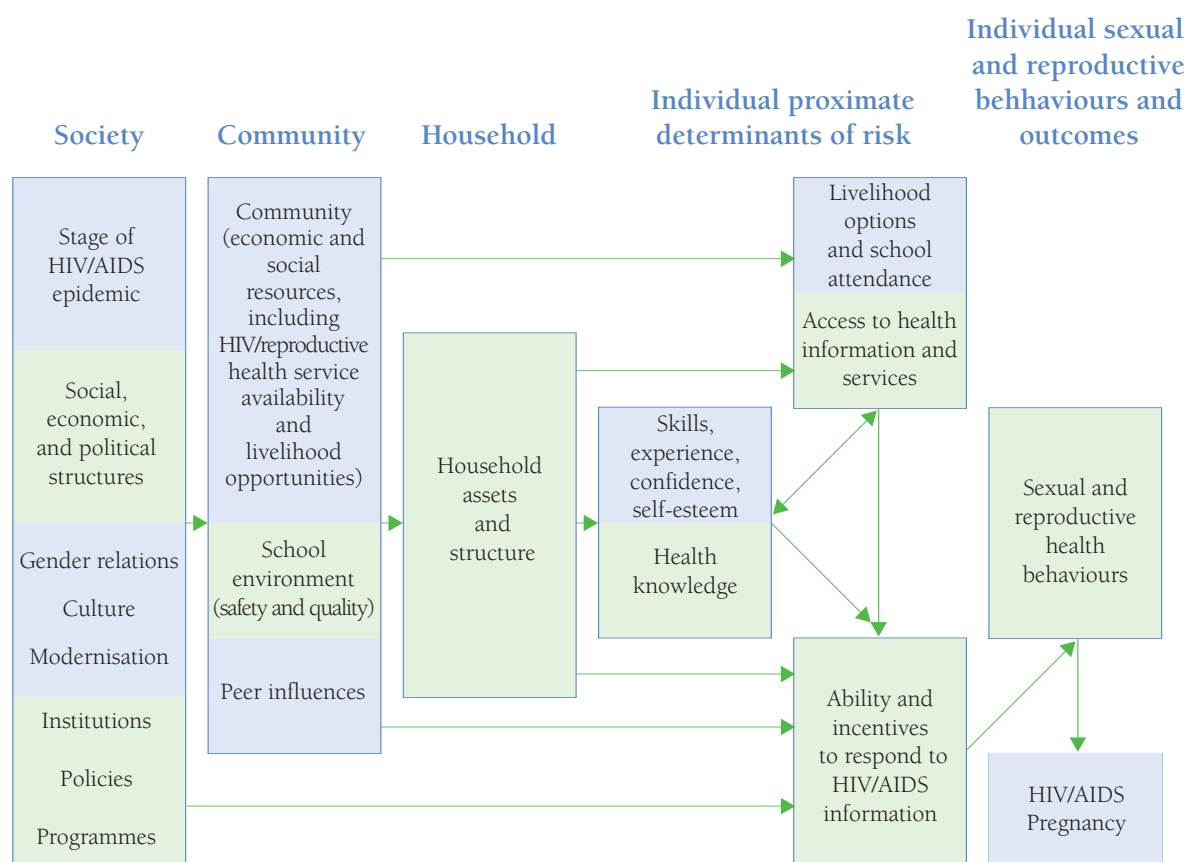
- Connectedness with religious organisations
- Connectedness with schools
 - Availability of education
 - Safe school environment
 - Academic performance and aspirations
- Availability of youth programmes
 - Leisure activities
 - Counselling
 - Services for dealing with sexual abuse
- Relationship with other adults through community institutions

Communities

- Disorganisation (high unemployment levels, poverty, low educational levels, political instability, war, crime, high rates of migration)
- Social norms
- Lack of opportunities
- Policy (legality of contraceptives, age of legal marriage, health and educational services for the young)
- Policy (illegality of abortion, weak enforcement of rape laws)
- Mass media (provide role models and examples of responsible behaviour)
- Mass media (present pornography, sexually permissive and violent images)

Source: Adapted from Adamchak et al. (2000). FOCUS on Young Adults. A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs

Figure 3 Conceptual framework of influences on young people's risk of acquiring HIV



Source: Hallman (2005)

In developing her conceptual framework, Hallman (2005) broadened her scope to conduct a review of literature from a variety of disciplines that examine HIV risk among young women and men, including sociology, demography, economics, political economy, epidemiology, psychology, and anthropology (see Figure 3). The framework presents a model of the multiple influences of society, community, and household on proximate determinants of risk and sexual and reproductive behaviours and outcomes. Unlike models that view sexual behaviour as determined largely by individuals' beliefs and knowledge concerning

health, this framework acknowledges that knowledge interacts with skills, experience, confidence, self-esteem, livelihood options, and school attendance to affect sexual and reproductive health behaviours.

Questionnaire development

If one survey instrument were to capture all the relationships described in these conceptual frameworks it would be prohibitively long; rather, these models can help clarify which relationships are the most important for a study and can guide

questionnaire development. Main concepts can be operationalised into questions; some examples of question topics are given below.

Sexual behaviour

Age at first sex
Condom use
Experience of coerced/forced sex

Health knowledge

Sources of knowledge
Access to media
Trusted persons with whom questions
and problems can be discussed
Knowledge of HIV/STI prevention strategies
Access to health services

School attendance

Current enrolment status
Highest level of schooling completed
Appropriate grade for age

Household structure

Parental residence
Orphanhood status
HIV-affected members in household

Social isolation

Proximity to family, friends
Frequency of seeing family and friends
Mobility
Participation in community life, organisations

Economic vulnerability of family and individual

Work experience
Control of earnings
Savings

Resources for indicators

Adamchak, Susan, Katherine Bond, Laurel MacLaren, Robert Magnani, Kristin Nelson, and Judith Seltzer. 2000. *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs, Tool Series 5*. Washington, DC: FOCUS on Young Adults.

AIDSQuest. The HIV/AIDS Survey Library. Accessible at <http://www.popcouncil.org/horizons/AIDSquest/index.html>.

UNAIDS. 1999. *Sex and Youth: Contextual Factors Affecting Risk for HIV/AIDS*. UNAIDS Best Practice Collection. Accessible at http://www.unaids.org/html/pub/publications/irc-pub01/jc096-sex_youth_en_pdf.pdf.

World Health Organization (WHO), Family Health International, MEASURE DHS, UNAIDS, UNESCO, UNFPA, UNICEF, USAID, and the World Bank. 2004. *National AIDS Programmes: A Guide to Indicators for Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People*. Geneva: WHO.

Appendix G: ACASI

ACASI is a methodology the application of which in developing countries is still being assessed. No readily available “tool” for its application exists; however, a detailed description of its implementation is included here. The following information is excerpted from Mensch et al. (2003), which reports on an ACASI study in Kenya involving boys and girls aged 15–21.

The Kenya questionnaire was relatively short (65 questions in the Nyeri survey and 69 questions in the Kisumu survey); with approximately one-third of them sensitive questions about sexual behaviour, alcohol and drug use, contraceptive use, pregnancy, and childbirth. The respondent listened with headphones to the questions and to a selection of response options. The headphones and a mini-keypad were connected to a laptop computer that remained unopened in its carrying case during the interview. The respondent could choose the interview language: English, Kiswahili,

Kikuyu (in Nyeri), or Luo (in Kisumu). The sex of the voice on the recording matched the respondents’ sex, so that girls listened to a female voice and boys to a male voice. Respondents entered their answers using the mini-keypad. For dichotomous questions, “1” denoted “yes” and “2” denoted “no”; nondichotomous questions were given numbers that corresponded to response categories. Respondents who had difficulty remembering the categories could replay the question as many times as necessary. In Nyeri, after each answer was entered, the computer repeated the response and the respondent was given the opportunity to change it. A face-to-face exit interview was conducted immediately after the ACASI interview that queried respondents regarding their feelings about the survey and the interview. The interviewer noted whether anyone else was present during the ACASI survey and whether the respondent had trouble completing it.

