

CICRED'S SEMINAR

**Dynamic contextual analysis; an approach
to mapping and improving understanding
issues relating to young people's sexual and
reproductive health**

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**Dynamic Contextual Analysis; an approach to mapping and
improving understanding issues relating to young people's sexual and
reproductive health**

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Acknowledgements

First, I would like to thank CICRED for inviting me to participate in this meeting. Although the main focus of the meeting is on reproductive health amongst the poorer sectors of populations, the inclusion of a number of papers that are concerned with young people is to be welcomed. Not only are young people in many countries disadvantaged due to poverty, they are further disadvantaged due to their age.

Second, I would like to acknowledge that the work I shall be describing is a joint effort involving a number of people in different countries; in particular, in terms of the analysis in this paper, I would like to mention Nicole Stone (who works with me in Southampton) and Peter Aggleton of the Thomas Coram Research Unit at the Institute of Education in London.

The work I shall describe is part of the activities of the Safe Passages to Adulthood programme; this is a UK Government DFID funded New Knowledge programme established three years ago to explore aspects of young people's sexual and reproductive health in poorer countries. The programme is a collaboration between the Centre for Sexual Health Research at the University of Southampton, the Thomas Coram Research Unit, and the Centre for Population Studies at the London School of Hygiene and Medicine.

Background

Sexual health research amongst any populations is, without doubt, in its infancy. Until relatively recently, the majority of research in the wider area focussed on *reproductive* health and was primarily concerned with exploring factors associated with population growth and control (as well as maternal and infant health). The World Fertility Surveys, and their successors the Demographic Health Surveys, concentrated mainly on married women, contraceptive knowledge and usage, and the impact of various demographic and other factors on family size and composition. Extensive data were collected which assisted programme planners in improving accessibility to services, knowledge and efficient usage of alternative methods, and so on, focussing in countries with poorly developed health and educational infrastructures and with limited resources to improve conditions.

Many important issues were relatively ignored, from both research and policy perspectives. Most, if not all, societies have had in place formal and informal regulations which control (or at least *attempt* to control) sexual expression amongst young people based on religious and/or cultural imperatives. Such regulations affect not only *when* but also *with whom* sexual relations are permitted. The regulation of sexual conduct was primarily seen as the responsibility of family and other close relations, with support from legal, community and religious institutions. Under these circumstances, little need was seen to explore this area closely (quite apart from the ethical and methodological challenges that would have been raised).

However, a number of factors led to an increase in the academic and policy interest directed towards young people. Perhaps the most important of these was the realisation of the enormous impact that HIV and AIDS was having in many poorer countries; the ages at which infections were appearing made it clear that there was a level of sexual activity occurring amongst young people that had previously been denied, or simply ignored. Attention became focussed on ways of encouraging the adoption of safer sexual activities, be these less (or no) sex or greater use of barrier

methods of protection. Information and education programmes directed towards young people were seen as the major way forward. In order to approach this effectively, it was realised that research was urgently required on this hitherto neglected area.

Much of the early work relied on questionnaire data and operated within a positivist framework; in other words, different variables are 'measured' (such as knowledge, attitudes towards risk, specific sexual attitudes, peer group views, and similar issues) and these are then modelled (with varying levels of statistical sophistication) in attempts to explain self-reported risk behaviours.

It cannot be denied that these surveys have produced a great deal of important and relevant descriptive data; amongst other benefits they have made it quite clear that many young people do indeed engage in sexual activity! They have also led to a deeper understanding of areas that demand greater attention in educational initiatives, such as correct transmission routes for HIV, conception and contraception, and other related issues. Indeed, many of the results of such studies have demonstrated just how inadequate education on sexual issues is in most parts of the world.

Further, within the context of increasing ages at first marriage in most countries, data pointing to a lowering of age at first sexual conduct led to a realisation that the 'window of risk' was increasing in many areas. The picture that emerged in many countries from these early research efforts differed considerably from the 'ideal' model of sexual abstinence until marriage and faithfulness within it.

However, whilst a great deal of value can be gained from these questionnaire survey-based approaches, there are also many limitations. These include

- the relative ignoring of the actual social contexts in which early sexual conduct occurs;
- the dynamics of situations are overlooked;
- the focus on individual perceptions and cognitions diverts attention away from wider structural aspects;
- work within a traditional family planning and/or demographic framework tends to overlook the range of other factors that influence young people's sexual conduct;
- areas of interest are primarily defined by the researchers, often derived from US dominated models of health behaviour;
- by striving to obtain representative samples of young people and presenting aggregated data, the diversity of experience and contexts is often overlooked;
- in most cases, the sampling approaches used cannot deal adequately with obtaining data from those young people who are not in full-time education or who are in other ways marginalised.

Although the emphasis on physical aspects of sexual health (and the associated risk behaviour) were the major driving forces in encouraging and enabling greater research efforts, other crucially important issues became apparent as the range and scope of research approaches developed; these might be grouped under the heading of 'psychological' aspects of sexual health. Whilst quantitative survey research (concentrating on knowledge, attitudes, beliefs and practices) provides broad

descriptive patterns, the more penetrative qualitative approaches to research reveal many issues that helped to explain the patterns obtained.

Primary amongst these was the crucial importance in many countries of gender relations. Many studies demonstrated ways in which men exercise power over women in many domains, including sexual relationships; this takes various forms, ranging from, at one extreme, physical violence and coercion to, at the other, subtle and not so subtle means of persuasion and pressure operating within a discourse that assumes male superiority. More recent work has moved beyond simple analyses of 'nasty' males and 'powerless' females to develop deeper understandings of the many pressures on young men to appear 'macho'; such pressures may arise from media images, peers, parents, and other sources.

Closely related to this emphasis on matters of gender identities and the impact on sexual conduct is the issue of alternative forms of sexual expression. In a climate in which male and female roles are clearly prescribed within peer groups as well as by legal, cultural and religious institutions, research on same-sex conduct is relatively sparse. Indeed, many poorer countries – especially in Africa - fail to include any questions on same sex behaviour in surveys.

A further consistent finding to appear from the expanded research agenda has been the very wide variations in the experiences and contexts in which young people live their lives. Such data provide a corrective reminder – not always appreciated – that there is no unitary condition of 'adolescence' that can be applied in all contexts. In some societies within countries, very early marriage and childbearing is the norm, in others, early sexual activity is associated with income generation in order to cope with extreme poverty, others follow more typical western patterns of serial monogamy, and so on. The reasons why, and the factors that affect the conditions under which, young people engage in sexual activity are many and varied, and there is no simple approach to the improvement of sexual health in its broadest sense.

Whilst wide variation in young people's sexual conduct has always existed, cultural and economic changes occurring within many societies have introduced further factors which need to be considered. For example, in many societies, moves towards urban living from rural areas has created separation of young people from their traditional sources of support and guidance, the increasing globalisation of mass media has exposed young people to new images and lifestyles, increased demands for education and/or material possessions have led to closer links between sexual conduct and economic exchange, and so on.

Intervention efforts

Many international aid agencies have introduced programmes directed towards the improvement of young people's sexual health. The majority of this effort involves the introduction of different types of intervention aimed at improving knowledge of, and accessibility to, contraception, whilst rather less work has been directed towards the more social and psychological aspects such as self-esteem, gender equality, economic independence, and so on. Various reviews have brought together evaluation data,

such as it is, from such interventions in an effort to find the magic formula for success - ‘*what works?*’ has become an urgent guiding principle.

Clear cut and unambiguous formulations are hard to find. Many studies suffer from a lack of clear evaluation guidelines, specific forms of intervention are frequently difficult to isolate from others, and so on. However, some reviews have been carried out and have identified some key principles to guide future programmes. Some of the key principles can be summarised as follows:

- there needs to be greater acceptance that young people are sexually active and that to continue to treat them as ‘innocent children’ does not serve society’s interests;
- sex education should be introduced at earlier ages, be more focussed on relationship issues rather than just biological issues, and acknowledge that people engage in sexual activity for many reasons other than reproduction;
- the association between STI history and HIV susceptibility points to the need for early help seeking and treatment to be more widely accepted;
- there needs to be an increase in services which are young person friendly, accessible, non-judgemental and responsive to young people’s expressed needs;
- gender issues and alternative forms of sexual expression need to be acknowledged in education and service settings;
- interventions which are responsive to cultural and community dynamics are more likely to be effective;
- regular and close consultation with young people as well as with key community gatekeepers (for example, parents, teachers, religious leaders, etc.) is likely to lead to more successful and sustainable interventions;
- there needs to be greater acceptance and awareness of the diversity of young people’s lifestyles and needs;
- more intensive research is needed on the relationships between structural and dynamic factors that affect risky conduct, service provision, and other issues.

International policy developments

The increasing concerns regarding young people’s physical and psychological sexual health have been recognised in a number of international policy agreements. The 1994 UN International Conference on Population and Development (the Cairo conference), the UN World Conference on Women (held in Beijing in 1995) and the 1999 New York meeting (ICPD + 5) all drew attention to the need to devote considerably greater attention to young people and their needs. Similarly the United Nations Convention on the Rights of the Child, signed by all countries in the world bar two, clearly offers young people the right to full information and support in the context of health-related decisions.

At the same time as these international policy developments have been occurring, it is clear that, in many settings, there exists strong resistance to the acceptance of increasing sexualisation amongst young people. For religious, political and other reasons, the introduction of national and regional initiatives to improve young people’s sexual health has been somewhat slower than it could have been. For example, moves towards increasing the availability of contraception to unmarried young people do not sit comfortably alongside views that sex is solely for the

purposes of procreation; fears exist that informing young people about sexual matters will encourage experimentation and earlier activity, a situation that runs counter to views that sexual activity should be restricted to marriage and stable (heterosexual) relationships; providing health services for people who engage in same-sex activity is seen as condoning (and maybe encouraging) ‘unnatural’ practices; and so on.

What has been difficult to get across in many cases is that such beliefs run directly counter to initiatives urgently required to improve sexual health amongst young people. The accumulating body of research evidence, as well as the various agreements to international policy development, should be leading to considerably greater attention being paid to young people and their needs. However, through the continuing inadequate provision of education and services, through the marginalisation of those most at risk, through the denial of unequal distribution of power, there are few signs of such improvement in many parts of the world.

Dynamic Contextual Analyses – rhetoric and reality

As part of the *Safe Passages to Adulthood* DFID funded new knowledge programme, a number of Dynamic Contextual Analyses (DCAs) were conducted. Selected researchers from leading institutions in six countries were invited to participate between September 1999 and May 2000; the countries were Kazakhstan, Mali, Zimbabwe, Peru, Mexico and Brazil. The aims of the DCAs were, in the light of increasing research knowledge and international policy development, to ‘take stock’ of the situation regarding young people and sexual conduct in each of the countries. Partners were asked to carry out a number of activities, including the following

- gather information on the extent and quality of sexual health data amongst young people;
- identify gaps in routine data-collection;
- summarise the legal and policy framework within each relevant government department;
- interview appropriate personnel in the relevant government departments;
- visit some selected educational and service settings to assess the extent to which the ‘official’ policies are being carried out in practice;
- discuss sexual health issues with samples of young people;
- summarise the activities of international and local aid agencies and NGOs;
- summarise previous research on young people within the country;
- identify barriers and opportunities for progress;
- suggest priorities for future research agendas.

Two researchers from each country attended a preliminary workshop in Brighton to clarify and amend the process, to receive training where necessary, to agree budgets, and so on. Fieldwork lasted up to six months, during which time each site received at least one visit from members of the SPA team. A second workshop in May 2000 received reports and discussed the implications, further activities, and so on.

Each of the reports contained a great deal of information regarding many aspects of sexual conduct and related issues; for the purposes of the current activity, emphasis is placed on the *barriers* to improved provision and the *opportunities* that exist for

change. The priorities for future action are identified; naturally these reflect the assessments of the researchers involved and it is acknowledged that other priorities may have emerged had different people carried out the tasks. Further, since only six countries were involved, no claims can be made regarding any universal application. Having said this, however, information from other countries not involved in the DCAs does suggest that many of the issues identified in these six countries are, in fact, fairly universal.

Tables summarising the key points to arise from each of the DCAs are attached, and the discussion that follows is based on these summaries.

Summary of major barriers and opportunities in PERU

<i>domain</i>	<i>major barriers</i>	<i>major opportunities</i>
<i>educational provision</i>	<ul style="list-style-type: none"> ➤ lack of standardised programmes ➤ some key issues omitted ➤ teachers not universally trained 	<ul style="list-style-type: none"> ➤ compulsory sex education programme in state primary and secondary schools ➤ general support for sex education amongst young people and parents
<i>health services</i>	<ul style="list-style-type: none"> ➤ limited access to contraception and HIV screening for under-16s ➤ differential provision in urban and rural areas ➤ physical facilities often poor ➤ reliant on local initiatives 	<ul style="list-style-type: none"> ➤ community based intervention programmes ➤ NGO activity aimed at range of target groups ➤ collaboration between NGOs and Government ➤ staff attitudes generally supportive
<i>policy initiatives</i>	<ul style="list-style-type: none"> ➤ some distrust of population control especially in poorer areas ➤ silence on abortion, sexual diversity, violence and abuse ➤ failure to recognise diversity and disenfranchised groups ➤ charity focussed rather than based on community development ➤ some evidence of lack of co-ordination ➤ financial constraints ➤ political instability ➤ influence of Catholic church in limiting initiatives ➤ unclear separation of young people from children 	<ul style="list-style-type: none"> ➤ political climate supportive of greater attention to young people's SH needs ➤ increasing professionalism of staff ➤ increasing multi-sectoral networks
<i>research initiatives</i>	<ul style="list-style-type: none"> ➤ limited resources ➤ restricted presentation of age-related data from national surveys 	<ul style="list-style-type: none"> ➤ accumulating body of good research ➤ active research agenda identified, including more detailed demographic and epidemiological aspects, sexual violence, abortion, constructions of sexuality, young men, risk perception, assessment of health services and sex education, interpretation of media messages ➤ highly competent researchers available

Summary of major barriers and opportunities in MEXICO

<i>domain</i>	<i>major barriers</i>	<i>major opportunities</i>
<i>educational provision</i>	<ul style="list-style-type: none"> ➤ lack of training for teachers ➤ biological emphasis in curriculum ➤ fear amongst teachers of parental reaction ➤ some personal opposition amongst teachers 	<ul style="list-style-type: none"> ➤ build on popular programmes involving youth-to-youth, theatre, etc. ➤ improved training of teachers ➤ more dynamic interactive teaching
<i>health services</i>	<ul style="list-style-type: none"> ➤ lack of training for health professionals ➤ programmes fail to recognise diversity of sexuality, urban-rural, ethnicity ➤ specialist young people's services not known about by young people ➤ some evidence of lack of anonymity ➤ lack of resources and limited availability of services 	<ul style="list-style-type: none"> ➤ improve training of health professionals ➤ improve publicity and accessibility of specialist provision
<i>policy initiatives</i>	<ul style="list-style-type: none"> ➤ divided society – more open government hampered by opposition ➤ lack of co-ordination between agencies ➤ lack of stability in programmes 	<ul style="list-style-type: none"> ➤ young people expressing needs for greater openness ➤ lack of legal restrictions ➤ some indications of increased openness at higher levels
<i>research initiatives</i>	<ul style="list-style-type: none"> ➤ quite substantial base of data, but tends to concentrate on urban areas ➤ little work on impact of migration ➤ substantial gaps ➤ poor evaluation of current programmes 	<ul style="list-style-type: none"> ➤ evaluation of programmes ➤ explore decision-making processes more fully ➤ targeted work with migrants ➤ improve condom distribution in rural areas and ensure anonymity

Summary of major barriers and opportunities in BRAZIL

<i>domain</i>	<i>major barriers</i>	<i>major opportunities</i>
<i>educational provision</i>	<ul style="list-style-type: none"> ➤ increasing drop-out amongst poorer children ➤ disjunction between information provision and behaviour change 	<ul style="list-style-type: none"> ➤ increasing use of youth oriented media ➤ some innovative and broad based sex education programmes
<i>health services</i>	<ul style="list-style-type: none"> ➤ limited access for young people ➤ structural features leading to vulnerability 	<ul style="list-style-type: none"> ➤ strong data base ➤ some innovative initiatives funded by World Bank and others
<i>policy initiatives</i>	<ul style="list-style-type: none"> ➤ conservative nature of social welfare policies ➤ some lack of co-ordination in practice 	<ul style="list-style-type: none"> ➤ strong policies concerning young people's rights (in theory) ➤ apparently co-operative relations between government and NGOs
<i>research initiatives</i>	<ul style="list-style-type: none"> ➤ gender issues tend to be seen exclusively as women's issues ➤ some confusions between concepts of 'youth', 'adolescents' and 'young people' 	<ul style="list-style-type: none"> ➤ some strong research teams with good links with NGOs ➤ moves to greater attention given to diversity and relationship with risk and vulnerability ➤ focus on poorer populations and vulnerability ➤ attention to transitions to adulthood in different settings ➤ need to improve evaluations of existing and new programmes

Summary of major barriers and opportunities in MALI

<i>domain</i>	<i>major barriers</i>	<i>major opportunities</i>
<i>educational provision</i>	<ul style="list-style-type: none"> ➤ relatively low school attendance especially by girls and particularly low in rural areas ➤ limited SH programmes ➤ teachers of Family Life Education often un-motivated 	<ul style="list-style-type: none"> ➤ UNFPA / UNESCO initiatives in FLE ➤ establishment of more flexible schooling arrangements ➤ peer education programmes
<i>health services</i>	<ul style="list-style-type: none"> ➤ overall poor quality of services ➤ no particular targeting of young people ➤ staff shortages ➤ high use of traditional medicine ➤ separation of social from medical aspects of sexual health ➤ very limited resources ➤ lack of training ➤ illegal abortions ➤ high levels of FGC 	<ul style="list-style-type: none"> ➤ aim to reduce FGC through education
<i>policy initiatives</i>	<ul style="list-style-type: none"> ➤ population policy conflicts in some respects with legal position ➤ no special sexual health programme for young people ➤ large gender inequity 	<ul style="list-style-type: none"> ➤ new Ministries of Youth and Sports, and Women, Families and Children ➤ link population policy with legal framework ➤ some very innovative NGOs
<i>research initiatives</i>	<ul style="list-style-type: none"> ➤ little on young people, apart one recent survey 	<ul style="list-style-type: none"> ➤ active plans at CERPOD ➤ priority areas include seasonal migrants, young married women, domestic servants ➤ improve fit between rhetoric and practice of SH through training ➤ improving status of women

Summary of major barriers and opportunities in ZIMBABWE

<i>domain</i>	<i>major barriers</i>	<i>major opportunities</i>
<i>educational provision</i>	<ul style="list-style-type: none"> ➤ school attendance patchy in some areas ➤ high drop out amongst women in rural areas ➤ lack of space in curriculum in some private sector schools ➤ overloading of programmes in some schools by NGO activity ➤ lack of materials, lack of trained staff, lack of support 	<ul style="list-style-type: none"> ➤ improve co-ordination of efforts of government and NGOs ➤ encourage strategic approach to ensure widespread coverage ➤ widespread training and development of participatory practice ➤ greater consultation with local community
<i>health services</i>	<ul style="list-style-type: none"> ➤ lack of use of health services due to poverty ➤ negative attitudes amongst staff ➤ limited awareness of diversity amongst young people and their needs ➤ high staff turnover in voluntary support organisations ➤ 	<ul style="list-style-type: none"> ➤ currently developing policy for improved delivery of services for young people ➤ some very active NGOs
<i>policy initiatives</i>	<ul style="list-style-type: none"> ➤ lack of employment opportunities ➤ suspicions between Government and NGOS ➤ structural problems and inadequate planning and co-ordination ➤ conflict between UN Convention on Rights of the Child and traditional rights of parents 	<ul style="list-style-type: none"> ➤ well-developed laws and policies to promote sexual health amongst young people ➤ National AIDS Council being established at present
<i>research initiatives</i>	<ul style="list-style-type: none"> ➤ fairly extensive descriptive KAP research over past few years ➤ lack of data on meanings and nature of early sexual activity ➤ statistics on STIs not stratified by age and sex ➤ some opposition to research on sexual conduct 	<ul style="list-style-type: none"> ➤ some active research teams ➤ improvement in collection of basic statistical data ➤ greater attention to diversity of contexts of early sexual activity

Summary of major barriers and opportunities in KAZAKHSTAN

<i>domain</i>	<i>major barriers</i>	<i>major opportunities</i>
<i>educational provision</i>	<ul style="list-style-type: none"> ➤ no specialist teacher training ➤ sex education closely linked to moral training ➤ lack of materials ➤ increasing rates of school drop-outs 	<ul style="list-style-type: none"> ➤ young people increasingly aware of need for improvement ➤ recognition by some teachers of issues ➤ recent changes in laws about sex education
<i>health services</i>	<ul style="list-style-type: none"> ➤ lack of unified programme ➤ lack of training of staff ➤ lack of resources 	<ul style="list-style-type: none"> ➤ increasing interest in need for policy development
<i>policy initiatives</i>	<ul style="list-style-type: none"> ➤ strong opposition to improved sex education ➤ no specific policies on sexual health amongst young people 	<ul style="list-style-type: none"> ➤ increasing support for improved policy and legal framework ➤ multi-sectoral support ➤ build on enthusiasm of young people
<i>research initiatives</i>	<ul style="list-style-type: none"> ➤ limited to one recent survey 	<ul style="list-style-type: none"> ➤ needs focus on risk areas as well as general population ➤ improved collection of basic data on prevalence of sexual ill-health ➤ KABP measures as well as qualitative approaches

Key emergent themes

A number of themes emerged consistently from the DCAs, some of which have already been identified in published and unpublished material. These are presented below in categories although it should be recognised that there is overlap between them.

paucity of routine data-collection

There is a consistent lack of adequate data collected on sexual ill health that would permit a more accurate assessment of need and priorities. In some cases, suitable data are not recorded in health settings due simply to lack of resources or management capability and/or systems; in others, denial regarding sexual activity amongst young people seems to be inhibiting the development of suitable systems of data recording. In cases where reasonable data are recorded, these are often not disaggregated by, for example, age or area of residence; such data have, in less poor country settings, enabled the design of targeted efforts towards prevention.

Of course, some aspects of sexual ill-health and morbidity are not recorded simply because they do not 'exist'. The illegality of abortion in many countries is not conducive to accurate recording and assessment of need (quite apart from the impact it has on morbidity and mortality). A similar point can be made regarding female genital cutting; in Mali, even though there is strong medical opposition to the practice (and indeed some doctors refuse to participate in the practice), it is widely carried out through informal networks and thus unmeasurable.

Further barriers to accurate assessment of need are the fairly widespread use, in some countries, of traditional forms of treatment and medication, and the availability of contraceptives (including hormonal contraceptives) from non-regulated outlets. Neither of these sources of so-called health care contributes to the collation of accurate data on patterns of provision and need, and so are unable to help to identify shortfalls in services.

School-based educational provision

There are many problems associated with educational provision in relation to the sexual health needs of young people. In the poorer of the poor countries, such as Mali, relatively few young people attend school; for example, fewer than 5 percent of young women in rural areas attend school beyond primary level, and less than half do so in urban areas. In Kazakhstan, as elsewhere, there is concern regarding the increasing numbers of young people who drop out of school before reaching 15 years.

In countries in which school attendance is considerably higher, many criticisms of school based sex education are reported. Many of these are similar to criticisms that have also been voiced regularly in developed country settings. Syllabi are reported as being too biological, minimalist, overly concerned with moral issues, neglectful of matters relevant to improving communication, failing to deal with issues of gender and power, ignoring the range of forms of sexual expression, and so on.

There was fairly strong support in Kazakhstan for greater efforts towards sex education, but it was clear in the discussions with many of the policy makers that what they had in mind was ‘moral education’; that is, better means of preventing young people from having sexual relations prior to marriage. Similarly, the content of Family Life Education in some African countries is slanted towards reproductive issues within stable relationships, as opposed to dealing adequately with young people’s sexual conduct *per se*.

Sex education in the south and central American countries is associated with fairly strong opposition from the Catholic Church; this affects what it is permissible to cover as well as making some teachers very wary of negative parental reactions. It was also reported that some teachers allowed their own personal and moral views to unduly affect their teaching.

Lack of adequate training for teachers arose as an issue in nearly all cases. Even in countries such as Peru in which fairly progressive policies are in place, a clear need was identified for more widespread and consistent training of teaching staff.

Most of these are very practical barriers to improved sex education in schools. The Peruvian research team (along with a research team working in Costa Rica) has identified a most crucial issue relating to the discourses used in sex education. In simple terms, they have analysed the ways in which the discourses of health and religion dominate school based programmes; these are at odds with the discourses relevant to young people, which are more likely to be based on love, relationships and pleasure.

Health service provision

The major barriers identified under this heading relate to accessibility, staff training and attitudes, lack of confidentiality and, due to these problems, a lack of willingness amongst young people to use the limited facilities that are available.

Many countries do not make separate and specialist provision for young people. This creates physical barriers to access, such as inappropriate opening hours and difficulties in travel, as well as personal barriers, reported in terms of long waiting times, unsympathetic and sometimes disapproving staff attitudes, lack of recognition of the range of young people’s needs, and others. These features, alongside generally poor levels of resourcing, are not conducive to adequate contraceptive supply or early testing for STIs and HIV. Further, any charges that are made for consultations and provision act as a powerful disincentive.

A further issue that arises in some contexts related to the issue of confidentiality. For young people who are engaging in sexual activity in contexts where this is discouraged, feeling assured that their help-seeking behaviour will be treated with discretion is an essential aspect of a good service. Although the DCAs did not permit a detailed investigation of this area, there was certainly a deep suspicion amongst many of the young people involved that this acted as a disincentive to attendance. The issue appears to be particularly pertinent in rural areas, where health staff are likely to be drawn from the local community.

Development of national policies

Although some of the countries have fairly well developed national policies relevant to young people's needs regarding sexual activity, the overall impression from the DCAs and other material is that these have not been translated into effective strategies for action. Some lack of co-ordination between government departments is evident, and lack of stability in the political climate additionally hampers progress.

Even in countries in which there are seemingly well-developed policies, these tend to be restricted to 'mainstream' sexual health (and biological) issues; other related and crucial issues are rendered invisible. For example, same sex activity is generally unrecognised in many countries, making it difficult to ensure adequate support and service provision, abortion is in some cases not permitted but action is not taken against those who carry out the operation illegally, female genital cutting is widespread in some countries but is not dealt with under existing laws on assault, gender issues often remain ignored, the specific needs of some marginalised groups are simply not acknowledged, and so on.

Barriers to improvement

Obviously, there are some material barriers to improving the position of services and educational provision for young people in relation to their sexual health; these include lack of resources to enable adequate staffing structures, physical facilities, contraceptive supplies and testing facilities within health services, good educational material and regularly trained teachers in school settings, sufficient numbers of staff able to work in non-school settings, and so on.

But there are more fundamental barriers to progress that need to be acknowledged. The very powerful influence of the church in many countries has a large effect on official policies, as well as on the attitudes and approach of some of the staff on the ground whose own personal views block what may be, on paper, progressive policy positions. By maintaining a traditional view of sexual activity as being related solely to reproduction within stable relationships, and simultaneously refusing to accept the increasing levels and diversity of young people's sexual conduct, pro-active means of providing support and appropriate education are not encouraged. This situation continues despite the accumulating evidence available to provide reassurance that earlier and more open approaches to sexuality education do not encourage higher levels of sexual conduct, and that accessible service provision is an essential requirement for improved sexual health outcomes.

In many of the countries, a further barrier to improvement involved an apparent lack of co-ordination in activities, whether this is between government departments or between NGOs, or both. In some cases, official policies were seen as being contradictory, NGOs were seen to be competing for limited funding rather than collaborating effectively, some duplication of effort was noted, and so on.

Opportunities for change

But there are some encouraging indications that changes are occurring and that future progress will be made. Some strong research units are developing which have good

links with international agencies as well as with their own governments. More attention is being given to lessons learned from poorer country settings through the publications of international agencies such as UNAIDS and others.

Amongst the lessons being learned is that there are some ways of improving education through ways that are not particularly resource intensive. These include, for example, using peer education, working with services that already exist for young people (such as sports clubs), involving popular – and increasingly globalised - media outlets, and maximising the enormous potential within local communities.

But perhaps the major change needed is the recognition that young people can no longer be ignored in policy determination and/or in the implementation of policy into action. Whether the argument is made in terms of pragmatic health considerations or in terms of human rights and egalitarian principles, greater clarity and sense of purpose are needed.

It needs to be more widely recognised that the traditional medical, biological and moralistic approaches to *reproductive* health need to be replaced by ways of thinking that fully acknowledge young people's autonomy, diversity and needs in the arena of *sexual* health. The processes involved in conducting DCAs in these countries have helped to identify areas where greater focus could and should be directed.

Footnote

Hard copies of the DCA manual are available for participants of this conference, and electronic copies are available for downloading from the Safe Passages to Adulthood website. The site also includes summaries of the reports from Mali, Mexico, Peru and Zimbabwe.

Further information on the Safe Passages to Adulthood programme can be found at the website, including details of other activities, research instruments developed, etc.
<http://www.socstats.soton.ac.uk/cshr/SafePassages.htm>

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