Qualitative "Resumen"
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Erica Nelson

Qualitative research activities in Managua, Cochabamba and Cuenca have confirmed what was suspected in the proposal stages of the CERCA project: sexual and reproductive health interventions must be designed to meet the needs of the specific spaces and cultural contexts in which they will take place. It may seem an obvious point, but adolescent sexuality and sexual behaviors cannot be de-linked from the complex gender, socio-economic, cultural and educational contexts in which they develop. If we intend to impact positively on these behaviors and facilitate "empowerment", then we must necessarily take these complexities into account, and this is not an easy task.

The health challenges affecting Latin American youth are well documented. Statistics show that high rates of pregnancy, unsafe abortions, HIV and STI transmission, and unmet demand for contraceptives persist among young women and men in many areas of the region.[1] We also know that these health issues impact negatively on young people's lives beyond clinic walls, making the achievement of academic, professional and personal goals substantially more difficult, if not impossible.[2] The three cities chosen as intervention sites for the *Community-embedded reproductive health care for adolescents* (CERCA) project – Managua, Nicaragua; Cochabamba, Bolivia; and, Cuenca, Ecuador – are in some ways no different from any other country where policy and program responses to this issue have been inadequate. Young *managuënses, cochabambinos,* and *cuencanos* confront the same barriers to healthy sexual and reproductive lives as their peers in Africa, South and South-East Asia, and much of the Americas: insufficient public health services and access to free or low-cost contraceptives; a lack of adolescent-friendly health clinics and health service providers; taboos preventing the open discussion of sex and sexuality in the home, school or church; and practices of early marriage and early sexual debut.[3]

Even as we know that similar challenges to adolescent sexual and reproductive health (SRH) exist across national and regional borders, we also know

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[1] WHO, 2007, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*; Canning, D., J. E. Finlay, and E. Ozaltin, 2009, "Adolescent Girls Health Agenda: Study on Intergenerational Health Impacts." Harvard School of Public Health, unpublished; Sedgh et al, 2009, "Abortion: Worldwide Levels and Trends", http://www.guttmacher.org/presentations/2007/10/10/AWWtrends.pdf; Molina et al, 2010 "Family Planning and Adolescent Pregnancy", Best Practice & Research Clinica Obstetrics and Gynaecology 24 (2010) 209 – 222; IRBD, 2008, El estado de la salud sexual y reproductiva en America Latina y el Caribe: una vision global, Washington DC; WHO "Social Determinants of Adolescent Sexual and Reproductive Health: Informing Future Research and Programme Implementation", Ed. Shawn Malarcher, WHO, 2010

[2] UNFPA, 2007, Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy".

[3] See footnote 1.

that top-down, undifferentiated public health strategies do not work.[4] What, then, makes the SRH concerns of adolescents in Managua, Cuenca or Cochabamba unique? What cultural or social explanations lie behind these hard statistics and how do we apply this knowledge to an intervention strategy?

Given CERCA's objective of involving local communities in all phases of project design, implementation and evaluation, the first step has necessarily been to ask local people directly: *what SRH challenges do young people face here, in this place, and how do you think they should be addressed?* To this end, qualitative methods were applied to select neighborhoods and public health centers in Managua, Cochabamba and Cuenca to establish a basic understanding of the similarities and differences in local understandings of adolescent SRH problems and needs.

In-depth interviews with health service providers and community leaders, focus group discussions with young people and their parents, and, finally, community-led ethnographic research revealed important differences in young peoples' conceptualization of sexuality and sexual choices at the level of individual high schools, let alone the differences witnessed between urban and peri-urban communities. We (the principal researcher and assistants in Bolivia and Nicaragua) heard young people speak with many voices about what they need and want from their peers, their mentors and their parents in terms of education, orientation and support. What might work for one family or one health worker is not going to be the same for another – this much was apparent even from the rapid assessment tool used by each country team to identify key factors and responses to the "problem" of teen pregnancy.[5] There are many opinions – all valid – about what teens "need" or what families "need" when faced with dramatic changes in telecommunications (access to internet, TV, videos, cell phones), increased human mobility (both internal and external migration), changing gender dynamics and family structures.

If we are to truly and meaningfully involve local communities in all phases of project design, implementation and evaluation we must not shy away from the complexity or open-endedness of qualitative results. It would be easier, of course, if we could diagnose the relevant cultural norms, family dynamics, educational and socio-economic factors which contribute to risky sexual behavior as easily as we can diagnose pregnancies and STIs in a clinic setting. Instead, this research *process* has helped to build relationships of trust with young people, health providers,

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[4] International Youth Federation (2007), A Framework for Integrating Reproductive Health and Family Planning into Youth Development Programmes; Alford et al, 2005, "Science and Success in Developing Countries: Holistic Programs that Work to Prevent Teen Pregnancy, HIV and Sexual Transmitted Infections"; Advocates for Youth, 2005.

[5] I put "problem" in quotation marks because I think it is important for the CERCA consortium to be sensitive to the different ways that people might understand teen pregnancy. For example, in cases where a young couple has been monogamous leading up to the pregnancy and intend to marry in advance of the pregnancy or immediately following the birth of the child – this may be seen by some as "not a problem." If the focus is less on targeting a "problem" and more on empowering adolescents to make their own, hopefully healthy, choices, then I think we as a consortium will be better able to respect and incorporate the diversity of local beliefs.

community leaders and parents in selected intervention sites, just as the research *results* have highlighted key issues for consideration as we head into the intervention phase of Proyecto CERCA.