WP6 WORKING REPORT
June 28, 2013
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INTRODUCTION

The objective of WP6 as stated in the original proposal has been to, "*analyze how the interventions are perceived by adolescents, health providers, the community and health authorities and how these perceptions influence the process itself."* More specifically, the University of Amsterdam's medical anthropology department and Center for Global Health and Inequality program, represented on this project by Drs. Erica M. Nelson and Alexander Edmonds, have been responsible for *"defining the tools and methods for qualitative research with respect to the intervention process of the implemented CERCA strategies"* and "*implementing the qualitative research tools and methods for assessing the intervention action results and processes of the applied strategy."*

In the first (pre-intervention) phase of the project, these objectives required an application of both participatory and researcher-led qualitative methodologies to better understand the specific adolescent sexual and reproductive health needs of communities in all three CERCA sites (Cuenca, Ecuador; Cochabamba, Bolivia; and Managua, Nicaragua). Through in-depth interviews with health service providers and community leaders, focus group discussions with adolescents and parents of adolescents, and participatory ethnographic research, we discovered that perceptions of ASRH "needs" varied widely between generations (young people, parents, grandparents). These different notions of what needed "fixing" in terms of health services and sexual health education – and the impact of these differences -- remained an unresolved tension throughout the project, one that we continued to examine and probe during the intervention period.

In the second (intervention) phase of the project, ethnographic methods including participant observation, participatory collaborative research, in-depth semi-structured interviews, visual ethnography, and focus group discussions, were brought to bear on challenges and questions shared by all three CERCA project sites. Building on the research completed during the first phase of the project, Partner 5 used these methodological tools to open up dialogue between adolescents, parents and grandparents living in target communities, as well as between these same communities and CERCA consortium partners. In addition to guiding CERCA team members in Nicaragua, Bolivia and Ecuador as they carried out quarterly focus groups discussions with community members, Partner 5 conducted in-depth fieldwork in the semi-rural parish of Chiquintad (Cuenca) over a period of five months with the aim of achieving a deeper understanding of the barriers to communication on sex and sexuality within multi-generational households. This second stream of research led to the production of a twenty-minute documentary, "Tres Generaciones", that has since been shown at international conferences,

published in a peer-reviewed journal, and used as a research tool in the final round of focus group discussions carried out between January and March 2013.

At all stages of this process, Partner 5 maintained a continuous dialogue with the CERCA consortium on research activities and results, contributing to the "feedback loop mechanisms" so crucial to the success of action research. Key to this feedback loop was the participation of South Group, ICAS and U Cuenca staff as ad-hoc qualitative researchers. Their contributions of transcriptions and notes, discussed at length via Skype with Partner 5, formed the backbone of four internally published research reports. During the pre-intervention research period, Lic. Limbert Cabrera (South Group), Lic. Octavio Rodriguez and Lic. Gloria Medina (ICAS), and Lic. Adriana Verdugo, Dr. Pablo Sempertegui and Dr. Zoybeida Robles (U Cuenca) helped to carry out focus group discussions, and in the case of ICAS and South Group, conduct in-depth interviews and scoping exercises in participating communities. During the intervention stage, Lic. Marco Ballesteros (South Group) and Lic. Octavio Rodríguez (ICAS) held quarterly focus group discussions with an established group of "community committee members", while in Ecuador, Dra. Diana Encalada and Lic. Ma. José Sarmiento (U Cuenca) provided note-taking support for focus groups led by Partner 5. For three-to-six month periods throughout the project, Partner 5 contributed to the understanding of community members' perceptions of Project CERCA through participant observation, semi-structured in-depth interviews (both on tape and on camera), and informal interviews.

The nature of ethnographic research is at once cumulative and responsive. In practice, this means that there have been two parallel analytical processes at play: first, a running analysis of focus groups, in-depth interviews and participant observations presented formally and discussed informally with consortium members since the initiation of research in the summer of 2010; and second, a reflective analysis of collected data made possible in part by Partner 5's alternating periods of physical separation from the intervention sites and the communities involved. The comparative study report due in month 48 (Deliverable 7) will build on what is written here, using these last months of Project CERCA to achieve greater analytical depth than is now possible. For these reasons, this document will contain itself to a discussion of four important results of the qualitative research: 1) the delineation of distinct, and often contradictory viewpoints on adolescent sexual and reproductive health needs, attitudes and behaviors not just between countries, or across generations, but at the micro level of neighborhoods, high schools, and local parishes; 2) the identification of cross-generational dialogue on sex and relationships as relevant to the development of adolescents' gender and sexual behavior norms, and concomitantly, influencing consortium practices with regards to parental and grandparental involvement in intervention activities; 3) identification of culturally-informed "loose talk" or "gossip" both on the part of adults and young people, as relevant to adolescent sexual health decision-making, and finally, 4) the demarcation of degrees of "community-embedded-ness" across

intervention sites, as perceived by project participants and as revealed by participant observation.

METHODS

Pre-Intervention

During the pre-intervention research phase, Partner 5, in consultation with Octavio Rodriguez, Gloria Medina (ICAS) and Limbert Cabrera (South Group), chose a mix of methodologies that would work given the timelines and the existing state of relationships with selected participating communities. Principally, we placed participatory ethnographic research at the heart of our strategy. This method, based on the "PEER" technique pioneered by Kirstan Hawkins and Neil Price of the University of Wales, involved the recruitment and training of young people to develop research questions on SRH and support as they carried out interviews with their peers.[1] In order that the South Group and ICAS research assistants could carry out two-week participatory research projects at intervention sites, Partner 5 hosted a facilitator training in Cuenca from 24 – 26 May, 2010 to the Lics. Cabrera, Rodriguez, Medina, as well as Lic. Adriana Verdugo and Drs. Pablo Sempertegui and Zoybeida Robles (Proyecto CERCA-Cuenca).

By initiating the research process in this collaborative way, we were able to communicate quite strongly Project CERCA's commitment to a youth-led approach to ASRH education and health services. As will be discussed in the results section, the replication of the "PEER" method both at the pre-intervention and intervention wrap-up stages, went a long ways towards making young people and parents of young people feel that their opinions, perspectives, and *analytical capabilities* had contributed to the success of the project. This method also formed the cornerstone of relationship building with "change agents" at the community level: about a quarter to half of the young people who participated in the "PEER" process in the pre-intervention stage continued to be visible and vocal advocates for the project nearly two years later.

In addition to the use of the "PEER" approach, more traditional qualitative research methods were applied to the pre-intervention situation analysis, including focus group discussions (with separated groups of young women and young men, target ages 14-17), in-depth interviews with health care providers and community leaders, and participant observation in target intervention sites.[2] These will be discussed in greater detail in the results section.

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[1] Neil Price and Kristan Hawkins, "Researching Sexual and Reproductive Behaviour: A Peer Ethnographic Approach," *Social Science and Medicine 55* (2002): 1325 – 1336; See Options consultancy website for more information on the PEER approach: http://www.options.co.uk/peer/

[2] Unless stated otherwise, all finding summarized in this report are based on typed transcripts, observational notes, and interview notes collected by Lics. Rodriguez, Medina, Cabrera, Ballesteros, and the Qualitative Research Lead. All participants in qualitative research were required to first give either oral (in the case of in-depth interviews and

It bears mentioning that one of the limitations of ethnographic research is that it gains in depth what it loses in breadth. The quality of relationships with key informants is more crucial than the quantity of key informants. Thus, in contrast to knocking door-to-door for survey purposes, this research required substantial effort to create and nurture relationships of trust with participants in "PEER" research, in-depth interviews, and focus group discussions on the sensitive topic of adolescent sexual and reproductive health. In the pre-intervention stage, the consortium partners had not yet forged relationships at the community level beyond local elites (e.g. parish priests or religious leaders, heads of schools, political leaders, and directors of health services). What the qualitative research most needed was the opinions and perspectives of those at whom the interventions would be aimed – namely adolescents and parents/grandparents/significant adults responsible for adolescents. In order to achieve the trust necessary to carry out this research, much of the pre-intervention research efforts consisted of becoming "known entities" to young people and families in designated target communities, through participant observation, informal conversations, and introductory meetings.

Intervention

Once the intervention period was underway, we were able to begin using an additional methodological tool called "community committees." This methodology was designed in response to the limited human resources (one .25 FTE in Bolivia and Ecuador and one .10 FTE in Nicaragua) that each consortium partner was able to supply to the qualitative research component of the project. This ruled out the continuation of in-depth interviews, participant observation and "PEER" work at the country-level with consortium-designated research assistants. Instead, Partner 5 determined that periodic focus group discussions, carried out in all three countries in the same time frame and using the same facilitation guide, would allow for the exploration of complex issues related to ASRH with a dedicated group of young people and parents/grandparents of young people (contributing to the overall research), while simultaneously giving consortium partners the opportunity to get direct community feedback on the project. In parallel with the "community committees", Partner 5 spent extended periods of time (six months in Ecuador in 2012, and then three weeks in each country in early 2013) conducting rigorous ethnographic research using a combination of all previously mentioned methods.

For each of the five rounds of "community committee" meetings, Partner 5 developed the facilitation guide in direct response to conversations, interviews and observations from fieldwork in Cuenca. Partner 5 would then discuss these ideas

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interviews conducted by *colaboradores comunitarios*) or written consent (in the case of FGs and the work of *colaboradores comunitarios)*. Given the sensitive nature of SRH-focused research, all participants were offered complete anonymity. Unless they requested otherwise, no names are given in this report. The transcripts and notes are kept by the Qualitative Research Lead in accordance with European standards of Human Research Subjects protocol and will be destroyed within a 5-year period following the publication of any Project CERCA-related articles or reports.

with Lic. Ballesteros in Cochabamba and Lic. Rodriguez in Managua to see which issues and questions could be cross-culturally relevant. At the country level, these "community committees" were divided into two to four groups of young people and, separately, parents and grandparents of young people (see "results" section for details). For the final round of community committee meetings facilitated by Partner 5 in each country, these groups were combined to encourage cross-generational dialogue on the challenges of communication on sex, sexuality and romantic relationships within families.

RESULTS

Pre-Intervention

An overarching result of the qualitative research has been the recognition of the diversity and multiplicity of adolescent lives and experiences, not just on a country-by-country basis but at the level of individual high schools and neighborhoods. By placing young people and their families at the center of this research process, and by rejecting hierarchical and uni-directional research methods, we were able to go beyond traditional public health survey results and gain a deeper understanding of the socio-cultural factors impeding the improvement of adolescent sexual and reproductive health. As one consortium partner explained, "we have learned to listen to our target groups."[3]

From the very beginnings of the research process, at the pre-intervention situation analysis stage, we understood that an examination of the full range of cultural, historical, economic and structural factors that influence the state of ASRH in each of the three cities was not possible. We were able to flag, through preliminary research, cross-cutting issues such as attitudes towards sexual diversity, differences in parental/societal/adolescent responses to unwanted pregnancies, and the impact of outward migration on family structure and emotional environment in affected areas of Cochabamba and Cuenca. In the pre-intervention stage, the identification of multiple factors influencing ASRH at the local level was presented to consortium partners so that they might take these factors into account when designing education and outreach messages (result 1).

More importantly, the results of pre-intervention research (both quantitative and qualitative) led to Partner 5' identification of cross-generational communication on sex, sexuality and relationships as a focus area for future intervention research (result 2). From the outset, project CERCA identified "improving communication" between adolescents and parents/significant adults on SRH-related issues as an intervention objective.[4] Quality of communication, whether between an adolescent

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[3] Translated quote taken from Skype meeting to discuss results of community committees rounds 3 and 4, December 2012

[4] Decat P, Nelson E, Meyer S, Jaruseceviene L, Orozco M, Segura Z, Gorter A, Vega B, Cordova K, Maes L, Temmerman M, Leye E, Degomme O. "Community embedded reproductive health intervention for adolescents in Latin America: development and

and a parent, grandparent, aunt, uncle, older cousin or "significant adult", was also identified both by the pre-intervention quantitative survey, and in pre-intervention focus groups, as a key factor influencing adolescent SRH behaviors.

Table 1. Pre-Intervention Research Activities (May 2010 – May 2011)

Pre-Intervention	*Cuenca, Ec*	*Cochabamba, Bo*	*Managua, Ni*
Total In-Depth Interviews	*18*	*20*	*10*
*Total Peer Interviews***	*20*	*9*	*20*
Total Focus Groups	*5*	*3*	*3*
Total On-Camera Interviews	*8*	*n/a*	*n/a*

***Refers to interviews carried out by peer researchers. These were not recorded but researchers took notes for each interview, which were later discussed and analyzed together with the lead researcher.*

Intervention

In pre-intervention focus groups and PEER research in all three cities young people expressed a desire to learn more from their "significant adults" about how to negotiate romantic relationships, how to prepare for decision-making related to sex, how to deal with issues of jealousy and control in male/female relationships, and the specifics of how available contraceptive methods work to prevent unwanted pregnancies and/or sexually transmitted infections. In all three cities young people stated a desire to have "*más confianza"* (more trust) with their parents in order to be able to talk about these issues. A sampling of young people's demand for improved sex education and better communication with their parents can be seen in the short film, "Voces de Cuenca", which was produced and directed by Erica Nelson (Partner 5) and Dylan Howitt: http://www.youtube.com/watch?v=L8o0kFfUddY

At the same time, in-depth interviews revealed a significant gap between what adults (parents, grandparents, community leaders, health professionals, and teachers) assumed young people know about sex, sexuality and contraceptive methods versus young people's stated desire for more information and discussion on these topics. More specifically with regards to health professionals, focus group discussions led by U Ghent and Lithuania University of Health Sciences found that health professionals in all three cities shared the perception that the information on contraceptive methods is freely available but that young people are not making use of it.[5] However, young people countered these claims in focus groups and PEER

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evaluation of a complex multi-centre intervention". BMC Public Health. 2013 Jan 14; 13(1): 31.

[5] Jaruseviciene L, Orozco M, Ibarra M, Cordova Ossio F, Vega B, Auquilla N Medina J, Gorter Ac, Decat P, De Meyer S, Temmerman M, Edmonds AB, Valius L, Lazarus JV. "Primary healthcare providers' views on improving sexual and reproductive

research, stating that they are not getting the information that they need whether because "*verguenza*" (embarrassment/shame) prevents them from entering health centers, or because they receive inadequate information and support from existing health center services and health support staff in schools.

Intervention

During the intervention stage, the "community committees" (CCs) method became central to the CERCA consortium's ability to get continuous feedback from local parents, grandparents and young people in target areas on intervention actions. This method also helped to identify and explore key issues impacting on ASRH, including the significance of cultural factors not previously taken into account by the project. The non-hierarchical and dialogic nature of this method, and the commitment of the facilitators to open-ended discussions instead of "teaching points", meant that these sessions were genuinely guided by community members in terms of the issues and problems they wanted to discuss.

Table 2. Intervention Research Activities (January 2012 – April 2013)

Intervention	*Cuenca, Ec*	*Cochabamba, Bo*	*Managua, Ni*
Total In-Depth Interviews	*30*	*14*	*20*
*Total Peer Interviews***	*11*	*10*	*14*
Total Focus Groups	*18*	*13*	*15*
Total On-Camera Interviews	*7*	*n/a*	*n/a*

Lic. Rodriguez, Lic. Ballesteros and Dr. Nelson facilitated five separate rounds of CCs , with 2-4 groups each, keeping to the original participants as much as was possible from the first round onwards. The topics of these CCs included: 1) Generational Differences and Talking about Sex and Relationships in the Family; 2) Gossip, Scandal and Stigmatization; 3) Sex vs. Sexuality and Challenges to Achieving Sexual Health; 4) Perceptions on what "Virginity" Means and Ideals of "Couple-dom"; and lastly, 5) Generational Differences, Part 2. From the very first round, participating young people made clear their demand for additional spaces "*donde nos pueden escuchar y dejar hablar"* ("where we are listened to, where we can just talk, Cochabamba) versus being on the receiving end of lectures on contraceptive methods or the benefits of abstinence. Similarly, parents/grandparents/adult carers of adolescents expressed a desire for additional opportunities to "*compartir*

convivencias" ("share life experiences", Cuenca) related to communication with adolescents about sex and relationships. These demands, relayed to consortium partners, informed increased efforts at parental/grandparental/significant-adult involvement in intervention activities beginning in the spring of 2012 (result 2).

In all five CCs including those on separate topics, how adults judge, comment, advise, or observe adolescent sexuality was a constant thread of discussion and debate. From the first CC, adult participants in all three cities expressed anxiety over changing models of parenting and a perceived loss of control over young people's sexual behavior. On the one hand, previous generations *"vivían una ambiente más vertical, más represivo"* ("lived in a more vertical, more repressive environment," parent, Cochabamba) and parents acknowledged that they did not want to treat their children in the same way: *"Porque a mi mama me puso el freno fuerte…No puedo ser así con mis hijas"* ("My mom put the brakes on me, hard…I don't want to be like that with my daughters", Managua). But on the other hand, parents in all three cities perceived a rise in *libertinaje* (libertine behavior) among young people and worried that this resulted from a loss of parental authority.

In round 2, we considered the content and impact of "loose talk" and gossip related to perceived deviations from sexual behavioral norms. Specifically, we considered the different ways that young women and young men get classified according to sexual experience (whether real or assumed). Both young and adult participants in the CCs in all three countries came up with long and varied lists of pejoratives to describe sexually active young women and non-sexually active young men. From "roses without petals who don't count for anything" and "ball warmers" (sexually active young women) to "future priests" and "mama's boys" (male virgins), this taxonomic exercise made evident the ease with which young people are classified both by their peers and by their communities if they deviate from cultural expectations of sexual behavior.

A second issue raised by this round of CCs was the distinction made by adult participants between social vigilance and gossip. For the parents and grandparents, aunts and uncles, they felt it a duty to inform their neighbors and families if a young woman was spotted out late at night in the company of a young man, or spied at the health centre seeking contraception, or suspected of having "provoked" an abortion. There was some debate in these sessions about whether this conjecturing and "loose talk" helped or hindered the achievement of ASRH objectives, such as access to scientifically-accurate information on contraceptive methods and access to SRH care at health centers, for both young men and young women.

The prevalence of gossip or verbal vigilance of adolescent sexual behavior in all three cities, as revealed in this second round of CCs but also underscored by interviews, informal conversations and participant observation throughout the intervention period, proved problematic to the project. In an internal report on this second round Partner 5 highlighted an inherent tension in the development of education and communication outreach campaigns: if we recognize the stigmatization of certain adolescent sexual behaviors as having a negative impact on access to information and services, how can we talk about the "prevention of teen pregnancy" or delaying sexual debut without participating in culturally acceptable moralistic discourses on sexually active young women and/or non-sexually active

young men? How can we talk about sex and sexuality in ways that are positive, but at the same time preventative? That these tensions were not wholly resolved by intervention activities was made clear by fieldwork conducted in the final months of the project. However, it was nonetheless the case that this qualitative research highlighted the significance of these cultural norms to the intervention, in particular the common practice of shaming and stigmatizing sexually active young women and non-sexually active young men (result 3).

For the third round of CCs we used a short open-ended survey adopted from the U.S. based ASRH website www.scarlateen.org to go into greater depth on the challenges to ASRH both from the perspectives of young people and adults. The survey was done in such a way that individuals could mark off from a list of possible challenges to the achievement of sexual health (in the broadest sense of the term "health") as many challenges as they thought relevant. Cumulatively the top 5 most-picked responses out of a possible 16 were, in order (from CCs in all three cities):

1) Being clear about what I want or don't want
2) Being comfortable with my own body
3) Having, maintaining or respecting the sexual limits of others
4) Evaluating what I want and what I like (sexually)
5) Understanding how sex, like and love are or are not the same thing

What this survey and the resulting discussions revealed was that two-thirds into the intervention, those most actively engaged with Project CERCA were still a long ways from achieving the necessary self-awareness to make healthy sexual choices. Interestingly, adult participants were the only ones who chose "not using constantly, or never using, contraceptives" as a challenge facing young people, whereas young people showed greater concern about self-awareness and relational aspects of sex and sexuality.

By the third round of CCs we had established the interconnectedness of cultural norms concerning adolescent sexual behaviors (e.g. female sexual purity and male sexual virility), the practice of gossip in communities related to young people's sexual behaviors and expressions and sexuality, the breakdown of communication between young people and their parents/grandparents/significant adults on issues related to sex and relationships, and the use of contraceptive methods. This interconnectedness was most obvious in interviews with health personnel, both those trained by the project and those working on behalf of the project. These interviews showed that, in spite of assumptions to the contrary, health personnel are very much influenced and guided by the same cultural norms that impact on ASRH in target communities. They are not, by virtue of their professional training, objective bystanders to the stigmatizing and moralizing forces that seek to contain and control adolescent sexuality.

A detailed examination of such interviews will be looked at more closely in the comparative study report (month 48), but it is worth including a few examples here. In the first instance, speaking with a health care provider in Cuenca about generational changes, she lays out the sexual norms she was raised to uphold:

> "Yo nunca di un mal paso hasta los 31 años que me case…Porqué así me criaron, eso mi madre me decía, mis abuelos , pero nunca me decían feo sino tienes que cuidarte, tienes que evitar tener cosas con varones, y como yo era más reservada no me involucraba mucho con los jóvenes."
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> (I never took one wrong step until I got married at 31…because that is how I was raised, that is what my mom told me, my grandparents, never in a bad way but that I had to take care of myself, I had to avoid having anything happen with men, and since I was more reserved I never got involved much with young men.)

Later in this same interview when asked if young people ask her for advice on contraceptives at the health center where she works, she explained,

> "Conmigo, como soy de aquí entonces tienen vergüenza de preguntar entonces, ellos los que quieren dicen con qué métodos me cuido, como tengo que hacer, con quien hablo, pero muy poco por que yo soy de aquí entonces muy poco porque a lo mejor yo les digo a los padres, a la familia."
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> (With me, since I'm from here they are too ashamed to ask, the ones that want to ask about what methods to use, how to use them, who to talk to, but on the whole very few because since I am from here then I might tell their parents, their families.)

In a second example, with a health professional from Cochabamba (also female), she told of how her 19 year-old son became a father at 17:

> "Como le decía ya, es difícil para la mamá hablar de eso, porque precisamente por eso creo que es… mi hijo mayor tiene su hijita tal vez por falta de comunicación, tal vez falta de confianza."
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> (Like I said before, it is difficult for mothers to talk about this, and precisely for this reason I think that…my eldest son had his daughter because of this lack of communication, lack of trust.)

Later in this same interview, she offered examples of how she talks about sex and relationships with her 14 year-old daughter:

> "Pero yo le digo, siempre le digo no? "Janneth tienes que tener cuidado porque alguna vez los varones son malos" y ellos nos dicen…"si tú me quieres de verdad vas a digamos tener una relación con él" y eso implica seducir, pero no es propio… tienes que conocerla a una persona bien además todavía no es la edad en que ellos puedan empezar una relación, ahora si, si tienen que protegerse para que sea una responsabilidad compartida no? Por que como decían el otro día el joven de…que nos hizo escuchar la charla, bien preparado el decía no? que"¿ porque siempre tienen que culpar a algo, a

> muchos años que ya habían pasado, el tiempo pasa y cambia, todo cambia no? Pero no tienen que perderse los valores aunque ya ha pasado el tiempo, porque si no estamos perdidos."
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> (I always say, I always say, right? "Janneth, you have to be careful because sometimes men are bad and they say things like, 'if you really love me then we will have relations [sex] and this implies seduction, but it isn't right…you have to really know someone first and besides this isn't the age to be starting a relationships, though, of course, you have to protect yourself because it is a shared responsibility, right? Its like that young man said the other day in the talk, very well-spoke, he said, there is always going to be this blaming, all these years that have passed, times pass and change, everything changes. But that doesn't mean losing our values even though time has passed because if we do we are lost.)

This last quote captures perfectly the cultural and generational conflicts raised by this project. On the one hand, this health professional who received training from project CERCA on "adolescent-friendly communication" recognizes that contraceptive methods are important and a mutual responsibility ("you have to protect yourself"), yet at the same time expresses her belief that young people shouldn't be having sex, that young men will push young women for sex, and that her generations' "values" (code here for abstinence until marriage) should be reaffirmed.

The ambivalence of adults on what constitutes "acceptable" adolescent sexual behaviors, both those running or involved in the interventions and those targeted by interventions, belied the stated health objectives. What the first three results of the qualitative research show is a working out, an evolution, of sexual norms with regards to adolescent sex and sexuality in light of improved contraceptive information and access that is in its incipient stages in these three cities. Adults' contradictory messages about what young people "need" to achieve a state of sexual and reproductive "health" (contradictory both in the sense that these messages are gendered but also inconsistent given the diversity of parent, grandparent, teacher, and health professionals' attitudes towards sex and sexuality in adolescence); confusion over what adults think young people know about sex and relationships versus what they say they *want* to know, the prevalence of gossip and verbal policing of adolescent sexual behavior, and the real barriers to open communication at the family level between adolescents and adults, are all evidence of this evolution in progress.

To what degree the project was able to be a positive force in the evolution of cultural and social norms that have proven barriers to ASRH remains to be seen. Quantitative data will give some indication of success at the level of knowledge, attitudes and practices, but an intervention period of 18 months is simply not enough time to engender profound cultural shifts. The key to this kind of change would be ongoing, sustained efforts at the community level that short cycles of funding do not permit. This leads to a final result of the qualitative research, which is the demarcation of degrees of "community embedded-ness" across intervention

sites, as perceived by project participants and as revealed by participant observation (result 4). Again, this is a result that will be explored with greater depth in the final comparative study report.

At the very beginning of this project, the "community committees" methodology was envisioned as a way of maintaining ongoing relationships with key informants and of getting regular feedback from project participants on intervention activities. In practice, the open and non-hierarchical nature of the CCs far outweighed their usefulness as pseudo-steering-committees. What we quickly discovered, and what continued to be the case up until the very final months of the intervention, is that participating community members – both young people and parents/grandparents/significant adults – were much more interested in talking about all aspects of sex relationships than they were in talking about how to improve the project intervention. A constant refrain was that they wanted *more*: more discussion groups, more community outreach activities, more peer-to-peer support, more information on contraceptives, more help in figuring out how to talk to parents or how to talk to children. In practice, the CCs were, for many participants, the only occasions when they directly engaged with Project CERCA.

The way that each group of CCs evolved over time further underscored differences in degrees of community embedded-ness that consortium partners achieved. In Managua, the interventions' extensive use of Friends of Youth and peer-to-peer counseling at the neighborhood level made it possible to keep up with the same group of CC participants from start to finish. This high level of participation reflected the intensive nature of ICAS' outreach efforts in target neighborhoods and the personal connection between community members and project staff. In Cuenca, it proved more difficult to get parental involvement because parents and grandparents were far less familiar with the project having received at most one or two school-based lectures on ASRH (versus door-to-door education campaigns in Managua). Young people's participation was determined in large part by their social group affiliation – e.g. the CCs tended to attract participants who belonged to a single "clique" within their high schools and, in fact, expressed concern when young people from competing cliques showed up. In Cochabamba, the CCs struggled due to a lack of participation. This was not for lack of efforts to recruit CC members, but reflected the dispersed education strategy employed by South Group. This small team could not achieve the necessary depth of trust or regularity of contact with any one group of young people or parents due to education and outreach campaigns that stretched across a large geographic area, which made both the identification of communities (not just geographic zones) and community "embedded-ness" quite difficult. In retrospect, the diversity of consortium intervention strategies and practices required individually tailored research methods, rather than an attempt at a standardization of qualitative methods that would allow for comparative findings.

As we have sought to understand the complexity and multiplicity of cultural factors that influence ASRH outcomes, we have also realized the untapped potential for additional research. Existing site-specific data on ASRH barriers and needs from an anthropological or sociological perspective, beyond the level of Masters theses or municipal reports, is virtually non-existent in Cochabamba and Cuenca. Managua has had greater attention paid to these issues, in part through the work of CERCA

consortium members ICAS and CIES, though there is much that remains to be examined at the local (e.g. neighborhood) level.

What this research has achieved above all else is the identification of a wide range of issues that impact ASRH which require dialogic interaction and exploration, instead of unidirectional communication and outreach approaches. If we recognize that deeply rooted socio-sexual norms inform communication with young people on sex and sexuality in ways that then impact on their sexual and reproductive health, change must necessarily happen at the micro-level of families and homes, the place where young people learn what is expected from them as they move from childhood to adulthood, and from platonic relationships to sexual ones.

RECOMMENDATIONS

In the original project proposal, U Ghent stated that qualitative research is "particularly suited for understanding complex behavior and motivations and for understanding problems that vulnerable populations are confronted with." Partner 5 would also contend that it is also particularly suited to questioning the cultural norms and practices, the complex behavior and motivations, of the populations in charge of program and policy decision-making, and of health service delivery. The use of the "community committees" exposed the difficulties of engaging "vulnerable populations" in non-hierarchical ways, and concomitantly, the fact that facilitators themselves often required just as much "working out" of their beliefs and cultural assumptions regarding sex and relationships as did the parents and adolescents we targeted. How to achieve adolescent sexual and reproductive "health", where health is taken to mean a wide range of behaviors, practices, and self-knowledge, is not self-evident, nor does the process of achieving it look the same for every adolescent, or every community.

With this in mind, Partner 5 would like to make three recommendations that will be expanded upon in the final comparative study report.

1) We recommend that a process of "values clarification and attitude transformation", based on a model used by IPAS (http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation--Introduction-to-abortion-values-clarification-and-attitu.aspx) be used in the very beginning stages of an ASRH intervention with project team members and any health professionals who will be involved. This kind of process would enable the identification and clarification of values that might impact – positively or negatively – on the ways that ASRH gets talked about and gets worked on over the course of an intervention period. If CERCA had gone through such a facilitated process it might have been possible to know at an earlier stage how project organizers and health professionals' own experiences of advice-giving and advice-receiving on sex and relationships might impact on CERCA communications campaigns and on-to-one clinical and informal counseling of young people. This process would also have helped make clear the importance of parental/grandparental peer-to-

peer support as communicating with your own children on sex and relationships is tricky for everyone, even those with professional training.

2) We also recommend that greater emphasis and resources be put towards non-hierarchical "spaces of dialogue" on issues of sex, sexuality and relationships, both uni-generational and multi-generational. Both young people and adults, in each round of the CCs and in formal and informal interviews, communicated their desire for more opportunities to talk about these issues with the support of a facilitator. Young people especially said they wanted to go beyond lectures on condoms, STIs and unwanted pregnancies and get a better handle on how to deal with their romantic and/or sexual relationships. Parents (and grandparents charged with looking after adolescent grandchildren) expressed a desire to have more support in learning how to better talk about these issues in their homes. None of this kind of learning can be achieved with on-off workshops or classrooms lectures. The "abordaje familiares" used by ICAS were well received by community members, as were the "community committees" in all three countries, although both methodologies are labor and time intensive.

3) Finally, any given ASRH intervention needs to decide from the beginning if they are seeking breadth or depth of project intervention actions because trying to do both at the same time is an exercise in frustration. If "community embedded-ness" is a primary goal, then this research has made clear that consistent, intensive and individual attention must be given to the communities involved in order to have meaningful participation and feedback from those targeted by interventions. It is also important to recognize that definitions of who forms a given "community" might not match municipally zoned districts, neighborhood or village boundaries.