

# Annotated bibliography of young people's sexual and reproductive health

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## **Introduction to the bibliography**

This bibliography is intended to provide a guide to up-to-date and relevant literature on young people's sexual and reproductive health for investigators undertaking research in less developed countries. The original version covered publications up to the end of 1999 and the present updated version incorporates literature up to the end of 2001. This bibliography does not provide an exhaustive list of documents: rather it seeks to present selected highlights of the literature in English that is now available to researchers in this field. Three main areas are covered: substantive findings of research and theoretical developments, research design and methods, and questionnaires.

### **Substantive findings of research and theoretical developments**

Articles describing substantive findings of research selected for this bibliography cover a number of research areas in young people's sexual and reproductive health. The selection of papers is particularly focused on the following topics: young people's sexual behaviour, sexual coercion, dual protection, sexual/reproductive health seeking, quality of care/provider perspectives, and special needs of migrant and refugee youth. A small number of papers on interventions are also included. The following topics have been added to this updated version: abortion, laws and policies affecting youth sexual and reproductive health, and operations research and evaluation of interventions. Items under all topic areas were chosen according to the geographical focus of the study on less-developed regions and countries, the use of appropriate and sound methods, and publication date. New articles were preferred because the situation for young people in many countries can change rapidly. Most were published after 1994.

The papers containing substantive findings in this bibliography are divided into two broad categories: reviews and specific examples. The specific examples examine a particular topic within a given geographical boundary. They range from a qualitative study of teenagers in a school (Eyre *et al.* 1998) to a large-scale survey of military conscripts in Thailand (Nelson *et al.* 1996). The reviews, on the other hand, summarise findings from previous studies, or analyse existing data to focus on particular topics (for example, using Demographic and Health Surveys data from different countries). They may also use existing findings to formulate new theoretical approaches (for example Vanwesenbeek *et al.* 1999). The geographical scope of the reviews is usually wide, often encompassing one or more world regions. Studies of sexual behaviour form the largest part of the bibliography, and these can be divided further into studies based on quantitative data, studies based on qualitative data, and finally, those based on both qualitative and quantitative findings or general reviews. Studies providing a purely descriptive account of behaviour in a particular local context – of which there are now many in existence – have been excluded from the articles added in the update in favour of studies considered to be of more general relevance.

Reviews and specific examples are included in this bibliography for each of the principal topics described. These are listed in Table 1.

**Table 1.**

**Substantive findings: references according to principal topic and type of study**

Topic	Reviews	Specific examples
<b>Sexual behaviour</b> Quantitative studies	AGI 1995 Herdman 1997 McDevitt <i>et al.</i> 1996 Quinn 1996 Senderowitz 1995 UN Population Division 1998	Brabin <i>et al.</i> 1995 Eggleston <i>et al.</i> 2000 Halpérin <i>et al.</i> 1996 Jewkes <i>et al.</i> 2001 Johnson <i>et al.</i> 2001 Konde-Lule <i>et al.</i> 1997 Meekers & Calvès 1999 Minis & Padian 2001 Murray <i>et al.</i> 1998 Nelson <i>et al.</i> 1996 VanLandingham <i>et al.</i> 1995
Qualitative studies	Dowsett <i>et al.</i> 1998 Ingham 1992 UNAIDS 1999 Wellings <i>et al.</i> 2000	Ahlberg <i>et al.</i> 2001 Dowsett <i>et al.</i> 1998 Helitzer Allen <i>et al.</i> 1994 Ingham 1992 Kirkman <i>et al.</i> 2001 Shefer & Foster 2001 Silberschmidt & Rasch 2001 UNAIDS 1999 Zheng <i>et al.</i> 2001
Both qualitative and quantitative	Bledsoe & Cohen 1993 Brown <i>et al.</i> 2001 Caldwell 1999 Jejeebhoy 1998 Khan 2000 Kiragu 2001 Mahler & Rosoff 1998 McCauley & Salter 1995 Parker <i>et al.</i> 1998 Radhakrishna <i>et al.</i> 1997 Rivers & Aggleton 1998 Rivers & Aggleton 1999 SARA/AED/CERPOD 1997 Senderowitz 1997b Varga 2001 Warwick & Aggleton 2001 Zabin & Kiragu 1998	Ankomah & Ford 1994 Cáceres <i>et al.</i> 1997 Dare & Cleland 1995 Eggleston <i>et al.</i> 1999 Görgen <i>et al.</i> 1998 Gupta & Weiss 1995 Hersh <i>et al.</i> 1998
<b>Sexual coercion and violence</b>	Anarfi 1993 De Bruyn 2001 García Moreno & Watts 2000 Gordon & Crehan 199? Gupta & Weiss 1995 Heise <i>et al.</i> 1999; Heise 1995 Jewkes <i>et al.</i> 2000 Maman <i>et al.</i> 2000 McCauley & Salter 1995 Ouattara <i>et al.</i> 1998 Schensul <i>et al.</i> 1993 Singhanetra-Renard 1997	Ajuwon <i>et al.</i> 2001 Benjamin 1996 Cáceres <i>et al.</i> 2000 Holland <i>et al.</i> 1992 Kippax <i>et al.</i> 1990 Wood <i>et al.</i> 1998
<b>Dual protection</b>	Anonymous Berer 1997 Blanc & Way 1998 Blaney 1994 Cates & Stone 1992 Davis & Weller 1999 Elias & Coggins 1996 Liskin <i>et al.</i> 1990 Population Council & FHI 2001 Rivers & Aggleton Rosenberg & Gollub 1992 Sheeran <i>et al.</i> 1999 Steiner & Joanis 1993	Coggins <i>et al.</i> 2000 Green <i>et al.</i> 2001 Hart <i>et al.</i> 1999 Lindsay <i>et al.</i> 1999 MacPhail & Campbell 2001 Meursing & Sibindi 1995 Riehman <i>et al.</i> 1998 Rivers <i>et al.</i> 1998 Rosenthal <i>et al.</i> 1998 Santelli <i>et al.</i> 1997 Woodsong & Koo 1999

Topic	Reviews	Specific examples
<b>Health seeking and quality of care</b>	Bruce 1990 Dixon Mueller 1993 SARA/AED/CERPOD 1997 Senderowitz 1997a Senderowitz 1997b Senderowitz 1997c Senderowitz 1999 Waszak 1993	Abdool Karim <i>et al.</i> 1992a Abdool Karim <i>et al.</i> 1992b Kim <i>et al.</i> 1997 Miller <i>et al.</i> 1998a
<b>Refugee/migrant youth</b> Refugee youth	Caraël 1997 Gardner & Blackburn 1997 Stanecki & Way 1996 Women's Commission 2000	Gardner & Blackburn 1997 Long 1997 Nduna & Goodyear 1997 UNHCR 1999
Migrant youth	Anarfi 1993 Schensul <i>et al.</i> 1993 Singhanetra-Renard 1997	Benjamin 1996
<b>Law and policy</b>	CRLP 1999a CRLP 1999b CRLP 1999c CRLP 1999d CRLP 2000a CRLP 2000b CRLP 2000c CRLP 2000d CRLP 2001a CRLP 2001b	
<b>Operations research/ interventions</b>	Adamchack <i>et al.</i> 2000 Aral & Peterman 1996 Horizons 2000 Hughes & McCauley 1998 Kirby 2001 McCauley & Salter 1995 Parker <i>et al.</i> 1998 Rosen 2000 Senderowitz 1997c Senderowitz 2000 Varga 2001 Women's Commission 2000	( <i>evaluations of interventions</i> ) Cash <i>et al.</i> 1997 Fine 1988 Kim <i>et al.</i> 2001 Kirby <i>et al.</i> 1994 Mitchell DiCenso <i>et al.</i> 1997 Oakley <i>et al.</i> 1995 Speizer <i>et al.</i> 2001
<b>Abortion</b>	Bankole <i>et al.</i> 1999 Barnett 2000 De Bruyn 2001 Jejeebhoy 1998 Radhakrishna <i>et al.</i> 1997 Rahman <i>et al.</i> 1998 Rogo 1993 Singh & Wulf 1994 United Nations 2001	Ankomah <i>et al.</i> 1997 Bohmer & Kirumira 1997 Palma & Quilodran 1995

Papers on theoretical aspects of young people's sexual behaviour are included in the bibliography. In them, theoretical approaches used in past research are explained and new, more sophisticated frameworks set out. The following have been selected: Bajos 1997; Ferrand & Snijders 1997; Grimley *et al.* 1997; Guizzardi 1997; Ingham 1992; Ingham *et al.* 1996; Ingham & van Zessen 1997; Van Campenhoudt 1997; Van Campenhoudt 1999; Van Campenhoudt & Cohen 1997; Vanwesenbeek *et al.* 1999.

### Research design and methods

Papers in this bibliography on research design and methods form two groups. In the first group are those focusing on methodological issues, ranging from the general (e.g. discussions of quality of

qualitative research (Devers 1999)) to the specific (e.g. how to use focus groups (Hennink & Diamond 1999)). In the second group are examples of studies that have used some of the different methods available. The types of data that are obtained in practice using the different methods can be seen in these examples. Some of the best of the studies identified use more than one method. Studies may mix quantitative methods – for example by collecting cross-section survey data on knowledge, attitudes and behaviours, and also taking serum samples from the participants to assess prevalence of disease in the study population. Other studies use more than one qualitative method, and some studies combine qualitative and quantitative methods. Papers in the bibliography on research design and methods are listed in Table 2, according to their principal focus. Tables 1 and 2 are not mutually exclusive.

**Table 2.**

**Research design and methods: References according to method and focus**

Method	Methodological issues	Example of use of method
<b>General</b>	Aral & Peterman 1996 Devers 1999 Ferry <i>et al.</i> 1995 Fife Schaw & Breakwell 1992 Gillies 1996 Huygens <i>et al.</i> 1996 Jewkes <i>et al.</i> 2000 Patton 1999 Weiss <i>et al.</i> 1996 Warwick & Aggleton 2001 Wight & West 1999	
<b>Combined methods:</b> Quantitative methods	Johnson <i>et al.</i> 2001 Minis & Padian 2001	Bankole <i>et al.</i> 1999 Brabin <i>et al.</i> 1995 Konde-Lule <i>et al.</i> 1997 Nelson <i>et al.</i> 1996 Ray <i>et al.</i> 1998
Qualitative methods	Helitzer Allen <i>et al.</i> 1994	Ahlberg <i>et al.</i> 2001 Dowsett <i>et al.</i> 1998 Eyre <i>et al.</i> 1998 Lear 1995 Mfono 1998 Palma & Quilodran 1995 Schensul <i>et al.</i> 1993 Singhanetra-Renard 1997 Tarr & Aggleton 1999 UNAIDS 1999 Varga 1999 Waldby <i>et al.</i> 1993 Zheng <i>et al.</i> 2001
Both quantitative and qualitative	Adamchack <i>et al.</i> 2000	Ankomah <i>et al.</i> 1997 Ankomah & Ford 1994 Cáceres <i>et al.</i> 1997 Cash <i>et al.</i> 1997 Dare & Cleland 1995 Eggleston <i>et al.</i> 1999 Görge <i>et al.</i> 1993 Görge <i>et al.</i> 1998 Nduna & Goodyear 1997 Ray <i>et al.</i> 1998 SARA/AED/CERPOD 1997 Silberschmidt & Rasch 2001
<b>Surveys</b>	Bowling Eggleston <i>et al.</i> 2000 Ferry <i>et al.</i> 1995	Anarfi 1993 Blanc & Way 1998 Caraël 1995

Method	Methodological issues	Example of use of method
	Fife Schaw & Breakwell 1992 Wight & West 1999	Cáceres <i>et al.</i> 2000 Halpérin <i>et al.</i> 1996 Jewkes <i>et al.</i> 2001 Kim <i>et al.</i> 2001 Lindsay <i>et al.</i> 1999 Meekers & Calvès 1999 Murray <i>et al.</i> 1998 Riehm <i>et al.</i> 1998 Santelli <i>et al.</i> 1997 Singh 1998 Singh & Samara 1996 Speizer <i>et al.</i> 2001 Stanecki & Way 1996 UN Population Division 1998 VanLandingham <i>et al.</i> 1995
<b>Focus group</b>	Hennink & Diamond 1999 Wellings <i>et al.</i> 2000	Coggins <i>et al.</i> 2000 Green <i>et al.</i> 2001 Hart <i>et al.</i> 1999 MacPhail & Campbell 2001 Shefer & Foster 2001 Woodsong & Koo 1999
<b>In-depth interview</b>	Holland <i>et al.</i> 1994 Ingham <i>et al.</i> 1996 Ingham <i>et al.</i> 1999 Wight & West 1999	Berglund <i>et al.</i> 1997 Eyre <i>et al.</i> 1998 Görge <i>et al.</i> 1993 Holland <i>et al.</i> 1994 Holland <i>et al.</i> 1992 Kirkman <i>et al.</i> 2001 Long 1997 Meursing & Sibindi 1995 Meyer-Weitz <i>et al.</i> 1998 Peart <i>et al.</i> 1996 Rosenthal <i>et al.</i> 1998 Wood <i>et al.</i> 1998
<b>Other methods:</b>		
Analysis of records/documents		Mfono 1998
Computer-assisted data collection		Johnson <i>et al.</i> 2001
Diaries		Coxon 1994
Discussion group		Balmer <i>et al.</i> 1997 Bohmer & Kirumira 1997
Field trials of health interventions	Smith & Morrow 1996	Mitchell DiCenso <i>et al.</i> 1997
Free listing		Eyre <i>et al.</i> 1998
Longitudinal survey		Konde-Lule <i>et al.</i> 1997
Memory work		Kippax <i>et al.</i> 1990
Meta-analysis		Sheeran <i>et al.</i> 1999
Mystery client		Abdool Karim <i>et al.</i> 1992b
Narrative research	WHO/ADH 1992	Ajuwon <i>et al.</i> 2001 Nnko & Pool 1997 WHO/ADH 1992
Observation		Kim <i>et al.</i> 1997
Other participant methods	Shah <i>et al.</i> 1999	
Situation analysis	Miller <i>et al.</i> 1998b	Miller <i>et al.</i> 1998a
STD as marker of behaviour	Quinn 1996	

## Questionnaires

Included in this bibliography are a number of questionnaires that have been used in previous studies (Cleland *et al.* 1998; Morris *et al.* 1993; Serbanescu & Morris 1998; UNAIDS 1997; WHO/CREHPA;

ZNFPC) and a “question bank” made up of questions collated from a variety of surveys (Gipson & Mathur 1999). In addition, a protocol for comparative qualitative studies is included that has been used in Europe and Mexico (Ingham *et al.* 1996). This protocol contains a detailed list of topics for use in qualitative data collection.

## **Summary of the bibliography**

Table 3 summarises all items in the collection. The citation is followed by type of methodology, if appropriate, and the topic or topics covered. Studies considered to be of particular interest, because of their high quality and/or interesting results, are marked with an asterisk. Keywords have been assigned to each item to assist in electronic searches. The keywords used are listed in the appendix.

**Table 3.**

**Summary of the bibliography by citation, methodology, and topic, indicating items of particular interest**

Citation	Methodology		Topic ! = principal focus N = secondary focus										Of particular interest	
	Quantitative	Qualitative	Sexual behaviour	Sexual coercion/ violence	Dual protection	Sexual/reproductive health seeking	Quality of care/provider perspectives	Special needs of migrant/refugee youth	Law and policy	Operations research	Abortion	Intervention		
Abdool Karim <i>et al.</i> 1992a		!			N		!							
Abdool Karim <i>et al.</i> 1992b		!				!	!							
Adamchack <i>et al.</i> 2000	!	!							!					*
AGI 1995	!		!											
Ahlberg <i>et al.</i> 2001		!	!											
Ajuwon <i>et al.</i> 2001		!	!	!										
Anarfi 1993	!		!		!					!				
Ankomah & Ford 1994	!	!	!	N	N									
Ankomah <i>et al.</i> 1997	!	!									!			*
Anonymous					!									
Aral & Peterman 1996									!					
Bajos 1997	!	!	!		N									
Balmer <i>et al.</i> 1997		!	!	!							N			
Bankole <i>et al.</i> 1999	!										!			
Barnett 2000											!	N		
Benjamin 1996		!								!				
Berer 1997					!									
Berglund <i>et al.</i> 1997		!	!	N										
Bernard 1995a	!	!												*
Bernard 1995b	!	!												
Blanc & Way 1998	!		!											
Blaney 1994	!	!			!									
Bledsoe & Cohen 1993	!	!	!											
Bohmer & Kirumira 1997		!	!	!		!	!				N			
Bowling	!													
Brabin <i>et al.</i> 1995	!		!											*
Brown <i>et al.</i> 2001			!	N							N			

Citation	Methodology		Topic ! = principal focus N = secondary focus										Of particular interest	
	Quantitative	Qualitative	Sexual behaviour	Sexual coercion/violence	Dual protection	Sexual/reproductive health seeking	Quality of care/provider perspectives	Special needs of migrant/refugee youth	Law and policy	Operations research	Abortion	Intervention		
Bruce 1990	!	!				N	!							
Cáceres <i>et al.</i> 1997	!	!	!	!	!									*
Cáceres <i>et al.</i> 2000	!		N	!										
Caldwell 1999	!	!	!		!									
Caraël 1995	!		!											
Caraël 1997	!		!					!						
Cash <i>et al.</i> 1997	!	!	!											
Cates & Stone 1992	!				!									
Cleland <i>et al.</i> 1998	!		!											
Coggins <i>et al.</i> 2000		!			!									
Coxon 1994		!	!											
CRLP 1999a									!		!			
CRLP 1999b			N	!		!	!		!		!	!		
CRLP 1999c									!		N			
CRLP 1999d			!	!		!	!		!		!	!		
CRLP 2000a			N	!		!	!		!		!			
CRLP 2000b			N	!					!		N	N		*
CRLP 2000c			N	!					!		N	N		*
CRLP 2000d			N	!					!		N	N		*
CRLP 2001a			N	!			N	!	!		N	N		
CRLP 2001b			N	!					!		N	N		*
Dare & Cleland 1995	!	!	!											
Davis & Weller 1999	!				!									
De Bruyn 2001			N	!							!			*
Devers 1999		!												
Dixon Mueller 1993	!	!	!	N		N	!							
Dowsett <i>et al.</i> 1998	N	!	!											*
Eggleston <i>et al.</i> 1999	!	!	!											*
Eggleston <i>et al.</i> 2000	!		!											
Elias & Coggins 1996	!				!									

Citation	Methodology		Topic ! = principal focus N = secondary focus										Of particular interest	
	Quantitative	Qualitative	Sexual behaviour	Sexual coercion/ violence	Dual protection	Sexual/reproductive health seeking	Quality of care/provider perspectives	Special needs of migrant/ refugee youth	Law and policy	Operations research	Abortion	Intervention		
Eyre <i>et al.</i> 1998		!	!	!										*
Ferrand & Snijders 1997			!											*
Ferry <i>et al.</i> 1995	!		N											*
Fife Schaw & Breakwell 1992	!	!	!											
Fine 1988		!	N									!		
García Moreno & Watts 2000			!	!										
Gardner & Blackburn 1997	!	!	N	N		N	N	!			N	N		
Gillies 1996	!	!										!		
Gipson & Mathur 1999	!													
Gordon & Crehan 199?			N	!				!						
Görgen <i>et al.</i> 1993	!	!	!											
Görgen <i>et al.</i> 1998	!	!	!											
Green <i>et al.</i> 2001		!			!									
Grimley <i>et al.</i> 1997			!		!	N								
Guizzardi 1997			!											
Gupta & Weiss 1995	!	!	!	N	N									
Halpérin <i>et al.</i> 1996	!			!										*
Hart <i>et al.</i> 1999		!			!									
Helitzer Allen <i>et al.</i> 1994		!	!											
Heise 1995	!	!		!	N									
Heise <i>et al.</i> 1999	!	!	!	!	N									
Hennink & Diamond 1999		!												
Herdman 1997	!		!											
Hersh <i>et al.</i> 1998	!	!	!									N		
Holland <i>et al.</i> 1992		!	!	!										*
Holland <i>et al.</i> 1994		!												
Horizons 2000										!		!		
Hughes & McCauley 1998	!	!				!	!					!		
Huygens <i>et al.</i> 1996	!	!	!											
Ingham 1992	!	!	!											*

Citation	Methodology		Topic ! = principal focus N = secondary focus										Of particular interest	
	Quantitative	Qualitative	Sexual behaviour	Sexual coercion/ violence	Dual protection	Sexual/reproductive health seeking	Quality of care/provider perspectives	Special needs of migrant/ refugee youth	Law and policy	Operations research	Abortion	Intervention		
Ingham <i>et al.</i> 1996		!	!											*
Ingham & van Zessen 1997		!	!											*
Ingham <i>et al.</i> 1999		!	!											
Jejeebhoy 1998	!	!	!	N		N					N			
Jewkes <i>et al.</i> 2000	!	!		!										*
Jewkes <i>et al.</i> 2001	!		!	!										
Johnson <i>et al.</i> 2001	!		!											
Khan 2000			!	!							!			
Kim <i>et al.</i> 1997		!				N	!							
Kim <i>et al.</i> 2001	!		!			!				!		!		
Kippax <i>et al.</i> 1990		!	!	N										
Kiragu 2001			!									!		
Kirby <i>et al.</i> 1994	!											!		
Kirby 2001												!		
Kirkman <i>et al.</i> 2001		!	!											
Konde-Lule <i>et al.</i> 1997	!		!											
Lear 1995		!	!	N	N									
Lindsay <i>et al.</i> 1999	!		N		!	!								
Liskin <i>et al.</i> 1990	!				!									
Long 1997	N	!		N						!				
MacPhail & Campbell 2001		!	!		!									
Mahler & Rosoff 1998	!		!	N		N								
Maman <i>et al.</i> 2000			N	!										*
McCauley & Salter 1995	!	N	!	!		N	!					!		
McDevitt <i>et al.</i> 1996	!		!											
Meekers & Calvès 1999	!		!		N						N			
Meursing & Sibindi 1995		!	!		!									
Meyer-Weitz <i>et al.</i> 1998		!				!								
Mfono 1998		!				!	!							
Miller K <i>et al.</i> 1998		!					!							

Citation	Methodology		Topic ! = principal focus N = secondary focus										Of particular interest
	Quantitative	Qualitative	Sexual behaviour	Sexual coercion/ violence	Dual protection	Sexual/reproductive health seeking	Quality of care/provider perspectives	Special needs of migrant/ refugee youth	Law and policy	Operations research	Abortion	Intervention	
Miller R <i>et al.</i> 1998		!					!						
Minis & Padian 2001	!		!										
Mitchell DiCenso <i>et al.</i> 1997	!											!	
Morris <i>et al.</i> 1993	!		!										
Murray <i>et al.</i> 1998	!		!										
Nduna & Goodyear 1997	!	!	!	!				!					
Nelson <i>et al.</i> 1996	!		!		!							N	
Nnko & Pool 1997		!	!										
Oakley <i>et al.</i> 1995	!											!	
Ouattara <i>et al.</i> 1998		!	N	!									
Palma & Quilodran 1995		!	!										
Parker <i>et al.</i> 1998	!	!	!									N	
Patton 1999		!											
Peart <i>et al.</i> 1996		!	!	N	!								
Population Council & IFH 2001					!								
Quinn 1996	!		!										
Radhakrishna <i>et al.</i> 1997	!	!	!	!	!	!					!		
Rahman <i>et al.</i> 1998									!		!		
Ray <i>et al.</i> 1998	!	!	!		N								*
Riehman <i>et al.</i> 1998	!				!								
Rivers & Aggleton (a)	!	!	!			!	!	!					
Rivers & Aggleton (b)	!	!	!		!								
Rivers <i>et al.</i> 1998		!	N	N	!								
Rogo 1993	!	!									!		
Rosen 2000												!	
Rosenberg & Gollub 1992	!				!								
Rosenthal <i>et al.</i> 1998		!	!		!								
Santelli <i>et al.</i> 1997	!				!								
SARA/AED/CERPOD 1997	!	!	!	!		!	!						
Schensul <i>et al.</i> 1993	!	!	!		!			N					

Citation	Methodology		Topic										Of particular interest	
	Quantitative	Qualitative	Sexual behaviour	Sexual coercion/ violence	Dual protection	Sexual/reproductive health seeking	Quality of care/provider perspectives	Special needs of migrant/ refugee youth	Law and policy	Operations research	Abortion	Intervention		
Senderowitz 1995	!	N	!			!								
Senderowitz 1997a	!	!				!	!							
Senderowitz 1997b	!	!				!	!							
Senderowitz 1997c	!	!	!			N	N							
Senderowitz 1999	!	!				!	!							
Senderowitz 2000						N	N					!		
Serbanescu & Morris 1998	!													
Shah <i>et al.</i> 1999		!												
Sheeran <i>et al.</i> 1999	!		!		N									
Shefer & Foster 2001		!	!											
Silberschmidt & Rasch 2001		!	!								!			
Singh 1998	!		!								!			
Singh & Samara 1996	!		!											
Singh & Wulf 1994	!										!			
Singhanetra Renard 1997	!	!						!						
Smith & Morrow 1996	!	!										!		*
Speizer <i>et al.</i> 2001	!									!		!		
Stanecki & Way 1996	!							!						
Steiner & Joanis 1993	!				!									
Tarr & Aggleton 1999		!	!		!									*
UN Population Division 1998	!		!											
UNAIDS 1997	!													
UNAIDS 1999		!	!	!	!									*
UNHCR 1999						N	N	!				N		
United Nations 2001									!		!			*
Van Campenhoudt & Cohen 1997			!											
Van Campenhoudt 1997			!											
Van Campenhoudt 1999			!											
VanLandingham <i>et al.</i> 1995	!		!		!									
Vanwesenbeek <i>et al.</i> 1999		!	!	!	!									*

Citation	Methodology		Topic ! = principal focus N = secondary focus										Of particular interest	
	Quantitative	Qualitative	Sexual behaviour	Sexual coercion/violence	Dual protection	Sexual/reproductive health seeking	Quality of care/provider perspectives	Special needs of migrant/refugee youth	Law and policy	Operations research	Abortion	Intervention		
Varga 1999		!	!	!	!									*
Varga 2001			!									N		*
Waldby <i>et al.</i> 1993		!	!		!									
Warwick & Aggleton 2001	!	!	!							!		!		
Waszak 1993	!	!				!	!							
Weiss <i>et al.</i> 1996	!	!	!	!		N	N							
Wellings <i>et al.</i> 2000		!	N											
WHO/ADH 1992		!	!											
WHO/CREHPA	!													
Wight & West 1999	!	!	!											*
Women's Commission 2000			N	!		N		!	!			!		
Wood <i>et al.</i> 1998		!	N	!										
Woodsong & Koo 1999		!	!		!									
Zabin & Kiragu 1998			!			N	N				N	N		
Zheng <i>et al.</i> 2001		!	!					!						
ZNFPC	!													

## **Annotated bibliography**

Abdool Karim Q., Abdool Karim S.S., Preston Whyte E. (1992). Teenagers seeking condoms at family planning services. Part II. A provider's perspective. South African Medical Journal **82**(5): 360-362.

This is a small study highlighting some problems in providing services to young people. Students interviewed 12 female staff members of 12 family planning clinics in Durban, South Africa, to determine staff ability and preparedness to promote condom use among teenagers to prevent the spread of AIDS. The clinic staff were relatively knowledgeable but did not take the opportunity to counsel teenagers about sexually transmitted diseases and AIDS when distributing condoms neither did they counsel them about other contraceptive methods. The staff had a positive attitude toward AIDS education. Family planning personnel considered condoms unreliable contraceptives rather than a means of protecting against HIV infection and few promoted condom use along with a more reliable contraceptive. Constraints on AIDS education in each consultation were large numbers of clients and inadequate facilities. They felt the pamphlets distributed with condoms offered teenagers enough information about condom use. This article accompanies part 1 on clinic users' perspectives.

Abdool Karim Q., Preston-Whyte E., Abdool Karim S.S. (1992). Teenagers seeking condoms at family planning services. Part I. A user's perspective. South African Medical Journal **82**(5): 356-9.

This study assesses accessibility of condoms to teenagers at selected family planning services in Durban. Twelve randomly selected clinics in Durban were visited by each of four teenage fieldworkers. During visits, the fieldworkers' experiences were recorded in detailed notes, which were subsequently analysed for content. The fieldworkers experienced difficulty in locating a few of the clinics and some were embarrassed by the reception they were given. When condoms were available, they were distributed in a setting that lacked privacy. Information on how to use condoms was given only in pamphlets if at all. Overall, the study concludes that it was difficult for teenagers to obtain condoms from clinics providing family planning services in Durban. This article accompanies part 2 on providers' perspectives.

Adamchack S., Bond K., MacLaren L., *et al.* (2000). A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs. Washington, DC: FOCUS on Young Adults.

This book provides a detailed guide to monitoring and evaluation (M&E) of youth programmes. In Part 1, the chapters consider the following topics in turn: concerns about monitoring and evaluating programmes, framework for programme M&E, developing an M&E plan, indicators, evaluation designs to assess programme impact, sampling, data collection and M&E work plan, analysing M&E data, using and disseminating results, tables of youth reproductive health indicators. Appendices are provided which include sampling schemes for core data collection strategies, and how to calculate sample size requirements. Part 2 concerns instruments for M&E: checklists, tally sheets, reporting forms, questionnaires, composite indices, inventory of facilities and services, observation guide for counselling and clinical procedures, interview guide for staff providing reproductive health services, guide for client exit interview, questionnaire for debriefing mystery clients, community questionnaire, comprehensive youth survey, focus group discussion guide for in-school youth, assessing coalition effectiveness worksheet, parents of youth questionnaire. Other useful tools and guides are available in addition to this one on the FOCUS on Young Adults website.

AGI (1995). Women, families and the future: Sexual relationships and marriage worldwide. New York: Alan Guttmacher Institute: 6 pages.

This is a six-page fact sheet with information on sex behaviour and the timing of sexual initiation, marriage, and first births in 39 developing countries and the US. Data are mainly from the Demographic and Health Surveys. The authors point out that timing of sexual relationships and marriage is important because prolonging the period between puberty and marriage increases the likelihood that young women will have premarital sexual relationships, with attendant risks of pregnancy, unsafe/illegal abortion, sexually transmitted diseases and HIV/AIDS. Later marriage ages allow women to prolong their education, delay first births, and accumulate employment experience. The fact sheet contains a table which shows timing of marriage and first birth among young women in the 40 countries and a table which presents data on the sexual behaviour of single women in 28 countries in sub-Saharan Africa and Latin America. Conclusions drawn from the data in these two tables are summarised for the sub-Saharan region as well as for Latin America, North Africa and the Middle East, and Asia. Program and policy implications of these findings are discussed.

Ahlberg B.M., Jylkäs E., Krantz I. (2001). Gendered construction of sexual risks: implications for safer sex among young people in Kenya and Sweden. Reproductive Health Matters **9**(17): 26-36.

Perceptions of risk and sexual practices among young people in Kenya and Sweden are compared in this study. Questions generated in discussions were used in Kenya, and in Sweden in-depth interviews and focus group discussions were held. In both countries, topics were the body, perception of sexual risk and sexual practices. Level of knowledge was dramatically lower in Kenya than in Sweden. Young people in Kenya are not provided with adequate information and services: they use the "safe period" as their protection and pregnancy is an overriding concern. Communication within the couple and lack of condom use are problems in both countries. Even where there is access to information and preventive services, they may not be used optimally. In both countries, boys had more sexual freedom and girls were more controlled through labelling and rumours. Girls were assigned responsibility for safer sex.

Ajuwon A.J., Akin-Jimoh I., Olley B.O., Akintola O. (2001). Perceptions of sexual coercion: learning from young people in Ibadan, Nigeria. Reproductive Health Matters 9(17): 128-136.

This study used narrative research method to examine sexual coercion from the perspectives of 77 young people aged 14-21 in Ibadan, Nigeria. The behaviours perceived to be coercive, and the contexts in which they occur were explored in four workshops. All four identified similar coercive behaviours and developed narratives of the events that typically lead up to them. Behaviours included rape, unwanted touching, incest, assault, verbal abuse, threats, unwanted kissing, forced exposure to pornographic films, use of drugs for sedation, and traditional charms for seduction, and insistence on abortion if unwanted pregnancy occurs. Perpetrators included acquaintances, boyfriends, neighbours, parents and relatives. The narratives revealed the inability of young people to communicate effectively with each other and resolve differences.

Anarfi J.K. (1993). Sexuality, migration and AIDS in Ghana - a socio-behavioural study. Health Transition Review 3: 45-67.

This paper describes results of a 1991 survey in Ghana, in which 1360 men and women were interviewed to examine risk factors associated with migration. The study is not specifically about young people, but contains relevant information. The survey examines attitudes towards virginity, age at first sex, sexual activity, extramarital relations, and types of migration. Most respondents believed that women and daughters should be virgins when they marry but only 10% of males and 13% of females were virgins at marriage. Northern Tribes had the highest proportion of virgins at marriage (25%). Urban people tended to experience first intercourse earlier than rural people (earliest ages, 8 years vs. 11 years). Christians and people with no religion were more sexually active at younger ages than other religions (earliest age, 8 years vs. 13-19 years). About 66% of ever-married males and 50% of ever-married females have had at least two sexual partners. Sixty-seven percent of men said that it was common for men to have extramarital affairs when their wives were breastfeeding. Most migrants (57.5%) had sexual intercourse in their migration in the last month. Sixteen percent of internal migrants and 42% of international migrants had at least two sexual partners. 66% of migrants did not use condoms. About 90% and 75%, respectively, believed that having sexual intercourse with a complete stranger is bad. Most respondents knew what behaviours place people at risk for AIDS. People with AIDS, especially women, were stigmatised.

Ankomah A., Aloo Obunga C., Chu M., Manlagnit A. (1997). Unsafe abortions: Methods used and characteristics of patients attending hospitals in Nairobi, Lima, and Manila. Health Care for Women International 18(1): 43-53.

Women treated for complications of induced abortion were studied in three countries. The study used structured interviews of 626 abortion patients from five hospitals in Nairobi (Kenya), Lima (Peru), and Manila (Philippines) plus 24 in-depth interviews with doctors, nurses, social scientists, officials, and community leaders. Two focus group discussions were conducted per country with abortion patients. The proportion under 25 years old was 26% in Manila, 45% in Lima, and 91% in Nairobi. Eighty-four percent of abortion patients in Nairobi were single compared with 77% in Manila and 21% in Lima; 77% of women in Nairobi had no children compared with 29% in Lima and 11% in Manila. In general, Nairobi abortion seekers tended to be young women who migrated to the city and were concerned pregnancy would impede their social mobility. In Lima and Manila, abortion was sought to limit births within union, generally for financial reasons. Eighty percent of Kenyan women, 65% of Manila women, and 48% of those in Lima reported never-use of contraception. When presented with 11 scenarios that might justify an abortion, the only indication the majority in all three cities supported was pregnancy resulting from rape. Women reported use of abortifacient agents such as livestock droppings, chemicals and detergents, herbal medicines, and overdoses of over-the-counter medications, as well as insertion of sharp objects into the uterus. Ninety-eight percent of Kenyan respondents compared with 36% in Peru and 24% in the Philippines claimed illegal abortion was common; 92%, 75%, and 35%, respectively, were aware of at least one woman who died after an unsafe abortion. All of the women in Kenya and 89% in the Philippines reported it was difficult or very difficult to obtain an abortion; most were obtained through a secret referral system and involved unsanitary conditions.

Ankomah A. & Ford N. (1994). Sexual exchange: Understanding pre-marital heterosexual relationships in urban Ghana. In: Aggleton P., Davies P., Hart G. (Eds.) AIDS: Foundations for the Future. London, UK: Taylor & Francis.

Premarital sexual behaviour and partner changes in urban Ghana are examined in this study. The authors review social exchange theory and note that sexual exchange is becoming increasingly popular in modern Ghana because of gender inequalities in access to power and resources. Methodology consists of a quantitative survey (random sample of 400 single women 18-25 years old), 39 in-depth interviews with men and 39 with women, and six focus groups, three each with men and women. The respondents' sex behaviour is summarised in terms of age at first sexual intercourse (42% before age 16), current number of sexual partners (63% of the sexually experienced had only one partner), and duration of sexual relationships (median 13 months). To examine relationships involving material gain, general views on exchange principles within relationships are examined - most women and men consider this natural and are consciously aware of it. This is then used to explore respondents' attitudes towards the material gain that characterised their own sexual relationships. Traditionalist versus revisionist views of premarital partner sharing are contrasted, and it is noted that male polygyny was generally acceptable if the women's material needs were not jeopardised. Sexual relationships that ultimately did not result in material gain are then considered (those in which the men reneged on their payments). By their responses, women could be classified as immediate exchange strategists, who switched partners or adopted multiple partnerships to improve their situation, or as deferred exchange strategists, who continued the relationship in the hope that things would improve. Finally, economic or normative ways of changing the pattern of transactional sex to reduce the risk of HIV infection are discussed.

Anonymous Dual protection: Reappraising the condom as contraception (Background paper).

This background paper provides a useful summary of issues in dual protection. The paper describes the two meanings of dual protection. In family planning, dual protection means simultaneous use of two methods, while in HIV prevention, dual protection may mean "single method dual purpose". Contraceptive effectiveness versus efficacy is discussed. Finally, methods for dual protection are considered.

Aral S.O. & Peterman T.A. (1996). Measuring outcomes of behavioural interventions for STD/HIV prevention. International Journal of STD and AIDS 7(Suppl 2): 30-38.

The need for outcome measures of behavioural STD/HIV interventions is the subject of this paper, but many of the issues also apply to interventions research more broadly. The authors present a structured overview of the major challenges facing the behavioural intervention field today, especially as they apply to STD/HIV prevention. Outcome measures are essential for intervention research, program evaluation, and surveillance. The implications of using a particular outcome measure for the conclusions and interpretation to be deduced from the findings may differ, depending on whether it is used in the context of intervention research, program evaluation, or surveillance. Outcomes may be measured at the individual or population level. The authors analyse various aspects of the selection, definition, and empirical specification of outcome measures associated with STD/HIV prevention-related behavioural interventions and come to three main conclusions about choice of outcome measures. The first priority is to identify and define the outcome of interest, both conceptually and operationally. The researchers need to consider carefully the implications of context (surveillance, program evaluation, and intervention research) and level of measurement (individual vs. population). The proper choice of the outcome of interest is more important than issues of measurement error. Second, researchers should focus carefully on the issue of the use of surrogate measures (e.g. behavioural outcomes as surrogates for biomedical outcomes of interest). They should clearly state all assumptions made in choosing a particular surrogate outcome. Third, consideration of context is very important when choosing outcome measures. Each context (surveillance vs. program evaluation vs. intervention research) implies a distinct set of strengths and weaknesses for each possible outcome of interest.

Bajos N. (1997). Social factors and the process of risk construction in HIV sexual transmission. AIDS Care 9(2): 227-237.

The theoretical aspects of "risk" are examined in detail here. The paper refers to existing qualitative and quantitative studies for illustration. Different approaches used to analyse the process of risk construction in terms of HIV transmission are reviewed. Individualistic approaches focus on understanding how individual risk representation is constructed. The paper then looks at risk as a social construction, where it is considered that the process of risk construction occurs in relation to other people and is affected by social context. This constructivist research can help explain why some people do not protect themselves, for example because of marginalization processes and gender roles. It also shows why preventive behaviour may differ according to type of partner.

Balmer D.H., Gikundi E., Billingsley M.C., *et al.* (1997). Adolescent knowledge, values, and coping strategies: Implications for health in sub-Saharan Africa. Journal of Adolescent Health **21**(1): 33-38.

This study investigated the experiences and knowledge of adolescents in Nairobi, Kenya to understand how the decisions they make affect their health. Data were collected from discussion groups. Two hundred and sixteen community centre attendees aged from 12-22 years (equally divided between males and females) who lived in lower socio-economic areas were recruited. The youth were assigned to age-delimited groups of 12 and met over a period of six months. An equal number of groups were all male, all female, and mixed. The educational distribution of the participants varied according to age and was normal for Nairobi. Each group met with a qualified counsellor who facilitated discussion. The minutes of the group meetings provided qualitative data. During the first six weeks of meetings, the facilitators led the groups through a series of exercises to create an atmosphere in which the youth felt free to express themselves. During the 20-week second stage, an open agenda was used, and the facilitators restricted their role to clarifying issues and resolving conflicts. The topics, which were ranked according to the percentage of time they consumed, included (in order): emerging sexuality, drugs, alcohol, pregnancy, rape (many of the girls were victims and some of the boys were perpetrators), suicide, marriage, religion, abortion, sexually transmitted diseases/AIDS, parents, contraceptives, money, masturbation, lying, politics, language, and leisure/sports. Values expressed in order of importance were parental love, education, honesty, employment, religion, money, personal freedom, friendship, beauty, marriage, and politics. Coping strategies were use of drugs, stealing, masturbation, alcohol, providing sex for favours, non-cooperation, lying, secret language, clubs, silence, religion, and exercise/sports.

Bankole A., Singh S., Haas T. (1999). Characteristics of women who obtain induced abortion: a worldwide review. International Family Planning Perspectives **25**(2): 68-77.

This study analyzed characteristics of women who obtained induced abortions. Data were obtained from national statistics, ad hoc surveys, and hospital reports. Statistical data were provided on the percentage distribution of abortions by age for the most recent year (1981-96) for 56 countries. Countries are grouped by level of reliability of data. Findings indicate that the highest number of abortions occurred among women 20-24 years old and 25-29 years old. The proportion of abortions among those under 20 years old was under 10% in 21 countries, 10-20% in 25 countries, and 20% or higher in nine countries. Young women were a dominant user group in some countries, such as Nigeria, Cuba, Bulgaria, Estonia, Hungary, Romania, Russia, and the US. Young women may be a large proportion hospitalized for complications, such as in Lusaka, Zambia. Abortion ratios rose with age in most countries. Abortion ratios by age exhibited a U-shaped pattern. Compared to unmarried women, married women had a higher number of abortions in developed countries. Fifteen countries had higher unmarried abortion ratios than married ratios. Distribution by parity varied widely by country. More than 50% of abortions occurred among women with at least one child. Abortions varied by ethnicity in some countries. Abortions tended to be higher among educated women, but the education impact in some countries varied by age.

Barnett B. (2000). Better services can reduce abortion risks. Network **20**(3).

This short article summarises the issues around abortion for young people, particularly in countries where abortion is illegal. Consequences of unsafe abortions are summarised. Provision of contraception services and postabortion care are discussed.

Benjamin J.A. (1996). AIDS prevention for refugees. The case of Rwandans in Tanzania. AidsCaptions **3**(2): 4-9.

This paper describes the case study of the Benaco refugee camp in Tanzania. The particular needs of young people are addressed. The civil war in Rwanda in 1994 led to thousands of refugees fleeing to Tanzania and Zaire. Within days, the population of the Benaco refugee camp grew to more than 250,000, making it the second largest city in Tanzania. HIV infection rates in some sectors of the Rwandan population had been among the highest observed in Africa and high levels remained among the refugees from Rwanda. Lessons learned from the experience of this camp are described and recommendations made for providing reproductive and sexual health care to refugees.

Berer M. (1997). Dual protection: Making sex safer for women. In: Ravindran T.K.S., Berer M., Cottingham J. (Eds.) Beyond Acceptability: Users' perspectives on contraception. London: Reproductive Health Matters for the World Health Organization, pp. 109-21.

This article summarises the issues involved in dual protection, and uses data from existing studies for illustration. It looks at the problems of promoting dual protection, discusses who needs dual protection, the extent of risk, dual protection methods, and users' perceptions of risk. The paper discusses condom use and points out that despite the advantages of a method under women's control, female condoms are even less promoted or available than male condoms. The limited data on acceptability, use, and effectiveness of dual protection methods imply that intensive, costly, large-scale public health

investment is required to achieve significant reductions in unwanted pregnancies and infections. Campaigns in all world regions have shown that men and women at risk are willing to use condoms and other means of dual protection when client counselling, health worker training, and support for negotiations with partners are available. The paper concludes with a discussion of implications for policies and services.

Berglund S., Liljestrand J., Marin F.M., *et al.* (1997). The background of adolescent pregnancies in Nicaragua: A qualitative approach. *Social Science and Medicine* **44**(1): 1-12.

This qualitative study uses in-depth interviews with 10 teenage girls, five adult women, five adult men, and two focus groups of 12 teenage girls. The interviews provide rich data and are used to try to elucidate the contexts in which young women become pregnant in Nicaragua. Use of a qualitative approach allows relatively complex explanatory theories to be developed, which are discussed in the article. Unwanted pregnancy was overwhelmingly associated with absent fathers, family difficulties, problematic stepfather relations, poor mother-daughter communication, economic dependence, romantic illusions, needs for emotional affection, and a lack of alternative opportunities. The paper discusses machismo and contraceptive use, and the influence of the Catholic Church.

Bernard H.R. (1995). *Research Methods in Anthropology: Qualitative and quantitative approaches*. Walnut Creek, California: AltaMira Press.

This textbook contains comprehensive information about qualitative and quantitative social science research. Chapters examine the following topics: cultural anthropology and social science; the foundations of social research; anthropology and research design; sampling; choosing research problems, sites, and methods; the literature search; participant observation; informants; field notes: how to take, code and manage them; unstructured and semi-structured interviewing; questionnaires and survey research; scales and scaling; direct, reactive observation; unobtrusive observation; analysis of qualitative data; coding and codebooks for quantitative data; univariate statistics: describing a variable; bivariate statistics: testing relationships; multivariate analysis.

Bernard H.R. (1995). Sampling, pp. 71-101 in *Research Methods in Anthropology: Qualitative and quantitative approaches*. Walnut Creek, California: AltaMira Press.

This book chapter gives a step-by-step guide to issues in sampling, both in qualitative and quantitative research. It looks at why samples are taken and the types of samples that exist, then goes on to review probability samples, sample size, sampling theory, sample size in relation to population size, measurement of non-dichotomous variables, sampling frames, simple random samples, systematic random sampling, periodicity and sampling, sampling from a telephone book, stratified sampling, disproportionate sampling, weighting results, cluster sampling and complex sampling designs, maximising between-group variance, non-probability sampling (quota sampling, purposive sampling, convenience sampling, snowball sampling), probability proportionate to size, and finally, sampling in the field.

Blanc A.K. & Way A.A. (1998). Sexual behaviour and contraceptive knowledge and use among adolescents in developing countries. *Studies in Family Planning* **29**(2): 106-16.

This article presents an analysis of Demographic and Health Survey data from developing countries. The emphasis is on women aged 15-19, although data for older women are also included. Topics include sex behaviour and marriage; contraceptive knowledge/usage; contraceptive usage at first intercourse; and contraceptive failure, switching, and discontinuation. Tables illustrate 1) the percentage of all 15-19 year olds who have ever had sex and who have ever married in 37 DHS countries; 2) the percentage of those aged 20-24 and of women aged 40-44 who first married and first had sex by age 18 in 36 DHS countries; 3) the percentage of women aged 15-19 and 20-49 who know any contraceptive method by marital and sexual activity status in 37 DHS countries; 4) the percentage of women aged 15-19 and 20-49 currently using contraception by marital status and sexual activity status in 43 DHS countries; 5) the percentage of people who used contraception at first intercourse by country, age, sex, and marital status in 6 countries; and 6) 12-month life-table gross contraceptive discontinuation rates by country and age at start of use, by type of discontinuation. Young women's sexual behaviour and contraceptive knowledge/usage vary widely across and within regions, but overall patterns show that the gap between first intercourse and marriage has increased. Levels of contraceptive knowledge are high, and usage is higher but less successful among young unmarried women than among their married counterparts.

Blaney C.L. (1994). Dual-use prevents pregnancy, STDs. *Network* **May**: 18-21.

This brief article reviews the costs and benefits of two-method protection. First, the effectiveness of dual methods is reviewed, then the problems of convincing family planning clients to use two methods are discussed. Financial costs and feasibility of using two methods are considered.

Bledsoe C.H. & Cohen B. (1993). Social Dynamics of Adolescent Fertility in Sub-Saharan Africa. Washington DC: National Academy Press.

This book provides a thorough account of various aspects of young women's childbearing in sub-Saharan Africa. It addresses concerns that fertility in this group may be increasing. Using quantitative and qualitative data, the authors show that the most significant change in sub-Saharan Africa may not be a rise in overall adolescent fertility rates, but rather an increase in childbearing among women who do not appear to be married. The investigation draws from studies of areas of change in contemporary African life: education, health, social stratification, politics, and employment. Demographic and Health Surveys data are used to show the levels and trends in adolescent fertility. Chapters examine marriage, the social context of fertility and parenthood, the effects of early childbearing on education, work, and training. The report concludes that adolescent fertility outside marriage is only one of many changes affecting the lives of African women. Other important trends include rises in formal education, informal training, urbanisation, and the use of contraception. These trends are part of a social context that creates new opportunities for women and increases social opposition to adolescent fertility outside an approved relationship.

Bohmer L. & Kirumira E. (1997). Access to reproductive health services: Participatory research with Ugandan adolescents: Makrere University Child Health and Development Centre: 78 pages.

In this study, discussion groups were formed of young people and the meetings were recorded and transcribed over a period of three and a half months. The authors emphasise the importance both of establishing a rapport with the group members, and of the follow-up that was possible because of the time-scale of the data collection. The idea was to allow the young people to set their own agenda for discussion rather than having it imposed on them by the researchers, in order to find out what their real concerns were. The young people discussed a broad range of issues, but sexuality was the most salient topic. The 78-page report gives a very detailed account of the topics discussed, with quotes.

Bowling A. Questionnaire design, pp. 242-269 in Research Methods in Health: Investigating health and health services. Buckingham, UK: Open University Press,

A step-by-step guide to questionnaire design and implementation. This book chapter begins with information on planning a questionnaire-based study, and piloting ideas and topics. Questionnaire layout and the form of covering letters are reviewed. Advice on question form, order and wording is then given (response formats, open questions, closed questions, forms and prompts, form and under-reporting, form and knowledge, form and response sets). The next section concerns question items, batteries and scales. Different scales are described (single scale scores, Thurstone scale, Likert scale, Guttman scale, semantic-differential scale, other methods). Rules for order and wording of question are then presented. Examples are given throughout, and potential problems discussed.

Brabin L., Kemp J., Obunge O.K., *et al.* (1995). Reproductive tract infections and abortion among adolescent girls in rural Nigeria. Lancet **345**(8945): 300-4.

This study in a rural area of south-east Nigeria used a combination of structured interviews and medical examination to collect baseline data on reproductive tract infections and sexual health among unmarried 12-19 year old women. Data were also collected from older women because of local unacceptability of a study only of teenagers. Four hundred and fifty-eight teenagers took part (93% of the eligible population of the study area). The collection both of data on sexual behaviour and on medical status provides a fuller picture of sexual health, and allows better assessment of health care needs of the group. The study obtained baseline demographic, clinical, and microbiological data on reproductive tract infections and induced abortion. Forty-four percent of those under 17 and 80.1% aged 17-19 years were sexually active and at least 24% had undergone an induced abortion. Only 5% had ever used a modern contraceptive. Vaginal discharge was reported by 82%, though few sought treatment. Ninety-four percent of sexually active 12-19 year olds and 98% of sexually active women 20 years old or over had a gynaecological exam and were screened for reproductive tract infections. Of those aged less than 17, 20% had symptomatic candida and 11% trichomonas infections. Among those aged 17-19 years, chlamydia was detected in 11%, and symptomatic candidosis in 26%; this was the group most likely to have any infection (44%). Forty-two percent of sexually active adolescents had experienced either an abortion or a sexually transmitted disease. Syphilis was the only infection for which the incidence clearly increased with age.

Brown A., Jejeebhoy S., Shah I., Yount K.M. (2001). Sexual relations among young people in developing countries: evidence from WHO case studies. Occasional Paper, World Health Organization, Department of Reproductive Health and Research.

This paper reviews a number of studies conducted in poorer countries worldwide. The studies covered a variety of topics in the broad area of young people's sexual and reproductive health. Topics include the

context and nature of sexual relationships among young people (sexual debut, partners, coercion), the consequences of unsafe sexual activity (STDs, unwanted pregnancy, abortion, family support following an unplanned pregnancy), informed choices among youth and the content and sources of information, and gender imbalances influencing risky sexual behaviour. The report concludes with a summary and recommendations for programmes and for future research.

Bruce J. (1990). Fundamental elements of the quality of care: A simple framework. Studies in Family Planning 21(2): 61-91.

This paper is the basic background text on quality of care. It reviews what quality means and how high quality might be achieved. A framework for analysing quality of family planning services is proposed. The framework is made up of six parts: 1) choice of methods; 2) information given to clients; 3) technical competence; 4) interpersonal relations; 5) follow-up and continuity mechanisms; and 6) the appropriate constellation of services. Use of the framework as an analytical and practical tool is discussed. Each element is discussed, with data from existing studies used to illustrate points made.

Cáceres C.F., Marín B.V., Hudes E.S. (2000). Sexual coercion among youth and young adults in Lima, Peru. Journal of Adolescent Health 27(361-367).

Lifetime sexual coercion and that at first sexual experience were investigated among young adults in Lima, Peru. The sample in this study consisted of 629 sexually active young people drawn from representative samples of 611 16-17 year olds, and 607 18-30 year olds. Almost half the women and a quarter of the men in the study reported sexual coercion. Multiple logistic regression analyses revealed that those coerced at heterosexual initiation reported more lifetime sexually transmitted diseases and a lower age at first coitus than those not reporting coercion. Men reporting coercion at heterosexual initiation reported a lower number of lifetime heterosexual partners and less sexual knowledge than men not coerced. The authors conclude that coercion at initiation of heterosexual sex is a marker for subsequent riskier sexual career for both sexes, and is also associated with future homosexual experiences among men.

Cáceres C.F., Marín B.V., Hudes E.S., *et al.* (1997). Young people and the structure of sexual risks in Lima. AIDS 11(1): S67-S77.

The psychosocial factors associated with sexually transmitted diseases (STDs) and unintended pregnancy were investigated in a cross-sectional analysis (the Youth Sexual Cultures Study) involving 611 young men and women 16 and 17 years old and 607 young adults 19-30 years old from Lima, Peru. Teenage respondents were drawn from among those registering for military service, while young adults were recruited from those seeking work or study permits. The subjects filled out a self-administered questionnaire, and a sub-sample (N=858) provided blood specimens which were analysed for HIV-1, hepatitis B and syphilis. A preliminary qualitative study consisting of 20 focus groups and 40 in-depth interviews was used in questionnaire design, and the interpretation of the findings. Thirty-four percent of adolescents and 75% of young adults were sexually experienced. Of these, 33% reported paid sex and 35% had experienced sexual coercion. Only 11% of sexually active respondents used condoms consistently. Twenty-two percent of the heterosexually active reported an unplanned pregnancy in self or partner and 18% gave a history of STD symptoms or diagnoses. Analysis of serum specimens revealed incidences of 0.2% for human immunodeficiency virus, 6.7% for hepatitis B virus, and 1.5% for syphilis. Multiple logistic regression, controlled for age, sex, and socio-economic status, identified the following significant correlates of past or present STDs and unintended pregnancy: a perception of social norms as restricting condom use to casual sex, older age, sex combined with alcohol and drug use, a history of having been paid for sex or sexual coercion, and, among females only, first intercourse at a young age.

Caldwell J. (1999). Reasons for limited sexual behavioural change in the sub-Saharan African AIDS epidemic, and possible future intervention strategies. In: Caldwell J., Caldwell P., Anarfi J., *et al.* (Eds.) Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries. Canberra, Australia: Health Transition Centre, National Centre for Epidemiology and Population Health, Australian National University, pp. 241-256.

Drawing from existing studies, obstacles to sexual behaviour change in the African AIDS epidemic are identified. This book chapter provides an overview of the issues. Limitations to existing interventions and possible new interventions are then discussed. Obstacles to behavioural change are identified as the adherence to the present sexual culture; the refusal of leaders to recognise or come to terms with the situation; the sanguine acceptance of death; the silence about the epidemic and the reasons for this; and the limited number of relationships in which condoms are acceptable.

Caraël M. (1995). Sexual behaviour. In: Cleland J. & Ferry B. (Eds.) Sexual Behaviour and AIDS in the Developing World. London: Taylor & Francis.

Results from the WHO/GPA surveys on sexual behaviour are presented in this book chapter. Quantitative descriptive data are given for a number of different less-developed countries in Africa, Asia, and Latin America. The first section concentrates on young people: initiation of sexual activity, sexual experience, marriage, premarital sexual activity, and virginity. The roles of education and other sociodemographic variables are considered. The second section, which is not specifically about young people, deals with sex within and outside regular partnerships and commercial sex. The author notes that no attempt is made to assess underlying values and subjective meanings, but that the findings presented meet the need to provide descriptions of sexual behaviours, identify target groups, to monitor changes over time, and to evaluate the effectiveness of interventions. Findings are discussed with reference to previous knowledge of the countries concerned.

Caraël M. (1997). Urban-rural differentials in HIV / STDs and sexual behaviour. In: Herdt G. (Ed.) Sexual Cultures and Migration in the Era of AIDS: Anthropological and demographic perspectives. Oxford, UK: Oxford University Press, pp. 107-126.

The HIV/AIDS pandemic was initially centred in urban locations. Rural prevalence of HIV was assumed to be generally much lower, but recent studies show that several types of HIV epidemics are probably co-occurring across different groups in different areas, even within the same country. In this paper, the following topics are discussed: HIV seroprevalence in rural and urban areas, factors which influence the level and distribution of HIV infection (timing and dynamic of the HIV epidemic, behavioural and related factors that facilitate HIV circulation between networks, structural patterns in behaviours), and sexual behaviour and type of residence (premarital sex, sex outside regular partnerships, non-cohabiting partnerships, commercial sex). The growing evidence on HIV and STD seroprevalence suggests that a large urban-rural differential in HIV seroprevalence levels is typical of only a few countries. Gender, marital status, age, and some other demographic correlates examined in the WHO/GPA surveys were strongly correlated with sexual behaviours in all populations considered, although the strength of the associations varied considerably between locations.

Cash K., Sanguansermisri J., Busayawong W., Chuamanochan P. (1997). AIDS prevention through peer education for northern Thai single migratory factory workers. Washington DC: International Center for Research on Women, Women and AIDS Research Program.

This report describes an intervention to develop and implement a peer AIDS education program for single-sex groups and mixed-sex groups among migrants who worked as unskilled labourers in four factories in Chiang Mai City, Thailand. The findings of a study to assess the effectiveness of the intervention are presented. Qualitative and quantitative data were obtained from focus groups, in-depth interviews, and interviews before and after the intervention. Participants included females and males aged 15-25 years, educated to grade 6. Phase I was conducted during 1992-93. It demonstrated that peer education combined with culturally- and age-appropriate materials was an effective means of positively influencing women's knowledge, attitudes, beliefs, and behavioural intentions associated with AIDS prevention. Phase II tested the peer education model among female factory workers. The assessment focused on sexuality and sexual behaviour as it related to gender roles, social norms, and partner communication. The authors conclude that communication among a variety of persons on HIV/AIDS prevention can be enhanced by youth peer education programs. In the mixed group, both sexes learned to identify traditional gender views that interfere with the practice of safe sex. Mixed sex groups worked best when peer leaders and participants knew each other and when couples were included. Many had experienced an AIDS death or illness of a friend or relative since Phase I.

Cates W. & Stone K.M. (1992). Family planning, sexually transmitted diseases and contraceptive choice: A literature update - parts I & II. Family Planning Perspectives 24(3): 75-84; 122-128.

Part 1 and Part 2 together describe the effects of various contraceptive methods on both pregnancy and sexually transmitted diseases. Part 1 begins with a description of similarities and differences between STDs and unplanned pregnancy, and the effects of STDs on family planning. The male and female condom are then described. Part 2 reviews the effects on risks of upper reproductive tract infections of oral contraceptives, the IUD, tubal sterilisation and abortion. These are interpreted in the light of contraceptive "trade-offs" for individual couples, for communities, and for policymakers. With the method choices available couples have to trade off the contraceptive effectiveness of sterilisation, pills, implants, or IUDs, with the relatively high infection prevention of condoms and spermicides. For many women, depending on the cultural norms, there is no choice because they cannot negotiate use of any contraceptive or barrier method.

Cleland J., Konings E., Anarfi J. (1998). Looking deeper into the HIV epidemic: A questionnaire for tracing sexual networks. Geneva: UNAIDS.

Insights into sexual networks will increase understanding of the HIV epidemic. This questionnaire is designed to provide information on these networks. An introduction explains the rationale for this

questionnaire, and gives basic information about its use. Questions are asked on background characteristics, including age at first sex and first marriage, then relationship attributes are explored: type of relationship, duration, living arrangement, frequency of sex, use of condoms, place of first sex, duration of relationship before first sex, ongoing or ended relation, exchange of money. Partner characteristics are then requested: gender, age, education, ethnic group, marital status, and number of other sexual partners. Finally, there is a section on STDs and health issues.

Coggins C., Blanchard K., Friedland B. (2000). Men's attitudes towards a potential vaginal microbicide in Zimbabwe, Mexico and the USA. Reproductive Health Matters 8(15): 132-141.

Vaginal microbicides are being developed in an attempt to expand women's and men's options for protecting themselves against HIV and other sexually transmitted infections. Taking account of men's attitudes during product development and introduction could increase the likelihood that products are acceptable and used. To capture the perspectives of urban and rural men from a range of cultural settings, the authors conducted focus group discussions with taxi drivers and farmers in Zimbabwe, Mexico, and the USA. These explored HIV/sexually transmitted disease risk perception and prevention strategies, desirable characteristics of vaginal products and of a microbicide, and attitudes towards use of a potential product. Men were generally supportive of the idea of a microbicide; urban men were somewhat more supportive than rural men. Most thought microbicides would be preferable to condoms but many raised concerns about potential side effects. The men wanted these products to be as inexpensive and readily available as condoms, and differed as to whether a woman should have permission from her partner to use it. For microbicides to be widely used, the men thought they must not only be safe and effective, but should also have no negative effect on sexual pleasure. Further research is needed on definitions of pleasurable sex and the implications for microbicide formulation, as well as on partner communication about sexuality and prevention of infection. This study did not focus on young people, but many of the issues raised would apply to young people as well as older adults.

Coxon A.P.M. (1994). Diaries and sexual behaviour: The use of sexual diaries as method and substance in researching gay men's response to HIV/AIDS. In: Boulton M. (Ed.) Challenge and Innovation: Methodological advances in social research on HIV/AIDS. London, England: Taylor & Francis, pp. 125-148.

Different methodologies give different information on sexual behaviour. Diaries are suggested in this article as an option for obtaining detailed data. Various methods for collecting data in sex research are described, and diaries are compared to these. The method is described, with its advantages and disadvantages. The author's experience of using diaries is discussed. Analysis of diary data is then outlined. The reliability and validity of the data collected, and how these compare to interview data are then examined. Some of the data collected in the author's study of gay men's response to HIV/AIDS are presented.

CRLP (1999). Abortion laws in the post-Cairo world. New York City, USA: Center for Reproductive Law and Policy.

Changes in abortion laws since 1994 are summarised in this short report. Abortion laws have been liberalised in the following countries: Albania, Burkina Faso, Cambodia, Germany, Guyana, Seychelles and South Africa. Abortion laws have been restricted in El Salvador and Poland.

CRLP (1999). Adolescent reproductive rights. New York City, USA: Center for Reproductive Law and Policy.

This report summarises worldwide laws and policies affecting young people's reproductive lives and health. The report begins with a summary of the reproductive rights framework that emerged from the International Conference on Population and Development in Cairo, 1994. The following topics are then considered: access to reproductive health care for young people, education, early marriage, early childbearing and contraception, unsafe abortion, HIV/AIDS and sexually transmitted diseases, sexual violence and young people, female genital mutilation. For each topic, there is a section of background information, then recommendations and examples interventions that have tackled the issue are discussed.

CRLP (1999). Emergency contraception - Contraception, not abortion: an analysis of laws and policy around the world. New York City, USA: Center for Reproductive Law and Policy.

Laws relevant to emergency contraception (EC) around the world are summarised in this brief report. The report begins by reiterating that EC is contraception and not abortion. Abortion laws are then summarised and their exclusion of EC is highlighted. The laws are divided into those that explicitly recognise that pregnancy begins with implantation, those that refer to procedures at advanced stages of gestation, those that refer to termination of pregnancy or procurement of miscarriage and those that refer to conception.

CRLP (1999). Reproductive rights of young girls and adolescents in Benin: a shadow report. New York City, USA: Center for Reproductive Law and Policy.

In this report, the contents of the Convention on the Rights of the Child are linked to the legal and policy situation in Benin. The topics considered are safe motherhood, family planning, abortion, HIV/AIDS, sexually transmitted infections, sex education, marriage, sexual and physical violence. A shadow report for Mali is also available

CRLP (2000). Reproductive Rights 2000: Moving forward. New York, USA: Center for Reproductive Law and Policy.

This book summarises law and policy relating to reproductive rights worldwide. The chapters are: population, reproductive health, and family planning policies; contraception; abortion; HIV/AIDS and STIs; harmful traditional practices affecting reproductive rights: female circumcision/female genital mutilation (FC/FGM); rape and other sexual violence; marriage and family law; adolescents. The final chapter, "adolescents" discusses reproductive rights of this group, the vulnerability of these rights, access to reproductive health care, education including sexuality education, early marriage, early childbearing and contraception, unsafe abortion, HIV and sexually transmitted infections, sexual violence, FC/FGM as applies to young people. The chapter ends with recommendations for all of the topics discussed.

CRLP (2000). Women of the world: laws and policies affecting their reproductive lives. East Central Europe. New York, USA: Center for Reproductive Law and Policy.

This book forms part of a series produced by CRLP covering the laws and policies affecting women in different countries around the world. Each chapter covers a particular country and within that chapter the following topics are addressed: legal and political framework; health and reproductive rights; understanding the exercise of reproductive rights: women's legal status; the rights of young people. The section on young people is divided into the following sub-sections: reproductive health; marriage; sexual offenses against adolescents and minors; education; trafficking in adolescents. This book covers the following countries: Albania, Croatia, Hungary, Lithuania, Poland, Romania and Russia.

CRLP (2000). Women of the world: laws and policies affecting their reproductive lives. Francophone Africa. New York, USA: Center for Reproductive Law and Policy.

This book forms part of a series produced by CRLP covering the laws and policies affecting women in different countries around the world. Each chapter covers a particular country and within that chapter the following topics are addressed: legal and political framework; health and reproductive rights; understanding the exercise of reproductive rights: women's legal status; the rights of young people. The section on young people is divided into the following sub-sections: reproductive health; marriage; sexual offenses against adolescents and minors; female genital mutilation, sexuality education. This book covers the following countries: Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Mali, and Senegal.

CRLP (2000). Women of the world: laws and policies affecting their reproductive lives. Latin America and the Caribbean. New York, USA: Center for Reproductive Law and Policy.

This book forms part of a series produced by CRLP covering the laws and policies affecting women in different countries around the world. Each chapter covers a particular country and within that chapter the following topics are addressed: legal and political framework; health and reproductive rights; understanding the exercise of reproductive rights: women's legal status; the rights of young people. The section on young people is divided into the following sub-sections: reproductive health; marriage; sexual offenses against adolescents and minors; sexuality education. This book covers the following countries: Argentina, Bolivia, Brazil, Colombia, El Salvador, Guatemala, Jamaica, Mexico, and Peru. The 2000 supplement is available on-line in Spanish.

CRLP (2001). Displaced and disregarded: refugees and their reproductive rights. New York City, USA: Center for Reproductive Law and Policy.

The majority of refugees (around 80%) are women and children. A woman's reproductive health is particularly vulnerable when she is a refugee. This report summarises the types of risks faced by women and children who are refugees, including sexual and gender-based violence, high risk pregnancy and abortion, lack of contraceptive services, HIV and sexually transmitted infections, and limited reproductive health care services. The report then summarises the legal and policy framework of refugee protection with reference to the 1951 UN Convention and the 1967 protocol, the Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa, the Cartagena Declaration on Refugees, and International Human Rights standards. Women's and children's rights conventions are discussed in terms of their relevance for refugees.

CRLP (2001). Women of the world: laws and policies affecting their reproductive lives. Anglophone Africa. Progress report 2001. New York, USA: Center for Reproductive Law and Policy.

This book is an updated part of a series produced by CRLP covering the laws and policies affecting women in different countries around the world. Each chapter covers a particular country and within that chapter the following topics are addressed: legal and political framework; health and reproductive rights; understanding the exercise of reproductive rights: women's legal status; the rights of young people. The section on young people is divided into the following sub-sections: reproductive health; marriage; sexual offenses against adolescents and minors; female genital mutilation, sexuality education. This book covers the following countries: Ethiopia, Ghana, Kenya, Nigeria, South Africa, Tanzania, and Zimbabwe.

Dare L. & Cleland J. (1995). Assessment of the reproductive health needs of young adults in markets and motor parks of Ibadan. (unpublished).

Using a combination of methods, the sexual health of young people (aged 13-26) in markets and motor parks of Ibadan, Nigeria was investigated. Preliminary focus group discussions were held with the young adults. A behavioural survey of a random sample of 1488 respondents was then conducted. Following the survey interview, participants were invited to undergo a clinical examination that included collection of biological samples. A random sample of 10 percent of respondents was re-interviewed on returning for test results, to check consistency. A high degree of consistency between the two interviews was found, with the exception of reporting of coercive sex. The report contains details about the collection of the data, and problems encountered. This study is a good example of use of qualitative methods to guide and supplement use of a survey. The report contains data on the sociodemographic composition of the sample, sexual debut (age, circumstances, opinions), marriage and regular partnerships, knowledge, risk perception and behaviour, use of and attitudes towards contraception including condoms, knowledge of HIV/AIDS, presence of sexually transmitted infections.

Davis K.R. & Weller S.C. (1999). The effectiveness of condoms in reducing heterosexual transmission of HIV. Family Planning Perspectives **31**(6): 272-279.

This paper reviews studies of the effectiveness of the male condom in reducing HIV transmission during heterosexual vaginal intercourse. Information was taken from 25 published studies of serodiscordant heterosexual couples in a number of different countries. It is concluded from the meta-analysis that protection with condoms approximates 87%, but may be as low as 60% or as high as 96%. For always-users, HIV incidence was estimated at 0.9 per 100 person-years. Among never users, male-to-female transmission was estimated at 6.8 per 100 person-years, and female-to-male transmission at 5.9 per 100 person-years. Where the direction was not specified, transmission among never-users was estimated at 6.7 per 100 person-years.

de Bruyn M. (2001). Violence, pregnancy and abortion: issues of women's rights and public health. Chapel Hill, NC: Ipas.

This monograph provides a detailed literature review of the topic. The first part of this monograph presents information on the possible links between violence, pregnancy and abortion. Chapter 1 introduces the context, describing the sexual and reproductive health problems that violence against women can cause. Chapters 2-5 describe ways that violence can be related to pregnancy and abortion. The second section discusses measures that can be taken to address the problem. Chapters 6 and 7 suggest approaches for health promotion, based on the conceptual framework described in the earlier chapters. There is an extensive reference list. The review is not focused specifically on young people but many of the issues apply to this group.

Devers K.J. (1999). How will we know "good" qualitative research when we see it? Beginning the dialogue in health services research. Health Services Research **34**(5): 1153-1188.

Criteria for evaluating qualitative research are discussed. Traditional positivist approaches associated with quantitative work are frequently used to judge qualitative data, with the result that qualitative approaches are not used as frequently as they could be. Post-positivist criteria may provide more suitable means of assessing qualitative work. These argue that social reality can only ever be approximated - not only might individuals and groups have different interpretations of reality, but researchers also have their own values that can never be completely removed. These two theoretical positions (positivist and post-positivist) are described, and the new criteria for judging qualitative work that emerged are discussed. Finally, the relative merits of the different criteria, and their implications for research quality are examined.

Dixon Mueller R. (1993). The sexuality connection in reproductive health. Studies in Family Planning **24**(5): 269-82.

The author reviews research on sexual behaviour and compares the results from a large number of qualitative and quantitative studies. The importance of understanding social factors in sexual health is underlined, and illustrative examples are given. A framework for the study of sexuality is proposed, which comprises four elements: sexual partnerships (number of partners, characteristics of relationships with each); sexual acts (nature, frequency, and conditions of choice of sexual practices engaged in); sexual meanings (social constructions of sexuality); sexual drives and enjoyment (physiological and psychological aspects of sexuality). The implications of the use of this framework for service provision are discussed.

Dowsett G.W., Aggleton P., Abega S.-C., *et al.* (1998). Changing gender relations among young people: The global challenge for HIV/AIDS prevention. *Critical Public Health* 8(4): 291-309.

A comparative study of the social and contextual factors affecting young people's risk-related sexual behaviour was conducted in seven different countries. The study used qualitative methods to investigate the meanings of sexual activity and sexuality, the contexts of sexual activity, and specific behaviours. The methods employed were in-depth interviews, participant observation of everyday activities and social contexts, and focus groups. In some of the locations, additional methods were used. The countries in the study were: Cambodia, Cameroon, Chile, Costa Rica, Papua New Guinea, Philippines, and Zimbabwe. The paper discusses the methodology and sampling used in the project, and reports the results, comparing the countries studied. They found that three key concepts were useful in analysing the results: sexual cultures, sexual identities, and sexual meanings. The paper discusses these in turn. Gender relations were found to be central and this is discussed in some detail.

Eggleston E., Jackson J., Hardee K. (1999). Sexual attitudes and behaviour among young adolescents in Jamaica. *International Family Planning Perspectives* 25(2): 78-84.

This study describes sexual attitudes and behaviours among adolescents from low-income families attending poor quality schools in Jamaica and is a good example of use of combined quantitative and qualitative methods. Data were obtained from the Jamaican Adolescent Study among 945 male and female adolescents 11-14 years old in 1995 who attended five Grade 7 Project schools. Data were also obtained from focus groups among 64 male and female students. Fewer than 10% were informed about reproduction. Boys knew more than girls. Knowledge of methods was incomplete. Students generally disapproved of early sex. Boys had mixed approval of early sex. Both sexes thought contraception should be used. Sixty-four percent of boys and 6% of girls reported sexual experience. The mean reported age of first sex was 11.3 years for girls and 9.4 for boys. Focus groups revealed a disparity between actual sex behaviour and disapproval of early first sex. Sex experience was motivated by curiosity, love, and other notions related to having a boyfriend. Boys related having early sex to physical pleasure, elevated status among peers, and attainment of manhood. Girls were not likely to report sex behaviour to parents. Fewer than 50% used contraceptives at first sex. Students associated family planning with promiscuity. Most did not desire early parenthood. Girls pointed out societal disapproval of early sex and pregnancy.

Eggleston E., Leitch J., Jackson J. (2000). Consistency of self-reports of sexual activity among young adolescents in Jamaica. *International Family Planning Perspectives* 26(2): 79-83.

Consistency in reporting of sexual intercourse was examined using data from a three-round longitudinal study of 698 11-14 year olds in Jamaica. Respondents answered multiple questions about their first intercourse within each round of the survey, and the items were repeated in subsequent rounds. Rounds 1 and 2 were nine months apart, rounds 2 and 3 were 12 months apart. A multivariate logistic regression analysis was conducted to examine the factors independently influencing the likelihood that respondents would report their sexual experience inconsistently. The vast majority of respondents (95-100%) reported their sexual experience status consistently within a given survey round. However, when agreement of responses between rounds was examined, 37% of respondents (12% of girls and 65% of boys) responded inconsistently. Multivariate logistic regression analysis indicated that boys were nearly 14 times as likely as girls to report their sexual experience inconsistently. The authors conclude that this pervasive inconsistency in the reporting of sexual activity, especially among boys, means that there are limitations in relying on self-reported data to identify sexually active adolescents and to quantify that activity. These results also suggest that it is necessary to be cautious in using such data to evaluate the impact of interventions.

Elias C.J. & Coggins C. (1996). Female-controlled methods to prevent sexual transmission of HIV. *AIDS* 10(3): S43-S51.

This article presents a literature review of contraception research on female-controlled methods that prevent transmission of HIV/STD infections. The review outlines why female-controlled methods are needed: HIV infections among women are transmitted through vaginal intercourse, and the presence of STDs often facilitates transmission. Female-controlled methods are not a substitute for male condoms

but a form of protection for women who are unable to negotiate for safer sex and a way to increase choice. The options that exist are then described: new barrier methods (diaphragms, cervical caps, and female condoms), vaginal microbicides, existing spermicides, and novel vaginal microbicides. Research and product development challenges are then discussed.

Eyre S.L., Hoffman V., Millstein S.G. (1998). The gamesmanship of sex: A model based on African American adolescent accounts. *Medical Anthropology Quarterly* 12(4): 467-489.

The social context of sexual behaviour was investigated using a sample of African American high-school students in San Francisco. Qualitative methods were used, including free listing, and vernacular term interviewing. The data obtained were analysed following grounded theory and the findings explained in terms of a model of sex-related behaviour as a set of games. Three particular games are identified: a courtship game (where romantic interest is communicated and a relationship established); a duplicity game (draws on conventions of a courtship game to trick a partner into having sex); a prestige game (builds social reputation, typically based on gender-specific standards). The article concludes by examining the possible meanings of sexual behaviour for the young people in the study, and discusses the relevance of the findings for health promotion.

Ferrand A. & Snijders T.A.B. (1997). Social networks and normative tensions. In: Van Campenhoudt L., Cohen M., Guizzardi G., Hausser D. (Eds.) *Sexual Interactions and HIV Risk*. London: Taylor & Francis, pp. 6-21.

Approaches to studying sexuality have frequently been based on examination of individuals. This book argues that explanations of sexual behaviour should move away from individualistic approaches. This chapter proposes a view of sexual life as relational: the behaviour of partners is not only restricted by social context, but simultaneously influences and shapes the social context. There are five main postulates: that sexuality is dyadic (there is a focus on interactions between pairs of people); that a relation is viewed as a sequence of interactions, with an individual acting on the basis of the expected and perceived answers of another individual; that there is bargaining and change in the relationship over time; that relations are embedded in social networks (the relation is an element in each individual's system of interpersonal relationships as well as linking the two individuals); that norms and values are flexible (social norms are not rigid, and change in response to changes in situations). These postulates are explained in detail.

Ferry B., Deheneffe J.-C., Mamdani M., Ingham R. (1995). Characteristics of surveys and data quality. In: Cleland J. & Ferry B. (Eds.) *Sexual Behaviour and AIDS in the Developing World*. London: Taylor & Francis, pp. 10-42.

Survey characteristics and their effects on data quality are discussed. This book chapter deals specifically with the WHO/GPA surveys of sexual behaviour, but the issues raised have more general applicability for those designing and running surveys on sexual behaviour and health. How the data were obtained is described: the content of the WHO/GPA questionnaire and the survey protocol, translation of the questions, pre-testing, establishing rapport, organisation of fieldwork, support of national institutions, fieldwork arrangements, data entry and analysis. The second section is about potential problems with this type of survey and threats to its reliability: ambiguities in sexual terminology, general ambiguities, how questions are phrased, comparison between countries. Data reliability and validity are then addressed, and the approaches used to test these in the WHO/GPA surveys described. Consistency measures used are described: consistency with independent data sources, between men's and women's reports, and internal consistency. The third section presents the strategies used for analysing the data, selection of variables and regression modelling.

Fife Schaw C.R. & Breakwell G.M. (1992). Estimating sexual behaviour parameters in the light of AIDS: A review of recent UK studies of young people. *AIDS Care* 4(2): 187-201.

This paper reviews sexual behaviour surveys of young people in the United Kingdom to identify methodological problems affecting this type of research. The study reviews interviews, postal questionnaires and telephone surveys of randomly chosen samples from population listings or samples drawn from school populations. The paper focuses on specific sexual behaviour parameters relevant to HIV/AIDS transmission: proportion sexually experienced per age group, number of sexual partners, frequency of sexual intercourse, condom use, and anal intercourse. Despite varied methodologies, geographical locations, and levels of specific information requested, there are generally similar results. Important methodological problems are identified, however. A key problem is in the definition of terms. What constitutes sexual experience? Does anal intercourse imply homosexuality? The study recommends establishing standardised question formats.

Fine M. (1988). Sexuality, schooling, and adolescent females: The missing discourse of desire. *Harvard Educational Review* 58(1): 29-53.

Sex education in the US is examined using discourse analysis. The study uses in-school observation, archive analysis of 1200 students, in-depth interviews, analysis of writings by students, visits to other institutions and a survey. Prevailing discourses of female sexuality within public schools are examined. Four are identified: sexuality as violence, sexuality as victimisation, sexuality as individual morality, and a discourse of desire. The discourse of desire is found to be articulated only rarely in a classroom context in the US, although it is evident in less structured school situations. The author argues that schools implicitly organise sex education around a concern for female victimisation and do not acknowledge female desire. The paper argues for a sexuality education that takes into account positive as well as negative aspects of sexuality.

García Moreno C. & Watts C. (2000). Violence against women: its importance for HIV/AIDS. AIDS 14(Suppl 3): S253-S265.

This review examines the link between sexual violence and HIV/AIDS. Studies of prevalence of violence against women are presented and different types of violence described: domestic violence, forced sex, sexual abuse, sexual coercion, sexual trafficking, rape in war. The links with HIV/AIDS are then discussed, with reference to women in general, and also focussing on children and young girls. Violence may not just be a cause of the HIV/AIDS epidemic, but also a consequence of it. Infected women may suffer violence when they reveal their HIV status. Interventions to improve the situation are then suggested: the need to recognise violence and incorporate this recognition into programmes is highlighted.

Gardner R. & Blackburn R. (1997). People who move: New reproductive health focus. Population Reports Series J(45): 1-27.

Migrants, refugees, and internally displaced persons have specific reproductive health needs. This issue of Population Reports provides a summary of data and issues relating to this group. Young people are not the specific focus, but many of the concerns addressed apply to young as well as to older people. The report begins with an introduction including definitions of terms. The main issues in fertility and family planning are summarised, for example rural-urban migrants are usually not exactly like those who stay behind, and the process of moving often upsets family life and reproductive behaviour. Fertility and contraceptive knowledge and use of migrants is compared to those of non-migrants. Reproductive health concerns of people who move are addressed: AIDS and other STDs, safe motherhood, violence against women and unsafe abortions. Personal characteristics of this group are considered: demographic characteristics, social and economic status, and cultural differences. The final section examines reproductive interventions for people who have moved, and international efforts for refugees and internally displaced persons. An extensive bibliography ends the report.

Gillies P. (1996). The contribution of social and behavioural science to HIV/AIDS prevention. In: Mann J.M. & Tarantola D.J.M. (Eds.) AIDS in the World II: Global dimensions, social roots, and responses. New York: Oxford University Press, pp. 131-158.

HIV-related social and behavioural research published during 1991-93 is examined. The first part of this book chapter identifies and discusses the conceptual frameworks that have been used in social science research on HIV/AIDS. Methodological approaches applied to the study of sexual behaviour in the context of HIV/AIDS are reviewed. The methods discussed are quantitative (general population surveys, surveys of behaviour of target populations) and qualitative (experiences of sexuality, construction of social identity and roles, systems and sexual life). The final part of the paper considers the role of social science in evaluating the outcomes of HIV prevention efforts. A number of examples are given of interventions and evaluations. The author notes that reliance upon quantitative survey research has been criticised, that there has been a lack of exploration into the social context of behaviour, limited discussion of national and local policies, limited evaluation of interventions, and poor elaboration of concepts of sexuality. This chapter assesses the content, quality, and direction of HIV-related social research.

Gipson J. & Mathur S. (1999). Youth survey question bank: Frontiers/Horizons.

This is a collection of questions compiled from a number of different existing surveys, intended to provide source material for developing country researchers designing surveys of youth reproductive health. The collection is divided as follows: leisure activities and concerns; risk behaviours; social support and sex education; sexual practices, partners and pregnancy; contraceptive knowledge and use; STDs and HIV/AIDS; health seeking behaviour; reproductive health knowledge and self-efficacy; social norms and gender roles.

Gordon P. & Crehan K. (1997). Dying of sadness: gender, sexual violence and the HIV epidemic. SEPED Conference Paper Series, UNDP.

An overview of the link between sexual violence and HIV is provided in this brief review of the literature. The review considers the scale of sexual violence; sexual violence in conflict situations; determinants of sexual violence; consequences of the violence and barriers to justice. In the second part, the authors outline the work that is needed in future to attempt to address these issues, reviewing the need for prevention, consideration of the needs of survivors, law enforcement and the judicial process, involvement of NGOs and international bodies. The focus is not specifically on young adults, but many of the issues addressed are relevant for this group.

Görge R., Maier B., Diesfeld H.J. (1993). Problems related to schoolgirl pregnancies in Burkina Faso. Studies in Family Planning **24**(5): 283-94.

Pregnancy and motherhood in teenagers in a small town in Burkina Faso are described. This study examined the factors contributing to pregnancy, and the situation of the children, once born. Data were obtained in 1991 from focus group interviews of 28 teenage mothers, repeated in-depth interviews with three of the teenagers, and interviews with teachers, parents of student mothers, and medical personnel. Information was double-checked with clinic records. The paper describes family, student and teacher reactions to early pregnancy and motherhood, the father's role, the effect on the mother's education, the child's situation, attitudes toward contraception and pregnancy, the mother's social environment, and factors related to early pregnancies (lack of knowledge, conflicting social messages, self-esteem). Parental reaction was generally negative and non-supportive. Mothers aged 15-17 years were treated more negatively than the 18-20 year olds. Teachers tended to ignore the situation. Student mothers viewed themselves as unchaste and old. Relationships with the father varied according to their means and abilities. Girls refused offers of marriage because it would prevent further schooling, but continuing education was found not to be compatible with raising an infant. The teenage mothers were reluctant to use modern contraceptives and had low opinions of family planning services. Not all of the girls wanted to be pregnant, and some wished to terminate their pregnancies.

Görge R., Yansané M.L., Marx M., Millimounou D. (1998). Sexual behaviour and attitudes among unmarried urban youths in Guinea. International Family Planning Perspectives **24**(2): 65-71.

Premarital sexual behaviour was examined among urban youths in Guinea. Data were obtained from structured interviews of 3603 15-24 year old males and females from three towns (Faranah, Kissidougou, and Gueckedou). The stratified cluster sample included 2114 primary and secondary school youths and 1489 out-of-school youths (OSYs) (apprentices and informal sector workers). Focus groups were conducted among 25 same-sex groups comprising 192 persons. The mean age of first intercourse was 16.3 years for females and 15.6 years for males. Students had a significantly later mean age at first sexual intercourse than OSYs. Sexually active young men had a greater mean lifetime number of sexual partners (4.0) than women (2.1). Female students had fewer partners than female OSYs. Forty-two percent of females and 44% of males did not have coitus in the previous month. Forty-five percent of females and 51% of males had sex 1-3 times. Youths preferred periodic sexual experiences. Youths reported a pressure from peers and partners to have sex. Sexually active women tended to have older partners. Only about 25% knew first coitus could result in pregnancy. Eleven percent could not distinguish effective from ineffective contraception. Twenty-nine percent reported use of condoms, 20% relied on the calendar method, and 14% relied on the pill. Fifty-three percent had never used any method. Non-use was higher among OSYs.

Green G., Pool R., Harrison S., *et al.* (2001). Female control of sexuality: illusion or reality? Use of vaginal products in south west Uganda. Social Science and Medicine **52**: 585-598.

Use of female-controlled vaginal products was investigated in Uganda using focus group discussions. One hundred and thirty one women participants selected from a range of methods, including female condom, contraceptive sponge, film, tablets, foam and gel. They used each for five weeks and their favourite product for a further three months. The women perceived a major advantage to be the fact that they could use the products without their partner's knowledge (apart from the condom), but most revealed use of the products to their partners. Some of the women's partners were also interviewed for the study. In general, both the men and women in the study preferred these methods to the male condom. Women liked them particularly because they felt that they had greater control over their method use, although negotiation with male partners was often involved. The study does not specifically address issues that might be faced by young people in using such products, but some of the issues faced by the older women are likely to be similar for younger adults.

Grimley D.M., Prochaska G.E., Prochaska J.O. (1997). Condom use adoption and continuation: A transtheoretical approach. Health Education Research **12**(1): 61-75.

Use of condoms can reduce an individual's risk of contracting and transmitting sexually transmitted diseases, but most programs have demonstrated little effect upon overall condom use. This paper presents a theoretical model of behaviour change related to condom use, based on individual-orientated

models such as Stages of Change. The Transtheoretical Model of Change (TMC) presented in this paper suggests viewing change in condom-use behaviour as an incremental process through a series of stages. Measures and models of condom use based upon the TMC are described, and preliminary findings with diverse populations presented. Intervention implications are discussed.

Guizzardi G. (1997). Norms of relationship and normative tensions. In: Van Campenhout L., Cohen M., Guizzardi G., Hausser D. (Eds.) Sexual Interactions and HIV Risk. London: Taylor & Francis, pp. 223-233.

Approaches to studying sexuality have frequently been based on examination of individuals. This book argues that explanations of sexual behaviour should move away from individualistic approaches. This chapter summarises the different levels of analysis possible, and the tensions that exist between them, reviewing previous chapters in the book. The role of the individual, the social network and the macrosocial are examined. All three are considered to be vital in understanding sexual behaviour.

Gupta G.R. & Weiss E. (1995). Women's lives and sex: Implications for AIDS prevention. In: Parker R.G. & Gagnon J.H. (Eds.) Conceiving Sexuality: Approaches to sex research in a postmodern world. New York: Routledge, pp. 259-270.

Preliminary findings from the Women and AIDS program reveal some of the barriers to women's AIDS prevention. This paper is not specifically about young people but many of the issues discussed apply to young as well as older women. Data are from 17 studies in developing countries worldwide and look at the interaction between women's social and economic status and risk of HIV infection. Drawing upon the findings from the program, the paper analyses how cultural norms, together with women's social and economic dependency, can limit a woman's ability to negotiate safer sex with her partner; restrict her access to information and knowledge about her body; increase likelihood of selling sex for survival; increase vulnerability to physical violence in sexual interaction; and compromise self-esteem.

Halpérin D.S., Bouvier P., Jaffé P.D., *et al.* (1996). Prevalence of child sexual abuse among adolescents in Geneva: Results of a cross sectional survey. British Medical Journal **312**: 1326-1329.

The extent to which sexual abuse had been experienced was examined in a quantitative survey of 1193 young people (13-17 years old) in Geneva. The article describes the precautions that were taken in view of ethical considerations arising from the sensitive nature of the information sought. The article gives details of procedures and follow-up that were necessary to the success and ethics of the study, including co-operation of the schools involved, and of the young people themselves. Thirty-four percent of girls and 11% boys reported having experienced at least one sexually abusive event. Prevalence of abuse involving some form of penetration was 6% among girls and 1% among boys. One-third of those abused had experienced abuse more than once. Abusers were known to their victims in two-thirds of cases. Ninety percent of abusers were male, and 35% came from the victim's peer group.

Hart G.J., Pool R., Green G., *et al.* (1999). Women's attitudes to condoms and female-controlled means of protection against HIV and STDs in south-western Uganda. AIDS Care **11**(6): 687-698.

This study investigates female-controlled methods of HIV prevention. Data were collected in 18 focus-group discussions with women aged 17-54 in south-western Uganda. The study is not specifically of young women, but many of the issues raised apply to this age group. A total of 138 women, from rural villages, urban family planning clinics and a truck-stop town, were recruited to participate in discussions about the male condom, the female condom and existing formulations of vaginal microbicide products. Three themes emerged: problems with men's control over the male condom; the importance of control over and secrecy about protective measures; and sexual pleasure associated with different methods. The female condom, while being perceived as an improvement over the male condom, was recognised as having limited value because of the need to agree its use prior to sex taking place. Other products were considered to be significantly better than the female condom. The sponge in particular was perceived as having advantages over every other product. Women liked the fact that it could be inserted some time before, and left in place some time after, sexual intercourse, that it was effective for multiple instances of intercourse, and that men would be unaware that it was being employed.

Heise L., Ellsberg M., Gottemoeller M. (1999). Ending violence against women. Population Reports Series L(11).

Two of the most common forms of violence against women are abuse by intimate male partners and coerced sex. The majority of women who are abused by their partners are abused many times. This issue of population reports provides a review of gender-based violence worldwide. While the focus is on all gender-based violence, there are sections specifically dealing with young people and many of the general issues also apply to this group. Findings about the prevalence of intimate partner abuse, and explanations of this abuse are presented. Sexual coercion is examined, including forced sexual initiation, forced sex within marriage, and sexual abuse in childhood. The impact of violence on reproductive health is then discussed: effect on sexual autonomy, unwanted pregnancy, compromised

HIV protection, and other gynaecological problems. Finally, general implications of the effects of gender-based violence are discussed, and the role that health providers can play in addressing these issues. Among other topics, tables present data on: physical assault on women by an intimate male partner; prevalence of forced first intercourse; prevalence of child sexual abuse; help-seeking by physically abused women; variations in men's attitudes and rates of abuse.

Heise L.H. (1995). Violence, sexuality, and women's lives. In: Parker R.G. & Gagnon J.H. (Eds.) Conceiving Sexuality: Approaches to sex research in a postmodern world. New York: Routledge, pp. 109-134.

This book chapter first reviews surveys from a large number of less developed countries showing prevalence of violence against women, including battery and rape. Second, the impact of violence on women's sexual and reproductive lives is discussed, including the ability of women to control their own fertility and to protect themselves against STDs including HIV. Finally, the social contexts of violence are discussed, and factors contributing to violence identified. Gendered violence is not inevitable, the author asserts, and reflects wider power structures and concepts of maleness rather than biologically determined drives.

Helitzer Allen D., Makhambera M., Wangel A.M. (1994). Obtaining sensitive information: the need for more than focus groups. Reproductive Health Matters 3: 75-82.

Research in Malawi attempted to identify locally appropriate communication channels for passing on HIV/AIDS information, teaching prevention skills, and promoting risk-reduction behaviour in young women in rural areas. In the course of the research, the authors compared focus groups to interviews as sources of data. One hundred and twenty in-depth interviews and 32 focus group discussions were held with 60 representative young unmarried girls (who were not attending a boarding school) and members of their social networks in two villages. The specific goal of the data collection was to learn about the social and information networks of the girls in three age cohorts (10-12, 13-15, and 16-18 years old): how they learn about sexuality, their perceived risk of HIV infection, their experience with sex, and the skills they have to avoid HIV infection. The study was also designed to indicate differences between actual behaviour and idealized social norms. It was found that whereas most of the girls admitted in the private interviews that their friends had told them about menstruation, in the focus groups, the girls followed the public standard of behavior which prohibited discussion of menstruation around or by the pre-puberty girls. When the girls were asked about the initiation ceremony, they revealed some information indirectly during the interviews but revealed less during the focus groups. Some girls reported that they were given information about sexual behaviour during the ceremony which increased their curiosity about intercourse. When the girls were asked about sexual enhancement techniques, contraception, and abortion, their answers followed the same pattern. They admitted to more knowledge privately in interviews than they did in focus groups. Also, the girls in the older cohorts had more specific knowledge about these topics as well as about sexually transmitted diseases and AIDS. In conclusion, the focus groups elicited more socially "correct" answers and produced good data on social norms, but the one-on-one interviews provided good data on actual knowledge and experience. The authors conclude that community-based research on sexuality and reproduction should include both methods of data collection and suggest that in-depth interviews be conducted first, with participants asked at the end of the interview whether they have revealed anything which they would be unwilling to discuss in a group of peers and whether any topic was discussed which should have been avoided. This research indicated that the initiation ceremony may provide an appropriate place for the introduction of AIDS risk reduction information to these young women.

Hennink M. & Diamond I. (1999). Using focus groups in social research. In: Memon A. & Bull R. (Eds.) Handbook of the Psychology of Interviewing.: John Wiley & Sons, pp. 113-141.

Use of focus groups is described in this book chapter. The chapter begins with a discussion of what a focus group is, and what the benefits and drawbacks are of using this technique to collect data. Advice is given on when to use focus groups. The second section deals with planning the focus group research: defining the research problem, considering research outcomes. Practical issues are then discussed: group composition, participant selection, group size, number of groups, and location. Guidelines are given on developing the question route, question design, and on the roles of the focus group team. The tasks of the moderator are examined step by step, from arrival of the participants, and starting the session, to moderating techniques and group management. Finally, the chapter looks at data management, analysis and reporting. An appendix contains examples of a question route and a post-session questionnaire.

Herdman C. (1997). The impact of early pregnancy and childbearing on adolescent mothers and their children in Latin America and the Caribbean. Washington D.C.: Advocates for Youth.

This short fact sheet summarises available data about teen childbearing in Latin America. Data are taken from various surveys, including Demographic and Health Surveys. Summaries are given of

teenage fertility, teen pregnancy, negative consequences of early childbearing, maternal mortality, early pregnancy and the life and health of the child, high teenage fertility and poverty and low educational achievement.

Hersh L., Lane C., Feijoo A. (1998). Advocates for Youth Factsheet: Adolescent sexual and reproductive health in sub-Saharan Africa. Washington D.C.: Advocates for Youth.

This short fact sheet summarises available data about teen sexual and reproductive health in sub-Saharan Africa. Data are taken from various qualitative and quantitative sources. Summaries are given of youth sexual activity, early sexual activity and the link to youth morbidity and mortality, the effect on youth reproductive health of cultural, economic and social factors, and the effect of programmes and policies on knowledge, attitudes and practices of youth.

Holland J., Ramazanoglu C., Scott S., *et al.* (1994). Methodological issues in researching young women's sexuality. In: Boulton M. (Ed.) Challenge and Innovation: Methodological advances in social research on HIV/AIDS. London, England: Taylor & Francis.

This feminist study used in-depth interviews with young women in the UK. One goal of the research was to develop a theory of the social construction of sexuality, identifying the processes and mechanisms the women used "to construct experience and define their sexuality and sexual practices [and] to examine the relationship between these processes and broader gendered power relations" (p.222). The study used feminist methodology to conduct the research, emphasising inequalities of gender and the extent of men's dominance in heterosexual relations. The paper discusses the approach used, then three further sections look at research techniques and sample selection for this type of study, the ethics of interviewing on sexuality, and finally how to interpret in-depth interview data.

Holland J., Ramazanoglu C., Sharpe S., Thomson R. (1992). Pleasure, pressure and power: Some contradictions of gendered sexuality. The Sociological Review **40**(4): 645-674.

The Women Risk and AIDS Project was a UK-based qualitative study. Young women were interviewed about their sexual experiences and in this paper a subset of 39 young women's experiences are analysed. The paper focuses on coercion, and identifies a number of types of pressure the women experienced to have sex. The authors classify the pressures young women experience in sexual encounters into three groups: the personal, the social, and pressures coming directly from men. The qualitative data presented in this paper is focused principally on young women's responses to male sexual pressure. Two classes of pressure are discussed. First, verbal pressure: persuasion or coercion.; second, physical pressure: intimidation, sex when drunk, child abuse, use of force or threat of force. Among their findings were the difficulties of defining what is "rape" when men may force sex but not see it as rape and women are reluctant to describe experiences as rape because they feel complicit in what happened. Women mostly discussed sex in terms of men's needs or pleasure or in the context of feelings about men or a relationship, rather than in terms of their own pleasure.

Horizons (2000). Peer education and HIV/AIDS: past experience, future directions. New York, NY: Population Council, International Center for Research on Women, International HIV/AIDS Alliance, Program for Appropriate Technology in Health, University of Alabama at Birmingham, Tulane University.

Peer education often involves training a member of a group to give support or information to other members of the same group. Peer education is one of the most widely-used strategies to address the HIV/AIDS pandemic. A project coordinated by UNAIDS and the Horizons Project in collaboration with other organisations was designed to identify components and principles that influence HIV/AIDS peer education programme quality and effectiveness, as well as gaps in operations research. The project set out to gather information from research and field experience to help strengthen peer education programmes. The report presents the results of this process, incorporating key findings and recommendations in the following topic areas: integration of HIV/AIDS peer education with other interventions; finding and keeping peer educators; training and supervising peer educators; gender, sexuality and the sociocultural context; programme activities to foster behaviour change; care for people living with HIV/AIDS; stakeholders; programme sustainability; evaluation and operations research.

Hughes J. & McCauley A.P. (1998). Improving the fit: Adolescents' needs and future programs for sexual and reproductive health in developing countries. Studies in Family Planning **29**(2): 233-245.

Although the demand for sexual and reproductive health programming for young people in developing countries is growing, there is little evidence on the characteristics of effective programs. Available literature indicates there is a poor fit between existing programs and the needs of young people. This paper reviews the evidence about programmes and considers the need for approaches that can help young people obtain information, skills-building opportunities, counselling, and clinical services. Six planning principles for programmes are outlined, following the work of the WHO/UNFPA/UNICEF Study Group on Adolescent Health and Development: 1) recognise and address the fact that the program

needs of young people differ according to their sexual experience and other characteristics; 2) begin with what young people want and what they are already doing to obtain information and services; 3) include building skills as a core intervention; 4) engage adults in creating a safer, more supportive environment in which young people can develop and learn to manage their lives; 5) use a greater variety of settings and providers - both public and private, clinical and non-clinical - to provide sexual and reproductive health information and services; and 6) build upon what exists by linking existing programs and services in new ways so that they reach many more young people.

Huygens P., Kajura E., Seeley J., Barton T. (1996). Rethinking methods for the study of sexual behaviour. Social Science and Medicine 42(2): 221-231.

Methods used to study HIV risk and spread in rural Uganda are reviewed and critiqued. Although the examples are drawn from Uganda, this article gives a good overview of methodological issues in sex research more generally. The application of various methods of studying sex behaviour in a series of six studies are examined, including quantitative studies, focus group discussions, interviews and other qualitative methods. The objectives of the various studies were different, hence the multiple research strategies. The following methodological factors influencing the research and the results are identified: the research model, the meanings of research questions, and personal factors affecting the interview relationship. While the impact of these factors cannot be completely eliminated, precautionary measures can be taken to reduce their negative effects. Comparing data obtained through different methods proved useful not only as a validity test, but also as a means of interpreting the data on a more profound level.

Ingham R. (1992). Personal and contextual aspects of young people's sexual behaviour: A brief methodological and theoretical review. Geneva: World Health Organization.

A review and critique of the main theoretical approaches used in study of sexual behaviour and a review of research findings. The paper contains a section on methodological issues, then goes on to examine theoretical approaches used in the study of sexual behaviour. First, theories of individual differences, including Mosher's theory of sex guilt, and Byrne et al's theory of erotophilia/erotophobia. Limitations of these theories are identified as failure to distinguish different meanings that sexual activity might have for males and females, or the different contexts in which such activity takes place. Behavioural models are then examined, for example the Theory of Reasoned Action, the Health Belief Model, the AIDS Risk Reduction Model. Many of these models deal primarily with intentions. Very few studies have been performed which relate intentions to actual behaviour, so the explanatory potential of the models is often restricted to exploring internal cognitive consistencies. The underlying concept of individual rational decision making which is implicit in many of the more social cognitive models has been criticised. The review then covers sexual scripts and discourses. Gagnon proposes that individuals engaged in sexual activities can be regarded as following prescribed scripts which are learned or acquired from a variety of sources, including peers, parents, the media and others. Heterosexual relations understood in terms of discourses are then discussed. Both model building and sexual scripts are dependent on improved understanding of social and normative contexts, as well as interpretations and meanings within particular cultures and sub-cultures. A review of recent research is then presented. The choice of data collected is discussed, and findings on the following topics are given: patterns of sexual activity; meanings of sexual activity; community understandings of sexual activity; reported sources of information about sex and HIV/AIDS; impact of HIV/AIDS on young people's sexual activity; structural and contextual analyses of sexual behaviour.

Ingham R., Jaramazovic E., Stevens D., *et al.* (1996). Protocol for comparative qualitative studies on sexual conduct and HIV risks. Southampton, UK; Utrecht, NL: European Commission Biomed Concerted Action.

This is a standardised protocol designed for use in different settings to provide comparative qualitative data from semi-structured/in-depth interviews and focus groups. The comparative data can be collected through the use of a set of detailed topic lists that are common to each site. The document begins with an introduction including the rationale for collecting data that can be compared between sites. Results of studies using this protocol in the UK and the Netherlands are also presented. Section 1 gives an overview of how the authors identified what they regard as the key issues to be explored, and how to incorporate these into data collection in the most time-efficient way. Section 2 provides a summary of the theoretical basis of the project, and elaborates the research questions that can be addressed using the data obtained. This section contains a multifactoral theoretical framework developed on the basis of previous research findings that articulates the factors that appear to affect outcomes. Section 3 covers sampling, selection of sites, interviewer selection, training and support, and other practical advice. Section 4 summarises theoretical priorities, and discusses the detailed topic lists suggested for the interviews and focus group discussions. How each topic fits with the overall approach is described. Section 5 examines different approaches to data analysis that are possible with the materials obtained. Section 6 identifies some potential applications of the protocol, with examples.

Ingham R. & van Zessen G. (1997). From individual properties to interactional processes. In: Van Campenhoudt L., Cohen M., Guizzardi G., Hausser D. (Eds.) Sexual Interactions and HIV Risk. London: Taylor & Francis, pp. 83-99.

Approaches to studying sexuality have frequently been based on examination of individuals. This book argues that explanations of sexual behaviour should move away from individualistic approaches. In this chapter a theoretical framework is described that places the interaction between the two partners at the centre of the analysis. The framework is based on qualitative research with young people in Europe. The chapter begins with a review of previous theoretical approaches. Risk perception and the social dimensions of sexual behaviour are discussed, with qualitative data presented as evidence for the critique of previous theoretical approaches. The link between intentions and behaviour, and the effect of the wider social context are examined. Finally a new, dyad-orientated approach to the study of sexual behaviour is proposed.

Ingham R., Vanwesenbeeck I., Kirkland D. (1999). Interviewing on sensitive topics. In: Memon A. & Bull R. (Eds.) Handbook of the Psychology of Interviewing.: John Wiley & Sons.

Interviews on sensitive topics are described in this book chapter, with illustrative reference to interviews on sexual conduct. While each section is brief, this chapter provides a useful practical guide for research projects where qualitative interviews (on sensitive or non-sensitive topics) will be collected. A brief background of research into sexual conduct (theoretical approaches and qualitative approaches) is followed by consideration of relevant issues over and above the actual interview process itself. These issues are: sampling and obtaining participants (theoretical sampling, sampling sites, sampling methods, approaching participants, and sample size), selection and training of interviewers and protocol design. Finally the interview process itself is addressed (inconsistencies and barriers, emotions, interviewing about sex, practical matters).

Jejeebhoy S.J. (1998). Adolescent sexual and reproductive behaviour. A review of the evidence from India. Social Science and Medicine **10**: 1275-1290.

Available data are reviewed to produce profiles of sexual, reproductive, and health behaviour, knowledge, and attitudes among 10-24 year olds in India. Quantitative and qualitative data sources since the 1980s are used. The flaws in the studies examined and methodological problems in collection of this type of data are discussed. Evidence is presented for this young group about marriage patterns, sexual activity both within and outside marriage, fertility and family planning, health risks of early marriage and childbearing, induced abortion, knowledge of sexual, contraceptive and reproductive health, attitudes towards marriage and sex, sexual and reproductive decision-making, and use of family planning and reproductive health services. The report highlights the lack of research on reproductive health of young people in India in terms of sexuality, reproductive morbidity, abortion-seeking and sociocultural factors underlying behaviour.

Jewkes R., Vundule C., Maforah F., Jordaan E. (2001). Relationship dynamics and teenage pregnancy in South Africa. Social Science and Medicine **52**: 733-744.

Teenage pregnancy in South Africa was examined using a case-control design. The study investigated 191 pregnant teenage women, and 353 sex, school or neighbourhood and age-matched controls. All were from township areas of Cape Town. A structured questionnaire was used to obtain information which was then analysed using logistic regression techniques. In this paper, the focus is on relationship dynamics and their association with the risk of pregnancy. Both groups had been dating for a mean of 2.5 years, and about half were still with their first sexual partner. Partners of pregnant teenagers were significantly older, less likely to be in school and less likely to have other girlfriends. The pregnant teenagers were significantly more likely to have experienced forced sexual initiation and reported being beaten more often. They were less likely to have confronted their boyfriend on discovering that he had other girlfriends - a measure of assertiveness within the relationship. Failure to confront boyfriends and forced sexual initiation were both linked to pregnancy and to one another. The authors argue that these findings can be attributed to unequal power relations within the relationship that are reinforced by violence.

Jewkes R., Watts C., Abrahams N., *et al.* (2000). Ethical and methodological issues in conducting research on gender-based violence in South Africa. Reproductive Health Matters **8**(15): 93-103.

Ethical issues surrounding research on violence are discussed, based on experiences from three large gender-based violence surveys in South Africa and one in Zimbabwe. The authors discuss safety of researchers and research subjects from violence arising because of the research project; risks of traumatization of researchers/respondents; impact of work on violence in researchers' own relationships; risks of under-reporting; need for follow-up that will benefit women experiencing violence.

They suggest guidelines for research to help take these issues into account. They give illustrative examples of the specific problems they encountered in their own research.

Johnson A.M., Copas A.J., Erens B., *et al.* (2001). Effect of computer-assisted self-interviews on reporting of sexual HIV risk behaviours in a general population sample: a methodological experiment. *AIDS* **15**(1): 111-115.

To develop methods to maximize the accuracy of reporting HIV risk behaviours in a general population survey, the authors assessed the feasibility of using a computer-assisted self-completion interview (CASI) in comparison with pen-and-paper self-completion interview (PAPI). A probability sample survey of residents aged 16-44 years in Britain, with alternate assignment of addresses to interview by CASI (462) or PAPI (439) was used. Personal interviews exploring demographic and sexual behaviour variables were carried out using the two methods. Principal outcome measures were the impact of CASI in relation to PAPI on data quality and rates of reporting a range of behaviours. RESULTS: A total of 901 interviews were completed; 829 individuals were eligible for and accepted the self-completion module. Internal consistency of data items was greater with CASI than PAPI and item non-response was lower. Overall, there was no significant difference in rates of reporting between CASI and PAPI. The main effect for CASI compared with PAPI in a generalized estimating equation (GEE) analysis was an OR (95% CI) of 1.04 (0.92-1.17). Variables were also examined individually, including homosexual partnership (adjusted OR 1.26 95% CI 0.69-2.29), payment for sex (adjusted OR 0.68 95% CI 0.29-1.59), masturbation (adjusted OR 0.89 95% CI 0.66-1.22) and five or more partners in the past 5 years (OR 0.85 95% CI 0.61-1.19). There was no evidence of a consistent effect of CASI on rates of reporting sexual HIV risk behaviours in this sample. CASI resulted in improvement in internal consistency and a reduction in missed questions.

Khan A. (2000). Adolescents and reproductive health in Pakistan: a literature review. Islamabad: Population Council.

This report reviews research and findings on young people aged 10-19 and reproductive health in Pakistan. Material is drawn from national surveys and medical research, supplemented by information gathered by non-governmental organisations. There are clear gender differentials in access to health care, with girls facing more difficulty than boys at puberty. Sexuality of young people is little researched, primarily due to taboos restricting open discussion of the topic. Legal controls make sex outside marriage punishable by death. Young men are particularly anxious about masturbation and homosexuality. Female sexuality is tightly controlled, particularly that of unmarried girls. Young people of both sexes desire more information about sexuality. There is no law specifically prohibiting child sexual abuse, and concrete action has not been taken to combat child trafficking and sexual abuse. There is little information on HIV levels among young people. Informal assessments suggest that induced abortion is widespread but laws and policies make safe abortion difficult. Average age at marriage is increasing in Pakistan: 26.5 for men and 22 for women.

Kim Y.M., Kols A., Nyakauru R., *et al.* (2001). Promoting sexual responsibility among young people in Zimbabwe. *International Family Planning Perspectives* **27**(1): 11-19.

In 1997-1998 a multimedia campaign in Zimbabwe promoted sexual responsibility among young people, and strengthened their access to services by training providers. Baseline and follow-up surveys were carried out, each involving around 1400 young people (aged 10-24) of both sexes. Surveys were conducted in five campaign and two comparison sites. Logistic regression analysis was used to assess exposure to the campaign and its impact on young people's reproductive knowledge and discussion, safer sexual behaviours and use of services. Awareness of methods increased in campaign areas, but general reproductive health knowledge changed little. Young people in campaign areas were 2.5 times as likely as those in comparison sites to report saying no to sex, 4.7 times as likely to visit a health centre and 14.0 times as likely to visit a youth centre. Contraceptive use at last sex rose significantly in campaign areas (from 56% to 67%). Launch events, leaflets and dramas were concluded to be the most influential campaign components. The more components respondents were exposed to, the more likely they were to take action in response.

Kim Y.M., Marangwanda C., Kols A. (1997). Quality of counselling of young clients in Zimbabwe. *East African Medical Journal* **74**(8): 4-5.

Young clients (12-24 years old) were observed in clinic consultations. A total of 418 consultations were observed at 38 health facilities throughout Zimbabwe. Subsequent interviews with clients and service providers suggested that young people often face a lack of privacy, inadequate provider attention, and a narrow focus on reproductive health. Although providers had an average of nine years of family planning experience, only 6% had received training on counselling young clients in the past year. Fifty-six percent of consultations observed were for family planning, 20% were for antenatal care, and 18% were for HIV testing or treatment of a sexually transmitted disease (STD). Observers noted that 23% of sessions

could be heard by other clients and 36% were interrupted by another staff member. Only 34% of clients were informed the session was confidential. Most providers thought parents should be notified if a young client was pregnant (89%), HIV-positive (74%), or engaged in sexual intercourse at "too young an age" (73%). Only 28% thought those under 16 years old - the legal age of consent - should be provided with contraception. Providers rarely addressed concerns such as physical and emotional changes of adolescence, alcohol and drug use, and family problems. Clients 12-16 years old seemed particularly shy and anxious in counselling sessions. Overall, 69% of clients simply responded to the provider's questions and with as few words as possible; 40% acknowledged they did not bring up pressing concerns and 22% stated they wished they had had more time to talk during the session.

Kippax S., Crawford J., Waldby C., Benton P. (1990). Women negotiating heterosex: Implications for AIDS prevention. Women's Studies International Forum 13(6): 533-542.

Using qualitative memory work with Australian women, the authors explore past experiences of women's sexual encounters. The data gathered are analysed in terms of the three discourses documented by Hollway (the male sex-drive discourse, the have/hold discourse, and the permissive discourse). The authors also examine the data in terms of Irigaray's three permissible figures for women (virgin, wife-mother, and whore). They focus on how women negotiate specific outcomes in heterosexual interactions, the extent to which they are able to negotiate at all, and the absence of a socially acceptable place for female sexual desire.

Kiragu K. (2001). Youth and HIV/AIDS: can we avoid catastrophe? Population Reports, Series L, No. 12.

This issue of Population Reports focuses on youth and HIV. The first part of the report gives HIV statistics by region and country for young people and provides some discussion of these statistics. The ways young people become infected with HIV are then discussed. Social and cultural factors increasing young people's vulnerability to HIV infection are examined: lack of information, gender differences, poverty and deprivation, social intolerance and discrimination. HIV-related interventions are discussed: AIDS education; mass media communication; encouraging increased use of condoms and dual protection; voluntary counselling, testing and referral; HIV treatment and care; youth livelihood approaches. Suggestions are made about what works and what does not work. Outreach and the importance of involving families and addressing the particular needs of young men are discussed. The final part of the report addresses the consequences of inaction: projected HIV levels are presented along with the potential social and economic consequences of a worsening epidemic.

Kirby D. (2001). Understanding what works and what doesn't in reducing adolescent sexual risk-taking. Family Planning Perspectives 33(6): 276-281.

This short paper summarises a review of studies by the author on sexual risk and protective factors for young people in the US. The paper outlines the influence of norms, the influence of connectedness (i.e. connectedness of individuals to social groups), and evidence from evaluations of programmes. The author suggests that a relatively simple social norms-connectedness framework explains a large number of the findings from the various studies. Although the focus of the analysis is the US, the findings have implications for understanding behaviour in other countries.

Kirby D., Short L., Collins J., *et al.* (1994). School-based programs to reduce sexual risk behaviours: A review of effectiveness. Public Health Reports 109(3): 339.

School-based sexual health programmes in the US were assessed for effectiveness in this study. Only programmes that measured programme impact were included. Twenty-three studies of school-based programmes published in professional journals were identified and examined. It was found that while not all sex and AIDS education programmes significantly affected adolescent sexual risk-taking behaviour, specific programmes did delay the initiation of intercourse, reduce the frequency of intercourse, reduce the number of sex partners, and increase the use of condoms or other contraceptives. Effective programmes included a narrow focus on reducing sexual risk-taking behaviours that may lead to HIV-STD infection or unintended pregnancy; they used social learning theories as a foundation for programme development; they provided basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse through experiential activities designed to personalise the information; they included activities addressing social or media influences on sexual behaviour; they reinforced clear and appropriate values to strengthen individual values and group norms against unprotected sex.

Kirkman M., Rosenthal D.A., Feldman S.S. (2001). Freeing up the subject: tension between traditional masculinity and involved fatherhood through communication about sexuality with adolescents. Culture Health and Sexuality 3(4): 391-411.

An explanation for difficulties experienced by fathers in communicating about sexuality with their children is suggested in this study. In-depth interviews were conducted with 51 people (19 young

people, 18 mothers, 14 fathers) from 19 families. Parents discussed experiences of communicating about sexuality during their childhood as well as in their current families. Fathers were positioned in discourses of both traditional masculinity and involved fatherhood. These subject positions are incompatible and frequently led to problems, confusion, or withdrawal from overt communication about sexuality. In spite of the dominance of traditional masculinity, there was evidence that fathers struggled also to position themselves as men who valued relationships and endorsed co-operation between the sexes. This paper highlights barriers to increased connection and intimacy for fathers who appear to desire such relationships with their children.

Konde-Lule J.K., Wawer M.J., Sewankambo N.K., *et al.* (1997). Adolescents, sexual behaviour and HIV-1 in rural Rakai district, Uganda. *AIDS* **11**(6): 791-799.

The sex behaviour and HIV serostatus of 824 13-19 year olds in 31 randomly selected community clusters of rural Rakai district, Uganda, were surveyed and followed-up during 1990-92. The study used structured interviews plus serum samples, which were analysed for HIV-1. Baseline data were collected in 1990 and 1991 and in 1992 further data were collected, including follow-up of as many of the original participants as possible. No one under age 15 years was infected with HIV. Two percent of men and 19% of women aged 15-19 years were HIV-seropositive. Twenty-one percent of women who were married or in some other consensual union were infected with HIV, as were 29% of women reporting no permanent relationship and 4% of women who reported being in no current relationship at all. After multivariate adjustment, the following characteristics were significantly associated with HIV infection: female sex, age 17-19 years, residence in trading centres or trading villages, and a history of sexually transmitted disease symptoms were significantly associated with HIV infection. Seventy-nine percent of the young people provided a follow-up serological sample. While no men aged 13-14 years seroconverted during the study, HIV seroconversion was 0.6 per 100 person-years of observation among women aged 13-14 years. There was an average of 1.1 and 3.9 seroconversions per 100 person-years of observation among men and women aged 15-19 years, respectively, before reaching age 21 years. The mortality rate among HIV-positive adolescents aged 15-19 years, at 3.9 per 100 person-years of observation, was 13 times higher than that among the HIV-seronegative. By 1992, there was almost universal knowledge of the sexual transmission of HIV, a smaller proportion of youth reported having sex with multiple partners, and the level of condom use had increased over baseline.

Lear D. (1995). Sexual communication in the age of AIDS: The construction of risk and trust among young adults. *Social Science and Medicine* **41**(9): 1311-1323.

Using in-depth interviews, questionnaires (N=159), informal interviews and secondary sources, sexual communication was investigated among university students in California. This study examined how gender and sexual orientation influence negotiations for safer sex, strategies used to reduce risk, and barriers to safer sex. The article begins with a summary of relevant theory, then presents data collected. The following were examined: influence of sex education, youth as a developmental stage of life, drinking, friends, construction of risk of HIV infection, ways of managing risk, ways of managing knowledge of own risk, categories of relationships and the implications for protection, construction of trust within relationships, and negotiating safer sex.

Lindsay J., Smith A.M., Rosenthal D.A. (1999). Conflicting advice? Australian adolescents' use of condoms or the pill. *Family Planning Perspectives* **31**(4): 190-194.

Data from a 1997 national survey of 3550 Australian secondary school students aged 15 and 17 years old were used to examine teenagers' method choices and patterns of advice-seeking about contraception and STD prevention. Of the 961 currently sexually active students, 94.8% were using at least one contraceptive method. The most frequently-used method was the condom (78.0%), followed by oral contraceptives (OCs) (44.7%) and withdrawal (13.5%). Thirty-one percent were using condoms exclusively, and 10% were exclusively using OCs. Older students and those who had sought contraceptive advice were more likely to use OCs than condoms exclusively, while those who had had only casual partners in the past year were less likely to use OCs exclusively instead of condoms. The more students believed that their peers used condoms, the less likely they were to report exclusive use of OCs. Parents were the most frequent source of advice about contraception, followed by physicians and teachers. The most common sources of advice about HIV and other STDs were parents, teachers, and then physicians.

Liskin L., Wharton C., Blackburn R.D., Kestelman P. (1990). Condoms - now more than ever. *Population Reports. Series H* **36**(RH Training Materials).

Condom use worldwide is summarised in this edition of Population Reports. The report opens with data on prevalence of condom use in different countries, obtained from Contraceptive Prevalence and Demographic Health Surveys. Condom use outside marriage and by young people is discussed. The number of condoms that should be used to prevent diseases and/or pregnancy is far lower than actual

numbers used. Data from laboratory studies are then presented, showing the effectiveness of condoms against pregnancy and against disease. There is a section on why condoms fail, and on how condoms might be promoted more successfully. Counselling of condom users and barriers to use are discussed. Finally, practical aspects of increasing the distribution and quality of condoms are addressed.

Long L.D. (1997). Refugee women, violence, and HIV. In: Herdt G. (Ed.) Sexual Cultures and Migration in the Era of AIDS: Anthropological and demographic perspectives. Oxford, UK: Oxford University Press, pp. 87-103.

The author examines the risk factors faced by refugee and displaced women in conflict situations and describes the physical protection issues faced by these women at various stages of refugee experience. Brief case histories of young women are provided to illustrate the variety of women's experiences. Data were obtained from interviews conducted in a number of locations as part of larger demographic and ethnographic studies. Women are disadvantaged by their relative poverty and their lack of security and women and young girls in refugee situations may provide sexual favours in exchange for food. Some refugees complain that increased sexual activity is due to lack of other options. Reproductive health services are usually of poor quality and not readily accessible.

MacPhail C. & Campbell C. (2001). 'I think condoms are good but, aai, I hate those things': condom use among adolescents and young people in a Southern African township. Social Science and Medicine **52**: 1613-1627.

This study is a good example of the use of focus groups to explore social and community norms affecting young people. Levels of heterosexually transmitted HIV infection are high among young people in South Africa. Knowledge about HIV is high but perceived vulnerability and reported condom use are low. Surveys on behaviour have been carried out and this paper uses qualitative methods to complement existing knowledge gleaned from these survey data. This study uses focus group discussions to explore community and social factors that hinder condom use among youth in the township of Khutsong, near Careltonville. There were 44 male and female participants aged 13-25. The paper highlights six factors hindering condom use: lack of perceived risk; peer norms; condom availability; adult attitudes to condoms and sex; gendered power relations and the economic context of youth sexuality in the area. The authors note that while dominant social norms were evident, there was also evidence of a critical awareness of these norms among many young people. Some also challenge these norms and behave in other ways.

Mahler K. & Rosoff J.I. (1998). Into a new world: Young women's sexual and reproductive lives. New York, New York, Alan Guttmacher Institute **56**.

Using data from the Demographic and Health Surveys, and further survey data from China, France, Germany, the UK, Japan, Poland, and the UK, this report documents the conditions of the lives of young women worldwide. The first section reviews the biological and social aspects of the teenage years on women, and the similarities of their experiences. Next, social context is described in terms of social changes, urbanisation, poverty, and education. Section 3 summarises the timing of first intercourse and marriage. Section 4 covers issues and trends related to childbearing before age 18: childbearing at early ages is declining but continues in many parts of the world and is often unplanned. Particularly affected are rural populations with little education. In the next section, contraceptive practice among young people is summarised, and problems of access to contraception discussed. The sixth section deals with exposure to reproductive health risks such as poor pregnancy outcomes, clandestine abortion, sexually transmitted diseases, HIV/AIDS, and female genital mutilation. The final section makes recommendations for services that will meet young women's needs.

Maman S., Campbell J., Sweat M.D., Gielen A.C. (2000). The intersections of HIV and violence: directions for future research and interventions. Social Science and Medicine **50**: 459-478.

Available literature on HIV and violence is reviewed in this paper, with the aim of answering four questions: 1. How does forced sex affect women's HIV risk; 2. How do violence or threats of violence affect condom use; 3. Is the risk of violence greater for women living with HIV than for other women; 4. What are the implications of existing evidence for the direction of future research and interventions? Twenty-nine studies from sub-Saharan Africa and the USA are reviewed. The scope of the problem of violence against women is described, including physical abuse, sexual abuse (in adulthood and childhood), then the authors address the questions listed above. The studies reviewed are summarised in a detailed table. The authors identify a number of methodological limitations in the studies and suggest that more prospective studies are needed, and that standardised definitions would be useful. They note the absence of men from much of the research. The paper does not consider young people in particular, but many of the issues described also apply to young people.

McCauley A.P. & Salter C. (1995). Meeting the needs of young adults. Population Reports Series J(41).

Young adults have reproductive health needs that differ from older adults. This issue of Population Reports summarises survey data on the sexual activity of youth, related health problems, and contraceptive use. The differences between the needs of younger and older adults are discussed. Risks for young people are outlined, including sexual violence and coercion, health risks of early pregnancy, unintended pregnancy and unsafe abortion, and social and economic consequences of early childbearing. Programmes that have been implemented for young adults are summarised in a large table, and young people's needs are discussed. Results of programme evaluations are presented. An extensive bibliography ends the report.

McDevitt T.M., Adlakha A., Fowler T.B., Harris Bourne V. (1996). Appendix: Detailed tables, pp. A1-A27 in Trends in adolescent fertility and contraceptive use in the developing world. Washington DC: Bureau of the Census,

This report summarises findings from the US Census Bureau's International Data Base and other demographic surveys on the reproductive behaviour of young women in 56 developing countries. This appendix contains tables with demographic data on magnitude of teenage fertility and the proximate determinants of fertility: residence, educational level, marriage age, and contraceptive usage.

Meekers D. & Calvès A.-E. (1999). Gender differentials in adolescent sexual activity and reproductive health risks in Cameroon. African Journal of Reproductive Health 3(2): 51-67.

Gender differences in adolescent sexual behaviour and reproductive health risks in Cameroon were investigated. Data were obtained from the 1996 Adolescent Reproductive Health Survey, a baseline survey conducted in the towns of Edea and Bafia. Fifty-five percent of females and 70% of males were sexually experienced. The study examined gender differences in sexual initiation, unsafe sexual behaviour, condom use, and sexually transmitted diseases and abortion. Explanatory variables included age, school enrolment, extent of discussion of sexual issues, views about females introducing condom use, and knowledge of sources of supply of condoms. Logistic regression techniques were used. Younger women were more likely to have become sexually active by 15 years old. Those currently enrolled in school were less likely to have begun early sexual activity. Five percent of women aged 12-17 years and 14% of men aged 12-17 years exchanged money or gifts for sex. A higher proportion of older youth had exchanges for sex. Five percent of women aged 12-17 and 16% of males aged 12-17 had two or more regular sexual partners. The proportion with multiple partners significantly increased with age. Around 40% of those aged 12-17 years had used condoms at least once. Nine percent of females aged 15-17 years and 20% of females aged 18-22 years had had an abortion. Risk of having a sexually transmitted disease in the previous year was higher for females among those with multiple casual partners and was higher for males with multiple regular partners.

Meursing K. & Sibindi F. (1995). Condoms, family planning and living with HIV in Zimbabwe. Reproductive Health Matters 5: 56-67.

A project of intensive counselling and support provided the qualitative data for this study in Zimbabwe. The study participants were 72 men and women aged 9-55 with HIV. Repeat contacts with the participants were made, and counselling and support given by the researchers. The themes discussed in this paper are condoms and family planning with HIV infection, gender roles and expectations in sexual relationships (marital relationships, extramarital and premarital relationships), living with HIV in marriage, HIV before marriage, HIV where marriage is not an issue (relationships centred around money or pleasure). The authors find that in Zimbabwe, men have sexual freedom and power over women within relationships, and the use of a condom still depends on the men's willingness. Men dislike using condoms, which is a major barrier to HIV/STD prevention both before and after a positive HIV diagnosis. HIV positive people are stigmatised, reducing the likelihood that they will be open about the diagnosis, and many of the participants reported keeping their diagnosis secret from their sexual partners.

Meyer-Weitz A., Reddy P., Weijts W., *et al.* (1998). The sociocultural contexts of sexually transmitted diseases in South Africa: Implications for health education programmes. AIDS Care 10(1): S39-S55.

In the context of widespread STDs including HIV, more understanding of illness representations was sought. Eighty-eight patients seeking care at two STD clinics in South Africa were interviewed. Interviews were conducted with 67 Xhosa- and Zulu-speaking patients in clinics in Cape Town, Western Cape, and 21 in the rural areas of Kabokweni, Mpumalanga. All but 25 of the participants were under age 30. Study findings suggest that STD patients' illness representations reflect their sociocultural understanding of disease and of culturally defined gender relationships. These representations affect patients' general perceptions of the causes of STDs, their perceptions of the risk of contracting STDs, the seeking and use of formal and traditional medical care, and notions of prevention.

Mfono Z. (1998). Teenage contraceptive needs in urban South Africa: A case study. International Family Planning Perspectives 24(4): 180-183.

The needs of urban teenagers for sexuality education and contraceptive services in South Africa were investigated in 1995 using qualitative methods. Problems encountered in accessing family planning (FP) services were assessed. Data were obtained from young people who used four service delivery points (SDPs) in urban Gauteng province, and from providers. Information was collected from direct observations, informal discussions, focus groups, and administrative records. Findings indicate that three out of the four clinics were suitable for serving teenage clients. Service at the first visit included a medical and reproductive history intake, physical examination, determination of needs, sexuality and contraceptive education, and counselling. Contraceptives were distributed at all sites. Nurses discussed side effects. All SDPs posted literature on family planning, sexually transmitted diseases, and AIDS. Two centres had more complete walk-in services. The other two centres were more formal. One site was at a university where contraceptive choice was limited. All SDPs had adequate equipment. All but one SDP viewed clients favourably. Most teenagers were unmarried students and preferred hormonal methods, especially injectables. Focus groups revealed communication difficulties with parents. Boys assigned responsibility for contraception to girls. Males were more regular clients. Most visited clinics after sexual relations began. Teenagers preferred separate services for youth. Most viewed teenage pregnancy as a disaster.

Miller K., Miller R., Fassihian G., Jones H. (1998). How providers restrict access to family planning methods: Results from five African countries. In: Miller K., Miller R., Askew I., *et al.* (Eds.) Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from situation analysis studies. New York, NY: Population Council.

Situation analyses of family planning services in five countries (Botswana, Burkina Faso, Kenya, Senegal, and Zanzibar (Tanzania)) are reported. The following provider-imposed restrictions to family planning access are investigated: marital status, spousal consent, parity requirements, minimum and maximum age requirements. These restrictions are examined with respect to six contraceptive methods: combined oral contraceptives, condoms, IUDs, injectables, implants and female sterilisation. In some of the settings examined, women were required to be married before receiving contraceptives, some required spousal consent. It was found that minimum age restrictions were common (13 years old). Of all the locations examined, Zanzibar was found to have the most restrictive policies, and Senegal the least.

Miller R., Fisher A., Miller K., *et al.* (Eds.) (1998). The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A handbook. New York, NY: Population Council.

The situation analysis approach to analysing health care provision is described. The rationale for using this method of study is presented, and compared with knowledge, attitudes and practice surveys. In situation analysis, a number of approaches to evaluation are integrated: a systems perspective, visits to a large sample of service delivery points, a client-orientated focus on quality of care, structured interviews with clinic staff and clients, recording of clinic facilities on the day of the visit, direct observation of all client-provider interactions on the day of the visit. The paper outlines study design, data collection instruments, study implementation, programmatic uses of situation analysis studies, and the relationship to impact studies and operations research. Finally, methodological issues are discussed.

Minnis A.M. & Padian N.S. (2001). Reliability of adolescents' self-reported sexual behavior: a comparison of two diary methodologies. Journal of Adolescent Health 28(5): 394-403.

Two methods were compared for obtaining data about sexual and contraceptive behaviour among young women. The methods were a written calendar that the individual was asked to fill in every day, and an automated telephone interview where the individual called a free number and responded to questions by pressing numbers on the telephone key pad. The study used a randomised controlled trial design with 105 sexually active, female 15-19 year olds. It was found that the automated telephone diary was an acceptable, even preferred, alternative to written calendar diary. The authors suggest that it also elicited more accurate reporting of contraceptive behaviour. Incentives were offered to encourage the provision of information. These methods would not be possible to use in all settings because of their reliance on literacy (written diaries) and suitable infrastructure (telephone interviews). Nevertheless, they add to the repertoire of methods available for collection of data on sexual behaviour.

Mitchell DiCenso A., Thomas B.H., Devlin M.C., *et al.* (1997). Evaluation of an educational program to prevent adolescent pregnancy. Health Education and Behaviour 24(3): 300-312.

Two sex education programmes for teenagers were compared in Hamilton, Ontario, Canada, using a randomised, controlled trial. This study compared the outcome of the McMaster Teen Program with that of a conventional didactic sex education program using a sample of grade 7 and 8 students in 21 public schools. The trial involved four-year follow-up of 2111 students in the 11 experimental (McMaster) schools and 1263 students in the 10 control (conventional) schools. The mean age of the students when

the program began was 12.6 years. No significant differences were found between the groups in time to first sexual activity for males or females or time to first pregnancy. The only significant difference found was that more sexually active males in the experimental group reported always using birth control at post-test 2. Logistic regression analysis for sexual intercourse, contraceptive usage, and pregnancy revealed that males with educational goals beyond high school were less likely to engage in sexual intercourse. Females were less likely to engage in sexual intercourse if they were from an ethnic family, were less responsive to external pressure, and had educational goals beyond high school. Lower responsiveness to external pressure predicted responsible contraceptive usage for both boys and girls. Limitations of the study are discussed.

Morris L., Warren C.W., Aral S.O. (1993). Measuring adolescent sexual behaviours and related health outcomes. Public Health Reports 1: 31-36.

This article describes the design of the Youth Risk Behaviour Surveillance System (YRBSS) questionnaire which was created after identification of the major health outcomes associated with pregnancy and sexually transmitted disease (STD) in adolescents and with regard to national health goals promoted by the United States Public Health Service in "Healthy People 2000" (1990). Negative outcomes associated with pregnancy are discussed and include unintended pregnancies, miscarriages, stillbirths, abortions, pregnancy complications, maternal deaths, low birth weight or premature infants, and children at higher risk of disease, disability, or infant death. Statistics for youth STD are described, including chlamydia, gonorrhoea, syphilis, pelvic inflammatory disease (PID) associated with gonorrhoea and syphilis, chancroid, herpes simplex virus, human papilloma virus, human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS). The fourteen national health objectives relating to sexual behaviour among adolescents are summarised. In developing the questionnaire, seven behaviours were chosen (learning about HIV infection, sexual intercourse, age at first sexual intercourse, number of sexual partners, use of alcohol or drugs before sexual intercourse, use of contraceptives, and use of condoms) and two health outcomes (pregnancy and STD). The YRBSS is the only school based, surveillance system continuously monitoring sexual behaviour and related health outcomes in adolescents throughout the United States.

Murray N.J., Zabin L.S., Toledo Dreves V., Luengo Charath X. (1998). Gender differences in factors influencing first intercourse among urban students in Chile. International Family Planning Perspectives 24(3): 139-44.

This study examined factors associated with early sexual initiation in Chile. Data were obtained from a baseline survey among 4248 urban students aged 11-19 years in March 1994. The survey was conducted before a sex education and reproductive health services program was initiated. It was hypothesised that early first sexual intercourse (FSI) would be associated with family structure, parental education, academic performance, peer group influences, use of drugs and alcohol, and attitudes toward sexuality and early parenthood. The instrument was based on one used to evaluate a sex education program in Baltimore, Maryland. Bivariate analyses and analyses of five separate multivariate logistic models were performed. The findings confirm that the factors associated with initiation of FSI were the same in the US and Chile. The final reduced model revealed that the significant factors associated with increased odds of FSI for males were as follows: age, attitudes about the type of relationship appropriate for sexual intercourse, a perception of the ideal age of FSI, their current relationship, perception of peers' sexual experience, belief that early parenthood limits employment options, and ever having smoked or used marijuana. For women, the significant factors predicting sexual initiation were the same in individual and final models for sexual attitudes and relationship variables. The attitudes toward early pregnancy and ever having smoked cigarettes became insignificant in the final model. Significant factors were similar for both sexes.

Nduna S. & Goodyear L. (1997). Pain too deep for tears: assessing the prevalence of sexual and gender violence among Burundian refugees in Tanzania: International Rescue Committee.

Sexual and gender-based violence were investigated among Burundian refugees in Tanzania. This report describes the methods and findings of the project. Participatory methods were used, and qualitative and quantitative approaches were combined. The authors discuss their experiences using both types of approach and the report provides an insight into the practical implications of use of different methods to research sensitive topics. The results of the study are reported in terms of people most vulnerable to sexual violence, the types of violence reported, the perpetrators of the violence, and three case studies of different experiences of violence reported in in-depth interviews.

Nelson K.E., Celentano D.D., Eiumtrakol S., *et al.* (1996). Changes in sexual behaviour and a decline in HIV infection among young men in Thailand. New England Journal of Medicine 335(5): 297-303.

There is a high seroprevalence of HIV among sex workers in Thailand. In an effort to reduce the incidence of HIV infection, the Ministry of Public Health began a program in 1990 and 1991 to promote

the use of condoms during commercial sex. The authors evaluated the effect of that and other programs to prevent HIV infection in Thailand. Five cohorts of 21-year-old men from northern Thailand conscripted into the army by lotteries in 1991, 1993, and 1995 were studied. A total of 4311 men were tested for HIV antibodies by enzyme-linked immunosorbent assay, with confirmation by Western blot assay. The 10.4-12.5% prevalence of HIV infection found in the 1991 and 1993 cohorts fell to 6.7% in the 1995 cohort. The seroprevalence was only 0.7% among men who did not have sexual relations with a sex worker before 1992. Over the study period, the proportion of men who reported having sexual relations with a sex worker fell from 81.4% to 63.8%. At the same time, over the period 1991-95, the men's reported use of condoms during the most recent sexual contacts with sex workers increased from 61.0% to 92.5%. In 1995, 15.2% of men had a history of a sexually transmitted disease, compared with 42.2% in 1991. The authors conclude that public health programs in Thailand have led to changes in sex behaviour among young men, especially an increased use of condoms.

Nnko S. & Pool R. (1997). Sexual discourse in the context of AIDS: Dominant themes on adolescent sexuality among primary school pupils in Magu district, Tanzania. Health Transition Review 3: 85-90.

Students in Tanzania are at risk of contracting and transmitting HIV. This paper presents the dominant themes of sexual discourse among adolescent primary school students in Magu district along the south-eastern shores of Lake Victoria in Tanzania. Eleven primary schools are situated in the study area, Kisesa ward. Fifteen girls aged 13-15 years and 16 boys aged 5-18 years from six of the schools participated in a narrative research-based study conducted in workshops over the course of two days. The dominant themes presented from the students' discourse on sexual relationships are love and sex, sexual desire, money and rewards, deception, and the fear of pregnancy. Risk of HIV infection is increased by non-availability of condoms and the proscribed nature of sex and condom use among the students.

Oakley A., Fullerton D., Holland J. (1995). Behavioural interventions for HIV/AIDS prevention. AIDS 9: 479-486.

The aim of this study was to identify and review critically behavioural interventions in the HIV prevention and sexual health fields. Electronic and hand searches were conducted to retrieve relevant published and unpublished reports of outcome evaluations. A methodological review was carried out to identify those with sufficient methodological strengths to generate reliable conclusions about effectiveness. Soundly designed studies were defined as those that met the four core criteria of employing control groups, providing pre- and post-intervention data and reporting on all targeted outcomes. A total of 68 separate reports of outcome evaluations were located. Only 18 were judged to be methodologically adequate. Major problems found were lack of a control group or non-equivalent/unbalanced control groups, small sample sizes, failures to report pre-intervention measures, short follow-up, and high attrition rates. Academic reviewers were more likely than the authors of papers to judge reports of evaluations as providing insufficient information to assess effectiveness. The authors conclude that evaluation design in this field needs to be improved. Recommendations include more use of randomised controlled trials and the raising of publication standards by journals.

Ouattara M., Sen P., Thomson M. (1998). Forced marriage, forced sex: The perils of childhood for girls. Gender and Development 6(3): 27-33.

This article reviews the findings of three projects on non-consensual marriage and forced sex using research by Anti-Slavery International on child marriage in parts of West Africa, an investigation by Save the Children of children's views of early marriage, and research conducted by CHANGE on women's resistance to domestic violence in Calcutta, India. Girls who marry before 15 years of age are more likely to be illiterate than their older counterparts, more likely to be dowry payment brides, less likely to come into contact with development projects, have higher rates of infant mortality, and are most vulnerable to sexual violence. In many cases, intercourse is initiated before the girl begins to menstruate. Although adult women also face sexual violence within marriage, this problem is more traumatic for girls who lack information about sex. Sex with girls below a certain age is usually covered by rape legislation, but in countries such as India, this is mitigated by the religiously defined personal laws.

Palma I. & Quilodran C. (1995). Adolescent pregnancy in Chile today: From marriage to abortion. Reproductive Health Matters 5: 12-21.

Focus group discussions and in-depth interviews are used to examine the consequences of teenage pregnancy in Chile. Teenage women may get married, live with their partner outside marriage, be a single mother, give their child up for adoption, or abort the foetus. Although abortion is illegal in Chile, research indicates that there are 130,000-150,000 clandestine abortions in the country per year. One-third of abortions produce complications requiring hospitalisation. The proportion of women under age 24 hospitalised for abortion-related complications increased from 36% of the total in 1970 to almost 49% in 1985. The authors investigated the consequences of each course of action available to young,

pregnant women from working classes in Santiago. Each course of action has risks, obstacles, and challenges requiring a significant degree of sacrifice. The young women fear the loss of their future, of self-esteem, and of the affection of their partners, parents, and friends. They also fear that their child will ultimately reject them when they learn of their mother's premarital pregnancy. Young mothers have their rights curtailed and their access to work and school restricted or denied.

Parker R., Khan S., Aggleton P. (1998). Conspicuous by their absence? Men who have sex with men (msm) in developing countries: Implications for HIV prevention. Critical Public Health 8(4): 329-346.

Men who have sex with men are frequently absent from policy and programme agendas. This paper examines how homosexual behaviour and HIV/AIDS has been addressed in different parts of the developing world, and the implications this has for programmes. Research in sub-Saharan Africa, South and Southeast Asia, and in Latin America is discussed. The authors emphasise that despite evidence that men who have sex with men are an important population vulnerable to HIV infection in every region of the world, this evidence has continually been denied and neglected. Some of the programmes that have been targeted at this group are described.

Patton M.Q. (1999). Enhancing the quality and credibility of qualitative analysis. Health Services Research 34(5).

This overview examines ways of enhancing the quality and credibility of qualitative analysis. Three inquiry concerns are discussed. First, rigorous techniques and methods for gathering and analysing qualitative data, including attention to validity, reliability, and triangulation (of qualitative and quantitative data, of multiple qualitative data sources, using multiple analysts, using different theoretical perspectives). Second, the credibility, competence and perceived trustworthiness of the qualitative researcher, and researcher effects on study findings. Third, philosophical beliefs about evaluation. Qualitative methods have in the past been characterised as "soft" as opposed to the "hard" quantitative methods. There is now more of a consensus that what is important is to match methods appropriately to empirical questions and issues, rather than advocate only a qualitative or only a quantitative approach for all problems.

Peart R., Rosenthal D., Moore S. (1996). The heterosexual singles scene: Putting danger into pleasure. AIDS Care 8(3): 341-349.

This article uses qualitative interviews to investigate the relationship between 'pleasure', 'danger' and contemporary feminist theory. It attempts to offer an explanation of ways in which categories of pleasure and danger operate within the discourses of heterosexuality to construct perceptions of HIV risk. Data were collected from a study of the sexual attitudes and practices of 112 sexually-active, single, heterosexual adults (58 men and 54 women), aged 20 to 40 years (mean = 27 years) who agreed to be interviewed when approached at night-clubs and public "singles" bars around Melbourne, Australia. In the analysis, the following themes are discussed: that sexuality is not solely pleasurable or dangerous; that heterosexualised notions of pleasure and danger provide misperceptions of HIV risk; that logic of identity obscures risk within the discourse of heterosexuality. Attitudes to condom use are specifically discussed.

Population Council & IFH (2001). The case for microbicides: a global priority (revised edition). New York, NY: The Population Council and International Family Health.

The status of microbicides is reviewed in this report. Development of microbicides has been driven by the HIV/AIDS epidemic and the need for female-controlled methods. Development of microbicides and acceptability studies are reviewed. The report highlights a number of challenges to be addressed: the need for increased investment, both from the public and private sectors; the need to identify and address constraints to availability and access and scientific and research challenges. The report concludes by enumerating priorities for future action.

Quinn T.C. (1996). Association of sexually transmitted diseases and infection with the human immunodeficiency virus: biological cofactors and markers of behavioural interventions. International Journal of STD and AIDS 7(Suppl 2): 17-24.

This paper discusses the value of using infection with STD as a marker of behaviour. Sexually transmitted diseases (STDs) interact uniquely with HIV infection, regardless of the form of sexual transmission of HIV. Both STDs and HIV infection are behaviourally and biologically intertwined with one another. This concept is called epidemiologic synergy since they facilitate the sexual transmission of one another. Assuming that one accepts this concept, innovative and comprehensive STD control programs along with community and individual-based prevention programs should provide a more effective HIV control program by reducing the efficiency of HIV transmission in high-risk individuals. Public health workers can assess the effectiveness of these programs by monitoring incident STDs in high-risk groups. Other benefits of using incident STDs as markers for HIV prevention include: biological validation of self-reported behavioural change, possible association between self-reports of behavioural

change and recall or social desirability bias, representation of a major target population for HIV programs by people at risk for STDs, and sensitive, specific, and noninvasive STD-assays. Disadvantages of using incident STDs as markers for HIV prevention are: incident STDs are unreliable for detecting deficiencies in one individual component (e.g. condom use), they can be used only in areas with a high STD prevalence and high transmission probability, STD diagnostic assays are not 100% sensitive and specific, and untreated/undetected STDs at enrollment may be mislabeled as incident STDs at follow-up. Questions remain about the validity of self-reported condom use and the use of STDs to evaluate individual intervention measures, such as condom use, within a short period of time. Monitoring of HIV incidence would be ideal, but takes too long. Valid measures of condom use and other risk behavior are needed to determine risk status and changes in risk status over time. Further research is needed to develop more accurate measures.

Radhakrishna A., Gringle R.E., Greenslade F.C. (1997). Identifying the intersection: Adolescent unwanted pregnancy, HIV / AIDS and unsafe abortion. Carrboro, North Carolina,: Ipas.

This publication looks at the potential negative consequences of youth sexual activity. The first part describes adolescent vulnerability to HIV and unwanted pregnancy due to sexual violence and coercion, physiological vulnerability, economic pressures, physical vulnerability to infection, cultural expectations, barriers to services, and partner behaviour. The second part looks at the sequelae of unwanted pregnancy and unsafe abortion that occur as a result of disappointing family expectations, legal and logistical barriers, the lack of resources for abortion care, and interrupted opportunities for education. Part 3 examines unmet need to prevent HIV infection, unwanted pregnancy, and unsafe abortion. Finally, ways to promote global action are discussed and key questions for research are presented.

Rahman A., Katzive L., Henshaw S.K. (1998). A global review of laws on induced abortion, 1985-1997. International Family Planning Perspectives 24(2): 56-64.

This article provides a brief summary of abortion laws in 152 nations and dependent territories with populations of at least a million and documents changes in these laws since 1985. Classification of abortion laws according to level of restrictiveness (to save the mother's life, to preserve the mother's physical health, to safeguard her mental health, on socioeconomic grounds, and without restriction as to reason) reveals that 41% of the world's population lives in the 49 countries that allow abortion without restrictions regarding reasons. The article then reviews the prevalence of other legal restrictions, such as gestational age, third-party authorization, type of medical facility and personnel, mandatory counseling requirements, restrictions on information, and fees. The review of trends since 1985 shows that 19 countries have reduced restrictions on abortion, and only one country has increased restrictions. This review provides regional summaries and also notes important changes in individual countries. The final section of the article covers factors that affect abortion availability, such as varying interpretations of laws, enforcement, the attitude of medical staff, and responses to the efforts of anti-abortion groups. It is concluded that most of the world's women live in countries where abortion is legal under many circumstances and that the global trend toward liberalizing abortion laws has continued and has enhanced the availability of safe abortion services.

Ray S., Latif A., Machezano R., Katzenstein D. (1998). Sexual behaviour and risk assessment of HIV seroconvertors among urban male factory workers in Zimbabwe. Social Science and Medicine 47(10): 1431-1443.

The behaviours that place heterosexual men at risk of HIV/AIDS were investigated through a cohort analysis of men who became HIV-positive in the course of a long-term study of factory workers in Harare, Zimbabwe. Data were collected through structured questionnaires, blood samples tested for HIV, qualitative case studies and interviews. The study enrolled 2717 workers from 40 factories in Harare in 1993-95. Nineteen percent were HIV-positive at study entry. Fifty-seven percent of the 1678 initially seronegative subjects seroconverted during the study period. Significant risk factors in this cohort included being in the 18-24 year age group (47%) and a having a sexually transmitted infection in the seroconversion period (23%). Seroconverters were twice as likely as men who remained HIV-negative to have paid for sex in the year preceding study enrolment. Divorced and widowed men and married men who were not residing with their wives were at higher risk of infection than married men living with their wives. Education, employment status, salary, and housing status were not associated with seroconversion. Over 40% of the seroconverters had been counselled on staying HIV negative. Because men tended to assess their risk of exposure on the basis of faulty criteria (e.g. character, physical appearance, background), they rarely used condoms.

Riehman K.S., Sly D.F., Soler H., *et al.* (1998). Dual-method use among an ethnically diverse group of women at risk of HIV infection. Family Planning Perspectives 30(5): 212-7.

Promotion of condom use among women who use efficient contraception is essential to protect them from sexually transmitted diseases (STDs), including HIV, as well as pregnancy. Fear of negative

reactions from a male partner may limit dual method use among women who are economically dependent on men. To understand the factors that influence dual method use, interviews were conducted with 522 low-income US women at risk of HIV who attended 21 public health, family planning (FP), and STD clinics or economic assistance centres in Miami, Florida (US), in 1994-95. Fifty-four percent were concerned about both pregnancy and AIDS; 32% were worried about AIDS only and 5% about pregnancy only. Twenty percent of respondents reported dual method use. Overall, 36% of women used condoms (either alone or along with another method). The rate of dual method use was 16% among Whites, 24% among Blacks, and 21% among Hispanics. The likelihood of dual method use was significantly enhanced among women who were not married, worried about both pregnancy and AIDS, had ever had an STD, were confident they could refuse sex with a man who would not use a condom, and made FP decisions jointly with their partner. Women who regarded condoms as only somewhat effective in preventing HIV infection or who shared economic decision-making with their partner rather than making such decisions alone were least likely to use dual methods. Black and Hispanic women were significantly more likely than White women to use condoms in conjunction with efficient contraception.

Rivers K. & Aggleton P. (1998). Adolescent sexuality, gender and the HIV epidemic (A concept and discussion paper prepared for the UNDP HIV and Development Programme). New York: United Nations Development Programme: 55 pages.

This review examines the risk to young people of STD/HIV infection. Evidence from a variety of studies is presented. In the first part, it is noted that not all young people are at equal risk of HIV infection, and causes of vulnerability are discussed. Young people have less access to information, services and resources than older adults. The concept of "adolescence" is examined. In the second section, social factors increasing vulnerability to HIV infection are described including living/working on urban streets, economic deprivation, traditional gender stereotypes, sexual activity of men with other men, and young age itself. In the third section, sex education received by young people is outlined, with examples from various parts of the developing world. HIV-related work with young people is discussed, and effective approaches summarised. Finally, principles for future work to prevent HIV infection are presented.

Rivers K. & Aggleton P. (1999). Men and the HIV epidemic. New York: United Nations Development Programme: 32 pages.

Gender relations and dynamics, especially versions of masculinity, are discussed as related to HIV risk. Evidence from around the world is presented. After the introduction, the authors discuss gender and the HIV epidemic: gender and development, gender inequalities and masculinity, masculinities and sexual health, and gender and other inequalities. The second part examines issues around working with men: the need to involve men in prevention of HIV infection, findings about condom use, groups of men at special risk (truck drivers, migrants), workplace programmes, men who have sex with men, and finally gender and care for people living with HIV/AIDS. The paper ends with a discussion of lessons learned and recommendations for future work.

Rivers K., Aggleton P., Elizondo J., *et al.* (1998). Gender relations, sexual communication, and the female condom. Critical Public Health 8(4): 273-290.

A multi-site study was conducted to examine the effect of the introduction of the female condom on women's capacity to negotiate safer sex. The study was conducted in Costa Rica, Indonesia, Mexico, and Senegal. At each site, in-depth interviews, document analysis and observation were used over a two to three month period to assess prevailing gender relations, sexual communication, negotiation and reproductive decision-making. After this initial stage, an intervention took place designed to strengthen women's capacity in sexual negotiation, including distribution of female condoms and provision of guidance on their use. Some of the participants were sex workers. Findings of the studies are reported under the following headings: prevailing gender roles and relations; sexual communication; perceptions of risk; negotiating safer sex; the female condom. The paper concludes that there are two main factors constraining women's heterosexual behaviour and choices: economic dependence on men, and gender stereotypes. The female condoms were most successful in enhancing communication and women's empowerment among sex workers who already had some skills of negotiating safer sex with clients, in couples where the men were supportive of family planning, in places where community involvement was important and men could be reassured that peer acceptance was high, in situations where the female condom was preferable to the male condom, and where use of the female condom could be eroticised.

Rogo K.O. (1993). Induced abortion in Sub-Saharan Africa. East African Medical Journal 70(6): 386-395.

There is confirmation from hospital-based studies that unsafe abortion and its complications have been the cause of up to 50% of maternal deaths in sub-Saharan Africa. In this article, estimates of induced abortion in this region are presented. In all parts of Africa induced abortion is illegal or severely restricted by law. The legal status of abortion and abortion services are discussed: who provides

abortions? What are their medical and social consequences? Future prospects for resolving abortion issues are examined.

Rosen J. (2000). Advocating for adolescent reproductive health: addressing cultural sensitivities. Washington, DC: Pathfinder International, FOCUS on Young Adults.

This brief summary provides an overview of the issues of cultural sensitivity arising from introduction of youth sexual health interventions. The summary discusses how interventions can be affected by beliefs about sexuality and about the role of the family, as well as by restrictive laws and policies. Strategies for overcoming these possible obstacles are then discussed. Strategies include dissemination of accurate and understandable information about the intervention, open communication, youth involvement, involvement of traditional and religious leaders, and caring adults, establishing national guidelines, training health workers, introducing interventions gradually.

Rosenberg M.J. & Gollub E.L. (1992). Commentary: Methods women can use that may prevent sexually transmitted disease, including HIV. American Journal of Public Health **82**(11): 1473-1478.

Methods available to women for protection against STD/HIV are reviewed, with evidence from quantitative studies. Latex condoms provide more protection against passage of STD organisms and HIV than sheep intestine condoms, but in one study 33% of latex condoms leaked particles the same size as HIV. A meta-analysis shows condoms can reduce STD infection rates by 50%. Protective effectiveness depends on consistent and compliant condom use. The same reduction has been shown among women who use vaginal spermicides. Cytomegalovirus (CMV) cannot pass through the female condom. The active ingredient in most spermicides, nonoxynol-9, inactivates HIV, CMV, herpes simplex virus-2, hepatitis B virus, *Neisseria gonorrhoeae*, *Treponema pallidum*, *Trichomonas vaginalis*, and *Candida albicans*. Benzalkonium chloride, chlorhexidene, and menfegol have the same effect as nonoxynol-9. The vaginal sponge containing spermicide may reduce STD or HIV infection because it provides a physical barrier, absorbs the ejaculate, and destroys the organisms. Even though diaphragms and cervical caps can protect the cervix from *N. gonorrhoeae* and *Chlamydia trachomatis*, they do not protect the vagina and vulva. Observational studies comparing the effect of condoms, diaphragms, or spermicides on the risk of STDs indicate a consistently lower STD risk among diaphragm users. Douching, oral contraceptives, IUD, and female sterilisation provide no protection against STDs and HIV.

Rosenthal D., Gifford S., Moore S. (1998). Safe sex or safe love: Competing discourses? AIDS Care **10**(1): 35-47.

Interviews with heterosexual men and women recruited at discos and bars in Melbourne, Australia, in 1993 revealed a tendency - especially among women - to construct sex as "safe" within the discourses of "love" and "romance." The 112 respondents (mean age, 27.4 years) were asked to narrate their experiences of sex, love, romance, and safety, with particular emphasis on casual sexual encounters. Casual sex was viewed as an essential strategy in the search for love, and sexual safety practices were related more to their anticipated impact on finding love than on an assessment of the potential of sexually transmitted disease transmission - a view consistent with cultural notions of femininity in sex as the relinquishment of control for the sake of love. Both men and women commented on the difficulties of raising the issue of condom use and HIV/AIDS prevention with someone they had just met. This difficulty was even more pronounced among women, who tended to believe insistence on condom use would result in the loss of a sexual encounter with romantic potential. Many men reported they use this perception of potential rejection to convince women to engage in unprotected sex.

Santelli J.S., Warren C.W., Lowry R., *et al.* (1997). The use of condoms with other contraceptive methods among young men and women. Family Planning Perspectives **29**(6): 261-267.

The prevalence of combined use of condoms and non-barrier contraceptive methods for the purpose of dual protection against pregnancy and sexually transmitted diseases (STDs) was investigated using data from the 1992-93 US Youth Risk Behaviour Survey. In this nationally representative sample of 4260 sexually active youth 14-22 years of age, 37% of females and 52% of males reported reliance on the condom at last intercourse as the primary method to prevent pregnancy. An additional 8% of females and 7% of males had used a condom for non-contraceptive purposes. Condom use at most recent intercourse was reported by 25% of males whose sexual partner was using oral contraceptives (OCs) and 21% of OC users. Black women had the highest and Hispanic women the lowest rate of dual condom/OC use. Other significant independent predictors of combined condom/OC use were - among males - younger age, engaging in fewer non-sexual risk behaviours (e.g. seatbelt non-use), and instruction about HIV in school and - among females - younger age, older age at first intercourse, fewer non-sexual risk behaviours, no sexual partners in the previous three months, and discussions with parents or other adults about HIV. These findings suggest that, for the majority of young people, the

condom is primarily viewed as a means of preventing pregnancy and that prevention of HIV and other STDs is not a separate goal.

SARA/AED/CERPOD (1997). Youth in danger: Results of a regional survey in five West African countries: Support for Analysis and Research in Africa/Academy for Educational Development/Centre d'Etudes et de Recherche sur la Population pour le Développement Bamako.

Focus groups, individual interviews and quantitative data from the Demographic and Health Surveys are used to produce a profile of the sexual and reproductive health of young people in five West African countries: Burkina Faso, the Gambia, Mali, Niger, and Senegal. The study looks at age at first marriage, sexual activity before marriage, births before marriage, family planning among 15-19 year olds, sexually transmitted diseases and HIV/AIDS, and health of the teenage mother and her child. Early marriage is common in rural areas and rarer in urban areas where an increasing number of women are still single at age 20. Limited data on premarital sex indicate that it is more prevalent in the urban areas. Modern contraceptive use in the Sahel appears to be among the lowest in the world and in all countries, sexually active unmarried women showed lower levels of modern contraceptive use than older, unmarried women. Barriers to use of family planning and STD clinics are identified.

Schensul S.L., Oodit G., Schensul J.J., *et al.* (1993). Young women, work and AIDS-related risk behaviour in Mauritius. Report in Brief: International Center for Research on Women.

The HIV risk of young, unmarried women employed in the export processing zone of Mauritius was the subject of this study. Data collection techniques used included key informant interviews, observation techniques, and secondary analysis of survey data. An open-ended structured interview was developed based on the findings of the previous work, from which a survey instrument was developed. The survey was carried out on 500 young women in the export processing zone. Female factory workers tended to come from female-headed families with an average of 5.3 children and were endeavouring to supplement the family income. The average age at entry into the labour force was 16.7 years and monthly income averaged US\$100. Most study participants were ambivalent about the effect of work on their lives. Positive aspects cited included freedom and independence, increased power within their families, the opportunity to be more comfortable around men, and higher self-esteem. Negative aspects included lack of time, friction with parents, exposure to sexually promiscuous men, and the potential for gaining a bad reputation by association. Thirty-two percent indicated they had boyfriends, but had to keep their relationships secret because of a lack of family sanction; another 30% were engaged. Most women were reluctant to discuss sex-related issues with a male partner. There was almost no use of condoms among the 15% of respondents who reported being sexually active; the main barriers to condom use were the perception that condoms are only for married women, the belief they cannot prevent pregnancy, and concerns about reduced sexual pleasure. The majority considered themselves at low risk of AIDS, but also demonstrated a lack of accurate knowledge about the AIDS virus and its transmission. Peers were found to facilitate positive attitudes about premarital sex but to lack knowledge of risk assessment and AIDS prevention.

Senderowitz J. (1995). Adolescent health: Reassessing the passage to adulthood. Washington DC: World Bank.

This discussion paper reviews health issues for young people, with an emphasis on reproductive health. Data from a variety of sources are included. The paper contains sections on the following topics: knowledge of sexuality and contraception; knowledge of HIV/AIDS; source of sexual information; sexual activity by age and marital status; marriage and consensual union; adolescent fertility rates by region; use of contraception and family planning; abortion prevalence, morbidity and mortality; consequences of adolescent childbearing; STDs and HIV/AIDS; sexual abuse and exploitation; genital mutilation; need for and access to reproductive health services. A section about nutritional and other health needs of youth follows. Finally, programme approaches are presented. The paper concludes with an overview of policy issues in this subject area.

Senderowitz J. (1997). Health facility programs on reproductive health for young adults. Washington DC, Pathfinder International, FOCUS on Young Adults 22(51).

This paper: 1) provides a summary of project models for adolescent reproductive health care; 2) describes types of facilities for young adults; 3) identifies 12 areas where lessons were learned; 4) identifies key components of program design, infrastructure readiness, and five implementation areas; and 5) discusses nine critical research areas. This paper is based on a literature review of published documents and observations based on field experience. Reproductive health facility programs usually treat married young women for pregnancy and childbirth. Family planning service programs usually treat older, married women who have completed childbearing. Family planning clinics with reproductive health programs usually attract older people. Peer projects and drug stores tend to be the sources of information, counselling, and products for many young people. Provision of services to unmarried young people is examined. Preliminary actions involve a strategic approach, a target audience, needs

assessment, youth, community, and parental involvement, evaluation and monitoring, and continuation and replication. Key elements identified for youth services include preliminary actions, facility characteristics, scheduling and clinic hours, service provision, and costs.

Senderowitz J. (1997). Young people and STDs/HIV/AIDS. Part I: Dimensions of the problem. Washington DC: Pathfinder International, FOCUS on Young Adults.

This pamphlet summarises data and issues around sexually transmitted diseases (STDs) among young people. Because women, unlike men, often show no symptoms for the most common STDs, they are diagnosed and treated less frequently than men. Even when young people have symptomatic STDs, they may not want to seek care and/or health care providers may be reluctant to treat them. Infection with STDs increases a person's susceptibility to HIV infection and can also cause tubal infection and infertility. Two-thirds of all reported STD infections in the developed world are among men and women under age 25; the proportion of STDs among youth is higher in developing countries. Examples of prevalence data are presented for a number of specific STDs. The biological, behavioural, and cultural reasons why young people are vulnerable to STDs and HIV are briefly outlined, and the health and social consequences of high STD rates among young people considered.

Senderowitz J. (1997). Young people and STDs/HIV/AIDS. Part II: Programs to address the problem. Washington DC, Pathfinder International, FOCUS on Young Adults.

This short pamphlet reviews projects designed to prevent STDs and HIV among young people. These are usually based upon education, communications, and counselling activities. They tend to be located in schools, health care facilities, residential treatment centres, or through outreach into the types of places in which young people congregate. Some evidence of program success has been observed from the few projects thus far evaluated. Examples of projects in the US and selected developing countries are noted, together with lessons learned.

Senderowitz J. (1999). Making reproductive health services youth friendly. Washington DC: Pathfinder International, FOCUS on Young Adults: 54 pages.

"Youth friendly" services are needed worldwide if young people are to be provided with adequate health care. This review examines the characteristics of services that are able to meet young people's needs, in clinics, in youth centres or through outreach activities. Basic components are identified, and include providers specifically trained to serve young people, privacy, confidentiality and accessibility. The author reviews why young people need special services, what services they need, and service delivery. Barriers to use of services are outlined, and how these barriers can be overcome. Provider, health facility, and programme design characteristics are discussed. Case studies of attempts to institute youth-friendly services are described, as are prevention and reproductive health promotion programmes. Outreach and community-based approaches are then considered. The final section summarises strategies to make services youth friendly, and future needs to improve programming.

Senderowitz J. (2000). A review of programme approaches to adolescent reproductive health: US Agency for International Development: 63 pages.

This detailed report summarises programme approaches that have been used to improve youth reproductive and sexual health. The report identifies effective approaches based on a review of programmes mainly undertaken in poorer countries. Information gathering and analysis for the report included interviews with over 70 professionals and a review of a wide range of documents including published evaluations, programme reports, organisational publications, issue reviews and analyses, project descriptions and proposals, presentations, informal memos and other materials. Despite the urgent need for effective interventions, most programme approaches have been scattered, poorly documented, and not rigorously evaluated. The report highlights three main areas: fostering an enabling environment; improving knowledge, skills attitudes and self-efficacy; improving health-seeking and safer sex practices. The author concludes that programmes should be designed to form sustainable and comprehensive frameworks using multiple interventions rather than one-off, scattered efforts. Programme planners should prepare to foster an enabling environment before introducing programmes. Choice of partner agencies and selection and training of staff are critical. Young people should be viewed as assets within programmes. Gender dynamics should be considered when designing and implementing programmes. Mass media can be selectively used at all levels of programme development. Both formal and informal programmes should be increased. Young people should have access to appropriate services where they receive respectful and confidential treatment. More research is needed to understand determinants of risky behaviour, the potential for alternative venues for providing reproductive health information, ways programmes can be expanded, and to develop more effective methods of research and programme evaluation.

Serbanescu F. & Morris L. (1998). Young Adult Reproductive Health Survey, Romania, 1996. Final report. Bucharest, Romania, International Foundation for Children and Families 252.

This is the questionnaire from the 1996 Young Adult Reproductive Health Survey in Romania. The survey was conducted among a nationally representative sample of 2047 men and 2025 women aged 15-24 years. The questionnaire is divided into the following sections: identification and household details; sociodemographic characteristics; sex education; fertility and pregnancy; family planning knowledge and sexual experience; current and past contraceptive use; women's health; socioeconomic characteristics; knowledge of AIDS.

Shah M.K., Zambezi R., Simasiku M. (1999). PLA methods: The toolkit. In: Listening To Young Voices: Facilitating participatory appraisals on reproductive health with adolescents.: Care International in Zambia, FOCUS on Young Adults, pp. 25-73.

In this book chapter, a variety of qualitative methods are described. Practical examples from field experience in Zambia are given. The methods covered are: social mapping, census mapping, transect walks, venn diagram, ranking and scoring, wealth and well-being ranking, daily time use analysis, seasonality analysis, trend analysis, body mapping, picture stories/cartooning, case studies, stories and portraits, role plays, participatory census of sexual behaviour, and causal impact analysis (flow diagrams). The types of issues that can be explored with each method are illustrated in a table at the beginning of the chapter.

Sheeran P., Abraham C., Orbell S. (1999). Psychosocial correlates of heterosexual condom use: A meta-analysis. Psychological Bulletin 125(1): 90-132.

Using a meta-analysis of 121 empirical studies, mostly from the US and Europe, this paper reviews correlates of condom use among heterosexual samples. Variables were organised in accordance with the AIDS Risk Reduction Model. It was found that demographic, personality, and labelling stage variables had small average correlations with condom use. Commitment and enactment stage variables had some relationship. Attitudes toward condoms, behavioural intentions, and communication about condoms were the most important predictors of condom use. The authors conclude that behaviour-specific cognitions, social interaction and preparatory behaviours are more important for condom use than knowledge and beliefs about threat of infection.

Shefer T. & Foster D. (2001). Discourses on women's (hetero)sexuality and desire in a South African local context. Culture Health and Sexuality 4(3): 375-390.

Discourses of heterosexual sexuality are investigated among young men and women at the University of the Western Cape, South Africa. Focus groups involving more than 100 students were conducted and discourse analysis carried out on the transcripts. The study highlights the lack of a positive discourse on women's sexual desires, and continued double standards in the construction of masculine and feminine sexualities, with men viewed as positively sexual while women are representative of love and relationships. There are some marginal voices contradicting these discourses and challenging the hegemonic construction of women as passive, lacking sexual desire and responsive to male active sexuality.

Silberschmidt M. & Rasch V. (2001). Adolescent girls, illegal abortions and "sugar daddies" in Dar es Salaam: vulnerable victims and active social agents. Social Science and Medicine 52: 1815-1826.

Explanatory factors for illegal abortions among young women in Dar es Salaam are investigated using open-ended interviews. Women aged 15-19 presenting at a hospital with incomplete abortion were invited to participate in the interviews. In addition rural women of the same age who had used herbs to self-induce abortion were interviewed in a focus group. The authors conclude that the young women are not only victims but active social agents engaging in high-risk sexual behaviour, often to gain material benefits. They are often not aware of the risk and there are social barriers to their access to services providing education about sexuality and contraception.

Singh S. (1998). Adolescent childbearing in developing countries: A global review. Studies in Family Planning 29(2): 117-136.

This study analysed the most recent Demographic and Health Survey data available for 43 developing countries (20 in sub-Saharan Africa, 10 in Latin America, five in North Africa and the Near East, and eight in Asia) to document current levels and recent trends in the rate of teenage childbearing, the timing of first births, and births to unmarried women. The study also considered 1) socio-economic differentials arising from urban or rural residence and educational attainment, 2) whether births to adolescents are planned, and 3) the consequences of unsafe abortion. Some sub-Saharan countries are experiencing a reduction in the rate of adolescent childbearing, but the proportion of adolescent births will continue to increase unless unmarried couples adopt contraception. Unexpected small decreases and increases in

adolescent childbearing occurred in Latin America. The largest and most uniform declines in early childbearing occurred in North Africa and Asia along with increases in the age at first marriage.

Singh S. & Samara R. (1996). Early marriage among women in developing countries. International Family Planning Perspectives 22(4): 148-157.

This study examines trends in first marriage, consensual unions, and cohabiting unions among women under 20 years old. Data were obtained for 40 countries from Demographic and Health Surveys. Marriage timing was grouped for the proportion of all women aged 20-24 years who married by ages 15, 18, and 20 years. Women were most likely to marry at young ages in sub-Saharan Africa. 60-92% of women aged 20-24 years married by age 20. High proportions of early marriage were found in Bangladesh, Guatemala, India, and Yemen. In developing countries other than sub-Saharan African countries, marriages before the age of 18 years ranged between 20% and 33%. Marriages before the age of 20 years ranged between 33% and 50%. In developed countries such as France or the US, first marriage by the age of 18 years among 20-24 year olds represented 11% of all first marriages. Japan was one of the few countries with a very low proportion of early marriages: 2% of 20-24 year olds married before the age of 20 years. Marriage before the age of 18 years was uncommon in Botswana, Namibia, the Philippines, Sri Lanka, and Tunisia and comparable to US and French proportions. Marriage before the age of 15 years was common only in Bangladesh and Niger (50%). Very early marriage ranged between 10% and 27% in Cameroon, Liberia, Mali, Nigeria, Senegal, Togo, Uganda, Guatemala, India, Indonesia, Pakistan, Sudan, and Yemen. The median age at first marriage ranged widely within and across regions. Over time the proportion married before the age of 20 years declined for cohorts aged 20-24 years, 30-34 years, and 40-44 years. The magnitude of decline in the proportion married before age 20 varied substantially across regions. Increases were larger and more widespread in North Africa, the Middle East, and Asia. Later age at marriage was more prevalent among urban women, in countries with greater urbanisation, and among women with at least a secondary education in urban areas. The implications of these data are discussed.

Singh S. & Wulf D. (1994). Estimated levels of induced abortion in six Latin American countries. International Family Planning Perspectives 20(1): 4-13.

Approximate levels of induced abortion can be estimated in countries where the practice is illegal. Using data on the number of women hospitalised for treatment of abortion complications, correcting for underreporting and misreporting and adjusting to eliminate spontaneous abortions, the authors estimate levels of abortion in Brazil, Chile, Colombia, the Dominican Republic, Mexico and Peru. An estimated 550,000 women are hospitalised each year as a result of complications from induced abortion and a total of about 2.8 million abortions are estimated to occur in these countries annually when women not hospitalised as a result of induced abortion are taken into account. Extrapolating to the region as a whole, the authors estimate that about 800,000 women are probably hospitalised because of complications of induced abortion in Latin America each year, and an estimated 4 million abortions take place. The abortion rate most likely ranges from 23/1000 women aged 15-49 in Mexico to 52/1000 in Peru, and the absolute number ranges from 82,000 in the Dominican Republic to 1.4 million in Brazil. From 17% of pregnancies in Mexico to 35% in Chile are estimated to end in induced abortion.

Singhanetra-Renard A. (1997). Population movement and the AIDS epidemic in Thailand. In: Herdt G. (Ed.) Sexual Cultures and Migration in the Era of AIDS: Anthropological and demographic perspectives. Oxford, UK: Oxford University Press, pp. 70-86.

This book chapter describes the nature of population movement and labour migration in Thailand, the sex migration into the country, and social mobility among poor rural women through commercial sex work in the north, where AIDS cases are concentrated. The relationship between population movement and the HIV/AIDS epidemic in northern Thailand is examined. Labour migrants are a major group within industry and abroad. Thai borders are not policed, and many poor are international labour migrants. Labour migration in Chiang Mai is used to explain the case of construction workers. The patterns of migration in border areas complicate the diffusion and control of HIV/AIDS. The northern Thai spirit cult that served to limit extramarital and premarital sex has declined. Opportunities for casual sex are facilitated by substandard housing at work sites. Medical, moral, and development factors are interrelated. The chapter ends with a discussion of culture, sexuality and sexual culture, and gender-power relations in migration.

Smith P.G. & Morrow R.H. (Eds.) (1996). Field trials of health interventions. London: Macmillan Education Limited.

A comprehensive guide to designing, planning and running field trials of health interventions, including education interventions. The book contains chapters on types of interventions and their development; study design; study size; ethical considerations; community involvement; censuses and mapping; randomisation and coding; outcome measures and case definition; questionnaires; qualitative research

in field trials; field organisation; field laboratory methods; data processing; methods of analysis; preparing grant applications; and reporting and using results.

Speizer I.S., Tambashe B.O., Tegang S.P. (2001). An evaluation of the "Entre Nous Jeunes" peer-educator program for adolescents in Cameroon. Studies in Family Planning **32**(4): 339-351.

A quasi-experimental design is used in this study to evaluate the "Entre Nous Jeunes" programme in Nkongsamba, Cameroon. The programme was designed to promote STD/HIV preventive behaviours. The 18-month intervention was carried out in one community and a control community was investigated to provide comparative data. A baseline survey using a random household sample of approximately 400 12-25 year olds per community was carried out in both communities before intervention, then a follow-up survey with similar numbers of people was carried out 17 months later. Multivariate analyses indicate that contact with a peer educator is significantly associated with greater spontaneous knowledge of modern contraception and symptoms of STDs. It is also associated with greater use of modern methods, including condoms. The authors conclude that in the absence of the peer education programme, contraceptive use in the intervention community would have been significantly lower. This study is one of the few examples of use of this type of design to evaluate peer education interventions.

Stanecki K.A. & Way P.O. (1996). The dynamic HIV / AIDS pandemic. In: Mann J.M. & Tarantola D.J.M. (Eds.) AIDS in the world II: Global dimensions, social roots, and responses. New York: Oxford University Press, pp. 41-56.

The HIV/AIDS pandemic is discussed in terms of quantitative data on prevalence in different countries and among different sub-populations (blood donors, pregnant women female sex workers, and STI patients). Urbanisation may lead to permanent, temporary or seasonal migration from rural to urban areas. It is noted that migrating and travelling people tend to be young, are frequently economically productive and are at greatest risk of HIV acquisition. The implications of urban-rural movements for the HIV epidemic is discussed. In Latin America and the Caribbean, sub-Saharan Africa, and Southeast Asia, the HIV/AIDS pandemic impact is intensifying in certain geographic areas and expanding to reach others. HIV epidemics progressed rapidly during 1994/95 in Latin America and the Caribbean. In countries with already existing epidemics, HIV infection rates have typically increased in all population groups previously affected. In countries relatively untouched until recently, substantial increases in levels of infection have generally occurred. HIV seroprevalence is at or above 2% among urban pregnant women in the Bahamas, British Virgin Islands, Haiti, St. Kitts, Guyana, and Honduras. In sub-Saharan Africa, there has been a consistent and rapid increase in HIV seroprevalence among pregnant women. The capital cities of Uganda, Zambia, and Malawi harboured infection levels of 20% or greater by 1993. Data on urban female sex workers show infection levels of greater than 30% for many countries in the region. HIV epidemics in Asia have expanded substantially since the early 1990s. Recent data from countries not previously included in the HIV/AIDS Surveillance Database document rapid HIV spread even in countries without the large transnational population movements seen in Thailand and India.

Steiner M. & Joanis C. (1993). Acceptability of dual method use [letter]. Family Planning Perspectives **25**(5): 234.

Kestelmen and Trussell argue that the combined use of condoms and spermicides confers protection against pregnancy comparable to that offered by oral contraceptives, while also protecting against sexually transmitted diseases. It is assumed that the contraceptive mechanisms of condoms and spermicides work independently during perfect use. The author of this letter warns that using a combination of two methods is comparatively expensive and that sexually active individuals may use one or both methods less conscientiously than they would use each method on its own. Family Health International conducted a multi-site acceptability study over three weeks comparing contraceptive film with foaming tablets in the Dominican Republic, Kenya, and Mexico. Fifty-one participants in the Dominican Republic reported 449 coital episodes; 47 in Kenya reported 592 episodes; and 50 in Mexico reported 615 episodes. 99%, 94%, and 99%, respectively, were protected by at least one method. The use of both methods, however, amounted to 4%, 43% and 75% of all coital episodes, respectively. These results point to the existence of different acceptance levels for dual method use. More research into the determinants of dual method use is called for.

Tarr C.M. & Aggleton P. (1999). Young people and HIV in Cambodia: Meanings, contexts and sexual cultures. AIDS Care **11**(3): 375-384.

Using qualitative data, this study examines sex workers and their clients in Cambodia, a group particularly affected by the country's rapidly developing AIDS epidemic. Data were collected through 281 individual interviews with 13-26 year old men and women, 62 further interviews with older informants, 15 focus group discussions, and participant observation. Two hundred and eighteen people aged 13-26 years participated in individual interviews. Findings are reported from an examination of dominant discourses about sex and sexuality in Cambodia, contemporary patterns of sexual behaviour among

young people, sexual meanings and practices, sexual relations among young people involving payment, and sexual relations not involving payment.

UN Population Division (1998). Entry into reproductive life. In: World Population Monitoring 1996. New York: United Nations, pp. 41-83.

Using available survey data, this chapter reviews a number of aspects of young people's entry into reproductive life. The chapter contains sections on the following: menarche, marriage (timing of first marriage, cohabitation, women's education, residence and age at first marriage); and sexual activity before marriage (initiation of sexual activity among adolescents, initiation of sexual activities and age at marriage, never-married women and their sexual activities, patterns of sexual behaviour: gender differentials, socio-economic differential with respect to sexual activities: education and residence). Relevant quantitative data are presented and discussed.

UNAIDS (1997). Multi-site study questionnaire 1: Men and women: UNAIDS.

Questionnaire containing questions on household details, then questions for individuals: identification, background characteristics, marriage, sexual relations with other partners than spouse, STDs and health issues.

UNAIDS (1999). Sex and youth: Contextual factors affecting risk for HIV/AIDS. Geneva: UNAIDS.

Findings from qualitative studies in Cameroon, Cambodia, Chile, Costa Rica, Papua New Guinea, Philippines, Zimbabwe are presented. The report is in three sections. The first, "Young people and risk taking in sexual relations", contains a comparative analysis of data collected in interviews and discussions with nearly 3000 young people in these seven countries. Similar themes and issues emerge: concepts of youth, the challenge to traditional cultures, modernisation and urbanisation. The second section, "Community Responses to AIDS" looks at data from Dominican Republic, India, Mexico, Tanzania and Thailand, and identifies local beliefs about HIV/AIDS, the community and household responses and the inter-relations between the two. Key factors influencing the responses include the existing economic situation, prevailing relations between men and women in the communities and households, local beliefs in health and health care and local levels of stigmatisation. Recommendations are made for policy and programme development. The third section, "Use of the female condom: Gender relations and sexual negotiation", is based on research in Costa Rica, Mexico, Senegal and Indonesia. Data were collected from the four countries on gender relations, sexual communication and negotiation followed by an intervention to strengthen women's capacity in these latter areas. The comparative analysis identifies economic dependence on men and gender stereotypes as the two major factors constraining women in their sexual behaviour. The report finishes with specific recommendations.

UNHCR (1999). Reproductive health of young people. In: Reproductive Health in Refugee Situations: An inter-agency field manual.: United Nations High Commissioner for Refugees, pp. 89-95.

The reproductive health needs of young people in refugee situations are reviewed in this chapter. The characteristics of young refugees are summarised: young people often lack a well-developed future orientation that can be reinforced by refugee or displaced status, the behaviour of young people in refugee or displaced situations may not be subjected to the same kind of scrutiny as it would under normal circumstances, young people are not a homogenous group, in many countries with high STD/HIV prevalence, the most vulnerable group is young women. Principles to consider in promoting reproductive and sexual health are given: young people should participate, service providers must understand the cultural sensitivities surrounding the provision of information and services to young people, programmes should identify and encourage peer leadership and communication, it is essential to have links between health and community workers, young people need privacy, confidentiality must be guaranteed, the gender of the service provider is usually important.

United Nations (2001). Abortion Policies: A global review. New York, USA: United Nations, Department of Economic and Social Affairs, Population Division.

This comprehensive review of abortion policies worldwide provides country-by-country statistics and profiles under the following sub-headings. A. Abortion policy: grounds on which abortion is permitted; additional requirements. B. Reproductive health context: government view of fertility level; government intervention concerning fertility level; government policies on effective use of modern methods of contraception; percentage of currently married women using modern contraception; total fertility rate; age-specific fertility rates for women aged 15-19; government concern about morbidity and mortality resulting from induced abortion; government concern about morbidity and mortality resulting from induced abortion; government concern about complications of childbearing and childbirth; maternal mortality ratio; female life expectancy at birth.

Van Campenhoudt L. (1997). Operationalizing theories for further research. In: Van Campenhoudt L., Cohen M., Guizzardi G., Hausser D. (Eds.) Sexual Interactions and HIV Risk. London: Taylor & Francis, pp. 181-188.

Approaches to studying sexuality have frequently been based on examination of individuals. This book argues that explanations of sexual behaviour should move away from individualistic approaches. This short chapter summarises the main points made throughout the book, and discusses methodologies for using these theoretical perspectives in research.

Van Campenhoudt L. (1999). The relational rationality of risk and uncertainty reducing processes explaining HIV risk-related behaviour. Culture, Health and Sexuality 1(2): 181-191.

This paper provides a good summary of the "interactional" approach to studies of sexual behaviour. The author draws from chapters in his edited book (Van Campenhoudt et al. 1997. Sexual Interactions and HIV Risk) and from other sources to summarise the approach. Theoretical treatment of risk and reducing uncertainty are discussed.

Van Campenhoudt L. & Cohen M. (1997). Interaction and risk-related behaviour: Theoretical and heuristic landmarks. In: Van Campenhoudt L., Cohen M., Guizzardi G., Hausser D. (Eds.) Sexual Interactions and HIV Risk. London: Taylor & Francis, pp. 59-74.

Approaches to studying sexuality have frequently been based on examination of individuals. This book argues that explanations of sexual behaviour should move away from individualistic approaches. In the first part of this chapter the first three chapters of the book are summarised, and the points made analysed and discussed. First systems theory is examined, then social network theory, then cognitive and social psychology and finally relational sociology. In the second part, the main theoretical dimensions of an interaction perspective are outlined: the situational dimension of the relationship, the temporal dimension, the meaning of the relationship, the power within the relationship, emotional dimensions, and status of risk within relationships.

VanLandingham M., Suprasert S., Grandjean N., Sittitrai W. (1995). Two views of risky sexual practices among Northern Thai males: The health belief model and the theory of reasoned action. Journal of Health and Social Behaviour 36: 195-212.

A sex practice survey was conducted in 1991 among a sample of 1472 university undergraduates, soldiers, clerks, and labourers living in the high HIV-prevalence area of Chiang Mai, Thailand. Self-administered questionnaires were used. The Health Belief Model (HBM) and the Theory of Reasoned Action (TRA) were applied to the data to analyse the unsafe sex practice of using condoms inconsistently when having sexual intercourse with sex workers. In a multivariate analysis, consistent condom use was positively associated with knowledge about the consequences of HIV infection, knowledge about the benefits of condom use in preventing infection, positive attitudes about condoms, absence of heavy alcohol consumption, low general propensity toward risk-taking, and high socio-economic status. The authors stress that Thai males usually visit sex workers in groups of close friends. An individual's perception of peer group norms on condom use was the most significant predictor of consistent condom use and contributes the most in explaining the results of multivariate analysis. Accordingly, the TRA, which better incorporates peer group effects, models empirical results better than the HBM. Both models, however, are criticised for failing to allow for the indirect social influences upon individual behaviour.

Vanwesenbeek I., Zessen G.V., Ingham R., *et al.* (1999). Factors and processes in heterosexual competence and risk: An integrated review of the evidence. Psychology and Health 14: 25-50.

Factors influencing heterosexual risk behaviour are reviewed in this article. Evidence from a range of studies is presented. Specific areas reviewed are use of contraception, particularly condoms, and sexual aggression. A theoretical framework is presented to integrate the different studies and findings, based on the concept of interactional competence. The framework is explained in detail. The competence of both heterosexual partners is related in this paper to factors in childhood and adolescence, the wider sociocultural and interpersonal context, the specific meanings and functions of sexuality for the individual, and aspects of the immediate context. The implications of this framework for the study of sexual behaviour are discussed.

Varga C.A. (1999). South African young people's sexual dynamics: Implications for behavioural responses to HIV/AIDS. In: Caldwell J.C. (Ed.) Resistances to Behavioural Change to Reduce HIV/AIDS Infection. Canberra: Health Transition Centre, pp. 13-34.

This study explores the potential contribution of sexual dynamics to the spread of HIV among South African youth. Data were collected through focus-group discussions, narrative research method, and in-

depth interviews. Study participants were Zulu-speakers aged between 11 and 24 years. The paper begins with a description of the HIV epidemic in South Africa, and its effect on youth. The study results are then presented, personal use of condoms is examined, then the use of condoms in relationships, sexual coercion, gender, peer pressure and confronting HIV status. The paper then discusses barriers to HIV-related behaviour change in this group. These include poor communication, gender-based violence, and peer pressure.

Varga C.A. (2001). The forgotten fifty percent: a review of sexual and reproductive health research and programs focused on boys and young men in sub-Saharan Africa. African Journal of Reproductive Health 5(3): 175-195.

Existing literature on sexual and reproductive health research and programming among boys and young men in sub-Saharan Africa. While there is a growing body of literature on young women, much less is known about male sexual and reproductive health and its potential connection to well-being. The author argues that both societal and individual vulnerability to HIV/AIDS infection are heavily influenced by socio-cultural factors and societal norms, and that gender and sexuality are among the most powerful of these elements. Gaps in the literature are identified using a modified version of Dixon-Mueller's framework which illustrates how sexuality and gender influence reproductive health outcomes. The framework focuses on sexual partnerships, sexual acts, sexual meaning, sexual drives and enjoyment, and sexual knowledge and awareness.

Waldby C., Kippax S., Crawford J. (1993). Cordon sanitaire: "Clean" and "unclean" women in the AIDS discourse of young heterosexual men. In: Aggleton P., Davies P., Hart G. (Eds.) AIDS: Facing the second decade. London: Falmer Press.

There is a documented tendency among heterosexual men to consider themselves able to "tell" if a potential sexual partner is likely to carry HIV. This study analyses this belief in detail. The authors use Douglas' work on pollution rules and ideas that suggest that notions of pollution and infection are a means of control and prediction of "chaotic" phenomena such as illness and sexual desire, which threaten established social boundaries (and physical boundaries in the case of sex). Using in-depth interviews and discussion groups with 18-24 year old men in Sydney, Australia, the authors describe a model in which the man creates a personal map of infectious and safe relations, a hierarchy of infection in the form of concentric circles with him in the centre, surrounded by women whose imagined infectiousness increases as they are allocated positions further and further away, creating a perceived margin of safety. This model is based on notions of "other", with known women considered to be more likely to be "clean". The men are less likely to use condoms with these "clean" women, regardless of actual risk of HIV infection.

Warwick I. & Aggleton P. (2001). Learning from what young people say... about sex, relationships and health. London: Institute of Education, Safe Passages to Adulthood Programme.

This report provides a useful summary of practical and theoretical issues surrounding research into young people's sexual behaviour. It provides a relatively easy-to-follow guide to the essentials of this type of research. The report is divided into the following sections: background; beliefs about health (professional and lay understandings of health and illness); understanding young people and sex (images of young people, cultural dimensions of sex, sexual health cultures among young people); working with and involving others (how best to involve other people, some practical and ethical issues); preparing and planning the study (value of case studies, finding suitable research questions); collecting information (where, how and from whom information can be gathered); analysing and using findings (analysing what young people say about sex, relationships and health; maximising the likelihood that findings will be used).

Waszak C.S. (1993). Quality contraceptive services for adolescents: Focus on interpersonal aspects of client care. Fertility Control Reviews 2(3): 3-6.

This article reviews what is known about young people's reproductive health service needs, using illustrative findings from existing studies. The themes examined are: development of trust, respect for confidentiality, ensuring privacy, involving parents where possible, the pelvic exam, addressing negative feelings about contraceptive use, method-related information, dual protection, side effects of contraceptives and effects of contraceptive use on daily life.

Weiss E., Whelan D., Gupta G.R. (1996). Vulnerability and opportunity: Adolescents and HIV/AIDS in the developing world. Findings from the Women and AIDS Research Program. Washington DC: International Center for Research on Women.

This report presents some findings of the first phase of the Women and AIDS Research Program conducted by the International Center for Research on Women, using qualitative and quantitative data collection techniques. The main findings highlighted are that sexual initiation for many girls occurs

before menarche; that economic gain and sexual coercion underlie many young women's sexual experiences; that the social expectation of virginity does not necessarily protect young women from STDs and HIV/AIDS; that gender differences in socialisation contribute to HIV/STD vulnerability; that the social costs of HIV prevention may be too high to motivate behaviour change; and that young people need and desire communication with trusted adults. The authors note that a combination of qualitative and quantitative methods works best for collecting data on sex behaviour from young women, and enlisting the participation of young people enhances research and program outcomes. Policy and program recommendations are presented.

Wellings K., Branigan P., Mitchell K. (2000). Discomfort, discord and discontinuity as data: using focus groups to research sensitive topics. Culture Health and Sexuality 2(3): 255-267.

The use of focus groups to research sensitive topics is discussed with reference to three different research projects conducted in the UK on sensitive topics. The authors discuss the ways that expression of views on sensitive topics may be facilitated within the focus group. They note that "data" can include such elements of the discussion as discomfort, use of humour, discord and discontinuity. They conclude that the sensitivity of topics should not in itself preclude use of focus group methods, but that there are considerable challenges to be met when analysing the data obtained.

WHO/ADH (1992). A study of the sexual experience of young people in eleven African countries: The narrative research method. Geneva: World Health Organization Adolescent Health Programme Division of Family Health. 47: 5.

This report gives details of the narrative research method of data collection and presents results from 13,121 adolescents and young adults aged 10-24 years living in Benin, Burkina Faso, Cote d'Ivoire, Senegal, Togo, Kenya, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe. Participants were asked to describe the most typical story of initial sexual experience, using a set of standard story options. There was substantial agreement about what constituted the most typical story. One particular story tended to occur more frequently than others in each of the two regions investigated and the same story was usually found in all countries of the region. Such widespread sharing of one narrative representation of initial sexual experience may imply the existence of a common adolescent culture which crosses national and cultural boundaries. The predominant story tended to be shared by both male and female respondents in each region. Narrative representations are presented, followed by consideration of the implications of the research for health education and promotion programs.

WHO/CREHPA Sexual risk behaviour and knowledge and attitude towards condom use and HIV/AIDS transmission among men in five border towns of Nepal: WHO/CREHPA Collaborative Research Study.

This is a short questionnaire used to investigate HIV in men in Nepal (10 pages). Questions are asked about background characteristics, mobility/migration, safer sex, knowledge and attitude towards condom use, knowledge about STD and AIDS, sexual activity, promiscuity, and sexual risk behaviour.

Wight D. & West P. (1999). Poor recall, misunderstandings and embarrassment: Interpreting discrepancies in young men's reported heterosexual behaviour. Culture, Health and Sexuality 1(1): 55-78.

Since the advent of AIDS, there is a greater need to obtain accurate data on sexual behaviour. Findings are presented from a comparison of data collected in a questionnaire survey with those collected through in-depth interviews. Fifty-eight young men from Glasgow, UK were interviewed twice, first as part of a general health and lifestyle survey and then a year later in an in-depth interview about sex. Considerable discrepancies were observed between the two studies in reported sexual behaviour and knowledge. Poor concordance was observed between age and use of contraception at first intercourse and on the number of sex partners at age 18 years. In addition, there was almost no consistency between the studies in terms of the participants' understanding of the notion of safer sex. The most likely explanations for the discrepancies between the studies are poor recall, inadequate understanding of the question, and differing presentational concerns, especially related to embarrassment. Poor recall and embarrassment are particularly possible explanations because they can account for discrepancies in both directions. The in-depth interview data appear to have greater validity than the survey data, and the authors identify means of improving survey methods on sex.

Women's Commission (2000). Untapped potential: Adolescents affected by armed conflict - a review of programs and policies. New York, NY, USA: Women's Commission for Refugee Women and Children.

This detailed report examines the needs of young people affected by armed conflict, and the interventions and policies in place that pertain to this group. The report is not specifically focussed on sexual and reproductive health, but considers this as part of the overall discussion of young people's well-being. The final part of the report contains an appendix with an extensive annotated bibliography.

Wood K., Maforah F., Jewkes R. (1998). "He forced me to love him": Putting violence on adolescent sexual health agendas. Social Science and Medicine 47(2): 233-242.

Using semi-structured interviews gender violence within sexual relationships was investigated. Interviewees were 24 pregnant Xhosa-speaking adolescents (average age, 16.4 years) from Khayelitsha, a township in peri-urban Cape Town, South Africa. Most informants were originally from rural areas of the Eastern Cape and had come to Cape Town with parents seeking employment or for schooling. The interviews revealed that violence is a consistent feature of sexual relationships, in rural as well as urban areas, and serves to enforce male control of sexual intercourse. This control is further strengthened by male-imposed constructions of sexual intercourse as a required part of the relationship contract, peer ostracism of sexually inexperienced girls, taboos against intergenerational transmission of sexual information, and cultural acceptance of female silence and submission. Twenty-two of the 24 women reported having been beaten by their boyfriends on multiple occasions, primarily when they attempted to refuse sexual intercourse. Being beaten could also be precipitated by attempts to end a relationship, talking to other men, or requesting contraceptive use. Assault was perceived by many women as an expression of love.

Woodsong C. & Koo H.P. (1999). Two good reasons: women's and men's perspectives on dual contraceptive use. Social Science and Medicine 49(5): 567-580.

This article presents perspectives of African-American women and men on dual contraceptive use based on focus group discussions conducted in the USA. Although the context is not poorer countries or of young people, this is one of the few studies specifically of dual protection. Dual use here refers to the concurrent use of two contraceptive methods for two reasons: protection against pregnancy and against sexually transmitted infections, specifically male condoms and a female method. Although this prescription was rarely followed in actual practice, the participants expressed the view that a condom should always be used as protection regardless of a woman's use of other contraceptive methods. Both sexes stated that suggestion of condom use can elicit either positive reactions (e.g. that it shows respect for the woman) or negative ones (e.g. that it indicates multiple sex partners). The need for dual protection was recognized, but problems arose in practicing it primarily because of the distrust between partners. Most participants reported that they had little trust in their partners. Focus group participants further stated that asking their sexual partners to use condoms as an additional method would only receive a negative response.

Zabin L.S. & Kiragu K. (1998). The health consequences of adolescent sexual and fertility behaviour in sub-Saharan Africa. Studies in Family Planning 29(2): 210-232.

This review of the literature on the health consequences of adolescent sexual behaviour and childbearing in sub-Saharan Africa reveals substantial variation according to context. Survey data are reported and limitations of these data discussed. Factors identified as having an impact on early sexual onset and childbirth are younger age at menarche, erosion of social and cultural controls on premarital sex, the abandonment of pubertal rites of passage, and more widespread schooling. Childbearing at young ages has been associated with pregnancy-induced high blood pressure, anaemia and haemorrhage, obstructed and prolonged labour, infection, and higher rates of infant morbidity and mortality. Cultural and biological factors increase the likelihood of transmission of sexually transmitted diseases, including HIV, among young women. Many negative sequelae are exacerbated by cultural practices such as genital mutilation. Level of care required by teenage women who are delivering a first child is considerably greater than that required by healthy adult women, and many women's health services are hostile to young people who initiate premarital sex and may even deny treatment.

Zheng Z., Zhou Y., Zheng L., *et al.* (2001). Sexual behaviour and contraceptive use among unmarried, young women migrant workers in five cities in China. Reproductive Health Matters 9(17): 118-127.

This paper uses focus group discussions (146 young women aged 16-25) and in-depth interviews (58 young women and key informants) to examine reproductive and sexual health knowledge and behaviour of young, unmarried women in China migrating to cities (Beijing, Guangzhou, Shanghai, Guiyang, and Taiyuan) from rural areas. The study also examines their access to and needs in relations to family planning. Some of the women were sexually active and living with their boyfriends, who most expected to marry. Most of the women lacked basic information about reproduction and contraception and did not know where or how to obtain contraception. There were social, psychological and economic barriers to accessing services. Only a small proportion of those who were unmarried were using contraception, so induced abortion often resulted from unprotected premarital sex. Pleasing male partners played an important role in unprotected sex. Family planning systems are not orientated to provide services to unmarried young people.

ZNFPC National Youth Reproductive Health Survey Ages 10-24: Zimbabwe National Family Planning Council.

This is the questionnaire from the Zimbabwe National Youth Reproductive Health Surveys. The survey contains the following sections: identification; household schedule; sociodemographics; family background; education and literacy; work and income; behavioural issues (smoking etc.); adolescent communication and media exposure; partner relations, sex and pregnancy; health seeking behaviour; family planning knowledge and use; STDs and AIDS; household characteristics.

## Appendix

### Keywords used in the electronic form of the bibliography

abortion	focus groups	policy
Africa	free listing	qualitative
Argentina	Ghana	quality of care
Asia	Guatemala	quantitative
Australasia	Guinea	questionnaire
Australia	health seeking	randomised controlled trial
Benin	in-depth interviews	ranking and scoring
body mapping	India	records
Bolivia	Indonesia	refugees
Botswana	interventions	review
Brazil	interview	risk
Burkina Faso	Jamaica	role plays
Burundi	Kenya	Rwanda
Cambodia	Latin America	seasonality analysis
Cameroon	law	self-administered
Canada	Malawi	questionnaires
Caribbean	Mali	Senegal
Carribean	Mauritius	serum sample
case studies	memory work	sexual behaviour
case-control study	men	situation analysis
causal impact analysis	men who have sex with men	social mapping
census mapping	meta-analysis	South Africa
Chad	methods	specific example
Chile	Mexico	stories and portraits
China	Middle East	sub-Saharan Africa
coercion	migrants	survey
Colombia	mixed methods	Sweden
computer-assisted methods	msm	Switzerland
Costa Rica	mystery client	Tanzania
Cote d'Ivoire	narrative research method	telephone survey
Côte d'Ivoire	Netherlands	Thailand
daily time use analysis	Nicaragua	The Gambia
diaries	Niger	theory
discourse analysis	Nigeria	Togo
discussion groups	North Africa	transect walks
document analysis	North America	trend analysis
Dominican Republic	observation	Uganda
dual protection	operations research	UK
El Salvador	Pakistan	USA
emergency contraception	Papua New Guinea	venn diagram
ethics	participant observation	violence
Ethiopia	participatory census of sexual	wealth and well-being ranking
Europe	behaviour	Zambia
example of method	Peru	Zanzibar
example of methods	Philippines	Zimbabwe
flow diagrams	picture stories/cartooning	