



Addressing the Social Dynamics of Sexual and Reproductive Health: CARE's Explorations with Social Analysis and Community Action

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Overview

In seeking to identify and address the underlying causes of poor sexual and reproductive health (SRH), the CARE USA SRH team and staff in several countries where SRH programs operate have experimented with using **social analysis** and a related approach of **social analysis and action** to identify, analyze and address the barriers to and promoters of good SRH. In this paper, we review our experience to date with social analysis and related community action and describe:

- what social analysis is,
- the evolution of the concept within the SRH team,
- how social analysis and action approaches can be used and implemented in SRH programming,
- related issues and challenges, and
- possible next steps in the development of analysis and action approaches.

This paper makes a case for the role of social analysis and action in developing programming to address the social causes of poor SRH. It suggests that social analysis could be a vital tool in achieving sustained improvements in SRH for CARE's partner communities. This paper reflects CARE's initial explorations of social analysis and thus is not intended as a field guide. We do, however, hope it contributes to further development of approaches to promote the sexual and reproductive health of CARE's clients around the world.

Introduction to Social Analysis

The need for social analyses in our health programs is implicit in the 2005-2010 CARE Health Strategy and CARE's use of right-based approaches (RBA)¹ to programming. Both put forward the concept of addressing underlying causes as a new direction in CARE's development programming. They articulate the belief that without addressing the **underlying causes** of poverty, rights will not be realized, and both lives and livelihoods will remain insecure (McCaston & Rewald, 2004). CARE's Health Strategy effectively captures this linkage between poverty, livelihoods and health:

"CARE believes that health and well being are fundamental human rights, and that efforts to identify, prevent and manage health risks for the most vulnerable are requisite to breaking the causal cycle between poverty and poor health. In this cycle, poor health is both a consequence and an underlying cause of poverty (UCP)." (CARE USA Health Strategy, 2005)

The concept of addressing underlying causes has shifted CARE's focus from analyzing immediate needs and causes, such as lack of basic health services, to searching for deeper reasons for these surface problems. As such, it has complemented, rather than replaced, CARE's ongoing work to meet immediate livelihood needs.

Adopting RBA and addressing underlying causes has also forced the CARE USA SRH team, as well as other units across the organization, to reflect on our program focus and reconsider our

¹ See RBA references in Annex 2.

programming methodologies. Most notably, we have increased our focus on **improving social positions** by addressing, for example, human rights, inequalities and discrimination as key underlying causes of poverty and poor health.² On a practical level, we have had to develop new methods for intensively analyzing social positions as the basis for identifying these underlying causes (McCaston & Rewald, 2004). Through this course of action, we have developed the process of social analysis and action.

Identifying Underlying Causes

In order to understand social analysis, it is important to further explore the meaning of “underlying causes” within a SRH context. Underlying causes of poor SRH can be large-scale, such as conflict or global trade restrictions, or local, such as harmful social customs or gender relations. Issues at both levels can be critical and are often interrelated.

In many cases, underlying causes work together to form social, political, economic and environmental barriers to good SRH. Considering issues at all levels and understanding how they are related is critical to achieving a thorough, relevant analysis of the social dynamics of poor SRH.

Social analysis is relevant for use on both a large scale and at the local level. It is one way of uncovering underlying causes, from the very personal (such as issues of trust, dislikes/likes and optimism/pessimism) to the highly structural (such as conflict, corruption and poor governance). It can also help local stakeholders reflect on their own perceptions of underlying causes and their impact, as local perceptions can sometimes differ greatly from those of a development agency.

This paper focuses primarily on social analysis at the local level and sets the process within an iterative programming approach, where lessons learned are captured and implemented.

Defining Social Analysis

There is no single definition of “social analysis.” Indeed, in the published literature, the term is used in widely different ways, from analyzing national-level policies to undertaking anthropological fieldwork.

Within the CARE programming context, social analysis could be defined as:

- The exploration of the social component of well being,
- Understanding the social complexities that aid or impede the fight for health within a programming context, or
- Transforming knowledge into concrete steps to address health and social issues within a reflection-action cycle (this is the action part of social analysis, discussed later).

Historically, CARE and other development agencies looked at health issues independent of – or, at the very least, not in relation to – other socio-economic factors. Exploring the social

² For further information about the underlying causes of poverty, see Annex 2.

component of well being means understanding health as a process shaped by socio-cultural and economic factors. Social analysis is the starting point; it helps communities identify their SRH challenges and the environmental factors behind them.

Traditional baseline assessments have reflected our narrow understanding of health, collecting data around a limited set of variables and focusing our attention primarily on the service-delivery level. Social analysis reflects CARE's more integrated approach to health, because it engages communities in asking and answering questions such as:

- What are the prevailing social norms, values, ideologies and beliefs among this group of people, and what caused them to be this way?
- How are these beliefs expressed in social constructs such as gender, kinship rules, rites and rituals?
- How are these constructs embodied in daily actions, behaviors and relationships in relation to the health problem?
- How are these concepts embedded in policies, structures and health systems that impede or enhance health?
- Is their effect on health positive or negative, and how?

Box 1: Illustrative social constructs³ and related operational terms

Power: ownership, access, control or location of key resources, such as deep tube wells.

Gender: women's control over income, participation in decision making, knowledge of legal rights, self-esteem.

Kinship: levels of wealth, segregation, marriage rules, personal likes/dislikes, conflict.

Social class: a person's standing in community affairs. Whose voice is hidden? Who is respected?

Operationalizing Social Analysis at the Community Level: Social Analysis and Action

CARE has approached the development of social analysis as a programming, rather than research, tool, based on the belief that social analysis must not simply result in academic reflection, leaving behind disappointed or even disempowered communities. Such static research becomes outdated quickly, like a snapshot in time, whereas a community's reality continues to evolve, shift and transform. Social analysis and action acknowledges that research and analysis are carried out with a purpose: to implement action in the form of an intervention.

³ A "construct" is a concept that is developed (constructed) for describing relations among phenomena. A construct (such as power) may exist but is not observable.

Guiding Principles of Social Analysis and Action

The social analysis and action process reflects the principles that have shaped it (Box 2). These principles reflect the commitment of social analysis to valuing and validating the voice of community members as they analyze their own social phenomena and how they relate to SRH. One key issue in this regard is the use of language and labels in maintaining the integrity of the social analysis process. In trying to ensure that the process reflects local beliefs and knowledge, CARE has made an effort to move away from classifying groups of people according to outsiders' categories. Studies of the roles and attitudes of CARE staff have yielded results that demonstrate our own hidden biases (Martinez, 2004). In developing social analysis, CARE has been conscious of these biases and their impact. For example, we have avoided grouping women based on their gender alone, choosing instead to allow them to self-differentiate by kinship, caste, age and/or other context-specific factors.

Box 2: Principles of social analysis and action

- Social analyses need freedom to adapt to each local context.
- Social analyses should be set within the reflective framework underscored by principles of collaboration, participation and empowerment.
- Communities should control the process.
- The inquiry uses an appreciative, or salutary, stance that focuses on what makes people resilient as well as vulnerable.
- Methodology is guided by critical thinking and imaginative use of tools.
- There can be many different analyses at different macro and micro levels.
- The outcomes we hope for are improved knowledge, increased community competency and social change for better health.

Understanding how these social factors are interwoven is also critical, forcing us to ask further questions: Why, for example, is one woman suffering from a chronic illness while her neighbor is in good health? This approach of differentiation allows both CARE and the community to identify influential figures or factors affecting the health of a group or an individual (see Box 3) and potentially identify those most in need.

A Key Underlying Principle: Community Facilitation

Recognizing that community members are the experts in understanding their own health needs and social realities is fundamental to social analysis. For this reason, social analysis and related actions are led by community members. The development worker plays the role of facilitator, while community members plan the analyses, collect and analyze the information and organize future actions. This way, they identify their priority health concerns, which may differ from those identified by a development agency. Communities

are then better prepared to plan interventions consistent with their own reality, and a greater sense of ownership is created. This entire process develops a community's ability to address health-related issues.

This approach falls in line with the RBA principle to promote empowerment, as articulated in this statement: "We stand in solidarity with poor and marginalized people, and support their efforts to take control of their own lives and fulfill their rights, responsibilities, and aspirations ..."
(CARE International Programme Standards Framework, 2003).

Box 3: The hidden role of grandmothers

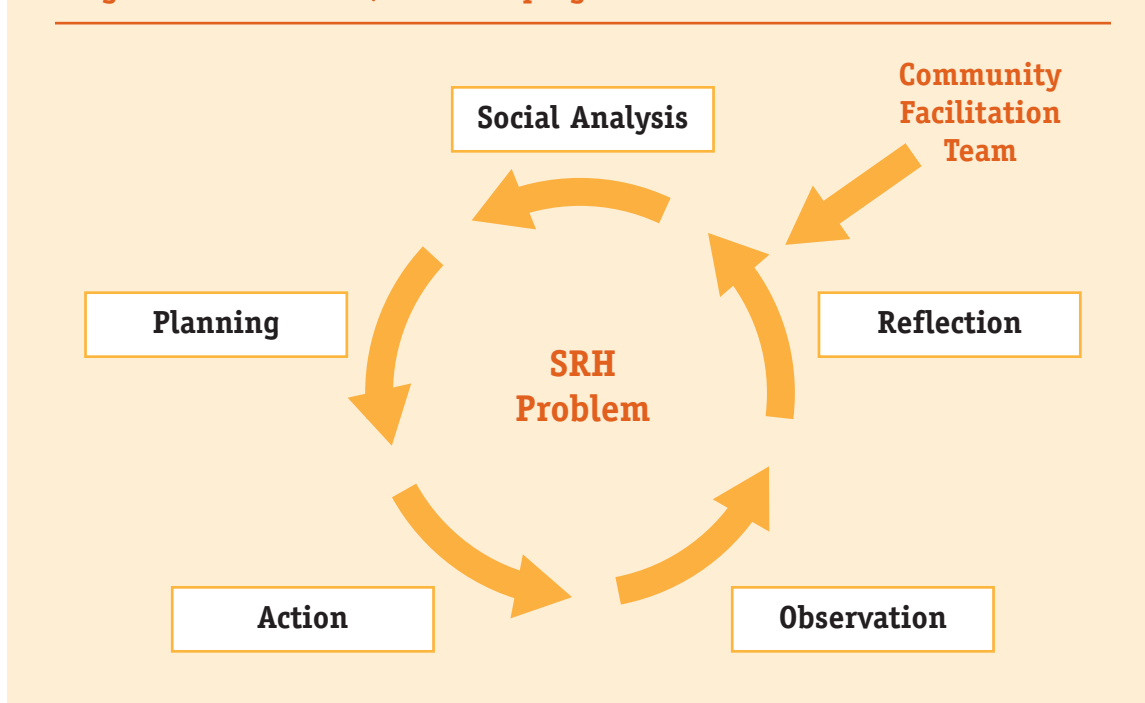
Grandmothers in Senegal play an influential health advisory role, and researchers investigated the impact of this role through formative qualitative research. Their findings revealed that grandmothers were key to maintaining a family's well being, but that they were providing harmful nutrition advice to women of reproductive age. The critical role of grandmothers, though, had been overlooked by an external NGO working to improve maternal and child nutrition through traditional behavior change communication (BCC) approaches, which targeted only mothers for child nutrition information. Subsequently, the advice (in the form of BCC messages) would be superseded by the advice provided by the grandmothers, and mothers' nutrition status did not significantly improve. The researchers and program planners successfully designed a new approach whereby grandmothers were trained using participatory methodologies in modern nutritional practices. As a result, the health and nutrition status of both women and their children improved dramatically compared to other areas where only mothers were involved in nutrition education activities.

This study demonstrates how findings from social analysis, and recognition that communities understand certain social issues missed by external actors, even before research is carried out, can lead to more successful health programs, as measured by traditional health indicators.

From Aubel et al. (2004) "Senegalese grandmothers promote improved maternal and child nutrition practices: the guardians of tradition are not averse to change."

Social analysis and action makes the link between knowing and doing within a repetitive program framework that consists of cycles of reflection, analysis, planning, action and observation. This framework has its basis in action research, which tries to transform research results into action. Researchers or development workers act as facilitators, with community members undertaking the research, carrying out the action and undergoing transformational change as a result (see Diagram 1).

Diagram 1: Reflective, iterative program framework



Stage 1: Engaging Stakeholders

Engaging stakeholders in the social-analysis process is a critical first step in establishing a community facilitation team and creating community ownership. In any society, influential community members are usually key to securing much-needed local political will and thus can greatly influence social analysis and the activities that emerge from it. Working with our community partners, CARE project staff members identify key stakeholders and leaders to approach with the challenge of accepting responsibility for the social analysis.

Discussions with community leaders should emphasize that the project needs their input and support to succeed. The goal is not just to create buy-in to the process but also to acknowledge leaders and seek their advice and blessings. Leaders need to be convinced that their involvement will not only create a successful project but will also be worthwhile to them and their mission to serve their communities (in RBA language, their “duty” to ensure the health of community members). Finally, it is most important that once project staff members have completed their work and the project funding has ended, community leaders feel a sense of obligation to those they serve to keep the project going.

While engaging political will is necessary, significant community representation and ownership among diverse sectors of society is also crucial. This could involve approaching existing community groups or actively seeking out “invisible” groups, those whose voices are absent from normal community or political decision making. Invisible groups are not usually immediately identified by community leaders.

It is critical to empower groups who experience discrimination or social exclusion to express their voice and rights to health. This may not always be easy and will almost inevitably cause ripples of unease, sometimes leading to threats and outright conflict if it is perceived as upsetting the balance of local power. Staff members and participants will need to be prepared for these potential threats through systematic conflict analysis and planning. Annex 2 (Benefit Harms) contains pertinent reading for anticipating, reducing and mediating politically tense situations that development workers may encounter.

Stage 2: Reflection

The cycle represents an initial opportunity for community members to come together to discuss SRH challenges they face. This first reflection involves community members identifying the SRH problem they would like to work together to address. By general agreement, the group defines this problem as relevant to everybody's well being; this is the first step to ensuring community ownership. At the later stages of this discussion, which may take place over numerous sessions, community members identify a shared goal, such as improving antenatal class attendance. Creating this goal ensures that community members have a clear, shared focus and can ultimately experience a sense of accomplishment in addressing their own challenges.

There are very simple ways of enabling this type of reflection. One method aims to deepen analysis through cycles of questioning – repeatedly responding to answers with a simple “why?” Social mapping exercises have also been successfully used as a starting point for further investigations into underlying causes. (Annex 1 includes a case study outlining a recent CARE social analysis in Sierra Leone, which presents other options for facilitating reflection processes.)

Stage 3: Social Analyses

The reflection then moves to a discussion of why the SRH problem exists, and social analysis is introduced as a method of investigation. The process of social analysis allows community members to discuss what the various socio-economic causes of the SRH problem might be. This process of determining causes requires wide consultation using agreed-upon investigative methods, and one round of social analyses is unlikely to get to the root cause(s). The facilitators of the social analysis therefore work with community members to structure a process that is thorough, participatory and respectful, in order to identify the most deeply rooted issues, some of which could be considered taboo.

To date, CARE has experimented with a range of social analysis methodologies, all of which draw on existing participatory methodologies and seek to combine them to the greatest effect. (Section 7 further discusses potential social analysis methodologies.)

Stage 4: Planning

The outcomes of the social analyses inform community efforts to address underlying causes of poor SRH. Community members may be advised to plan small, incremental interventions,

so that adjustments can be made based on observations. The facilitation team should also encourage community members to consider potential positive or negative impacts of any planned action/intervention during these initial stages. (The reference section includes guides to assessing potential impacts.)

Stage 5: Action

Community members put their plan into place and, we hope, begin to see beneficial changes.

Stage 6: Observation

Through observation, we can learn what has succeeded or failed and why. Therefore, it is critical that CARE staff and the community facilitation team observe the action in order to assess the link between outcomes and interventions during the next reflection stage. Observation can also be integrated throughout the cycle so that the entire process is documented and analyzed. Observation includes active data collection, analysis and evaluation of changes. (See Annex 2 for more methods, including the Most Significant Change Technique, which CARE staff members have found particularly valuable during these experimental stages of social analysis.)

Methods of recording these observations are also key, enabling reflection on both the process and results, and allowing for analysis of what worked, what did not and, most important, why. Recording the steps of the process also aids replication and scale up of successes, feedback, dissemination and evaluation. (The reference section includes further reading on documentation processes.)

Stage 7: Back to Reflection

The next reflection stage takes place after an agreed-upon amount of time and can be used to analyze the results, assess original hypotheses or discuss the need for more social analyses. It is also an opportunity to integrate evaluation stages throughout the project life, instead of just at the end.

Box 4: Using community mechanisms for action in Ghana

A countrywide, community-based health planning and services (CHPS) initiative in Ghana recognizes the tradition of strong community leadership of chiefs and councils of elders. Accordingly, when the CHPS project decided to expand into a new rural community, the first step was to consult the traditional leaders and involve them in program planning. The leaders then engaged their community through local communication mechanisms, such as drawing on *zurugelu* (community togetherness) and the system of traditional action committees and community *durbars* (discussion forums), which were usually scheduled on market days for maximum attendance and impact. Through song, dance and public discussion at a *durbar*, the leaders mobilized the community to support health services volunteerism, which resulted in the building of a health center. The CHPS program also used *durbars* for conducting health education and gauging community reactions to services.

The CHPS project demonstrates the success of working with existing community institutions and methods of communication, which helps generate wide dissemination of the project goals as well as fosters community inclusion and ownership of the process.

Adapted from the series, "What works? What fails?" (www.ghana-chps.org)

Methodologies for Social Analysis and Action

To date, social analyses have been carried out at different levels: from the analysis of government policies to personal grudges within a community. Whatever the focus, the selection of social analysis methodologies should have an eye toward the kind of conversations they can enable, the reflection they will catalyze and the understanding they can begin to create about the social dynamics of SRH.

CARE is testing different approaches to determine which are best suited to different contexts. Any method that investigates social phenomena and processes, if used in the right way, can potentially be used in a social analysis. The best methods will be determined by specific objectives, hypotheses and subject matter, as well as the characteristics of the informants, time and resources. (Box 5 presents possible social analysis and action methodologies.)

Box 5: An illustrative list of social analyses and action tools

Participatory Mapping: Exercise in which small groups map their community, focusing on homes, schools, churches, rivers and other features important to the community.

Focus Group Discussions: Discussions with project participants, chosen based on different demographic characteristics (e.g., gender, age, tribe). A focus group aims to elicit information on social norms related to a given topic and to generate discussion around that topic.

Informal Discussions: Informal discussions with community members about important themes that do not follow a set of questions or a script.

Key Informant Interview: Interviews with community members who are considered experts on a given topic. Key informants may include community leaders, religious leaders, teachers or political officials. The interviews often follow a semi-structured questionnaire.

Timeline: A tool to help stakeholders reflect on their lives as adolescents in order to understand what is happening to adolescents today.

Role Playing: Participants in role playing take on prescribed roles and act out situations in those roles.

Story Telling: Facilitators tell a story focused on a specific topic/theme. The story often includes key messages and is intended to capture the audience's attention.

Daily Time Use Analysis: An analysis of how one spends their time during the day.

Problem Tree Analysis: A visual problem analysis tool that can be used both by field staff and the community to specify and investigate the causes and effects of a problem and to highlight the relationships between them.

In choosing methods for social-analysis discussions, facilitation groups should:

- Consider which methods can best investigate the questions being asked – this includes judging how sensitive the questions are;
- Let the community decide what is most culturally appropriate or comfortable;
- Triangulate data using several methods to verify answers;
- Analyze the results correctly – ask a separate group from the community to check the analysis results and see if they make sense;
- Be creative by adapting exercises;
- Decide what “lens” to use; this will direct the inquiry (e.g., a gender approach employs an array of gender-analysis tools);
- Be aware of bias in the approach used and how members' subjectivity and beliefs might affect the use of tools and the overall process;
- Identify individual and group evaluation needs, the baseline and endline data required for each set of needs, and the tools that will be helpful; and
- Determine if the exercise could harm the participants – e.g., would participation in discussion of a taboo subject lead to domestic abuse or social marginalization?

Whatever method used must thoroughly explore the social dynamics of SRH and understand them in an integrated manner. Because these methods are largely qualitative and full participation by community members is key, **Participatory Learning and Action (PLA)** methodologies fit very well in a social analysis and action cycle. They help staff and communities understand issues in a participatory way and help them take action to address these issues. (See the CARE manual “Embracing Participation in Development: Wisdom from the field.”) Used correctly, PLA approaches can help communities visually identify, understand and prioritize SRH-related issues. These approaches can also enable communities to take analysis into their own hands, and out of those of the external facilitator.

Finally, facilitators should avoid “methods fixation,” whereby people get so involved in the exercise that they forget to listen to what is being said. In addition, some people can use tools too rigidly within the parameters set by standard guidelines. In both cases, questions can be left unanswered, or people can fail to follow up on interesting leads.

Issues and Limitations of Social Analyses and Related Community Actions

As stated at the outset of this paper, the development of social analysis and action approaches is a work in progress. CARE staff members involved in this process have thoroughly reflected on both the challenges and advantages of the process. The following are some of the challenges CARE staff have faced in implementing social analyses.

Validity of findings. Delving into a community’s social phenomena can lead to sensitive, personal discussions that reflect and are affected by power relationships. These relationships can impact participants and the data generated. Facilitators should be well-versed in methods for carrying out inquiries that limit bias and invalidity of findings. Most good methodology guides will include sections on validity.

Safety of participants. Ensuring the safety of participants and not violating their rights is more difficult to achieve. “Analyzing Power Structures in Rural Bangladesh” uses several innovative ways to meet this goal, and the Benefits/Harms section in Annex 2 includes other useful resources.

Building evidence. An increasing number of CARE interventions use different types of analysis to identify underlying causes, with varying levels of success. Similarly, staff members are designing innovative interventions to address underlying causes identified through analysis. Evaluating and documenting innovative projects in this area is key to measuring the impact of social analysis on improving people’s health.

The need for evidence is part of a larger problem: Visible and measurable outputs can take a long time, but donors and project managers can pressure project staff to provide tangible, quantitative results. In addition, the nature of social analysis is such that establishing causal connections is difficult, not least because qualitative data are regarded as “soft” when compared to quantifying impacts. The creation of a solid, methodologically rigorous evidence base for

SRH interventions is crucial to gaining donor support for social analysis and action approaches to SRH programming.

Feasibility: How likely is it that communities can really be engaged to the extent advocated (especially considering other competing activities and tasks)? How do development workers shift from being implementers to facilitators? Both these problems must be solved so communities become self-sufficient and empowered to deal with the problems social analysis is trying to address.

Information gathering: Setting boundaries to the social-analysis process is a key concern, because failure to do so can result in staff getting caught in a continuous information-collection-and-analysis mode. From the outset of the process, staff and participants need a sense of the type and quantity of information they require, understanding that flexibility will be required. This will help them know when to stop collecting information.

Information analysis: Once the information is gathered, CARE and its partners need to make sure that there is enough capacity to analyze that qualitative data. Whether through paid staff or consultants, projects need to have the ability to systematically organize, analyze and utilize the data collected. Without that ability, the richness of the social analysis process will not be realized.

Summary

This paper has explored social analysis and action as a way of identifying, analyzing and addressing underlying social causes of poor SRH. It explains how social analysis and action can increase understanding of why an SRH problem exists, and re-focus the attention of CARE and our community partners on the often forgotten social aspects of health and illness. In this paper, we have looked at social analysis and action as a problem-solving process owned by communities that takes place within a reflective programming framework.

To further develop social analysis and action as a methodologically rigorous process, practical experimentation must be carried out, documented and shared, and lessons learned. In particular, there is a need to:

- Develop an evidence base in which examples are evaluated by set criteria;
- Create a database of tools and methods, which includes creating new methods and adapting existing ones;
- Disseminate methods through virtual peer-reviewed journals and other means; and
- Begin answering some of the inherent problems outlined, such as how to protect individuals in targeted communities.

Annex 1

A Case Study of Conducting and Using Findings from Social Analysis: The CARE-Sierra Leone Sexuality and Youth (SAY) Project⁴

In post-conflict Sierra Leone, CARE is addressing youth reproductive health (YRH) issues through the Sexuality and Youth (SAY) project. The goal of the SAY project is to improve the decision-making abilities of young people aged 10–19 with regard to reproductive health and related social issues through access to information and increased dialogue at the societal level. In this project, the aim of a social analysis assessment was **to better understand the environment that influences, shapes and sometimes determines adolescent reproductive and sexual behaviors in order to understand the complex array of factors around adolescent decision-making, and to determine if there are socio-cultural challenges that the project must overcome.**

To date, there have been two cycles of social analysis. The **first wave**, conducted by project staff during an early SAY project planning meeting, occurred almost spontaneously. At this meeting, project staff members were introduced to concepts of sexuality and how gender influences sexuality. Participants analyzed specific YRH issues facing youth and constructed problem trees to begin to delineate factors that can lead to unintended pregnancies and forced marriages of young girls. Each problem tree listed factors under “society,” “culture” and/or “tradition”; staff were challenged to take these “boxes” of factors and unpack them. At this point, the social analysis began, based on staff members’ own experiences as well as experiences of friends and colleagues. (See the box at right for some of the findings.)

The discussion raised many issues for the SAY staff. If initiation and secret societies play such critical roles in SRH information and outcomes, then the SAY project would need to find some way to ensure that members in secret societies get involved in SAY issues.

The SAY project team planned the **second wave** of social analysis more formally, and carried it out in two chiefdoms that would be reached by the SAY

Some Findings from the “First Wave” Social Analysis with Project Staff, September 2004

Much of the conversation focused on the importance of men and women’s secret societies in Koinadugu society. Because of secrecy, there was a limit on what the group could discuss, but in general, they acknowledged that the societies are very powerful institutions; through their mandated actions, they can drive people away who deviate from social norms. Not being initiated into a secret society means stigma/marginalization for an individual and for their family.

A main purpose of the secret societies is the initiation of young girls and boys – not just into the societies themselves but also into the larger community, as adults. A key part of initiation is circumcision for both males and females. The group felt the secret societies would not exist to the same extent they do now without the practice of female genital circumcision (FGC). That is, FGC was a key underpinning of secret-society members’ roles and responsibilities to the larger community, and was linked to almost every aspect of SRH for both males and females. Information on SRH, for example, was provided almost exclusively and formally by secret society members.

Conversation also centered on the problem of early, often forced, marriages. Early marriage for girls aged 14-18 is expected. Marriage has religious and/or cultural underpinnings, and the family identifies husbands for the girls. It most often involves girls who do not attend school. Early marriage and early initiation may be pushed culturally, for if a girl gets pregnant before initiation, she must leave the community. The girl’s parents are sanctioned and must pay money if the girl loses her virginity. This does not hold true for boys; parents do not mind if boys lose their virginity.

⁴ Taken from the 2004 CARE Sierra Leone document “A Social Analysis on Adolescent Reproductive Health in Kabala, Koinadugu District, Sierra Leone for the Sexuality and Youth Project.”

project. One village from each chiefdom as well as the district headquarter town was selected for analysis. Two ethnically and religiously distinct villages were selected – one dominated by the Limba tribe, which is Christian, the other by the Muslim Fullah tribe. The social analysis team selected these villages because CARE already works in them and has an established rapport. This was important because field researchers would be discussing sensitive topics (e.g., reproductive health, sex and sexuality).

Methods and Analysis

All methods were qualitative and included focus group discussions (FGDs), key informant interviews and participatory exercises (e.g., life-line and values exercises). The teams met with a wide range of stakeholders, including district- and village-level leaders and chiefs, elderly men and women, and boys and girls. CARE staff underwent a two-day training session in the methodologies prior to the social analysis assessment.

Focus Group Discussions

SAY staff developed five questions to guide the FGDs, which were facilitated by two people. Over eight days (Dec. 8-15, 2004), 24 FGDs took place, each taking 3-4 hours. The FGDs were conducted in the morning and the data were reviewed and shared in the afternoon to fill in any gaps or missing observations. The findings were laid out in a table to aid comparison across questions, themes and demographic groups, making it easy to summarize SRH issues faced by adolescents and to examine dissimilarities between groups. The survey coordinators developed a set of questions to help the team think critically when analyzing the FGD results.

Lifeline Exercise

The lifeline exercise provided a fictitious story about a typical woman's life in Koinadugu, from birth to old age. Participants drew a line representing their lives, depicting important events and influences with symbols or pictures. Happy events were drawn above the line, sad events below the line. Once complete, field researchers facilitated a discussion on the information in the lifeline. Lifeline exercises were conducted with the elder men and women in two villages; four exercises were conducted in all, involving 20 women and 21 men. The purpose of these exercises was to gain a better understanding of the SRH events (positive or negative) in an individual's life and to

Selected Findings from the Second Wave of Social Analysis of YRH Issues, SAY Project, December 2004

Sexual activity of youth

Girls and boys are engaging in penetrative sex at early ages, in places hidden from their parents.

Girls engage in transactional sex with older men, due to chronic, debilitating poverty.

Abortions using traditional herbs are common.

Prevention of unintended pregnancies and STIs using condoms and family-planning methods are not well known and hence infrequently used.

Social issues related to sex

Forced, early marriages are common and may be caused by widespread poverty and a belief that early marriage saves girls from risky sexual behaviors outside of marriage.

All stakeholders, whether adults or adolescents, males or females, leaders or non-leaders, expressed feelings of helplessness or lack of control concerning the sexual activity of young people.

Religion and tradition continue to define ideal behaviors; these are not always in sync with actual behaviors.

Both boys and girls learn about the techniques of penetrative sex from pornographic movies.

Boys and girls acknowledge that the consequences of engaging in early sex are more severe for girls than for boys.

record any major differences between the two ethnic groups (Limba and Fullah). Lifeline exercises were also used to triangulate the information from the other interviews and exercises.

Values Exercise

The values exercise was conducted with 14 groups, seven from each village. All groups felt the values they identified were a true reflection of their community and society. They also agreed that they learned their values from their parents, church/mosque and/or ancestors. However, it seems there was a lack of clarity regarding exercise instructions. Participating groups understood values to mean activities, occupations (e.g., farming, football, school) that they “value,” as opposed to values by which they live their lives (e.g., integrity, honesty, commitment). The number of times a “value” was mentioned by each group indicated the ranking of the values by importance.

The data analysis was conducted in a number of stages: The initial stage took place immediately after data collection and was followed by an independent review of data by the CARE-Sierra Leone technical advisor. A preliminary draft of results was circulated and, finally, a series of discussions with all SAY project staff members over a one-week period resulted in finalizing the conclusions and recommendations.

From Social Analysis to Action: How These Findings Have Been Used

The findings from this assessment were used to help design a baseline survey, refine the project design and inform future social analysis assessments.

The baseline survey was designed to collect information on knowledge of SRH and perceptions of self-efficacy of young people. The social analysis information was used in designing a set of contextually defined sentences that reflected situations in which a person’s self-efficacy in handling the situation could be assessed.

Key program recommendations for the team, derived in part from the findings from the social analysis, include ensuring that adults as well as young people are reached by the SAY project, and that efforts to involve members of secret societies in SAY activities are explored. Staff planned feedback sessions to present the main findings of the analysis for the two villages that participated in the social analysis. These findings were presented in the form of a play, which highlighted socio-cultural factors that led to early marriage (or not, such as girls staying in school) and difficult deliveries. In these feedback sessions, discussions on what communities could do to address YRH issues led the project to better understand how adults could be more involved in YRH issues at the community level and how SAY could support this effort.

What Will be Explored in the Third Wave of Social Analysis?

The social analysis revealed additional social factors that influence the SRH choices of adolescents that require greater understanding. For example: 1) What is “taught” during initiation ceremonies for adolescents, complementing or contradicting teachings of gospel and the Koran? 2) Why has there been a shift in the age at which girls are initiated, from 18 to 12 years old? Some informants indicated that girls were having sex earlier, thus the need to change the age of the initiation rites. But why are girls having sex earlier? Is it due to poverty? 3) What is the customary law that surrounds and supports early marriage? What is the process for changing customary laws?

Annex 2

Annotated Bibliography and References

CARE General Documents

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Available from the portal link below, this document outlines the health unit strategy for the next five years, including how to refocus work to take account of underlying causes of poor health, and a rights-based approach to programming. Available at: http://mycare.care.org/portal/server.pt?space=Opener&control=OpenObject&cached=true&in_hi_ClassID=18&in_hi_userid=513&in_hi_ObjectID=273527&in_hi_OpenerMode=2

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This document is “intended to provide CARE program staff with a set of concepts, approaches and tools that can be used to capture critical socio-political information for consideration in program design.” Available from Kathy McCaston (McCaston@care.org).

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McCaston & Rewald (2004), A Conceptual Overview of Underlying Causes of Poverty CARE: USA (Draft)

This second paper in a three-part series “provides a basic overview of the underlying causes of poverty and is dedicated to helping CARE understand the ‘basics’ of the underlying causes of poverty.” This draft is based on an extensive literature review. Available from either Kathy McCaston (McCaston@care.org) or Michael Rewald (rewald@care.org).

Rights-Based Approaches

CARE USA (2004), Incorporation of a Rights-Based Approach into CARE’s Program Cycle: A Discussion Paper for CARE’s Program Staff

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CARE (2001), Basic Introduction to Human Rights and Rights-Based Programming Workbook: Facilitation Guidebook

“The aim of these preparatory materials is to help the reader prepare to facilitate a basic rights-based programming workshop. This manual is for relief and development workers thinking about applying a rights-based approach to their work.” Available at: www.careinternational.org.uk/resource_centre/civilsociety/basic_introduction_to_human_rights.pdf

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Social Analysis Theory

Klouda T (2004), Context-specific Social Analysis

The case for carrying out context-specific social analysis as well as other challenges. Available from Tony Klouda (klouda@care.org).

Hughes, I., Ed (2004), Action Research Electronic Reader

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World Bank (2003), Social Analysis Sourcebook: Incorporating social dimensions into Bank supported projects

This document provides a detailed description of how the World Bank is using social analysis, which differs from social analysis as defined by the CARE SRH Team. This sourcebook is useful for seeing how other organizations use social analysis, and it also provides extensive information on the World Bank’s methodology. Available at: [http://lnweb18.worldbank.org/ESSD/sdvext.nsf/61ByDocName/SocialAnalysisSourcebookEnglish-PDF/\\$FILE/Social+Analysis+Sourcebook+FINAL+2003+Dec.pdf](http://lnweb18.worldbank.org/ESSD/sdvext.nsf/61ByDocName/SocialAnalysisSourcebookEnglish-PDF/$FILE/Social+Analysis+Sourcebook+FINAL+2003+Dec.pdf)

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CARE Sierra Leone (2004), A Social Analysis on Adolescent Reproductive Health in Kabala, Koinadugu District, Sierra Leone for the Sexuality and Youth Project

This paper outlines a first wave of social analysis undertaken by CARE Sierra Leone, including the methods used, analysis strategies, results and recommendations. Available from Jaime Stewart (stewart@care.org).

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This document explores theatre as an interactive tool to bring to light sensitive issues and provide people with a supportive environment within a conflict setting in which to discuss them. Available from CARE-Burundi Country Director Kassie McIlwane (kassie@cbinf.com).

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The project sought to decrease sex workers' vulnerability to HIV. An analysis showed that their powerlessness, rather than their behavior, made them vulnerable. Subsequently, the project developed several innovative interventions to change the situation. Available from CARE Bangladesh (carebang@bangla.net).

General Theory

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“This guide is intended for use by staff of humanitarian aid organizations working in conflict-affected settings who wish to begin or strengthen their own inter-organizational relationships, particularly those partnerships that strengthen health initiatives. Thus, the intended audience for this guide is project managers and program designers working in conflict settings. However, the concepts and principles will be useful to any organization working in partnerships – regardless of the setting and the area of intervention. This guide will introduce basic concepts of inter-agency partnerships, with a focus on the critical areas in designing, entering into, and managing and sustaining partnerships.” Available from either Susan Igras (igras@care.org) or Doris Bartel (dbartel@dc.care.org).

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This pilot guidance booklet intends to: “describe the thinking behind humanitarian protection; identify the key elements of basic programming that enable agencies to be more protection-focused in their work; and offer some general guidance on how to monitor and evaluate humanitarian action and its results in specific protection terms.”

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