The Socio-cultural Drivers of Sexual and Reproductive Health for Adolescent Girls in Ethiopia
### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>A360</td>
<td>Adolescents 360 project</td>
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<td>ASRH</td>
<td>Adolescent sexual and reproductive health</td>
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<tr>
<td>EDHS</td>
<td>Ethiopia Demographic and Health Survey</td>
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<tr>
<td>EHNRI</td>
<td>Ethiopia Health and Nutrition Research Institute</td>
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<td>EPHI</td>
<td>Ethiopia Public Health Institute</td>
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<tr>
<td>GBV</td>
<td>Gender-based violence</td>
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<td>HEW</td>
<td>Health extension worker</td>
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<td>HMW</td>
<td>How might we question</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>mCPR</td>
<td>Modern contraceptive prevalence rate</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MPH</td>
<td>Master of Public Health</td>
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<tr>
<td>PAR</td>
<td>Participatory action research</td>
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<tr>
<td>PI</td>
<td>Principle Investigator</td>
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<tr>
<td>PSI</td>
<td>Population Services International</td>
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<td>PSI/E</td>
<td>Population Services International Ethiopia</td>
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<tr>
<td>REB</td>
<td>Research Ethics Board</td>
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<tr>
<td>SERC</td>
<td>Scientific Ethical Review Committee</td>
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<tr>
<td>SNNP</td>
<td>Southern Peoples Nationals and Nationalities</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>UCB</td>
<td>University of California at Berkeley</td>
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<tr>
<td>YPAR</td>
<td>Youth participatory action research</td>
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SUMMARY

The 2011 Ethiopia Demographic and Health Survey (EDHS) reported the mean age of marriage and mean age of sexual debut to be 16.5 and 16.6, respectively, suggesting that large proportions of Ethiopian women tend to marry and become sexually active during adolescence. Adolescent girls who marry young face a number of sexual and reproductive health challenges including unintended and closely spaced pregnancies, complications during delivery, maternal morbidity and mortality, and unsafe abortions. Research on adolescent sexual and reproductive health (ASRH) often lacks the meaningful engagement of adolescents in the research process. This means that the solutions developed out of the research often do not adequately reflect the sociocultural context in which adolescents live.

Objectives: This formative research was conducted in order to uncover insights about adolescent girls’ (15-19 years old) values, beliefs, and behaviors related to sexual and reproductive health (SRH). It also aimed to understand how the values, beliefs, and behaviors of influencers in girls’ lives (e.g. parents, peers, male partners, and community leaders), impact girls’ access to SRH information, products and services. This included investigating how cultural norms and expectations related to puberty, sexual debut, marriage, contraceptive use, sexuality, childbearing, maturity and adulthood, influence the contraceptive motivations, emotions, cognitions, and behavior of adolescent girls.

Research methodology: This exploratory and descriptive research employed qualitative research methodologies involving focus group discussions, individual interviews, photo narratives, and observations. The formative research for Ethiopia was implemented in four regions: Addis Ababa, Afar, Oromia, and Tigray. The research team interviewed 294 participants in 127 sessions. The participants included: married and unmarried adolescent girls (15-19 years-old), community leaders, adolescent boys, mothers and fathers of adolescent girls, husbands of adolescent girls and health providers. Research ethical approval was obtained from the PSI Research Ethics Board (REB) in Washington D.C. and the Ethiopia Public Health Institute’s (EPHI) scientific research ethics committee, in Ethiopia.

Results: Unmarried girls are excited about educational opportunities and the prospect of starting a family. They are experiencing more interactions with boys than the past generation, which is creating anxiety for their parents and elders. They grapple with wanting to be a “good” girl and making their parents proud, while being a naturally curious adolescent. They are largely underserved by current SRH health services.

These results are being used to generate insights and opportunity areas for designing innovative solutions for improving uptake of voluntary modern contraception by adolescent girls.
INTRODUCTION

Background
Adolescent girls (age 15-19 years old) constitute nearly one tenth of the total population in Ethiopia. These adolescents face disproportionately poor sexual and reproductive health (SRH) outcomes when compared to their older counterparts. Adolescents start having sex at an early age. The median age at first intercourse in Ethiopia is 16 years for girls and the median age at first marriage is 16.1 years indicating that for most girls, marriage drives sexual debut. By 15 years old, 29% of females are sexually active and by age 18, 41% of adolescent girls are married (Mini EDHS, 2014). Many Ethiopians have a strong cultural value for married young couples to bear a child within the first year of marriage. About one quarter of all girls experience their first birth before 18 years old, a number that climbs to 52% by age 20.

In Ethiopia, current use of modern contraceptives among married adolescent girls (15-19 years old) is 40%, and among all adolescent girls (including those that are sexually active and unmarried), it is just 9%. The unmet need for contraception is 30% among married girls and 37% among unmarried sexually active girls. (Mini EDHS, 2014). To address these issues, the Ethiopian Federal Ministry of Health is implementing a national Adolescent and Youth Reproductive Health Strategy in an effort to enhance reproductive health and well-being among young people in Ethiopia aged 10-24 years old.

Adolescents 360 (A360) is a four-year project led by PSI, with a $30 million investment from the Bill & Melinda Gates Foundation and the Children’s Investment Fund Foundation. The project aims to increase access to and uptake of voluntary modern contraception among adolescent girls (15-19 years old) in Ethiopia, Nigeria and Tanzania. The long-term, strategic outcome of the project is to increase the sustained use of voluntary modern contraception among adolescent girls, 15-19 years old, beyond the three project countries and the length of the project. To achieve this strategic outcome, the project focuses on two primary outcomes including (i) increased voluntary modern contraceptive prevalence rate (mCPR) among adolescent girls (15 to 19 years old) in the project intervention areas and (ii) the adoption of the A360 approach to design interventions for ASRH within and beyond the project intervention areas.

The A360 approach is an interdisciplinary approach that, through working in partnership with young people, fuses core elements of public health, marketing, human-centered design, developmental neuroscience and cultural anthropology. This project also engages youth as partners in the research and intervention design and leverages new technology as a critical tool. This interdisciplinary approach is being used to develop high-performing ASRH programs that are affordable and scalable.

The project conducted formative research aimed to generate insights about adolescents’ lives, their social context, and their experience with accessing SRH information, products and services. These insights will guide the development of design opportunities for supporting adolescent girls to access voluntarily modern contraception.

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1 Unmet need defined as the number or percent of women who desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method.
**Research Objectives**

This formative research was conducted in order to uncover insights about adolescent girls’ (15-19 years old) values, beliefs, and behaviors related to SRH. It also aimed to understand how the values, beliefs, and behaviors of girls’ influencers (e.g. parents, peers, male partners, and community leaders), impact girls’ SRH.

This research aimed to:

- Explore the cultural norms and expectations for adolescent girls related to puberty, sexual debut, marriage, contraceptive use, sexuality, childbearing, maturity and adulthood;
- Assess the underlying influences, motivations, cognitions, and behavior of adolescent girls in relation to sexuality and contraception;
- Map adolescent girls’ trajectories of sexual and reproductive life, beginning with puberty and moving to sexual debut, marriage and childbearing;
- Explore the roles community influencers play in adolescents’ decision-making processes and engagement with health services;
- Build the capacity of young women and young men in the community to meaningfully engage in research.

**RESEARCH & DESIGN METHODOLOGY**

**Formative research design**

The formative research was exploratory, combining elements of qualitative research practices from the fields of ethnography and design research. Youth were engaged as partners in the research process. Qualitative data collection methods were used to engage adolescent girls and boys, parents and husbands of adolescent girls, health workers and community influencers. Methods included conducting observations of adolescent boys and girls in public places, using photo narrative, holding group discussions, and individual in-depth interviews.

**Study site**

The formative research for Ethiopia was implemented in four regions: Addis Ababa to reflect the diversity of urban Ethiopian populations; Tigray and Afar to represent rural populations; and Oromia to represent a semi-urban population. These regions were also selected based on an analysis of where there are high levels of need and safety for the research team to conduct research. Although the Afar region is not an A360 project implementation site, insights gathered there will inform the A360 approach in Ethiopia and can be used by other projects.

Landscape and market analyses conducted in early 2016 showed that contraceptive service and product delivery is specifically failing married adolescent girls living in rural Oromia and urban Addis Ababa. Selection of Kebeles (smallest administrative units in a region), was based on presence of a local partner operating in the areas and being within one hour’s drive from the main town in the region. The Kebele sites were also selected in consideration of the security and safety of the research team and the highest levels of need. Table 1 shows the sites selected.
**Study population**

Within the selected study site, the research team recruited and interviewed a variety of people who were identified as influencers of ASRH. The research team interviewed:

- Married and unmarried adolescent girls, ages 15-19 years-old, as the primary population of interest.
- Community leaders including teachers, health care providers, Health Extension Workers, pharmacy workers, religious leaders, NGO staff, clan leaders, and local government officials.
- Peers and family members including adolescent boys (15-19 years-old), parents, parent-in-laws of married adolescents, and male partners of adolescent girls.

The table below shows the number of research participants interviewed by region and by method.

**Table 2. Number of participants interviewed**

<table>
<thead>
<tr>
<th>Research participants</th>
<th>Addis</th>
<th>Afar</th>
<th>Oromia</th>
<th>Tigray</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent girls</td>
<td>22</td>
<td>10</td>
<td>26</td>
<td>25</td>
<td>83</td>
</tr>
<tr>
<td>Adolescent boys</td>
<td>10</td>
<td>7</td>
<td>13</td>
<td>16</td>
<td>46</td>
</tr>
<tr>
<td>Community influencers</td>
<td>8</td>
<td>3</td>
<td>9</td>
<td>15</td>
<td>35</td>
</tr>
<tr>
<td>Fathers</td>
<td>8</td>
<td>18</td>
<td></td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Mothers</td>
<td>17</td>
<td>9</td>
<td>19</td>
<td>10</td>
<td>55</td>
</tr>
<tr>
<td>Health extension worker</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Husbands/Partners</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Health provider</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>67</strong></td>
<td><strong>45</strong></td>
<td><strong>99</strong></td>
<td><strong>83</strong></td>
<td><strong>294</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interview methods</th>
<th>Addis</th>
<th>Afar</th>
<th>Oromia</th>
<th>Tigray</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One on One interview</td>
<td>15</td>
<td>15</td>
<td>27</td>
<td>23</td>
<td>80</td>
</tr>
<tr>
<td>Group interview</td>
<td>14</td>
<td>5</td>
<td>13</td>
<td>15</td>
<td>47</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>29</strong></td>
<td><strong>20</strong></td>
<td><strong>40</strong></td>
<td><strong>38</strong></td>
<td><strong>127</strong></td>
</tr>
</tbody>
</table>
RESEARCH IMPLEMENTATION & LESSONS LEARNED

PSI led this research, in collaboration with IDEO.org, the Center on the Developing Adolescent at University of California Berkeley (UCB), a social-cultural anthropologist, Triggerise, youth researchers, and local partners from the selected study communities. During data collection, the field research teams consisted of 3 to 4 trained youth researchers, 2 to 3 staff from PSI Ethiopia (PSI/E), and 2 to 3 staff from IDEO.org. This staffing is inclusive of the field research coordinator from PSI/E and a skilled translator.

Data collection instruments

Research tools used for data collection included interview guides, activities to facilitate discussions on SRH topics, and the use of story-telling and narrative development. The research data collection tools were designed by IDEO.org and PSI, with contributions from UCB on the developmental neuroscience perspectives to enrich the content.

The core principles of data collection were to establish empathy with research participants, listen to them, value their opinions, and respect them in order to understand their context. Interviews were conducted using detailed qualitative interview guides that contained a variety of discussion tools. Each team had the flexibility to choose which of these tools was most appropriate for the audience.

The discussion tools within the interview guide included the following:

- **Photo Narrative**: a tool in which the audience takes photographs that illustrate their daily lives e.g. typical day, things or places that make them feel happy or worry; people and events that are important to them; etc. Photos are then discussed in group or one-to-one settings in order to generate insights.
- **Card Sort**: a method in which individuals sort different topics by their level of importance to them in order to better understand values surrounding sexuality, owning property, and/or future family preferences.
- **Context**: An interview tool used to start conversations about the perceived value, status and associations related to adolescent girls in the community.
- **Topic spectrum**: a tool used to understand girls’ perspectives on sources of SRH information. During interviews, discussion of sensitive topics were limited to those appropriate or comfortable for the research participants.
- **Trusted Source Bulls-Eye**: a tool used to facilitate discussion about girls’ most and least trusted sources of information or service delivery related to sexual and reproductive health, particularly contraception.
- **Story telling**: the tool that introduces hypothetical stories and discussion about those stories, in order to determine research participants’ reactions to adolescent girls’ needs, and health-seeking behaviors and services.
All research interview guides were written in English and translated into the three languages of Oromifa, Tigrigna, and Amharic spoken in the study regions. The interview guides were then proofread by the young researchers for relevance, and finalized for field data collection. During field interviews, researchers mostly read the guides aloud in English and then a local translator translated them, without reference to the translated guides. Similarly responses were translated from local language to English for note taking.

IDEO.org and PSI meticulously designed the data collection tools, which participants liked working with. The exception was a set of cards with emojis showing different emotions. This activity did not work, because the ways of describing emotion on the cards did not resonate culturally in Ethiopia. Otherwise, the data collection methods were well received by research participants, and allowed people to talk about sensitive issues in an indirect and therefore non-threatening way.

Training of data collectors
A 7-day training boot-camp was conducted in Addis Ababa for all A360 project partners. The participants included 14 young researchers, 9 PSI/E staff, 5 PSI Washington staff, 12 A360 project partners, 8 observers from partner countries, and 1 donor representative. Data collectors received extensive training on the research protocol, data collection guides, recruitment and consent procedures. The youth researchers received additional training in research methods and research ethics, and were mentored during field data collection. Field practicums were conducted in selected communities in Addis Ababa for participants to practice using the interview guides, interview techniques, translation, note taking and consent procedures. Researchers were also trained on “daily downloads” – a rapid daily synthesis process to capture salient themes – and data coding.

Key learning from the research training boot-camp

| #1: | #2: Establish roles within research teams. Identify responsible persons for each research component -- consent and ethics procedures; safety; data downloads, etc. Train them on their roles and familiarize them with their tools. |
| #3: Build in more practice time. Get field teams more comfortable with processes before going into the field. Practice specific roles (note taking, leading interviews, downloading data, etc.) |

Recruitment of research participants
Health extension workers (HEW) supported the recruitment of adolescent research participants. Adult researchers from PSI/E assisted in recruitment of community influencers, health service providers and parents. Recruiters met with the local leaders and sought permission to conduct research in the communities. Recruiters were responsible for obtaining parental or spousal permission, according to the recruitment protocol. The inclusion criteria for adolescent boys and
girls were that they had to be 15-19 years old and living in the designated study site. In compliance with Ethiopian laws and research ethics, permission, consent, and assent practices were followed. Parental/guardian permission was obtained for all unmarried adolescent boys and girls under 18 years old. Permission from husband was obtained for all married adolescent girls. Married adolescent girls, under 18 years old, living with their parents and not living with their husbands were treated as minors. Both parental or husbands’ permission and the individual adolescents' assent were required before interviews. Unmarried girls over 18 and all boys over 18 consented to participate in research on their own. The processes of obtaining permission and informed consent were separated. All research activities were conducted in a place deemed safe by the research team and participants. These included schools, health facilities, kebele administration offices, homes, and other community locations.

Local partners recruited parents, parent in-law, service providers, community influencers and partners through their community networks. The inclusion criteria for parents and in-laws was having an adolescent son or daughter aged 15 to 19 years, or a daughter in-law 15-19 years. Focus groups were conducted for males and females separately.

**Key learning related to recruitment of research participants**

<table>
<thead>
<tr>
<th>#1: Recruit through more diverse networks.</th>
<th>#2: Be creative when recruiting girls under 18.</th>
<th>#3: Use daily download to evaluate saturation.</th>
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</thead>
<tbody>
<tr>
<td>Recruiting through the same HEW for the whole week may have biased the information we heard.</td>
<td>It was a challenge to talk to married girls under 18 because of the legal age of marriage.</td>
<td>Daily downloads should have been used to assess if teams had reached information saturation and decide whom and where to recruit for additional useful data.</td>
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</tbody>
</table>

**Data collection**

The main methods of data collection were through group interviews and one on one in-depth interviews. Adolescent girls and boys, partners to adolescent girls, and community influencers participated in both group interviews and one-on-one in-depth interviews. HEWs and health service providers participated only in one-on-one in-depth interviews. Parents participated only in group interviews. There was variation in the choices teams made for what interview methods to use with different audiences.

A youth and adult researcher jointly facilitated group interviews. A third member of the research team took notes. Where the adult researcher did not speak the local language, a translator was assigned. Single sex group interviews were conducted to understand how adolescents perceived adult expectations and norms related to sex, relationships, and contraception and how those perceptions influenced adolescents’ decision-making processes. Researchers of the same sex as participants conducted all individual interviews.

Interviews were conducted in the appropriate local language and translated into English for note taking. The majority of interviews lasted 60 minutes. When extra time was needed to complete the interview, research participants were asked for permission to extend the interview an extra 10 to 15 minutes.
Key learning during data collection

| #1: Allow first person questions in research. The inability to ask first person questions limited actionable learnings and real life stories. |
| #2: Tailor methods to specific end users. Consider unique objectives for each stakeholder group and ensure conversation flow is appropriate and meets these objectives. Root methods in drivers and segmentation, when possible. |
| #3: Simplify the consent process to make it less intimidating. The consent process should be more concise and accurately translated into local dialects ahead of time to ensure comprehension. |

Data management

Each research team received a kit that included all of the required documentation for the field research. The kit content included: interview guides, discussion facilitation tools, consent/permission/assent forms, a copy of the research protocol, contact information sheet, response protocol for gender-based violence disclosures, field safety and security instructions, instructions for data coding, space for interview notes, and data download forms.

After completing interviews each day, the team discussed the information and downloaded the content into top learning, memorable quotes, questions, and key observations. Downloading included sieving and summarizing critical learnings from the interview notes taken, based on team comprehension of the responses. Key themes, highlights, and questions were recorded on sticky notes during the information download. Each interview session was assigned a unique code, and downloaded data was identified by the code. Digital photos of both the interview notes and downloaded data were taken and uploaded on password protected Google drive for analysis. Physical notes and download stickies were kept by the team leaders and these were subsequently handed to the IDEO.org team leader.

Key learning about daily information download

| #1 When possible, build in mid-research synthesis moments. Take time to share back with the whole team to identify lingering questions and areas to focus on in upcoming research days. |

Data analysis

The entire research team engaged in identifying relevant themes and ensuring data was analyzed with a youth and cultural lens. Data synthesis was conducted in four stages.

- **Stage 1 – Daily Download**: At the end of each day in the field, each research team member captured their top learning, ideas, and stories on sticky post-it notes, and then put these on big sheets of paper. The team shared inspiring stories, learnings, and quotes and observations, which helped to inform the emerging findings.

- **Stage 2 – Identifying Themes**: In order to synthesize data across interviews, common themes were identified for each research participant category. This involved reviewing the
downloaded data to find patterns, compelling insights, consistent problems, identifying
tension between need and action, identifying shifts in ways of thinking and action, and
surprises. The ideas and quotes that resonated for the majority of researchers were sorted
and moved to a new board. Out of the most compelling data, patterns and relationships
were searched to identify emerging themes. The sticky notes classified as top learning and
quotes were gathered and sorted into common themes. The themes were merged into
opportunities for design.

- **Stage 3 – Create Insight Statements:** The goal of this stage was to identify how the data
  pointed towards design solutions. The process involved taking all themes and rephrasing
  them into what felt like insights for the research. The team looked through the original
design challenge and used the evaluation standard to refine insights.

- **Stage 4 – “How Might We” Questions:** The fourth stage was to translate the insight
  statements into “how might we” (HMW) questions that were used to trigger innovative
  thinking towards potential solutions. HMW questions were used to generate a number of
  possible answers that became part of the launch pad for brainstorming.

Given the interdisciplinary focus of A360, we reviewed the insights and HMW questions to
ensure they were informed by socio-cultural anthropology, local Ethiopian experience, youth
culture, and developmental science.

**Ethical consideration**

Ethical approval to conduct the formative research was obtained from the PSI Research Ethics
Board (REB) and the Ethiopia Public Health Institute’s (EPHI) scientific research ethics
committee. The research team obtained informed consent from all persons who were
interviewed after explaining the goals and objectives of the research, confidentiality safeguards,
and the potential risks and benefits to research participants. No names of individual informants
were recorded or used in this report. No face or identifiable photos were taken as part of the
research.

**Consent process:** The field researcher who administered the consent script was matched by
gender to study participants. Verbal consent was administered individually before the start of the
interview and was witnessed by a member of the research team. Research participants received
a copy of contact information for the principle investigator (PI) and local ethics committee in
case they wanted to make an inquiry related to the research.

**Parental / husband permission:** For unmarried girls 15-17 and married girls 15-17, signed
permission from parents and husbands/partners respectively was obtained prior to participation
in the research. Adult researchers or the local partner obtained this permission.

**Risk of privacy:** To mitigate the risk of privacy due to parental interference and learning the
content of the discussions, the interviews were held in safe spaces within the community such
as schools, churches, kebele offices or other places where interruptions could be avoided.
These safe spaces allowed participants to give confidential responses without fear of
interruption.

**Gender-based violence:** Field research teams were trained to record any disclosure of
violence, abuse or coercion (witnessing or direct experience) in a non-judgmental fashion.
Where a participant expressed discomfort or stress during the interview, the interviewer
reminded the participant they were free to stop the interview at any time, not to answer any
questions that made them uncomfortable, and allowed the participant time to recover before
proceeding with the interview. Field research teams were equipped with a standard script to inform anyone who made a disclosure of victimization. The script provided names, offices and phone contact numbers for where to get support services in the region. The research teams did not end up having to implement this protocol. One woman in Oromia disclosed an experience of rape more than 3 years in the past but she was comfortable sharing the story.

Limitations
The research participants were recruited from within the network of HEWs or PSI/E’s community partners, hence the informants and results tended to appear homogenous and research teams were getting to saturation after just a few interviews.

Interviews with 15-year-old adolescents did not yield much information, as many of them showed ignorance on the topics or shy to share their sexual experiences. Some girls were so shy it was difficult to get them to actively participate in the research. Some girls would not look any of the interviewing teams in the face. The most difficult interviews were with girls who did not go to school and were mostly cloistered in the house. Because of these challenges, more meaningful information was derived from interviews with older adolescents. As a result, the study results may not accurately be generalizable to younger adolescents.

In Addis Ababa the urban context made it difficult to identify the roles of community influencers. As compared to more rural settings, in an urban context community ties are often looser because many diverse cultures and strangers are living together in close quarters. As such, the responses obtained from the perceived community influencers might not fully represent their actual influence among adolescent girls.

Insufficient time was given to pre-testing consent forms and data collection tools with the research audience. Field teams reported that it was hard to get a conversation started when having to obtain consent first. The teams struggled to make the consent process clearer, concise, and easier to understand.

The field teams rarely used the local language translated tools, and instead used the English tool to conduct interviews, relying heavily on the translator. There was not enough focus on ensuring consistency and quality of verbal translation of key terminologies and interpretations used in the local languages.