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sexual health

research findings for development policymakers and practitioners

Community HIV prevention in India

The Sonagachi Project is a successful HIV prevention project in India, led by sex workers. However, it has actively engaged with powerful local groups, calling into question its claim to be a community-led project. Has it failed to live up to its values, or simply done what is necessary to survive?

Community participation is intended to involve marginalised people who lack power and resources, and actively engage them in decision-making. However, social relations in marginalised communities are often based on exploitation and are therefore unequal. How do community-led projects put the ideals of participation into practice?

Researchers from Glasgow Caledonian University in the UK, and West Bengal Civil Service in India, took the Sonagachi Project as a case study. They observed the project's participatory activities and conducted 39 interviews with a range of people, including sex worker employees and their clients, health and development professionals, and brothel managers. They looked in particular at the unequal social relations that exist in the local community and how the project engaged with them.

The researchers found that relationships with non-sex worker interest groups have a strong influence on the project. To gain access to the red light district where sex workers operate, the project had to build good relations and negotiate carefully with powerful local men's clubs and 'madams' (owners of rooms used by sex workers).

Further findings show:

- The clubs who own the premises where the project runs it's clinics, benefit from having their buildings maintained and gain influence over the project.
- Health and development professionals play leading roles, mediating between sex workers and funding agencies, setting up systems for documenting work and ensuring accountability.
- Madams are involved in local problem-solving meetings with the project, some sitting on committees.
- As the project won increased public support and funding, it was able to buy its own premises and reduce its dependence on the clubs.
- Sex workers took on supervisory and leadership roles as they acquired the necessary skills.

The authors note that the Sonagachi Project might seem to compromise the principles of community leadership. However, in order to succeed for 14 years, it has been necessary for the project to engage with powerful groups, particularly those who can stop it operating. They suggest that funding agencies' high expectations of community participation may not be realistic and may also discourage community projects from acknowledging the real dilemmas they face. They conclude that:

- Much time and effort is needed to build the skills of marginalised groups, such as sex workers, so that they can take on leadership roles.
- Practitioners, project evaluators and policymakers should take unequal power relations into account, rather than denying that they exist.
- Funding proposals for participatory projects should consider how to manage relationships with powerful groups and deal with resistance.

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'The Necessary Contradictions of 'Community-led' Health Promotion: A Case Study of HIV Prevention in an Indian Red Light District', *Social Science and Medicine*, 64(2), pages 496-507, by Flora Cornish and Riddhi Ghosh, 2007

Competitive voucher schemes

Improving access to maternal health care

Access to maternity health services is vital for reducing maternal mortality in developing countries. Analysis by the London School of Economics in the UK suggests that competitive voucher schemes could improve service equity and efficiency, offer a choice of providers, increase responsiveness and improve standards of care.

Reproductive and child health (RCH) services in many developing countries are free and financed by taxes. Disadvantages of this approach include:

- huge financial investment by governments, with little flexibility to move resources
- health budgets spent mostly on salaries rather than drugs or equipment
- limited consumer choice, no competition and poor quality services
- little incentive for staff to improve performance or be responsive to patients
- inequalities across socio-economic groups, in health outcomes and access to and use of services.

Both the rich and poor use private health care for services such as antenatal care, births, and in-or out-patient care. Therefore any strategy to improve access to RCH services must involve private providers, especially where public health care is inadequate. However, it should also be in line with government thinking and patient preferences, and move towards performance-related funding.

Subsidising demand among key patient groups may be better than using the same resources to subsidise supply. Demand-side financing gives power to consumers and repays providers based on number of clients. Competitive voucher schemes are one demand-side approach. A government or donor funds a voucher agency to produce and distribute vouchers, and contract and train service providers. Recipients exchange vouchers for goods or services at a provider of their choice. Providers return the voucher to the agency and are repaid according to their contract. Such schemes can:

- target subsidies more accurately
- provoke demand for under-used services
- offer simpler administration than other demand-side subsidies
- reduce some of the problems with provider-induced demand
- increase technical quality by including standards in provider contracts

Limitations include high administrative and transaction costs, over-servicing due to the direct link between outputs and payment, supplier-induced demand, and risk of corruption. More pilot schemes are needed to address these concerns, and also assess factors making governments and donors reluctant to implement voucher schemes, such as:

- an ideological objection to working with the private sector or a belief that private sector services will cost more
- unfamiliarity with voucher schemes
- policy issues of targeting certain populations
- a lack of government administrative capacity.

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'Improving Access to Reproductive and Child Health Services in Developing Countries: Are Competitive Voucher Schemes an Option?', *Journal of International Development*, 19(7), pages 975-981, by Mrigesh Bhatia and Anna Gorter, 2007

Young couples' abortion decisions in Nepal

The government of Nepal legalised abortion in 2002 and services became operational in 2004. Since then, thousands of women have used these legal abortion services. How do young couples reach the decision to terminate an unintended pregnancy?

Early marriage and early childbearing are social customs in Nepal, with one in six women having at least one child between the ages of fifteen to nineteen. By the age of 24, 66 percent of women have had at least one child. Although most are informed about modern contraceptive methods, only 9 percent of 15 to 19 year olds use them.

Until abortion was legalised, Nepal had one of the worst maternal death ratios in Asia. Unsafe abortions contributed significantly to this, with the Ministry of Health reporting that 54 percent of all maternal deaths in hospital resulted from unsafe abortions. By December 2006, 151 government-approved abortion facilities were operating and 85,000 women had had legal abortions.

A study by the Centre for Research on Environment Health and Population Activities in Nepal, and the University of Southampton in the UK, uses data from a 2003 study to examine young couples' decisions to abort unintended pregnancies in Nepal. Most unintended pregnancies in this study probably occurred prior to the legalisation of abortion, or when abortion services were still poorly developed.

The study found that:

- A high number of pregnancies among young married couples were unintended, yet relatively few couples had actually had abortions or had attempted them.
- Multiple factors affected the decision to abort unintended pregnancies, including husbands views, health service providers, family and social networks, and socio-economic circumstances.
- Women were more likely to make an independent decision to abort if they had experienced a short interval between births, if their husband suspected them of infidelity, or if they faced other hardships.
- While some young women discussed their options with their mothers-in-law, friends and close relatives, this had little effect on their final decision.
- Factors central to the decisions included economic issues, cultural and religious beliefs, a fear of social stigmatisation and a fear of sterility or ill-health.
- Incorrect information about abortion law and services was being provided to young couples by some medical staff.

The study recommends that the government:

- increases access to family planning and abortion services, in particular targeting young couples
- educate communities about family planning and legal abortion services through social marketing and private-public partnerships
- work towards ensuring the pricing of services is transparent and affordable to overcome barriers to access
- assist husbands in playing a more important role in decision-making and include them in reproductive health and rights programmes
- provide extensive professional training for medical staff to ensure they provide abortion information to couples
- update the health service training curricula in line with the legal status of abortion
- devise extensive education programmes for the public.

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'Factors Affecting Abortion Decisions among Young Couples in Nepal', *Journal of Adolescent Health*, 40, pages 535-542, by Mahesh Puri, Roger Ingham and Zoe Matthews, 2007

Sex education needs of Thai teenagers

Increasing economic prosperity in Thailand has been accompanied by the erosion of traditional cultural and religious values. Studies show that more Thai teenagers are having sex at an earlier age, with a corresponding decline in young people's sexual health.

Researchers with the Department of Primary Care and Population Sciences at University College London in the UK, examined the successes and problems of school-based sex education programmes in order to inform sex education policies in Chiang Mai province, northern Thailand.

The study used several methods to discover what teenagers know about sex, and to explore the beliefs and values of teenagers, parents, teachers and policymakers in relation to sex and sexual health. They examined tensions within and between groups, cultural influences on perceptions and behaviour, and what school-based sex education is currently being provided.

The study was based in six secondary schools in Chiang Mai province. The schools were selected to obtain the maximum variation in pupils' socio-economic background, cultural norms, religion and geographical location. Separate questionnaire surveys were conducted among 2,301 secondary school age pupils and 351 parents, and focus group studies involved 185 pupils in 20 groups, and 24 parents in 2 groups.

The study's findings show:

- There is widespread confusion over roles and identity, with teenagers feeling pulled towards both traditional norms and 'modern' behaviour.
- Almost all the teenagers are very aware of, and curious about, sexuality.
- Teenagers' knowledge of sex and sexual health issues is highly variable, with girls recalling more information from sex education lessons than boys.
- Teenagers are most likely to talk to their peers about sex. The next preferred source of information is mothers (for girls) and older friends (for boys). Pupils also reported using films, magazines and the internet to fill in gaps in their sex education.
- There are inconsistencies in parents' attitudes to sex education. Over 90 percent believe that sex education and reproductive health services should be available to teenagers, but 70 percent disapprove of sex education in school. Only 10 percent are willing to be their children's first source of information about sex.
- The attitudes of teenagers suggest that it is a girl's responsibility to learn about and control sexual activity. For boys, self-restraint is not expected and condom use is routinely avoided.

The findings suggest a pattern of behaviour characterised by mutual mistrust between teenagers and parents, secrecy, disobedience, risk-taking and sometimes coercion of girls by boys. Idealised gender roles and increasing opportunities for privacy create the preconditions for coercive, unprotected sex.

Five approaches are suggested for policymakers to improve sex education:

- targeted training, support and mentoring for teachers
- peer-led sex education for teenagers
- story-based scenarios to promote applied learning
- local development of education materials
- use of trained sexual health professionals to address the learning needs of pupils teachers and parents.

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