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communicating international development research

Left out?

Coverage of adolescent reproductive health programmes in Ethiopia's capital

In sub-Saharan Africa, most adolescent reproductive health programmes are at the pilot stage and scaling these up remains a challenge. But are they reaching the intended people? A study conducted by the Population Council and the Ethiopia Ministry of Youth and Sports, looks at the coverage of youth programmes in two slum areas of Addis Ababa, Ethiopia.

Many studies have shown an impact of youth programmes on reproductive health (RH) knowledge and attitudes, but fewer have demonstrated behaviour change. Weaknesses of current youth programmes include the narrow focus on fertility, family planning and HIV without regard for adolescent boys' and girls' diversity and the range of local contexts.

This study looked at the coverage of different sub-groups of young people of the eight peer education programmes and six youth centres operating in low income and slum areas of Addis Ababa. Most of the programmes are run by local and international non-governmental organisations. They offer some recreational equipment, along with RH education activities such as videos or group discussions. All have some HIV-related content and some include family planning information and condom distribution.

A population-based survey was conducted of more than 1,000 adolescents aged 10 to 19 living in the programmes' catchment areas. Adolescents were asked if they had had contact with a peer educator in the last year or had visited a youth centre. In analysing who the programmes had reached the results showed that:

- Boys were roughly twice as likely to have been reached by youth programmes compared to girls.
- Older adolescents, especially older boys, are most likely to be reached by youth programmes.
- Girls who work long hours and who are isolated, such as domestic workers, are least likely to be reached by programmes and benefit from them.

This research shows that programmes may not be reaching the most vulnerable groups of young people. Patterns of work, mobility and social networks are gendered and may affect whether a young person takes part in a programme. The researchers recommend:

- paying attention to the specific circumstances of young people in the local setting, particularly vulnerable, hard-to-reach sub-groups, including girls
- monitoring who the programmes do and do not reach
- using other strategies to reach girls more effectively, such as outreach at the household level or single-gender programmes, or other models such as livelihoods programmes or non-formal education.

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'Differential use of adolescent reproductive health programs in Addis Ababa, Ethiopia', *Journal of Adolescent Health* 38, pages 253-260, by Annabel Erulkar et al, 2006

Barriers to adolescent contraceptive use in South Africa

One third of young women in South Africa become pregnant before the age of 20 despite contraception being free-of-charge. What barriers are preventing them from using contraception?

The South African Medical Research Council carried out a study to find out what barriers were preventing South African teenagers from using contraception. Many South Africans today become sexually active at an early age, have unprotected sex, have more than one partner and often do not use contraception. Teenagers are now at the forefront of the AIDS epidemic in South Africa. Sixteen percent of pregnant women under the age of 20 are HIV positive.

Individual in-depth interviews were carried out with 35 girls aged between the ages of 14 and 20 in Limpopo province over a three week period in 1997. Limpopo province is one of the poorest parts of the country. Discussions with small groups of girls were also carried out and nursing staff were interviewed at the 14 study clinics.

Nurses' attitudes were a major barrier to teenagers getting hold of contraception. The nurses were uncomfortable about providing teenagers with contraception as they felt they should not be having sex. They were judgemental and unhelpful when responding to contraception requests. The girls described it as 'harassment'.

The study found that often social pressures prevented young women from using contraception. The girls felt they would only be accepted as women once they had proved their fertility and men put pressure on their girlfriends to get pregnant. Despite public concern about teenage pregnancies, many mothers wanted their teenage daughters to become pregnant so they could have a baby at home again.

If the girls did use contraception, inaccurate information about reproduction often prevented them from using it correctly:

- The teenagers were worried that a condom could be left inside the vagina and would have to be removed by a doctor in hospital.
- They believed the contraceptive injection could cause infertility. If menstruation was irregular they called it a 'blockage' and would stop using contraception until the bleeding started again.
- Some of the teenagers believed that they could prevent pregnancy by only taking contraceptive pills on the days their boyfriends visited them.
- Some young women also believed that changing their sexual partners regularly or abstaining from sex in the second half of their menstrual cycle could prevent pregnancy.

In order to reduce the number of teenage pregnancies, the study recommends:

- sex education at school before the age of 14 when young people become sexually active
- more information for teenagers about avoiding sexually transmitted diseases
- providing detailed information about contraception and its side effects
- better management and training for nurses so they can deal sympathetically with teenagers requiring contraception and provide the necessary information
- education campaigns that take away the stigma of teenage sexuality so that girls are not afraid to ask for contraception.

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'Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa', *Reproductive Health Matters* 14(27), pages 109-118, by Kate Wood and Rachel Jewkes, 2006

Reducing HIV infection

Female sex workers in India

Sex workers face a significantly higher risk of infection than most other groups. If HIV prevention activities are to reach sex workers, it is essential to understand their characteristics and sexual behaviour.

The HIV prevalence rate in India is relatively low at less than one percent, yet a higher prevalence rate is reported in six states, including Andhra Pradesh. In this state, the majority of people are infected through sex and the disease is largely spread through sex work. Female sex workers have a far higher infection rate than pregnant women in India – in Andhra Pradesh, 16 percent of sex workers are HIV positive.

An estimated one percent of India's adult women are involved in sex work. Their activity is largely secretive because Indian society and the law discriminate against female sex workers. Moreover, relatively little is known about their attributes. For instance, which girls or women are more likely to become involved in sex work and when?

Data were collected on the socio-demographic and sex work characteristics of a large group of female sex workers in rural and urban areas of Andhra Pradesh in India. These data were part of the baseline study for the Frontiers Prevention Project by the Administrative Staff College of India's Centre for Human Development, the National Institute of Public Health in Mexico and the UK's International HIV/AIDS Alliance in 2003 and 2004.

Of the female sex workers interviewed, 5,101 or 75 percent were street-based, 1,499 or 23 percent were home-based and 139 or 2 percent were brothel-based. The researchers found that:

- In comparison with the female population of Andhra Pradesh, a higher proportion of female sex workers were aged 20-34 years (76 percent), belonged to a scheduled or lower caste (35 percent) and scheduled or lower tribe (11 percent), were illiterate (75 percent) and were separated/divorced (31 percent).
- Female sex workers in the trade for over five years were more likely to be home or brothel-based, illiterate, based in small urban towns and to have entered sex work aged 12-15.
- Female sex workers in rural areas entered sex work at a younger age (on average 22 years) and had a shorter gap between their first vaginal intercourse and first sex-for-money encounter (7 years), compared with those in large urban areas (24 years and 9 years respectively).

This shows that women who are illiterate, of a lower social economic status and have fewer economic opportunities are particularly vulnerable to HIV infection. The study recommends that:

- A holistic, long-term approach to HIV prevention must be a joint effort between the National AIDS Control Organization and the Department of Women and Child Development, focusing on women aged 21-34 years, illiterate and from scheduled castes and tribes.
- The myths, misperceptions and fears preventing married couples' access to and use of condoms need to be addressed effectively to promote condom use between female sex workers and their clients and regular partners.
- The unfavourable legal environment must be changed to increase female sex workers' access to the broad range of services available to them, including HIV prevention.

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'Demography and sex work characteristics of female sex workers in India', *BMC International Health and Human Rights* 6(5), by Rakhi Dandona et al, 2006
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Community support for better antiretroviral therapy outcomes in Malawi

Since 1999, Médécins Sans Frontières (MSF) has been developing an AIDS programme with the ministry of health in Thyolo, a rural district of southern Malawi. The programme includes community support. In 2003, Thyolo introduced antiretroviral therapy (ART) for some individuals. Has the presence of community support influenced ART outcomes?

Between 2003 and 2005, researchers led by Médécins Sans Frontières (MSF) reviewed ART outcomes in the areas of Thyolo where community support was available and compared them with areas which lacked such support. Three of the seven traditional authorities in Thyolo were providing community support through volunteers, community nurses and trained family carers.

The basic package of care included home management of HIV-related opportunistic infections, early referral to medical help for patients with possible drug reactions and risk signs, counselling on drug adherence, support to family carers, and tracing defaulters (those who had not attended follow-up appointments for three months or more). Further activities included information, education and communication; nutritional support; and vocational training for AIDS orphans.

Between April 2003 and December 2004, there were 1,634 HIV-positive people involved in the study who were on ART. Of these, 55 percent lived in areas offering community support while 45 percent were from areas without such support. Results showed that:

- ninety-six percent of those who received community support were alive and continuing ART at the end of the study, compared with 76 percent of those who did not receive community support
- the death rate was 3.5 percent for those who received community support, compared with 15.5 percent for those who did not
- the percentage of defaulters was 0.1 for those receiving community support and 5.2 percent for those without support
- only 0.8 percent of those who had community support stopped ART, compared with 3.3 percent of those without community support.

The researchers conclude that community support leads to much lower death rates and better overall outcomes for ART. They note that in a country like Malawi with high HIV prevalence (14 percent of those aged 15-49) and limited resources, health workers are reluctant to take on the burden of community-based outreach work. They argue that:

- HIV and AIDS are chronic lifelong conditions whose treatment and care, including ART, must be continuous and ongoing. The community can play an important role in this regard.
- policymakers should think of ways to sustain community resources and identify the parts of the community that will need further support
- policymakers need to make sure that they do not simply pass on to communities those activities that should be the responsibility of the public services or other partners.

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'Community support is associated with better antitretroviral treatment outcomes in a resource-limited rural district in Malawi', *Transactions of the Royal Society of Tropical Medicine and Hygiene* 101(1), pages 79-84, by Rony Zachariah et al, 2007

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