



HIV/AIDS & STI NEWS

From the DFID Knowledge Programme on HIV/AIDS & STI

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From the editorial board



This is the **fifth newsletter** from the DFID* Knowledge Programme on HIV/AIDS and STIs. The Programme is funded by the Department for International Development, UK, and based at the London School of Hygiene and Tropical Medicine (LSHTM) and the Medical Research Council (MRC), Social and Public Health Sciences Unit, University of Glasgow. It has five areas of research: 1) Determinants of sexual behaviour; 2) Biological risk factors for HIV and STI transmission; 3) Factors affecting use and effectiveness of care and prevention services for HIV/AIDS and STIs; 4) Impact and cost-effectiveness of interventions against HIV and STIs; and 5) HIV/AIDS and STI prevention and care priorities and policies.

These newsletters provide a forum for the exchange of research within the Programme and introduce other relevant research from Programme members. They form a useful means to exchange information such as updates on projects underway, conferences, new grants, etc. Initially, the selected articles reflect the contents of our bi-annual scientific meetings

in London or Glasgow, but contributions from Programme members are invited. Please email your suggestions and comments to: Tamsin.Kelk@lshtm.ac.uk. Also see the Programme's website: <http://www.lshtm.ac.uk/dfid/aids/>

Philippe Mayaud, David Mabey, Graham Hart and Tamsin Kelk

IN THIS ISSUE

We present proceedings from a joint seminar on Young People's Sexual Health in Developing Countries, bringing together work in progress from the HIV/AIDS & STI Knowledge Programme and the Safe Passages to Adulthood new Knowledge Programme, held in June 2003 at LSHTM.

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Young people's sexual health

Introduction

Three main themes are apparent in these presentations from disparate countries. First there is the dissonance between young people's behaviour and the values of older generations in their societies. Consequently young people's sexual relationships have to be clandestine and sexually explicit interventions, such as school-based condom demonstrations, are rarely acceptable. Trying to achieve sexual health promotion in such an unsympathetic context is like swimming against a powerful current. This suggests that we should try and change the policy climate, but this must be done in such a way that it does not undermine a country's own readiness to take the initiative.

Secondly, relationships between the sexes and cross-gender communication are central to any heterosexual sexual health programme. Focusing on the behaviour of young men might achieve more than targeting young women, given that in all these societies men are generally dominant, at least in the initiation and early phase of sexual relationships.

Thirdly, in these societies condoms are associated with illicit sex, and this association is often reinforced by programmes addressing HIV and other STIs. It is far more difficult to negotiate condom use in order to prevent STIs than pregnancy. Yet there already is a demand amongst young people for pregnancy prevention: this risk is far more imminent to young people than HIV. Better collaboration between family planning and HIV professionals is, therefore, long overdue.

John Cleland, Safe Passages to Adulthood, LSHTM

Contradictory sexual norms & expectations in Tanzania

There has been a long running debate as to whether sexual cultures in sub-Saharan Africa are permissive or characterised by restrictive rules, rituals and self-restraint. The HALIRA study, using participant observation, focus group discussions and in-depth interviews, has investigated the sexual behaviour of rural youth in northern Tanzania. Here we outline the main features of sexual culture in this area and highlight both permissive and restrictive norms and expectations for young people.

Sexual activity is **constrained** by clear norms of:

- **school pupil abstinence** – relating to status not age; maintained by the old not the young; punishment varies from beatings to nothing; generally worse for girls, pregnant school girls face expulsion
 - **female sexual respectability** – hugely important for women; criteria of respectability include having 1 or few partners, not initiating sex, only accepting a high price for sex, modest clothing/behaviour, not having STI
 - **taboos around discussion of sex** – particularly across generations, hence no parental sex education.
- However, these norms are incompatible with expectations that **encourage** sexual activity:
- that **sexual activity is inevitable** unless prevented – social life is highly segregated by sex; most interaction between sexes is attributed to sexual interest; non-sexual friendships between sexes are almost inconceivable
 - **sex is a female resource** to be exploited – virtually all sex outside marriage involves material exchange (ranging from Tsh.100–2000; Tsh.600=US\$1); payments decline with ongoing relationship
 - **restrictions** on sexual activity are **relaxed at festivals** – partly because control is less feasible, partly serving a ritual function
 - **masculine esteem** is boosted through sexual experience – there is great peer pressure to lose virginity and have many

partners; parents are indulgent towards sons' sexual activity.

Differential commitment to these norms and expectations reflects conflicts between generations (parents want children's respect and obedience; children seek consumption and masculine esteem) and genders (sexual double standards).

Young people appear to manage the contradictions by concealing their sexual relationships. This almost certainly contributes to their short duration and high levels of partner change, as relationships are not reinforced through social recognition and there is little scope to develop intimacy through non-sexual contacts.

These sexual beliefs are socially constructed and subject to social change, e.g. through the shifting balance of power between generations or widespread introduction of schooling. They are part of the slightly varying cultures shared within different social groups in the villages. Modifying them will require collective approaches, such as *MEMA kwa Vijana*.

Daniel Wight, SPHSU, MRC Glasgow with M Plummer (LSHTM), G Mshana (NIMR, Tanzania), J Wamoyi (NIMR), Z Salamba (NIMR) and D Ross (LSHTM)

Exchanging sex for gifts in rural northern Tanzania

The study's objective was to understand how the exchange of sex for gifts affects HIV-related risk behaviour among rural adolescents. Young women's main motivation for sex is material gain; for men it is sexual desire and masculine esteem.

The material to be exchanged is agreed when sex is negotiated, e.g. sugar cane, soap or money (Tsh.100–2000). Gifts are determined by factors such as length of relationship, the partner's respective intentions of the relationship, the girl/woman's age, financial needs, the boy/man's perceived affluence, the season.

Sexual negotiations are initiated by men. Some bully women into agreeing to have sex by fabricating stories about gifts given. Most young people involve intermediaries (*posta*) in negotiations. *Posta* relay messages and persuade (pressure) the person to accept a sexual proposal. Men also use intermediaries to give a young woman a gift without explanation, before approaching her directly. If a man reneges on promises of gifts, the woman will change partners. If men cannot maintain the gifts or money, women will look for a more lucrative relationship.

Reasons for seeking material exchange include:

- **Poverty** – to alleviate extreme poverty, but also school girls bought school books, uniforms, etc.
- **Desire for commodities** – e.g. hygiene and beauty products; men with an income are in high demand; most parents lack a regular income and rarely meet daughters' requirements.
- **Peer pressure** – female peer pressure influencing the desire for commodities, plus pressure to gain as much as possible from a sexual encounter, to conform to conventional consumption, and to participate in discussions about sexual exchange.
- **Gaining capital** for small businesses – by some enterprising women.
- **Symbolic reasons** – men can demonstrate affection through generosity and consistency of gifts; size of gifts can be interpreted as a sign of affluence, and eligibility for marriage.

Transactional sex and HIV

Material exchange for sex is likely to increase the risk of HIV transmission:

- It provides a dynamic for partner change.
- It makes particular people attractive as sexual partners, who, given the current distribution of HIV, are more risky, e.g. affluent men, newcomers from towns.
- It can create a further barrier to use of condoms; condom use is uncommon, and men want 'value for money'.

Conclusions

Most young women have sex for material reasons, but not only

in extreme poverty. Interventions to alleviate extreme poverty are unlikely to reduce transactional sex, but they could help young women to resist high-risk partners or unprotected sex.

Transactional sex exacerbates the risk of HIV transmission. Interventions could take a harm reduction approach and train young women to explicitly incorporate safer sex into negotiation for gifts/money, although this is constrained by the need for women to maintain their reputation.

Joyce Wamoyi, National Institute of Medical Research, Tanzania with G Mshana (NIMR), M Plummer (LSHTM), D Wight (MRC Glasgow), D Ross (LSHTM) and AMREF

Condoms: beliefs, access and use in NW Tanzania

As part of the HALIRA study, the beliefs, access and use of condoms were investigated in rural Mwanza, Tanzania. Comparison and intervention groups were studied, using participant observation and focus group discussion.

Beliefs

Common associations around condoms and HIV/AIDS were that condoms are used: by commercial sex workers; in illicit/abnormal sex (not for 'normal' sexual activity); by people with STI/HIV; and that use implies a lack of trust of a partner. A number of myths surrounded the use of condoms (e.g. new condoms already have HIV) and they aroused suspicion.

Trust was a major concern. Trust of a partner negates the need to use a condom: "Men who use condoms are those who do not trust their lovers [*wapenzi*]. She has never used them because she and her lover [*mpenzi*] trust each other." Condom use reflects on a person's reputation.

Condoms were thought to reduce the pleasure of sex, though this was perceived rather than experienced. Further, for efficacious, healthy sex, it was believed that semen needed to pass from man to woman, unobstructed. Finally, condoms were thought to **reduce fertility/potency** in men, leading to increased pressure on women not to use condoms.

Access and use

A small number of condoms were available in a few shops. But people felt embarrassed buying them, and there were social barriers to women buying them. They were available in health clinics, but here there were problems of distance and eligibility barriers, the latter particularly for youth and women. Again, embarrassment and confidentiality were problems.

Reported use of condoms was very low: "...in a group of 100 you may find only one or two or none." There was widespread unfamiliarity with condoms. Ignorance about HIV/AIDS/STIs and their transmission contributed to non-use of condoms.

Condom promotion and distribution

A **social marketing** initiative was introduced to increase condom availability and access for young people, and to educate and inform them. Condom promoters and distributors (CPDs) formed part of this initiative.

On evaluation, there was low awareness of CPDs. They sold stock to friends, had a small but regular clientele, but little more widespread. Customers were generally men aged 20-35; female CPDs had a more heterogeneous clientele. Quantities sold were relatively small, and CPDs' income was minimal.

Various logistical problems hindered the initiative's success:

- **Confidentiality and education**: CPDs encountered problems of shyness and embarrassment among themselves and/or among clients. Particular problems existed regarding male-female CPD/client relationships, in light of the social segregation existent between the sexes.
- CPDs were **unsuccessful role models** as they themselves had low condom use.
- **Perceptions** about condoms did not encourage their use.

Conclusions

- Reported condom use was very low.

- More work is needed with adolescents.
- CPDs' interpersonal and communication skills need strengthening in CPDs.
- Gender issues need to be addressed.

Tom Ingall & Mary Plummer, LSHTM

The MEMA kwa Vijana (MkV) project in rural northern Tanzania

This intervention aimed to reduce HIV incidence, STI prevalence and unwanted pregnancy in 15–19 year olds, to delay onset of sexual intercourse, decrease risk behaviour and increase utilisation of health services. It had to be capable of being scaled-up to national level within 5 years; implemented by teachers, health workers and existing community groups; fit with existing supervision systems; and have marginal costs per capita total population. The intervention encompassed:

- **community activities**
- **in-school sexual and reproductive health education**
- **STI case management at youth-friendly services**
- **condom promotion.**

A process evaluation study aimed to document the process, the extent of delivery, quality of delivery and confounding factors.

Community mobilisation

This relatively small component was immediately successful. It responded to the community with respect and clarity, and won support from those opposed to the intervention. However, many parents were not well informed about the programme and some negative rumours were spread. In-school youth were targeted, so misinformation and ignorance on AIDS, condoms and risk reduction remained widespread in the community.

Schools

This was the main and most effective component. The curriculum was appropriate and easy to follow; teachers and pupils were eager for information; participants were enthusiastic, even without pay; information and skills training was comprehensive; and the vast majority of sessions were taught and taken seriously in exams.

Limitations arose where pupils had poor Swahili and literacy, and there was daily and seasonal absenteeism. Condom demonstrations were forbidden. Moreover, there were incidences of sexual abuse and corruption.

In the class peer component, the dramas were popular, but peer educators are rarely able to be "agents of change".

Health services

Success here was modest. Simulated patients research found intervention health care workers (HCWs) less judgemental. The intervention HCWs were enthusiastic about MkV and claimed youth attendance had increased, but this popularity may relate to the free STI drugs. Some problems of corruption or decline in quality of services occurred. Accessibility was limited; with only 1-2 facilities, many youths were unaware of the services and there was still fear of reproach and poor confidentiality.

Condoms

Condom promotion and distribution was generally not successful. At village kiosks some were available, but at high price and with poor confidentiality. At health centres they were free, but problems were distance and again poor confidentiality.

Promotion and distribution was time-consuming, expensive and inefficient. Sales were low and to adult males only. Some CPDs were inappropriate: bad role models sexually, not always confidential, falsified records, frustrated with limited earnings.

Recommendations

Future adolescent interventions should be based within broader social interventions (target out-of-school youth), with attention to poverty and income generation. National and local advocacy and awareness-raising are needed to reduce sexual

exploitation of pupils by teachers. Beliefs about traditional, local medicine (the most common type of health care) need addressing. 'Serial monogamy' and reduction of partners need reinforcing. Condom demonstrations in school should be introduced, if permitted. Other ways to promote and distribute condoms should be explored.

Angela Obasi, LSHTM

Related Work from the Safe Passages to Adulthood new Knowledge Programme

Young Malians' fears of hormonal contraceptive use

This qualitative study, for the Centre for Development and Population Activities (CEDPA), examines the context of contraceptive decision-making among young people in urban Mali. It focuses on how views about side-effects are formed and reinforced; and the link between side-effects, social relations and method choice.

The study examines unmarried women's contraceptive decision-making in a context where:

- Women's marital status is largely derived from child bearing;
- Sterility is highly stigmatised;
- Polygamy is highly prevalent, leading to great competition between women.

The study used in-depth interviews with peer educators, clients, non-clients and health care providers, as part of the peer education programmes of ASDAP (Bamako) and ASEEM (Sikasso).

Reasons for non-use

The main reason cited for non-use of the Pill and injectables was the belief that use led to **sterility**. Perceived consequences of sterility in marriage are divorce, acquisition of a co-wife, marginalisation by in-laws and rejection by the community.

Beliefs about conception and menstruation

Young people had very inaccurate ideas about the physiology of conception. They placed a strong emphasis on the importance of blood in aiding formation of the foetus - any disruption to bleeding was seen as affecting future fertility.

The Pill was seen to neutralise sperm and to block up the reproductive organs by accumulating within them. Injectables were seen to alter the state of the blood to make conception impossible; to kill the sperm as they travel through the blood; and to close the uterus. Interviewees believed that these effects would be indefinite. Only (Western) medical intervention could help if you wished to conceive after using such contraceptives.

Side-effects of the Pill and injectables

Known side-effects of the Pill are amenorrhea, mid-cycle spotting and, rarely, prolonged bleeding; and of injectables, amenorrhea, spotting and prolonged bleeding. Prolonged bleeding is perceived to be caused by 'maraboutage' (witchcraft). Its consequences for the woman are marital disharmony and social ostracisation; she cannot pray, have sex or prepare food. Amenorrhea is perceived to be caused by maraboutage, pregnancy or use of contraception. The woman is considered sterile, loose or to have had many abortions. She will face marital disharmony and social ostracisation.

Health care providers acknowledged that young women were concerned about their future fertility, and these concerns guided their prescription of methods. They said they talk to young women about side-effects and tell them there is no problem with fertility after use, but the women are still concerned.

Conclusions

- Future rather than current fertility concerns may be behind young people's choice of method. Condoms are preferred because they have no side-effects.
- Social rather than biological consequences of side-effects are important.

- Low use is likely to persist in an environment where: women gain status from child bearing (particularly in a high polygamy setting); beliefs in 'maraboutage' persist, even among the highly educated; knowledge of reproductive physiology is poor; women have to minimise the spread of rumours that could jeopardise their marital and social relationships.

Sarah Castle, Centre for Population Studies, LSHTM

Why young women drop out of school in Nandesari, India: rationale and design of study

This project is being carried out in association with Deepak Charitable Trust (DCT), a local NGO. Nandesari region is located 20 km north of urban Baroda in Gujarat, and populated predominantly by conservative Rajputs.

Study rationale

Female adolescence in Nandesari is characterised by minimal education, restricted mobility, low levels of independence and autonomy, and early marriage and childbearing. In 1995, a small-scale study by DCT revealed that 19% of young women were illiterate, only 3 girls were in 10th grade, and 40% of young women aged 15-19 years reported being married.

The major reason stated by young women for dropping out of school was distance/access; parents were apprehensive about sending their daughters far to school. In another study by DCT, it became clear that unmarried young people in the region were more sexually active than originally thought. There were anecdotal reports of young women being removed from school and married off quickly.

Study aims

These are to examine:

- reasons for early school drop-out among young women;
- decision-making processes that lead to their withdrawal from school and entering into marriage;
- relationships between early school drop-out, sexual teasing, coercion and early marriage;
- social norms regarding female education, school attendance and marriageability;
- community perceptions regarding the sexual behaviour of unmarried young people;
- whether and to what extent unmarried young people are engaged in sexual activities.

Methodology

The study is being conducted in 3 villages in Nandesari:

- *Phase 1: Audit* - involving 105 respondents: 12 married, 12 engaged, 81 unmarried; 51 left school prior to grade 7; 31 still in secondary school.
- *Phase 2: Focus group discussions* - of young women aged 15-19; mothers; fathers; young men with sisters under 20; and key community members.
- *Phase 3: In-depth interviews* - with young women (aged 15-19); brothers; and mothers. One hundred interviews in total, 15 cases of matched IDs for a young woman's mother and elder brothers, and 10 cases of interviews with any mothers or brothers of young women.

The project is due to finish in March 2004.

Rachel Partridge, Centre for Sexual Health Research, Southampton University

Effecting change: a study of school-based sex education in Nepal

This study was carried out in collaboration with - SOLID Nepal (Society for Local Integrated Development). The programme of action established focused initially in sex education in schools.

Five-day workshop (June 2001)

This first undertaking was organised to see what activities

already existed; to design research on parents', teachers' and young people's views on school-based sex education; and for research methods training. The inauguration ceremony included the Minister for Women, Children & Social Welfare and Deputy Secretary for Education, and received extensive national press coverage.

Exploring barriers (July 2001 – March 2002)

This study, in 6 sites across the country, explored the barriers and opportunities for improved secondary school sex education. Parents and teachers were interviewed, and focus group discussions held with students. Findings were:

- Reproductive health, family life education and safe motherhood are included in the current curriculum.
- Classes are biomedical in focus; teaching methods didactic; lacking relevance to young people's lives; time allocated is limited.
- Knowledge is poor amongst young people, and young people, parents and teachers all support change.

A national 3-day dissemination conference (April 2002) was held to facilitate the exchange of research, programme experiences and cooperation, and to provide an evidence-base for consciousness-raising and advocacy efforts, for policy planning purposes, and for guideline development. Participants included researchers, parents, young people, civil servants, NGOs, GOs, media, Minister of Education & Sport, National Youth Forum, Minister for Health, FPA Executive Director.

Follow up

We were approached by the Curriculum Development Committee (CDC) at the Ministry of Education and Sport. After planning meetings held in November 2002, 3 participatory workshops were held in February 2003 with: master trainers; CDC staff, NGOs and young people; and staff from the Faculty of Education, Tribhuvan University. A 3-day workshop for journalists was also held.

Curriculum development activities

We worked through knowledge, skills and values, and demonstrated small group participatory working. 'Traditional' values are of great concern, so people were made aware that the activities need not threaten them. Core group curriculum development tasks were set for the next 3 months, and monitored by e-mail contact. The aim is to develop a relevant national curriculum for each school year. A small grants scheme has been introduced for monitoring and evaluation at the University (administered by SOLID and CSHR). Discussions have started on developing series of Teachers' Guides to support the new approaches.

Some reflections

Introducing widespread, school-based sex education and addressing barriers to change are more useful approaches than just trying to change young people's behaviour. It is essential to be non-threatening, and to consider the wider contexts within which change is desired. Key people need to be involved to ensure support and continuation, and for careful handling of conflict and concerns. A combination of research and advocacy approaches should be used.

We believe that school-based sex education, with suitable curriculum development, will be a cost-effective approach.

Roger Ingham, Centre for Sexual Health Research, Southampton University

For a list of programme publications, please see the programme's website: <http://www.lshtm.ac.uk/dfid/aids/>

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