RESEARCH AND CAPACITY BUILDING FOR THE PROMOTION OF SEXUAL HEALTH AND WELL-BEING IN AFRICA

Johannesburg, February 27, 2004
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Report of a Seminar held at the First Congress for the Advancement of Sexual Health and Rights in Africa which took place in February 2004 in South Africa.

Organised by
Africa Regional Sexuality Resource Centre, Lagos, Nigeria

Made possible by a grant from the Ford Foundation

Published by
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Cover design and layout

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# Table of Contents

- Acknowledgements .......................................................... 1
- Introduction .................................................................. 2
- Full Text of Presentations by Africa Sub-Regions: ............. 3
  - East Africa .............................................................. 4
  - North Africa ............................................................. 6
  - South Africa ............................................................... 7
  - West Africa ............................................................... 8
- Conclusion ................................................................. 9
- Appendix: Briefs On the Panellists ................................. 10
We acknowledge with gratitude the assistance and support of all those who contributed in various ways to the success of the seminar - Research and Capacity Building for the promotion of Sexual Health and Well Being - and the production of this report. These include in no particular order, the following:

ARSRC Advisory Council members with special thanks to Ms. Nomonde Bam and her very supportive staff at the Health Systems Trust in Johannesburg; Executive Director of Action Health Incorporated (AHI), Mrs. Nike Esiet and other staff of AHI, especially Mrs. Uduak Akin and Ms. Chieme Ndukwe; The Ford Foundation and its programme officers most especially Dr. Babatunde Ahonsi (West Africa Office, Lagos) and Mr. William Okedi (South Africa Office, Johannesburg); the panelists and chair, our guests at the seminar whose active participation and interest in the subject area set the lively tone of the seminar; the Director of ARSRC, Dr. Richmond Tiemoko and other staff - Mr. Olatunbosun Oluwunmi, Mr. Olusegun Sangowawa, Mrs. Arit Oku-Egbas as well as many others who provided logistic, secretarial and editing support.
The seminar titled “Research and Capacity Building for the Promotion of Sexual Health and Well-Being in Africa” was held on February 27, 2004 during the First Congress for the Advancement of Sexual Health and Rights in Africa. The sexual health congress, the first of its kind in Africa, was organized under the auspices of the World Association of Sexology (WAS), and co-hosted by the Southern African Sexual Health Association (SASHA), Planned Parenthood Association of South Africa (PPASA) and the Africa Federation for Sexual Health and Rights (AFSHR). The venue of the seminar and congress was the Crowne Plaza Sandton Hotel in Johannesburg, South Africa.

For Africa Regional Sexuality Centre (ARSRC), hosts of the seminar, the congress presented a rare and precious opportunity to further the goals of the Center by promoting discourse and opening up public dialogue around issues of sexuality. This, indeed, was a strategic setting for the seminar because of the presence of hundreds of key stakeholders including sexuality professionals, as well as students and youth from around the African continent who provided a rare flavour to the debates. Also present were friends of Africa from the other continents of Africa.

ABOUT ARSRC
The Africa Regional Sexuality Resource Centre (ARSRC), located in Lagos, Nigeria, is a project of Action Health Incorporated (AHI) established in 2002, as one of the four sexuality resource centres set-up around the world under the Ford Foundation-funded initiative - “Global Dialogue on Sexual Health and Well-Being”. The aim is to promote more informed and affirming public dialogue on human sexuality and to contribute to positive changes in relevant policies and programmes, by creating mechanisms for learning and advocacy at local, regional and global levels. Activities under the initiative focus on four of the most populous countries in Africa: Egypt (North Africa), Kenya (East Africa), Nigeria (West Africa) and South Africa (Southern Africa).

OBJECTIVES OF ARSRC:
1. Expand and shape the discourse, thinking and action on sexuality in the region in favor of healthy, respectful, responsible and pleasurable sexuality
2. Nurture and build professional capacity in the emerging field of sexuality
3. Build links between kindred organizations and individuals in Africa working on sexuality issues

STRATEGIES
1. Promote regional consultations and alliance-building
2. Establish / maintain resource centre facilities
3. Promote information exchange and public education
4. Provide capacity building, training and leadership development

Website: www.arsrc.org
the world.

Why the choice of this topic? Why the focus on research and capacity building one might ask? There is no doubt that on the African continent the study of sexuality is a new emerging area begging to be explored and often misunderstood and misrepresented. In the scheme of things, research and capacity building are akin to building blocks that serve as a solid foundation providing the rationale for choice of programs and actions, and the choice of methodology for implementing such actions and programs. As the chairperson of the panel, aptly noted, the seminar grappled with major questions such as: In what ways is the body of research shaping action and how in turn is action influencing the research agenda in this region? To what extent is evidence shaping what we do around sexuality? To what extent is the research environment breaking new boundaries and shaping action in new kinds of ways? And to what extent is the research responsive to the needs and the action on the ground? These are some of the key questions posed by the seminar and which the four distinguished panelists tackled from several interesting and novel angles.

Without pre-empting the excellent presentations made by the eminent scholars representing four sub-regions of Africa, let us invite the reader to study the proceedings of this ground-breaking seminar not just for the purpose of acquiring knowledge for knowledge’s sake but with the objective of leading change on the continent by promoting healthy and pleasurable sexuality. This is while bearing in mind the popular maxim - act locally but pursue a continental or global level vision.

Full Text of Presentations by Africa Sub-Regions:
- West Africa
- North Africa
- East Africa
- South Africa
I. Introduction

Despite three decades of capacity building, there is still little research on the health problems of the poor. This is even more acute regarding the sexual health of people in West Africa. Research is essential in improving the status of sexual health in any community. Good quality research is a key tool for identifying sexual health problems and their causes and demonstrating their importance to the promotion of sexual health and well-being. It also assists in formulating solutions and evaluating progress of sexual health interventions. Sexual health research demands for interdisciplinary and integrated research. In West Africa, responding to this requirement poses great challenges to current research efforts both within and outside the universities. This presentation begins with an overview of the socio-cultural aspects of sex in West Africa. It then highlights some gaps in existing sexual health research in the region and presents some capacity needs for sexual health research. The paper goes on to suggest ways to strengthen the capacity of sexual health researchers. In several respects the paper is limited to experiences in English-speaking West Africa.

II. Some Socio-Sexual, Cultural and Research Issues in West Africa

It is important to put the current paucity of research on sexuality in some perspective. Until the onset of HIV/AIDS, sexual life in Africa received little attention from serious researchers despite the 'great inquisitiveness in Victorian Europe about African sexual customs and the widespread belief in the sexual superiority of the African' (Bleek, 1976:25). The sexual prowess of the African was described as 'unfettered sexuality' either to be envied or feared (Schoepf, 1991). This was expected because most studies that dealt exclusively with sexuality in Africa at this time were mainly anthologies and impressionistic notes by missionaries and travellers.

In the region, as elsewhere in Africa, the force of social change resulting from formal education, increasing urbanization, and the increasing cost of living, among others, has blended to produce changes in socio-sexual culture. In Ghana, Nigeria and several parts of West Africa, it is clear that even in some of the societies where premarital sex was not formerly permitted, it is now considered normal (Ankomah, 1998). In some societies in these countries, premarital multiple sexual partnering, serial monogamy as well as partner switching is fairly common.

To fully understand premarital sexual relationships in the region, it is useful to view some premarital relationships as basically transactional, resulting in sexual exchange where sexual services are exchanged for material gain- a system quite different from prostitution. Similar findings have come from some Nigerian cities such as Benin City (Omorodion, 1993); in Ibadan and Zaria, (Barker and Rich, 1992); and in comparatively rural areas as for example among the Ekiti of western Nigeria (Orubuloye, Caldwell, and Caldwell, 1991). It must be pointed out however, that, there is a great diversity of sexual relationships. It is therefore misleading to generalize (which unfortunately some researchers have done) about African sexuality, or even a West African one as if the region is one homogenous entity. There is a variety of mutually contradictory sexual norms in West Africa, and even within countries. So when in West Africa
Caldwell, Caldwell and Quiggin (1991) claimed uniformity of premarital sexual relationships and observed a perfect fit called the 'Ekiti model' which meant pervasive societal acceptance throughout history of premarital sexual relationships, it was perhaps an overgeneralization.

Mair had five decades ago observed a continuum: In attitudes towards sex relations before marriage, extremes of severity and tolerance are represented by the Nupe, who prohibit them altogether, and the Korongo and Mesakin of the Nuba hills among whom premarital licence is complete, and chastity and virginity play no part (Mair, 1953:118).

III. Some Gaps in Existing Sexual Health Research

While the quantity and quality of sexual health research in the West African region has improved in recent years, there are still several gaps. A few are highlighted here:

* Research output on violence against women has been very general. Community- and health facility-based research as well as behavioural research on violence, including longitudinal studies on the consequences of sexual violence, and the vulnerability of adolescents to sexual abuse are sorely needed.

* The sexual rights of adolescents in West Africa is a poorly researched area. Further research is required to gather information on sexual and reproductive rights, and explore the barriers that young persons face making choices given the prevalence of transactional sex, sexual coercion and exploitation of young women.

* Detailed information on gender roles and life skills (in contrast to knowledge) to negotiate good sexual health outcomes among teenagers, including married adolescents, is lacking.

* STI seeking behaviour and treatment of young persons is an area with limited research evidence.

* Today there are internationally accepted definitions of some indicators in sexual health, but there is an urgent need for further research on the
identification of some indicators given their importance in the sub-region. These include indicators measuring violence against women and transactional sex.

IV. Capacity Building Needs for Reproductive Health Research in West Africa

The capacity of academic and research institutions in West Africa to respond to research needs in sexual health is very limited. Developing research capacity in sexual health increases the input of local researchers into the solution of the region’s problems. Research conducted locally by local people is more likely to be more timely and cost-effective in addressing local problems than is research conducted by researchers unfamiliar with the region and its context.

Lack of Funds and Other Resources

While this may be true of other parts of Africa, the lack of funds and other resources necessary for research and research training is a most obvious constraint to building research capacity in West Africa. Resources lacking include not only the availability and conditions of equipment used in sexual health research training, but also infrastructure and services such as electricity, maintenance etc. Access to sexual health information and networks through libraries and electronic communication is very difficult. In addition there is problem of access to sexual health journals. Although a few peer-reviewed journals with African flavour and coverage have started to emerge, they appear to be based mainly in Southern Africa and access to them in West Africa is as difficult as those published in western countries.

Weak Socio-Political Status of Sexual Health Research in West Africa

Again while this may not be limited only to the region, it is particularly pronounced. The social and political status of sexual health research is particularly weak in the region. Local research results achieved are often not perceived as contributions to development. The general lack of political commitment may be exacerbated in Nigeria where religious and ethnic considerations may undermine local research even further.

Low recognition of researchers

At the individual level, Nigeria and Ghana have international level sexual health researchers. The weak economic situation in the region, which expresses itself, among others, in low salary levels forces researchers to do short-term, demand driven consultancy work. It is sad but true that increasingly, researchers from West Africa (and not infrequently their collaborators from the North) are motivated in sexual health research not mainly in the desire to make their knowledge useful in a development context but with expectation of personal benefit. Supplementary payments are often included in research partnership programmes, but these are uncoordinated, highly variable, and often hidden, sometimes to avoid overheads being transferred from individual researchers to general university funds. Talks and
discussions with colleagues have revealed that if sexual health researchers, and indeed the whole scientific committee, is used to shape public opinion, many researchers may obtain greater satisfaction from their work and find greater acceptance in society, and hence reduce other activities that divert them.

Unreliable Behaviour of Donor Agencies

Donor funding of sexual health research is often unreliable and adapted to the needs of recipient countries. Donors grant several fellowships in sexual and reproductive health research every year especially in Ghana and Nigeria. However, most are not linked to any research programmes. The number given every year varies greatly and they are often given in a hurry; just before donors’ financial year ends. (This is often to ensure donors avoid being financially penalized by their home governments for under-spending). Sometimes donors select foreign institutions as awardees and these institutions may not have strong programmes in sexual health research. Most of the emphasis on sexual health research capacity is unfortunately limited to scholarships and travel with intensive monitoring during the period, compared with lack of donor monitoring or even interest after the training. Some donors are quick to withdraw funds and terminate all existing research grants in times of political instability. The region that suffers most from this on the continent is the West African region given the long history of military insurgencies.

V. The Way Forward

Enhancing sexual health research capacity can be defined broadly as the process by which knowledge can be increased in order to understand the phenomena of sexual health. It also means promotion of sexual health in different situation and thereby solving problems. Capacity building relies on three key areas: augmenting the number of researchers in sexual health; strongly supporting research-related institutions and organisations, and enhancing the quality of sexual health research in both its basic and applied dimensions.

Assistance From the North Can Only Be Supplementary

Local research capacity, even within strong and credible research institutions must have national support. Without the support of local and national programmers, outside funding cannot be effective in developing sustained leadership for the solution of sexual health problems. National investments are needed, particularly in Nigeria, to research support infrastructure and systems of higher education in order to maintain a pool of incoming talents.

In Nigeria, with over 50 universities, a principal objective of building research capacity in sexual health should be research centres of excellence in the three main geographical regions and other evidence-based sexual health organisations (such as the Society for Family Health). These institutions should be identified based on specific criteria that include demonstrated institutional commitment to addressing sexual health issues. Although these may be individual institutions, the emphasis should be on building networks of these multiple sites, thus, enabling them to communicate effectively with one another. Emphasis should also be on designing initiatives around problems, not institutions! Good research requires a critical mass of trained professionals within an institution, so that initiatives do not crumble when one or two faculty members relocate. Approaches taken should permit flexibility in responding to and working with programme focused organisations and governments departments, and should also recognize the time constraints commonly faced by full-time faculty staff. To reduce the waste on poor and patchy ill-funded research not likely to be of credible national importance, national governments with research institutions should establish a limited list of urgent research priorities most relevant to national needs.
Sexual Health Research Should Be Institutionalised

Sexual health research has so far been restricted in the main to university based individuals. Linkage between Universities, NGOs and other non-university institutions need to be seen to be working towards a common goal. Research on sexual health is not aptly institutionalised. At the moment, there are no structured courses in sexual health, although a few health-oriented graduate programmes do undertake certain aspects of sexual health in the course of training.

Capacity Building Must Be Sustainable.

By definition, capacity building involves sustainability, not only in the individual skills and capabilities built, but also in its translation into organisational capacity. In Nigeria, in particular, most of the support is bound to individual capacity building and is hence of limited sustainable character in terms of institution building. Financial support can help research institutions in West Africa to maintain their activities and formulate their own research agenda. But this is rare, as donors see little value in doing this. Usually a significant component of research cooperation is related to the funding of researchers in the North who carry out research in the south with the support of local researchers.

Furthermore, most funding schemes appear not to allow for or to foresee greater long-term support—an indispensable prerequisite for effective institutional capacity building. Long-term commitment through ‘funding consortia’ with varying financial contributions over time from each donor involved may be an option. This is now taking place in Nigeria where donors have agreed to fund large scale multi-round reproductive and health surveys for about eight years, conducted mainly by indigenous researchers.

Research should be treated as a key component of the development process. The research component of sexual health programmes need to be emphasised and clearly budgeted. Donors are often not particularly interested in evaluating capacity building components of projects. One way of enhancing capacity is to track the success of capacity enhancing initiatives.

South-South cooperation is fine but can also be donor driven. The pooling of resources through networking efforts in the bid to share and exchange ideas is an essential element of research capacity building. Unlike East and Southern Africa, where South-South networks are in existence, (e.g. University Science, Humanities and Engineering Partnerships in Africa USHEPiA) research networks are rare indeed in West Africa. There is record of successful sexual health networking in West Africa. The West African Sexual Networking Group with researchers based at University of Ado-Ekiti, Nigeria and University of Cape Coast, Ghana succeeded between 1991-1998 to undertake research and train several young researchers in sexual health research. At the moment there appears to be no viable network of sexual health researchers in English-speaking West Africa. It must be noted, however, that regional cooperation, which is often praised, sometimes can be donor rather than demand driven and hardly reflects the aspirations of the partner institutions. Such collaboration tends to be somewhat artificial in nature, fulfilling the mandate of the funding party.

Making Research Findings User Friendly

The cost of disseminating sexual health information is huge in West Africa, especially in Nigeria, because of its size. Sexual health researchers stand to gain more from sharing their results. Although this may be changing, health correspondents in national newspapers are often not well-trained and only a handful understand sexual health research. They often report the sensitive aspects of research making their reports seem sensational and hardly educational. However, Nigeria is improving with the arrival of a
new donor initiative InterNews which provides training and facilities for health personnel in the media. To reduce the interaction cost of sexual health research, donors and other stakeholders may need to train journalists working with key national newspapers. In this case, sexual health research findings get written and published in plain English in national newspapers.

Enhancing Capacity of Users of Research And Teachers of Research

Research is poor in West Africa because there are poor users of research. Unless public officials, the media, industry, community groups, programme implementers, and others use research, the status of research and researchers will continue to be low. In a sense, therefore, these groups should also be targets for capacity building in the use of research. Politicians, editors of media houses, industry and other stakeholders could be trained to appreciate the importance of research. The effectiveness of capacity building will depend on a step-by-step approach, beginning with existing capacity building activities. Some university graduates of statistics or social sciences who have undertaken courses such as Research Methods and who apply for research positions in organisations may be found not to have ever analysed data using computers. West African universities need to accept these grave shortcomings, develop courses that ensure that student attachments with industry are mandatory in research related courses. Teachers of research-related courses must themselves be willing to learn new ways of doing research.

VI. Conclusion

West Africa has a pool of researchers in sexual health. Harsh economic conditions in addition to other infrastructural and institutional impediments have limited the pace of effective capacity building of other researchers in sexual health. Capacity of researchers in the field may be enhanced through the establishment of networks, presenting research findings in a friendly and usable manner, and motivating governments, programmers and the business community to use research.

References


I. Introduction

During the past few decades the subject of sexuality has gained some ground both as a public health issue and as a locus of research in the social sciences in the North Africa region.

In the field of social sciences, a growing number of analytical perspectives on sexuality have developed; from a conventional study of sexuality as a set of customs and mores to the study of sexuality in terms of biological determinism, and to the more recent cultural analysis of sexuality based on the social construction theory, which “would examine the range of behaviour, ideology and subjective meaning among and within human groups, and would view the body, its functions and sensations as potentials which are incorporated and mediated by culture” (Vance, 1991).

In the field of health and medicine, recent focus on studying sexuality grew mainly out of concern with the outbreak of HIV-AIDS among particular social groups and communities in the late 1970s, but also as a result of concern over other sexually transmitted infections (STIs). However, this interest in studying sexuality has been fostered only in as much as it is related to disease control, thus relegating sexuality to the physiological and, by extension, to the medical domain.

More recently sexuality has been recognized as part of the definition of reproductive health, giving credibility to the study of sexuality in the context of population policy. This perspective incorporates sexuality and sexual health including the socio-cultural aspects, gender and power relations into the reproductive health outcomes.

Most countries of the North Africa region adhere to the WHO definition of reproductive health “as a condition in which reproduction is accomplished in a state of complete physical, mental and social well-being, and not merely as the absence of disease or disorders of the reproductive process”, and to the definition of sexual health as “the experience of the ongoing process of physical, psychological and socio-cultural well being related to sexuality” (PAHO-WHO, 2000).

II. The Status Of Sexual Health In The North Africa Region

During the last thirty years, societies in the North Africa region have had development on their agenda. To this end, national public health policy-makers and planners have made concerted efforts to control population growth. The implementation of such policies have been deemed vital to the pursuit of development goals when resources are limited. However, since ICPD (1994) and the growing threat presented by Sexually Transmitted Infections (STIs) and HIV AIDS, reproductive health in general, and sexual health in particular have received increased attention. However, one of the main barriers to improving sexual and reproductive health is the low level of literacy, especially among women. In many, if not most countries of the region, literacy rates are still relatively low (Azemat, 1995; Egypt-DHS, 2000) resulting in a dramatic lack of knowledge and awareness about sexual and reproductive health.

It is especially important in this respect to reach...
young people between ages ten and twenty-four who have emerged as the world’s largest population sector. They represent 34.4 percent of the population of North Africa and the Middle East (WHO, 2001). The youth are considered to be healthy and energetic, but unfortunately, they are more inclined to high-risk sexual behaviour that lead to many preventable morbidities, especially in the presence of a shortage of information and the required services. Youth reproductive health is affected by several factors including, family, school, community and government policies. Furthermore, as a category, youths suffer from marginalization and neglect as far as their sexuality and sexual health is concerned. They lack specialised counselling services as well as timely and optimal information, and are constrained by taboos, stigma, and economic problems. In other words, youths suffer from unmet needs regarding their reproductive health.

**Sexual Health Focus**

An increasing number of studies is being conducted in the region to assess the level of reproductive tract infections (RTIs) among women for the purpose of adopting appropriate health policies. Many of these studies have underlined the fact that women bear a heavy burden of gynaecological diseases at an early age. A community study conducted in Egypt showed that the majority of women (around 85 percent) living in rural areas suffer from one or more reproductive tract infections and 56 percent from genital prolapse (Khattab et al., 1999).

The determinants of women’s reproductive health are very often of a socio-cultural nature. Low socio-economic status, illiteracy, and lack of health information lead to misconception about many illnesses and limit preventive practices. This situation in turn leads to an increase in the prevalence of infection. Moreover, women tend to internalize their health problems for a number of reasons: services may not be available or accessible, women’s status in the household may not allow them to seek health care, they may feel shy to report reproductive tract infections RTIs—some of which are sexually transmitted. They feel shy to report infections because of the stigma this may attract from the community (Khattab, 1992). Women also tend to perceive discharges and pelvic discomfort as part of their nature and lot in life. As a result, a woman in a developing country is probably far less likely than a woman in a developed one to seek and to receive care at an early stage of infection, before the infection ascends to the upper reproductive tract leading to long-term, harmful consequences in terms of reproductive capacity (Dixon-Mueller and Wasserheit, 1991; O-Relly, 1986).

**III. Sexually Transmitted Infections And Power Relations**

In developing countries women are among the most exposed to sexually transmitted infections. What makes their situation worse is their lack of decision-making power regarding sexual and health-seeking
behaviour. In many of these communities, cultural stigmatisation of sexually transmitted diseases combined with the dependency and inferior social position of women serve to deny them access to information concerning reproductive health.

In the case of Egypt, medical authorities have been slow to respond to the increasing magnitude of STIs, and most funding available for STIs control is directed towards HIV-AIDS. According to a short unpublished report conducted in a skin and venereal disease hospital situated in a traditional district of Cairo, the majority of patients who consult the hospital for STIs are males, and forty percent reported some sort of drug addiction. The most common STI condition is Gonorrhoea. The overall rate of STI morbidities is higher for men than for women but the morbidities caused by infection are generally more severe in women. This is because many of the STIs are asymptomatic in women while they are symptomatic in men; hence women are more vulnerable (Abdel Mobdi, 1998). Moreover, because of the social stigma attached to STIs, men tend to make better use of the available medical services, and thus can get better diagnosis and treatment.

HIV-AIDS

Although HIV-AIDS is not a prevalent disease in most countries of the region, there has been a slow but steady increase in the numbers of reported cases (20,000 cases in Morocco). Currently HIV-AIDS is not a serious public health problem in Egypt for instance. However, there is research evidence that behaviour generally associated with an HIV epidemic exists, but is largely hidden.

As we have noted, there is also evidence of high rates of reproductive tract infections, some of them sexually transmitted. Condoms are unpopular and rarely used. All these suggest that unless efforts to prevent the spread of HIV increase and intensify, AIDS could become a major public health problem in the future (Lenton & Khattab, 1997).

IV. Social and Cultural Determinants of Sexuality in the Region, and their Relation to Health in General.

Culture

Historical evidence indicates that many religious traditions outlive religious precepts. In some eras and places, traditions take on the guise of religion and religious precepts lose their power and are no longer recognized.

Gender is an essential tool in examining the cultural aspects of life in the North Africa region. In spite of economic, political and social changes, gender roles continue to affect sexual relations strongly. Despite the diversity of legal codes and their application in the countries of North Africa, and despite the positive impact of various reforms on women’s position, the North Africa region ranks low regarding the Gender Empowerment Measure, literacy and participation in political and labour forces (UNDP, 2002).

Religion

In the context of the majority of the societies of the North Africa region, religion (Islam is the religion of the majority, followed by Christianity), is a fundamental part of culture which shapes the daily lives of individuals, in the context of Islam, religion not only provides doctrines (Aqua’ed), which are taken from the Qu’ran and are not meant to be debated, but offers prescriptions to guide conduct and
action (Mo‘amalat/Ebadat). This is a style and a mode of life for Muslims to follow, and covers all aspects of relationships including the domain of sexuality.

However, we need to differentiate between jurisprudence (Islam proper: Qu’ran and Hadith) and what is being practiced by people in most countries of the region. The variety of interpretations of some issues in Islam reflects individual perceptions. For instance, in a book on women’s status in Islam the author (Mernissi, 1975) states that the dowry is the bride price in Islam, while other people interpret the dowry to be a present meant to strengthen the couple’s relations and affection (Sabeq, 1990).

In Islam, relations between men and women are based upon complementarity; Islam acknowledges the right of both men and women to sexual fulfilment. In Islam, sexuality is legitimized only within the institution of marriage. In contemporary societies of the region women’s and men’s perceptions of sexuality continue to be legitimized within the institution of marriage (Khattab, 1996; Major, 2000), which is reinforced through socialization, formal education and religious teachings. Extramarital or premarital relations are considered reprehensible and shameful. Divorced and widowed women are also forbidden from being sexually active as long as it is not within a legalized relationship.

However, as mentioned earlier, most societies have a double standard with regard to this issue, being more lenient, for example, with men. In contemporary times, in some countries of the region, laws have applied differential punishment for men and women who engage in adultery.

Unlike other religions, Islam does not confine sex to the purpose of procreation, but acknowledges physical love for enjoyment. The Qur’an abounds in verses describing the genesis of life based on copulation and physical love. Regarding sexuality education, Al Azhar’s institutes and schools address sexuality and family relationships such as spouses’ rights and obligations. However, this does not always apply to other schools.

Impact of Domestic Violence on Sexual Health

We believe that violence against women does not need to be physical in order to be considered reprehensible and condemnable. It is the state of ignorance in which women live and are confined in the North Africa region that is the most shameful violence committed against them. When women are denied education and access to knowledge, they are deprived of their basic human right to read and write, to learn about their role in society, their duties, obligations and rights including their sexual rights. This is a form of violence against women. During visits to many countries of the region women have expressed a major concern; they believe they must always be available for their husbands, even when they are tired or ill. Obviously, they are not aware that Islam says that personal health comes before religious precepts, and therefore could never be the basis for coercion of women to have intercourse unwillingly. The sexual act as perceived by Islam is an act of love, intimacy and affection. Furthermore, women who suspect that their husbands have a sexually transmitted disease, and the signs are showing on the male sex organ, have the right to ask for divorce. While divorce is not the ultimate objective, at least treatment and abstinence for prevention of disease must be sought.

Identification of Perceived issues and concerns of sexual health in the region.

Presently, the major issue of concern in the North Africa region is the increase of STIs. Part of this rise is due to the fact that there is no information and education on STIs which is targeted at youth. Again, because STIs are stigmatized, it is difficult to assess prevalence. Very often, when people suspect they have an infection, they would go directly to the pharmacy and ask for an antibiotic. These are sold over the counter without need for a prescription. Thus, many cases go unrecorded.
Physical violence against women is a public health issue related to sexuality. Physical violence includes battering, harassment, rape and incest. Recently, the problem has become recognised at the national level in some countries of the region. NGOs are most active in this area of work because NGOs have, in general, a good relation with the communities they work in.

Another area of concern is youth and sexuality due to the changing cultural values and the constant exposure of youth to various cultural currents. In Egypt and Tunisia, the media have started to address the subject of sexuality more openly. Some NGOs in countries of North Africa, like the Red Crescent, and the Boy and Girl Scouts offer information about STIs and HIV/AIDS.

V. Sectors Which Should Integrate Sexual Health And Well-being Into Their Programs.

All sectors should cooperate in dealing with the issue of sexual health, and use a holistic approach in defining issues, priorities and programs. There is need for collaboration between people working in the social, medical, economic and religious spheres. Furthermore, it is essential to have young people participate because they can raise their own concerns as equal partners within the societies they live in.

NGOs can make a tremendous contribution to achieving sexual health, but they need to be supported by political and religious leaders, health advocates, as well policy planners in the fields of health, education, culture, and media.

VI. Approach to Sexuality Issues in the Region

Review of available literature shows that culture is very important, as important as religious doctrines, in shaping perceptions, attitudes and practices regarding sexuality and sexual behaviour. Although socio-economic changes are taking place in many countries of the region, cultures and traditions still prevent the providers of knowledge and information (teachers, educators, trainers, parents, peer groups) from addressing the subject of sexuality, initiating dialogue and providing information. Furthermore, teachers and counsellors do not receive the appropriate training on how to address the subject of sexuality. In the few areas where sexuality and sexual health are meant to be addressed in the curricula, teachers refrain from discussing these issues openly; thus the information is not passed on to students. Some believe that if they discuss these subjects with youth they are encouraging them to be promiscuous. Nevertheless, studies have shown that this is not the case.

The Qu’ran and the Hadith discuss sexuality and sexual health openly and without ambiguity. It is time for Muslims to do likewise and change cultural attitudes, beliefs and practices that are detrimental to sexual health.

VII. Strategies to Promote Sexual Health

Research

In the region there is an increasing body of researchers who have opted to adopt a comprehensive approach to women’s health research, focusing on achieving a state of complete well-being, as opposed to achieving simply the absence of disease or infirmity. They thus, advocate the incorporation of sexuality and sexual health into policy formulations, delivery of health services and design of educational materials.

As mentioned earlier, available research in the region underscores the need to link sexuality with family planning programs. However, social taboos regarding sexuality continue to dominate even in medical practice, limiting discussions in this area to the technical aspects of sexuality and a disease-oriented approach.

Action-Oriented Research

More recently, the number of action-oriented research projects in the region has increased; especially those conducted to support the implementation of interventions. Most of these are conceptualised within the context of gender mainstreaming.
Thus, many associations and NGOs are actively involved in providing education about health in general, reproductive and sexual health, the elimination of female genital cutting and counselling on legal rights. Furthermore, in most countries of the region, women's councils have been set up and are actively involved in eradicating illiteracy, raising women's political and social status, and eradicating violence against women.

Gaps in Sexuality Research in North Africa
In recent years, sexual health research has increased in the North Africa region, however there are still some gaps that need to be addressed.

* There is a need for more in-depth studies on youth perceptions and knowledge about sexual health
* More qualitative studies are needed on youth (male/female), men and women to assess their knowledge about sexually transmitted infections and sexual practices which augment the transmission of infections
* Little is known about youth sexual practices in the North Africa region and, thus, in order to develop strategies to raise awareness and to provide services more research is needed in that area.

A few studies conducted in the region have highlighted the general state of ignorance in which women live regarding their general health, sexual health, and sexual rights. Therefore, there is a need for more studies on:

* Women’s perceptions and knowledge regarding sexuality and sexual health
* Women’s awareness of sexual rights as provided by Islam
* Gender and the Power of Negotiation Within Sexual Relationships

Amendment of Laws
In Egypt until recently, rapists were not punished by the law as long as they married their victims. However, following persistent efforts on the part of many local NGOs, this law has been amended and the rapist is now considered a criminal.

As mentioned earlier, regarding female genital cutting, the Ministry of Health has forbidden the practice in its hospitals and clinics and this decision has been supported by religious leaders both Christians and Moslems.

Regarding marriage contracts, one change has been made in favor of women: a new clause has been added that gives the woman the right to seek divorce.

Sexuality education
There is a consensus in the region that sexual knowledge and education among children and young people, and especially among women is often inadequate and, thus, ineffective. This has grave impact on how they approach issues of sexuality in adulthood.

The lack of knowledge and information stems from two major factors: the changing social dynamics throughout the region, and the inability of formal educational structures to meet the need for sexuality education.

There is also a need for trained professionals. Therefore, there is a pressing need to design and develop training packages and at the same time, to prepare other educational packages targeted at parents. This to enable them provide sexual socialization for their children according to their ages.

VIII. Identification of the Resources Available for the Promotion of Sexual Health in the Region.
Most countries of the region are composed of traditional societies in which social norms and values are strongly sanctioned. These norms and values shape and influence beliefs, attitudes and practices in the various aspects of social life. Furthermore, all issues pertaining to reproduction, fertility and sexuality are perceived to be of a private nature. Therefore, a holistic approach to health in general, and reproductive health and sexuality in particular, will be a more acceptable approach for this region.
Nonetheless, there are successful efforts throughout the region to tackle this issue of improving sexual health, through raising awareness and providing information, education and communication programs. In some countries, national programs have been initiated and implemented on family planning, reproductive health, family health and HIV-AIDS to provide knowledge and information. Some training programs also exist for counsellors in the context of HIV-AIDS national programs.

Building Capacities

In theory, in all medical and nursing schools, there are sexual health programmes. Unfortunately in practice, these are usually ignored. Furthermore, there is no training provided on communication and counseling skills in the context of sexuality.

Other Issues

It is important that parents and family members learn how to re-establish inter-generational networks that used to exist in the past and that have since broken down.

Through these networks, family members used to provide knowledge and information to the young ones, especially about sexuality.

Peer Groups are very important. A lot can be achieved through peer education, since peers have significant influence on each other. Some HIV/AIDS prevention programmes in Sub-Saharan Africa have been successful because they have incorporated peer groups and this can be replicated.

The role of the media in raising public awareness about sexuality and reproductive health issues in a culturally sensitive manner, needs to be promoted and sustained.

IX. Role of the Africa Regional Sexuality Resource Centre

The Africa Regional Sexuality Resource Centre can play a leading role regarding key issues of concern in sexuality by cataloguing all research done on the continent, identifying the gap in both in research and capacity building, and helping to identify organizations willing to fund such work.

In conclusion, an organization such as the Africa Regional Sexuality Resource Centre can contribute, through networking and publishing of successful ‘stories’ and projects in the context of sexual health. The Centre can also encourage public dialogue on human sexuality by supporting positive changes in relevant policies and programs on the African continent.

Reference


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I. Introduction

In East Africa, as in the rest of humanity, sex fulfils biological, cultural and economic as well as political functions. It is used to gratify psychobiological drives; reinforce marriage life and social relationships; express affection, intimacy and love; fulfil cultural imperatives and is part of socialization and relaxation.

Sexuality operates in two dimensions—the masculine and the feminine—which arise from biological characteristics of an individual. Men are conscious of their masculinity and they deploy it in different ways—sometimes instrumentally in order to achieve a particular objective. For example, in earlier times, most households in East Africa were polygynous. This permitted men to have sexual relations with several women, and as such men were not used to sexual abstinence. Such traditional norms and values defining men and masculinity are still deeply embedded in most men in East Africa (Silberschmidt, 2001).

Throughout history, female identity has been linked to female sexuality. Female sexuality is associated with modesty, restraint and secrecy while male sexuality is associated with the public sphere, and with authority and dominance. In such a context, it then becomes clear that there are different norms, values and expectations that are associated with being a woman and being a man.

Research on male sexuality in East Africa (Silberschmidt, 2001) reveals that the concepts of masculinity and femininity are being challenged by the inability of men to head households as the main or sole breadwinners. The result of this is male disempowerment arising from men’s incapability to fulfil social roles and expectations and the accompanying lack of social self-esteem. These can be attributed to socio-economic changes such as unemployment in rural and urban East Africa. In compensation, male identity and self-esteem have increasingly become linked to sexuality and sexual manifestations as men attempt to strengthen their identity and masculinity through multiple partnered sexual relationships and sometimes sexually aggressive behaviour.

Although East Africa has complex and contrasting cultural networks with varying cultural beliefs and practices, certain elements of traditional culture and subservient female roles prevail in Kenya, Uganda and Tanzania.

II. Sexual Inequality

Patriarchal culture in the region has heavily influenced the legal and value systems, as well as governance structures that uphold the unequal status of girls and women as regards sexual activity.

A number of commonly observed traditional practices are recognised as being directly responsible for sexual submissiveness of women and girls: widow inheritance, widow "cleansing", wife sharing, exchange of land and (or) cattle for wives and polygamy are some of the key practices which are stacked against women’s sexual health.

Aside from these traditional practices, there are the social norms, which dictate clear differences between males and females. Male youth have been cultured to believe it is a sign of manhood to control relationships.
Females are brought up to believe that males are superior in all spheres of life and should be the masters in sexual relationships. The rigid implementation of traditional practices such as dowry payments make women men's property, said Ambrose Achier of the Kenya Ethical and Legal Network during an IRIN conference in Arusha 2003.

While men's promiscuity outside and within marriage is tolerated, women are expected to remain "pure". Furthermore, low levels of education among girls and women undermine their negotiating power generally, and particularly in matters relating to sex. Many young girls are pulled out of school early to perform household duties, care for sick relatives or be married.

In addition, “young women are kept ignorant about sex - this is viewed as a sign of innocence,” said Dr. Patrick Orege, Deputy Director of the National AIDS Control Council in Kenya at the Arusha Conference (IRIN, 2003). This in turn makes them totally unprepared for sexual relations, and equally unable to negotiate safer sex. They lack the power and determination to say 'No' or 'Yes' to sex.

Sexual violence at home, school, the workplace and other social centres, such as churches and water collecting points is also rampant in the region and not adequately studied.

III. Sexual Relationships

Heterosexuality constitutes the acceptable mode of sexual relations. Traditional African marriage systems are still prevalent in East Africa. Throughout the region, laws provide for a variety of marriage regimes - usually civil, customary, Christian and Islamic - but the way in which individuals negotiate through these systems differs from one country to another. Most societies are traditionally polygynous, but the practice has declined in the last century due to colonisation and conversion to Christianity (Tungaraza, 1995).

Polygamous Marriages

Polygamous marriages are common in the region. These involve multiple sexual partnerships. These marriages have the characteristics of envy, jealousy, competition, neglect, and frustration. Often there exists the spirit of competition among co-wives over the number of children and/or their sex as well as sexual access.

The practice of polygyny differs from one religious or ethnic group to another. For example, the Asians in the region allow for polygyny, but rarely practice it (Thobani, 1984). In Swahili culture, polygyny is common though it is unusual for a man to have four wives (Sims, 1984). Among men who have more than one wife, there is little uniformity of living arrangements. Each wife may live separately from the other and from her husband, who circulates between his wives' households, or they may all live together,
Much demographic research on polygyny has focused on its impact on fertility. However, the demographic significance of polygyny extends beyond its direct impact on the approximate determinants of fertility (Timaeus, 1998). It is probable that polygyny is indicative of adherence to traditional decision-making patterns in the family.

Levirate or Remarriage

Widows are considered free to seek relationships of a sexual nature with any male partner. Many cultures in East Africa have no law or custom restricting the sexual behaviour of widows unless such a widow has been “inherited”. Usually, if the one who inherits the widow cannot fulfil the sex function, he is most likely to be divorced.

“Come We Stay”, Trial or Temporary Marriages

These are common today but do not conform to traditions or laws governing marriage and coital activity. This is a situation whereby two live together as wife and husband but are not legally or officially joined either by law or custom. There is little or no documented literature on this type of sexual relationship.

Concubinage

Concubinage exists all over the world. As practiced within the context of East Africa, concubinage legitimates sexual access on the part of a man to more than one woman, outside marriage. Although it clearly represents a double standard, concubinage is believed to offer women some protection and other benefits. Thus, the abandonment of concubinage in parts of Africa left women poorer. Former concubines were left without legal rights of wives or concubines but still dependent financially. In contemporary East Africa, women who in the past might have become concubines because of their economic and social vulnerability, might today have multiple male partners without the previous assurance that their partners would support children from the union, financially (Johnson-Odim et al, undated).

Prostitution

Prostitution occurs under a variety of conditions that reflect different degrees of control of female sexuality. It offers a strategy for family survival, and in some occasions, mirrors increased autonomy of women.

With rapid social change, breakdown of traditions and customs and harsh economic realities, prostitution is becoming rampant in urban areas. Oftentimes, this creates an opportunity for abused women to escape from abusive or unwanted marriages. There, operating as entrepreneurs rather than under the supervision of pimps or other authorities, they support themselves and their children by selling sexual and domestic services to men. In addition, prostitutes are able to keep their children, an option that is not often available to women in patrilineal societies, where children belong to the husband’s lineage (Johnson-Odim et al, undated). Although prostitutes have more control over their sexuality and their lives, it is not the best of options as it is a “choice” made by women within a context of gender and class inequality. The extent to which prostitution is practised in the region is not known due to the fact that it is not legal in the three East African countries. Widespread poverty and unemployment compound the status quo by forcing women and girls to engage in risky sex even with their partners and husbands.

IV. Sexually Transmitted Infections (STIs) and HIV/AIDS

Evidence from demographic and health surveys show that at least 90 percent of the people in the East African region are aware of the causes and modes of transmission of STIs and HIV; with the urban population being more informed than the rural
populations. Despite being well informed, behaviour change is slow as many still indulge in risky sexual behaviours. This situation has led to high infection rates and many who are affected by HIV/AIDS.

A number of factors seem to hinder change of risky sexual behaviour. These include unplanned sexual intercourse especially among the youth as well as cultural and religious beliefs. In some situations, HIV/AIDS-related symptoms are attributed to curses, and breaking of coital norms. These beliefs hinder certain groups from using proper preventive and management procedures, thus disposing individuals to HIV and hampering the containment of the virus.

In Kenya, for example, Taha et al. (1998) in a study of nearly 10,000 schoolgirls between the ages of 12 and 24 reported that on average, girls lose their virginity when they are between ages 14 and 15. Often, girls become infected at younger ages than boys. About 22 percent of 15-19 year-old girls in the general population were already infected with HIV, compared with just 4 percent of boys of the same age.

This indicates that young girls are getting infected through having sex with older men. Some girls may choose such relationships because they come with gifts, money or other favours attached. On the other hand, they may be forced into these sexual encounters. Forced sex with an infected partner carries a high risk of HIV infection for girls. When the vagina is dry or when force is used, abrasions and cuts are more likely and the virus can more easily find its way into the bloodstream. What’s more, condom use is unlikely in such situations. To date, there is no reproductive health education in Kenyan schools to prepare girls to avoid early sex or to adopt safer sexual practices.

In Tanzania, as is generally the case for sub-Saharan Africa, there were about 1.5 women to every male living with HIV/AIDS in 2003, Leoni Msimbe, a director from Tanzania’s Ministry of Community Development, Gender and Children told a workshop in Arusha, Tanzania (IRIN, 2003). While this ratio may be somewhat exaggerated by the fact that more data is available on women due to routine antenatal tests, it is widely accepted that women and young girls are increasingly more vulnerable to infection.

The ratio of girls to boys aged between 15 and 19 in the region who are HIV positive is 6:1; often as a result of rape, coercion or sex with older men (IRIN, 2003). While biology may play a significant role in the high rates of transmission (females are twice as likely as males to be infected during unprotected sex), man-made socio-political factors are making the situation worse.

Female condoms have been found to be inappropriate and inadequate in the context and culture of East Africa, and have been largely unsuccessful in providing protection for women. For example, the Ugandan Ministry of Health purchased 1.2 million female condoms but found that women were not familiar enough with their anatomies to use them, said Vashita Kibirige of the Ugandan Ministry of Health. “Culturally, women are brought up not to touch any of their private parts” Kibirige observed (IRIN, 2003). The condoms were also beyond the reach of most women, costing up to 10 times as much as the male condom.

Aside from both men’s and women’s reluctance to wear condoms within the context of marriage, in cultures where the value of women is dependent on their ability to reproduce, they are compelled to have unprotected sex, placing themselves and their babies at risk.

Up to 80 percent of infections among women occurred in “stable relationships” where the man had become infected elsewhere, Orege of the Kenyan
National AIDS Control Council pointed out (IRIN, 2003).

Indeed, the reality is that sex workers are often better able to protect themselves than housewives because they are more empowered to insist on safer sex. There is a need to strengthen gender and HIV/AIDS policies and for the three countries to share best practices.

The consensus is that implementing community-based education programmes, which should involve cultural and traditional leaders, is one of the strategies to engender behavioural change. But with so many different communities and languages in each of the countries, initiatives need to be tailor-made to reach different segments of the population. Therein lies the challenge, which without adequate resources is impossible to achieve. In the meantime, and for as long as the status quo remains, more and more women and girls will continue to lose their lives.

**Research on Condom Use**

Using data from a 1995 survey - Negotiating Reproductive Outcomes Study in Uganda, Brent Wolff and Ann K. Blanc wrote a paper describing the process of decision-making regarding condom use, and the role of AIDS awareness initiatives in promoting negotiation of sex and condom use among couples in high and low HIV prevalence settings in Uganda. The study showed that despite a high level of knowledge about HIV and its modes of transmission in both settings, less than two percent of couples reported current use of condoms with their regular partners. However, nearly a third of men and women reported that they had discussed the use of condoms. Data from focus groups revealed a strong association between condoms and extramarital partnerships that poses a formidable social barrier to condom use within stable unions. Data from surveys confirms that a majority of men and women consider condom use inappropriate within marriage.

Hoffmann, O. et.al (2001) in a study of the correlates of HIV status among women in a high-risk environment in Tanzania found that among a cohort of 600 female workers at bars, guest houses, restaurants and local brew shops aged 16 to 39 years in southern Tanzania, initial HIV prevalence in the cohort was 67.8 percent. This prevalence was much higher than that obtained from sentinel surveys of antenatal care attendees (15-24 years of age) in the same region which showed 15 percent seropositivity in 1999. They also found low correlation between HIV status and reported risk behaviour. This was not expected and they postulate three reasons: first, the high prevalence among women in this high-risk environment; second, the tendency to under-report high-risk behaviour; and third, the early start of infection in lifetime. Validation employing other methods as well as information about risk behaviours is needed.

Carael, M. et.al (2001) conducted a research study to assess the link between partnership status and the probability of having one or more casual or non-regular sexual relationships within a period of 12 months. Data from sample surveys conducted in Kampala and Lusaka in 1989/90 under the auspices of the Global Programme on AIDS was utilized. The results showed non-regular sexual networking was more common among individuals in relatively informal primary partnerships than among married individuals, and also more common among those with multiple primary partners than those in monogamous unions.

Ann K. Blanc and Brent Wolff in a study on the impact of gender on decision-making regarding condom use in two districts of Uganda found that couples in stable sexual unions face barriers to discussions and use of condoms; with women being relatively more disadvantaged than men. Only partial support was found for the hypothesis that a sense of
empowerment regarding decisions about sex lowers barriers to condom negotiation. Widespread poverty and unemployment compound the status quo by forcing women and girls to engage in risky sex with all sorts of people, as well as their partners and husbands.

Inadequate and corrupt legal systems in the region, and a lack of political will to “interfere” in family matters mean that women often lose everything they own. “HIV and poverty are mutually reinforcing - HIV pushes people into poverty,” said Uganda’s Minister of Gender, Labour and Social Development, Zoe Bakoko-Bakoru during the IRIN Arusha Conference. Poverty places people at a high risk of HIV by forcing them to engage in risky sexual practices.

Bills that are drafted tend not to adequately address women issues. The consensus is that more needs to be done to protect women’s rights by legalising the sex industry, criminalizing marital rape and wilful infection, and imposing heavier penalties on rapists. In addition, laws protecting human rights need to be harmonised to ensure basic protection. In Kenya - in the field of family and land laws - Islamic law, Hindu law, customary and statutory laws are "all working against each other" (IRIN, 2003). It has been observed that the political will for change is also lacking. Bills that might improve women’s status are not being passed or even debated because a male-dominated parliament simply would not accept them. It has not been possible to introduce legislation in Kenya in the areas of polygamy, Female Genital Mutilation (FGM), wife inheritance and wife sharing, which are widespread and deeply rooted.

V. Pregnancy Related Deaths

Limited access to health services during pregnancy and childbirth is associated with high maternal mortality in the region. In a study of 203 pregnant women in Tanzania, it was found that no advice was given to 60 percent of the women who were attended by clinic staff, although half of the women were associated with identified risk factors (Strahan, 1999a).

A study of maternal deaths in a district of Kenya, during 1981-88, found that only 28 percent of the mothers who died had attended an antenatal clinic at any time, and among those who did, 52 percent were already in the third trimester before visiting the clinic. Among the women who did attend an antenatal clinic, only 34.8 percent had any height or girth recording, while 95.7 percent had a blood pressure recording (Strahan, 1999b).

Pregnancy-related deaths increase due to non-availability of blood transfusion services or rejection of transfusions because of fear of HIV infection. The unavailability of blood transfusion services was cited as contributing to 22.6 percent of maternal deaths in Thika sub-district hospital during 1981-88. (Strahan, 1999b). In a study of maternal deaths at five hospitals in Kampala in Uganda during 1980-1986, lack of blood for transfusion was cited as a common patient-management factor, which contributed to maternal deaths. (Strahan, 1999b). Strahan also highlighted other studies where blood shortages were implicated in 35 percent of maternal deaths in Tanzania.

Ectopic pregnancy, although potentially life threatening, appears to have been little considered in African medical literature. This may be because of lack of diagnostic equipment, such as a laparoscope. However, ectopic pregnancies appear to be a significant risk factor for pregnancy-related deaths among African women.

East African women are further exposed to the risk of death because treatment of complications is often delayed. For example, in a study of 1,077 women admitted to eight hospitals in various locations in Kenya having undergone abortions during the period 1981-1988, only 37.8 percent reported to the hospital within 24 hours of noticing the initial symptoms (Strahan, 1999b). In addition, Strahan documents a
Abortion

Abortion is the induced termination of a pregnancy before the embryo or foetus is capable of survival outside the womb. This issue has created moral, social and economic concerns since the beginning of time. Individuals, churches, NGOs and governments have taken different stands on this issue.

An estimated 1.5 million abortions occur annually in Africa and most of these occur in situations where medical attention for the women involved is inadequate (Strahan, 1999b). The result is high morbidity and mortality among women. Abortion has several adverse consequences including anaemia. Anaemia is a common complication of induced abortion. For example, Strahan cites two Kenyan studies: one, conducted in coastal Kenya where anaemia was identified as a cause of death in 99 percent of the cases and another study of women admitted to eight hospitals in various regions during 1988-89. 17.8 percent were reported to have anaemia as a complication of illegally induced abortion.

VI. Sexual Violence Against Women

Violence is defined as the use of physical force or strength or verbal expression to unjustly assault, injure or emotionally harm any individual human being. Domestic violence is perpetrated within the domestic unit and is an epitome of unequal power relationships between women and men. Violence is embedded within societal and cultural norms that perpetuate inequality between women and men, children and their caregivers. These norms condone discrimination against women and children, including their chastisement by the adult male of the household (Sati et al, 2001; Ravestijn, 2002; COVAW, 2002). Historically, cultural beliefs and practices appear to have sanctioned domestic violence.

Domestic violence includes violence perpetrated by intimate partners, ex-spouses or friends, sexual violence in the home, abduction and trafficking of children, female genital mutilation and witch hunting. Men may also be victims of domestic violence although they are more often the perpetrators. Young girls also experience violence in the form of defilement (defined as sex with a person younger than sixteen years of age) and incest.

In Kenya, cases of rape have increased over the last five years; from 1392 cases in 1998 to 2000 cases in 2002 when compared to less than 600 in 1992. Similarly, offences of abduction and indecency have also increased though at a slower rate (Republic of Kenya, 2002; 2003). The figures are obviously underestimates because many cases go unreported for a variety of reasons including fear of community reaction, lack of trust in the Police, lack of money for litigation, death threats from perpetrators, and the long winded reporting and follow-up procedures required by the Police. Data from the 2003 Kenya Demographic and Health Surveys (KDHS) shows that incidence of domestic violence in Kenya varies by region, occurring more frequently in Nyanza, Central and Rift valley provinces (Central Bureau of Statistic and Macro-international, 2004). Unfortunately, the government is hesitant to legislate or take appropriate action on violence against women involving their intimate partners because it happens in what is considered the private sphere of the home.

Media reports in Kenya indicate that compared with the year 1997, 1999 saw a significant increase in cases of defilement of children; from 46 cases in 1997 to 82 in 1999. In some reports, parents married off their daughters during school holidays. For example, in 1997 The East African (EAS) reported that a husband sent away one of his wives when she demanded to know why he gave their nine-year-old daughter away in marriage to a primary school boy. This was
apparently done because of the dowry the marriage would attract. (EAS, 8/12/1997). 98 cases of sexual abuse were reported in the media involving young people aged between two and 17 years. In more than half of the cases, the victims were below 14 years.

Studies in Kenya indicate high episodes of domestic violence among married women (Johnson, 2002b undated). Only 39 percent of the married women reported that they did not experience violence. Husbands made up 56 percent of perpetrators of women's sexual abuse. Causes of domestic violence included misunderstandings over money issues, disagreements over the children, pregnancy, food, alleged spousal promiscuity, "public embarrassment of the husband", alcoholism and drug abuse, disputes over land and other property, inheritance disputes as well as problems of infertility and impotence.

According to a 2001 report of the International Federation of Women Lawyers (FIDA) in (IRIN, 2002), domestic violence was the most common human rights violation in Kenya. Of a total of 62 deaths reported between January and September 2001, 29 involved a man killing his wife. "This means that 47 percent of all murders nationwide were the result of domestic violence. Other manifestations of domestic violence included fractures, amputations, other visible marks, and missing hair and teeth", said Martha Koome, FIDA-Kenya's chairperson.

Sexual Abuse of Minors

As in many other parts of Sub-Saharan Africa, children in East Africa suffer sexual abuse, at the hands of their parents or other relatives. Children who have been sexually abused, especially by parents or relatives develop a high sense of guilt, confusion and helplessness. Sexual abuse at home is associated with injuries (ranging from cuts and bruises, to permanent disabilities), unwanted pregnancy, sexually transmitted infections including HIV/AIDS, depression, anxiety disorders, post traumatic stress, irritable bowel syndrome and various psychosomatic manifestations. A sexual attack within the family is a painful and difficult experience for a child and other members of the family.

Many young girls in Kenya, Tanzania and Uganda also go through rites of passage which may include Female Genital Mutilation (FGM). This procedure may involve excision of the clitoris and in some places, infibulation. Although circumcision of women is viewed as a rite of passage in many cultures, it is believed to limit women's sexual desire. Hence, it is considered a violation of human rights. Both Tanzania and Kenya have prohibited the practice, but there is little enforcement (Hosken, 1982).

In Tanzania girls are circumcised at an early age by about 20.5 percent of the country's 130 main ethnic groups. The country lacks laws expressly prohibiting the practice, according to a 2001 US State Department report on Tanzania's Human Rights practices (IRIN, 2002).

Early Marriage

The other problem girls face is marriage at a very young age. Each of the East African countries has laws prescribing the minimum age at marriage, but the practice tends to continue because of customary and religious dictates. Muslim girls tend to marry at a younger age than their contemporaries. Islamic or customary law in Kenya. Children can be legally married off by their guardians before puberty (Mucai-Kattambo et. al., 1995). In such cases, girls are simply battered into marriages for dowry by their parents, and sometimes by their elder brothers. Early marriages are also rampant among the pastoralist communities of East Africa.

The practice of child marriage has not been adequately studied but there is a general feeling that the practice is on the decline.
VII. Capacity for Sexuality

Government ministries of health, education, and social services; departments of local universities, churches, women groups, non-governmental organisations, donor agencies such as the Department for International Development (DFID), the United States Agency for International Development (USAID) and some foundations are implementing sexuality programmes at various levels in the region. Governments legislate, lay down policies and form coordinating bodies to oversee sexuality-related research and intervention activities. Donors, on the other hand, provide most of the required funds for research in sexuality. But as it is with most donor-driven research and intervention studies, sustainability and capacity building is not assured; and in the absence of sustained research and interventions, the knowledge of levels and trends of sexuality issues is sketchy.

Except for the widely shared knowledge from the World Fertility Surveys of the 60’s and 70’s, Contraceptive Prevalence Surveys of the 80’s and the more recent Demographic and Health Surveys, many scholars and NGO’s who study sexuality work in isolation without any visible collaboration or networking. In these circumstances, there is limited opportunity to share experiences and duplication of efforts is a real danger.

Research reports are usually not disseminated to the local communities where research has been conducted. There are usually no budget lines for this level of dissemination. But even where funds are not limiting, dissemination is restricted to occasional seminars at the national capital cities to a select group of people. It is, therefore, not surprising that despite increasing research on sexual behaviour largely in response to the AIDS epidemic, little change in risky sexual behaviour is known to have occurred among East African Communities.

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I. Introduction

In Southern Africa, many of the intervention strategies designed to promote sexual health and well-being tend to be large-scale, mass-media campaigns supplemented by some small social and outreach mobilisation activities. These large mass media campaigns tend to be a direct response to the huge HIV/AIDS problem in Southern Africa where the prevalence figures reported for South Africa by the South Africa Department of Health Antenatal Survey now stands at 26.5 percent (Department of Health, 2003). This has also led to considerable research being conducted around HIV/AIDS as well as other related areas of sexual health. Much of the research undertaken however consists of large quantitative studies designed to evaluate this type of intervention.

A few examples of the types of studies that have recently been undertaken are; the Nelson Mandela/ Human Sciences Research Council (HSRC) HIV/AIDS study; Department of Health Khomanani studies; the Soul City Evaluations, Kaiser Foundation’s ‘Love Life’ Youth Study, and most recently the UNAIDS study. It is acknowledged that these studies are very important in shedding knowledge on HIV/AIDS. It is not the intention of this paper to denigrate them, but to highlight some very important gaps in the research being conducted however.

II. New Challenges

Because HIV/AIDS, STI’s and various other sexual health issues are a relatively new arena, new challenges are encountered at each step of the research and communication process. This is particularly true in the Southern African context where HIV/AIDS prevalence is the highest in the world, resulting in a considerable amount being spent on ‘cutting edge’ research around sexual HIV/AIDS issues. This, however, also means that to a large extent, we are learning as we go. Communicators need to realise that we are moving into a new phase of sexual health communication. Although we have been highly successful in creating the awareness and increasing knowledge around sexual health issues like HIV/AIDS/STIs, we are not achieving the type of behaviour change that will result in significantly improved sexual health practices in general and, which would in turn lead to a substantial drop in HIV/AIDS prevalence rates.

III. Sustaining Behaviour Change

While a number of researchers may disagree with this statement and may provide evidence that condom usage inter alia has definitely increased, is this sufficient? Epidemiologists would probably argue that this is an important first step and therefore to be considered “real” behaviour change. But looking at the situation from a more sociological perspective, are attitudes and beliefs around positive sexual health changing? The author of this paper believes that until interventions make inroads at a social, cultural and attitudinal level, these small changes in sexual practice cannot be seen to be real and sustainable behaviour change.

No one can deny the success that has been achieved in creating awareness and knowledge around core sexual health issues, but perhaps it is time to ask...
ourselves, should we not be moving beyond “awareness” strategies? Intervention strategists probably believe that they are already achieving this. But, until research shows greater change in people’s attitudes, it would be difficult to accept that change is really taking place. Perhaps, if the different research approaches gave greater direction in the design of these intervention strategies, the interventions would be more appropriate and effective. For this to happen, recognition needs to be given to the role of research and it is essential that intervention strategies are research-based.

Because positive sexual health messages are contrary to many cultural, religious and traditional values and practices, many people experience feelings of dissidence. For example, one of the main messages that have come out of South Africa over the last few years is; “speak to your children about sex”. To put a message of this nature out without putting into perspective the socio-cultural context is highly problematic in South Africa, particularly because it is a multi-religious, multilingual and multi-cultural society. Therefore, to communicate messages of this nature at a mass media level, where one message and one medium fits all, is clearly not the answer to getting people to assimilate these messages into their lives, which in turn will result in real behaviour change.

Need for More Interactive Media

In terms of sexual health and well-being, researchers and communicators in Southern Africa need to realize that we should be moving into a new stage of communication. Mass media has been highly effective in creating awareness but certainly less effective when it comes to persuading people to change their attitudes and behaviour. It is believed that interactive media, leadership involvement and social mobilisation are the kinds of media interventions that are more likely to assist communities to engage with these sensitive issues that often run contrary to their traditional beliefs and practices. Hence, a different media approach needs to be adopted. Utilizing these more interactive forms of communication, context-relevant messaging should be the goal. These kinds of messages will more likely assist individuals to work out solutions for themselves within their own value systems and hopefully within a more receptive society.

IV Research Gaps

This leads to the issue of research gaps. The kind of research we need is research that is going to look at values, cultures, traditions, religions, beliefs, social networks as well as the environments in which they occur. It is encouraging that some researchers are already beginning to move in this direction. Examples include the Nelson Mandela / HSRC National Study on HIV Prevalence, Behavioural Risks and the Mass Media; and the Dept. of Health / Social Surveys Khomanani Formative Research Study conducted in 2002.
But even when studies like these have been done, intervention strategists and advertisers do not always utilise the results. Those who design communication campaigns often claim that they carry out detailed formative research before designing any campaign. That is all very well, but a lot of that formative research focuses purely on the campaign and the sexual health issues at hand and not on the environment and the social context. Until we have a better social understanding of the different groups within our society and understand their respective religious and cultural attitudes, beliefs and values and until we understand the different sub-cultures that exist, it will be very difficult to design appropriate, relevant and focused intervention strategies. Emphasis should be placed on designing messages to reach a specific target group as well as on identifying the most appropriate media for the messages.

**Identifying Strategic Groupings**

Another important aspect of research that has not been adequately emphasized is the identification of strategic groupings and networks as well as an exploration of social infrastructure within different types of communities. There is a need to look at leadership - the different types of leadership and the roles that they play within the community. We have to look at the NGOs and the CBOs, churches and church organisations, women’s groups, youth groups, professional services, nurses, traditional healers, social workers and others. All these groupings play very unique and important roles in the community. It is, and only when we understand these roles, how they interrelate and the influences they have on different groups within the community, can we really start designing appropriate interventions that will engender behaviour change.

In terms of research, what needs to be done is identify the most appropriate community mobilisation vehicles to carry the particular intervention. Although some intervention strategies involve the establishment of partnerships with various NGOs, this is generally not sufficient. It is thus important to understand the relationships between the different groupings as well as the dynamics of who influences whom on what issues.

**Lessons Learned**

For example, Social Surveys conducted an extensive study for Health Systems Trust on male sexuality and it was very clear from the findings that the men in the six communities in which the research was conducted, were feeling disempowered. A lot of them had been laid off and were unemployed while their female partners were still employed. They were no longer able to play their traditional roles in terms of leadership and as providers. In addition, they also considered the fight against HIV/AIDS and STI's a woman's role. Thus, it became clear that if we brought in a lot of the NGOs - most of whom were being managed by women - it would not have had the required impact.

The strategy was to involve male leaders who in turn influenced other male members of the community to support the issues. The point to be made is that this was the traditional and tested method of involving men in community activities. Male respondents observed that unless their leaders identified an issue and brought it to their attention, they did not consider it important enough to justify their involvement. By having a clear understanding of the cultural and traditional processes and structures, as well as the male attitudes in the target communities, it was possible to design a meaningful and effective intervention. The intervention not only got the cooperation of the men in the target community, but was also able to give them back some of the dignity and leadership edge that they felt they had lost.

The process of sharing our research findings with
the male members of the community and also identifying strategic mobilisation groups, assisted the men to identify their own intervention priorities as well as, to develop the skills they needed to implement the interventions. Hence, they felt they owned or had a stake in the intervention that evolved from this process. As a result, the intervention had a far stronger chance of being sustainable once it was run and managed by the community.

V. Capacity-Building

Thus, based on experience, the author of this paper is of the opinion that capacity-building and social mobilization are crucial elements for the success of sexual health interventions in the context of Southern Africa.

Successful interventions can only be the outcome of good and solid research. Researchers really do need to come to the forefront and lead the way. Interventions that are based on the communities’ own priorities and not priorities of outsiders have a greater chance of creating behaviour change because individuals are able to work out solutions for themselves within their own cultures, traditions and social context. They are more likely to influence other groups in the community, thereby increasing the likelihood of establishing an enabling environment, which, in itself, will encourage individual behaviour change.

References


Panelists as well as members of the audience spoke based on sub-regional viewpoints and drew effortlessly from their wealth of academic as well as lived experiences in these regions. Nonetheless, there were several points of convergence. Contributions from the floor also tended to be supportive of the viewpoints expressed by the panellists. Some interesting points were raised by the delegates who attended the panel. One delegate pointed out that there are widely differing national and even ethnic perceptions about sexual health across the continent, therefore, developing a sub-regional or continental level agenda would be quite difficult. Another delegate drew attention to the apparent absence of research on menopausal females. Yet another delegate emphasized the importance of making research accessible and establishing a comprehensive research database for the continent.

Below are some of the key, cross-cutting sexuality and sexual health issues that emerged from the presentations of the four panelists and contributions of other delegates.

**Key Findings (Cross-Cutting Issues)**

* The continent has witnessed significant changes in socio-sexual culture which have had immense and even grave impact on the sexual health and well-being of men, women, youth and children in the region. The magnitude, causes, and consequences of these changes need to be investigated, researched and the outcomes of research utilized in program implementation and policy formulation.

* There is the need to institutionalise sexuality and sexual health research. While sexual health research has so far been the main preserve of individual researchers in the continent’s universities and some development agencies, these have worked largely in isolation. Therefore, efforts should be made, firstly, to build “Centres of Excellence” in the respective sub-regions and secondly, to develop strategies which would link these Centres of Excellence with all levels of stakeholders including families, government, religious and social groups. In this way, scholars, NGOs and other bodies conducting research or interventions in the area of sexuality would be empowered to network and share their findings and experiences for greater impact.

* Research and interventions on rights, gender and youth issues are critical for the promotion of sexual health and well-being on the continent. Cultural and religious traditions and norms reinforce a double standard regarding sexuality and sexual health issues which increases vulnerability of especially women and youth with quite dangerous consequences. These need to be addressed through research and appropriate interventions.

* There exist huge gaps in sexuality and sexual health research which need to be urgently filled. Some of the more urgent and overarching subjects include sexual violence as well as child sexual abuse; teenage and youth sexual knowledge, attitudes and rights; sexual identities and orientation; post-menopausal sexuality; gendered power relations and sexual health decision-making.
* Creative methods must be employed to finance sexuality and sexual health research which emphasize more national, regional and continental sources rather than donor assistance from the North for reasons of continuity and sustainability.

From the foregoing, building capacity for research to promote sexual health and well-being of the peoples of Africa certainly poses some real challenges. The obstacles appear formidable unyielding cultures and traditions within a rapidly changing social milieu; religious dogmatism; ignorance, poverty; illiteracy, lack of institutional structures, skills and finance, amongst others. The seminar has also proffered some answers, the way forward so to speak. The bigger challenge is how the general body of sexuality stakeholders will turn these suggestions into solutions that work for them in their respective localities.
Chair, Prof. Helen Schneider

Helen Schneider is a medical doctor with specialist training in Community Health. She has been working for the Centre for Health Policy (CHP) for about ten years. CHP is a multidisciplinary health policy research unit based in the School of Public Health, University of the Witwatersrand, Johannesburg, South Africa. Her term at CHP was interrupted by a one year spell as a consultant at WHO in Geneva on the Global Programme on AIDS.

In 1996 she became the Director of CHP and was in 1998, accorded the status of Director of the Research Group on Health Policy of the Medical Research Council. Schneider’s research interests include HIV/AIDS and STIs; especially the policy and health systems aspects; quality of health care; and the organizational and other challenges to health sector transformation in South Africa. She is a member of the boards of the Medical Research Council and Soul City and of the government National Essential Health Research Committee.

Hind Abou Seoud Khattab PhD

Hind Khattab is an anthropologist with over forty years of research and professional experience in the fields of applied population and medical anthropology, health education and counselling. She has conducted extensive research work in the Middle East, North Africa and West Asia regions as well as in the United States. She has academic and consultancy experience with local, regional and international organizations.

In 1988, Khattab and a multidisciplinary group of researchers founded the Reproductive Health Working Group, focusing on research and technical consultation in child health, reproductive health, and family resources for health, in the West Asia and North Africa regions. Khattab is also a board member of the Red Crescent Society, Egypt; the National Council for Women, Egypt, and is the Chairperson of the Egyptian Society for Population Studies and Reproductive Health, a local NGO that conducts research in the fields of health, reproductive health, gender, sexuality, and health education. She has also been involved in the dissemination and publication of many studies including research on Women, Reproduction, and Health in Rural Egypt, also known as the Giza Study.
Augustine Ankomah PhD

Augustine Ankomah, a teacher, researcher and professional in Reproductive Health, currently works in Abuja, Nigeria, as the Senior Technical Advisor in Applied Research for the Society for Family Health. He holds a doctorate in Applied Population Research from University of Exeter, UK; a BA degree in Sociology from University of Ghana, and an MSc in Demography and Social Statistics from University of Ife, (now Obafemi Awolowo University), Nigeria. He was a university lecturer for many years having taught at University of Cape Coast, Ghana; University of Exeter, UK; and University of Wales at Swansea. Dr Ankomah's research work has focused on the sexual behaviour of young persons and implications for reproductive health, particularly with regard to HIV/AIDS and its prevention. He has been a consultant to several international organisations and has organised research training courses and workshops and undertaken research in many countries including Nigeria, UK, Kenya, Tanzania, South Africa and Vietnam. He has also led and coordinated international collaborative population and reproductive health research teams, working with professionals from Kenya, Peru and the Philippines. He has published in several international journals, contributed chapters to books.

Evasius Kaburu Bauni PhD

A demographer working with Kenya Medical Research Institute/Wellcome Trust Research Laboratories in Kilifi, Kenya, Bauni heads the Census Department which runs a longitudinal epidemiologic-demographic surveillance system (Epi-Dss) along the coast of Kenya. The Epi-Dss which has an area of 706 sq. kms and a population of 210,000, collects demographic data and provides useful background material to support clinical research. Prior to joining the research centre in 2001, Bauni worked for African Population and Health Research Centre (APHRC), Nairobi (1997 to July, 2001); United Nations Population Fund, Nairobi (1994 to 1996) and Kenyatta University, Nairobi (1986 to 1993). Between 1998 and 2001 Bauni carried out a study funded by WHO on Family Planning and Sexual Behaviour in the Era of STDs and HIV/AIDS in Nakuru District of Kenya.
Bev Russell is Managing Director of Social Surveys, a specialist social and development research company based in South Africa, which she established in the mid-80’s. Much of the early social research she undertook was related to low-cost housing, hostels, urban planning and infrastructure development. Soon the focus expanded to include education, health, energy and environmental studies. She has recently established Social Surveys Africa, with over 20 country offices with the capacity to undertake developmental research and support strategic planning and policy development in Africa.

Over the past decade, health has been a core focus of the work undertaken by Russell and her team at Social Surveys. Areas covered include: youth sexuality, domestic violence, hypertension, water and sanitation, and HIV/AIDS. Russell has over 20 years of research experience both in the UK and Southern Africa. She graduated from the University of the Witwatersrand where she studied Psychology, Sociology and African Languages.