Sexual and reproductive health

From reproduction to rights: Participatory approaches to sexual and reproductive health

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- ## Introduction

This special issue of PLA Notes focuses on participatory approaches to sexual and reproductive health[1]. It brings together accounts of exciting initiatives from around the world that hold the potential for transforming an arena that has tended to provide information and services rather than seek to engage people more actively in processes of change. Ranging from innovative uses of participatory methods to enhance communication and understanding to strategies to amplify the voices of people who would otherwise remain unheard in policy and institutional processes, the articles in this issue offer food for thought and lessons from experience.

Reflecting a wider shift from reproduction to rights, the use of participatory approaches poses important challenges for sexual and reproductive health (SRH) work. It is always easy to criticise with hindsight, but ten years ago, crudely speaking, mainstream agencies viewed women largely as breeders and therefore, focused narrowly on family planning, maternal/child health and traditional birth attendant training as part of their health programmes. Only women in the 15-45 years cohort were the 'targets' of this

work. Little attention was paid to younger or older women's sexual and reproductive concerns. Men's involvement and *their* SRH needs remained unaddressed.

Similarly, any mainstream agency working on sexually related illness focused on HIV prevention with female sex workers and male truck drivers (their clients). Whilst epidemiologically, they may have been the groups who appeared then to be most 'at risk', sex workers, already stigmatised by society, were then ostracised yet further by others for their apparent association with HIV prevention work. Ironically, in many cases, sex workers became champions of safer sex practices, while the rest of society which had condemned them, continued to ignore its own vulnerability.

In such an approach, mainstream agencies also assumed that *heterosexual* transmission of HIV (and other sexually transmitted infections, STIs), was the only sexual route. Now we are much more aware of the diversity of sexual orientations, not just homosexuality but others as well, and of the diversity of SRH needs which people have, rather than just using a narrow Western model of health care, sickness control and 'simple' heterosexuality, which influenced the approach of agencies a decade ago.

Much has changed; and much still needs to change. More work is needed to break open the boxes that surround 'target groups' and recognise the complexity and fluidity of sexual and reproductive identities and experiences in different

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[1] This issue builds on previous RRA/PLA Notes issues on Health (RRA Notes 16, 1992) and HIV (PLA Notes 23, 1995). Further resources include the excellent field guide by Kaul Shah et al. (1998), the IDS Sexual Health Information Pack (SHIP) and the IIED Trainers' Guide (1995).

cultural contexts. The articles in this issue address some of these broader concerns, from body image to breast cancer, from vasectomy to gender-based violence.

There remain a number of SRH issues on which we have sought, and failed, to find accounts of participatory initiatives, including abortion, female infanticide, female circumcision, work with men who have sex with men etc.. The methods and processes that the articles in this issue describe, however, have relevance beyond the specific SRH issues that their authors focus on. They offer a range of ways of opening up the space to rethink ideas about sexuality, gender and sex, and to engage people *as people* in strategies for change.

Breaking down walls: SRH, rights and development

Ten years ago, very little attention was paid to SRH issues by anyone outside the health sector. But we can now see how SRH intersects with everyday livelihood issues, whether in terms of agricultural cycles (Howson and Smith, this issue) or access to and control of money and other resources (Simasiku et al., this issue). It has become evident that SRH is more than a 'health issue'. There is also increasing recognition of the links between different aspects of SRH. Recent research in India (Martin et al. 1999) draws attention to significant levels of wife abuse in Northern India. They found that abusive men were more likely to engage in extramarital sex and have STD symptoms, thus placing their wives at risk of STD infection as well as unplanned pregnancy. Such research supports informal findings from many different countries (Shaw and Jawo, Howson and Smith, this issue) and highlights how essential it is for us as development workers to make these connections in our work.

Connections need to be made beyond the domain of SRH work. Rethinking SRH as a development issue allows us both to focus on the rights dimensions of SRH work and its relevance to broader development concerns. The need to do so becomes all the more pressing with the spread of HIV and the devastating threat that AIDS presents for livelihood security and for the safety and survival of those most vulnerable to infection. It raises issues that lie at the heart of the development process itself; and with that, implications for participatory work that go beyond sectoral boundaries. SRH is closely related to and spills over into so many varied aspects of our lives; our self-esteem, our livelihoods (Butcher, this issue), our environment (Lynn, this issue), our education, our life prospects and so on.

SRH - A human rights issue

In South Africa, UNAIDS recently reported the death of Gugu Dlamini, a 36-year-old mother. She died in December 1998 due to a beating delivered by neighbours in her own home. They had accused her of having brought shame to their community, Kwamashu, in the outskirts of Durban, after she openly revealed on December 1, World AIDS Day, that she was HIV positive (UNAIDS press release, 5 Jan 1999). The stigma faced by those infected with HIV and by their families and friends is a huge problem to be overcome in the fight against the virus. Yet until positive people feel confident enough to be open about what has happened to them without being vilified or killed, we will never benefit from the lessons which they could share with us.

As this example so powerfully illustrates, SRH is an issue of human rights, one that is central to any other development efforts. Millions of girls and women suffer the multiple hardships and consequences of physical, sexual or psychological abuse, such as beating, rape, or abuse of their children, with no opportunity to escape from the abusive relationships in which they find themselves (Heise et al. 1999). Unwanted teenage pregnancies, domestic violence, untreated and undiagnosed sexually transmitted infections and the spread of HIV are issues that spill over into all dimensions of people's lives, with

far-reaching consequences. These issues raise challenges for every dimension of development work. And the challenges of change, in turn, stem from addressing fundamental questions of equity, access, rights, inclusion and control.

A triple taboo: gender, sex and death

There is increasing recognition of the need to be innovative, exploratory, daring in our participatory development work. Nowhere is this need more challenging than when addressing SRH issues. In SRH work we face a triple taboo of gender, sex and, in the cases of gender violence, breast cancer, some childbirth, some female circumcision and HIV, death.

Gender equity is a subject of much contention around the world. And, as many of the articles in this issue show, gender issues are often at the heart of many SRH problems. In some cases, such as the example of the Supreme Court of Zimbabwe's recent decision to withdraw women's rights to equal inheritance with men, a right gained 19 years ago at Independence, the barriers to addressing key concerns in SRH lie in institutionalised male dominance. In others, reluctance to move beyond everyday forms of interaction can in itself provide a potent obstacle to even beginning to raise gender issues within contexts of SRH work.

Talking openly about sex and desire remains a taboo in many cultural contexts. Often the language of sex is an area of contention. Words in common use by young men, for instance, about sexual parts of the body or sexual activities, may be totally unacceptable to older members of the same community. Challenging the boundaries of acceptability raises a number of uncomfortable issues; it also creates significant difficulties for SRH work in contexts where taboo and silence limit the possibilities of opening spaces for people to be able to express themselves and share their experiences. We find it even harder to discuss death and its consequences for loved ones and dependants. In most communities, death is something which we fear and which we try not to think or talk about, in case we will hasten its arrival by so doing.

A fourth problem: whose priorities?

A fourth problem that some of us face as development workers is the fear by many that all SRH work, be it concerning HIV, family planning or whatever, is based on a preoccupation with population control driven by priorities set elsewhere (Shaw and Jawo, this issue). A concern with addressing the gender issues that lie at the heart of SRH is equally seen by some as an attempt to impose the norms of one culture onto others. In Africa, AIDS has come to be known in many places as 'American Initiative to Discourage Sex', indicating perceptions that place a concern with HIV prevention, as with gender equity and other SRH issues, as a project inspired by Northern agendas.

These issues raise a number of dilemmas. On the one hand, they demonstrate the ethical importance that we should attach to enabling people to determine their own concerns and form their own opinions, rather than rushing in with an outside agenda. On the other, thorny questions remain about our own perceptions of 'right' and 'wrong', and where we might legitimately intervene to bring about change. These are challenges that run through participatory work more broadly, but are especially significant in the domain of SRH.

So SRH work is faced with multiple dilemmas. How can we enable people to learn about how their bodies work and about their relationships with others, in order to help themselves to lead healthy and safe lives, whilst at the same time minimising the extent to which others are alienated by the frankness of those discussions? How do we respond when there are direct conflicts of views and values? And how do we work in ways that minimise the extent to which we, as outsiders, are tempted to impose our own

opinions on others, on issues where we clearly are 'taking sides' and, in doing so, challenging dominant values?

HIV – a growing picture

The growing threat of AIDS has now challenged us to face up to these taboos and grapple with these dilemmas. In most countries, the momentum of the HIV epidemic continues unabated. In 1999 an estimated 5.6 million people worldwide were newly infected with HIV, one every six seconds (Kaleeba et al., 2000). Although HIV is a global phenomenon, sub-Saharan Africa is bearing the main brunt of the epidemic (Hunter and Williamson 1998, UNAIDS 1999). In the last twenty years, the HIV epidemic has swept through sub-Saharan Africa with increasingly destructive force. It has so far killed over 13 million men, women and children in Africa south of the Sahara (UNAIDS 1999). Families and communities have been devastated and in some African countries, the course of human development has been set back by decades and life expectancy rates are falling dramatically.

Asia too is suffering the consequences of a rapid rise in HIV infection. India now has an estimated 4 million infected people, the greatest for one country in the world (UNAIDS 1999). A recent study of married monogamous women found that HIV infection amongst them is increasing and that the most likely means of infection is through unprotected sex with their husbands (Gangakhedkar et al. 1997). Elsewhere in Asia, though, there is cause for hope. In Thailand and the Philippines, a sustained success is reported in the reduction of HIV risk and in lowering or stabilising HIV rates (UNAIDS 1999).

There is no cause for complacency elsewhere in the world. The greatest increases in HIV infections in 1999 were in the former Soviet Union (UNAIDS 1999)[2]. In the USA, what began as an epidemic amongst a particular group, gay

men, has now spread to other marginalised groups, including poorer populations of African Americans (Batchelor, this issue). Britain has the highest teenage pregnancy rates in Europe and a new HIV infection every 5 hours.

• Participatory approaches – what can they offer?

Over the last few years, there has been an explosion of interest in participatory methodologies. This has been supported by the realisation that involving people more actively in setting priorities and determining needs can make a difference. In SRH work, there has been recognition of the need to move beyond simply giving people information to enabling them to gain the 'power within' to begin to bring about change in intimate relationships that put them at risk.

Many of the articles in this issue address directly the potential that participatory methodologies and approaches offer SRH work. Most draw on the corpus of techniques that has come to be known as 'PRA' (Participatory Rural Appraisal) or, more recently, 'PLA' (Participatory Learning and Action). What does 'PRA' or 'PLA' mean in practice? The answer to this is many things to many different people! The contributors to this issue use 'PRA' and 'PLA' in different ways too; rather than put forward any definitions, we use a generic term 'PRA/PLA' here[3].

Addressing vulnerability

Edstrom et al. (this issue) set out the context in which this change in approach has come about, highlighting the limitations of conventional Information Education and Communication (IEC) strategies and illustrating the opportunities participatory approaches open up for

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[2] Many of these new infections were related to intravenous drug use as well as sex.

[3] Some people distinguish PLA from PRA in terms of the kinds of techniques used; others according to what the aims of the process might be and so on. By retaining a general category PRA/PLA, we recognise that each reader and contributor may interpret these terms differently.

analysis and action. Starting with the concept of vulnerability as central to effective HIV prevention, the article emphasises the need to go beyond individual behavioural change to address the complexities of HIV related vulnerability within communities. In a summary of a seminar on girls and young women and HIV, the UK AIDS Consortium raises issues that are central to SRH work more broadly. From vulnerability being rooted in inequalities, to strategies for engagement, to the need for advocacy at different levels to build accountability, their article also points to the need for an integrated and multi-dimensional approach to SRH.

Against this backdrop, the articles in this issue offer a rich array of ways of addressing issues of vulnerability at a range of levels and in a variety of contexts. All draw on participatory methodologies and many contribute new and innovative methods.

Creating space for voice

Highlighting both the centrality of gender and also the need to go beyond describing 'how things are' to analysing root causes, the article by World Neighbors and their programme partners describes practical tools for facilitating reflection and analysis on reproductive health issues in Nepal. Rull Boussen et al. (this issue) describe, how the use of PRA/PLA tools in needs assessment enhanced collaborative planning between NGOs, government and community members in Egypt. As in the Nepalese example, the authors describe the integration of PRA/PLA with methods from popular education, such as problem-posing sessions and root causes analysis. This facilitates moving beyond simply gathering 'voices' that describe how things are, to critical reflection on underlying causes to engage people as active shapers of how things might be.

Simasiku et al. focus directly on the vulnerability of young people, illustrating the use of PRA/PLA methods as an entry point for exploring sensitive issues with adolescents in Zambia. Kaim and Ndlovu also describe how such methods can be an entry point for a process that sought to engage young people in determining their needs and identifying solutions. Using the medium of a popular 'agony aunt' column in a Zimbabwean magazine suggested in initial PRA work, young people's own stories and experiences formed the basis for materials on SRH for use in schools. Kaim and Ndlovu's article highlights the importance of ensuring 'buy in' from a range of stakeholders for SRH work, illustrating the impact that the project had on changing relationships between students, teachers and community members. This is reflected in Kaleeba et al. (this issue) who show how an innovative School Health and AIDS Prevention programme has been enhanced by the involvement of parents, local government, religious leaders, youth representatives and health organisations through a District Level Steering Committee. Forder (this issue) also focuses on the gendered vulnerability of young people, in this case female Cambodian factory workers, where participatory methods have opened spaces in which voices can be heard.

Facilitating interaction and learning

Forder draws attention to the importance for facilitators to have dealt with some of their own issues around sexuality; yet the time and space to do so is often limited. She highlights some of the ambiguities that surround the role of the facilitator: when and whether to intervene, how to model behaviours that participants can feel freer to adopt and the ways in which the attitudes of facilitators may both block communication and be a perceived problem by participants. As Edstrom et al. and others also point out, skilled facilitation is of key importance in participatory SRH work. Yet what happens when organisational and other constraints make those skills scarce, as Shaw and Jawo, for example, demonstrate in the Gambian context? Hobbs and Simasiku address this issue, offering a pragmatic approach that seeks to

overcome some of the difficulties that can be anticipated.

Gordon and Phiri take up the question of facilitation involved in tackling some of the sensitive issues that surround SRH work. Echoing the point made by Edstrom et al. that information alone cannot change behaviour, their article describes the innovative use of a range of participatory methods in work with Zambian family planning Community Based Distributors (CBDs). These ranged from PRA/PLA to drama, to the use of pictures and stories, to non-directive peer counselling. They focus on the dynamics of interaction between and within groups of men and women, offering important lessons for the facilitation of peer and open group sessions. One important lesson from this insightful piece is the importance of recognising that while a neutral space may be created in the moment of an externally facilitated activity, once people return to their private spaces, things that are said and done in public may have serious repercussions.

Opening up dialogue

As Shaw and Jawo demonstrate, by making space for women and men to express their concerns, participatory processes can also begin to address vulnerabilities at a community-wide level. Shaw and Jawo's article, based on ongoing work in Gambia, describes the adaptation and use of 'Stepping Stones[4]', an interactive training process that brings drama, assertiveness training and visualisation together to open up dialogue between different gender and age groups. In this context, a positive association was found between participation in these activities and a reduction in wife beating, and raised awareness of risky behaviours associated with HIV and STDs.

Highlighting issues that resonate with many of the papers in this issue, Shaw and Jawo's paper describes some interesting innovations, both in terms of method and strategy. They emphasise safer sexual

practices in the prevention of infertility as an entry point to preventive sexual health work. The authors describe innovations they used: from 'secret ballots' (see also Simasiku et al., this issue) and body mapping of 'turn ons' and 'turn offs'. As a similar illustration of how the flexibility of participatory methods offers scope for innovation and adaptation to the purpose and context, Butcher et al., (reprinted in this issue[5]) describe an innovative approach to condom promotion and evaluating peer education amongst sex workers.

Batchelor's article (this issue) takes body mapping a step further in its use to explore issues of desire, sensuality and body image with front-line health workers in the southern United States. All too often, discussions about sex are couched in terms of preventing diseases/pregnancy rather than in terms of pleasure and desire. What Batchelor's article so powerfully reminds us is that unless people are treated as people with emotional and sexual desires and needs, rather than as victims or vectors of disease, sexual health work can so easily fall into 'medicalising' the problem and missing the mark. Sturley's article is also an important reminder of the need to locate medical interventions, in this case vasectomy in Nepal, within the complexity of cultural meanings associated with their perceived and actual impact. Again the use of body mapping provided an entry point to exploring experiences that might otherwise have been ignored.

Building bridges

All too often, project evaluation marginalises the voices of those whom projects are designed to help, missing opportunities for building better relationships between agencies and those they work with. As Batchelor and Sturley's articles make clear, there is much to be gained from this interaction. Sellers and Westerby's article describes how young people and service providers came together in a participatory evaluation of sexual health provision. As well as

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[4] See Welbourn, A. (1998).

[5] Reprinted from *PLA Notes* 33, October 1998.

detailing useful tools, and an innovation that has wider use in monitoring, the 'barriers wall', they demonstrate the value of participatory approaches in building bridges between service providers and users. Smith and Howson's account of participatory evaluation of CAFOD and partners' HIV prevention work in Southern Africa also contributes tools, such as the significant changes matrix, with the potential for building closer relationships between stakeholders. It also highlights the empowering aspects of this process for workers, as well as participants.

Making connections

Many of the articles in this issue make explicit the links between SRH and gender. Lewis' article provides a powerful example of a process that integrates a more subtle approach to gender. Aiming to build 'critical literacy about gender and power' with young people in Estonia, workshops integrated a range of levels, approaches and techniques: academic input with participant's own experiences, films and theatre with participatory drama, newspaper collage with young people's own messages and stories.

Lastly, Lynn et al., describe a process in the UK that made connections between the national and the local levels on a women's health issue that is a growing concern: breast cancer. This article demonstrates the links that can be built between advocacy and empowerment through a participatory process.

• Lessons learnt – we need to:

Why…

- Recognise that SRH issues touch all aspects of our lives and therefore the overall physical, material and psychological quality of our well being. Bad SRH can be both a cause and a result of a poor quality of life (Wanduragala – see Tips for Trainers, this issue).
- Acknowledge universally widespread gender violence, physical, sexual and psychological, and recognise that sexual and reproductive health is a human rights issue...

Who…

- Work with boys and men as well as girls and women.
- Don't put people in 'boxes' and label them as 'heterosexual' or 'homosexual' but work with their own self-definitions, their own experiences and identities.
- Acknowledge the importance of gaining support from gatekeepers and the opportunities of making them 'champions' of change; include parents, teachers, religious leaders, community leaders, government officials etc.
- Acknowledge that young people are often sexually active before parents and others realise (or want to accept) and that they are at risk through lack of information and support
- Build on the clear evidence that good sex education for young people, which also includes relationships, assertiveness and communication skills, delays the onset of sexual activity and makes it safer when it starts. Denying young people access to information is to deny them the right to have safer sex and reduce their vulnerability to infection and pregnancy
- Acknowledge that young women are particularly vulnerable to infection and exploitation
- Recognise that ordinary people, if given the right support, are quite capable of developing their own workshop material.
- Don't forget that older people have sexual health concerns, both related to the life-course (such as menopausal and impotence symptoms) and as part of a wider adult population (such as STIs, HIV and AIDS)

How…

- Recognise that there is a need for active collaboration and co-operation between different agencies and institutions at different levels of the

system, e.g. youth friendly clinics, sex worker-protective laws.

- Always include gender awareness as part of processes designed to bring about changes in attitudes and behaviour towards SRH issues.
- Recognise that 'gender' is not simply a 'women's issue' and that strategies may be needed for enabling men to address their gender issues and SRH needs *as men.*
- Create opportunities for trainers/facilitators to process and internalise issues for themselves before facilitating/training others.
- Make spaces for people to work in peer groups as well as to come together in open sessions; recognise the importance of working sensitively with this structure to ensure confidentiality and positive outcomes.
- Be open to new methods of learning: PRA, drama/role-play and assertiveness.

What…

- Avoid blueprints: adapt existing materials or develop new materials to suit the cultural and social settings in which SRH work is done.
- Recognise the range of levels/contexts in which participatory activities can make a difference; from work with local communities and particular interest groups, to work with health, education and social care workers to work on national policy issues and campaigns.

Where…

- Start from where local people are; e.g. infertility, rather than STIs, unwanted pregnancies rather than HIV etc.

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REFERENCES

Gangakhedkar R.R., Bentley M.E., Divekar Anand D. 1997: "Spread of HIV infection in Married Monogamous Women in India" in Journal of the American Medical Association *Vol.278.*

Heise L., Ellsberg M. and Gottemoeller M. 1999: "Ending Violence Against Women" Population Reports vol XXVII, No. 4. Series L, No. 11. Johns Hopkins Center for Communication Programs and CHANGE, Baltimore.

Hunter S. and Williamson J. 1998 Children on the Brink. Strategies to support children isolated by HIV/AIDS, USAID, Washington.

Kaleeba N., Kadowe J., Kalinaki D., and Williams G. 2000 Open Secret: Facing Up To HIV and Aids In Uganda Strategies for Hope Series No. 15, Strategies for Hope, Oxford.

Kaul Shah, M., Zambezi, R., & Simasiku, M. (1998) The use of PLA Methodology in partnership for adolescent sexual and reproductive health (PALS): a field guide. CARE International

Martin S.L., Kilgallen B., Amy Ong Tsui, Kuhu Maitra, Kaushalendra Kumar Singh, Lawrence L. Kupper, 1999 *Sexual Behaviors and Reproductive Health Outcomes Associations With Wife Abuse in India,* Journal of American Medical Association, Vol.282: 1967-1972

UNAIDS Press release 23 November 1999 London

Welbourn, A. (1998) Gender, participation and HIV: a positive force for change in Guijt, I.& Kaul Shah, M. (Eds) The Myth of Community. IT publications