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CONTENTS

ABOUT AJRH

African Journal of Reproductive Health (AJRH) is published by the Women's Health and Action Research Centre (WHARC). It is a multidisciplinary and international journal that publishes original research, comprehensive review articles, short reports and commentaries on reproductive health in Africa. The journal strives to provide a forum for African authors, as well as others working in Africa, to share findings on all aspects of reproductive health, and to disseminate innovative, relevant and useful information on reproductive health throughout the continent.

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The Women's Health and Action Research Centre (WHARC) is a registered non-profit organization, committed to the promotion of women's reproductive health in sub-Saharan Africa. Founded in 1995, the centre's primary mission is to conduct multidisciplinary and collaborative research, advocacy and training on issues relating to the reproductive health of women. The centre pursues its work principally through multidisciplinary groups of national and international medical and social science researchers and advocates in reproductive health.

WHARC receives core funding and support from the Ford Foundation and technical cooperation and mentorship from International Perspectives on Sexual and Reproductive Health and Studies in Family Planning. Principal funding for the journal comes from the Consortium on Unsafe Abortion in Africa. The goal of the centre is to improve the knowledge of women's reproductive health in Nigeria and other parts of Africa through collaborative research, advocacy, workshops and seminars and through its series of publications – the *African journal of Reproductive Health, the Women's Health Forum* and occasional working papers.

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SOMMAIRE

Editoriaux

Articles

APROPOS AJRH

La Revue Africaine de santé de la Reproduction (RASR) est publiée par le Women's Health and Action Research Centre (WHARC). C'est une revue à la fois pluridisciplinaire et internationale qui publie des articles de recherche originaux, des articles de revue détaillés, de brefs rapports et des commentaires sur la santé de la reproduction en Afrique. La Revue s'efforce de fournir un forum aussi bien à des auteurs africains qu'a des professionels qui travaillent en Afrique, afin qu'ils puissent partager leurs découvertes dans tous les aspects de la santé de reproduction et diffuser à travers le continent, des informations innovatrices, pertinentes et utiles dans ce domaine de santé de la reproduction.

La R*ASR* est indexée et figure sur I'Index Medicus/MEDLINE. Les résumés et les tables des matières sont publiés en ligne par INASP sur le site web *http:*//www.ajol.info/*ajol* tandis que le texte est publié à http://www.ajrh.info par Bioline International sur le site web *http://www.bioline.org.br/.* Il est également résumé dans *Ulrich Periodical, feminist Periodical et African Books Publishing Records*

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Le WHARC est une organization non gouvernementale à but non-lucratif s'engageé dans la promotion de santé de la reproduction chez la femme en Afrique sub-saharéenne. Fondé en 1995, le Centre a pour objectif principal de mener des recherches pluridisciplinaires et en collaboration, de promouvoir et de former des cadres en matières relatives à la santé de la reproduction chez la femme. Le Centre travaille surtout à travers des groupes mutidisciplinaires de chercheurs aussi bien nationaux qu'internationaux en sciences médicales et en sciences économiques dans le domaine de santé de la reproduction.

Le WHARC recoit une aide financière pricinpale de la Fondation Ford et bénéficie de la coopération technique de l'*International Perspectives on Sexual and Reproductive Health* et de *Studies in Family Planning*. Le financencement principale pour la revue vient de la part du Consortium on Unsafe Abortion in Africa. L'objectif du Centre est d'ameliorer la connaissance en matière de santé de la reproduction chez la femme au Nigeria et dans d'autres régions d'Afrique à travers la recherche en collaboration, le paidoyer, des ateliers et des séminaires à travers des séries de publication - *La Revue africaine de santé de la reproduction, Le Women's Health Forum* et des rapports des recherches de circonstance.

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EDITORIAL

Unlocking the Benefits of Emergency Obstetric Care in Africa

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Emergency Obstetric care (EmOC) is the form of clinical care that responds to un-expected complications of pregnancy such as haemorrhage and hypertensive crisis in pregnancy. In a recent publication, the UNFPA identified two forms of EmOC[1] as including Basic Emergency Obstetric Care (BEmOC), and Comprehensive Emergency Obstetric Care (CEmOC). BEmOC consists of services such as administration of antibiotics, uterotonic drugs, and anti-convulsants; manual removal of retained placenta; removal of retained products following delivery or abortion; assisted vaginal delivery, possibly with a vacuum extractor; and basic neonatal resuscitation procedures. By contrast, CEmOC consists of all the basic functions enumerated above, but also includes institutional ability to perform caesarean sections safely and to administer blood transfusion as well as the provision made for the advanced treatment and resuscitation of sick babies. BEmOC are expected to be carried out in primary health centres, while CEmOC has to be implemented in secondary or tertiary health care facilities, enabling the strategic adoption of a systems approach for addressing the problem.

A UNICEF, WHO and UNFPA joint statement further recommends that for every 500,000 people, there must be at least four facilities offering BEmOC, and at least one facility offering CEmOC services[2]. Such facilities must not only be physically available, but they must also have the required number of trained and experienced staff, equipment and consumables to carry out the emergency obstetric treatment needed to save the lives of women and children.

Unfortunately, for many countries in sub-Saharan Africa, these basic components of EmOC are often not available, which in large measure account for the high rates of maternal, stillbirth and neonatal mortality in the region. Evidences abound that Phase III delay (the type of delays that occur after pregnant women arrive in health facilities)[3] accounts for up to half of the maternal deaths[4] that occur from pregnancy complications in Africa. Phase III delay also acts as a dis-incentive to women using facility care. Thus, in aggregate form, Phase III delay appears to be the most important single type of delay that need to be acted upon to reduce the high rate of maternal and newborn mortality in African countries.

Recent data suggests that available BEmOC and CEmOC in many parts of Africa are not only of low quality; they are also inaccessible and respond poorly to the needs of pregnant women. A recent study[5] that investigated 378 health facilities in six developing countries, including Kenya, Malawi, Sierra Leone and Nigeria, reported that fewer than one in four facilities designated to provide CEmOC were able to offer the nine required signal functions of care, and only 2.3% provided all seven signal functions. The study concluded that health facilities in surveyed countries do not have the capacity to adequately manage emergency obstetric complications that lead to maternal and newborn mortality. A paper by Bamgboye and colleagues in this edition of the African Journal[6] also reports poor quality and inaccessible BEmOC and CEmOC in Ibarapa Local Government Area in Southwest Nigeria, which testify to the persistence and continuity of the problem at the local level.

Maternal mortality reduction in developing countries was one of the unfinished agenda in the Millennium Development Goals and remains one of the key indicators for measuring the attainment of the Sustainable Development Goals. If the goal of further reducing the number of maternal deaths is to be achieved by 2030, now is the time to focus on improving the quality of emergency obstetric services, especially within the context of sub-Saharan Africa. Due to the recognition that women will likely continue to delay in seeking orthodox maternity care, we hold the view that the improvement of the quality, timeliness, and responsiveness of EmOC is one of the most important interventions that need to be undertaken to reduce maternal and newborn mortality in the African region. Oladapo et al[7] in a recent study reviewing 998 maternal deaths and 1451 near-miss cases in Nigeria made the point that getting to maternity care centres is not enough: there must be a purposefully designed action plan and effective emergency obstetric services to prevent maternal and neonatal deaths.

It is within this context that the Women's Health and Action Research Centre (WHARC), a Nigerian national non-governmental organization is actively pursuing a series of implementation research activities aimed at improving the quality of BEmOC and

CEmOC in the country. With funding from the World Health Organization[8], WHARC has completed a number of quantitative and qualitative formative studies that assess the quality of CEmOC in eight referral facilities in four geo-political zones of the country. The assessment asked the important questions: 1) to what extent do the health facilities meet the WHO criteria for the delivery of CEmOC services? 2) how available in these facilities are the known interventions for preventing maternal and newborn mortality, and how knowledgeable are health providers working in these facilities about the applicability and use of these key interventions?; and 3) how do women respond to existing care, and what do they see as barriers to use of orthodox maternity care? The results of the formative research have now been disseminated and are widely available[9], and again illustrate the paucity of the kind of CEmOC needed to deal with a huge problem of this nature.

The good news is that key stakeholders including policymakers and government officials are working with WHARC to design effective interventions to address the identified gaps. The multi-faceted and composite interventions being proposed would be tested for effectiveness in a quasi-experimental research design that would be implemented in randomly selected sites across the country. If proved to be effective, we believe the engagement of policymakers in every phase of the study will help to ensure that the interventions are integrated into policy and scaled throughout Nigeria's health care system.

A parallel study is also being undertaken by WHARC with funding from the International Development Research Centre (IDRC)[10], Canada to improve the use of Primary Health Centres (PHCs) by pregnant women and the quality of BEmOC offered by PHCs in Nigeria. Although PHCs are the entry points to Nigeria's health care system, these facilities are hardly available for use by vulnerable women, especially those in hard-to-reach rural populations in the country. Most Nigerian rural populations tend not to have secondary and tertiary care facilities; they are often without evidence-based orthodox care, and are then left to use ineffective local remedies provided by traditional birth attendants. To this day, only about 34% of Nigerian women are attended at delivery by skilled birth attendants, with the large majority of pregnant women delivering in their homes or with unskilled traditional birth attendants. Yet, it is known that most maternal deaths occur in these circumstances where women deliver unattended or with unskilled birth attendants. To address this, WHARC is undertaking formative community-based participatory research to identify the demand and supply factors that account for women's poor use of PHCs for maternal and newborn care in the country. In collaboration with national and international stakeholders at the University of Ottawa, Canada, the Centre hopes to use the results of the formative research to implement a series of interventions to improve women's use of PHCs linked to effective referral facilities. We believe this would help resolve the present lack of access to orthodox maternal and child health care to majority of rural women in the country.

The clear message in this editorial is that there is a need to evolve an effective health system in African countries that provides composite BEmOC and CEmOC for dealing with obstetric emergencies that lead to maternal and neonatal mortality. Several years ago, Professor Kelsey Harrison in his elegant prospective studies conducted at the Ahmadu Bello University in Zaria, northern Nigeria[11] reported that 90% of women who died during pregnancy were "unbooked emergencies". These were women who had not received antenatal care throughout the pregnancy, who tried to deliver at home but failed to do so, but who then presented as dire emergencies in hospital after experiencing severe complications of pregnancy. After over 30 years, the problem still remains the same, without any substantive effort made to resolve it either in Nigeria or in many other African countries. If the current effort to promote human development through the Sustainable Development Goals is to be achieved, African countries need to focus on strongly positioning the effective delivery of emergency obstetric care as an important equity, human rights and social justice imperative.

Conflict of Interest

None

References:

1. UNFPA. Setting standards for emergency obstetric and newborn care. October 2014. Accessed from http://www.unfpa.org/resources/setting standard.
2. UNICEF, WHO, UNFPA. Guidelines for monitoring the availability and use of obstetric services 1997. United Nations Children's Fund, New York. [http://www.amddprogram.org/v1/resources/UN GuidelinesEn.pdf]. Accessed March 2016.
3. Thaddeus S, Maine D. Too far to walk – maternal mortality in context. Soc Sci Med 1994; 38: 1091-1110
4. Okonofua FE, Abejide OR, Makanjuola RO: Maternal mortality in Ile-Ife, Nigeria: A study of risk factors. Studies in Family Planning 1992; 23, 5:319 – 324.
5. Ameh C, Msuya S, Hofman J, Raven J, Mathai M, Broek N van den. Status of emergency obstetric care in six developing countries five years before the MDG targets for maternal and newborn health. PloS One 2012; 7(12): e49938.

6. Bamgboye EA, Adebiyi AO and Fatiregun AA Assessment of Emergency Obstetric Care Services in Ibadan-Ibarapa Health Zone, Oyo State, Nigeria.
7. Oladapo, O., et al. When getting there is not enough: a nationwide cross-sectional study of 998 maternal deaths and 1451 near-misses in public tertiary hospitals in a low-income country. BJOG: An International Journal of Obstetrics & Gynaecology, 2015.
8. Women's Health and Action Research Centre (WHARC). An intervention to improve the quality of emergency obstetric care in referral facilities in Nigeria. WHARC WHO H9-TSA-282-Final Protocol, 2015-2018
9. Women's Health and Action Research Centre (WHARC). Assessing the nature and quality of emergency obstetric care for preventing maternal and perinatal mortality in 8 secondary and tertiary hospitals in Nigeria: results of a formative research study. Available at: http//www.wharc-online.org
10. Women's Health and Action Research Centre (WHARC), University of Ottawa, Canada. Increasing Women's Access to Skilled Pregnancy Care in Primary Health Centres to Reduce Maternal and Perinatal Mortality in Nigeria. A proposal funded by IDRC
11. Harrison K. 1985. Childbearing, health and social priorities: a survey of 22,774 consecutive hospital births in Zaria, northern Nigeria. BJOG 1985; 92 Supplement 5, 1-119.

EDITORIAUX

Révéler les avantages des soins obstétricaux d'urgence en Afrique

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Les soins obstétricaux d'urgence (SOU) constituent la forme de soins cliniques qui répond à des complications inattendues de la grossesse telles que l' hémorragie et la crise hypertensive pendant la grossesse. Dans une publication récente, le FNUAP a identifié deux formes de SOUC1 comme incluant les soins obstétricaux d'urgence de base (SOUB), et les soins obstétricaux d'urgence de soins complets (SOUC). SOUB se compose de services tels que l'administration d'antibiotiques, des médicaments utérotoniques et les anticonvulsivants; l'extraction manuelle du placenta; l'élimination des produits retenus après l'accouchement ou l'avortement; l'accouchement vaginal assisté, probablement à l'aide d'une ventouse obstétricale; et les procédures de la réanimation néonatale de base. En revanche, les SOUC comprennent toutes les fonctions de base énumérées ci-dessus, mais comprend également la capacité institutionnelle pour effectuer des césariennes en toute sécurité et d'administrer une transfusion sanguine, ainsi que les dispositions prises pour le traitement avancé et la réanimation des bébés malades. Les SOUB devraient être menés dans les centres de santé primaires, tandis que les SOUC doivent être mis en œuvre dans les établissements de soins de santé secondaires ou tertiaires, permettant l'adoption stratégique d'une approche systémique pour résoudre le problème.

Une déclaration conjointe de l'UNICEF, l'OMS et le FNUAP recommande en outre que pour chaque 500.000 personnes, il doit y avoir au moins quatre établissements qui assurent les SOUB, et au moins un établissement qui assure les services des SOUC2. Ces établissements ne doivent pas seulement être physiquement disponibles, mais ils doivent aussi avoir le nombre requis de personnel qualifié et expérimenté, des équipements et des consommables pour mener à bien le traitement obstétrical d'urgence nécessaire pour sauver la vie des femmes et des enfants.

Malheureusement, pour de nombreux pays d'Afrique sub-saharienne, ces composants de base de SOU ne sont souvent pas disponibles, ce qui est responsable en grande mesure des taux élevés de mortalité maternelle, de mort naissance et de la mortalité néonatale dans la région. Il y a beaucoup d'évidences qui montrent que le retard de la phase III (le type de retards qui se produisent après l'arrivée des femmes enceintes aux établissements de santé)3 sont responsables de jusqu'à la moitié du décès maternel4 qui se produisent suite à des complications de la grossesse en Afrique. Le retard de la Phase III agit également comme une démotivation aux femmes qui se servent des soins dans des établissements. Ainsi, sous forme agrégée, le retard de la phase III semble être le type unique le plus important du retard qui devrait 'être sollicité pour réduire le taux élevé de mortalité maternelle et néonatale dans les pays africains.

Les données récentes suggèrent que les SOUC et les SOUC disponibles dans de nombreuses régions d'Afrique ne sont pas seulement de faible qualité; ils sont également inaccessibles et répondent mal aux besoins des femmes enceintes. Une étude récente5 qui a été menée auprès de 378 établissements de santé dans six pays en développement, dont le Kenya, le Malawi, la Sierra Leone et le Nigeria, a indiqué que moins d'un établissement sur quatre qui étaient désignés pour assurer les SOUC étaient capables d'assurer les neuf fonctions nécessaires de signaux de soin, et que seulement 2,3 % avaient assuré toutes les sept fonctions de signaux. L'étude a conclu que les établissements de santé dans les pays étudiés ne possèdent pas la capacité de gérer

de manière adéquate les complications obstétriques d'urgence qui mènent à la mortalité maternelle et néonatale. Un document par Bamgboye et ses collègues dans ce numéro de cette revue6 signale également la mauvaise qualité et le manque d'accès aux SOUB et aux SOUC dans l'administration locale d'Ibarapa au sud-ouest du Nigeria, qui témoignent de la persistance et de la continuité du problème au niveau local.

La réduction de la mortalité maternelle dans les pays en développement a été l'un des objectifs inachevés dans les Objectifs du Millénaire pour le développement et reste l'un des principaux indicateurs pour mesurer la réalisation des objectifs du développement durable. Si l'on doit atteindre le but de réduire davantage le nombre de décès maternels d'ici 2030, il est maintenant temps de se concentrer sur l'amélioration de la qualité des services obstétricaux d'urgence, en particulier dans le contexte de l'Afrique subsaharienne. En raison de la reconnaissance du fait que les femmes continueront probablement à tarder dans la recherche de soins de maternité orthodoxe, nous sommes d'avis que l'amélioration de la qualité, la rapidité et la réactivité des SOU constituent des interventions les plus importantes qui doivent être entreprises pour réduire la mortalité maternelle et la mortalité néonatale dans la région africaine. Oladapo et al7, dans une étude récente ont passé en revue 998 décès maternels et 1451 cas évités de justesse au Nigeria ont fait remarquer que l'obtention de centres de soins de maternité ne suffit pas: il doit y avoir un plan d'action délibérément conçu ainsi que des services obstétricaux d'urgence efficaces pour prévenir les décès maternels et néonatals.

C'est dans ce contexte que le Women's Health and Action Research Centre (WHARC), une organisation nationale et non gouvernementale nigériane poursuit activement une série d'activités de recherche de mise en œuvre visant à améliorer la qualité des SOUB et SOUC dans le pays. Grâce au financement de l'Organisation mondiale de la santé8, le WHARC a réalisé un certain nombre d'études de formation quantitatives et qualitatives qui évaluent la qualité des SOUC dans huit centres de référence dans quatre zones géopolitiques du pays. L'évaluation a posé les questions importantes:1) Jusqu'à quel point les établissements de santé répondent-ils aux critères de l'OMS pour la prestation des services des SOUC? 2) Jusqu'à quel point les interventions reconnues pour la prévention de la mortalité maternelle et néonatale sont-elles disponibles dans ces établissements, et quel est le niveau de la compétence des prestataires de santé qui travaillent dans ces établissements par rapport à l'applicabilité et l'utilisation de ces interventions clés ?; et 3) comment est-ce que les femmes réagissent aux soins actuels, et qu'est-ce qu'elles voient-ils comme des obstacles à l'utilisation des soins de maternité orthodoxe? Les résultats de la recherche formative ont été diffusés et sont largement disponibles9, et illustre encore la rareté du type de SOUC nécessaire pour faire face à un énorme problème de cette nature.

La bonne nouvelle est que les parties prenantes clés, y compris les décideurs et les responsables gouvernementaux travaillent avec le WHARC pour concevoir des interventions efficaces pour combler les lacunes identifiées. Les interventions à facettes multiples et composites qu'on propose seraient testées pour vérifier leur efficacité dans un modèle de recherche quasi-expérimentale qui serait mis en œuvre dans des sites choisis au hasard à travers le pays. Si son efficacité´est confirmée, nous croyons que la participation des décideurs au niveau de toutes les phases de l'étude aidera à veiller à ce que les interventions soient intégrées dans les politiques et dans la mise à l'échelle partout dans le système des services médicaux du Nigeria.

Le WHARC entreprend également une étude parallèle, grâce au financement du Centre de Recherche sur le Développement International (CRDI) 10, au Canada, afin d'améliorer l'utilisation des centres de santé primaires (CSP) par les femmes enceintes et la qualité des SOUB offerts par les CSP au Nigeria. Bien que les CSP soient les points d'entrée dans le système des services médicaux du Nigeria, ces établissements ne sont guère à la disposition des femmes vulnérables, en particulier celles des populations rurales qui sont difficiles à atteindre dans le pays. La plupart des populations rurales nigérianes ont tendance à ne pas avoir des établissements de

soins secondaires et tertiaires; elles n'ont pas souvent de soins orthodoxe qui est fondé sur des preuves, et elles sont ensuite laissées à se servir des remèdes inefficaces fournis par des accoucheuses traditionnelles. A ce jour, seulement à peu-près 34% des femmes nigérianes sont assistées à l'accouchement par des accoucheuses qualifiées, avec la grande majorité des femmes enceintes qui accouchent à domicile ou chez des accoucheuses traditionnelles non-qualifiées. Pourtant, il est reconnu que la plupart des décès maternels surviennent dans ces circonstances où les femmes accouchent sans surveillance ou auprès des accoucheuses non qualifiées. Pour résoudre ce problème, le WHARC entreprend la recherche participative formative communautaire pour identifier la demande et l'offre des facteurs qui expliquent la mauvaise utilisation chez les femmes des CSP pour les soins maternels et néonatals dans le pays. En collaboration avec les parties prenantes nationales et internationales à l'Université d'Ottawa, Canada, le Centre espère utiliser les résultats de la recherche formative pour mettre en œuvre une série d'interventions visant à améliorer l'utilisation des CSP liés aux établissements d'orientation efficaces des femmes. Nous croyons que ceci aiderait à résoudre le problème du manque actuel d'accès aux soins de santé maternelle et infantile orthodoxes par la majorité des femmes rurales dans le pays.

Le message évident dans cet éditorial est qu'il y a la nécessité de faire évoluer un système des services médicaux efficaces dans les pays africains qui assurent des SOUB et des SOUC composites pour faire face aux urgences obstétricales qui mènent à la mortalité maternelle et néonatale. Il y a plusieurs années, le Professeur Kelsey Harrison, dans ses élégantes études prospectives menées à l'Université Ahmadu Bello à Zaria, au nord du Nigeria11 a rapporté que 90% des femmes qui sont mortes pendant la grossesse étaient des «urgences qui ne s'étaient pas préalablement inscrites». Il s'agissait des femmes qui n'avaient pas reçu des soins prénatals pendant la grossesse, qui ont essayé d'accoucher à domicile, mais n'ont pas réussi à le faire, mais qui se sont ensuite présentées à l'hôpital comme des situations d'urgence graves après avoir subi de graves complications de la grossesse. Après plus de 30 ans, le problème reste toujours le même, sans aucune tentative sérieuse pour le résoudre ni au Nigeria ni dans de nombreux autres pays africains. Si l'effort actuel pour promouvoir le développement humain à travers les Objectifs du Développement Durable doit être atteint, les pays africains doivent se concentrer sur l'effort de bien mettre en place la prestation efficace des soins obstétricaux d'urgence comme une action importante, les droits de l'homme et l'impérative de la justice sociale.

Conflit d'intérêts:

Aucun

Références

1. le FNUAP. Etablissement de normes pour les soins obstétricaux d'urgence et les soins du nouveau-né. Octobre 2014. Consulté de la norme http://www.unfpa.org/resources/setting.
2. l'UNICEF, l'OMS, le FNUAP. Indications générales pour la surveillance de la disponibilité et l'utilisation des services obstétricaux Fonds des Nations Unies pour les enfants, 1997. New York. [Http://www.amddprogram.org/v1/resources/UNGuidelinesEn.pdf]. Consulté mars 2016.
3. Thaddeus S, Maine D. Trop loin pour marcher - mortalité maternelle dans le contexte. Soc Sci Med 1994; 38: 1091-1110.
4. Okonofua FE, Abejide OU, Makanjuola RO: Mortalité maternelle à Ile-Ife, au Nigeria: Une étude des facteurs de risque. Studies in Family Planning, 1992; 23, 5: 319-324.
5. Ameh C, Msuya S, Hofman J, Raven J, Mathai M, Broek N van den. Situation des soins obstétricaux d'urgence dans six pays en développement de cinq ans avant les objectifs de l'OMD à l'égard de la santé maternelle et néonatale. PloS One 2012; 7 (12): e49938.
6. Bamgboye EA, Adebiyi AO et Fatiregun AA Evaluation des services des soins obstétricaux d'urgence dans la zone medicale d'Ibadan-Ibarapa, Oyo State, Nigeria.
7. Oladapo, O. et al. Lors de l'obtention, il ne suffit pas: une étude transversale à l'échelle nationale de 998 décès maternels et 1451 quasi-accidents dans les hôpitaux publics tertiaires dans un pays à faible revenu. BJOG: Revue internationale d'Obstétriques & de Gynécologie 2015.
8. Centre de recherche-action (WHARC) Santé et des femmes. Une intervention visant à améliorer la qualité des soins obstétricaux d'urgence dans les

structures de référence au Nigeria. WHARC OMS H9-TSA-282-Protocole final, 2015-2018
9. Women's Health and Action Research centre (WHARC). L'évaluation de la nature et la qualité des soins obstétricaux d'urgence pour prévenir la mortalité maternelle et périnatale dans 8 hôpitaux secondaires et tertiaires au Nigeria: Résultats d'une étude de recherche formative. Disponible à l'adresse: http//www.wharc-online.org
10. 1Women's Health and Action Research Centre (WHARC), Université d'Ottawa, Canada. L'augmentation de l'accès des femmes aux soins de grossesse qualifiés dans les centres de santé primaires pour réduire la mortalité maternelle et périnatale au Nigeria. Un projet financé par le CRDI.
11. Harrison K. 1985. Accouchement, la santé et les priorités sociales: une enquête sur 22,774 naissances à l'hôpital consécutives à Zaria, au nord du Nigeria. BJOG 1985; 92 Supplément 5, 1-11

COMMENTARY

Sexual and Reproductive Health needs Of LGBT

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Introduction

The Constitution of South Africa, Act 108 of 1996 prohibits any South African to be discriminated on the grounds of sexual orientation[1]. Recent evidences suggest that, the risk of acquiring HIV is higher in homosexuals than in people who engage in heterosexual sex in countries like South Africa with high epidemic[2]. Currently, very little is known about the epidemic amongst Lesbian, gay, bisexual and transgender people (LGBT) in the country and there is little advocacy towards the group's inclusion in HIV and STI prevention programmes[3]. This report focuses on the sexual and reproductive health needs of LGBT people. LGBT people are sexual minority group which includes: men who sleep with men, women who sleep with women, men or women who sleep with both sexes, as well as people who self-identify themselves as their opposite sex although their genitals show otherwise. The main sexual and reproductive health needs of LGBT in South Africa are summarised in the table below: See Table 1

Policies

The HIV/AIDS and STI National Strategic Plan (NSP) 2007-2011 is the policy that embraces the needs of LGBT in South Africa after lobbying and advocacy by LGBT sector.

Programmes

Although LGBT is touched on in the broad NSP, there are no specific and targeted programmes in place to address the needs of LGBT people[4].

Services

NGOs such as Triangle project support groups (Cape Town), Durban gay and lesbian community as well as OUT LGBT Well-being (Gauteng) render services for LGBT in specific constituents of South Africa. Treatment Action Campaign is also an NGO which is at the forefront of HIV human rights campaigning[4].

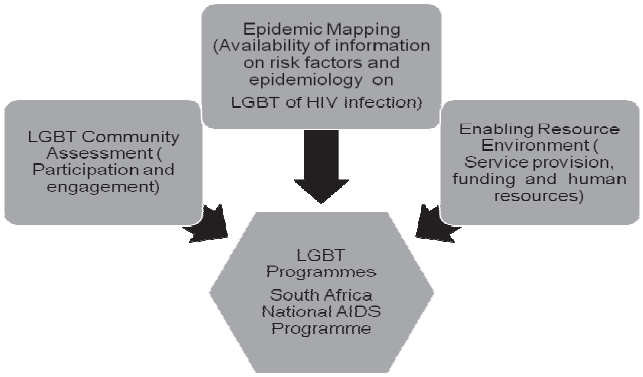
Method

This commentary was preceded by an effective overlook of the South African 1996 Constitution; peer reviewed journal articles on LGBT, homophobic attacks in South Africa, HIV/AIDS; and policy documents on sexual and reproductive health needs of vulnerable minority groups including LGBT. In order to establish evidence of sexual and reproductive health needs of the LGBT group in South Africa, the UNAIDS Country Harmonization and Alignment Tool (CHATS), was used as the framework to assess the sexual and reproductive health needs of LGBT in South Africa. This tool was used to assess how inclusive and participatory LGBT groups are in the South African national AIDS response; how effective coordination and funding partnerships for the national AIDS response is; and how to improve partnerships to strengthen the response to AIDS by assessing the needs of LGBT. The overarching goal in this is to factor the sexual and reproductive health needs of LGBT in South African national AIDS response so as to make the national AIDS response more comprehensive to be emulated by countries of similar settings.

Assessment of needs

The assessment of the needs of LGBT, who are often categorised as sex minorities can be done using the framework of the UNAIDS Country Harmonising Assessment Tool (CHAT) below:

Figure 1: A Framework for Assessing Evidence of Sexual and Reproductive Health needs of LGBT. Adapted from UNAIDS CHAT[5].



LGBT Participation in HIV/STI Responses

The total participation and involvement of a community is paramount to the successful implementation of policies and programmes[6]. However, if specific stakeholders who are the target of these policies and programmes are not actively and genuinely involved, the policy risks gaps to the detriment of this target group. The constitution of South Africa is one of the most advanced in Africa and frowns upon sexual orientation discrimination. LGBT marriages were made legal in 2006[4]. Yet, the societal attitude towards LBGT defeats the constitutional protection of the rights of LGBT[4].

The HIV/AIDS and STI National Strategic Plan (NSP) 2007-2011, provided an avenue for LGBT people`s thoughts to be considered in HIV/STI responses after engagement of all stakeholders including LGBT extensively[7]. However, this was made possible because of the critique and lobbying by some vocal LGBT activist groups for about 6 months after the first NSP draft was released[8]. In South Africa, LGBT people are classified as high risk group for HIV/STI[9] but that notwithstanding, they are somehow missing from all HIV/STI programmes and policies. The NSP does admit that the needs of LGBT people must be met by specific programmes tailored to suit their specific needs. Involvement of LGBT community in the implementation of NSP specific programmes development and the provision of dedicated funding for such programmes remain a challenge.

A national network of LGBT people called the Joint Working Group embarked on studies to address the needs of its members at the constituency level. In 2006, activists played an instrumental role to cause the review and revision of the screening tool for blood donors of the National Blood Transfusion Services Policy[10].

Mapping the epidemic and key risk factors

The direct link between LGBT and heterosexual HIV/STI transmission is unknown in South Africa.

Table 1: Indicating the Needs of LGBT People in South Africa

NEED	COMPONENTS
Participation and engagement in HIV/STI responses	• Genuine involvement in design of policies and programmes
Mapping HIV/STI epidemic, including the information on key risk factors	• HIV/STI prevalence among LGBT • Risk behaviour information and education
Enabling environment for service provision	• Specific outreach to LGBT • Train staff to work effectively with LGBT individuals • Avoidance of stigma and discrimination • Counselling and testing availability and accessibility • Initiatives to promote prevention and care for HIV/STI LGBT people.

The Demographic and Health Survey Indicators for LGBT people verses heterosexual counterparts remain non-existent in South Africa. Information on the incidence and prevalence of HIV/STI and associated risk factors among LGBT is very limited in South Africa[12]. The proportion of LGBT people who engage in same sex or sex with both genders remains unknown. The stigma and discrimination characterised by HIV/AIDS has made it more challenging, characterising it among LGBT people who experience similar stigma[13].

There have been several surveillances done on pregnant women attending antenatal clinics and household surveys in South Africa. However, none

of these surveillances focussed questions on LGBT sexual activities. This could be solely because of concerns about privacy[13].

Table 2: Showing Estimates of HIV Prevalence among Adults aged Between 15-49 Years in South Africa.

Year	Source	Adult (15-49 years)	Adult men (15-49years)	Adult women (15-49 years)
2002	[14]	15.6%	12.8%	17.7%
2005	[13]	16.2%	11.7%	20.2%
2007	[15]	18.8%	15.5%	22.0%

The above shows that different studies lack the specific information on the prevalence of HIV/STI among LGBT in South Africa.

Research conducted by the Triangle Project and the Centre for applied Psychology among 948 LGBT people in Cape Town[16], showed that 12% of men and 1% of women are HIV positive; 15% of men and 5% of women had an STI in the previous 2 years; 23% of men and 31% of women had never tested for HIV among people aged between 16-24 years, 44% had never tested for HIV. Specific research like this targeted at LGBT people is a good step for surveillance of LGBT people. However, findings from this research cannot be generalised in South Africa and the limitation of this could be the sampling method used.

Enabling environment for service provision, funding and human resources

Although the South African constitution and political environment promote the rights of LGBT people, this has not caused a turnaround in the access to healthcare services and resources[8]. A state-run HIV prevention campaign was challenged by LGBT organisations in South Africa in 2005, but these challenges were ignored and no messages were directed towards the LGBT community[18]. Stigma and discrimination at healthcare facilities also compound the isolation of the LGBT community from programmes[18]. Currently, health services for LGBT people are provided by LGBT organisations whose source of funding are from foreign donors[4]. Information gathered by LGBT organisations suggest that most LGBT people are asked questions bias to heterosexuality by health professionals when they go for treatment and hence delay in presenting complications like haemorrhoids, rectal bleeding and genital infections because of fear that their sexual orientation would be discovered[19]. Health workers in South Africa do not receive the specific additional training to meet the psychological and physical needs of LGBT people in order to show the needed compassion and acceptance of whom they are[4]. Nonetheless, LGBT organisations have bridged the gap in the last years. For instance, a project called the Triangle project showed satisfaction with medical practitioners among homosexuals who attended clinic in Cape Town[20]. However, a study like this is not a general representation of the issue in South Africa as the research participants were already members of the Triangle project support group and there may have been problems with the methodology of the research.

Context

Political

The Apartheid era in South Africa was noted to be a dictatorial society and strong emphasis was placed on laws regulating sexual behaviour. There was criminalisation of sex between men and pornography until 1996[21]. There is now freedom of political association, speech and sexual preference in this post-apartheid era[4]. South Africa, a member of the United Nations has, like all members, aligned towards achieving the Millennium Development Goals which has 4 of its components as direct bearing on sexual and reproductive health. South Africa is therefore required to protect and respect the sexual rights of its citizens regardless of sexual orientation. LGBT issues are virtually not touched on in the South African Department of Health. There is no specific LGBT healthcare provided by government as against LGBT organisations that seem to provide the only care for this group in the country with resource limitations[22]. The government however focuses on the mainstream sexual and reproductive health of its citizens.

Socio-cultural

In South Africa, HIV and STI are commonly viewed as invasion of the body by dirt which makes the blood dirty[23]. Sex-related issues elicit negative responses such as feeling of guilt and shame. They are thus demanded not to be discussed in public. Sexual behaviours deviating from the "normal" are severely criticized across the country[4]. Heterosexism is viewed in South Africa as the "normal" and is all over the media, in religious teachings, education as well as healthcare. As such, there is usually a neglect of LGBT in policy discussions such as HIV/STI policies[22]. Prejudice and silence on LGBT practices has thus become the order of the day. Being lesbian or gay was considered and is still considered as a "sickness" and very un-African[4].

It is worthy to note that, it is not possible to compare South African LGBT people and communities to those of developed worlds like United Kingdom, Australia and the United States of America. This could be because of the diversity of culture and social backgrounds in these advanced countries. LGBT identities in South Africa differ with respect to race[22]. Until recently, the most vocal LGBT people were white males predominantly placed in high social class. However, the large majority of LGBT individuals are poor unemployed blacks, a true reflection of the South African community in general[24]. These under-resourced black LGBT are deemed in the society as the most vulnerable subsets of the community often under-researched. To date, most LGBT research is primarily focussed on rich, white and vocal people[4].

Recommendations

Based on the findings above, I will suggest the following recommendations to the South African National AIDS Commission:

1. The LGBT community should be closely involved in the formulation of programmes and policies. Involvement will ensure that policies and programmes enacted will respect and protect the rights of the LGBT community to privacy on the grounds of their sexual orientation.
2. Sentinel surveillance should be initiated to determine the prevalence of HIV/STI among LGBT. This should also include research on the contexts and social situations of HIV/STI transmission and the appropriate HIV/STI prevention and care strategies. These researches will provide insights into barriers to care and expose funding constraints in health services as well as behaviours of health care professionals.
3. There should be a supportive programme development which should include dedicated financial and human resources, appropriate guidelines and improved access to and coverage of HIV/STI prevention, treatment and care services for LGBT. Acceptance of LGBT and safer- sex campaigns and skills training, including the use of condoms, voluntary counselling and testing as well as the promotion of lower-risk sexual practices are essential.

Conflict of Interest

I confirm that there are no conflicts of interest.

Author's Contribution

AM carried out the literature review on LGBT in South Africa and solely wrote all the sections of this work from the introduction, assessment of needs, context and recommendations. AM read the final manuscript and approved before submission.

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References

1. REPUBLIC OF SOUTH AFRICA. 1996, Constitution of the Republic of South Africa. [online]. [Assessed 19 May 2012]. Available from :http://www.info.gov.za/documents/constitution/1996/a108-96.pdf
2. BEYRER, C. 2008. Hidden yet happening: the epidemics of sexually transmitted infections and HIV among men who have sex with men in developing countries. *Sexually Transmitted Infections*, 84(6), pp. 410-412.

3. REPUBLIC OF SOUTH AFRICA. 2007. HIV & AIDS and STI Strategic Plan 2007-2011. [online]. [Assessed 21 May 2012]. Available from: http://www.info.gov.za/otherdocs/2007/aidsplan 2007/khomanani_HIV_plan.pdf.
4. HUMAN SCIENCES RESEARCH COUNCIL. 2009. From social silence to social science. Same-sex sexuality, HIV/AIDS and gender in South Africa. [online]. [Assessed 21 May 2012]. Available from: http://www.hsrcpress.ac.za/product.php?productid= 2265&freedownload=1.
5. UNAIDS. 2007**.** Country Harmonization and Alignment Tool (CHAT). [online]. [Assessed 19 May 2012]. Available from: http://data.unaids.org/ pub/report /2007/jc1321_ chat_en.pdf.
6. LEVENSON, J.S. 2003. Policy interventions to combat sexual violence: community notification and civil commitment. *Journal of Child Sexual Abuse*, 12(3-4), pp. 17-52.
7. KAPP C. 2007. South Africa unveils new HIV/AIDS plan. *Lancet Worlds Report*, 369(9573), pp. 1589-1590.
8. RISPEL, L.C., and C.A., METCALF. 2009. Breaking the silence: South African HIV policies and the needs of men who have sex with men. *Reproductive Health Matters*, 17(33), pp. 133-142.
9. SHISANA, O., A. BHANA, C. CONNOLLY, S. JOOSTE, W. PARKER, V. PILLAY, T. REHLE, L. SIMBAYI and K. ZUMA. 2007. South African national HIV prevalence, HIV incidence, behaviour and communication survey. Cape Town: HSRC Press.
10. HEALTH SYSTEM TRUST. 2007. Blood donation: FDA grapples with same issues as SA. [online]. [Accessed 22 May 2012]. Available from: http://www.hst.org.za/news/ blood-donation-fda-grapples-same-issues-sa
11. VAN HARMELEN, J., R. WOOD, M. LAMBRICK, E.P. RYBICKI, A.L. WILLIAMSON and C. WILLIAMSON. 1997. An association between HIV-1 subtypes and mode of transmission in Cape Town, South Africa. *AIDS*, 11**(1)**, pp. 81-87
12. CLOETE, A., L.C. SIMBAYI, S.C. KALICHMAN et al., 2008. Stigma and discrimination experiences of HIV positive men who have sex with men in Cape Town, South Africa. AIDS Care, 20**(9)**, pp. 1105-1110.
13. SHISANA, O., T. REHLE, L.C SIMBAYI et al., 2005. South African National HIV prevalence, HIV incidence, behaviour and communication survey. Human Sciences Research Council Press, Cape Town.
14. SHISANA, O., and L. SIMBAYI et al. 2002. Nelson Mandela/ HSRC study of HIV/AIDS: South African national HIV prevalence, behavioural risks and mass media household survey, 2002. Cape Town: HSRC Press
15. ACTUARIAL SOCIETY OF SOUTH AFRICA. 2003. Projections of HIV indicators abstracted from the Actuarial Society of South Africa. [online]. [Accessed 23 May 2012]. Available from: http://www.assa.org.za/aids/content.asp?id=1000000 449
16. RICH, E. 2007. Levels of empowerment among lesbian, gay, bisexual, transgender (LGBT) people in Western Cape, South Africa. Cape Town: Triangle Project.
17. Vilakazi, 2006
18. JOHNSON, C.A. 2007. Off the map: How HIV/AIDS programming is failing same-sex practising people in Africa. New York: International Gay and Lesbian Human Rights Commission.
19. WELLS, H. and L. POLDERS. 2005. Gay and lesbian people's experience of the health care sector in Gauteng. Joint Working Group Research Initiative, conducted by OUT LGBT Well-being in collaboration with the UNISA Centre for Applied Psychology. Pretoria.
20. CROWE, D. 2005. A descriptive report of selected data collected during the Living PoZitively support group survey conducted by the Triangle Project. Cape Town: Triangle Project.
21. NEL, J.A. 2005. Hate crimes: A new category of vulnerable victims for new South Africa: In DAVIS, L., and R. SNYMAN (Eds). Victimology in South Africa. Pretoria: JL van Schaik.
22. SAMELIUS, L., and E. WAGBERG. 2005. A study of policy and administration: Sexual orientation and gender identity issues in development. [online]. [Assessed 26 May 2012]. Available from: http://www.sida.se/Global/Nyheter/SIDA4948en_Sexual_Orientation_ web%5B1%5D.pdf
23. MEYER-WEITZ, A., P. REDDY, W. WEIJTS, B. VAN DEN BORNE and G. KOK. 1998. The socio-cultural contexts of sexually transmitted diseases in South Africa: Implications for health education programmes. *AIDS Care*, 10(2), pp. 39-55
24. REID, G., and T. DIRSUWEIT. 2002. Understanding systemic violence: Homphobic attacks in Johannesburg and its surroundings. *Urban Forum*, 13(3), pp. 99-126

REVIEW ARTICLE

Review of Sexuality Studies in Africa: Setting a New Post-2015 Research Agenda

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ABSTRACT

At the nexus between reproductive health, population and development is the subject of sexuality which has generated extensive discourse in the past two decades. In this paper, we review Africa sexuality studies published between 1994 and 2015 with the aim of synthesizing the available evidence and suggesting a new research agenda for post-2015. Review findings showed that previous studies covered the five components of sexuality – practices, partners, pleasure/pressure/pain, procreation and power to different extents. Risky sexual behaviour was prevalent from adolescence till older ages. Literature on pleasure, pain, procreation and power reflect the complex diversity driven by traditional norms, gender roles and attitudes across the continent. Knowledge gaps were highlighted and new agenda suggested for sexuality research. *(Afr. J Reprod Health 2016; 20[1]: 21-28).*

Keywords: sexual behaviour, sexual violence, sexual pleasure/satisfaction, gender roles, socio-cultural norms, sub-Saharan Africa.

Résumé

Au centre du lien entre la santé de la reproduction, la population et le développement est le sujet de la sexualité qui a suscité un grand discours au cours des deux dernières décennies. Dans cet article, nous passons en revue les études sur la sexualité en Afrique qui ont été publiées entre 1994 et 2015 dans le but de synthétiser les éléments de preuve disponibles et de proposer un nouveau programme de recherche pour l'après-2015. Les résultats de cet examen ont montré que les études précédentes ont porté sur les cinq composantes de la sexualité – des pratiques, des partenaires, le plaisir / la pression / la douleur, la procréation et la puissance à des degrés divers. Le comportement sexuel à risque était très répandu dès l'adolescence jusqu'à un âge plus avancé. La documentation sur le plaisir, la douleur, la procréation et la puissance reflète la diversité complexe soutenue par les normes traditionnelles, les rôles des sexes et les attitudes à travers le continent. Des lacunes dans les connaissances ont été mises en évidence et un nouvel ordre du jour a été proposé pour la recherche sur la sexualité. *(Afr. J Reprod Health 2016; 20[1]: 21-28).*

Mots-clés: comportement sexuel, violence sexuelle, plaisir sexuel/ satisfaction, rôles des sexes, normes socio-culturelles, Afrique sub-saharienne.

Introduction

Since the introduction of the Millennium Development Goals (MDGs), the challenges facing sexual and reproductive health have been at the forefront. Five out of the eight MDGs were related in some ways to sexual and reproductive health. These were eradication of poverty and hunger, promotion of gender equality and women empowerment, reduction of child mortality, improvement of maternal health, combating HIV/AIDS, malaria and other diseases[1]. The key to addressing the challenges and goals related to sexual and reproductive health is a better understanding of sexuality. Research has addressed aspects of sexuality including its definition, components and associated factors in African contexts[2-4]. While research has assisted in the partial acheivement of the MDGs, many African countries were unable to meet the goals. This failure is indicative of the additional work that research, policy and practice needs to do to further development on the continent. As the international community set a new agenda for post-2015, it is necessary to appraise the knowledge gained from research in the past two decades and make suggestions for sustaining or improving the progress made so far.

Apart from a book on review of sexual behaviour in sub-Sahara Africa published in the

late 1980s[4], previous reviews of sexuality studies in sub-Saharan Africa focused on sexual behaviour of in-school adolescents and youths[5], school-based sexual health interventions to prevent STI/HIV[6], parent-child communication about sexuality and HIV/AIDS[7]. While these past reviews have contributed in no small measure to shaping the search for possible solutions to sexuality challenges, however, an inclusive examination of literature related to aspects of sexuality such as sexual practices, partners and pleasure, pressure and pain is necessary. This review covers this broader context and therefore aims to synthesize existing research on sexuality in Sub-Saharan Africa over the past two decades, identify knowledge gaps and subsequently suggest a research agenda for post-2015.

Methods

Literature Search strategy

Pubmed, Medline, African Journals Online (AJOL), Bioline international and POPLINE databases were searched for original articles published in English Language between 1994 and 2015. Different combination of the following search terms were used: sexuality, sexual behaviour, sex practices, sexual pleasure, sexual satisfaction, sexual enjoyment, sexual assault, sexual coercion, forced intercourse, unwanted sex, gender roles, gender norms, and sub-Saharan Africa. Table of contents of major journals publishing articles in the subject area were also searched. These include: African Population Studies, African Journal of Reproductive Health, Reproductive Health Matters among others.

Results

Findings from the review are described in a systematic manner under sub-headings that capture the five components of sexuality as articulated by Gupta[8]. These are: practices, partners, pleasure/pressure/pain, procreation and power.

Sexual practices

At least one of three indices were commonly used to describe sexual behaviour. These indices were: condom use at last sex, multiple sexual partnership and sex with casual or commercial partner. Age at sexual debut/initation was also reported in some studies. In this regard, the topical issues can be grouped under the following sub themes: adolescents and youth sexual behaviour, adult male and female sexual behaviour, sexual behaviour in special groups (such as older adults and persons living with HIV).

Sexual behaviour among adolescents and youths

Though there were variations in the age range for most of the studies on adolescents, many of them were among respondents aged 10–24 years. Male-female differences in condom use, age of sexual debut and multiple partnership were commonly reported. There were a few multi-country studies on adolescent sexual behaviour based on nationally repsentative data such as the demographic and health surveys (DHS) and AIDS indicator surveys[9,10]. About a quarter have initiated sex before age 15 years, though the proportion declined over time. Female sex and low level of education were associated with early sex debut. Multiple sexual partnerships though decreased over time, was more common among males and urban residents.

Madise et al contributed evidence on the link between poverty and risky sexual behaviour among adolescents using nationally representative data from Burkina Faso, Ghana, Malawi and Uganda[11]. Girls in the wealthiest wealth quintile in Burkina Faso, Ghana and Malawi had later sex debuts compared to those in the poorest quintile. Among boys, wealth was not significant except in Malawi where those in middle quintile had earlier sexual debut. There was no association between wealth status and multiple sex partnership.

The surge in the interest of researchers in adolescent sexual behaviour is related to the HIV/AIDS and STIs prevention programmes. As a follow up to this, studies were conducted to assess the extent to which correct knowledge of HIV/AIDS has resulted in behaviour change. Unfortunately, evidence from Nigeria[12], Botswana[13] and Uganda[14] showed that being knowledgable about HIV/AIDS do not necessarily translate into safe sex practices by adolescents.

Though migration is the least researched component of population change in sub-Saharan Africa, evidence emerging from an urban health and demographic surveillance system in a slum area of Nairobi suggests that there was no significant difference in risky sexual behaviour between migrant and non-migrant youths[15]. Further studies would be required to ascertain the generalizability of this observation. Out of school youths constitute a special group whose sexual behaviour have also been studied. Kunnuji found that food deprivation was a significant predictor of early sex debut and multiple partnerships among youths in a slum area of Lagos State, Nigeria[16]. Other factors that predisposes out-of-school youths to risky sexual behavior include alcohol consumption and influence of peer pressure[17].

Uchudi et al conducted a multilevel analysis of the determinants of multiple sexual partnerships in 20 SSA countries using DHS data collected in 2003-2008[18]. The results showed that individual factors (early sexual initiation, young age, education, media exposure and working for cash away from home) and cultural context (permissive sexual norms) are the main determinants of multiple sexual partnerships. These patterns of results point to the need for life course perspectives on the determinants of sexual behavior.

The advent of the internet and other information technology platforms seems to have increased the complexity of the dynamics of sexual behaviour among youths. These technological tools have resulted in a new phenomenon known as cybersex–involvement in online sexual activities. A study among youths and adolescents in Lagos, Nigeria revealed that about 50% were involved in online sexual activities such as visiting pornographic sites, sex chats, cybering and satisfaction of sexual urge via the internet[19]. Intensity and time of internet use were the strongest predictors among other factors.

While sexual behaviour among adult females has received greater attention from researchers, the experiences of males has more or less being neglected, aside from few studies in which gender differences are reported. A qualitative study among sexually active men and women in Mozambique revealed that traditional norms and beliefs about masculinity played strong roles in forming male sexual behaviour[20]. These community norms and beliefs about male sexual behaviour are not limited to Southern Africa alone. Orubuloye et al in a large community-based mixed method study in Nigeria found that most of the men and women believed that though sexual activity are permitted only in a marriage, men are by nature sexually polygynous[21]. This was corroborated by Mitsuga et al who reported that about 1 out of 10 sexually active Nigerian men were involved in extra-marital affairs[22].

Sexual behaviour among other groups

Due to its connection to reproductive health, studies on sexual behaviour were most often conducted among men aged 15-59 years and women aged 15-49 years. Evidence shows that sexual activity is common among older persons. This was demonstrated by results from Malawi which indicated that 26.7% of women and 73.8% of men aged 65 years above were sexually active[23]. Findings from a qualitative study among older adults (age 50-75 years) in southwestern Nigeria also showed that sexual activity is viewed as important in old age and there were gender differences in sexual desire/pleasure[24]. How older adults go about satisfying their sexual desire is therefore an important research question deserving further investigation especially in high HIV prevalence settings.

Among sex workers, unsafe sex practices were associated with alcohol consumption as revealed by a recent study in Uganda[25]. Also, there are speculations that initiation of antiretroviral treatment promotes risky sexual behaviour in HIV positive persons[26]. The evidence is not consistent given the different findings from diverse contexts[27,28].

Sexual partnership

Studies on different forms of sexual partnership seems to be scarce in Sub-Saharan Africa. This may not be unconnected with the perceived stigma and unfavourable environment for these type of sexual relationships. For instance, South Africa is the only country in the sub-region that has decriminalize same-sex relationships. Rabie et al

investigated the construction of sexuality among young gay men in semi-rural South Africa and found that the respondents constructed their sexuality as "being like a woman"[29]. Another South African study explored condom use experiences and reported on factors that inhibit and facilitate usage[30]. Factors found to aid condom use include alternative sexual strategies while reduced sexual pleasure was reported as discouraging condom use. Even though, global evidence suggest that this group have higher risks of HIV, it is however very difficult to conduct studies among them[31,32].

Pleasure, Pressure and Pain

The quest for sexual pleasure and enjoyment/satisfaction is a major factor determining how men and women engaged in sexual acts. The literature on this aspect of sexuality appeared to be skewed towards certain issues. This review showed that sexual satisfaction/pleasure has most often been investigated in regard to contraceptive use[33], male/female circumcision[34] and sexual functioning among survivors of non-communicable diseases such as diabetes[35] and stroke[36]. In addition, sexual pleasure was found to be studied while investigating different sex practices especially among women. For example, Bagnol et al reported on two sex practices among Mozambiquan women–elongation of the labio minora and insertion of natural or synthetic products into the vagina (dry sex)[37]. These practices were usually undertaken for female identity and enhancement of sexual pleasure. Another study among women in Uganda and Tanzania revealed that intravaginal practices were driven by cultural norms and social expectation on hygiene, sexual pleasure, and relationship security among others[38]. Though these practices varied from culture to culture, the motivations were very similar with sexual pleasure featuring repeatedly[39,40].

The promotion of male circumcision as a strategy for HIV prevention has also attracted the interest of researchers to investigate the effect of male circumcision on male sexual functioning and satisfaction[34]. Evidence is however mixed. Results from Kenya suggest that male circumcision does not have any negative effect on sexual satisfaction or functionning[41]. A study in Malawi found that female partners of circumcised men had greater sexual satisfaction[42] while another study in KwaZulu-Natal, South Africa found that voluntary medical male circumcision was associated with better perception of masculinity, male identity, sexual performance and pleasure[43]. Concerning female circumcision, it is widely condemned in the reproductive health circle. Though the evidence on its effect on sexual functioning is inconclusive, however, a study in Lagos, Nigeria showed that female genital cutting adversely affect their sexual functioning[44].

The search for interventions to control or eradicate pressure/pain in sexuality must have contributed to the quantity of research in this area. Terms used to connote pains and pressures include: sexual coercion, unwanted sex, non-consensual sex, forced intercourse, sexual assault, sexual abuse, sexual harrassment, and sexual violence. While prevalence varied widely depending on the context and definition of the term used, the summary is that these negative experiences are quite common in Sub-Saharan Africa. While evidence on causes are sparse, there is overwhelming facts to show that male intimate partners are the greatest perpetrators and female partners are the victims[45,46]. There were evidence to show that females also inflict pains/pressures on their male counterparts[47,48]. Findings also suggest that the main driving force behind these attitude is traditional norms and cultural beliefs that portray men as being superior to women and therefore can use every means to get whatever they want including sexual intercourse[49-51]. A common denominator for most of the pain/pressure experiences is alcohol use by either partners. In addition, males with multiple partners were very likely to inflict pain/pressure in form of coercion, forced sex, unwanted sex etc[52,53]. Sexually transmitted infections, HIV/AIDS, depression, low self-esteem and post-traumatic stress disorder are common consequences of these acts[50,54,55]. In the light of these, programmes on protection of women reproductive health and rights need to be sustained. Research efforts on innovative and effective interventions have also become imperative.

Power and procreation

Power is the most important component of sexuality because it influences how all the other components are expressed and experienced[8]. For instance, power determines whose interest superseed in procreation (number of children), contraceptive use (sex practices), and sexual pleasure/pain. Power as a sexuality component have been operationalised in terms of gender-imbalance in decisionmaking on sexual relationships. Specifically, power is viewed as ability to make choices[56]. The distribution of this ability between men and women makes the concept of power and gender to be intertwined. This complex relationship underscore the relevance of the third millenium development goal that focussed on gender and women empowerment. The extant evidence is that unequal power balance in favour of men is driven largely by hegemonic masculinity and the predominant patriachal beliefs and structure in sub-Saharan Africa[21,57,58]. Caldwell et al argued based on evidence from several countries that while constructs/definition of adolescence was driven by international, economic and social forces, in sub-Saharan Africa, contemporary adolescence was been shaped by the traditional culture with implications for sexuality and reproduction[59]. This notion is supported by several empirical studies especially those that investigated gender-based violence, condom use, and HIV. Even though, females are on the receiving end of males domination, they also believed it is right because that is what the traditional norms dictates[58,60]. Evidence from Post-apartheid South Africa showed that change is possible but challenging. A qualitative study among undergraduates showed that though there have been dramatic changes in gender norms and recognition of women rights, women were still restrained by traditional construction of gender roles[61]. Gender power imbalance is one area that need urgent intervention in sexual and reprodcutive health.

Conclusion

Knowledge gap and research agenda

In view of the available evidence, some knowledge gap which could form the fulcrum of a new research agenda are highlighted. Majority of the existing studies do not provide useful information on the characteristics of sex partners apart from the type (regular, casual or commercial). It is necessary to collect richer data on the identity of sex partners, circumstances leading to formation and dissolution or concurrency of sexual relationships. Since sexuality is partly driven by cultural norms and beliefs, qualitative studies exploring the roles/influence of contextual characteristics are needed. Definitely, such studies would need to go beyond the conventional cross-sectional designs. This should be with a view to explore how sexual identity, orientation, practices and other behaviour evolve especially in adolescence and younger ages.

Further evidence are needed on determinants of specific sexual behaviour. This becomes important given the point that knowledge of HIV/AIDS do not result in safe sexual practices. A relevant question is why do men/women adopt certain practices/ behaviour? Has traditional/cultural norms about sex and sexuality changed over time and how do such changes affect sexual and reproductive health? Since family setting also affect adolescent sexual behaviour and family changes is one of the consequences of population dynamics; the consequences of family change for adolescent sexuality need to be better described. With the onset of phenomenon such as cybersex, design of prevention programmes would benefit from an in-depth knowledge of the aspect of sexuality most affected by technological advancement. For instance, does involvement in cybersex have any implication for safe sex practices?

More work need to be done in the area of data collection methodologies. Many of the existing studies are based on the conventional cross-sectional designs which is obviously deficient for causal inference. Mixed method designs that use qualitative techniques can be deployed to provide deeper understanding about sexual behaviour. Besides, health and demographic surveillance systems represent a fertile source of longitudinal data with which