

## ADVOCATING FOR ADOLESCENT REPRODUCTIVE HEALTH: ADDRESSING CULTURAL SENSITIVITIES

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### Introduction

Of the one billion young people worldwide, most still lack adequate reproductive health care. Programs to give youth the information and means to protect themselves against unwanted pregnancy and sexually transmitted infections often face resistance because they challenge deeply held cultural beliefs about sex, parenting, and the roles that men and women play. Such efforts are controversial in almost all countries and at all levels of society, provoking intense debate at international conferences, within national parliaments, in local communities, at schools, and inside the family. The success of adolescent reproductive health programs depends largely on recognizing these underlying beliefs, understanding how they manifest themselves as barriers, and employing a range of culturally sensitive strategies to address these obstacles. Each program faces a unique set of obstacles, thus requiring youth advocates to tailor their approach to local circumstances.

### What are the roots of the controversy?

**Beliefs about sexuality.** Traditions in many countries are in flux, particularly in those areas of the developing world undergoing rapid economic and social change. Nevertheless, all societies have “rules” about the sexuality of young people, and most discourage premarital sexual activity and childbearing outside of marriage.<sup>3</sup> In Asia, for example, many societies maintain strong taboos against premarital sex and discussion of sexuality among the young. Providing information and services to unmarried youth on sexuality and reproduction remains highly controversial in places as di-

verse as China,<sup>1</sup> India,<sup>2</sup> and Indonesia. Because adolescent sexuality is felt to threaten the social order in many cultures, a strong element of fear surrounds young people and their sexuality. One result is the common concern among adults that adolescent reproductive health programs will encourage adolescent sexual activity. Many societies also expect young men and young women to express their sexuality differently. Prohibitions on premarital sexual activity of adolescent girls are often far stronger and more energetically enforced than those placed on boys.<sup>4,5,6,7,8,9,10,11,12</sup>

**Beliefs about the role of the family.** Clashing beliefs about the role of the family, versus the role of health professionals, educators, and the state also generate controversy. Young people have traditionally learned about sex and reproduction through the extended family or via a network of neighbors or friends, often in conjunction with well-defined rituals or rites of passage. Sex education in the schools can be perceived as a challenge to these more traditional routes. Furthermore, most societies do not grant adolescents full legal, economic, and social rights. Adult control over young people’s access to health education and services, including contraception, is seen as natural. Programs that seek to bypass this control for public health reasons often face stiff resistance.<sup>13,14,15,16</sup>

### What barriers result?

**Restrictive laws and policies.** Responding to perceived public wishes to restrict the actions of young people, politicians and government officials often enact laws and formal policies that limit their access to reproductive health care. Such regulations usually require a minimum age, parental

consent, or that a person be married to receive the service.<sup>17,18,19,20</sup> In the United States, for example, most states require women under 18 to obtain the consent of or notify one or both parents prior to an abortion.<sup>21</sup> In many countries of the Middle East and North Africa, laws restrict access to sexual and reproductive health services for young people, and government programs are uncommon.<sup>22,23</sup> Omitting any reference to youth in national health policies and service guidelines can similarly limit access, since health workers in many countries tend to be cautious about providing a service to young people without some legal backing.<sup>24</sup> Media censorship can also restrict the flow of information to youth. In India, censors blocked television advertisements for a socially marketed condom.<sup>25</sup> Similarly, government officials in Zambia initially rejected advertisements for condoms as too explicit for a youth audience.<sup>26</sup>

**Informal barriers.** Even where no formal restrictions exist, many health workers refuse or are reluctant to provide unmarried or childless young people—especially young women—with contraceptives. Teachers and other professionals who interact with youth share similar biases.<sup>27,28,29,30,31</sup> In Egypt, for example, most doctors are unwilling to prescribe contraceptives to a married adolescent girl until after she has had her first child.<sup>32</sup> In Senegal, clients posing as unmarried adolescents were denied contraceptives after requesting them.<sup>33</sup> In Latin America, despite a program and policy climate that is more positive than in other regions, many individual health workers still refuse to provide youth with family planning information and services.<sup>34,35,36</sup>

**Differential treatment for boys and girls.** Many field staff act on underlying biases that limit girls' access to care. In Jamaica, for example, health workers are much more likely to serve boys than girls. One study found that less than one-fifth of Jamaican providers would give condoms to girls compared to more than two-thirds who said they would give condoms to boys.<sup>37</sup>

**Community opposition.** Traditional and religious leaders—who view themselves as the repository and transmitters of community values and beliefs—are often in the forefront of opposition to adolescent reproductive health programs. Religious groups, for example, have strongly opposed school-based sexuality education in the United States, Mexico, and Kenya.<sup>38,39</sup> Despite an improving climate for adolescent reproductive health programs in parts of sub-Sa-

haran Africa—particularly as societies recognize the enormous impact of the HIV/AIDS crisis on young people—resistance from religious and traditional leaders are features of most countries.<sup>40,41,42,43</sup>

### What strategies can overcome these obstacles?

**Inform the debate.** Accurate and understandable information can defuse conflict and mobilize support for programs by demonstrating the magnitude of adolescent health problems and by allaying fears that programs promote sexual activity. Support for HIV/AIDS prevention programs in sub-Saharan Africa has been bolstered by information on the size of the epidemic and its effect on young people.<sup>44</sup> In Zambia, for example, CARE used a participatory learning and action approach to analyze adolescent health problems in low-income urban areas and to design appropriate programs. An important result of the assessment was to raise awareness of adolescent reproductive health problems among health workers, parents, and other community members.<sup>45</sup> In Mexico, a successful effort to establish a nationwide sexuality education program relied heavily on research to overcome opposition from both organized religious groups and politicians fearful of public opinion.<sup>46</sup> A key study showed that students taking a pilot sex education course were more likely to use contraception but no more likely to have sex than students who did not take the course. As another powerful tool in gaining support from politicians, advocates used a public opinion poll showing widespread, though muted, support among parents for improving sexuality education. By publicizing the high level of public support for such programs, advocates helped embolden many supporters who might otherwise have remained silent.<sup>47</sup>

**Mobilize the community.** Particularly where resistance may initially be high, community involvement in the design and implementation of adolescent reproductive health programs has proved successful. One project, working in a rural area of Peru, used the community “self-assessment” approach to design culturally appropriate adolescent sexuality programs.<sup>48</sup> Project staff gathered information on youth concerns from young people and key adults, including parents, civic authorities, teachers, health workers, and clergy. Adults and youth formed adolescent health committees to identify and prioritize adolescent sexual and reproductive

health needs and to propose concrete actions. A community mobilization approach has proved successful in a wide range of countries, including Bangladesh, Burkina Faso, Egypt, and Kenya.<sup>49</sup>

**Communicate openly.** Open communication—through the mass media and at a more personal level—helps remove the taboo from discussing adolescent sexuality, and also can provide information, redefine social norms, and change attitudes and behaviors.<sup>50,51</sup> To address anticipated resistance to a new sexuality education program, government officials in Tanzania launched a mass media campaign using radio, television and newspapers. The campaign played a key role in bolstering public support for the program and gaining community acceptance.<sup>52</sup> Multicountry research from the Women and AIDS Research Program found that structured discussions among small groups of women made it easier to discuss sensitive topics of sexuality and reproduction. For example, teachers in Zimbabwe successfully used such techniques as an alternative to typical classroom interactions.<sup>53</sup>

**Involve youth.** Young people are among the most effective advocates for change, and several programs have channeled their energy and enthusiasm into helping modify social norms and lower barriers to youth programming. Members of the Youth Advocacy Movement of the Bahamas Family Planning Association produced a “photojournal” depicting issues of importance to youth. They presented these to Ministry of Health officials to highlight youth concerns as part of a broader campaign to advocate for greater attention to youth health.<sup>54</sup> In the Dominican Republic, advocacy by youth, including visits to legislators, a letter-writing campaign to local and national government officials, and rallies and other events were key to the recent passage of a national youth law.<sup>55</sup> In Brazil, community members initially ridiculed girls trained to speak to other youth on HIV/AIDS and sexuality. As the value of their work became apparent, the girls gained the respect of the community and changed beliefs about the proper role of young women in openly discussing sex.<sup>56</sup>

**Involve traditional and religious leaders.** Efforts to eliminate genital cutting of young girls in Africa have been most successful when they have engaged the keepers of those traditions as active partners.<sup>57</sup> After consultation with traditional leaders, one such program in Kenya persuaded communities to replace the traditional cutting ceremony with

symbolic gift giving, while preserving other aspects of the rite of passage. The number of girls participating in the alternative ceremony grew from 79 in 1996 to over 1,000 in 1998.<sup>58</sup> In the United States, many local programs to prevent teen pregnancy have drawn upon support from religious communities. For example, the health clinic at a Catholic church in Denver, Colorado, established a peer education program focused on the problem of teen pregnancy after surveying local youth on the problems they felt the clinic and the church needed to address.<sup>59</sup> The Lentera Project of the Indonesia Planned Parenthood Association, a peer education program to inform youth about sexuality, involved skeptical religious leaders in a number of its activities. Many who attended such events later became more accepting of the project’s work.<sup>60</sup> A program in Bangladesh that raised contraceptive prevalence among newlywed adolescents from 19 to 39 percent involved local religious leaders as a key component of its community awareness strategy.<sup>61</sup>

**Involve caring adults.** Many programs have overcome resistance by drawing on the support and active involvement of caring adults. In Algeria, the Family Planning Association involved parents, teachers, and social workers early in the development of a controversial peer education project.<sup>62</sup> In Kenya and Indonesia, parent education programs help parents overcome taboos to discuss sensitive topics with their children.<sup>63</sup> In Mexico, Peru and Chile, school-based sexuality education programs have special parent involvement activities, a component that has helped to convince local school administrators and teachers of the value of the program.<sup>64,65</sup> Mass communications efforts in a number of countries, for example, the Kenyan radio soap opera *Understanding Comes from Discussion*, have encouraged greater communication between parents and children.<sup>66</sup>

**Establish national guidelines.** Formulating national policies that authorize the provision of information and services to unmarried young people is an important step toward overcoming informal barriers. A current effort in China focuses on introducing guidelines for adolescent sexual and reproductive health care into national policies. The new guidelines hope to improve access for youth in the vast network of state-run family planning clinics.<sup>67</sup> The Jamaican Ministry of Health recently amended its Reproductive Health Service Delivery Guidelines to provide legal protection to health professionals wanting to provide information or services to youth

below the legal age of consent (16 years), many of whom are already sexually active.<sup>68</sup> Similarly, the national adolescent health program in Bolivia recently developed national service guidelines, which include authorization for providing family planning services. The new guidelines provide legal backing to health workers worried about a backlash from parents and the community.<sup>69</sup>

**Train health workers.** Recent efforts to introduce youth-friendly services in Cambodia, Zambia, and Zimbabwe all include training of health workers as a key component.<sup>70,71</sup> In Senegal, training in new national service guidelines focused on helping adolescents choose an appropriate contraceptive method and incorporated adolescents in role plays, counseling practice, and discussions of how to improve services.<sup>72,73</sup> Training of clinic staff is also a key element of a new adolescent reproductive health program of the China Family Planning Association that will serve the large numbers of young migrants who lack adequate reproductive health care.<sup>74</sup>

**Test the waters.** Where controversy is likely, a gradual approach has proved successful. In Kyrgyzstan, a national multimedia campaign to encourage young people to seek information about contraceptives was tried initially in just one city.<sup>75</sup> In the Philippines, youth media campaigns gradually addressed more sensitive issues, beginning with two popular songs, then progressing to a youth telephone hotline, television specials on youth issues, and a radio talk show for discussion of youth sexuality.<sup>76</sup> In Kenya, the alternative rite of passage gained approval among communities in one district and has expanded to three others. Other communities wanting to eliminate female genital cutting are now aware of the ceremony and have requested the program.<sup>77</sup> Youth telephone hotlines are a low-profile first step in countries where providing youth with information and services is highly controversial, including in Lebanon, Morocco,<sup>78</sup> and India.<sup>79</sup>

**Be inclusive.** Involving a broad range of key actors early in the process of policy or program development is an important way to address conflict and controversy.<sup>80,81,82</sup> Youth advocates in Bolivia and the Dominican Republic found that one of the keys to successful formulation of national-level youth policies with a strong reproductive health component was a multisectoral approach that involved a broad range of organizations, both public and private.<sup>83</sup> In the United States, advocates from over 70 organizations—many with widely

varying views on how to prevent teen pregnancy—formed the Michigan Abstinence Partnership to help youth abstain from sexual activity. Observers credit its success largely to the diversity of its membership.<sup>84</sup> In Jamaica, a broad-based effort to establish an urban adolescent reproductive health program overcame potentially divisive opposition by engaging key community members throughout the process.<sup>85</sup>

**Agree to disagree.** Youth advocates and their opponents can often disagree on the specific approach to addressing such problems as early pregnancy and high rates of sexually transmitted infections, but can find common ground in agreeing on the need to act. In one rural area of the United States, a proposal by health authorities to establish a school-based clinic providing contraception to students provoked a community outcry that persuaded the local school officials to veto the proposal. Nonetheless, a consensus emerged that the community needed to do something about the high rates of teen pregnancy. On their own, various community groups developed programs—including church-based abstinence education, improving access to family planning clinics, and expanding a YMCA program—and helped to lower the rate of teen pregnancy by 70 percent.<sup>86</sup>

*The In Focus series summarizes for professionals working in developing countries some of the program experience and limited research available on young adult reproductive health concerns. This issue was commissioned and supervised by FOCUS Policy Advisor Nancy Murray and FOCUS Deputy Director Lindsay Stewart and was prepared by James Rosen.*

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