

# The disparity between World Health Organization guidelines for reproductive health and location specific socio-cultural contexts: a case study from the

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### Introduction

With 1 in 30 women dying from complications related to their reproductive health Sub-Saharan Africa has the highest incidents of maternal and infant mortality in the world (United Nations Summit 2010). Improving reproductive health services such as access to contraception, detection of sexually transmitted infections, and legalizing abortion, many of these deaths could be prevented (Ketsela, 2007). While improving maternal and reproductive health globally is a relatively undisputed objective, the methodology to achieve this goal is debatable. Large development institutions such as the World Bank, the World Health Organization, and the United Nations, more or less monopolize the power to define the causes of, and appropriate responses to, maternal death and poor reproductive health services worldwide. These organizations place great emphasis on the need for 'skilled' reproductive health providers as well as 'skilled' birth attendants, yet despite these actors' efforts progress toward improving reproductive health globally is slow (World Bank 2010).

### Literature Review

#### Quick fixes and packages of intervention

Jim Yong Kim et al. write, "historically, public health specialists have enjoined their colleagues to 'keep it simple,' with standardized easy-to-implement and inexpensive interventions suitable for resource limited settings," this historical perspective applies to many of the WHO's contemporary policies as well, as the organization develops strategies and manuals to improve reproductive health care and reduce maternal mortality globally (2005). In 2010 the WHO developed the "Packages of Interventions for Family Planning, Safe Abortion care, Maternal, Newborn and Child Health" (WHO 2010). The document reads, "these packages of interventions are built on WHO standards, which can be adapted and implemented according to the needs and resource capacities of different contexts" (WHO intro. 2010). However, few educational programs actually do adapt the material according to the needs of their specific context, and even when they do, adaptation is not enough in cultures where most concepts provided in the manuals are abstractions and not obviously applicable to many social realities particularly in societies with many social injustices.

#### Human rights discourse

Cottingham et al. write that, "human rights have been named as central to achieving the goals and targets of the Millennium Declaration" (2010). On the contrary, in 'Love in the time of AIDS,' Mark Hunter argues that 'rights' discourse in itself is problematic because of the polyvalent meanings of 'rights' (2010). While Cottingham et al.'s argument closely relates to WHO ideology, Hunter's 'rights' analysis questions 'rights' discourse as a tool for development work altogether. Within Tswana society patriarchy, domestic violence, and corporal punishment of children are common yet the WHO guidelines for reproductive health education rely on concepts of equal rights, empowerment of women, and protection of vulnerable populations (Dr. T. Maundeni date: 2.9.2011).

This study examines the role of WHO guidelines used in two reproductive health courses at the University of Botswana and explores the difficulties in teaching material that often does not apply to students' understanding of the social and cultural context they exist in. The study begs the question: what has meaning on the ground where educators must find ways to teach WHO material effectively?

### Research Question

How is reproductive health taught at the University of Botswana- does it incorporate exclusively international development institutions' perspectives, or are Tswana perspectives and concerns also emphasized? To what extent does the curriculum comprise of abstract concerns that students find it hard to relate to, and makes sense of?

### Methods

- To explore the ways in which reproductive health is taught at institutions of higher education in Botswana I visited two reproductive health courses at the University of Botswana over a period of two months from February to March of 2011. I attended a total of 8 reproductive health classes, amounting to 10 hours spent in the field.
- This study utilized the participant observation method for data collection. The method was particularly advantageous for several reasons. Primarily, being already enrolled at the university as an international student provided me access to inconspicuously attend the reproductive health classes as a regular.
- As this study examines the interplay between the teacher and the teaching material provided by the WHO, as well as the interplay between the material taught and the students understanding of reproductive health issues, participant observation allowed me to observe these dynamics in the class room on a regular basis.
- My participation in the classes was strictly observational, however, being a participant allowed me to take notes during the classes.
- My data for this study were recorded as notes in my field journal during class time. I recorded both the events of the class as well as students' reactions and comments to class material in detail.

### Abstract

This paper examines the disparity between World Health Organization (WHO) manuals for reproductive health development and their implementation in the field. The WHO manuals are intended to be adapted to each field specific environment where they are implemented; however, adaptation does not always occur. This study utilized participant observation for data collection. Two reproductive health courses at the University of Botswana were observed over a period of two months in the spring of 2011. The study found that teachers of reproductive health courses at the University of Botswana rely heavily on WHO manuals, yet the educational material is minimally adapted to the reproductive health realities of Botswana. Furthermore, while WHO manuals permanently rely on concepts of human rights and equality for improving reproductive health globally, these concepts are largely abstract to students at the University. This begs the question whether WHO manuals have any effect at all in an environment where concepts of human rights and equality remain foreign. The findings in this study suggest that for WHO blueprints for reproductive health development to be effective in improving reproductive health services worldwide, the manuals must be location specific and deal with issues specifically pertinent in different regions of the world.



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### Data and Analysis

#### Applying reproductive health manuals to Botswana

One obstacle students face when studying reproductive health at the University of Botswana is that the issues presented in class are regularly portrayed as non-applicable to Botswana and therefore fail to familiarize students with the social problems within their own Tswana society. In five out of seven times in which Botswana was mentioned overall Botswana was mentioned in connection to progress, suggesting that whenever an example of Botswana is provided the examples are not provided to indicate how the problems explored in the course apply to Tswana society. Instead, whenever Botswana is mentioned in class, Botswana is mentioned to clarify that Botswana has 'progressed' and several issues applicable to the remainder of sub-Saharan Africa do therefore not apply to Botswana. While on occasion the situation of Botswana in fact, differs significantly from other sub-Saharan countries in regard to reproductive health issues, generally, Botswana struggles with many socio-political and socio-cultural issues that hamper the universal accessibility of reproductive health care to all and portraying Botswana as just 'progressed' is very unhelpful to student's learning about their own country's reproductive health problems. An example of when Botswana was mentioned in relation to progress was **"Of course, here [in Botswana] a lot of progress has been made in gender and the status of women in Botswana is very high. They know their rights and are very educated. Just look around the classroom, there are more women at UB than men. A graduate housewife is more respected by her husband than a non-educated wife."**

#### Contradictions in Content and Presentation of Learning Material

When the issue of sexual and domestic violence was introduced to class the teacher provided several bullet points of what constitutes as sexual and domestic violence. The teacher also said that sexual and domestic violence often is inflicted upon women because they are "weak and defenseless." When the teacher had gone through how sexual and domestic violence are violations of women's rights he added that sometimes **"fights become part of romance"** and that **"it is a very complex issue, some women love it, they enjoy the beating"** (02.01.2011). Instead of introducing students to the concepts of the 'abuse cycle' the teacher reinforces students' simplistic understanding of domestic violence. As some students said "there are benefits: the boyfriend may be good in bed" or **"when he beats her the first time he will bring a 1000 pula present afterward, and when he beats her the next time the gift will be maybe 2000-3000 pula"** (02.01.2011). Contrary to using the opportunity to dig deeper into why sexual and domestic abuse are violations of women's rights the teacher endorsed such viewpoints.

#### Students' Reflections and Responses to the Learning Material

During the class on Female Genital Mutilation (FGM) and rape the majority of the students in the class laughed. Students laughed the most when talking about marital rape and when talking about the loss of sexual pleasure that occurs in women who have gone through FGM (02.01.2011). Furthermore, during a class on maternal and infant mortality the students were asked which groups in Botswana are expected to have higher delivery related mortality and one student responded "the Basarwa because they have lower literacy, high teen pregnancies, and they have specific cultural beliefs: they don't visit the doctor and they practice their own medicine" (02.16.2011). The teacher agreed with the student's response without acknowledging that in Botswana not only the indigenous groups are excluded from national reproductive health services, but also the vast general population of poor people living in the country. Finally, after a student from Canada visiting UB for the semester had given an hour long presentation on domestic violence, privilege and oppression, the abuse cycle, and rape as a tool of war, a male student commented **"Sometimes when we discuss gender we attack men; now the soldiers [who use rape as a tool of war] are men, when women are soldiers they will rape men"** (03.09.2011). These examples illustrate the reflections and analyses students make in relation to the learning material they are provided with in class. The reflections and responses also indicate a problematic relationship between the educational material students are presented with and their own interpretations of issues or reproductive health as prescribed by the WHO and illustrate the necessity to adapt *global manuals to each specific context*.

### Conclusion

- The global manuals directed at reproductive health produced by the WHO are insufficient for educating students at the University of Botswana of the reproductive health problems existing in the country and educators at the university utilizing WHO manuals do not adapt the theoretical material to the Tswana context.
- The manuals manufactured by the WHO, to be implemented on a global scale must provide guidelines on how the material should be adapted to fit the local context. Ideally, location specific research should be conducted to create manuals directed at the developmental needs of each country specifically. At the very least the manuals should have clear instructions and guidelines on how each manual should be used and adapted.

