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Addressing social factors of adolescent reproductive health in the Republic of Georgia

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The influence of social factors on reproductive health has been highlighted by researchers in the last decade, yet programmes to improve adolescent reproductive health (ARH) rarely address social factors such as gender discrimination. Beginning in 2004, CARE International implemented and evaluated a three-year ARH project to address individual behaviour change, institutional capacity and local social norms related to ARH in a rural district of the Republic of Georgia. Community engagement strategies included: promoting community support for ARH by adolescent/adult volunteer change agents; building health providers' capacity to better meet the needs of adolescents; and using 'Theatre for Development' to promote community dialogue about social norms. Project evaluation data demonstrated improved knowledge, attitudes, behaviour about family planning, improved institutional capacity to provide adolescent services and some evidence of shifts in gender norms. Community engagement is critical for successful strategies to influence social norms that promote healthy reproductive health.

Keywords: adolescent; reproductive health; Georgia; community; social norms; gender

Background

The last 10 years have seen both a renewed international commitment to eliminate poverty and a renewed effort to understand the relationship between underlying social factors and health outcomes (Marmot and Wilkinson 2003, Irwin and Scali 2007). According to the World Health Organisation (WHO), most of the global burden of disease as well as the bulk of health inequalities are caused by social determinants (Irwin and Scali 2005). The research shows that greater gender equity at the household level is linked to improved health behaviours, such as seeking skilled antenatal and delivery care (Furuta and Salway 2006). Community social status and social norms can also influence reproductive health outcomes. In rural Bangladesh, for example, research found that the more central a woman is to her social network, the less likely she is to experience neonatal death (Gayen and Raeside 2007). In six African countries, significant associations have been found between community-level factors – most prominently, the level of approval for family planning among women – and reported use of modern contraceptive methods (Stephenson *et al*. 2007).

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Researchers addressing reproductive health concerns have called for more attention to programmes that employ broader strategies – for example, those that also target women's education, income or status – for improving reproductive health outcomes (Fillipi *et al*. 2006).

In 2004, CARE began to address social factors related to family planning and other reproductive health issues through a systematic approach that uses community mobilisation, a rights based framework and the 'challenging' of inequities in power dynamics. This approach led CARE to develop a theoretical model for social change for reproductive health, which was employed in the Republic of Georgia (CARE 2007).

There are many reasons why adolescents in Georgia face disproportionate vulnerabilities with regard to reproductive health. Georgia has one of the lowest rates of contraceptive use among countries in Eastern Europe and Eurasia, and, similar to other former Soviet states, it has a high abortion rate (Centres for Disease Control and ORC Macro 2003, Serbanescu *et al*. 2005). While a mix of contraceptive choices is available in Georgia, most reproductive health services are provided by doctors who typically have received little training in client-oriented counselling or meeting the reproductive health needs of adolescents (Serbanescu *et al*. 2005). Access to contraception was another challenge. A 2004 survey of health facilities in Georgia reported uneven contraceptive availability, with concern about contraceptive supply stockouts (Hudgins and Rao 2004).

In addition, research among adolescents in Georgia revealed a widespread lack of knowledge about sex, family planning and risks from sexually transmitted infections (STIs) and HIV/AIDS, as well as a clear lack of cross-generational discussion on these issues (Goodwin *et al*. 2004, Buckley 2005). The research from the Georgia Reproductive Health Survey in 2005 revealed that among sexually active young women, 99% did not use contraceptives at first sexual intercourse but only 78% of those women reported a desire to get pregnant; sexually active adolescent females in Georgia reported very rarely using or discussing condoms with their partners (Serbanescu *et al*. 2005). Several traditional cultural factors contributed to these problems: strong emphasis on family; an authoritarian dynamic between the older and younger generations; and very distinct roles for men and women, especially with regard to their expectations around sex, although these roles may be more prevalent in western and rural areas of Georgia than in urban centres (Dourglishvili 1997). Despite high rates of education and employment, women in Georgia still face inequitable gender norms and gender-based violence that negatively influence their reproductive health choices.

Project description

In 2004, CARE International in the Caucasus partnered with two local NGOs – the Guria Youth Resource Centre and Child is the Future – to launch the Guria Adolescent Health Project (GAHP). This three-year initiative aimed to improve adolescent reproductive health (ARH) in 10 rural villages in the country's western Guria district; the combined population of the villages was an estimated 19,000. Project objectives included: (1) improving life skills and reproductive health knowledge, attitudes and behaviour among adolescents; (2) establishing youth-friendly family planning and other reproductive health services; and (3) decreasing

public tolerance among adults and adolescents for the traditional practice of forcibly abducting (i.e., kidnapping) adolescent girls for marriage, a form of gender-based violence identified as a priority issue by adolescent project participants.

GAHP strategies were multilevel: (1) foster an enabling environment for adolescents by promoting changes in norms at the community level, through public dialogue and debate on reproductive health experiences, attitudes and values; (2) stimulate development of necessary knowledge, skills and attitudes of adolescents through dialogue and learning among adults and adolescents; and (3) strengthen reproductive health-service delivery.

The premise of the project was that community members can be powerful facilitators of sustainable changes in their own reproductive health and well-being. The project used an iterative reflection-action cycle called 'social analysis and action' to involve community participants in project design, implementation, reflection and corresponding redesign of activities. (For more information, see CAREs 'Ideas and action: Addressing the social factors that influence sexual and reproductive health'.) Project staff and community volunteers used social analysis and action to explore and identify key social factors, design implementation strategies, implement activities, reflect and analyse results, and modify activities accordingly throughout the life of the project.

This approach facilitated the development of locally appropriate interventions that challenged social factors, such as gender norms, that contributed to poor ARH. One innovative intervention used to identify and challenge social norms was Theatre for Development. Project staff used social analysis and action to develop basic storylines around pertinent issues. With the help of a theatre group consisting of a professional actor and three to five amateur volunteers (adults and adolescents), the project was then able to facilitate discourse and debate among a wide variety of community stakeholders on gender as well as reproductive health. The professional actor played one or more characters as well as the role of 'joker', or dialogue facilitator. As the joker, he challenged audience members to explain why the characters chose particular courses of action, and whether other choices would have resulted in better outcomes. This often involved interrupting the production so that audience members themselves could act out particular roles. Lively discussions among 75–200 audience members were common.

Developing local agents of change was another crucial project component. CARE and its partners identified and developed the capacity of 77 individuals as volunteer agents of change ('change agents') in their communities. These change agents included both adults and adolescents (34 female youth, 21 male youth, 14 female adults, eight male adults). The change agents worked as multi-generational teams to identify barriers to ARH and to develop action plans to address these barriers. Staff support to the change agents included training, technical guidance and facilitation of a process of learning, action planning, and reflection on successes and challenges throughout.

During the final year of GAHP, change agents in each target community assumed ownership of project implementation by designing and implementing their own community-based interventions. With support from micro-grant funding, a board of community volunteers was charged with managing project monitoring and evaluation – helping to ensure ownership of social-change priorities at the local level. One of these interventions aimed to improve the youth friendliness of pharmacists in

the area of contraceptive distribution. Posing as 'mystery clients', adolescents visited local pharmacists to ask for contraceptives. They recorded the pharmacists' responses and reported the results back to the pharmacies, with suggestions for improving communication. Each team of volunteers working on the initiative included both adolescents and adults, creating a platform for positive experiences in intergenerational relationships.

Although CARE stepped back from the community mobilisation and social-action interventions during the final year of the project, leaving them to the change agents, project staff continued to support some specific family planning and reproductive health interventions. For example, staff introduced a social marketing campaign to help change agents present key reproductive health content to families in their respective communities. Using print materials and low-cost videos, the agents went door-to-door sharing information and initiating dialogue on STIs, HIV/AIDS, access to contraception and other health issues facing adolescents.

In addition to changing healthcare provider attitudes about gender and reproductive health, the project also worked to strengthen reproductive health services by helping community participants to create a youth-friendly support group of enthusiastic adolescents and adults. One of their strategies was to physically rehabilitate health facilities to make them more youth friendly; this included remodelling them to increase privacy and confidentiality, and following suggestions from local youth on how to make them more aesthetically appealing. Project staff facilitated training sessions for doctors and nurses in district facilities to update their reproductive health knowledge; designed additional sessions to address the need for sensitive, non-judgmental youth services; and facilitated linkages with other reproductive health projects in Georgia to improve the supply of contraceptives in local clinics.

Results

Baseline quantitative and qualitative data, collected and analysed in the spring of 2005, were compared to final evaluation results from the summer of 2007. At both baseline and endline, a quantitative survey was given to adolescents aged 14–19 through face-to-face interviews, using female interviewers for female respondents and male interviewers for male respondents. The baseline survey was completed by 628 adolescents (323 male, 305 female) and the endline survey was completed by 1001 adolescents (484 male, 517 female). Qualitative research was conducted using three primary methods: (1) participatory action research methodologies that explored the realities of reproductive health for adolescents, with both adolescents and adults (at baseline); (2) approximately 10 focus group discussions among adults (especially parents of adolescents) and adolescents (about 80 people total) (at both baseline and endline); and (3) approximately 12 in-depth interviews with key informants (at both baseline and endline), including change agents (adults and adolescents), community stakeholders (adults) and project staff.

Data from the qualitative and quantitative final evaluations demonstrate the project's results on three levels: (1) individual knowledge, attitude and behaviours of adolescents; (2) structural and institutional changes; and (3) community-level changes in perception of social norms. Each of these result are discussed below.

Individual knowledge attitudes and practices

By the project's endline, 93% of adolescents in the target areas were aware that unwanted pregnancies are preventable, nearly double the level of awareness at baseline (43%). Adolescents also reported knowing more methods of contraception and having more accurate information about contraceptive methods. As shown in Table 1, 64% of adolescents at baseline had 'no response' to the question of how often an oral contraceptive must be taken to be effective, and 4% correctly reported 'daily', but two years later at endline, 57% reported a correct response of 'daily' and only 0.5% had 'no response'.

Both adults and adolescents noted that one of the most significant results of the project was the change in how the two groups communicate with each other about contraceptives. Parents in one focus group noted:

> The most significant change due to the project is that talking about use of condoms and purchase of contraceptives in the family has changed. I talked with my children and with neighbor women about the use of contraceptives and condoms, and found out we did not know many things.

Table 1. Individual family planning knowledge, attitudes, practices.

	Family planning variables	Baseline survey $n=628$		Endline survey $n=1001$	
1.	Aware girls can get pregnant the first time they have sex	Boys	48%	Boys	75%
		Girls	34%	Girls	80%
		Total	41.4%	Total	77.1%
2.	Believe that contraceptive pills can cause infertility or cancer	Total	84.7%	Total	37.5%
3.	If aware of FP, knowledge of at least one way to prevent pregnancy	Boys	59%	Boys	93%
		Girls	39%	Girls	93%
		Total	49.5%	Total	92.9%
4.	Of those who know, what are ways to avoid pregnancy	Abortion	42.4%	Condoms	92%
		Condoms	37.2%	Pills	67%
		Pills	17%	IUD	58%
		IUD	3%	Abortion	16%
5.	Know how often a woman should take contraceptive pills for them to be effective				
		Daily	4%	Daily	57%
		Before sex	3%	Before sex	8.6%
		After sex	2%	After sex	3.3%
		Don't know	27%	Don't know	29.3%
		No response	64%	No response	0.5%
6.	Know someone who has had an abortion	Yes	27.1%	Yes	8%
		No	43.9%	No	77.1%
7.	Have acquaintance who has used a contraceptive method	Yes	12.1%	Yes	29%

Table 1 shows the changes in knowledge and awareness that occurred among adolescents during the project – specifically, an increase in family planning awareness, a shift away from abortion as a family planning method, a decrease in false rumors about contraception and a better understanding among both girls and boys about family planning. The decrease in rate of 'no response' to the question of how often an oral contraceptive should be taken, from 64 to 0.5%, may indicate a reduction in stigma about reproductive health topics.

Structural and institutional changes

Baseline data showed that existing health services were underused, particularly by adolescents. There were several reasons: a lack of physical privacy and confidentiality, inadequate supply of contraceptives and the biased attitudes of doctors and nurses towards unmarried youth. At baseline, many adolescents said that they were unaware of local health services that provided information and treatment related to STIs and pregnancy prevention. As seen in Table 2, there were more sources of information on reproductive health information by the end of the project. Figure 1 shows the increase in adolescent clinic visits per month in GAHP's final year, after interventions aimed at increasing the 'youth friendliness' of the clinics were implemented; these interventions included social-marketing efforts.

After receiving capacity-building training in family planning counselling and youth-friendly services, doctors and nurses were more confident and more open to treating adolescents. Adolescents, in turn, reported that service quality had markedly increased. In one village, a group of adolescents reported the following:

> The quality of the services is now good; they provide full information and give good advice; it is a nice environment, and friendly. We can trust that it is confidential. Services are not expensive – 5 lari (approximately $2.40) for a consultation.

Table 2. Reproductive health information and services.

	RH information and service variables	Baseline survey $n=628$		Endline survey $n=1001$	
1.	Main sources of RH information (multiple responses allowed)	Television	34.6%	Television	48.8%
		Doctors	20.7%	Parents	47.6%
		Press	19.1%	Doctors	36.4%
		Parents	18.2%	Best friend	23.9%
				Press, books	12.3%
2.	Heard about health services in Guria that are ready to give adolescents info	Yes	11.6%	Yes	48.3%
		No	83.8%	No	33.5%
3.	Heard of health services that are diagnosing adolescents and treating STIs, HIV	Yes	5.0%	Yes	39.7%
		No	91.1%	No	39.9%

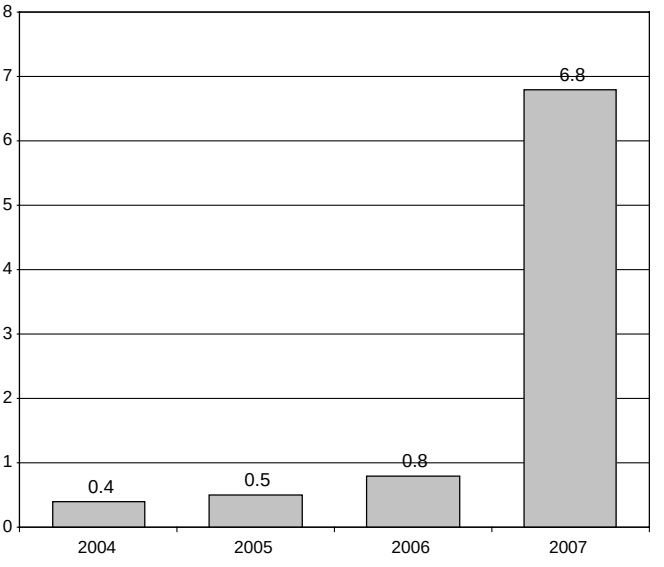

Figure 1. Average number of adolescent family planning visits per month.

One doctor working in an STI treatment clinic stated:

> This is a government venereal clinic; young people have been embarrassed to come here for services. This is a well-known place and they did not want to have people see them walking in here. We think the increase in patients is entirely due to improved service – more trust, better environment, trying to treat in as friendly a way as possible. We now have male and female providers to help the patients, so that they will not be embarrassed. We are now promoting a better service, better room and the fact of free condoms.

By the end of the project, doctors and nurses seemed to show more support and understanding with regard to their adolescent clients. One doctor reported:

> I am less judgmental now; for example, before if an unmarried girl came in, I would turn her away, but now I would do my best to help.

Community-level changes in perception of social norms

Formative action research conducted among adolescents at the start of the project indicated that, in addition to lack of information and services related to family planning, there were social factors that posed barriers to reproductive health, namely: (1) gender inequities related to the right to refuse sexual relationships; and (2) inequitable inter-generational relationships, specifically between adolescents and the adults in their lives; many adolescents reported feeling that they had limited say in decisions that most closely affect their lives (e.g., choice of school, spouse, profession) since parents did not consult them.

Evaluation data revealed evidence of some shifts in social norms beyond individual attitude change, including diminished stigma about contraception, more

support for delayed marriage and childbirth, and decreased tolerance for gender-based violence against adolescent girls.

Community members felt that contraception had become less of a taboo topic since the project began. One adolescent noted:

> The community has started to talk openly about these issues. Relations between adults and adolescents are better and they are more able to talk about contraception. Family planning, sexually transmitted diseases: Those issues were taboo before.

This finding was confirmed by surveys of individual adolescents, who stated that older family members were discussing family planning, HIV/AIDS and STIs with them more than they had at baseline (see Table 3).

Some participants noted in the endline survey that it was now more acceptable for young couples to delay marriage or childbirth. During the final evaluation, one mother stated:

> For my son and the wider community of adolescents, their plans for marriage and children are now changed. Now they would not marry early and are thinking longer view about their future. Now they are not having children before being able to support them, and they are using family planning to help their plans.

By the end of the project, both adolescents and adults reported a better understanding of gender norms and gender-based violence, specifically regarding the local custom of kidnapping girls for marriage. Some of the assumptions about this custom seemed to be changing. For example, a group of boys and girls in a focus group said:

> We have learned that kidnapping is violence. It is a rape and may have negative consequences. As a result, we have reevaluated our traditions about kidnapping.

In the endline survey, some adolescents reported taking action to prevent kidnappings in their villages. One parent reported seeing her own son changing his attitudes towards gender-based violence:

> Earlier, he was thinking only from the point of view of the boy and not the girl. Now he thinks of consequences for the girl. I have seen him arguing with others and trying to change their views about kidnapping.

Although there are no formal statistics on the prevalence of kidnapping in the target communities, CARE found anecdotal evidence that rates were dropping. One focus group of boys and girls reported seeing fewer examples of kidnapping in their community:

> Kidnapping used to happen in this community more than two times per year. Last summer was the last one; they are decreasing. They are decreasing because ... people

Table 3. Family communication on sexual and reproductive health issues.

	Baseline survey $n=628$	Endline survey $n=1001$
Older family members have spoken with me about:		
STIs	13.7%	28.1%
HIV/AIDS	14.2%	21.6%
How pregnancy occurs	10.7%	35.2%

are better informed due to theatre performances followed by discussions, and seeing the (media materials).

Discussion

CARE and its project partners aimed to improve ARH by addressing many related factors, with a central focus on community participation and ownership. Some evidence of success can be seen in the changes the project helped create on multiple levels, including individual behaviour change, institutional changes related to the way that reproductive health care is provided to adolescents, and short-term changes in social norms in the community.

Both qualitative and quantitative project data show improvements in knowledge, attitudes and behaviour related to reproductive health issues among adolescents, and also a reduced tolerance for gender-based discrimination and violence. Interviews and focus groups with adolescents and adults revealed that the change most often noted to be 'most significant' was related to improvements in both public and family level dialogue on topics previously considered taboo, most of them related to family planning. This may be related to the popularity of the Theatre for Development intervention, which promoted a public dialogue modelled on the dialogue that occurs between family members.

Several lessons emerged from the project's innovative design, implementation and evaluation process. The first lesson is related to the challenge of addressing factors related to stigma, discrimination and community power dynamics, which meant that project staff and volunteers needed to become more comfortable in understanding and addressing those factors by themselves. To improve human capacity, CARE dedicated resources to an iterative series of training workshops throughout the course of the project for project and partner staff as well as volunteers. Training topics included: reproductive health, adolescent issues, how to build positive partnerships, Georgia-specific gender issues that influence adolescent health, and conflict resolution and mitigation skills.

The second lesson to emerge was that addressing social factors meant challenging the normal community power dynamic, and that this resulted in considerable discomfort and even open resistance by some community stakeholders, including religious leaders. However, this situation was managed successfully through targeted strategies to open up public debate on taboo topics (e.g., through Theatre for Development), by strategic alliances and discussions with key stakeholders, such as religious leaders, and by supporting locally driven initiatives for change as designed by change agents.

Theatre for Development was an effective educational tool for supporting social and individual change for improved reproductive health in the project's conservative, rural setting. Its interactive style using fictional characters provided a safe space for individuals to talk about controversial or taboo subjects, such as gender and family planning, and to demonstrate more equitable behaviour in a publicly sanctioned way. The theatre activities also diffused 'ownership' of the controversial topics, since almost everyone – not just project staff – was discussing the issues. This public debate also allowed many participants to see that there were a variety of opinions present in their community, and that their own opinions, however much they differed from the 'norm', might be shared by others.

Thirdly, the iterative process of exploration, reflection and action among staff and community participants led to adjustments in project approaches. These adjustments helped ground project interventions firmly in local realities, with locally developed solutions. Project interventions were loosely defined to allow change agents to design and implement their own interventions in the final year of the project. This enabled change agents to believe in themselves, and inspired them to apply their energy and dedication to helping change social structures and norms that were barriers to good reproductive health. Community volunteers who worked to design and implement improvements to clinic services became more aware of adolescents' right to non-discriminatory healthcare services, and their ability to demand that right.

Many reproductive health programmes are designed around behaviour change interventions at the individual level, but in order to optimise success for adolescent programmes at scale, it is important to also include community-led interventions that address community norms around adolescent sexuality and reproductive health which may be barriers to adolescent health. To improve adolescent health, strategies of adolescent programmes should include advocacy and communication for social change to address social factors and community norms.

Conclusion

The active participation of community members in all stages of the project cycle was crucial to creating equitable and sustainable improvements in social norms and reproductive health. By using a systematic method to identify and address root causes of poor sexual and reproductive health, as well as by taking part in a learning cycle of regular exploration, reflection and action, target communities were able to become a driving force for changing inequitable social, gender and sexuality norms, and improving the reproductive health of adolescents.

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