IORG
INTERNATIONAL ORGANIZATIONS RESEARCH GROUP

Briefing Paper
Number 14 May 14, 2015

Six Problems with WHO's new policy recommendation: "Brief sexuality-related communication: Recommendations for a public health approach"

By: Rebecca Oas, Ph.D.

C-Fam | CENTER FOR FAMILY & HUMAN RIGHTS
NEW YORK · WASHINGTON, DC

Six Problems with WHO's new policy recommendation: "Brief sexuality-related communication: Recommendations for a public health approach"

By: Rebecca Oas, Ph.D.[1]

In May of 2015, the World Health Organization (WHO) issued a policy guidance[2] urging healthcare workers at all levels receive training and engage in impromptu counseling on matters relating to sexuality with both adult and adolescent patients. Its approach raises many concerns for the children it targets, for their families, and for healthcare providers.

The guideline document was produced by the WHO's Department of Reproductive Health and Research (RHR), which has taken an increasingly activist role in promoting abortion, acceptance of dangerous sexual behaviors, and the view that the only acceptable moral position on human sexuality is that any consensual sexual activity is legitimate. This policy recommendation is the latest in a series of examples of WHO's overreach of its mandate, its blatant disregard for parents who are the primary caregivers of their children, and its irresponsible push to turn healthcare providers at all levels into disseminators of a moral framework that is unacceptable to many patients seeking care, as well as many to providers.

1. The WHO policy recommendation takes the responsibility for health counseling out of the professional realm and into the hands of non-professionals.

WHO advocates the "opportunistic use of counseling skills" on matters of sexuality and creates a new term to define it: "brief sexuality–related communications," or BSCs. The healthcare practitioners who would be providing BSCs "whether a nurse, doctor, or health educator" would use these presumed skills "opportunistically with much less certainty about the duration of the encounter."

---

1 Rebecca Oas, Ph.D., is a biomedical scientist and Associate Director of Research for C-Fam.

2 Brief sexuality-related communication: Recommendations for a public health approach. World Health Organization, 11 May 2015 *[All quotations are taken from this publication unless otherwise noted.]*

IORG International Organizations Research Group

C-Fam

This approach places an undue burden on unqualified non-professionals and removes the safeguards afforded to patients within a context where trust is earned and a continuing relationship allows for follow-up. While WHO says that a "rights approach to BSC also requires provider commitment to confidentiality," it does not specify how this would be implemented, or which communications would be considered privileged under the law.

2. The scope of BSCs extends well into moral, ethical, and philosophical territories and does so using a haphazard, opportunistic approach.

According to WHO, "BSC takes into account the psychological and social dimensions of sexual health and well-being as well as the biological ones" and seeks to "support clients in reformulating their emotions, thinking and understanding, and subsequently, their behavior." This is troubling considering that adolescents will be recipients of BSCs. Such interventions are not the competency of non-professional counselors, especially those with little to no accountability, limited knowledge, and no "provider continuity." Even in the case of professional long-term counseling, patients have the right to choose a practitioner whose approach is consistent with their own moral views, including their religious and cultural views. Such a vetting process is absent entirely in the case of BSCs, which may be unsolicited, unwelcome, and utterly inconsistent with the beliefs and values of the patient, or in the case of adolescents, the adults legally responsible for their wellbeing.

In its narrow-focus of promoting sexuality, the BSC completely overlooks the critical role of health providers – and their need to be educated – in detecting victims of trafficking. One study found 87% of 107 trafficking survivors surveyed had contact with a health provider, yet they are "woefully unprepared to identify trafficking victims."[3] In some cases, the providers were complicit in trafficking.

3. WHO attempts to redefine the doctor-patient relationship in ways that justify overreach on the part of health care providers and do not necessarily provide practical empowerment to patients.

The policy recommendation makes a point of referring to health care recipients as "clients" rather than "patients" because "while the term 'patient' presumes a hierarchy in which the health-care provider knows best, the term 'client' positions the health-care provider as a supporter to help the person concerned to find solutions for him or herself." While this may serve as sufficient justification in the pages of a policy brief, it has little application in health care settings, where patients themselves may indeed see themselves as patients, or supplicants, receiving advice and care from a person with superior knowledge, skills and responsibilities in the area of health. Furthermore, the opportunistic approach to counseling inherently removes patients' agency by presuming their consent to receiving such communications, or the consent of legal guardians in the case of a minor.

3 The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. Lederer, L., Wetzel, C. A. Annals of Health Law. 2014: 23(1): 61-91.

Parents and patients may not be aware that a health worker is exceeding his or her competencies in providing such opportunistic counseling on sexuality.

4. For adolescents, whom they define as ten to nineteen years of age,[4] WHO assumes that non-professional "counselors" with no relationship to them are better placed to judge their "best interests" than their own parents.

The recommendation quotes WHO's Framework for Sexual Health Programmes, which says that "specific strategies are needed to expand services to hard-to-reach groups, such as adolescents […] Services should be available and accessible without parental consent, taking into account the young people's evolving capacity and best interests." Health care workers with transient relationships to adolescents are not better qualified to judge what is in a young person's best interest than their own parents, who have a long-term vested interest in and obligation for their well-being, especially in the area of health, and who are responsible for imparting values and moral standards in all areas, including sexuality.

According to the policy recommendation, "Because BSC is provided by a health worker, it has greater a likelihood of overcoming cultural sensitivities that exist in many contexts around information dissemination and support for adolescents in relation to sexuality." This blanket presumption that cultural sensitivities are wrong and lightly-trained employees know best will foster distrust and animosity in communities.

When the BSC strategy becomes known to local communities, it has the potential to create controversy that could damage the vital basis of trust between health workers and the patients they serve. It could also create disincentives for parents to bring their adolescent children to clinics for treatment when they need it, for fear of systematic attempts to erode their moral, cultural, or religious worldview.

5. The WHO policy guidance would bypass the expressed rejection by national governments of any consensus on "comprehensive sexuality education" for minors.

"BSC should not be chosen in preference over other effective interventions such as comprehensive sexuality education in schools," says the recommendation, while still calling it a "necessary" intervention for adolescents. In this way, WHO is attempting to co-opt community health workers to be the mouthpieces of the CSE agenda in a more informal and spontaneous capacity, relying on communities' established trust in these individuals.

Within the international community, "comprehensive sexuality education" (CSE) is a highly controversial term, owing to the extreme content in the most well-known CSE curricula and advocated by CSE promoters such as Planned Parenthood, which

4 http://www.who.int/topics/adolescent_health/en/

includes teaching children as young as 5 about masturbation, and that they can choose their own gender identity regardless of their biological sex.[5]

6. WHO recommends BSC strongly, yet admits the evidence supporting it is weak.

WHO makes two recommendations: (1) "BSC is recommended for the prevention of sexually transmitted infections among adults and adolescents in primary health services," and (2) "Training of health-care providers in sexual health knowledge and in the skills of brief sexuality-related communication is recommended." For both of these recommendations, WHO uses a system known as GRADE to classify the strength of the recommendation (strong or conditional) and the quality of the supporting evidence (high, moderate, low, or very low.) In both cases, WHO classifies its recommendations as "strong," despite the quality of evidence being classified as "low to moderate" and low – very low," respectively.

In defense of the BSC approach, WHO says, "There is no evidence that BSC leads to increased sexual activity in general, including among adolescents." The single study they cite as a source for this claim concludes among their findings that "[a]ny impact on sexual activity and condom use was short-lived."[6] With this questionable and sparse evidence base, it is questionable as to why WHO would recommend BSC so strongly.

---

5 Standards for Sexuality Education in Europe: A Framework for policy makers, educational and health authorities and specialists. WHO Regional Office for Europe and BZgA. 2010. Cologne: Federal Centre for Health Education, BZgA.

6 Boekeloo B, Schamus LA, Simmens SJ, Cheng TL, O'Connor K, D'Angelo LJ. A STD/HIV prevention trial among adolescents in managed care. Pediatrics. 1999;103(1):107–15.