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Commentary

Shock Unleashed by Recent US Administrative Actions Cannot Lead to Paralysis

Venkatraman Chandra-Mouli, M.B.B.S., M.Sc., Ph.D. [a,*], Robert Wm. Blum, M.D., Ph.D., M.P.H. [b], and Luchuo Engelbert Bain, Ph.D., M.Sc., M.P.H., M.B.A. [c]

[a] *World Health Organization, Geneva, Switzerland (retired)*
[b] *Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland*
[c] *African Population and Health Research Center, Nairobi, Kenya*

Over recent months, the current US administration's actions have upended international order with potential devastating consequences for the world's adolescents. Examples include the United States's withdrawal from the World Health Organization, the elimination or significant reduction of development and humanitarian assistance, the reinstatement of the Mexico City Policy, and the deletion/blocking of data and evidence from the websites of the Centers for Diseases Control and Prevention [1]. This profound disruption is against a backdrop of impressive global progress in adolescent sexual and reproductive health (ASRH) over the last 25 years, notably in low- and middle-income countries (LMICs).

In the context of the global backlash that these US actions are creating, there is a real risk that the painstaking progress made in LMICs will unravel. In this commentary, we reflect on the progress made in ASRH in LMICs and propose strategic actions for safeguarding—and see opportunities in even expanding—the gains achieved over recent decades. Above all, we view this moment as a powerful opportunity to lead with strength, act with hope, and turn this crisis into meaningful change.

Progress in Adolescent Sexual and Reproductive Health and Rights in a Growing Number of LMICs

In 2019, *the Journal of Adolescent Health* published a joint World Health Organization-United Nations Population Fund supplement highlighting progress in ASRH since the 1994 International Conference on Population and Development including steady reductions in levels of child marriage, female genital mutilation, HIV infection and deaths, and adolescent pregnancy; and describing the progress made by a small but growing number of countries in formulating enabling policies and implementing effective national government-led programs that were contributing to these improvements [2,3].

In early 2020, the COVID-19 pandemic upended our lives. Adolescents were largely spared of the direct effects of the pandemic but were hugely affected by its impacts on their education, food security, and their social lives, which in turn affected their mental health [4]. However, contrary to a number of worst-case scenario predictions [5–7], progress on ASRH continued, albeit with localized stalling and regression [8]. These advances happened because governments prioritized this work as important for their adolescents and worked with local and international organizations to maintain them. This progress is illustrated by the Zambian Ministry of Education's decision to continue with the scale-up of the country's school-based sexuality education program even in the face of concerted efforts to malign the program; the Moldovan Ministry of Health's decision to provide young people with free contraception as part of a package of health services financed through the national health insurance scheme; and the Nepalese government's liberalization of access to legal and safe abortion care to young people above age 16 without parental consent [9–11].

Real Risks of This Hard-Won Progress Unraveling

The advances that Nepal, Zambia, and Moldova (as well as other LMICs) have made over the past 30 years have not been achieved in a vacuum. The advocacy, technical, and financial support of a range of external agencies (albeit more substantial support to some countries than to other others) has contributed to this. The joint efforts of these agencies with their partners in LMICs including governments, local Non-Government Organizations (NGOs) and other civil society organizations, and young people themselves, have contributed to the positive trends. The US Government has been a key player in this journey, but the trends of the past few months strongly suggest that this will not continue. Whereas the United States was both a major funder and a champion of reproductive health, it has abruptly cut

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* Address correspondence to: Venkatraman Chandra-Mouli, M.B.B.S., M.Sc., Ph.D, 39 chemin de la Nonnette, 1292 Chambésy, Geneva, Switzerland.
E-mail address: chandramouli@bluewin.ch (V. Chandra-Mouli).

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funding and increasingly appears to become an active opponent to ASRH. The worrying developments in the United States come on the heels of a growing number of governments across the political spectrum cutting development assistance budgets (including the Netherlands, Sweden, and the United Kingdom), and the increasingly blatant attacks on sexual and reproductive health and rights (SRHR) from both state and nonstate players [12]. Put together, there is a real risk of this hard-earned progress unraveling.

Concrete Steps That Champions of ASRH Could Take

In response to these developments, there has been a recent flurry of articles by public health leaders from the LMICs challenging their political and governmental leaders to do more. Additionally, they propose an ambitious set of actions—redefine program priorities in line with local needs and problems; develop tailored strategies to address the priorities, resource government bodies and local NGOs adequately to execute them well; redefine research priorities tightly aligned to national needs and problems, and resource national institutions to carry out the needed studies and evaluations; invest in building local institutions and people, and incentivize them to make the best contribution they can; and identify and deploy domestic resources from levies, private-public partnerships, and local philanthropy [13–16]. All these recommendations are just as relevant to the health of adolescents as they are to other populations. Those of us who are committed to ASRH and to adolescent health more broadly will need to work in partnership with organizations that continue to remain committed to adolescent health, and with new partners to ensure that adolescents do not get sidelined.

Singh et al. [17] echo these comments with a particular focus on safeguarding the hard-earned gains in SRHR. First, they call for diversified and innovative finance schemes (such as blended financing that integrates private sector investment, philanthropic support, and government funding) and for strategically framing of SRHR within economic development and education/social protection initiatives. Second, they call for strengthening and streamlining health (and other) systems and drawing upon lessons learned during the COVID-19 pandemic to strengthen supply chain resilience. Third, they call for all those committed to SRHR to align around a coherent evidence-based vision for SRHR, and to martial robust evidence to counter misinformation, disinformation, and regressive policies [17].

However, as Ntusi, Kyobutungi et al., and Pai et al. note, for any of this to happen, power must shift from countries and institutions in High Income Countries (HIC) to those in LMIC [13,14,16]. Pai et al. stress that for real change to occur, individuals and institutions in HIC (including funding agencies and universities) must demonstrate allyship. True allyship involves individuals and institutions from high-income countries recognizing their positions of power and privilege and choosing to act as allies or accomplices rather than leaders, at times, by default. This approach requires intentionality to cede space, recognize, and amplify marginalized voices, as well as actively support leadership from LMICs. Even more importantly, LMICs as well as agencies providing technical and financial support from HIC must foster partnerships that advance genuine South-to-South collaborations that enhance decision-making, support autonomy, and mutual respect. But to assure true leadership of health initiatives in LMIC will require more than a shift in approach by those in HIC; it will also require acknowledging that entrenched decision-making classes within and outside governments in LMIC have benefited from the prevailing situation at the expense of the populations for whom support is intended [16].

This also calls for a new working relationship between funders from HICs and the organizations they support in LMIC. Ideally, funding agencies' priorities should be responsive and flexible and informed by national priorities. They should also be co-created with national partners. Conversely, LMICs have a moral and ethical duty to reject dictated agendas and priorities, to collaborate with dignity, and to carefully scrutinize any proposed support to ensure it aligns with broader national health and development plans.

We argue for a fundamental change in approach aware that such change will take time. Meanwhile, LMICs could take the lead by (1) reviewing current initiatives that are threatened with defunding; (2) establishing clear criteria for prioritizing initiatives whether or not they are threatened with defunding; (3) integrating priority initiatives into the existing health, education, social welfare and other service systems; (4) shifting extant funding to support these priorities; and (5) seeking partners in HIC who will support these priorities. For those activities that are priority, they must focus on building local capacity to lead as well as to implement and to assess the results of priority initiatives.

Conclusion

Today the world faces an unparalleled crisis precipitated primarily by the volte-face of the US administration from international development. Those of us dedicated to adolescent health and well-being are shocked and saddened, but we cannot afford to be paralyzed. We must get up, regroup, and move ahead. We must work on three fronts to navigate these difficult times: we must safeguard and build on the learning and the progress made in many LMICs; we must proactively and effectively counteract the attacks on ASRH and on SRHR more widely; and we must join forces with like-minded colleagues everywhere who are committed to not only adolescent health but to advancing social justice and autonomy in LMIC. In every crisis there is opportunity. We must seize the opportunity to forge a new paradigm for international development.

Together we will survive this crisis and come out stronger, though the road ahead will be difficult and long.

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