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Executive Summary

This dissemination package accompanies the poster presentation titled:

"Assent, Consent, and Care": Ethical Reflections on Participatory Research with Adolescents on Primary Dysmenorrhea in Lusaka, Zambia.

The study highlights the ethical complexities of engaging adolescents in sensitive health research. Through participatory visual methods such as DrawingOut workshops and in-depth interviews, the research explored girls' experiences of primary dysmenorrhea, while critically examining issues of assent, consent, and care.

Key Findings:

Adolescents often felt uncertain about their 'permission' to speak on menstruation due to cultural taboos.

Drawing activities created space for some to express menstrual pain for the first time.

Even with consent, stigma and surveillance limited openness.

Ethical clearance alone proved insufficient; true ethics demanded relational engagement and sensitivity.

Conclusion: Ethical adolescent health research requires a paradigm of care honoring agency without exposure, voice without pressure, and participation without assumption.

Title

"Assent, Consent, and Care": Ethical Reflections on Participatory Research with Adolescents on Primary Dysmenorrhea in Lusaka, Zambia

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ThemeAdolescents Policy, Legal Aspects, Consent, Rights, and Stigma

Abstract

Background
Adolescent health research often grapples with the tensions between protection and participation, particularly when it involves sensitive subjects like menstruation and pain. In Zambia, where menstrual health remains under-prioritized and under-discussed, this study sought to center adolescent girls' lived experiences of primary dysmenorrhea through participatory visual methods. In doing so, it raised critical ethical questions about assent, consent, voice, and care.
Methods
As part of a larger mixed-methods doctoral study, this qualitative phase involved adolescent girls aged 10–19 from public and private schools in Lusaka. DrawingOut workshops and in-depth interviews were used to elicit personal narratives of menstrual pain, stigma, and coping. Ethical protocols included obtaining written informed consent from participants aged 18–19, and dual processes of parental consent and adolescent assent for those under 18. A trauma-informed, gender-sensitive approach guided facilitation and analysis.
Findings
Beyond the data on pain and coping, the research process itself revealed how ethics must move beyond procedural compliance to relational engagement. Younger adolescents expressed uncertainty about "permission to speak" on topics deemed taboo. For some, the act of drawing became their first opportunity to articulate menstrual suffering. Others, despite formal consent, remained guarded due to school surveillance, fear of judgment, or internalized stigma. Facilitators often had to negotiate unspoken boundaries of silence, shame, and duty. These moments underscored that "ethical clearance" alone is insufficient when working with minors on embodied, gendered experiences.
Conclusion
This study illustrates that ethical research with adolescents requires a paradigm of care, not just consent one that honours agency without exposure, voice without pressure, and participation without assumption. As SRHR programs and policies increasingly call for youth engagement, researchers must confront the quiet power dynamics that shape how, when, and whether adolescents are truly heard.
Keywords:
Adolescent research ethics, primary dysmenorrhea, assent and consent, participatory methods, menstrual health, Zambia, SRHR, power dynamics, DrawingOut, feminist research

“Assent, Consent, and Care”: Ethical Reflections on Participatory Research with Adolescents on Primary Dysmenorrhea in Lusaka, Zambia

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Theme: Adolescents Policy, Legal Aspects, Consent, Rights, and Stigma

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BACKGROUND

Adolescent health research walks a tightrope, balancing protection with meaningful participation. In Zambia, menstruation remains shrouded in silence and stigma. When researching sensitive topics like primary dysmenorrhea (painful periods), ethical engagement must go beyond paperwork.

This study centered adolescent girls’ voices using participatory methods and in doing so, uncovered deeper questions:

- What does “consent” mean when silence is culturally enforced?

- How do we create space for girls to speak without pressure?
- Can ethical protocols truly protect when stigma lives in the classroom?

METHODS

How We Listened

As part of a mixed-methods doctoral study, we engaged girls aged 10–19 from public and private schools in Lusaka using:

- Drawing Out Workshops; Visual storytelling to express pain, stigma, coping

- In-Depth Interviews; Safe-space conversations guided by trauma-informed principles

Ethical Safeguards:

- ☐ Written consent (ages 18–19)
- ☐ Dual process: Parental consent + adolescent assent (under 18)
- ☐ Gender-sensitive, trauma-informed facilitation
- ☐ Confidentiality and emotional safety prioritized

KEY FINDINGS

What We Learned — Beyond the Data

The research process itself became a mirror for ethical tensions: Younger girls (10–14) often asked: “Am I allowed to talk about this?”, revealing how taboo silences voice.

For some, drawing was the first time they named their pain,not in words, but in color and shape.

Even with “consent,” many remained guarded,due to fear of teachers, peers, or internalized shame.

Facilitators constantly negotiated invisible boundaries: silence, duty, and cultural expectation.

Takeaway:
Ethical clearance ≠ ethical practice.
True ethics is relational, responsive, and rooted in care.

CONCLUSION & IMPLICATIONS

Rethinking Ethics: From Compliance to Care

Working with adolescents on embodied, gendered experiences demands more than forms, it demands presence, patience, and partnership.

For Researchers: Move beyond “tick-box ethics.” Build trust. Honor silence as much as speech.

For Policymakers: Youth engagement in SRHR must confront power; who speaks, who listens, and who decides.

For Ethics Boards: Review protocols must account for cultural stigma, surveillance, and emotional safety, not just legal consent.

Our Call: Let “care” be the compass, honoring agency without exposure, voice without pressure, participation without assumption.

KEYWORDS & CONTACT

Keywords:
Adolescent research ethics · Primary dysmenorrhea · Assent & consent · Participatory methods · Menstrual health · Zambia · SRHR · Power dynamics · DrawingOut · Feminist research

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Executive Summary

This dissemination package accompanies the poster presentation titled:

The Gendered Medicine of Pain: A Feminist and Biopsychosocial Lens on Adolescent Menstrual Health in Zambia

Primary dysmenorrhea (PD) also known as painful menstruation, is extremely common among adolescent girls in Zambia, yet it is routinely dismissed as "normal" or inevitable. This mixed-methods study challenges that silence by examining PD through an integrated feminist and biopsychosocial framework, revealing that menstrual pain is not only a clinical condition but a profoundly gendered experience shaped by biology, culture, and power.
Quantitative findings (n = 400) identified strong predictors of PD:

- Family history (AOR: 9.97)
- Somatic symptoms: headache (AOR: 12.41), diarrhoea (AOR: 11.26), nausea (AOR: 9.33), and breast tenderness (AOR: 4.73)
- Menstrual characteristics: moderate flow (AOR: 3.64) and cycle length of 31–35 days (AOR: 3.47)

Qualitative insights (n = 20; DrawingOut workshops + interviews) exposed the emotional and social weight of pain:

- Girls described feeling "sad and scared" during their periods, often withdrawing from peers and school.
- Cultural messages taught them to endure silently: "I have to be strong because I'm a woman… I should not complain."
- Harmful myths abounded: "If I cook with salt during my period, men will get sick."
- Many avoided conversations about menstruation altogether, running away when the topic arose.

Together, these findings show that menstrual pain in Zambia is both embodied and socially constructed. While biology matters, so do stigma, silence, and gendered expectations of resilience.
The study calls for SRHR policies and school-based programs that move beyond biomedical treatment to embrace gender-sensitive, youth-centered care, validating pain, dismantling shame, and creating safe spaces where girls can speak, rest, and be heard.

Abstract

Background:
Primary dysmenorrhea (PD) known as painful menstruation, is highly prevalent among adolescent girls globally, yet it remains under-prioritized in clinical practice and public health policy. In Zambia, menstrual pain is often normalized as an inevitable aspect of womanhood, rendering girls' suffering invisible. This study moves beyond biomedical reductionism by applying an integrated feminist and biopsychosocial framework to examine how PD is simultaneously shaped by biology, culture, and gendered power dynamics.

Methods:
Embedded within a larger mixed-methods doctoral study, this research combined:
A quantitative survey (n = 400) to identify biological and physiological predictors of PD, and
Qualitative inquiry (n = 20) using DrawingOut workshops and in-depth interviews to explore girls' lived experiences, coping strategies, and sociocultural interpretations of pain.
Data were analyzed using logistic regression (STATA) and thematic analysis (ATLAS.ti), guided by feminist and social constructionist theories.

Results:
Quantitatively, family history of PD emerged as the strongest predictor (AOR: 9.97; 95% CI: 4.18–23.78; $p < 0.001$). Other significant factors included headache (AOR: 12.41), diarrhoea (AOR: 11.26), nausea (AOR: 9.33), breast tenderness (AOR: 4.73), moderate menstrual flow (AOR: 3.64), and cycle length of 31–35 days (AOR: 3.47).
Qualitatively, girls described menstrual pain as emotionally and socially burdensome. Many reported withdrawing from school and peers, enduring pain in silence, and internalizing cultural messages that equate womanhood with stoicism. Harmful myths, such as the belief that cooking with salt during menstruation harms men, further reinforced stigma. DrawingOut sessions revealed pain as embodied, isolating, and morally charged, with one 17-year-old stating: "When I think about my period, it feels like a heavy cloud is over me… I just see the blood and pain, and it makes me feel sad and scared."

Conclusion:
Menstrual pain among Zambian adolescents is not merely a clinical condition but a gendered social experience rooted in silence, stigma, and systemic neglect. Effective SRHR responses must integrate biomedical care with structural, gender-sensitive interventions that validate girls' voices, challenge harmful norms, and create safe spaces for expression and support. A feminist-biopsychosocial approach is essential to transform how menstrual health is understood, researched, and addressed in low-resource settings.

Keywords:
Primary dysmenorrhea, adolescent girls, feminist theory, biopsychosocial model, menstrual health, gender and pain, DrawingOut method, Zambia, SRHR, mixed-methods research

The Gendered Medicine of Pain: A Feminist and Biopsychosocial Lens on Adolescent Menstrual Health in Zambia

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Theme: Adolescents and Sexual and Reproductive Health

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BACKGROUND

Primary dysmenorrhea (PD) is one of the most common gynecological conditions among adolescents worldwide, yet it remains poorly prioritized in both clinical practice and public health. For many girls, menstrual pain is normalized as an inevitable part of womanhood, leaving their suffering invisible and often untreated.

In Zambia, adolescent menstrual health is rarely discussed openly, and experiences of pain are shaped not only by biology but also by gendered expectations of silence, endurance, and resilience. This study applies a feminist and biopsychosocial framework to examine how adolescent girls experience and cope with PD, situating menstrual pain at the intersection of physiology, stigma, and social norms.

By centering girls' voices, the study highlights the need to reconceptualize menstrual health as both a medical and a gendered social issue that requires structural and programmatic attention within sexual and reproductive health and rights (SRHR).

Objective

- To identify biological and psychosocial predictors of PD.
- To explore adolescents' lived experiences of pain and coping, emphasizing gendered dynamics.

METHODS

- Design: Mixed-methods (quantitative survey, n=400; DrawingOut workshops + interviews, n=20).
- Frameworks: Biopsychosocial model + feminist/social constructionist theories.
- Tools: Structured questionnaire, DrawingOut workshops and in-depth interviews.
- Analysis: Logistic regression (STATA) + thematic analysis (ATLAS.ti).

Results – Quantitative Predictors

Table 1. Adjusted predictors of primary dysmenorrhea

Characteristics	Unadjusted		Adjusted	
	OR (95% CI)	P value	OR (95% CI)	P value
Menstrual cycle length				
31-35 days	2.50 (1.19, 5.29)	0.016*	3.47 (1.10, 10.96)	0.034*
Menstrual flow intensity				
Moderate	2.44 (1.38, 4.30)	0.002*	3.64 (1.35, 9.80)	0.011*
Discomforts during menstruation				
Breast Tenderness	3.43 (1.35, 8.67)	0.009*	4.73 (1.50, 14.90)	0.008*
Diarrhea	3.35 (1.19, 9.39)	0.021	11.26 (3.0, 42.38)	<0.001*
Headache	1.84 (0.70, 4.81)	0.215	12.41 (2.44, 63.23)	0.002*
Family history of Dysmenorrhea				
Yes	4.46 (2.41, 8.27)	<0.001*	9.97 (4.18, 23.78)	<0.001*

CI confidence interval, OR Odds ratio, % Percentage, Ref Reference, * Statistically significant at 5% significance level

Interpretation

- Family history is the strongest predictor.
- Somatic symptoms (headache, diarrhoea, nausea, breast tenderness) significantly increase odds of PD.
- Menstrual cycle characteristics and flow intensity are key biological risk factors.

Results – Qualitative Themes (from DrawingOut & Interviews)

"When I think about my period, it feels like a heavy cloud is over me. I just see the blood and pain, and it makes me feel sad and scared. "(17-year-old girl, DrawingOut workshop).

Drawing 1
"I did not like talking about it. When I find a group of people discussing it I would run away. "(17-year-old girl, DrawingOut workshop)

Drawing 2
"My grandmother was the first one to tell me about periods. She told me a lot about what not to do instead of warning me about the pain.....she told me that I should not put salt in the food I cook, if I do the men who will eat will get sick... she also said I should not put a baby on my back because it will die". (16-year-old girl, Interview)

"My mother tells me to be strong because I'm a woman, and that makes me feel like I should handle it on my own, even when it pains so much, I do not have to complain I have to be silent and not tell anyone I am sick." (13-year-old girl, Interview)

Conclusion

This study demonstrates that adolescent menstrual health in Zambia cannot be understood solely through a biomedical lens but must be recognized as a deeply gendered experience. While biological and physiological factors significantly contribute to primary dysmenorrhea, the ways in which girls interpret, express, and manage pain are profoundly shaped by cultural norms, stigma, and expectations of female endurance.

A feminist and biopsychosocial perspective reveals that menstrual pain is both embodied and socially constructed, underscoring the urgent need for interventions that address clinical management alongside the social dimensions of care.

Moving beyond normalization and silence, sexual and reproductive health programs must adopt gender-sensitive, youth-centered approaches that validate adolescents' voices, reduce stigma, and provide accessible, holistic support for menstrual health.

Recommendations

- Policy: Include menstrual pain management in adolescent SRHR frameworks.
- Practice: Provide school-based menstrual health support (rest spaces, pain management protocols).
- Research: Advance feminist participatory methods to capture hidden voices and silences around menstrual health.

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Executive Summary

This dissemination package accompanies the poster presentation titled:

“Drawing Out the Pain”: A Participatory Qualitative Study on Non-Pharmacological Coping Strategies for Primary Dysmenorrhea Among Adolescent Girls in Lusaka District, Zambia.

Adolescent girls in Lusaka, Zambia commonly experience primary dysmenorrhea (painful periods), yet their non-medical coping strategies remain overlooked in sexual and reproductive health (SRHR) policy and programming. This qualitative study, part of a larger PhD project, used DrawingOut workshops and in-depth interviews with girls aged 10–19 from public and private schools to explore how they manage menstrual pain without medication. Findings reveal that girls rely on a range of non-pharmacological strategies, including:

- Resting or sleeping through pain
- Applying warm compresses
- Self-massage
- Reducing physical activity
- Social withdrawal and isolation

These approaches are deeply shaped by cultural norms, stigma, and the normalization of silent suffering. Many girls hide their pain to avoid embarrassment or judgment, often missing school or disengaging from peers, impacting both their education and emotional well-being.
The study underscores the urgent need to integrate adolescent voices and lived experiences into SRHR and school-based health initiatives. Creating safe, supportive spaces to discuss menstruation can improve menstrual health literacy, reduce stigma, and promote more compassionate, effective care for adolescent girls in Zambia and similar settings.

Abstract

Background

Primary dysmenorrhea (PD) remains a prevalent yet under-acknowledged menstrual health issue among adolescent girls in low-resource settings. Non-pharmacological coping mechanisms, though widespread, are poorly understood within global sexual and reproductive health and rights (SRHR) frameworks. This study qualitatively explored the lived experiences of adolescent girls managing PD without medication in Lusaka, Zambia.

Methods

The study formed part of a larger mixed-methods PhD research project. This phase employed a qualitative participatory methodology, using DrawingOut workshops and in-depth interviews with adolescent girls aged 10–19 from public and private schools. Thematic analysis was conducted using ATLAS.ti to examine patterns on how girls cope with menstrual pain non-pharmacologically.

Results

Participants reported diverse non-pharmacological strategies rooted in cultural norms, embodied experience, and environmental constraints. Common approaches included resting, applying warm compresses, self-massage, reducing physical activity, and sleeping through pain episodes. Many girls preferred isolation during menstruation, often withdrawing from class, social activities, and discussions due to pain and stigma. The normalization of silent endurance reinforced these coping strategies, despite their impact on education and psychosocial well-being.

Conclusion

Adolescent girls in Zambia use a variety of non-pharmacological mechanisms to manage primary dysmenorrhea, shaped by social, cultural, and institutional silence around menstruation. Incorporating these insights into SRHR and school health programming, especially through safe spaces, can enhance menstrual health literacy and promote adolescent-friendly care.

Keywords: Primary dysmenorrhea, adolescent girls, qualitative research, DrawingOut method, non-pharmacological coping, SRHR, Zambia, menstrual health

Drawing Out the Pain: A Participatory Qualitative Study on Non-Pharmacological Coping Strategies for Primary Dysmenorrhea Among Adolescent Girls in Lusaka District, Zambia

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Theme: Adolescents and Sexual and Reproductive Health

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BACKGROUND

Primary dysmenorrhea (PD) is one of the most common menstrual health problems among adolescent girls, yet it often remains under-recognized, particularly in low-resource settings. Globally, adolescent girls report a range of menstrual pain management strategies, but most research and interventions have prioritized pharmacological methods, overlooking local, cultural, and non-pharmacological approaches.

In Zambia, menstruation is surrounded by stigma and silence, which further marginalizes adolescent girls in both educational and social environments. Understanding how young girls cope with dysmenorrhea without medication provides valuable insights for menstrual health literacy, school-based health interventions, and adolescent-friendly SRHR programming (Iacovides et al., 2015; Parker & Sneddon, 2021).

Objective

This study aimed to explore the lived experiences of adolescent girls in Lusaka, Zambia, focusing on how they manage primary dysmenorrhea using non-pharmacological coping strategies.

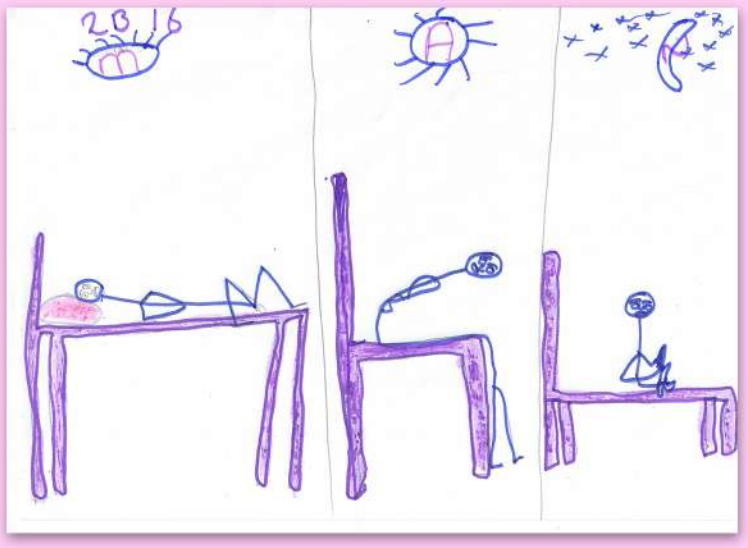
METHODS

This research formed part of a broader mixed-methods PhD project. The qualitative phase employed a participatory approach using the DrawingOut method, where adolescent girls (aged 10–19) were invited to express their experiences through drawings and discussions. Workshops were conducted in both public and private schools across Lusaka District. In addition, in-depth interviews were carried out to further capture individual perspectives. Data were analyzed thematically using ATLAS.ti software, which facilitated the identification of recurring themes related to coping strategies, cultural norms, and psychosocial impact (Braun & Clarke, 2006).

Conclusion

Adolescent girls in Lusaka adopt multiple non-pharmacological coping strategies for dysmenorrhea, but these approaches are constrained by cultural norms of silence and limited institutional support. Addressing these gaps requires embedding menstrual health education within schools, training teachers to provide adolescent-friendly support, and strengthening SRHR programming to acknowledge both pharmacological and non-pharmacological approaches.

Results



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Recommendations

- Establish safe spaces in schools for open dialogue on menstruation.
- Integrate menstrual health literacy into SRHR and school health curricula.
- Promote adolescent-friendly care that recognizes cultural context and diverse coping strategies.
- Encourage participatory methods in menstrual health research to amplify girls' voices.

Supporting Publications

Full papers related to this study can be accessed at the following links:

1. Journal of Health Research: https://jhr.ssu.ac.ir/article-1-1073-en.pdf
2. American Journal of Public Health Research: https://pubs.sciepub.com/ajphr/13/1/1/index.html

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