

Chapter 9**The Neglected Majority: Married Adolescents**

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Background

The majority of sexually active adolescent girls in developing countries are married. This statement may come as a surprise to many in the reproductive health field because so much attention has been focused on sexual activity among unmarried adolescents. While striving to meet the needs of all adolescents, we must recognize that married adolescent girls represent a particularly vulnerable—and largely invisible—population. For example, they are highly vulnerable to significant reproductive health problems, including pregnancy-related morbidity and mortality, sexually transmitted infections (STIs), including HIV infection, as well as non-sexually transmitted reproductive tract infections (RTIs). They suffer disadvantages in other areas as well—for example, they are less likely than unmarried girls to complete their education. Yet, despite their large numbers, elevated risks, and many unmet needs, married adolescent girls have rarely been the target of programmatic efforts.

Data in developing countries quantify the proportion of females who marry as adolescents. This proportion varies by region and country, but is high across the board—for example, in the mid-1990s the percentage of women aged 25–29 who married before age 18 was more than 72 in Mali, 55 in Nigeria, and 39 in Guatemala (Mensch, Bruce, and Greene 1998). In India, close to one-quarter of women aged 20–24 married before age 15; half married before age 18 (National Family Health Survey 1998-1999). Over 60

percent of sexually active adolescent girls were married in 37 of 45 countries that had recent Demographic and Health Survey (DHS) data available (Bruce 2001).

Adolescent girls typically have no say in the timing and terms of sexual intercourse and marriage—these decisions are made by parents and male partners. Once married, young females are often under pressure to prove their fertility by delivering a first child within 14 to 24 months after marriage (Mensch 1999). They often face this pressure in relative isolation. Married girls may live in homes that are remote from their natal families and familiar social networks; thus, they are frequently lonely (at least in the first months or years of marriage) and often lack allies, sources of information, social contacts, safe and acceptable places to go, and unimpeded access to health services.

When considering the issues related to marriage among adolescents, we must pursue two parallel policy and programmatic goals:

1. Intensify efforts to delay females' average age at marriage, at least past the internationally recognized legal age of 18 (the end of childhood as defined by the United Nations' Convention on the Rights of the Child).
2. Provide information, support, and social and economic opportunities to engaged and married adolescents, including those who are pregnant and those who are already mothers.

In many circumstances, marriage itself may constitute a gross violation of girls' rights. Many girls in many countries are married below the minimum age at which marriage is legal in their country and/or before age 18. In some countries where people must be at least 18 years old to marry legally, marriage of a girl younger than 18 is allowed with parental and/or judicial consent. This is the case in Guatemala, Mexico, and Nicaragua, where girls must be 18 years old to marry legally, but can be married at age 14 with the consent of a parent and/or judge (Moodie 2000).

Little thought has been given to whether married girls have access to reproductive health information and services. The reflexive response is “of course they do”—the assumption being that married girls have the same level of access as do older, married woman. In reality, being younger and less empowered in their husbands’ households and often extended families, married girls frequently lack decisionmaking power, exposure to outside/modern messages and health services, and mobility to access such services. For example, in Egypt, 54 percent of married 15–19-year-old girls cannot go to the local health center/doctor or can only go with an adult. Only 51 percent can go to the homes of relatives or friends by themselves (DHS 1995).

Marriage may impose severe limits on the social mobility of adolescent girls. Qualitative work undertaken by the Population Council in Senegal found that married girls report that “less freedom” and “less access to friends” are two of the key changes they experienced after getting married. Most girls interviewed in Senegal also observed the negative impact of marriage on their schooling (Diop 2000).¹ The Population Council is currently undertaking a study in Burkina Faso that looks at potential differentials in social networks and mobility between unmarried, engaged, and married adolescents (Brady 2001).

Little thought has been given to preserving married adolescents’ right to education. South Africa provides an example of this. Much policy attention was given to allowing girls with children to return to school—but none of this attention turned to the subject of marriage. Yet, while 45 percent of unmarried mothers aged 15–19 are in school in South Africa, only 27 percent of married girls are in school (Roberts 2000).

¹ An informal report of these results is available from the Population Council office in Senegal.

The isolation of married girls is central to their experience, affecting their psychological, social, and economic well-being as well as their health. A study in Indonesia found significantly less knowledge of key reproductive health issues among married girls compared to unmarried girls aged 15–19: 13 versus 31 percent knew what a condom was and 59 versus 86 percent had heard of HIV/AIDS. Only 10 percent of the married girls, versus 50 percent of the unmarried girls, reported having someone with whom to discuss the subject of sexuality (East-West Center 1999).

The younger that girls are married, the more significant the age gap between them and their husbands tends to be. Spousal differentials in age/seniority exacerbate gender differentials in power, further limiting married girls' ability to negotiate with their husbands. On average, 35 percent of the husbands of married girls aged 15–19 in developing countries, excluding China, are 10 or more years older than their wives (United Nations 2000). In Egypt, for example, 65 percent of adolescent brides marry men more than five years older than they are, and nearly one quarter (24 percent) marry men more than 10 or more years older (Mensch, Bruce, and Greene 1998).

Males' and Females' Average Mean Age at Marriage: Select Countries

Country (year of survey)	<u>Males</u> Average mean age at marriage	<u>Females</u> Average mean age at marriage	Differential between male-female average mean age at marriage
Bangladesh (1991)	24.9	18.1	6.8
Burkina Faso (1991)	27.5	18.9	8.6
Ghana (1993)	26.2	20.5	5.7
India (1991)	23.9	19.3	4.7
Mali (1995–96)	25.8	18.4	7.5

Source: United Nations Department of Economic and Social Affairs 2000

Early Marriage and Reproductive Health

In general, married women have more regular sexual relations than sexually active unmarried women. This is likely also to be true of married adolescent girls. For example, in Burkina Faso, 37 percent of married girls, but only 22 percent of unmarried (sexually active) girls had sex in the prior week. Married girls (aged 15–19) in Burkina Faso are two-and-a-half times more likely than sexually active unmarried girls (OR=2.4) to have had sex in the prior week (Clark 2002).

While marriage may offer social respectability and sanction to girls' sexual activity, it does not ensure that sexual relations are safe, voluntary, or pleasurable. Indeed, young married females are usually expected to be unconditionally available to meet their husbands' sexual demands and under pressure to bear children, regardless of their own desires and needs.

First intercourse within marriage can be frightening and in some cases traumatic for young wives. One young woman in Gujarat, India who had been married by age 18, described her experience of first intercourse: "I felt very scared, as I had never experienced such a thing before. The thought of being with a man made me feel scared." (Haberland, McGrory, and Santhya 2001).

In a different Council study in Uttar Pradesh, a young woman who was married at age 13 recalled her first sexual experience in these chilling words:

It was a terrifying experience. When I tried to resist, he pinned my arms above my head. It must have been so painful and suffocating, and I must have fainted, for I only remember getting up in the morning and finding stains of blood on the sheet (Khan et al. 1997).

While sexual initiation within marriage can be frightening for a young female, sex can become a desired and pleasurable part of the marital relationship—but this is not

always the case. We know that *much nonconsensual sex takes place within marriage*. For example, a study in Uttar Pradesh, India found that 29 percent of men reported sexually abusing their wives (Martin et al. 1999). General physical abuse is also an issue. In the Uttar Pradesh study, another 17 percent of men reported physical (but not sexual) abuse of their wives. The 1995 Demographic and Health Survey in Egypt found that 29 percent of married adolescent girls had been beaten by their husbands (and sometimes others) since marriage; of those beaten, 41 percent were beaten during pregnancy. While it is rarely easy for girls and women to walk away from abusive partners, it is likely even more difficult to do so in contexts in which being female and unmarried or divorced is socially unacceptable and stigmatized.

Abuse has been linked to specific negative reproductive health outcomes. For example, in the Uttar Pradesh study cited above, abuse was more common among men who had extramarital sex (six times as high for sexual abuse using force) and among men who had symptoms of STIs. Unplanned pregnancies were also much more common among wives of abusive men (Martin et al. 1999).

Even consensual sex within marriage is not necessarily safe. Men across countries and cultures have extramarital affairs—and this has implications for their and their wives' risk of contracting STIs. Even when females understand how to protect themselves, it may not be possible. In many (if not most) contexts, a newly married female insisting on condom use would be considered highly suspect. Young married females have the dual burden of risking such negative consequences while at the same time being biologically more vulnerable to STI infection (Shafer and Sweet 1990; Brookman 1990; see also Chapter 10). The pressure on new wives to conceive and prove fertility makes condom use even more unlikely among married adolescent girls.

Delayed conception may be a blessing in the sense that it protects against the risks of early childbearing, but it can create considerable anxiety and stress for young married females. In a study in Gujarat, young women who did not get pregnant promptly after marriage report that they were taunted and harassed by in-laws and neighbors:

It had been 2–3 years of my marriage, and I used to hear people saying that I still don't have a child. Even in D_____ [where the respondent and her husband moved after fights with her father-in-law regarding delays in conception], our neighbors used to ask me if I had a child or not (Haberland, McGrory, and Santhya 2001).

While there are often strong social norms that promote bearing a first child shortly after marriage, young mothers may very well be interested in delaying their second birth. However, young wives often require more social support, information on health/sexuality/fertility cycles, and negotiating strategies than do older wives, who have established communication patterns with their husbands and somewhat higher status in their households and husbands' families.

There may also be more potential for young married females to delay a first birth than one might think. For example, an in-depth qualitative study in Gujarat found among young wives an unexpected degree of interest in delaying a first birth. Over one-third of these females (13 out of 29 who were recently pregnant or had delivered their first child) reported that they *and their husbands* had desired to delay their first birth; however, only a handful had acted on this desire, and most did so by using the rhythm method incorrectly (Haberland, McGrory, and Santhya 2001).

About half of all girls in the developing world today will be married while they are still adolescents. A high proportion of these girls will have their first child before their twentieth birthday (see table below).

Percentage of 15–19-Year-Old Married Girls Who Have Ever Been Pregnant or Had a Child Before Their Twentieth Birthday: Select Countries

Country (year of survey)	Ever been pregnant (%)	Ever had a child (%)
Bangladesh (1996–97)	71	62
Benin (1996)	82	62
Egypt (1995)	71	51
Ghana (1998)	73	62
Malawi (1992)	73	58
Pakistan (1990–91)	63	49

Source: Population Council analysis of DHS data

First births have always posed special medical concerns. Certain conditions, such as obstructed labor, are more common in *prima paros*. As fertility falls and females have fewer children, a higher proportion of births will be first, thus higher-risk, births. These birth order risks are elevated if the mother is young and has not reached her full growth potential.² There are treacherous synergies in this situation: Where poverty is greatest, females generally marry at a younger age, are less educated, have less mobility, and are less likely to have their births attended. All of these factors are associated with elevated maternal mortality (Sloan 2000).

Young females pregnant for the first time often have very little idea of what to expect during delivery and have limited access to accurate information regarding antenatal care (ANC), delivery, and postpartum care (Haberland, McGrory, and Santhya 2001). We may miss an important opportunity in failing to give special attention to first-time married and pregnant young females, as new parents and their families may be more receptive to information and services at this seminal moment in young couples' lives.

² A recent study in the United States analyzed population-based birth outcomes and defined early adolescent childbearing (in that developed-country context) as births to mothers aged 15 or younger. Negative birth outcomes (infant mortality, very low birth weight, and very premature delivery) were found to be more common among girls 15 years old and younger than among older girls and women (Phipps and Sowers 2002). While informative, this analysis cannot be generalized to developing-country settings.

Interventions at the time of first pregnancy are likely to set patterns for future reproductive health, fertility, and infant/childcare practices. *First births may be powerful entry points for providing information and services that promote lifelong reproductive and maternal-child health and planned parenthood—yet few programs consider the special needs and opportunities associated with first births.*

Interventions for Married Adolescent Girls: Programmatic Considerations

Step one: diagnostic research

An objective and nuanced understanding of the transition to marriage and motherhood is critical to designing appropriate and effective programs for adolescent girls. In-depth interviews are recommended. Focus groups will generate information about attitudes, norms, and common myths/wisdom in a given setting, but they will not necessarily reflect much individual variation or change. Issues relevant to adolescent girls' lives—support, decisionmaking, control over assets, and so forth—are complicated, dynamic, and generally better captured through individual interviews. Quantitative data can provide important supplementary information about the scope of certain practices and basic demographic information. Sources include pre-existing surveys, household listing data, etc.

Below are illustrative questions to consider when determining the who, how, and what of adolescent marriage. Diagnostic research in advance of launching interventions for married adolescent girls should gather information about the following key dimensions of girls' lives: the transition to marriage, the transition to motherhood, and reproductive health knowledge and attitudes.

Transition to marriage

The transition to marriage is a critical time in the lives of adolescent girls, yet little is known about this passage. Gathering information about the before-and-after of this process will help not only to shed light on a shadowed topic but also to develop practical strategies to ease the transition to marriage, understand pros and cons of possible entry points for interventions, foresee potential challenges, and so on. Relevant questions to consider include:

- Do females have any say in choosing their husbands?
- What is the typical age differential between spouses?
- Is there a long period of engagement before marriage or several stages in the marriage process before the female moves in with her husband?
- Is the female expected to be sexually available to her fiancé/husband? Is the man still free to have sex with others?
- What is the experience of first sexual intercourse with a husband like for married girls?
- Are married girls' ties with their natal home upheld—that is, are there frequent and/or extended visits home?
- What is the proportion of nuclear-family and extended-family households among young married females?
- What is the proportion of polygamous and monogamous marriages? How does the transition to the marital household differ if the marriage is polygamous?
- Are young females in polygamous marriages more vulnerable? How?
- How much mobility do married girls have? Is it more or less than unmarried adolescent girls?
- What is the extent and depth of married girls' non-familial contacts? Do they have more or fewer of these contacts than do unmarried girls?
- Do young married females have access to money? What control do they have over assets?
- What is the nature of the communication between married girls and their new husbands? If the husband is a new acquaintance, how does spousal communication change over time?
- Do young married females form bonds or alliances with others in their households that support their interests?
- Is verbal, physical, or sexual abuse or violence present in the relationship?

Transition to motherhood

Customs surrounding motherhood—both social conventions and health practices—vary greatly from place to place. In some settings, pregnant females

traditionally return to their natal home late (sometimes very late) in pregnancy for delivery and postpartum care that can last several months or even a year. Before planning any interventions, it is important to understand local customs regarding childbearing, including familial control of events related to birth; it is also important to assess females' access to services and the appropriateness of service content. Relevant questions to consider include:

- Do young married females discuss family planning (e.g., contraception and timing/spacing of births) with their husbands?
- Who is involved in decisions regarding family planning? How much say do young married females have in this matter?
- Do young married and pregnant females receive antenatal care?
- What is the content of that care?
- Who makes decisions regarding care during pregnancy (e.g., regarding the mother's diet, workload, and health care)? How much say do young married females have in these decisions?
- Do young married females receive social support during pregnancy (e.g., help with housework, emotional support, and help in seeking services)? From whom? Do they encounter obstacles to receiving this support? Created by whom?
- Where do young pregnant females typically deliver: In their marital or natal home? At home or in a hospital?
- Who is involved in decisions regarding delivery? How much say do young females have in this matter?
- Who in a young pregnant female's family is present/helps during delivery?
- What postpartum practices (both positive and negative) are common (e.g., discarding colostrum, a period of isolation for mother and newborn, special and taboo foods)?
- Do young mothers receive any postpartum health services? What is the content of these services?
- Who is involved in decisions regarding postpartum care (e.g., regarding the mother's diet, workload, health care, self care, and care of the newborn)?
- Do young mothers receive social support during the postpartum period (e.g., help with housework, emotional support, help in seeking services, and help caring for the newborn)? From whom? Do they face any negative/unwanted interference during this period? From whom?
- Is abstinence practiced during pregnancy and/or the postpartum period? If so, what is the pattern of this practice? Who makes decisions regarding the stopping and resuming of sexual activity? During periods of abstinence, do male partners go elsewhere for sex?

Reproductive health knowledge and attitudes

Having reproductive health knowledge is vitally important to the well-being of married adolescent girls (as it is to the well-being of all sexually active people). Ideally, research on this subject should explore not only married adolescent girls' level of reproductive health knowledge, but also that of their partners and significant others, such as older women living in married girls' households (who are often sources of information for younger females who live with them). Relevant questions to consider include:

- When do girls first learn about sex? Before or after marriage? How and from whom?
- Do young females know:
 - when their fertile period is?
 - that both their and their partner's sexual behavior has implications for the transmission of STIs, including HIV infection?
 - that marriage is not in-and-of-itself protective against STIs, including HIV infection?
 - that STIs, including HIV infection, as well as some non-sexually transmitted RTIs, can harm the fetus?
 - that abstinence, male condoms, and female condoms are currently the only ways to protect against STIs, including HIV infection?
 - that douching (particularly with substances other than plain water) and inserting herbs or powders into the vagina are generally harmful and should be avoided?
 - about appropriate care during pregnancy (e.g., antenatal care, diet, workload) and how the fetus develops?
 - what happens during delivery?
 - signs of pregnancy/delivery complications?
 - what a safe-delivery kit is and where they can get one?
 - when/how to start breastfeeding and for how long, and that colostrum is very beneficial to the newborn?
 - about self-care during the postpartum period?
 - how to care for a newborn?
 - when to seek services for their newborn or themselves?
 - when they and their partners can resume sexual relations following delivery?
 - when they return to fertility following delivery?
 - About contraceptive methods, including how to correctly use natural family planning methods?
- What do young females feel about:
 - sexual pleasure (including among circumcised females)?
 - nonconsensual sex?
 - the possibility and acceptability of physical abuse within marriage, particularly in relation to sex and pregnancy?

Target populations of interventions

The target population of interventions that address the needs of married adolescent girls will vary from context to context. Determining the appropriate entry point(s) for a given intervention requires taking into account several factors: findings from diagnostic research, the strengths and interests of local organizations that could serve as intervention partners, the capacities of other programmatic collaborators, and funding considerations. Based on these considerations, interventions could variously target:

- Engaged adolescent girls and/or couples,
- Newly married adolescent girls,
- Newly married couples in which the wife is an adolescent,
- Young women pregnant for the first time and/or these young women and their husbands,
- New mothers/fathers, or
- Family members of married adolescent girls (including mothers, mothers-in-law, co-wives, and other senior female family members).

Protecting married adolescent girls' right to privacy

There are instances in which married adolescent girls are able to carve out some space and autonomy for themselves within the highly controlled environments in which they live. In order not to jeopardize this when working with couples that include an adolescent girl or with husbands of adolescent girls, it is vital to safeguard girls' interests by :

- First asking a married adolescent girl whether she is interested in involving her husband and letting her know how and how much he would be involved. Some married adolescent girls will not want to involve their husbands, and that must be accepted.

- Always ensuring that married adolescent girls have their own direct access to information and services, and sending/reiterating the message that they have the right to make their own decisions concerning their sexual and reproductive lives and their bodies in general.
- Never making partner participation mandatory.
- Ensuring confidentiality—and keeping it.

A central goal of working to improve the well-being of married adolescent girls is decreasing gender-based power differentials between male and female partners. Thus, if diagnostic research has revealed that the primary decisionmakers regarding family planning are the male partners of adolescent girls, the appropriate response is not to provide these partners with even more control by feeding information primarily to them; rather, it is to provide information and services *directly* to adolescent girls as well to their partners.

Positive partner involvement

That said, there are several important examples of how husbands and other male partners might be involved in a manner that positively affects adolescent girls' reproductive health. Programs in Istanbul, Turkey (Molzan Turan et al. 2002) and in Sfax, Tunisia (Coeytaux 1989) have demonstrated the interest of husbands in supporting their wives during birth and the postpartum period. Similarly in Egypt, Abdel-Tawab and colleagues (2002) found that husbands were not only interested in assisting their wives during postabortion recovery, but also that women with high levels of emotional support from their husbands had better *physical* recovery. In the program in Istanbul, couples in

which the husband was involved in the intervention³ were more likely to use modern contraceptive methods (Molzán Turán et al. 2002). The program in Sfax increased husbands' participation in postpartum care by selecting a socially significant day—the fortieth day postpartum—as a focus point for services (Coeytaux 1989).

Intervention: when, how and what?

When considering the relationships between policy concerning adolescents, marriage among adolescents, and desirable reproductive health outcomes, there are a number of intervention strategies that could be pursued.

The first strategy is to work through non-health sectors to offer girls the resources they need to defer marriage—e.g., increasing their educational opportunities, their access to and control of resources, and their bargaining power in marriage, as well as increasing knowledge of, and enforcing laws regarding, the legal age of marriage in every country. Two examples from Bangladesh illustrate the potential impact of such interventions on the timing of marriage:

- An innovative educational intervention offers evidence that parents are delaying the marriage of their 11–19-year-old daughters in response to a secondary-school scholarship program. In this program monthly stipends are deposited into a girl's bank account if she attends secondary school 65 percent of the time that school is in session and if she maintains a passing grade-point average (Arends-Kuenning and Amin 2000).
- Research indicates that unmarried adolescent girls' participation in wage-earning factory work within the garment industry is delaying marriage. There is evidence that the average age at marriage has increased both among these girls and among nonworking girls who live in working girls' communities (Amin et al. 1998; see also Chapters 8a and b).

³ This intervention is a prenatal/birth/postpartum education project comprised of antenatal group education sessions for couples; an informational booklet containing frequently asked questions about health during the pregnancy, childbirth, and the postpartum period; and a telephone hotline for mothers and couples in the postpartum period.

A second strategy is to work directly with married and soon-to-be-married adolescent girls. Any arguments made for interventions pegged to first births also apply to interventions targeting newly engaged or newly married adolescents.

Once the process of engagement/marriage has begun, it may be possible in some settings to work with married or soon-to-be married adolescent girls, their male partners, and other influential individuals in their lives to 1) increase their sexual/reproductive health knowledge base (including their understanding of the process of reproduction and of sexual/reproductive behaviors that are safe for adolescent girls, their partners, and any prospective children); and 2) increase their respect for females' sexual/reproductive rights and health and for gender equality in sexual and marital relationships.

In dealing with newly engaged and newly married adolescents and first-time parents, the goal is to promote a healthy and positive transition to marriage and motherhood that ensures the well-being of young mothers and their children, and to foster more open, egalitarian communication and shared decisionmaking between married adolescent girls and their husbands. Interventions targeting these adolescents should be multi-faceted. Ideally they would aim to increase responsiveness to the needs of newly engaged/married/pregnant/postpartum adolescent girls by:

- increasing reproductive health knowledge;
- improving reproductive health services; and
- expanding girls' skills, sense of agency, social networks, command over resources, and negotiating power in relationships.

Increasing reproductive health knowledge

Reproductive health knowledge can be increased by providing information to adolescent girls, their male partners, and other significant individuals in their lives by way of:

- Clinic- and/or community-based health services (this might require more interactive counseling, couple counseling, home visits to adolescent girls, and other creative measures). In a project in India, the Population Council and partners are undertaking home visits to young females and males to provide information and are also planning to offer clinic-based couple counseling to married adolescent girls who would like to include their husbands in counseling.
- Information/Education/Communication (IEC) materials specifically directed to newly engaged/married/pregnant/postpartum adolescent girls.
- Group-based interventions outside the health sector—e.g., literacy classes and livelihood and empowerment programs (see below)—that can also provide a venue for transmitting reproductive health information.

Depending on what diagnostic research identifies to be important gaps in reproductive health knowledge, information provided to engaged/married/pregnant/postpartum adolescent girls and influential others could be selected to promote knowledge of that:

- when the fertile period is
- a person and his/her partner's (or partners') sexual behavior has implications for transmission of STIs, including HIV infection
- marriage is not in-and-of-itself protective against STIs, including HIV infection
- STIs, including HIV infection, and some non-sexually transmitted RTIs can harm the fetus
- methods to protect against acquiring an STI, including HIV infection
- douching (particularly with substances other than plain water) and inserting herbs or powders into the vagina are generally harmful and should be avoided
- appropriate care during pregnancy (regarding antenatal care, diet, and workload)
- how a fetus develops
- what happens during pregnancy and delivery
- signs of pregnancy/delivery complications
- making a plan for a safe delivery
- when/how to start breastfeeding (including that colostrum is beneficial to newborns) and for how long
- self-care during the postpartum period
- caring for a newborn
- when to seek services for a newborn or new mother
- when a new mother and partner can resume sexual relations
- return to fertility postpartum
- contraceptive methods, including how to correctly use natural family planning methods
- sexual pleasure (including among circumcised women)

- how the husband can be supportive during pregnancy, birth, and the postpartum period
- no one deserves to be beaten

Improving reproductive health services

Depending on the findings of diagnostic research, the timing and targets of an intervention, and program priorities, existing reproductive health services may be enhanced or new services instituted to meet the specific needs and concerns of engaged/married/pregnant/postpartum adolescent girls.

A program targeting first-time mothers and mothers-to-be might seek to:

- Expand antenatal care services (often comprised primarily of iron folate supplementation and tetanus injections) to include information (regarding pregnancy and care during pregnancy and the immediate postpartum period) and preparation for delivery (making birth plans and having skilled attendants at birth).
- Help pregnant girls plan for delivery—i.e., work with them to develop explicit plans for safe delivery (whether at home or in an institution). The pregnant girl should participate in developing the plan and must understand what it entails. Other components might include provision of safe-delivery kits and information on signs of pregnancy and birth complications.
- Provide and expand postpartum services—a neglected area of reproductive health services. This might consist of providing in-home check-ups of new mothers and newborns (which could include offering information about self-care, newborn/infant feeding, and so on) and/or providing six-week postpartum check-ups for newborns and their mothers. Examples of such programs include:
 - The Sfax, Tunisia program cited above, which doubled its return rate because it chose a significant day for service provision and invited/examined mothers and children together (Coeytaux 1989).
 - A Population Council project underway in India, which includes at least one postpartum visit between birth and 6 weeks after birth for mothers and newborns, supplemented by information on self-care, complications, and where to go (exactly) for help.
- Offer married adolescent girls the option of including their husband (or mother/mother-in-law) in counseling sessions or other education activities.
- Provide IEC materials—including information about pregnancy/delivery/postpartum care for new mothers and newborns and about infant care—before and after delivery

to young mothers, their husbands, and senior female members of their families. How family members can help young mothers by offering practical and emotional support should be included in this material.

A program targeting recently engaged and/or married girls might seek to:

- Create a meeting space for these girls to expand their peer networks. This space could also serve as a venue to provide reproductive health information (see Chapter 7).
- Provide information on sexuality and reproduction, contraception, and RTIs. Increase girls' knowledge about STIs, including HIV infection, and how to protect against them, and provide girls with male and/or female condoms.
- Support girls in clarifying and achieving their reproductive intention. If a married girl wishes to delay a first birth, would she like help in discussing this with her husband? If so, the program could provide couple counseling and facilitate spouses' discussions/decisionmaking regarding appropriate contraceptive methods (including natural family planning methods) and how to use them properly.
- Inform girls and, if they wish, their male partners about existing reproductive health, family planning, antenatal care, delivery, and postpartum services.

Expanding girls' skills, sense of agency, social networks, command over resources, and negotiating power in relationships

Empowering married adolescent girls is a critical component of a comprehensive approach to improving their well-being. Information and services cannot be utilized if girls are unable to access them because of their lack of power, status, and mobility.

Group-based programs for girls are documenting important successes in increasing girls' sense of autonomy and agency, as well as their reproductive-health service utilization.

Similar programs for women include the ReproSalud program in Peru (Rogow and Wood 2002; Rogow 2000) and a World Neighbors program in Nepal (Arens et al. 2002). In both cases, women are brought together in groups (in the latter program, savings and credit groups) to work collectively on community health and/or development issues.

Raising reproductive health awareness and encouraging analysis of reproductive health issues is a critical component of both programs. Participants discuss, analyze, prioritize,

and develop strategies for dealing with reproductive and general health concerns. These strategies may range from means to obtain better-quality services from government facilities to means to develop safe sources of drinking water. The women in these programs identify their own primary concerns and strategies to address them (as opposed to being told what their concerns ought to be). The increased awareness and collective action fostered by these programs have positively affected participants' sense of agency, both in terms of their capacity to act on their own behalf in their communities and in their relationships. Group activities in the program in Nepal, coupled with improvements in/expansion of clinical reproductive health services, resulted in an 83 percent increase in the number of reproductive health visits to clinics in the area of the intervention.

Using similar group-based approaches in programs for adolescent girls is perhaps particularly necessary when dealing with married girls. Depending on the capacity of local staff/collaborating partners, it may be possible to involve married adolescent girls in group formation/social development initiatives that can improve their skills, expand their social networks, and contribute to their empowerment.

One social and economic development program for adolescent girls in Egypt has given special attention to assisting participants through the transition to marriage and motherhood. This was done after program staff recognized that once married, girls were dropping out of the program, often against their will. Program staff responded by negotiating with girls' male partners (once girls had become engaged) to ensure the girls' continued participation in the program. In Egypt, as in many places, even a relatively empowered girl is under pressure to become pregnant soon after marriage. Programmatic adjustments were made to accommodate this cultural reality: an infant care center was

added; married girls were explicitly told that they could return to work at three months postpartum; and program staff made sure to learn when participants' babies were three months old. Surprisingly and gratifyingly, many girls who became mothers while enrolled in the program returned to the program around 40 days after giving birth and clamored to re-enlist in their income-generating and social work. Interestingly, married participants started bringing their husbands to the program and asking how the husbands could be involved. Girls' spontaneous, self-generated interest in including their male partners, and partners' relative willingness to be involved, was noteworthy (Assaad 2000).

Groups for married adolescent girls might focus on livelihood activities that provide girls with economic skills, flexible savings schemes, and credit opportunities for them to develop micro-enterprise ventures, among other things (see Chapter 8a). Other programs could bring married adolescent girls together using the "hook" of community mobilization and development activities, such as organizing and maintaining safe drinking water systems, managing grazing and fodder use/production, and so on. In a Population Council project in India, for example, self-help group activities for adolescent girls will include lessons on legal issues and women's development, as well as "exposure visits" to public places (such as banks, post offices, and police stations). Girls will be encouraged to become involved in village development activities to speak out against under-age marriage and domestic violence. It is essential that group activities for married (and unmarried) adolescent girls respond to girls' self-expressed needs and concerns. Any of the activities they request can be supplemented with others that program staff deem useful (such as those to be undertaken in the project in India cited above).

Regardless of which activities provide group cohesion for adolescent girls (married and unmarried), these group settings can be used as venues to provide reproductive health information and linkages to services and to increase girls' understanding of the gender disparities that underlie females' reproductive health problems.

The key goals of interventions for married (as well as unmarried) adolescent girls ought to be to:

- help them to expand their peer and other social networks
- expose them to modern information and thinking
- help them to develop skills that they can use to increase their assets, decrease their workload, and improve conditions in their family and/or community
- enable them to bond with other girls by working as part of a group, which can increase both individual and group agency
- otherwise expand their options in life

Through effective and creative measures designed to promote these goals, programs reach a neglected and vulnerable majority—married adolescent girls—and lay a longer term framework for better health and development.

References

Abdel-Tawab, Nahla, Dale Huntington, Ezzeldin Osman, Hala Youssef, and Laila Nawar. 2002. "Recovery from abortion and miscarriage in Egypt: Does counseling husbands help?" in Nicole Haberland and Diana Measham (eds.), *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York: Population Council.

Amin, Sajeda, Ian Diamond, Ruchira Naved, and Margaret Newby. 1998. "Transition to adulthood of female garment-factory workers in Bangladesh," *Studies in Family Planning* 29, no. 2: 185-200.

Arens, Tom, Denise Caudill, Saraswati Gautam, Nicole Haberland, and Gopal Nakarmi. 2002. "'If many push together it can be done': Reproductive health and women's savings and credit in Nepal," in Nicole Haberland and Diana Measham (eds.), *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York: Population Council.

Arends-Kuenning, Mary and Sajeda Amin. 2000. "The Effects of Schooling Incentive Programs on Household Resource Allocation in Bangladesh," Policy Research Division Working Paper no. 133. New York: Population Council.

Assaad, Marie. 2000. "Mokattam: Catalyzing social and economic development and better reproductive health through investment in girls 12–20 years old," presentation at the Regional Workshop on Meeting the Participation and Development Rights of Adolescent Girls, November, Dakar, Senegal.

Assaad, Marie and Judith Bruce. 1997. "Empowering the next generation: Girls of the Maqattam Garbage Settlement," *SEEDS* no. 19. New York: Population Council.

Brady, Martha. 2001. Personal communication.

Brookman, R.R. 1990. "Adolescent sexual behavior," in K. K. Holmes et al. (eds.), *Sexually Transmitted Diseases*, 2nd ed. New York: McGraw-Hill.

Bruce, Judith. 2001. "Married adolescent girls: Numerous but unknown, neglected in policy and programs," presentation at UNFPA, June, New York.

Clark, Shelley. 2002. Personal communication (re: tabulations of 1998-1999 DHS data from Burkina Faso).

Coeytaux, Francine. 1989. "Celebrating mother and child on the fortieth day: The Sfax, Tunisia postpartum program," *Quality/Calidad/Qualité* no. 1. New York: Population Council.

Diop, Nafy. 2000. "Exploring married adolescents' lives: Results from a qualitative survey," presentation at the Regional Workshop on Meeting the Participation and Development Rights of Adolescent Girls, November, Dakar, Senegal.

East-West Center. 1999. "Indonesian survey looks at adolescent reproductive health," *Asia-Pacific Population & Policy* no. 51.

Haberland, Nicole, Elizabeth McGrory, and K. G. Santhya. 2001. Supplemental Diagnostic Report – Baroda (internal report of findings from diagnostic phase of the First-Time Parents Project).

International Institute for Population Sciences (IIPS) and Measure DHS+. "National Family Health Survey (NFHS-2) 1998-1999, Key Findings."

Khan, M.E., John Townsend, Ranjana Sinha, and Seema Lakhnpal. 1997. "Sexual violence within marriage: A case study of rural Uttar Pradesh," paper presented at the Annual Meeting of the American Public Health Association.

Martin, Sandra, Brian Kilgallen, Amy Ong Tsui, Kuhu Maitra, Kaushalendra Kumar Singh, and Lawrence L. Kupper. 1999. "Sexual behaviors and reproductive health outcomes," in *Journal of the American Medical Association* 282, no. 20.

Matasha, E., T. Ntembelea, P. Mayaud, W. Saidi, J. Todd, B. Mujaya, and L. Tendo-Wambua. 1998. "Sexual and reproductive health among primary and secondary school pupils in Mwanza, Tanzania: Need for intervention," *AIDS Care* 10, no. 3.

Mensch, Barbara. 1999. "Adolescent research and programs: Moving beyond the conventional," presentation to the World Bank, March.

Mensch, Barbara S., Judith Bruce and Margaret E. Greene. 1998. *The Uncharted Passage: Girls' Adolescence in the Developing World*. New York: Population Council.

Molzan Turan, Janet, Hacer Nalbant, Aysen Bulut, W. Henry Mosley, and Gulbin Gokcay. 2002. "Promoting postpartum health in Turkey: The role of the father," in Nicole Haberland and Diana Measham (eds.), *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York: Population Council.

Moodie, Nicolette. 2000. Personal communication.

National Population Council and Macro International, Inc. 1996. *Demographic and Health Survey 1995*. Calverton, MD: Macro International, Inc.

Phipps, Maureen and MaryFran Sowers. 2002. "Defining early adolescent childbearing," *American Journal of Public Health* 92, no.1: 125-128.

Roberts, Benjamin. 2000. Personal communication (calculation of 1996 South African Sample Census).

Rogow, Debbie. 2000. "'Alone you are nobody, together we float': The Manuela Ramos Movement," *Quality/Calidad/Qualité*, no 10. New York: The Population Council.

Rogow, Debbie and Susan Wood. 2002. "ReproSalud: Feminism meets USAID in Peru," in Nicole Haberland and Diana Measham (eds.), *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York: Population Council.

Shafer, M. and R.L. Sweet. 1990. "Pelvic inflammatory disease in adolescent females," in *Adolescent Medicine: State of the Art Review* 1.

Sloan, Nancy. 2000. Personal communication.

United Nations Department of Economic and Social Affairs. 2000. *World Marriage Patterns 2000*. New York: United Nations.