Recent results from three Population Council projects in Ethiopia demonstrate that evidence-based HIV prevention programs can reach large numbers of vulnerable girls and young women and increase their ability to avoid infection. See page 2.

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Recent results from three Population Council projects in Ethiopia demonstrate that HIV prevention programs shaped by evidence and designed for replication and scale-up can reach large numbers of the girls and young women at greatest risk and increase their ability to avoid infection.

HIV is the leading cause of death among girls aged 15–19 in Eastern and Southern Africa. Despite decades of investment and substantial progress against HIV, adolescent girls remain disproportionately at risk of infection. Few programs have taken a “whole girl” approach to addressing the multiple vulnerabilities to HIV infection—social isolation, economic insecurity, lack of access to services, and sexual and gender-based violence—experienced by the most marginalized adolescent girls in the poorest communities in Africa.

Building the Assets to Thrive: Addressing the HIV-related Vulnerabilities of Adolescent Girls in Ethiopia is a comprehensive review of three programs conducted and evaluated by the Population Council and the Ethiopian government: Biruh Tesfa, Meseret Hiwott, and Addis Birhan. These programs seek to reduce Ethiopian girls’ HIV risk by using similar methods to engage girls—and, in the case of one program, the males who play a role in their health and well-being.

These programs enroll socially isolated girls (or their husbands) using recruitment strategies that account for girls’ limited movement outside the household and their relative lack of power in decisionmaking. Girls meet in small groups, in safe public spaces, where they receive social support, information, and services. The programs focus on building sustainable individual protective assets such as self-esteem, problem solving abilities, confidence, and social networks supporting increased education and economic participation. They also link socially isolated girls both to higher-status adult female mentors who can serve as their advocates and to community institutions and services.

Evidence-based Programs

The foundation of the Population Council’s work in Ethiopia began in the early 2000s with extensive formative research: quantitative, population-based surveys among adolescents in the urban slums of Addis Ababa and remote, rural Amhara Region to understand the circumstances of the most vulnerable populations.

The Council and the Ethiopian Ministry of Youth and Sports (now the Ethiopian Ministry of Women, Children, and Youth Affairs) found that adolescent girls who were married or were rural-to-urban migrants/domestic workers were most vulnerable. In response, we developed programs for these populations: Biruh Tesfa, Meseret Hiwott, and Addis Birhan. These programs reach different participants in different geographic areas, but they share many similarities adaptable to the design, implementation, and evaluation of programs to benefit adolescent girls elsewhere.

Biruh Tesfa (Bright Future)

Biruh Tesfa began in 2007 and is ongoing. It serves out-of-school adolescent girls and young women aged 7–24 in urban slums, reaching 63,000 extremely vulnerable girls in 18 cities as of 2013. The program improves girls’ ability to protect themselves by reducing their social isolation and providing them with assets, such as a safe space to gather, caring and trustworthy adult mentors, friends, health information, services to reduce sexual exploitation and abuse, and functional literacy skills. Girls
gather in mentor-led groups according to age and educational level. In the meetings, mentors offer education on HIV and AIDS and related issues, as well as non-formal education and links to health services.

A Population Council evaluation found that girls in the program sites were twice as likely as girls in the control site to report having social support, to score highly on HIV knowledge questions, to know where to obtain voluntary HIV counseling and testing, and to want to be tested.

Meseret Hiwott (Base of Life) and Addis Birhan (New Light)

Meseret Hiwott was established in 2008 to support married adolescent girls and young women aged 10–24 in rural Amhara, the second largest region in Ethiopia and the one with the highest rate of early marriage. The program provided them with adult female mentors and a safe space to gather, as well as training in financial literacy, links to health services (including family planning and HIV and AIDS resources), and information on gender/power dynamics and spousal communication.

Addis Birhan, an offshoot launched shortly after Meseret Hiwott in response to community demand, was designed to support the goals of that program. Men and boys aged 10–85 married to adolescent girls were gathered into discussion groups focused on promoting caregiving to wives and children and addressing extramarital partnerships, alcohol abuse, and violence.

Both programs ran until 2013; Addis Birhan reached more than 135,000 boys and men and Meseret Hiwott reached more than 230,000 girls and young women. Girls in the program sites were significantly more likely than other girls to obtain voluntary HIV counseling and testing, use family planning, have their husbands accompany them to clinic visits, and receive assistance with domestic work from their husbands. Moreover, girls and young women from couples in which both the husband and wife participated in the groups benefited more than girls and young women in couples in which the husband did not participate.

Six Steps to Effective Programs for Girls

The Population Council’s experience in Ethiopia and elsewhere suggests the following six strategies are essential to the success of programs aimed at reducing gender inequalities and vulnerabilities:

1. Conduct and carefully link formative research findings to program design. Formative research, particularly population-based surveys, can be used to understand the circumstances and needs of local populations, identify those at highest risk of the worst outcomes, and shape program design to reach target groups. By developing programs that address the priorities and needs of target populations, program managers can increase the likelihood of program participation and effectiveness.

2. Employ mentors. The mentorship model builds trust and inspiration among program participants, who often lack caring, protective adults in their lives. Mentors serve as trusted adults to participants and also as higher-status advocates for girls.

3. Tailor recruitment and involve community gatekeepers. Because girls in many settings have far more limited mobility than boys, program mentors can reach and enroll them by going house to house—a method traditionally used by health extension workers. This method of recruitment not only results in reaching a higher proportion of a population in need of program services, but also allows mentors to negotiate with gatekeepers and observe and understand the home circumstances of girls in their groups.

4. Measure girls’ protective assets as indicators of program success. Research has identified several types of protective assets, including: friendship networks, ID cards, and a shelter in which to spend the night in an emergency. These assets can and should be measured and documented.

5. Monitor and evaluate programs. Monitoring and evaluation must be integral elements of any successful program in order to generate the evidence required to identify best practices, refine critical program elements, and eliminate ineffective approaches. Qualitative monitoring after programs are underway can provide important information for improving them—for example, to explore new areas for expansion or modification.

6. Design for scale-up by encouraging local ownership. Collaborating closely with local partners, including government agencies, will foster program sustainability. The sharing of knowledge and ownership is critical, since local partners will ultimately be responsible for conducting programs. Engaging large numbers of local residents creates lasting, normative changes within a community.

Well-designed programs—based on thorough formative research, planned to be replicable and scalable, carefully monitored and adjusted, and taking a “whole girl” approach—are effective in reducing HIV risk and increasing girls’ prospects for a safe and more productive life. These programs successfully reached the most marginalized girls in the poorest areas, such as married girls in rural areas and child domestic workers and migrants in urban areas. The Population Council’s experience shows that there is an appetite for these programs not only among vulnerable adolescent girls but also among their husbands and, eventually, their employers. Persistence and political will in the face of skepticism are key to the success of these programs, both of which are engendered by close collaboration with local ministries and community groups.

SOURCE

FUNDING
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Interest in sexuality, domestic violence, and gender inequities in South Asia has surged over the past 15 years, partly due to several high-profile cases of rape and other gender-based violence. However, many aspects of these complex topics—from men’s and women’s concepts of masculinity and sexuality to changing patterns of gender roles and the nature of violence—are still only partially understood.

A new compilation of studies published by the Population Council—*Sexuality, Gender Roles, and Domestic Violence in South Asia*—adds vital new evidence to the growing body of literature on these issues. Conducted by researchers from more than a dozen institutions, their work collectively suggests that gender dynamics in the region are evolving and that there are opportunities in the current environment to reduce sexual and gender-based violence.

“This book offers novel insight into what is seen as ‘typical’ behaviors in South Asia,” explains M.E. Khan, Senior Program Associate at the Population Council in India and lead editor of the publication. “We need to do everything we can to help reduce instances of violence and move in a positive direction, but programs to mitigate gender-based violence will only succeed if policymakers understand the root causes.”

*Sexuality, Gender Roles, and Domestic Violence in South Asia* acknowledges the large variations in attitudes and practices across the region and within countries. The book outlines further research needed to reduce gender-based violence in India and Bangladesh, as well as successful interventions that could be taken to scale. It is meant to shape the efforts of policymakers, researchers, clinicians, and program staff working on health and development programs in South Asia.

**The Roots of Sexual and Gender-based Violence in India and Bangladesh**

The authors state that the prevailing pattern of physical and sexual domestic violence against women in Bangladesh and India can be attributed in part to the male-dominated culture in the region. Many men feel driven to prove their masculinity, both physically and sexually. They believe that “real men” have power and must dominate their relationships. Even minor challenges, real or imaginary, to this authority may be settled with scolding or physical violence. In the words of a male respondent from Bangladesh: “Manliness should be in a real man’s every attitude. He should control his wife and maintain strict discipline in his family. He should have the ability to make everyone respect him.”

Men in South Asia largely believe that a man’s wife cannot refuse him sex. Many men (and some women) believe that husbands have the right to become angry if rebuffed sexually, and when persuasion does not work, they can force sex. “My wife once refused sex,” said one 24-year-old male respondent from Gujarat. “I got angry and forced her to have sex. After that my wife never refused me. What is the point in marrying if one cannot have sex with his own wife?”

A large proportion of women in Bangladesh reported having been abused physically, emotionally, mentally, or sexually at some point in their lives. Almost half of the women in a Bangladesh study had experienced forced sex during the past 12 months; indeed, almost all reported that they were forced to have sex against their will on their wedding night. Women reported being abused mainly for not meeting a husband’s expectations in matters such as managing the household, cooking, and taking care of children or because they argued with their husband. Most women remain in the abusive relationship because they do not have the economic security to care for their children outside of the relationship. Almost all of the women interviewed believed that some violence is normal in married life, and many that it is a “sin” to disobey their husbands. A female respondent in Bangladesh explained, “Some women consider violence like scolding and beating to be a normal part of married life, because they do not have a choice.”

**Opportunities to Gradually Shift the Environment for Men and Women**

Studies in the book suggest that “masculine” attitudes driving gender-based violence are not fixed: in India researchers found that men’s ideas about what constitutes masculinity are fluid and highly affected by socio-economics and work experiences. In fact, men who have consistent employment and higher earnings are likelier than others to believe that “real men” are honest with a strong character and do not engage in risky sexual behavior. This study demonstrates that masculinity can be decoupled from sexual risk-taking behavior.
Interventions offering men basic sex education and skills to increase their chances of consistent employment may successfully reduce gender-based violence.

A study included in the volume shows that during pregnancy husbands are relatively less aggressive and the incidence of violence declines. The authors argue that pregnancy provides a window of opportunity during which it may be possible to raise men’s awareness about the harms of gender-based violence and to reduce violence after childbirth.

There are signs that the power balance between men and women in South Asia is shifting. A new generation of Indian women is finding power through knowledge: greater educational opportunities and improved access to information about sexuality empowers these young women to communicate with their husbands about sex. In Bangladesh and India, women are finding a degree of sexual and financial security through paid employment outside the house. A female garment worker in Bangladesh explains, “I have become financially as well as mentally strong.”

The researchers in this book contend that to build upon this incremental change and shift the male-female power balance, policymakers must focus attention on interventions that increase accurate knowledge about sexual and reproductive health and rights, improve spousal communication, and expand educational and employment opportunities for women and men.

Looking Ahead: Gender-based Violence is Widespread but not Inevitable

While gender-based violence in South Asia is widespread, research by the Population Council and others has shown that there are also women not experiencing violence. Researchers generally agree that greater gender equity is required to reduce domestic violence and that promoting gender equity will require long-term interventions. However, studies in this publication suggest there may be some effective shorter-term interventions.

The data suggest that young women who marry later experience less violence, so finding successful ways to increase the age at marriage might reduce domestic violence.

“A small number of interventions have shown considerable promise,” says Ubaidur Rob, Population Council country director in Bangladesh. “We need to focus on the lessons of these innovative programs.”

The data suggest that young women who marry later experience less violence, so finding successful ways to increase the age at marriage might reduce domestic violence. In addition, formal education for girls and women, educational campaigns to inform women about their rights and legal protections, and access to contraception for women could be effective measures to reduce gender inequities and domestic violence.

Some programs for men have been well received and led to changes in men’s sexual attitudes and behaviors. For example, programs offering men counseling and sexual health services increase male participation in family reproductive health matters, including antenatal care and decisions about family planning.

However, many of these interventions have been relatively small, and have not been scaled up to cover major populations. A mixture of qualitative and quantitative research in connection with expanded programs of behavior change needs to continue to improve gender relations and reduce domestic violence and related problems. This research and programming should not take the place of long-term efforts at promoting widespread gender equity, but should be implemented simultaneously for the greatest impact.

Ethical Considerations in Sexual and Gender-based Violence Research

There are significant ethical issues to be considered when conducting research on gender, sexuality, and domestic violence. Participants’ autonomy, privacy, and right to make an informed choice about whether or not to participate in the research need to be protected. Both the researcher and participant must have the opportunity to weigh the risks and benefits of the research. Researchers must recognize that they are working with a vulnerable population and have a responsibility to protect those they interview. Research must also have a sound methodology, be ethically justifiable, conform to accepted scientific principles, be likely to lead to useful knowledge, and be used for the benefit of the community.

Although most of the ethical focus in research is on the protection and welfare of the participants, the safety and welfare of researchers, particularly those who collect data directly from the survivors of violence, are also a concern. Researchers dealing with issues of sexual and gender-based violence can be emotionally traumatized by the violence they learn about and this trauma must be addressed.

“Gender-based violence is unacceptable, but not inevitable,” states John Townsend, Population Council Vice President and Director of the Reproductive Health program. “With the right combination of thoughtful, research-based programs and education, we believe there is an opportunity to meaningfully change the environment for women and men in South Asia.”

SOURCE
The Government of India has opened more than 6,000 adolescent-friendly health clinics across the country to increase services, particularly reproductive health services, for young people. However, few young people have used the services. In the Youth in India study, conducted in 2010 by the International Institute for Population Sciences and Population Council, just seven percent of young men and three percent of young women reported ever receiving information on sexual matters from a health care provider. To understand the reasons for this circumstance, and to assist clinics in meeting the needs of intended clients, the Ministry of Health and Family Welfare asked the Population Council to assess the clinics from the perspectives of young people and health care providers in three states in India (Jharkhand, Maharashtra, and Rajasthan).

“Our goals were to better understand how adolescents in India view their health needs, including the obstacles they face in getting reproductive health information, and their preferences about how and from whom they get this information,” explains K.G. Santhya, lead Population Council investigator on these studies. “We also wanted to understand how health care providers view their role in responding to the health needs of young people, and the factors that help or hinder their efforts to provide effective information and services.”

**The Adolescent Perspective**

The researchers surveyed young people aged 15–24 who lived in villages surrounding selected adolescent-friendly clinics. They reached 736 young people in Jharkhand, 682 in Maharashtra, and 713 in Rajasthan. They found that young women were more likely than young men to seek help, and married women were more likely than unmarried women, but that a pervasive lack of trust in the health system stopped many young people from seeking professional help when they had concerns.

The quality of services received by clients at the adolescent-friendly clinics was mixed. Most clients said they were able to meet with a health care provider without any delay. Most reported that the health care provider paid attention to them when they described their complaint. None were worried that the provider would tell others about their health problems. And most reported that the provider did not shout at or make fun of them.

However, clients also reported that the clinics lacked privacy. Some reported that the consultation time with the providers or the information provided was insufficient and was, at times, moralistic and judgmental. One young woman reported, “There was no privacy; I felt shy to narrate my problem in front of others. The doctor was surrounded by male and female patients.” Another young woman said, “The doctor told me that he cannot prescribe an IUD for me since I am unmarried, and that he also cannot explain to me how the condom is used, but would explain it to my boyfriend.”

In general, most young people suggested that if they were to seek out help, they would prefer to receive health information from family and friends. When going to a health facility, young people preferred to see a doctor rather than a nurse or other health care provider. These preferences may be tied to a general lack of awareness that other health workers can provide quality services.

**The Health Care Provider Perspective**

The researchers also surveyed four types of health care providers—accredited social health activists, auxiliary nurse midwives, counselors, and medical officers in Jharkhand, Maharashtra, and Rajasthan. All of these providers asserted that they had received some basic training in adolescent reproductive health issues. However, for many, this training focused on “safer” issues such as nutrition and menstrual hygiene, and ignored the potentially more difficult or controversial areas like sexual relations, contraceptives, and pregnancy. Health care providers receive little, if any, training in non-judgmental communication methods with young people on sensitive topics, especially with opposite-sex adolescents, increasing provider discomfort with these topics.
While not explicitly covered in their trainings, most health care providers believed that young people should learn about pregnancy and contraception before marriage. Yet they also reported that most of the counseling they conduct with unmarried clients is for physical maturation concerns (menstrual hygiene and breast development for girls; growth of facial hair and voice change for boys). Contraception and pregnancy-related counseling is saved for married clients. Providers believe that girls should receive information about reproductive health from their mothers and female providers, while boys should learn from male providers. Indeed, providers reported that most of their interactions with clients break down along gendered lines.

**Recommendations for Improving Health Services**

Population Council researchers recommend that the Government of India take several steps to improve the quality of sexual and reproductive health services provided to young people in India, including:

- raising awareness among providers of common health problems experienced in adolescence.
- expanding the scope of services provided to young people.
- expanding the health care provider base to serve young people.
- sensitizing influential others in young people’s lives about their supporting role.
- improving the awareness and skills of health care providers to respond to the needs of all young people.
- raising young people’s awareness about the availability of adolescent-friendly clinics.
- improving the quality of services delivered at the clinics.
- monitoring and evaluating adolescent-friendly clinics.

Providers said they would be able to offer higher quality sexual and reproductive health services if they had better training. It would also help if front-line health workers were more aware of adolescent-friendly clinics, so that they could refer adolescents to seek help there, and if parents allowed or encouraged their children to seek care at these clinics.

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**Funding**

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Most current and nearly all future population growth in the developing world will occur in cities. As cities become more populated, they will need more water. Today, many cities are “water stressed”—defined as currently using at least 40 percent of available water.

However, the news is not all grim. A new study, the first to accurately estimate global urban water sources and water stress in large cities, has found that past analyses substantially overestimated water stress.

The study was led by Rob McDonald, senior scientist with the Nature Conservancy, and included a team of researchers from nine institutions, including Mark R. Montgomery of the Population Council. The scientists surveyed and mapped the water sources of more than 500 large cities (over 750,000 population) worldwide. The researchers used multiple computer models of global water distribution to estimate water use and water stress based on population and types of industry for each city.

The researchers found that water-stressed large cities exist in both developed and developing countries. The top ten most populous water-stressed cities are: Tokyo, Delhi, Mexico City, Shanghai, Beijing, Kolkata, Karachi, Los Angeles, Rio de Janeiro, and Moscow.

“Interestingly, many cities are not as water stressed as earlier estimates suggested. Previously, experts thought that around 40 percent of cities were water-stressed, but somehow large cities have found ways of getting access to much of the water they need: we found that only around 25 percent lack sufficient water,” says Montgomery. “Nevertheless, we should not become complacent. It’s likely that in poor countries many of the smaller cities are severely water-stressed. We couldn’t find enough data on small-city water sources to evaluate their needs. It might be that smaller cities facing difficulties with water supply never grow to become larger cities. We need to know a lot more about conditions in these smaller places—that’s where most urban residents live.”

When estimating water stress previously, researchers looked at maps of cities and nearby watersheds, assuming cities obtained water from nearby—but in this study, researchers delved much deeper. In addition to computer models, researchers found water source information by searching online to locate city water utilities and finding utility reports listing water sources and the amount of water withdrawn. This research showed that many cities have built infrastructure—pipes and distribution systems—that allows them to import water from distant watersheds. Past analyses substantially over-estimated water stress, at least for the bigger cities, because they ignored this infrastructure.

“Cities, like deep rooted plants, can reach quite a long distance to acquire the water they need,” says McDonald.

The study also explored the extent to which financial and water resources depend upon each other. Cities with adequate financial resources can pipe in water from great distances or invest in technologies such as desalinization. However, many of the world’s fastest growing cities are in poor developing countries, which cannot afford such strategies. To develop the prosperity needed to build this infrastructure, cities need vibrant economies. But without adequate water, it is difficult for economies to thrive.

“It’s a vicious cycle that water-stressed cities in less-developed countries will find difficult to escape without significant international aid and investment,” said Montgomery.

SOURCE


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