The Family Planning 2020 initiative aims to reach an additional 120 million women and girls in the poorest countries by 2020 with voluntary access to high-quality family planning.

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Family Planning Road Map Points Way to Equitable Access

More than 200 million women in the developing world who want to avoid pregnancy are not using a modern contraceptive method. The reasons include perceived or actual side effects, lack of availability and information, cost, and socio-cultural obstacles.

Participants at the London Summit on Family Planning, held in July 2012, set a goal to respond to this unmet need for contraception. They launched an initiative to reach an additional 120 million women and girls in the poorest countries by 2020 with voluntary access to high-quality family planning. Commitments totaling US$2.6 billion have been made by national governments, civil society, and the private sector as part of the initiative, known as Family Planning 2020 (FP2020).

The Population Council supports the goal of expanded access to family planning. A new Council report—The Unfinished Agenda to Meet FP2020 Goals: 12 Actions to Fill Critical Evidence Gaps—summarizes evidence from a wide range of sources on what factors shape family planning programs. The report proposes components of a new research and action agenda to bridge gaps in evidence; and provides an extensive annotated bibliography to serve as a knowledge base for future research. Ian Askew, Council director of Reproductive Health Services and Research, and Martha Brady, Population Council senior associate, co-authored the report.

“This is an opportune moment to address the unfinished family planning agenda with attention to quality, equity, and choice.” — Martha Brady, Population Council senior associate

said Askew. “Despite this success, continued investment in high-quality research is essential if all women are to benefit equally from having full access to these life-saving services.”

Evidence Gaps: Identifying What We Don’t Know

The Unfinished Agenda reviews published evidence on interventions to increase access, quality, and use of family planning. The authors consulted with family planning experts to sort the evidence into three broad areas: 1) social determinants of family planning demand and use, 2) health system determinants of family planning demand and use, and 3) dynamics of family planning demand and use.

Evidence indicates that the most influential social determinants of family planning use are typically girls’ and women’s social status and decisionmaking ability, level of education, marital status, age, and place of residence. They argue that considering inequities—particularly those resulting from poverty, sex, age, and marital status—is critical to identifying the most disadvantaged, vulnerable, and underserved populations with unmet need. These are the populations for whom family planning programs and investments should be prioritized.

The authors note that national health systems largely determine the institutional structures through which family planning is financed, delivered, and accessed. However, as not-for-profit and commercial organizations become increasingly important sources of information and services, an adequate understanding of how people access family planning can only be obtained by looking beyond just national health systems.

Research to inform future family planning investments should focus on the “total market”—that is, all involved sectors—so that all people are able to access affordable, quality
services. The authors also stress the need for more and stronger evidence to better understand how to strengthen health systems, thereby improving access to quality services.

Additional evidence is needed to understand the determinants of demand for and use of family planning so that programs can be tailored to meet the needs of specific groups, such as married and unmarried adolescents, marginalized ethnic populations, urban slum dwellers, and people living with HIV and AIDS.

**Filling the gaps: Proposed actions**

To fill the major knowledge gaps, the authors recommend 12 actions that should be prioritized by those investing in and undertaking research on family planning:

1. Conduct research that identifies the needs of the most vulnerable or underserved individuals
2. Evaluate interventions to reduce inequities and vulnerability
3. Understand the dynamics of contraceptive decisionmaking and use
4. Meet the needs of married and unmarried adolescents
5. Improve and sustain the quality of family planning services
6. Expand effective models of integrated services
7. Serve rural communities more efficiently and equitably
8. Reach the urban poor
9. Shape contraceptive markets to improve access
10. Expand access and increase affordability through innovative financing
11. Develop strategies for advocacy and accountability
12. Build capacity and improve research to generate evidence on family planning

**The road to access for all**

The challenges ahead for family planning programs will be to increase access while reducing inequities in people’s ability to use a method of their choice. A large amount of evidence exists that can inform responses by health systems and others to reduce unmet need for family planning; more efforts are needed to translate this evidence so that policymakers and managers can improve and expand their programs. However, sufficient evidence is lacking in the 12 areas identified above, for which further research should be conducted to ensure equity in access so that all girls and women can be equipped with the knowledge, skills, and technologies to demand and enjoy their reproductive rights, including family planning.

**SOURCE**


**OUTSIDE FUNDING**

United States Agency for International Development
Microbicides are biomedical products being developed to protect people against sexually transmitted infections, including HIV. Some microbicides are being designed as vaginal products for women, and others would be rectal products for either men or women. Several candidate microbicides have been developed and tested over the past two decades. Yet the results of clinical trials have been largely disappointing. Just one trial provided evidence that a vaginal microbicide could protect against sexual transmission of HIV. The results of a confirmatory trial are underway. Should it provide confirmation, several years would still be needed before a product is available in sufficient quantities.

There are many reasons why most of the trials have not shown hoped-for impact. One that is extremely important, yet has little to do with the quality of a microbicide itself, is related to adherence to the microbicide regimen; that is, participants in the trial correctly following guidelines for using the microbicide. Even if a microbicide is effective, it must be used correctly and consistently if it is to prevent transmission. That expectation has not always been met, contributing to results indicating limited or non-existent effectiveness. The lack of adherence to correct and consistent use by many trial participants has been seen in post-trial analysis.

Issues regarding adherence in microbicide trials are examined in “Microbicide clinical trial adherence: Insights for introduction,” a recent paper published in the *Journal of the International AIDS Society* and co-authored by Population Council researcher Barbara Friedland. The authors list lessons learned regarding adherence from their review of data and observations from the six large-scale microbicide efficacy trials completed to date. Based on those lessons, they also offer recommendations for such trials in the future as well as for when microbicides are eventually available for general use.

“This article is one element of a much larger Population Council effort to improve adherence in microbicide trials,” said Friedland.

**Improving adherence: Lessons learned and recommendations**

The authors organize their lessons learned under six categories. Some key points associated with each category are summarized below, as are some of the recommendations that followed. The need for better, and more extensive, information and support is a common theme across most of the categories.

**Adherence measurement in clinical trials**

Difficulties in measuring adherence have been apparent given the limitations of self-report and biological markers (such as drug levels in blood or urine). In regard to the former, for example, trial participants may intentionally or unintentionally misreport use of the product. For the latter, reliable biological markers may be adversely affected by factors such as the difficulty of measuring some drugs that are not systemically absorbed.

The authors suggest triangulation of multiple measures—i.e., using two or more evaluation methodologies and approaches—as a way to improve the accuracy of adherence measurement.

**Comprehension of microbicide use/instructions for use**

Some women participating in trials misunderstood instructions on how to correctly use microbicides. In many instances, such problems have been overcome when locally appropriate illustrated materials are available in addition to adequate counseling.

The authors recommend specialized training for service providers when microbicides are eventually introduced. The goal should be to provide users with evidence-based information. Such efforts should be preceded by the development of clear instructions for users that are regularly evaluated.

**Unknown efficacy and its effect on adherence/messages regarding effectiveness**

Some trial participants and clinic staff, when informed that the products’ value was “uncertain,” did not understand or believe what they were told. As a result, for example, some assumed the “active” microbicide product was completely effective and that they need not take additional measures to protect themselves from HIV.

The authors recommend that thorough and easily understandable information be made available to users of such products. Such information should be explicit about the known contraceptive and protective effects of the products as demonstrated by the existing evidence.

**Partner influence on use**

Although microbicides have long been championed as a “female-controlled” intervention,
trial participants often found it difficult to use them in secrecy or without informing their sexual partners. For some women, concern over hiding involvement in the trials, especially from partners, created problems with adherence.

The authors recommend more extensive and better-crafted up-front messages about the potential for negative consequences if use is discovered by a sexual partner. They also encourage more openness, in accordance with local norms, about a product’s effect on men’s and women’s sexual pleasure.

**Retention and continuation**

High rates of visit completion and retention are considered critical components for achieving adherence in microbicide trials. This is because participants who miss visits also miss the opportunity to refill products, which may result in non-adherence or non-persistent use, and ultimately can undermine the accuracy of efficacy estimates. At the same time, however, the authors observed that very high rates of retention do not appear to ensure high rates of actual product use. Thus, retention in trials is a necessary, but insufficient, condition for consistent product use.

The authors recommend regularly reassessing women’s needs and working with them as closely as possible to help maximize continuation and adherence. Women should also receive clear information about when and why to discontinue use (e.g., during pregnancy).

**Generalizability of trial participants’ adherence behavior**

More than 20,000 women have participated in large-scale advanced microbicide trials globally. Most have been in communities and environments where they are considered at high risk of HIV infection. However, while it makes sense to focus trials in this way, participating women may not be representative of those who will actually use microbicides. That possibility is especially great since some important population groups (pregnant women, post-menopausal women, and adolescents) have not been included in clinical trials. The authors recommend studies for populations who have not been well represented in microbicide trials to date. Such studies should seek to assess what might influence use of products as well as adherence.

**The need for variety and redoubling efforts**

Very few people are 100 percent adherent to any product, so it would be unrealistic to expect such behavior from all or even a majority of women who eventually use microbicides. The authors note, however, that collective adherence is likely to be greater if multiple types of products with varying use requirements are available. Variety of this sort is essential to address the issue of acceptability—whether users are able and willing to devote the time and attention to using a product as instructed.

The authors conclude by stressing the health and social importance of overcoming the challenges associated with developing safe and effective microbicides. In their view, the introduction of microbicides, and appropriate counseling on how to use them correctly and consistently, could create inroads for women’s empowerment while reducing their risk of HIV infection.

**SOURCE**

The vulnerability of adolescent girls in developing countries is recognized and well-documented. In few places, however, do they face as many deep-seated and complicated challenges as Egypt.

The country has made significant strides, in school enrollment, health, and economic development. Yet women and girls continue to face many challenges. Some 90 percent of Egyptian women have undergone female genital mutilation/cutting (FGM/C), often as teenagers. Girls are far more likely than boys to have never enrolled or to have dropped out of school after only a few years. And girls, particularly out-of-school girls, are more likely than boys to have limited mobility, which leads to social isolation, fewer friends, and fewer opportunities to fully participate in public spaces and play a meaningful role in society. Indicators like these underscore the need for new and innovative approaches to empowering girls.

The Ishraq program was launched in 2001 by the Population Council in collaboration with the Centre for Development and Population Activities (CEDPA), Save the Children, Caritas, and local non-governmental organizations (NGOs). Ishraq is the Arabic word for sunrise. The name signals the intentions of the partner institutions to build a brighter future by helping out-of-school girls, most of them poor, and to unlock their full potential in society. Ishraq was launched in Upper Egypt, the mostly rural provinces home to the vast majority of girls who had never attended school.

A recent Population Council report provides an extensive overview of the initiative. The report, titled “The Ishraq program for out-of-school girls: From pilot to scale-up,” shows the dramatically positive impact of participating in the program, for girls, their families, and their communities.

How the program operates: Goals and priorities

The goal of Ishraq is to empower out-of-school girls—and, by doing so, help transform their lives and break down barriers to their advancement. In practical terms, this has consisted of creating a multi-dimensional program that gives out-of-school girls from ages 12 to 15 the opportunity to learn and grow across a range of areas by receiving mentoring and support from specially trained personnel. (The term “out-of-school” refers to those not currently attending school. Some had never been to school, while others had dropped out before completing primary education.)

From the launch in 2001, program developers have identified potential participants by working with local NGOs and other community-based groups that interact with families on a regular basis. Substantial effort has been made to respect traditional norms and thus to explain the objectives of the project carefully, with the focus on why making girls more self-reliant and confident would benefit families and communities.

In each community where Ishraq operates, participating girls meet in youth centers in morning hours, when boys are at school. The use of such locations is symbolic because most youth centers had been considered boys’ domains, with girls essentially forbidden from visiting. Their exclusion meant there were few if any communal spaces where girls could meet people from outside their immediate families, including other girls who might become friends and confidantes.

Growth and expansion

The program evolved from a pilot phase, was expanded in 2004, and then scaled up in 2008. In the pilot and expansion phases in Upper Egypt, the program focused on three major components: building literacy, life skills, and sports. The literacy component is especially vital for girls who have never gone to school.
or who withdrew before achieving even basic ability to read and write in Arabic. The life skills component focuses on communication, team building, and critical thinking in addition to reproductive health, while the sports component includes not only physical fitness, but efforts to instill the values of team work, cooperation, and self-confidence.

In 2008, the Council began to institutionalize the program at the national level. Two additional program components were added during this scale-up phase: financial education and nutrition. To achieve scale-up, the project formed committees at village, governorate, and national levels to provide ongoing support to the program. (Governorates are the main administrative unit below the federal level, similar to provinces or states in other countries.) Staff from NGOs and youth centers helped replicate Ishraq in other communities using local resources, advocacy, and networking.

In 2011, Ishraq established girls’ clubs for Ishraq graduates in two villages in Menya and four villages in Beni Suef. Girls’ clubs provide graduates with financial support for private tutoring to help them make the transition into formal school and also enable them to maintain their social support system.

**Achievements**

The program has reached 3,321 girls in 54 villages across five of the most disadvantaged governorates of Upper Egypt. Although Ishraq focuses primarily on girls, it also offers some boys—brothers and other relatives of participating girls—the opportunity to participate in selected life skills classes for a brief period, usually six months. Those classes discuss gender issues along with other topics. The report notes that 1,775 boys have been reached directly through such classes. In addition, more than 5,000 girls’ parents, male relatives, and community leaders have also been indirectly engaged.

Rigorous evaluation of the program has included interviewing Ishraq participants and non-participants of similar backgrounds and characteristics; parents and brothers of participants before and after the program; and community leaders on village committees after the program began. Assessments looked at outcomes in five broad areas: 1) functional literacy; 2) mobility and access to safe spaces; 3) acquisition of life skills; 4) girl-empowering knowledge and attitudes; and 5) parents’ and brothers’ girl-related attitudes.

Findings from the impact assessments of the scale-up phase indicate that the program has had a remarkably positive effect on participants and communities. For example, 88 percent of Ishraq participants could write their sibling’s name compared with just 36 percent of non-participants. Nearly two-thirds (66 percent) of participants successfully identified at least one contraceptive method; the comparable figure for non-participants was 38 percent. Participants were twice as likely as girls in the comparison group to know that FGM/C is not mandated by religion (42 percent versus 21 percent).

In addition to expanding the physical spaces that girls could access, the program also gave them an opportunity to expand their social networks. Over 70 percent of Ishraq participants reported having more than one non-relative friend versus 44 percent of their counterparts in the comparison group. Such exposure and interaction with the larger world increased their self-confidence and sense of empowerment.

Despite these achievements, the report’s authors acknowledge ongoing challenges. Hard-won gains such as maintaining a permanent girls’ space in youth centers are often precarious. Changing deep-rooted attitudes and behaviors is difficult and will prove to be a lengthy process, as are efforts to replicate and institutionalize Ishraq at a national level.

**Lessons learned**

The report concludes with a discussion of lessons learned from the Ishraq experience. One overarching observation is the value of extensive, wide-ranging outreach and engagement. Implementing the program effectively and achieving sustainability requires a multipronged strategy that involves working with communities, government, and NGOs. The involvement of local communities, including parents and community leaders in village committees, is just as important as obtaining support from senior officials in governorate committees. Such officials have influence with counterparts from other governorates and district-level agencies where the program has expanded as part of the national scale-up effort.

A second key lesson is that program flexibility in terms of scheduling is essential to avoid high absenteeism and drop-outs. A third is that rigorous evaluation has helped shape changes in the program, including the addition of new program elements to address identified needs.

The report does not discuss the impact of the political instability and civil strife in Egypt since early 2011. The authors do suggest, however, that Ishraq remains a viable and stable program with the potential for continued scale-up and expansion. Much of the turmoil is confined to Cairo; the core Ishraq heartland remains in Upper Egypt and other rural areas where most out-of-school girls live.

**SOURCE**


**OUTSIDE FUNDING**

In many countries of the developing world, and especially in rural areas, girls who attend school do so for only a few years, often dropping out when they are in their early teenage years.

The reasons for school dropout vary. Education for girls is not considered important or is actively opposed in some societies. Often girls are expected to marry at an early age; few stay in school afterward, especially if they have children. Economic factors can be just as important because families sometimes cannot afford school fees for any or all of their children. When decisions must be made among siblings in regards to education, boys nearly always are given priority.

The slow but steady change in traditions and school access in parts of the developing world has provided more and more girls with opportunities to attend school regularly and remain enrolled longer. Yet as such barriers fall, it is important to consider other reasons why girls are absent from school or withdraw.

One potential factor often discussed in relation to adolescent girls is menstruation. There is no doubt that menstruation is associated with numerous physical, socio-cultural, and economic challenges for female students in the developing world. Among them are the physical discomforts and inconveniences of menstruation, ranging from cramps to headaches; lack of access to adequate sanitary materials and toilets on school grounds; and insufficient understanding of menstruation, which can lead to shame and poor preparation for dealing with the physical issues. Poverty plays an important role as well: even if sanitary napkins are available to purchase in a community, many girls and their families cannot afford them.

All of these problems may interfere with a student’s ability to participate in classroom activities. In some cases, they may limit her inclination or ability to attend school altogether.

However, despite the intuitively clear links between menstruation-related challenges and the quality and length of girls’ schooling (including absenteeism), little evidence exists as to whether there is a direct relationship. A recent Population Council study, “Menstruation and school absenteeism: Evidence from rural Malawi,” highlighted research aimed at better understanding such links and identifying potential entry points to overcome the main barriers.

The Malawi Schooling and Adolescent Survey

The authors—Monica Grant of the University of Wisconsin, Population Council senior consultant Cynthia B. Lloyd, and Council researcher Barbara Mensch—focused on Malawi for several reasons. The country has one of the highest recorded rates of school absenteeism among adolescents in sub-Saharan Africa. Also, data were available from the Population Council’s Malawi Schooling and Adolescent Survey (MSAS), a school-based survey undertaken from 2007–2013 in two rural districts in the southern part of the country. More than 1,600 students from 59 primary schools participated in the survey. All were aged 14–17 when they first participated in 2007; most were re-interviewed each year through the end of the survey.

The researchers used MSAS findings to create statistical models to explore potential factors affecting variations in menstruation-related absenteeism. The models contained school- and individual-level variables including type of toilets available and their cleanliness; privacy of school toilets; travel time to and from school; the presence of older female relatives at home; and parental encouragement for studying and school attendance.

What were the main findings?

Findings show that nearly one-third of female students reported missing at least one day of school during their previous menstrual period. However, the data indicate that menstruation accounts for only a small proportion of all female absenteeism. The lack of a gender gap in overall absenteeism underscores this finding.

The study’s authors interpret the results of their research as suggesting that absenteeism due to menstruation does not stem primarily from school environment (e.g., cleanliness and privacy of toilets). “Menstruation accounts for only a small proportion of female absenteeism among school-going adolescents in Malawi,” said Lloyd. “Absenteeism is not affected by features of the school environment such as the type, cleanliness, and privacy of toilet facilities.”

Findings clearly show, however, that factors associated with girls’ home environments can be significantly associated with
lower likelihood of absence during the last menstrual period. These include co-residence with older women (especially a grandmother) and the amount of time girls are able to study at home, which is partly related to parental support and encouragement.

What are the lessons for the future?
Based on these observations, the authors conclude that adolescent girls’ school attendance is unlikely to increase substantially through the improvement of toilet facilities or provision of sanitary supplies—interventions in support of girls’ education that have been proposed by many in the policy and NGO communities. Nonetheless, such interventions are likely to improve the quality of girls’ lives.

In addition, the authors note the potential value of increasing the availability of analgesics that lessen pain during menstruation. That recommendation is based on the finding that school absence at such times is closely related to the severity of physical symptoms. Almost 85 percent of girls who reported missing school during their last menstrual period said the primary reason was one or more of the following: heavy bleeding, cramps, or diarrhea.

The findings also reflect the critical importance of support at home. Female students with parents and other relatives who are invested in their education appear to be more motivated to avoid missing school for any reason, including menstruation. Efforts to increase support for girls’ schooling, such as policies that reduce domestic drudgery or provide after-school programs for girls that protect time for their studies, might be more successful than the provision of menstrual supplies in reducing absenteeism.

SOURCE

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**Recent Publications**

**HIV AND AIDS**

**POVERTY, GENDER, AND YOUTH**
Amin, Sajeda, Tareq Khan, Laila Rahman, and Ruchira Tabassum Naved. From Evidence to Policy: Addressing Gender-Based Violence Against Women and Girls in Bangladesh. Dhaka: ICDIR.B.
**Recent Publications**


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OTHER


Studies in Family Planning 44(3) and 44(4)

www.popcouncil.org/popbriefs
The sports component of the Ishraq program was an innovation in a context where girls did not traditionally play sports (see story on page 6).