Nearly 30 million people in Pakistan are between the ages of 10 and 19 years: the largest group of adolescents in the country’s history. Transformations in social roles, expectations, activities, and responsibilities distinguish adolescence from childhood and adulthood; this formative period has lasting consequences for individuals, families, communities, and nations. Until recently, however, little was known about the circumstances of adolescents in Pakistan. To address this situation, Valerie Durrant—while she was a Population Council Berelson Fellow—culled data on adolescents from earlier surveys and studies done in Pakistan. Her published analysis of this material, “Adolescent girls and boys in Pakistan: Opportunities and constraints in the transition to adulthood,” provides the first comprehensive picture of the lives of young people in Pakistan.

“This publication is a watershed,” says Zeba A. Sathar, a Pakistan-based Council Program Associate. “It's an authoritative piece on the demography of adolescence in Pakistan and it represents one of the most complete syntheses of information that we have on adolescents anywhere.”

Durrant relied mainly on data from two rounds of the Pakistan Integrated Household Survey: from 1991 and 1995–96. Although these surveys did not focus on adolescents, they proved a rich source from which to mine data about young people. Durrant compiled information on adolescents’ living arrangements, health, education, work, marriage, and childbearing.

“Many nongovernmental organizations are eager to create programs for adolescents, but no one really knows what they are doing, where to best reach them, or even what their needs are,” says Durrant. “This publication offers some answers.”

**Adolescents doing “nothing”**

Schooling, work, and marriage are perhaps the most significant activities in which adolescents engage. These activities represent socially recognized statuses and identities (e.g., “student,” “employee,” and “spouse”) that confer access to such social and economic rewards as education, money, and mobility.

One of Durrant's major findings was that 45 percent of adolescent girls in Pakistan are not in school, not engaged in economically productive work, and not married, indicating a significant loss of human potential. By comparison, 13 percent of boys aged 10 to 19 years are similarly doing “nothing.” While Durrant used the term “nothing” as shorthand for the activities of those not in school, not working for pay, and not married, she notes that the majority of these adolescents are not literally doing “nothing.” Rather, they are failing to engage in activities that would advance their social position, opportunities, and connection to social institutions outside the household.

Durrant found that many of these adolescent girls are working in the parental home. (Data on the amount of housework that boys do is unavailable in the Pakistan Integrated Household Survey, but Durrant believes it to be minimal.) A critical question that researchers need to resolve is whether housework prevents girls from engaging in other
Cultural Factors May Affect Personal Health Assessments

When researchers survey older people they commonly ask, “How would you rate your current health? Would you say that it is excellent, very good, good, fair, or poor?” The response to this question, referred to as self-assessed health, has been shown in various studies to provide a relatively accurate gauge of a person’s actual health. One study, for instance, showed self-assessed health to be a better predictor of mortality outcomes than a patient’s medical records. What conditions determine people’s judgments of their own health? Are the determinants of health similar in different countries? Are levels of self-assessed health similar in different countries after accounting for objective measures of health? Answering these questions would improve the ability of researchers to write health survey questions, compare the health of populations in various countries, and make policy recommendations.

Population Council demographer Zachary Zimmer and his colleagues explored the complexities of self-assessed health among elderly people in the Philippines, Taiwan, and Thailand. The researchers used data from a series of surveys conducted in these three Asian countries in 1996. Survey participants were aged 50 years and older and were chosen to be nationally representative.

The researchers evaluated the effect of a number of variables. Among objective measures of health, they looked at such functional items as ability to walk inside the home, dress, and lift objects. They also considered the presence of such chronic health conditions as high blood pressure, diabetes, and arthritis. The research team controlled for such demographic characteristics as age, sex, and whether residence was urban or rural. The team took note of such socioeconomic factors as education, number of household possessions (as a measure of income), and employment. The investigators took into account the extent of each person’s social network, for example whether they were married, had children, or lived with someone. Finally, the researchers factored in the effects of such unhealthy behaviors as smoking and excessive drinking.

Cross-cultural differences

The researchers found considerable variation in the way that older adults in the three countries assess their health. Overall, assessments were most likely to be favorable in Taiwan and least likely to be favorable in the Philippines. The team had expected this outcome, in part because Taiwanese are more likely than Thais or Filipinos to live in urban areas, and thus may have better access to health care. The investigators also found that objective measures of health, such as functional ability and chronic conditions, are correlated with self-assessed health in each country. The addition of virtually any chronic condition, for example, was accompanied by a downgrade in self-assessed health.

When the investigators performed a statistical analysis, however, they uncovered a striking “country effect.” Controlling for all the delineated variables, levels of self-assessed health are relatively similar between Taiwanese and Thais, but differ significantly from those in the Philippines. The probability of an older adult without any documented health problems reporting very good or excellent self-assessed health is 66 percent in Thailand and 60 percent in Taiwan, but only 25 percent in the Philippines. As these older adults experience increasing illness, their assessments decrease most sharply in Thailand and Taiwan, eventually becoming similar in all three countries. “Basically, unhealthy people in any of these countries are unlikely to say they’re doing well,” says Zimmer.

Many factors might explain the divergent health claims made in these countries. “Thailand has very good health programs for elderly people, and that could make people more positive about their health,” speculated Zimmer. “Conversely, the Philippines has very poor health care for the elderly, which may make people more pessimistic.” It is also possible that elderly Filipinos truly are in poorer health than their counterparts in Thailand and Taiwan, but that the objective measures used in these surveys were not sufficiently discriminat- ing to detect the differences.

Cultural factors may play a big role in how people assess their health. People in the Philippines, for instance, may be more modest about their health than are people in Thailand or Taiwan. Religion may also play a role. Thailand and Taiwan are predominantly Buddhist countries, while the Philippines is largely Catholic.

“We have to recognize when we use this question that there may be cultural influences on how people assess their health,” says Zimmer. “People’s views on their health may be influenced by who they are rather than how they feel.” The research team suggests that in order to clarify the cause of these variations, future research should expand upon the variables studied and investigate subtle cultural factors that may determine self-assessed health.

SOURCE

OUTSIDE FUNDING
U.S. National Institute on Aging
Nonoxynol-9 Rapidly Exfoliates Rectal Epithelium

New findings, deemed “sobering” by the Population Council scientists who conducted the research, suggest that products containing the spermicide nonoxynol-9 may increase the risk of HIV infection when used during rectal intercourse. David M. Phillips, of the Council’s Center for Biomedical Research, and his colleagues found that nonoxynol-9 caused the rapid exfoliation of epithelium when applied rectally.

Surveys in the United States have shown that 41 percent of men who have sex with men try to use products containing nonoxynol-9 as lubricants during rectal sex. This practice stems in part from a belief that such products may act as microbicides, protecting against infection with HIV. In addition to its ability to kill sperm, nonoxynol-9 (N-9) has been shown to inactivate viruses, including HIV, in vitro and can protect Rhesus macaques from vaginal infection with SIV, a simian virus related to HIV. The results of a clinical trial reported in 2000, however, showed that the use of products containing N-9 increased the likelihood of HIV infection in women. Other studies, done by Phillips and his colleagues, showed that N-9 caused mouse rectal epithelial cells to slough off and made mice highly susceptible to infection with herpes simplex virus-2, a virus structurally similar to HIV.

Testing N-9 in humans

After obtaining these results in mouse studies, Phillips and his team set out to determine the effect of N-9 on human rectal epithelium. The scientists compared the effects of two over-the-counter gels containing N-9—K-Y® Plus and ForPlay®—and two gels that do not contain N-9—methyl cellulose and Carraguard™, the Population Council’s leading microbicide candidate. Carraguard is made from carrageenan. (In 2000, Council researchers began conducting expanded safety and acceptability trials of Carraguard among women in South Africa and Thailand. The placebo used for comparison in these trials is methyl cellulose.)

Phillips and his colleagues examined rectal saline lavage specimens taken from four randomly chosen study participants: three men and one woman. Each participant was given a kit that contained the four test products in unmarked containers. Before applying any of the products, the study participants took a baseline lavage specimen, rinsing the rectum with saline and depositing the specimen in a collection vial containing fixative. Next, the participants applied the first formulation rectally and retained it for 15 minutes, then performed a lavage and collected the specimen.

“Eight to ten hours later, participants collected another lavage specimen. Each product was tested in this way, with participants allowing at least 72 hours between experiments. A total of 36 specimens were collected.

The four specimens collected 15 minutes after the application of K-Y Plus and two of the specimens collected 15 minutes after the application of ForPlay held contents the scientists termed “dramatically different” from the other specimens. These specimens contained hundreds of convoluted sheets of epithelial cells, large enough to be seen with the naked eye. Each sheet typically contained hundreds of cells. The specimens collected after the application of K-Y Plus, which is 2 percent N-9, contained far more cells than the specimens collected after the application of ForPlay, which is 1 percent N-9.

When the scientists examined these six specimens microscopically, they found that each sheet contained columnar and goblet cells, varieties of cells typical of rectal epithelial morphology. In contrast, the other specimens were composed primarily of unidentifiable amorphous material, plant cell walls, bacteria, and an occasional epithelial cell. “Removal of the rectal epithelium may enhance HIV infection because the primary target cells of HIV, lymphocytes and macrophages, are located in the lamina propria immediately below the gut epithelium,” Phillips concluded. “We therefore caution against the use of N-9-containing products during rectal intercourse.”

These findings challenge the conclusions of other scientists who recently found that Advantage 24®, a product containing N-9 at 3.5 percent, was not associated with rectal epithelial disruption. The researchers came to this conclusion on the basis of rectal tissue biopsies taken 12 hours after the application of Advantage 24. Phillips and his colleagues argue that the gastrointestinal epithelium rapidly repairs itself. Thus, biopsies taken 12 hours after N-9 application would not accurately show how the chemical damages rectal epithelium. This contention is supported both by the team’s previous mouse studies, which showed that mouse rectal epithelium recovered from N-9-induced damage in one hour, and by the current research, which showed epithelial damage 15 minutes after N-9 application, but no sloughing of epithelium eight to ten hours after N-9 application.

Still, Phillips acknowledges that more research is needed. “We’re working to prove more convincingly—with larger sample sizes—that use of N-9 during anal sex is risky. We’d also like to determine more precisely the length of time needed for rectal epithelial repair. One paper won’t do it.”

OUTSIDE FUNDING
The Bill and Melinda Gates Foundation, the Andrew W. Mellon Foundation, and the Rockefeller Foundation

SOURCE
Integrating Reproductive Health and Primary Care

The Reproductive Health Working Group, a research team established at the Population Council’s Cairo office, recently conducted an intervention in collaboration with the Egyptian Ministry of Health and Population to address the medical needs of rural Egyptian women. The researchers created a framework for the integration of reproductive health and primary care and applied it at three primary care centers in Giza. They also assessed the influence of the intervention on quality of care and demand for services.

Previous studies by the group showed that rural Egyptian women bear a heavy disease burden. The researchers found, for example, that the vast majority of women in two villages in Giza were experiencing at least one gynecological or related condition at the time of the study. The women in these villages indicated that they avoid consulting doctors in part because the quality and nature of available services are often inadequate.

The reproductive health framework

The idea of integrating reproductive health and primary care services gained wide acceptance after it was championed at the 1994 International Conference on Population and Development. Members of the working group sought to pinpoint the essential components of reproductive health services and to determine the feasibility of delivering them at the primary level.

The identification of essential services was guided by the findings on women’s needs from the previous study. The framework allowed for provision of nutritional advice, and screening and treatment for reproductive tract infections, anemia, hypertension, urinary tract infections, uterine prolapse, and diabetes, among other services. Moreover, the researchers created a simple, yet comprehensive system for keeping patient medical records. Previously, maternal and child health and family planning records were kept separately from primary care records. While this system was sufficient for statistical reporting, it hampered the ability of clinicians to see the whole picture of a patient’s health.

The new record-keeping system documented all patient visits in one file.

The research team outlined standards of care to be followed, such as increasing the duration of interactions between providers and clients, improving sanitary practices, and enhancing client privacy in the clinic. They also trained doctors and nurses in technical and communication skills and launched a community health education program.

“Health education, when conducted carefully, can enable women to make informed medical decisions. Our previous research showed that

many women in Giza were unaware of the medical significance of their symptoms, so improving their knowledge about health is vital,” says Population Council researcher Karima Khalil, a member of the study team.

In order to ensure an effective two-way referral system to higher treatment levels, the research team spent considerable time establishing links with local district hospitals. The team emphasized the importance of providing feedback to the primary clinician after the referral visit. Finally, the intervention entailed such basic infrastructure upgrades as painting clinic walls and replacing old microscope lenses.

The team developed and tested tools to monitor and evaluate every component of the work. They found that the health education program quickly increased the demand for reproductive health services and that women had favorable responses to the clinic upgrades. The time women spent waiting for their appointments decreased, while the amount of time they spent with the provider doubled.

Doctors became more sensitive to women’s privacy, and examination procedures and subsequent diagnoses improved greatly. Enhanced diagnostic procedures were also a result of training for laboratory technicians that was conducted as part of the intervention. Sterilization and hygienic conditions at the clinics improved markedly. Nurses became more enthusiastic about their jobs and began assisting doctors more than they had previously.

Several management issues at the clinics remained troublesome even after the intervention, however. While the doctors were in effect managers of the clinics, they had never received any management training. As a result, job descriptions and the division of responsibilities, particularly among nurses, were not generally followed. Attendance and punctuality were erratic in some cases. Moreover, medications, microscope slides, and disposable gloves were supplied irregularly. The research team recommended that the physicians would benefit greatly from a short course in management skills.

Another obstacle involved the two-way referral system. The arrangement did not function satisfactorily, perhaps as a result of bureaucratic obstacles within local district hospitals.

“While some challenges remain, this study has shown that a simple framework of essential reproductive health services can be provided at the primary care level,” concludes Khalil. “Doctors, nurses, and lab technicians can learn new procedures, and clients very much need and appreciate the new services.”

To confirm their findings and learn more about ways to improve integrated service delivery, the working group is currently testing the framework in 15 additional clinics in Giza.

SOURCE

OUTSIDE FUNDING
In order for family planning clients to make informed choices about contraceptive methods, clinicians need to determine their clients’ wishes and provide them with a selection of appropriate methods. Moreover, providers must detail side effects that might result from each method and instruct clients on how to use the chosen method. Studies have shown that in a number of countries, including Peru, these basic requirements are not always met. Urban family planning providers in Peru have stated that short counseling sessions resulting from case overload in clinics prevent them from giving clients complete information. Population Council researcher Federico León and his colleagues tested this claim by investigating the exchange of information in Peruvian clinics using women trained to act as clients.

**Simulated clients**

The researchers investigated 19 randomly chosen large urban health centers throughout Peru. Each clinic was visited on different days by six trained simulated clients. These clients were 28 healthy women aged 20 to 30 years, each of whom had previously given birth to one child. The women were trained to present the same client profile. When asked about their reproductive intentions, the women said they wanted to postpone pregnancy. When asked about their current use of contraception, the women said that they were using the rhythm method. When asked whether they wanted more children, given pelvic exams, given more specific information about the timing of the Depo-Provera shots, or asked about their current menstrual bleeding patterns.

Providers were inefficient in the use of their time. In 64 percent of the cases, for example, they discussed condoms extensively, despite the fact that the client was not interested in this method. (This figure does not include the 18 percent of providers who mentioned condoms as a method to use until the client could begin using Depo-Provera.)

“Providers should be more practical in assessing the needs of clients and helping them choose appropriate methods,” says León. “They should also focus more thoroughly on the method chosen by the client.”

The researchers found that in counseling sessions lasting 8 minutes or less, providers typically exchanged information with clients on roughly 14 of the 46 topics. When sessions lasted from 9 to 14 minutes, providers exchanged information with clients on about 19 of the 46 topics, a statistically significant increase. Further increases in the duration of sessions resulted in statistically insignificant improvement in information exchange.

“While very short sessions do limit the amount of information exchanged, it appears that the efficiency of information exchange diminishes when counseling sessions last more than 14 minutes. Changes in counseling strategy are needed,” explains León.

The researchers found that most providers spent a lot of time showing clients a flip chart depicting every available contraceptive method. Although they commend the intent to provide full contraceptive choice, the investigators also emphasize the importance of informing patients in detail about the side effects and use of their chosen method. They propose that providers explore the beliefs and attitudes of clients and their partners that are relevant to the use of family planning methods. Then the provider can focus on the few methods that are pertinent to the client’s situation and ask the client to make a choice. With the time saved in describing unsuitable contraceptive methods, providers could address all the important issues relating to the chosen method.

**SOURCE**


**OUTSIDE FUNDING**

United States Agency for International Development
Does HIV Affect Reproductive Choices in Zambia?

Do people alter their reproductive behavior in response to HIV/AIDS in settings where infection is prevalent? Are there ways that reproductive health and family planning services can help people make choices to reduce the risk of perinatal and heterosexual transmission of HIV/AIDS? Naomi Rutenberg, Population Council senior program associate, and her colleagues investigated these questions in Ndola, Zambia.

The situation in Ndola

HIV infection rates are as high as 20 percent among adult men and 30 percent among adult women in Ndola. The city serves as an entertainment and supply base for a substantial number of miners, seasonal workers, and truck drivers—a circumstance that fuels the HIV epidemic there. To assess the knowledge and attitudes of adults in Ndola, Rutenberg and her team conducted eight focus groups with a total of 76 participants and 23 in-depth interviews.

The researchers found that most participants were highly aware of and concerned about HIV/AIDS. These concerns, however, were not reflected in their decisions about childbearing. In fact, most people expressed confusion about how the presence of HIV would affect these decisions unless a person knew he or she was infected.

Economic factors have the most important influence on childbearing decisions, according to participants. In some cases, these economic factors are influenced by HIV/AIDS, such as when families adopt the children of relatives who have died of the disease. The extra burden raising orphans would impose on those relatives who have died of the disease comes out and makes HIV/AIDS a concern. Additionally, the vast majority of participants felt that the child would undoubtedly be born infected with HIV and die. Only a few respondents were aware that not all babies born to HIV-positive mothers become infected. One female focus group participant explained, “That is how it is when a woman is pregnant—that is when all the diseases in the body come out and make HIV because the disease is already in the body. Soon after delivery, everything just comes out and the baby does not live long, it dies, and for the mother also the disease becomes very serious.”

Most respondents felt that condom use would be the best method of avoiding pregnancy if a woman knew she was HIV-positive.

Knowledge of one’s HIV status is necessary for making an informed choice.

Participants reported that in such cases the stigma about condom use would be reduced and the need to negotiate use minimized. Evidence of such changes in reproductive behavior has not been found by other studies in the region, however; such studies show that knowledge of one’s HIV status sometimes influences later contraceptive use but not subsequent fertility. HIV-positive women may be giving birth when they would prefer not to. If they could avoid such births without facing stigma, they probably would do so.

Research and policy recommendations

Rutenberg and her colleagues conclude that we need to find out more about the factors that influence women and couples infected with or affected by HIV to continue childbearing. In the meantime, the investigators suggest that family planning and reproductive health clinics encourage women and men to evaluate their risks of contracting HIV and to consider having a free, voluntary HIV test.

“While knowledge of one’s HIV status may not be sufficient to influence fertility decisions, it is a necessary first step for making an informed choice,” states Rutenberg.

Clinicians should also emphasize concerns about children’s well-being. Suggesting behavior change for this reason may resonate more strongly with couples than do other rationales, such as preserving individual health. Finally, once a couple affected by HIV decide to avoid pregnancy, providers must be equipped to help them consider the benefits and drawbacks of various contraceptive methods.

SOURCE


OUTSIDE FUNDING

The Rockefeller Foundation and the United States Agency for International Development
Center for Biomedical Research


International Programs Division


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**Recent Publications**

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**Sathar, Zeba A. See Working Paper 143 (Policy Research Division).**

**Ul Haque, Minhaj.** *See Working Paper 143 (Policy Research Division).*


**Reports**


**Chikamata, Davy, Oliver Chinganya, Heidi Jones, and Saumya Ramarro.** "Dual needs: Contraceptive and infection protection in Lusaka, Zambia." Lusaka, Zambia: Central Statistics Office.

**Costello, Marilou P., Cecilia S. Acuin, Roy Dimavuiga, Roxanne Epe, Teresa Maganar, and Alberta Vargas.** "Matching grants program evaluation project for Digos, Tagum, Tacloban, Taytay, San Carlos, San Jose, and Desmarinas." Manila, Philippines: Population Council.


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Policy Research Division


Report

Working Paper
143 Sathar, Zeba, CYNTHIA B. LLOYD, Cem Mete, and Minhaj ul Haque. “Schooling opportunities for girls as a stimulus to fertility change in Pakistan.”

Other Publications

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activities or whether girls perform housework because there is nothing else they are allowed to undertake. Even after accounting for housework performed by adolescent girls, the activities engaged in by 10 percent or more of both adolescent boys and girls are unknown. Finding out what these young people are doing with their time is vital to planning positive and effective policies and programs for adolescents.

“Without surveying adolescents as members of households, as was the case with the surveys that collected on adolescents as members of households, it would be extremely difficult to create policies and programs fully suited to the needs of adolescents without surveying adolescents themselves.”

“This is a very vulnerable group,” states Durrant. “They are in the home, not linked to any social institutions. They are extremely hard to reach with information and programs.”

Gender disparity

Durrant’s research also highlighted large gender disparities between adolescent boys and girls in Pakistan. Adolescent girls, for example, are far more likely than boys to live in a household with neither parent, largely because of change of residence associated with their marriage. While 4 percent of boys aged 15 to 19 live with neither parent, 22 percent of girls in that age group live with neither parent. Adolescent boys are also more likely than girls to seek treatment for their ailments, though girls are slightly more likely than boys to report illness or injury. And boys have greater access to health information.

Although the age at marriage in Pakistan is higher than it is in India and Bangladesh, adolescent marriage is common. More than half of the women currently in their 20s were married during adolescence, compared to one-fifth of men. One-third of adolescent girls in Pakistan become mothers before age 20.

Improvements in girls’ schooling in urban areas have helped reduce the gender gap in education among urban adolescents; however, huge gaps persist between boys’ and girls’ schooling and literacy throughout rural Pakistan. While parents generally favor education for both daughters and sons, the shortage of nearby schools and qualified teachers inhibits girls’ schooling. (Most parents would prefer that their children attend single-sex schools and, in public schools, girls are taught only by women. Teachers are frequently absent because of the limited mobility allowed for women in Pakistan.)

Rural–urban gap

As this finding on education illustrates, there are great disparities between adolescent girls who live in rural areas and those who live in cities. “This signals a need to direct programs to rural adolescent girls,” asserts Durrant.

The rural–urban disparities do not stop at education. Rural adolescents work more than their urban counterparts, as indicated by both the percentage of adolescents who work and the number of hours worked. Urban adolescents, however, are more likely than rural young people to be paid for their work. Adolescent girls in rural areas, in poor households, and with illiterate mothers are more likely than other girls to be doing “nothing” and to become wives and mothers in their teens.

In addition to filling many gaps in knowledge, Durrant’s monograph has highlighted areas in which more information is badly needed. Using the publication as a guide, researchers in the Population Council’s Pakistan office are planning a survey of adolescents designed around issues central to this life stage rather than relying on information collected on adolescents as members of households, as was the case with the surveys that Durrant analyzed. Council researchers will use the new survey to investigate, among other things, the actual activities of adolescents who are now thought to be doing “nothing.”

“An important byproduct of doing this work is the knowledge that a lot can be learned about adolescents from existing data sets that were not compiled with this end in mind,” says Durrant. “Nevertheless, it would be extremely difficult to create policies and programs fully suited to the needs of adolescents without surveying adolescents themselves.”

SOURCE