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The First-time Parents Project in rural India demonstrated that the periods immediately following marriage and surrounding the first pregnancy and birth offer unique opportunities to improve the situation of married young women. See story, page 2.

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Empowering Married Young Women in India and Improving Their Sexual and Reproductive Health

“Despite increasing efforts to prevent early marriage in India, substantial numbers of girls will continue to marry as children, which carries immense social and health disadvantages,” says K.G. Santhya, a Population Council researcher. “This calls for increased investment in supporting married adolescent girls.” As recently as 2005–06, more than two-fifths of all women in India aged 20–24 were married by age 18. A growing body of evidence from India and elsewhere shows that the reproductive health situation and needs of married adolescents and young women are substantially different from those of both unmarried adolescent girls and married adult women, so that providing them with services is challenging. Recent policies and programs are attempting to address the particular needs of married adolescents and young women. Whether these programs will be effective is not clear because little evidence exists concerning the kinds of program models that improve the situation of married girls.

To address this knowledge gap and improve programs, the Population Council, in partnership with the Child In Need Institute in Kolkata, the Deepak Charitable Trust in Vadodara, and the International Institute for Population Sciences, Mumbai, initiated the First-time Parents Project. The project aimed to develop and test an integrated package of health and social services to improve married young women’s reproductive and sexual health knowledge and practices, enhance their ability to act in their own interest, and expand their social support networks. The project was formulated on the hypothesis that the periods immediately following marriage and surrounding the first pregnancy and birth, although they are times of substantial vulnerability, offer unique and powerful entry points for improving the situation of married young women.

First-time Parents Project

The team implemented the First-time Parents Project in two rural settings in India—Diamond Harbour Block in the state of West Bengal and Vadodara Block in the state of Gujarat. The project served several types of participants: newly married young women, young women pregnant for the first time, postpartum first-time mothers, husbands

“Programming for married adolescent girls needs to recognize their diversity, if it is to make a difference in addressing their varying needs.”

of these young women, their mothers and mothers-in-law, health-care providers, and the wider community. The project comprised three mutually reinforcing components: information provision, health-care service adjustments, and peer-group formation as a means of enhancing young women’s social support networks. The Council and its partners implemented project activities in 24 villages—12 in Diamond Harbour and 12 in Vadodara, each with a population of about 25,000. The project was launched in January 2003 and concluded in December 2004.

In order to track the extent of married young women’s exposure to the project and

assess the intensity and breadth of their participation in it, the team adopted a monitoring system. This system also enabled the Child In Need Institute and the Deepak Charitable Trust to monitor the progress of each component of the project and make adjustments in the implementation process when necessary.

The team used a quasi-experimental research design, with cross-sectional surveys undertaken prior to the implementation of the project (baseline) and at its conclusion (endline) in control and project villages. Respondents for the baseline survey included young women married during the two years preceding the survey, young women pregnant for the first time at the time of the survey, and young women who had delivered their first child during the 18 months preceding the survey. At the endline, the team expanded the eligibility criteria in order to track as many baseline respondents as possible. Hence, respondents for the endline survey included young women married during the four years prior to the endline survey who had never been pregnant; young women who were pregnant for the first time at the time of the endline survey; and young women who had delivered their first child during the four years prior to the survey. The team identified respondents for the baseline and endline surveys through a household listing in the study area, and invited all eligible women to participate in the survey.

Encouraging findings

The team found that in both sites the project had a significant positive net effect on most indicators reflecting married young women’s autonomy, social support networks, partner communication and support, and knowledge of sexual and reproductive health. These indicators include the ability to make decisions regarding purchases of food, clothing, and other items; having friends in their village; having

their partner's support during family conflicts; and awareness of contraceptive methods and complications of pregnancy. For example, in both sites, after controlling for potentially confounding factors, married young women who participated in the project were significantly more likely than those from the control group to have received a routine postpartum check-up.

The net effect of exposure to the project was mixed, however, with regard to indicators related to gender-role attitudes and attitudes toward domestic violence, such as believing that girls should be allowed to decide when and whom to marry or that a husband is justified in beating his wife if he does not like the food she cooked. Although exposure to the project had a significant positive net effect on gender-role attitudes in one of the sites, no independent effect was observed in the other site. Attitudes about domestic violence improved across all groups in both sites, but this change could not be attributed to the project.

The study also assessed changes in reproductive health practices. Exposure to the project had a significant positive net effect in one or both sites on such indicators as use of contraceptives to delay the first birth, obtaining comprehensive antenatal care, making delivery preparations, obtaining routine postpartum checkups, and following recommended breastfeeding practices. Breastfeeding immediately after delivery, and feeding of colostrum, for example, increased dramatically in Diamond Harbour among participating girls and young women. The project did not, however, appear to increase a young woman's likelihood of delivering her first baby in a hospital or clinic in either site.

This study has several limitations that may have exaggerated the effects of the project, including some self-selection of participants and loss to follow-up. Other shortcomings may have tended, however, to conceal the positive effects of the program. Most notably, although few baseline respondents in control villages reported receiving reproductive health services, at endline a substantial proportion of married young women in these villages had received information and services from government programs during the course of the project. This finding made it difficult to compare the endline situation of groups exposed to

the project with that of groups who were not exposed and to identify changes that were entirely attributable to exposure to the project. Also, as a consequence of the movement of young women between their natal and marital homes, exposure to the project was diminished for many of the participants. However, "the overall pattern and general consistency of the findings give us confidence in the results," says Nicole Haberland, a Council researcher.

This approach can be considered a model to replicate in other settings where early marriage is common.

Lessons learned

Several lessons can be drawn from the experience of implementing the First-time Parents Project that could be relevant for programs targeted at married adolescent girls. First, even within the subset of girls who are married, there is diversity; for example, some are trying to conceive, some hope to delay their first pregnancy, some are pregnant or have given birth recently. "Programming for married adolescent girls needs to recognize their diversity, if it is to make a difference in addressing their varying needs," says Santhya.

Second, many influential adults in the families of participating married young women were apprehensive of the social empowerment component of the project. The team recommends that, when working with married adolescent girls, staff should be trained to build activities into the project to allay the fears of influential adults in their families.

Third, the team found that as a result of married young women's lack of awareness, decisionmaking authority, control over resources, and restricted mobility, they are less likely than older women to seek appropriate and timely health care. Providers need to be sensitized to

the particular needs of married young women and should make efforts to provide sexual and reproductive health information and services directly to this group through outreach services.

Finally, the experience of several livelihoods programs and social-cohesion-building projects for adolescent girls has shown that these efforts may not reach many married adolescent girls. The experience of the First-time Parents Project shows that married adolescent girls *can* participate in such initiatives, but require particularly focused efforts. Moreover, findings from this project suggest that efforts to enhance married young women's control over their own lives and reduce their social isolation can also contribute to improvements in their reproductive health practices.

In short, the experience of the project demonstrates that improving married young women's reproductive health knowledge and practices, expanding their sources of social support, and involving them in activities with peers in safe spaces outside the home are feasible, and that these outcomes increase their power in their marital and familial relationships. Indeed, this approach can be considered a model to replicate in other settings where early marriage is common. The positive effects of the project on married girls' control over their own lives and on their antenatal, maternal, and newborn health practices are significant. These changes could have a beneficial influence on other longer-term indicators not considered in this study, such as practices surrounding the second birth, child health outcomes, and daughters' education. This model could also be integrated into existing government or nongovernmental services, and could be tested for implementation on a larger scale. ■

SOURCE

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Enhancing Promotion of the Female Condom

The Population Council is actively engaged in increasing knowledge about and expanding access to products women can use to protect themselves from HIV and other sexually transmitted infections (STIs). The Council's microbicide development program is a prime example of this effort, but the organization is also working to increase the availability and use of the female condom, the only safe and effective female-initiated method on the market today that provides simultaneous protection against unintended pregnancy and STIs, including HIV. Population Council representatives Martha Brady, Nafissatou Diop, and Sam Kalibala have been involved in promoting access to the female condom in various ways and settings, including through participation on the UNFPA-led Interagency Working Group on Comprehensive Condom Programming. Brady, along with colleagues from partner organizations, recently completed two investigations—one in Ghana and one in Kenya—into female condom use and ways to enhance promotion of and access to the product.

"There are several types of contraceptives that women can use, so the female condom might be overlooked in the mix of contraceptives," said Brady. "But female condoms are the only female-initiated product that offers protection against STIs, including HIV. In settings with moderate-to-high HIV prevalence, ensuring that the female condom is appropriately positioned might increase uptake. Our work in Kenya shows that it is feasible to position the female condom within HIV and AIDS programs, including through voluntary HIV counseling and testing programs (VCT)."

Kenya

In Kenya, the Population Council collaborated with Liverpool VCT Care & Treatment (LVCT), Family Health Options Kenya (FHOK), DelMonte, and Unilever to test and improve various approaches for making the female

condom available. The team worked in three service environments: at centers that offer VCT (LVCT); at centers that offer reproductive health, family planning, and HIV services (FHOK); and within private-sector workplace HIV and AIDS programs (at DelMonte and Unilever).

The work began with in-depth training of peer educators and counselors from the sites, followed by dedicated efforts to integrate the female condom into service provision. Free, adequate, and on-demand supplies of female condoms were provided at all locations, and women were encouraged to take and use them. Information about clients' knowledge, attitudes, and experiences with the female condom were gathered at all sites.

The findings suggested that the female condom is an acceptable method. Almost all participants were willing to recommend it to others. Clients were willing to pay for the product, but generally less than market prices. However, some women were not willing to try the condom. Their reasons for this reluctance ranged from "not needing such a method," to fearing their partner's response. The study found that the main motivators for use were: providers' recommendation, the novelty of the method, and the benefits of protection from both pregnancy and STIs.

To increase the use of the female condom, the researchers recommend developing a national strategic plan for female condoms with the input of key stakeholders; ensuring a consistent supply of affordable female condoms; engaging men as supportive partners to women using the product; and setting realistic expectations about uptake.

Ghana

In Ghana, the Council interviewed 21 key stakeholders—leaders at various family planning and HIV and AIDS organizations—to gain an understanding of the current and historical situation of the female condom: how organizations

acquire it, how the product is distributed, and how organizations include it in their programs.

Most of the stakeholders interviewed said that since a major launch of the product in 2000, momentum has waned and that financial support is lacking. Crucially, although stakeholders acknowledge the dual benefits of the female condom—as protection against both pregnancy and HIV—the product is promoted primarily through social marketing efforts and the Ghana Health Service's Reproductive and Child Health Department, not through HIV and AIDS programs.

Brady and her colleagues offer several recommendations for moving promotion forward in Ghana. Perhaps the most essential steps are to allocate funds for implementing a comprehensive female condom program and to define a strategy and increase the provision of female condoms within programs aimed at reducing HIV and AIDS transmission.

The Council remains engaged in efforts to enhance access to existing HIV-prevention products, simultaneously working to bring microbicides through the product-development process. The Council's current work to identify and test innovative models of access to the female condom will pay dividends later when microbicide products are available, as the pathway to access will have been paved. ■

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Identifying the “Bridging Population” in Pakistan

Pakistan currently has very low levels of HIV infection, with a prevalence rate of less than 0.1 percent. “Although the prevalence of STIs, and especially HIV, among the population of urban men in Pakistan is low, the country is witnessing a concentrated epidemic among high-risk groups,” said Ali Mohammad Mir, director of the Council’s HIV and AIDS program in Pakistan. “The potential of the epidemic to pass into the general population exists via people who have contact both with high-risk groups and the general population, a ‘bridging population.’”

The Pakistan National AIDS Control Program commissioned the Population Council to study STI prevalence and sexual behaviors among urban men. “Until this study was conducted, there was limited evidence regarding men’s nonmarital sexual behaviors,” said Mir.

The Council conducted 64 focus-group discussions in Karachi, Lahore, Quetta, Peshawar, Rawalpindi, and Faisalabad in 2007 to establish the appropriate terminology and approach for the questionnaire. Next, the team interviewed 2,400 men—400 men from each of the six cities—using the resulting structured questionnaire. Men were the focus of this study because the team believed them to be more likely than women to constitute the bridging population.

The researchers also tested the men for syphilis, gonorrhea, chlamydia, herpes simplex virus-2, and HIV. Nearly all of the respondents agreed to provide blood samples. A little more than 4 percent tested positive for at least one of the five STIs. The highest prevalence of the five infections was in Karachi (8.5 percent), followed by Lahore (5.3 percent), Faisalabad (4.0 percent), Quetta (4.3 percent), Rawalpindi (2.5 percent), and Peshawar (2 percent).

Risk behaviors

A little less than half of the men had had their first intercourse between the ages of 16 and 20. About one-fourth of the men reported ever having had nonmarital sex. Regardless of marital status, all respondents who reported ever having

sex were asked about condom use. Sixty-eight percent of respondents had ever had sexual intercourse; only 37 percent of these men reported ever having used a condom.

Fifteen percent of the respondents reported having had nonmarital sex in the past 12 months, and 12.5 percent reported having had nonmarital sex in the past three months. Respondents most commonly reported having nonmarital sex with females who were not sex workers (with “female friends”). The next most frequently reported category of nonmarital partner was the female sex worker. Less than

“Until this study was conducted, there was limited evidence regarding men’s nonmarital sexual behaviors.”

5 percent of men in all six cities reported having had sex with transgender sex workers (*bijra*). Of the men who reported having had nonmarital sexual intercourse during the past 12 months, more than two-thirds said they had never used a condom with any sex partner.

Ninety percent of the men had heard the term “HIV/AIDS.” Of the 10 percent who had not heard this term, almost two-thirds had received no education. Nearly one-fourth of respondents believed that HIV infection could be spread through the sharing of food, clothing, bedding, and toilets with an infected person. Only 9 percent of respondents had been tested for HIV, and only 23 percent considered themselves to be at risk of acquiring a sexually transmitted infection.

Identifying the bridging population

The researchers applied the common definition of “bridging population” as being those people who have sexual contact with both high-risk

groups and the general population. In Pakistan, this population includes married men who reported having had extramarital sex with a partner from a high-risk group (that is, a male or female sex worker, a male other than a sex worker, and/or a *bijra*) in the past 12 months and unmarried men who reported having had sex with two or more partners in the past 12 months, one of whom was in a high-risk category.

The total bridging population in the sample was 206; of these men, 141 reported sexual intercourse with a female sex worker during the past 12 months. Three-fourths of men in the bridging population were unmarried. Men in the bridging population were more likely than other men to be younger than 27, less educated (having no more than ten years of schooling), and living with their extended family (as opposed to living with a partner or in a nuclear family situation).

“To circumvent a future HIV epidemic in Pakistan, the National AIDS Control Program will have to develop communication strategies that target the young and uneducated segments of the population,” said Mir. “Further, credible messages that can help reduce vulnerability among young people are needed, and access to integrated reproductive health services should be enhanced.” ■

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their existence or their potential. One respondent explained, “Outsiders get data because they look for it; as a people we are not in the habit of finding and using data.” In other cases, the available data are of uneven quality or

A good place to start is creatively mining the data that are already available.

out-of-date. One government official reported, “Timeliness is a serious problem . . . by the time data are collected, analyzed, and the findings released, the context may have changed and the data become less useful.”

In many cases, the data—particularly local-level data—simply do not exist. Where they are lacking, or where resources are not available to mine them, the fallback position may be to use no data at all in planning. If central governments lack useful local-level data, they may shrink the budgets of lower-level governments without taking into account the real needs at these levels.

One reason for the lack of available data is a corresponding lack of human and technical resources. Respondents repeatedly mentioned insufficient skills among people involved in data collection and management. Furthermore, technical difficulties are widespread. Surveys are often left in paper form and are susceptible to damage. Even in areas with computer access, frequent power outages and inadequate equipment restrict online resources.

Finally, the knowledge and experience gap between those who collect information and those who would use it is wide. Lacking training in analysis, policymakers need to have data translated for them into more comprehensible formats, such as tables or maps. Similarly, journalists prefer lay language to statistical language.

Conclusions and recommendations

“Is there one ideal way to share data that will lead to increased use and eventually greater demand for data?” asks Baldwin. “The answer, in short, is no.” The researchers involved in these studies conclude that a multifaceted approach is needed, but a good place to start is creatively mining the data that are already available. “This would also likely motivate the groups who would lobby for more and better data and greater access to it,” said Judith A. Diers, a Council researcher. “A virtuous circle has to begin somewhere.” ■

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Analysis Examines Availability and Use of Data for Development

In order to plan and develop sound policies, evaluate programs, and lead development activities, government officials need adequate data, particularly demographic data. “Data for development can be likened to money in an economy or blood in the system of a human being,” explained one respondent to a recent Population Council study on demand for access to and use of data. Increasingly, such data are being gathered in the developing world, but are they reaching the people—government officials, policymakers, and others—who need them most? Do those people understand how to use the data to their fullest potential? With funding from the William and Flora Hewlett Foundation, Population Council researchers explored these and other questions in four African countries: Ethiopia, Ghana, Senegal, and Uganda. Researchers interviewed people who work in government agencies, civil society organizations, nongovernmental organizations, and the media, among others.

Determinants of demand

Global initiatives, such as the UN’s Millennium Development Goals, have intensified the pressure on developing countries to quantify progress. Additionally, international donors have increasingly requested evidence that their investments result in positive outcomes. Countries may lose funding if they are not able to produce the appropriate data. But this external demand for data will not increase evidence-based practice in countries if there is no local ownership of the process. The demand has to come from within, fueled by an understanding

of the power of data to support high-quality programs and policies. To date most data are collected and turned over to international entities. One official commented, “When it comes to our politicians, they need to look at a map

“Data for development can be likened to money in an economy or blood in the system of a human being.”

and see that in one district there are about 20 primary schools constructed by the government and in another district there is only one, so there is justification to allocate funds to the district that has been marginalized.”

Of course, data are not the only factor driving policies. Nevertheless, having current and appropriate information can help guide the development of policies and enable others to assess the implementation of those policies. As one government official noted, “The central government has been publishing amounts of funds released, but this is not enough. For example, if the funds are for roads, the information should indicate which roads—not just a lump sum for roads.” The challenges to making data available are exacerbated by the fact

that in many developing countries, including all four assessed in this study, a move is being made to decentralize strategic planning and budgeting, allowing local-level agencies to take on these functions. This decentralization means that data must be available for planning and budget execution at those local levels. Many data sets (such as the Demographic and Health Surveys) are available at the national and sometimes regional levels, but rarely at the district or lower levels. The census is the one data set that provides crucial data for smaller areas, but access to the census is often challenging. Council researchers found an understandable lack of local capacity for analyzing, understanding, or even accessing such data. Access to information means that the data have to exist, that they have to be easily obtained, and that there be a reasonable expectation that someone is available with appropriate skills to make use of the data.

Impediments to demand

“A number of factors seem to have discouraged researchers from releasing routine reports and distributing micro-data,” says Wendy Baldwin, director of the Council’s Poverty, Gender, and Youth Program. “Some fear that the data will be misused. Others cite a culture of secrecy and a need to maintain confidentiality.” To address these concerns, researchers often limit access to their data.

Moreover, in some instances, data are available, but potential users are unaware of

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Population Council, One Dag Hammarskjöld Plaza, New York, New York 10017 www.popcouncil.org

Writer/Editor: Gina Duclayan Editorial Board: Lisa Cowen, Judith A. Diers, James R. Foreit, Sarah Littlefield, Melissa May, and Katie D. Schenk

Production Manager: Y. Christina Tse Production Artist: Sura Rosenthal Copyeditor: Robert Heidel Editorial Assistant and Circulation: Debra Warn

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