

## SLIDE – 1 (a)

- India – second most populous country with a population of 1.03 billion
- India – is one of the 10 fastest growing developing countries
- However, per capita income remains low and 26 per cent of the population live below the poverty line

Table – 1 below gives a brief overview of the population characteristics of India and the state of Maharashtra where the project is located

Variable	India			Maharashtra		
	Overall	Men	Women	Overall	Men	Women
Population in numbers	1,027,015,247	531,277,078	495,738,169	96,752,247	50,334,270	46,417,977
Literacy Rate	65.38	75.85	54.16	77.27	86.27	67.51

## SLIDE – 1 (b)

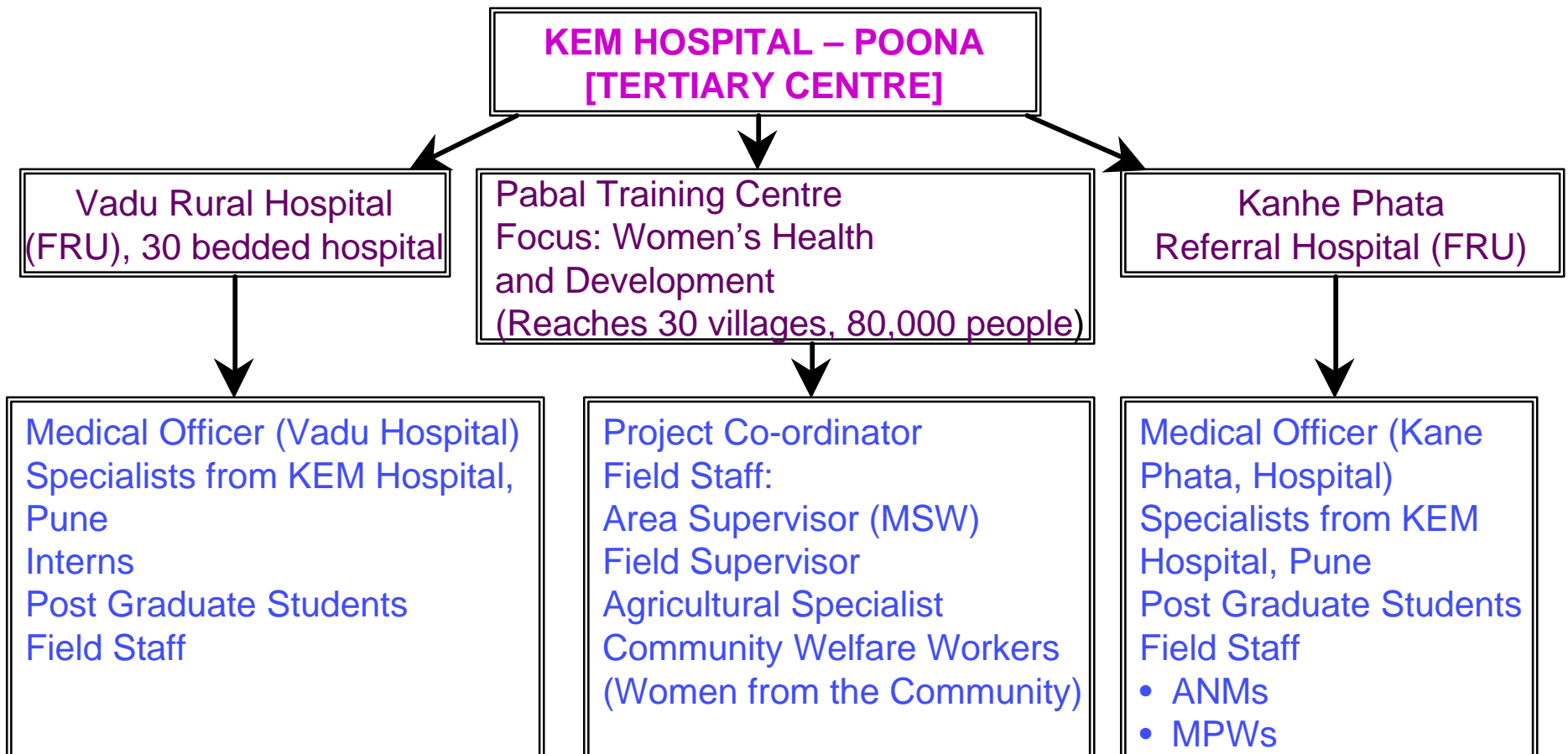
### ADOLESCENTS IN INDIA

- 300 million young people age 10-24 years in India
- Adolescents age 10-19 years represents over one-fifth of population
- 20 per cent of the boys and 44 per cent of girls between age 15 – 19 illiterate
- Two-thirds of married women of reproductive age married by 18 years
- 33 per cent married by age 15
- Among women between 20-24, almost half have given birth by age 20
- Poor reproductive health and high maternal mortality among adolescent girls
- Indian adolescent women have higher mortality risks than adolescent men
- Most adolescent sexual activity takes place within marriage

## SLIDE – 2(a)

- King Edward Memorial (KEM) Hospital is a Trust Hospital
- The KEM hospital Research Centre is 25 years old
  - ❖ Main areas of work
  - ❖ Social issues
  - ❖ Women's health such as maternal mortality, abortions, domestic violence, etc.

Figure 1: KEM organizational structure with two of its referral units and its out reach posts at Pabal



## SLIDE – 2 (b)

### SITE OF STUDY

- Rural Western Maharashtra – India
- Village Dhamari
  - ❖ Main village and 20 hamlets (Wadas)
  - ❖ Total population 5000
- Feasibility study
- Implemented in 3 phases
  - ❖ Preparatory
  - ❖ Implementation/ intervention
  - ❖ Post Intervention
- Duration 30 months
- Funding source – Rockefeller Foundation
- Co-ordinated by:  
International Centre for Research on Women (ICRW), Washington, DC
- Total cost of project – US \$71,820

## SLIDE – 2 (c)

**Figure 2: Phases of Project**

<b>Components and Time</b>	<b>RHE</b>	<b>Counselling</b>	<b>Referral System</b>	<b>Activities</b>
<b>First Phase</b> 6 months	<b>PREPARATION PHASE</b> Needs Assessment Planning the Intervention			Documentation Baseline data Collection and Analysis
<b>Second Phase</b> 8 months	<b>IMPLEMENTATION PHASE</b> Training of Educators			Modification in educational material
4 months	RHE Package Modification	Provision of Counselling in rural set up	Working out referral system and its functioning	Documentation, Modification, Monitoring and Evaluation
6months	Implementing RHE package in study area			
<b>Third Phase</b> 10 months	<b>POST INTERVENTION PHASE</b>			Documentation, Post baseline data collection, Data Analysis, Report writing

## SLIDE – 3 (a)

### TARGET POPULATION

- Married adolescents and young adult couples in Dhamari
- Married females in the age group of 14 – 25 and their husbands
- Total 243 couples
- Stratified sampling of target population
- 114 couples base line population for study
- Males – farmers, factory workers, shopkeepers, teachers, workers, labourers, etc.
- Females – housewives, farm workers
- 20% of male target population migrated for work during the two years of the study

## SLIDE – 3 (b)

### PROFILE OF BASELINE POPULATION

	Husband	Wives																						
<b>Median Age</b>	27 yrs	22 yrs																						
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- Mainly (97.4%) were Hindus
- 86.84% lived in joint families
- 40 per cent lived in Kaccha house; 40 per cent lived in mixed house and 20 per cent lived in Pakka house

## SLIDE – 3 (c)

### BROAD GOALS

- To test the impact of the feasibility study in the intervention site for improving the reproductive health of adolescents in rural Western Maharashtra

### OBJECTIVES

- To impart reproductive health education to rural married adolescents and young adults in order to make them aware about
  - Facets of high risk sexual behaviour which puts them at risk of RTIs, STIs and HIV infection
  - Services available for reproductive health problems
  - Importance of various aspects related to Reproductive Health such as, pregnancy, contraception, planned parenthood, dealing with unwanted pregnancy

## SLIDE – 3 (d)

### TITLE

“Promotion of Male Involvement in Adolescent Married Women’s Reproductive Health through Reproductive Health Education in a Rural Area of Maharashtra, India”

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*Laila Garda and Ujjwal Nene (KEMHRC, Pune, India )*

### Theme Category

- Involving Men as Partners in Maternal and Child Health
- Working with Men on Dual Protection in Prevention of HIV/ AIDS/ STIs and Pregnancy

## SLIDE – 4

### APPROACH UNDERTAKEN:

#### **Community Based Intervention Through -**

- Imparting Reproductive Health Education (RHE) in participatory manner
- RHE through peers
- Peers – Local people – Selected and trained for the programme
- Peer educators assured sustainability and replicability of Intervention

### PROFILE OF PEERS EDUCATORS

- All were local residents
- Five males and six females
- Education – Maximum 12<sup>th</sup> standard and Minimum 4<sup>th</sup> standard.
- Age range
  - Males – 21 yrs to 50 yrs
  - Females – 21 yrs to 38 yrs

## SLIDE – 5 (a)

### ACTIVITIES UNDERTAKEN

- Training of peer educators
- Reproductive Health Education (RHE) was imparted through Community Level Educators (CLEs)
- Target population of village covered in 21 “sapthas” in each phase

### STRATEGY

- Male Community Level Educators (CLEs) imparted Reproductive Health Education (RHE) to husbands, and female CLEs to wives
- Concept of “Prajanana Arogya Saptaha”
- Two phases of RHE – gap of three months
- Counselling services through trained counsellor in village
- RH clinical services in village
- Referral for counselling and clinical services by CLEs

## SLIDE – 5 (b)

### TOPICS COVERED IN RHE SESSIONS

- Reproductive and sexual anatomy and physiology
- Menstruation
- Pregnancy and delivery
- Contraception
- Abortion
- Infertility
- RTIs and STIs
- HIV - AIDS

## SLIDE – 6

### INDICATORS USED TO MEASURE RHE OUTCOMES

- Attendance in RHE 'saptahs'
- Percentage increase in counselling services
- Percentage increase in clinical services
- Pre and Post KAP
- Interviews with village leaders, older members of community, service providers on response to project

## SLIDE – 7 (a)

### MONITORING ACTIVITIES AND TOOLS

- **RHE**
- Percentage of target population who attended four sessions in saptah
  - ❖ Base line population (n=114 couples) – 67 %
  - ❖ Target population (n=243 couples) – 61 %
- Percentage of CLEs who complete RHE sessions successfully
  - ❖ Of the fourteen who completed training, eleven completed both phases of intervention
  - ❖ Two women CLEs discontinued due to pregnancy in later phase. Once CLE dropped out after completing training and pilot phase of project

### TOOLS USED

- Attendance record of participation in sessions
- Evaluation of sessions by supervisor
- Self evaluation by CLE
- Pre and post RHE session questionnaire
- Group discussions with participants after each session

## SLIDE – 7 (b)

- **COUNSELLING SERVICES**

- Percentage increase of people attending counselling sessions
- Percentage of people referred for counselling by CLEs
- Percentage of people other than target population attending counselling sessions
- Percentage of couples approaching counsellor for help

40% of target population attended three counselling sessions

### TOOLS USED

- Attendance record maintained by counsellor
- Documentation of people approaching counsellor for help and nature of help sought

## SLIDE – 7 (c)

- **CLINICAL REFERRAL SERVICES**

- Percentage increase of people referred through RHE sessions
- Percentage of people referred through counselling for RH problems
- Percentage of males referred for male reproductive health problem
- Percentage of people referred to apex hospital for specialized treatment
- Percentage of couples referred for assessment and treatment of infertility

70 % of target population who attended clinical services were referred from RHE sessions

## TOOLS USED

- Record keeping of cases referred for various services
- Record keeping of cases referred for various services for follow up sessions
- Informal individual interviews
- Record keeping of referrals for further investigation, medical and surgical help

## SLIDE – 8

### STAKEHOLDERS INVOLVED IN MAKING THE PROJECT SUCCESSFUL

- KEM Research Director and KEM outreach project staff
- KEM outreach centres staff at Pabal and Kendur
- Village head (Sarpanch)
- Village teachers
- Older members of community/ parents of young couples
- CLEs at Dhamari
- Private health providers in Dhamari and nearby villages – both allopathic and indigenous practitioners
- Government functionaries in rural area – PHC staff (ANMs, Doctors)
- ICRW and partner project teams

## SLIDE – 9

### STAKEHOLDERS – PARTICIPATION IN SUCCESS

- Earlier study area at Pabal and Kendur provided understanding of various RHE needs of rural adolescents and youth
- Peer Educators (CLEs) helped active involvement in the programme
- Respondents of Pre and post intervention survey helped effective planning of intervention
- Gatekeepers, decision makers of village supported target group to attend RHE sessions and services
- Private health providers provided insight into profile of target group and local issues in RHE in young couples
- Government functionaries provided space for training and local capacity
- ICRW and project teams for technical help

## SLIDE – 10

### OBSTACLES AND SOLUTIONS

- Simultaneous RHE sessions during village 'saptahs' made it difficult for husbands and wives to attend sessions due to child care needs
- Village/Local dynamics affected the involvement of CLEs
- Lengthy training of CLEs difficult as they have occupational and village commitments
- Both local leaders and elders in the home (MILs) in rural areas curious and anxious about programmes for young people
- All villagers, especially in 'wadas' could not attend all sessions of intervention due to distance from village
- Some CLEs had good understanding of RHE, but poor public communication skills

## SLIDE – 11

### OPPORTUNITIES THAT PROJECT BUILT ON

- The organizations previous work on Reproductive Health, HIV/AIDS and RTIs/ STIs in the area (outreach clinics) as well as another study on Reproductive Health in a nearby locality created a demand in project site for such services
- Governments policy to reduce HIV/AIDS and consequent emphasis of media (T.V., Newspapers) and local government efforts created an interest in local people
- Need for programmes for young people on RHE issues also sensitized local leaders to support the programme
- Support from leaders helped CLEs to participate in project – even though previously issue was perceived as ‘dirty’ and ‘private’

## SLIDE – 12(a)

### LESSONS LEARNED

- Local people (CLEs) effective in imparting information on sensitive issues such as Reproductive and Sexual Health
- Must train more CLEs than needed to allow for drop-outs (pregnancy, job, etc)
- Couple CLEs most successful in reaching rural adolescent and young married couples
- Training of rural youth needs to include two tiered approach
  - ❖ **Communication techniques**
  - ❖ **Knowledge and attitudes of the subject concerned**

## SLIDE – 12(b)

### LESSONS LEARNED

- Training must include combination of methodologies (songs, games, etc) keeping cultural comfortableness in mind. Eg. Songs on pregnancy failed with men
- Combination of two CLEs (same gender) for each session helps to support and strengthen the peer educators
- Holding separate sessions for each gender helped open discussion
- Training of CLEs requires 'hands on' exercises and practice session
- Counselling component in Reproductive and Sexual Health in young people in rural areas needs to be combined with referral/ clinical services as tangible results important in the beginning