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India
Reaching the Most Marginalized Adolescents:

Lessons from a Sexual and Reproductive Health Project for Mahadalit Youth

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Context

As the lowest ranking subset of the Dalit, or Scheduled Caste, in Bihar State in India, the Mahadalit population faces compounded barriers to accessing quality sexual and reproductive health (SRH) services. In particular, Mahadalit young people face many challenges in seeking care, including distance to facilities; lack of financial resources and independence; provider stigma; feelings of limited agency;[1] social discrimination; geographic isolation; and restricted access to public goods, services, and work opportunities. In Bihar, more than 40% of women are married before they turn 18, and 37% begin childbearing by age 19. Adolescents from Scheduled Castes are more than twice as likely to have a child by this age than those from upper castes.[2]

From 2016 to 2020, Pathfinder International, with funding from the David and Lucile Packard Foundation, provided Mahadalit adolescents access to quality SRH information and services through the Sashakt project. Sashakt, which means "empowerment" in Hindi, is implemented in three districts (Purnea, Katihar, and Araria) of Bihar and builds on learnings from the success of Promoting Change in Reproductive Behavior of Adolescents (PRACHAR), a predecessor Pathfinder project in Bihar. Given widespread early marriage and early pregnancy in the Mahadalit community, and in alignment with the National Adolescent Health Program (Rashtriya Kishor Swasthya Karyakram [RKSK]), the project identified unmarried and married adolescents ages 15 to 19 as key populations to engage. This brief documents Sashakt's assessment of its approaches and lessons learned from working with Mahadalit adolescents.

Implementation of Sashakt

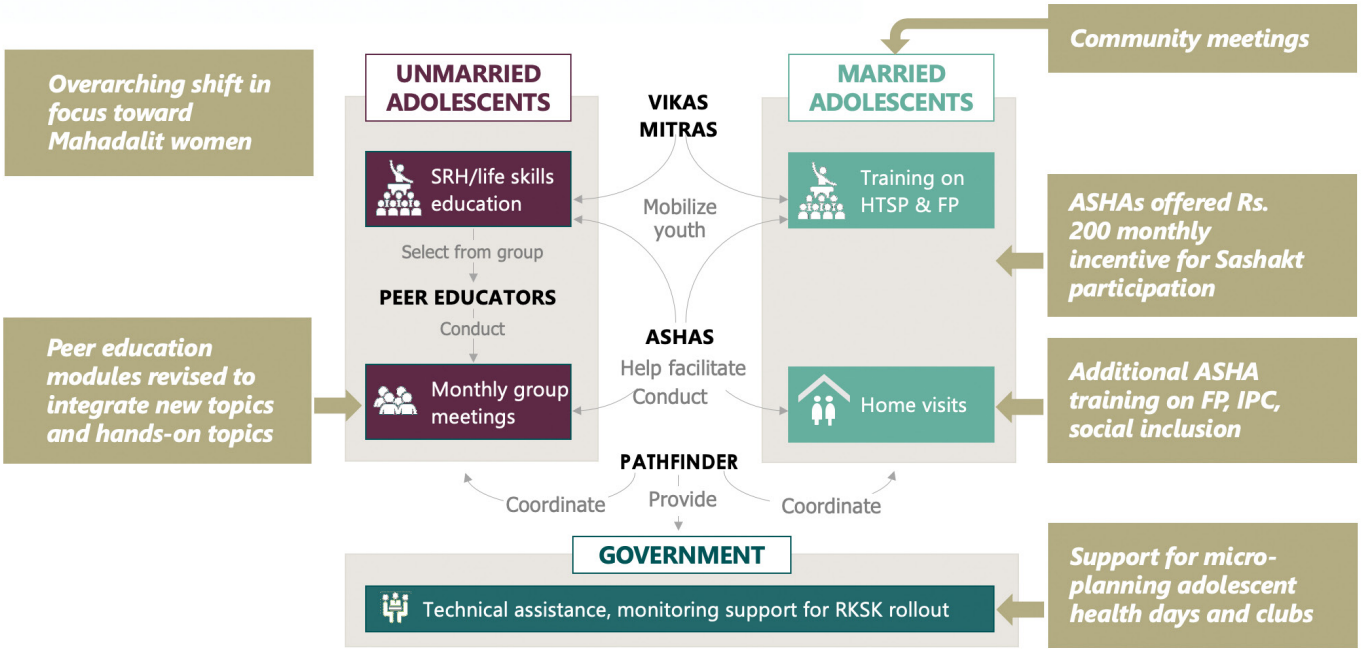
Sashakt gave more than 8,000 unmarried adolescents a two-day SRH and life skills training, followed by peer-educator-led monthly group meetings, known as supplementary learning sessions. More than 2,000 married adolescents received a one-day training on family planning (FP) and healthy timing and spacing of pregnancy (HTSP). This one-day training was followed by SRH-focused home visits and monthly community meetings conducted by community outreach workers, accredited social health activists (ASHAs), and Vikas Mitras appointed by the government and trained by the Sashakt project (Figure 1). The project trained more than 400 community volunteers as peer educators. An additional 192 community health workers were responsible for home visits and community meetings.

During implementation, emerging challenges required continuous adaptation. These included:

1. A high level of male migration for work.
2. A lack of motivation among frontline workers.
3. Inherent discriminatory attitudes.
4. Poor interaction during peer education sessions and stigma around discussing SRH topics, particularly among young women.
5. Difficulty engaging Mahadalit women.
6. The slow government rollout of RKSK.

Figure 1 highlights some of Sashakt's adaptations to these challenges.

FIGURE 1. Sashakt Program Model



1. "HEALTH FOR THE WORLD'S ADOLESCENTS: A SECOND CHANCE IN THE SECOND DECADE." GENEVA: WORLD HEALTH ORGANIZATION, 2014.
2. "NATIONAL FAMILY HEALTH SURVEY (NFHS-4), 2015-16: INDIA." MUMBAI: INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS) AND ICF, 2017.

Performance

After an initial pilot in 2016, the team assessed the success of Sashakt though a three-round mixed-method study from 2017 to 2019: (1) a baseline mixed-method study in 2017 before the transition of the project from pilot to full implementation phase, (2) a midterm qualitative assessment in 2018, and (3) a final mixed-method assessment in 2019. An international external agency conducted the assessments and shared them with project staff, the donor, and state officials. These assessments aimed to provide timely implementation lessons for adaptation during the life of the project and to document project outcomes to inform future programing and potential scale-up in similar contexts.

The baseline and endline assessments tracked program reach, uptake, perceptions, and status of key outcomes through household surveys among four groups of Mahadalit adolescents: married women, married men, unmarried girls, and unmarried boys. The baseline-endline comparative analysis included 1,129 participants (306 married adolescent women, 177 married adolescent men, 296 unmarried adolescent girls, and 350 unmarried adolescent boys), with 626 in the baseline and 503 in the endline.

The project collected midline qualitative data in addition to the qualitative information collected at baseline and endline. The project gathered these three rounds of qualitative data through focus group discussions with program participants, their mothers and mothers-in-law, and peer educators, as well as through in-depth interviews with frontline workers, government officials, and program staff. This data provided insight into how participants received the program, including design and contextual factors that facilitated or inhibited the program's reach and influence. This information helped to determine the program's potential for replication and scale-up.

Results

Exposure to the program was relatively high among unmarried adolescent girls (53%) but was limited among other adolescent subgroups. High rates of labor migration, festivals, and local harvest presented challenges in reaching adolescent boys, while work-related responsibilities kept some married adolescent women away from Sashakt activities. Those who participated generally thought highly of the quality and utility of the project activities. Midline qualitative data indicate that the facilitation of the initial SRH and skills training by "outsiders" lent credibility to the sessions and led participants to trust the information they received.

ASHA motivation and beliefs

Both the baseline and midline findings indicated low levels of motivation among ASHAs, who felt overburdened with work and inadequately compensated. At endline, only 27% of married adolescents reported receiving SRH information from an ASHA outside of a community meeting in the past three months, signaling room for improvement in outreach and supplementary learning sessions. Further, while ASHAs' views toward Mahadalits may have softened over the life of the project, they still need improvement. One ASHA expressed at midline, "[With regard to Mahadalits] If a person lives very dirtily, then how can we make them sit in our house equally to us?" While Sashakt conducted additional social inclusion training for ASHAs to try and address persistent discriminatory behavior (Figure 1), in the long term, even more sensitization may be needed to help ASHAs consider a broader remit that includes SRH. At endline, an ASHA said of Mahadalit adolescents, "They don't understand easily. Many of them are uneducated, so I have to explain 10 times to them. Only then will they understand, not the first time."

Participant knowledge and beliefs

More than 80% of participants recalled several key Sashakt topics, including FP, contraceptive methods, HTSP, marriage and relationships, negotiating childbearing decisions, responsible parenting, and access to programs for adolescents and Mahadalits. Levels of knowledge about the legal age of marriage were significantly higher at endline than at baseline across all subgroups (Figure 2) but remained low overall.

Opinions on the role of girls in decisions about marriage timing has improved among unmarried adolescent girls and boys (Figure 3), but most adolescents do not believe they will be involved in decisions about the timing of their own marriages. Except for married men, the proportion of adolescents believing that it is best to wait

FIGURE2. Knowledge About Legal Age of Marriage for Girls (%)

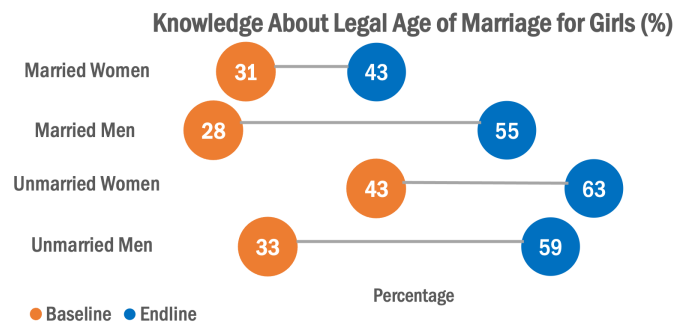
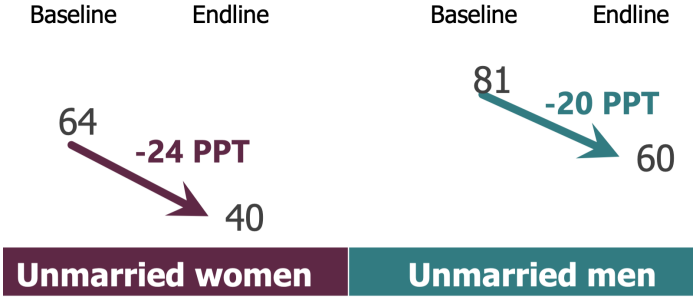


FIGURE 3. Believe Girls Should Not Be Allowed to Decide When to Marry (%)



two years after marriage to have a child increased significantly across all subgroups.

Preferred family size—already low at baseline—was largely unchanged, except among married adolescent women (for whom ideal family size decreased from 2.5 to 2.1). Adolescent men's and women's opinions about ideal family size differ. On average, men stated at endline that they want roughly 2.5 to 3 children, while women said they wanted closer to 2.

The proportion of married adolescent women reporting that contraceptive use should be a joint decision between a husband and wife increased significantly (12.5 percentage points, $p<0.05$). Among married adolescent men, however, this proportion decreased from 84% at baseline to 69% at endline. In focus group discussions, married men were vocal about taking on responsibility for FP decisions. In the future, incorporating activities into supplementary learning sessions and community meetings that not only promote knowledge acquisition but also help build communication and negotiation skills and autonomy of women are critical.

Lessons and Recommendations

It is essential to tailor content to the local context when working with special populations like Mahadalit adolescents.

Given widespread labor migration, Pathfinder needed to adhere to the migration calendar—a tool developed to monitor migration of families to adjust timing of activities such as home visits and community meetings—and do intensive mobilization to recruit boys for training. This level of effort is unlikely sustainable or scalable. In the future, it is worth considering other vehicles for sensitizing Mahadalit adolescent boys. Growing evidence suggests that digital solutions are a promising means of achieving social and behavior change regarding SRH and FP.[3] As 59% of married and 49% of unmarried boys reported having their own mobile phones, a digital health platform may be a suitable mechanism for sharing information.

To sustain project activities through existing systems such as the use of ASHAs, more groundwork must be laid in cultivating understanding and acceptance of the diversity among adolescents.

In general, Sashakt was successful in promoting SRH behavior among participants. But it is critical for adolescent SRH programs to consider the specific social and economic conditions and needs of the Mahadalit community and to strengthen the capacity of partner institutions, project staff, and volunteers accordingly. Throughout Sashakt, ASHAs continued to exhibit discriminatory views toward Mahadalits. Though they eventually stopped referring to Mahadalits as "dirty," "stupid," and uncivilized," as they did at baseline and midline, the ASHAs still attribute this population's lack of education and obstinacy, or "unwillingness to listen," as key barriers to awareness-building and behavior change.

Intensify training for peer educators in interactive activities; if possible, hire older, more experienced peer educators in the future.

Peer educators' uncertain grasp of the interactive activities integrated into supplementary learning session modules signaled the need for more focused trainings for peer educators. Trainings could more fully explain the learning objectives for the activities, give peer educators more time to understand and internalize the rationale, and provide peer educators opportunities to practice facilitating the activities. In the future, it may also be worth recruiting peer educators who are slightly older. Peer educators with more life experience and confidence might be easier to train to facilitate group discussions and lead interactive activities.

3. "DIGITAL HEALTH FOR SOCIAL AND BEHAVIOR CHANGE: NEW TECHNOLOGIES, NEW WAYS TO REACH PEOPLE." HIGH IMPACT PRACTICES IN FAMILY PLANNING (HIPS). WASHINGTON, DC: USAID, APRIL 2018. HTTPS://WWW.FPHIGHIMPACTPRACTICES.ORG/BRIEFS/DIGITAL-HEALTH-SBC/.

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All photos courtesy of Pravinkumar Shirsat.
Cover: ASHA using Sashakt IPC tools to explain contraceptives to a married adolescent during a home visit session
Other images illustrate Sashakt program activities.