Assessing Drivers of Positive Youth Development in India:
The Case of Gender Equity and Reproductive Health Interventions

By

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Abstract

Moving into a new era of the Sustainable Development Goals (SDGs), attaining health for all and pursuing gender equality and empowerment for women and girls are key pieces of the work ahead. To approach these goals, reproductive health access for adolescents that is couched in a gender equity framework should be considered. To understand its relevance and availability, this review focuses on the evidence base of adolescent health programs that address gender equity in India, a low resource country with wide health disparities. Analysis of relevant literature indicates that when programs are age-specific, comprehensive, and gender sensitive, they are of immense influence. Findings also show that when evidence based programs include fidelity assessments, the most effective results are attained for scalability.
# Table of Contents

Introduction ............................................................................................................................................. 4

Adolescent Health in India: Background and Rationale ................................................................. 4

Gender as a Driver of Health ............................................................................................................. 6

Barriers to Positive Adolescent Health Outcomes ........................................................................... 7

Interventions and Avenues for Opportunity ..................................................................................... 10

  Comprehensive Programming ........................................................................................................ 10

  Mechanisms of Instruction ......................................................................................................... 12

  Sustainability .................................................................................................................................... 13

The Comprehensive Rural Health Program (CRHP): Case Study ................................................... 14

  Implementation and Scale of Best Practices ................................................................................. 17

Conclusion ........................................................................................................................................... 19

References .......................................................................................................................................... 22

Acknowledgements ........................................................................................................................... 25
Introduction

India has the world’s largest youth population ages 10 to 24, accounting for 28% of its population or 356 million young men and women.\textsuperscript{1,2} In addition, the gender and health equity gap remains high, particularly in the poorest areas of the country. As the world launches into the era of the Sustainable Development Goals (SDGs), securing the health and wellbeing of individuals of all ages (Goal Three) and pursuing gender equality and empowerment for all women and girls (Goal Five) will have to encompass age-informed programs and approaches that address the unique lens of adolescence and early adulthood.\textsuperscript{3} This analysis reviews barriers to implementing effective gender equity and reproductive health interventions for youth in India, revealing a high need for comprehensive programming as well as greater evaluation of existing programs to understand best practices. From that assessment, avenues of sustainability are explored to promote lasting programs that invest in the youth of India. This review then examines the youth program of one nongovernmental organization (NGO) that pursues better health and social equity using a holistic approach, the Comprehensive Rural Health Project (CRHP) based in Jamkhed, India. The literature and the case study both document a clear need for additional comprehensive health programs, as well as the ability to assess their fidelity and measure impact for further learning and scalability.

Adolescent Health in India: Background and Rationale
The World Health Organization (WHO) recognizes the period of “adolescence” as ages 10 to 19 years, and “youth” is used by the United Nations (UN) to encompass ages 15 to 24 years. Adolescents have overlapping rights that international bodies have defined under the Convention on the Rights of the Child established in 1989, which protect them as children while still under the age of 18. India policy documents typically highlight the period of adolescence as 11 to 18 years. Legal provisions such as these instruct governments and health systems on how to best uphold the rights of this vulnerable population, protecting them according to their needs and capacities as they age. However, research finds that the distinction between childhood, adolescence, and young adulthood remains culturally undefined and consistent protections around this population are rarely enforced. Irrefutably, adolescence is a critical stage of human development and in order to deliver effective services to this population, it is imperative to understand the social, cultural, psychological, and contextual factors that encourage young people on a pathway of healthy adulthood. Key biological milestones and risk factors are understood in this period of development, but less compelling data exists around the key drivers that influence long term gender equity and positive reproductive health outcomes. There is a growing awareness that society-driven gender norms play a significant role in fostering gender equity and reproductive health in young women. However, the most effective ways to positively influence these norms is underutilized as a key strategy for violence prevention and improved maternal and child health outcomes. Additional factors such as social disadvantage and negative experiences in infancy and childhood can affect decision making.
around healthy relationships, educational attainment, and livelihood later in life.\textsuperscript{6} This cumulative effect of potentially negative or positive factors can impact health across the lifespan. In the same way, differences in health knowledge among adolescents translate into adult health disparities.\textsuperscript{10} Investing in the health of children and youth so that they have the knowledge and capability to grow into healthy adults, and then foster the healthy growth of their own children, is key to recognizing that interventions that foster healthy decisions about health should be delivered across the lifespan. This is sustainable health in the truest sense.

**Gender as a Driver of Health**

As they move from childhood to adulthood, adolescents experience changes in biology as well as new social roles that come upon them in ways and at times which are highly dependent upon culture, socioeconomic status, and gender. Gender norms affect the health and lives of boys, girls, men, and women alike as society promotes messages regarding male and female roles and accompanying expectations. These messages are internalized in the form of gender norms that can be inequitable and unproductive, and can lead to detrimental health outcomes for all.\textsuperscript{11} For example, norms of masculinity create an expectation for males to be knowledgeable and experienced with sex, which deters healthy information seeking and cultivates risky sexual behavior at a younger age. Even more prominent are the norms and expectations of femininity, which leave women in positions of powerlessness, susceptible to negative sexual and reproductive health experiences and violence.\textsuperscript{12} Results of one gender equity study demonstrate that males who report more inequitable gender bias are more likely to engage in risky sexual
behaviors including greater number of sexual partners, less frequent condom use, and partner violence.¹³

In countries with high fertility rates, such as India, young women face pressures to marry and start childbearing in adolescence. Despite a decline in early marriage worldwide, almost half of all women in India ages 20 to 24 were married as a child with wider disparities seen among poor, rural, less educated girls as well as those from scheduled castes or scheduled tribes.¹⁴ The compounding adjustments of early marriage including the resulting change in social support, navigating new dynamics of power structures in the family, experiencing early motherhood, and being moved from one’s own home into a spouse’s, can negatively affect physical and mental health, leaving young girls vulnerable to oppression, and potentially negative long term health.⁸,¹² In addition, early marriage leads to limited opportunities for youth to continue in school and to achieve potential independent livelihood. In order to address the imbalance of power in gender roles, which make their debut so early in India, initiatives that aim to intervene at young ages (10-14), involve people at the individual, family, and community levels, engage males, and promote structural drivers that can leverage gender equality as the norm such as opportunities for economic empowerment for women and girls can all make a tremendous positive impact.⁹

Understanding how to address the context in which adolescents, particularly female adolescents, are living gives insight into their opportunities and how to best approach the facilitation of positive health outcomes. Normalizing adolescent access to services from an early age is one promising approach. In Rwanda, for example,
one model being developed called “12+” aims to educate young girls about reproductive health before the onset of puberty. The program covers broad life skills and teaches girls how to make informed choices as they navigate the challenges of growing up as girls.¹

**Barriers to Positive Adolescent Health Outcomes**

Significant development challenges for India include the unique nature of its varying economies across 28 states, its socio cultural diversity, religion, geography, and rural versus urban contexts throughout the country. In each of these contexts, the most marginalized ethnic, religious, and minority groups tend to experience the most significant barriers to health care access compared to the rest of the population.¹⁵ Additionally, young women residing in rural areas are twice as likely as urban women to have their first birth by age 18; women with no education are 39 percent more likely to have their first birth before age 18, and just 1 percent of women who have had 12 or more years of schooling have their first birth before age 18.¹⁴,¹⁶ While significant measures have been taken to address the needs of youth, adequate programs for marginalized groups remain less available. Until recently, almost no national programs existed to reach unmarried, out-of-school girls in India. In addition, newly married, young girls, tend to receive very little, and less than adequate health care until they arrive at a health facility with their first pregnancy.¹⁴

Sexual health education that exists for males is also lacking. The notion of engaging in sexual practices out of wedlock is rarely addressed even though it is common and can be risky.¹³ One study of youth male students found that 17 percent of males who were sexually active reported they had made a girl pregnant and 8
percent of sexually active female youth students reported experiencing pregnancy.\textsuperscript{14} Further, very little data on abortion among youth exists in India, but general evidence suggests young women that are not married are particularly vulnerable to having no prenatal care or unsafe abortions.\textsuperscript{14} Thus, the heterogeneity and subsets of India’s youth population call for customized and multidimensional approaches that encourage all youth towards lifelong sexual and reproductive health. Standardized approaches are useful for understanding the evidence-based methodologies, but additional strategies must be tailored for specific populations of adolescents that align with their developmental needs as well as consider the contexts in which they are living.\textsuperscript{8,17}

Government-initiated programs and policies can be an influential factor in the potential progress or hindrance of positive youth health behavior. Despite legislation protecting the rights of children and adolescents against early marriage, interpersonal violence, and the legal protection of reproductive rights, a lack of enforcement and awareness about these laws among the general population remains.\textsuperscript{14} The Indian Government has conducted family life education (FLE) programs for youth since the 1960s, however, most education programs focus on sexually transmitted diseases, nutrition and hygiene, reproductive health, and contraception in the context of marriage.\textsuperscript{17} Until recently there has been no framework that encourages more equitable norms between genders.\textsuperscript{18} Today the FLE program has expanded to include objectives of developing emotionally secure children and adolescents, providing knowledge of the physical, psychological, and sociological aspects of sexual behavior, and developing decision-making skills.
among youth as they consider long term effects of their actions. This definitely shows policy progress.

One additional notable endeavor is the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG), or "SABLA" program, which was launched in 2010 as a pilot program in 200 districts across India. Targeting girls 11 to 18, this program uses a framework of equity and empowerment to engage young girls in adolescent reproductive and sexual health education and sexuality issues. It also covers life, social, and vocational skills including negotiating mobility within the family. It utilizes trained peer leaders to facilitate lessons, creating an environment of safe learning, and uses contextualized curricula catering to both in-school and out-of-school girls with programming distributed through various partnerships and local governments. While SABLA emphasizes the importance of monitoring and evaluation during this pilot stage, not much is known of its impact thus far except that SABLA has reached about 50,000 out of school adolescent girls in two states of India. More remains to be seen regarding the long term effectiveness and outcomes of the program.

**Interventions and Avenues for Opportunity**

**Comprehensive Programming**

As policies and programs begin to take previous shortcomings of services for youth into account, notable initiatives beyond government planning are beginning to address adolescent health more holistically, showing marked success. Comprehensive sexuality education has been shown to delay sexual debut, decrease frequency of sexual intercourse, decrease the number of sexual partners, and
increase the use of contraception at sexual debut.\textsuperscript{1,20} In addition, comprehensive sexuality education that incorporates gender equity frameworks and power dimensions have been shown to be far more effective than traditional programs at reducing rates of sexually transmitted infections and unintended pregnancy. As stated by Haberland, gender norms are proving to be a “gateway factor” in determining a range of adolescent outcomes as girls learn to perceive themselves as autonomous individuals and equal members within their personal relationships and in society.\textsuperscript{1,21} Beyond comprehensive sexuality education, comprehensive programing for youth also includes safe spaces for learning, gender equity frameworks, community support, programs that are responsive to the needs of marginalized groups, programs that incorporate girls’ practical needs, engage with girls on their aspirations, and expand their potential for independent livelihood.\textsuperscript{22} In addition, the earlier comprehensive programming starts, the more effective it can be; while notions of gender roles and parity are still developing within an individual, the opportunity to apply critical thinking around issues of gender and sexuality can positively affect attitudes.\textsuperscript{12}

Finally, comprehensive, gender transformative programming involves reaching youth beyond the walls of instruction. Messages must be delivered in settings that will challenge typical gender norms in the very places they are most often reinforced. This includes predominately male spaces or other areas where females are pressured to prove they belong such as in schools, social settings, and public spaces such as subways, bus lines, parks, and walkways. When these
Empowering messages are circulated beyond health centers or the classroom; health messages can have greater impact for both youth and the general population.\textsuperscript{5}

Additional success has been seen with the integration of health services. Integrated services are usually housed in multipurpose clinics that have the capacity and trained workforce to serve diverse populations. For example, a single clinic can provide reproductive planning services to women as well as men and adolescents, or incorporate STI prevention under reproductive health services. This can foster greater reach and accessibility and less stigma around the received services.\textsuperscript{5}

Integrated services are motivating for health clinics as well as patients who appreciate the convenience of an integrated service model, particularly if they are already travelling from rural regions to receive care. Considering their impact, integrated services can be adapted for adolescent populations as well. For example, those who are trained in adolescent programming can also be trained to deliver a variety of equity-based training materials. Integrated services and their mechanisms of delivery are key to reaching greater numbers of youth in ways that will elicit positive change.

**Mechanisms of Instruction**

Comprehensive education gives young people the skills and knowledge to mitigate reproductive health risks and exercise their rights, but what is the most effective means of delivery for these programs? School-based approaches to health education have the capability to reach the majority of adolescents where they spend most of their life at this stage. Presenting material in schools does significantly increase knowledge, particularly among adolescents who are poorly informed of
reproductive sexual health matters including contraceptives. However other research shows that it is often difficult to present health knowledge in ways students accept as relevant and authentic in school-based settings. Evidence is most clear about the context in which the material is delivered, meaning school-based programs that have appropriate curricula, time designated for delivery, and trained and supportive instructors, can prevent negative sexual health outcomes among adolescents. Additional evidence shows that the context of support is what matters most and that even outside of sexuality education programming, classroom culture and supportive environments foster critical thinking about social norms, gender identity, and girls’ rights. Education in a supportive classroom setting is usually delivered separately to males and females for gender specific content in order to mitigate embarrassment and promote a safe space for asking questions. So a school setting that facilitates a safe space where students feel open to ask questions and seek advice can serve as a powerful place of intervention for youth. However, because not all young people are in school, additional delivery mechanisms must supplement the supportive classroom learning environment to reach those youth who are not in school, and typically fall into more marginalized groups.

When building a supportive environment for learning, evidence points to the influence that peer educators can have on promoting healthy outcomes for youth. Peer educators become a bridge between service providers and youth as well as a support mechanism for social change around gender norms. They also tend to be highly committed to the purpose of the work and often do not cost a program
significant budgetary burden. One program found an 81 percent retention rate in the recruitment of peer educators even when they were not financially compensated.\textsuperscript{25} Peer educators are particularly essential for reaching rural or marginalized groups of adolescent girls, and even more so for those who do not regularly attend school. It should be noted that peer led education often requires more investment from implementing partners when they are recruiting, training and providing follow-up support to peer educators.

\textbf{Sustainability}

Interventions that promote social equity and health among adolescent girls and boys in India continue to provide limited information about long term outcomes and effectiveness. Promising interventions rarely receive continuous support from policy makers and budgeting often falls short from what is promised or needed for monitoring and improvement of programs.\textsuperscript{5} Evaluating programs also remains a significant barrier to sustaining them. Most population-based surveys of adolescents are conducted through schools even though youth who face the greatest vulnerabilities and health risks are those who may not be attending school and are not accounted for in baseline measurements.\textsuperscript{4} In addition, it is very common for sexual and reproductive health information to be collected only from young women who are married, leaving significant gaps in data around the health and behavior of young boys and unmarried girls.\textsuperscript{4} Moreover, there is a lack of unified indicators for constructing survey measures, which have the potential to allow for more robust comparisons and analyses and justify more comprehensive programming.
Additionally, it would be more helpful to use the life course approach to receive support and investment in adolescent initiatives so that governments, partners, and donors can understand child health advocacy as encompassing older children. This approach highlights the potential impact of multiple interventions delivered over time. Ongoing, age-appropriate interventions that address the changing challenges of a child as she grows have the potential to build on each other and cumulatively have an even more significant positive impact on a child’s life and long term health. Finally, engaging youth themselves in the identification of their own health concerns and solutions will help to ensure the relevance and sustainability of programs. As youth become valued stakeholders of their own health, there will be greater commitment from their communities and from decision makers to support them.

**The Comprehensive Rural Health Program (CHRP): Case Study**

One program that has surpassed the expectations of sustainability and progress is the Comprehensive Rural Health Program (CRHP). Founded in the 1970s in dry and rural Maharashtra, India, the CHRP serves about 250,000 community members and is rooted in principles of community-based work, which engages local community members as drivers and leaders of their own health and development. CRHP has a priority focus on the empowerment process and creating platforms for the most powerless to become leaders through training and enhancing individual and community competence. Programs focus on health outcomes; interventions include income generation, agricultural programs, hospital services and disability services. They also incorporate a social and economic empowerment framework.
and have been shown to have a powerful effect on mental health and social development.\textsuperscript{27} This holistic approach has contributed to the decline in the infant mortality ratio and a decline in communicable diseases including leprosy, tuberculosis, and malaria over the last thirty years.\textsuperscript{27}

The CRHP has also shown markers of impact from its health programs. One assessment found that participants who were taught about reproductive health topics and sociocultural factors that affect women’s health (including early marriage) had greater likelihood of identifying safe contraceptive methods, knowing HIV transmission risks, as well as identifying examples of violence against women.\textsuperscript{28} CRHP’s model is integrated, comprehensive, and positioned for sustainability. Emphasizing opportunity for empowerment and the use of local resources, CRHP combines training of community members, health education, and development activities with the goal of bringing social change from within.\textsuperscript{26} Providing leverage in the form of education and work to the most marginalized allows space for the power of the individual to see her own value and gain skills to overcome social barriers, while also receiving important health information and health promotion.

The CRHP also incorporates programs for adolescent boys and girls. Its current curriculum focuses on education and delaying early marriage, emphasizing the value of building up strong young women in the community.\textsuperscript{28} Taking a gender equity approach as a core tenet, the curriculum is set up to encourage young girls and their communities to realize that they have a fundamental human right to be recognized as equal to men, that they have the right to independent livelihood, and that they may make their own choices related to their health and wellbeing.\textsuperscript{28}
Additionally, a 10-week pilot training program was introduced in 2011 for adolescent boys with the aim of breaking down the social constructs of power and gender, and demonstrating how dismantling these internalized beliefs can help to eliminate discrimination and violence against women and girls. Components include recognizing interpersonal violence, increasing awareness of societal attitudes, and building social skills for leadership and advocacy.

The CRHP has created a holistic model that is self-sustaining, giving opportunities for empowerment and positive health behavior change. However, the impact of its initiatives, which hope to improve the status of women and girls in society, incorporate the marginalized into the wider community, and create self-reliance and prosperity, are difficult to measure. The CRHP should incorporate both process and outcome monitoring and evaluation in order to better understand what is working and how it can be applied to other communities throughout India and the world. Implementing measurement tools that evaluate change in knowledge and attitudes, gender-based stigma, self-efficacy, resiliency, and community norms can provide greater insight into CRHP’s programming and efforts. It will also promote a better understanding of how integrated and comprehensive interventions serve the health and needs of communities.

**Implementation and Scale of Best Practices**

While the CRHP delivers their youth program in many of the ways seen by implementation science as sustainable and scalable, this particular program has yet to be evaluated for its success in the same way as some of the organization’s more established programs. The CRHP adolescent program has incorporated evidence-
based learning methods including peer-to-peer models both in and outside of a
typical classroom setup, and it considers the community context in its health and
sexuality curriculum development. Again, however, while this program has
potential to impact the lives of young girls and boys in the community, the
evaluation and process improvement cycles must also be in place in order to best
understand what is working and what can be improved for greater impact.

Recent developments in implementation science show that existence of
evidence-based interventions only matter when they are effectively implemented.
Indeed, the barriers to successful implementation and scalability are many and
include gaps in information and research dissemination, resources, leadership,
training, and the political environment in which they are implemented. While
science and clinical knowledge serve a critical role in informing programs and
policies, there must also be a way to put that science into real-world practice, which
accepts the realities of the work as it is being done on the ground.

The CRHP could utilize additional implementation drivers, or infrastructure
components that can help them function at the most innovative and effective levels
of success. Implementation drivers include organizational drivers, which seek to
measure and assess the bigger picture strategies such as political and regulatory
systems that could be impacting the decisions, actions, or needs of a program.

Fidelity processing, which examines the extent to which each program or
intervention is being implemented in the way it was designed to be implemented,
could also amplify the work of the CRHP. Measuring fidelity gives members of the
organization information on what is working, where it is working (or not), and what
needs to be improved.\textsuperscript{29} Other drivers the CRHP could implement include a decision support data system, which can be used to process the outcomes of their programs. This system should be able to examine data and organize it for continued learning and outcome monitoring and track programming over time in a way that would demonstrate trends and improvement needs.\textsuperscript{29} Implementation capacity, evaluation and improvement cycles are additional implementation tools that can be incorporated as they also seek to understand, document, and improve the context in which they are operating. This is the best way to also garner insight for scaling a program.

In many ways, it appears that the CRHP has internalized frameworks of implementation in its work by including the overarching concepts of implementation as its approach. This has likely contributed to its long-term success. For example, when the CRHP farmers program was in its early stages, professionals that came from a nearby major city to assess the program were knowledgeable of the evidence of what could work for this community endeavor, but did not recognize the need to understand the context in which each of the communities were operating. The local leaders therefore did not trust him and the work was stagnant. Leaders at the CRHP recognized this immediately and eventually this professional was asked to leave the project.\textsuperscript{24} In addition, the formation of community teams that understand influencers of health including the social, economic, and political factors that affect the community and account for these changes as they make decisions and provide care is also a part of the CRHP model. These teams include not just the leaders, but also clinicians, administration, and other local government members.
This points to CRHP utilizing the key components of many implementation frameworks including assessment, collaboration, negotiation, monitoring, and self-reflection, coordinated leadership, and teams that understand the implementation process. This model allows for innovation, constructive modifications, and feedback throughout the implementation process. This type of leadership also facilitates the capacity building process, which enables sustainability. Finally, research, clinical expertise and patient values should be integrated and compensatory to create a holistic approach and set up programs for long-term success.  

**Conclusion**

Adolescents in developing country contexts have an added layer of risk as they navigate growing up in environments where child rights and protections, particularly for the most poor and marginalized, are loosely enforced or prioritized. The vulnerable stage of childhood and adolescence combined with poverty and discrimination can lead to significantly detrimental health outcomes. Comprehensive, integrated gender equity and health promotion catered specifically for young populations paired with evidence-based mechanisms of instruction are greatly needed. These programs must be implemented utilizing a lens that considers the unique context in which the work is being done, whether the curricula and programs are implemented with fidelity, and if they are being evaluated throughout the process in order to inform improvements, increase effectiveness, and pave the way for scale up. Increased access to sexuality education and reproductive health services for adolescents will give the platform for women to be empowered, reduce inequalities, and advance gender equity so that the potential for healthier
adolescents, male and female, is strengthened and sustained. Learning from the research as well as the experience of the CRHP, it is understood that prioritizing youth in a way that facilitates access, availability, education, and advocacy will be key components of positive youth development for the 369 million adolescents currently growing up in India.
References


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