Reproductive and Sexual Health Education, Care and Counseling for Married Adolescents in Rural Maharashtra, India

In India, a majority of married adolescents, particularly rural girls, have limited access to information and services that address their reproductive and sexual health. The KEM Hospital Research Centre, in collaboration with the International Center for Research on Women (ICRW), tested whether it is feasible in a rural context to provide married youth an integrated package of (1) reproductive health information, (2) clinical referrals and (3) reproductive and sexual health couples counseling. Results for rural Maharashtra showed that the extent of couple participation and the overall feasibility of the intervention varied for the three elements.

Methodology and Findings

To measure whether an integrated reproductive health education approach would work for married youth in rural India, KEM staff used monitoring tools to assess target group participation and the training and skills of youth community-level educators (CLEs). Tools included attendance records at reproductive health education (RHE) and counseling sessions, self and external evaluations of CLEs, group discussions and individual interviews with participants, case documentation by the counselor, and multiple records for clinical referral, including type of service and follow up. Staff assessed changes in reproductive and sexual health knowledge using quantitative data from baseline and endline surveys of 114 and 76 couples, respectively.

Feasibility of the integrated package: Participation in the reproductive health education sessions varied by number of sessions and topic. While most eligible couples attended at least four or more days, drop out was a concern, and fewer than half attended all sessions, primarily due to time and child care constraints. Monitoring data suggest that the counseling filled a need. The program encouraged almost one-third of young couples who were identified as needing counseling to seek it even though they had no prior exposure to counseling. More than half of these couples came back for follow-up sessions. Finally, the project components were set up so that participants in one component could easily access the others, an aspect of the program's integration that was measured in this study. The data showed that people made the links. For example, most new clinical referrals came through the health education sessions.

Figure 1: Youth Participation Rates in the Interventions

Attended at least one RHE session	89.3%
Attended four or more days of RHE	76.2%
Attended all RHE sessions	48.2%
Clinical referrals through RHE	70.0%
Clinical referrals through counseling	33.3%
Counseling referred through RHE	29.0%
In counseling coming for follow-up	55.0%

RHE: reproductive health education
Source: KEM-ICRW

Feasibility of using community-level educators*:* Young community volunteers were trained in reproductive and sexual health issues and communication skills, basic referral skills and basic counseling skills to refer youth to a professional counselor as needed. The study trained 11 CLEs, which included five men and six women. While the number is too small to come to any definitive conclusions about the feasibility of using CLEs, some lessons in how to choose, recruit, train and engage youth as peer CLEs have emerged. Specifically:

- The time and effort to train rural volunteers; prepare a manual for them to use in the field; and test, modify and finalize activities was much longer than envisaged;
- Continuous retraining was critical to ensure that CLEs adequately remembered the content as well as how to conduct health education sessions; and
- Pre-existing community perceptions and CLEs' acceptability in a community must be considered when choosing a CLE.

Increase in reproductive and sexual health knowledge*:* Pre- and post-intervention data on reproductive health education sessions showed that the degree of change in couples' knowledge varied by issue. Men's and women's awareness of various health issues particularly menstruation, delivery, contraception and abortion increased overall, but not for other issues covered in the sessions. Analysis of data from couples showed that even if an individual did not attend a session, their awareness increased if their partner attended. Qualitative data support this finding, suggesting that couples were discussing the reproductive and sexual health issues outside of the sessions.

Key Lessons Learned

- It is feasible to implement an integrated program of reproductive and sexual health among married youth in a rural area, with varying levels of success for different strategies.
- Activities such as health education, which require long periods of regular attendance, may not be feasible for rural youth because of young couples' time constraints from child care or household tasks.
- It is possible and acceptable in rural communities to offer reproductive and sexual health counseling to young married men and women, individually or as a couple.
- Community volunteers can be trained as peer educators, though they may need an expert nearby to help answer certain questions.

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Objective: Test whether it is feasible in a rural context to provide an integrated package of reproductive health education, counseling and improved clinical referrals for married youth.

Structure:

- Reproductive health education sessions trained and supported volunteer CLEs to conduct interactive sessions on various reproductive and sexual health topics.
- Counseling provided a professional counselor of reproductive and sexual health issues to whom the CLE can refer young married men, women or couples.
- Clinical referral provided a system of referrals via CLEs or the counselor to good, quality clinical services to address reproductive and sexual health concerns raised by project participants.

Target group: Married youth, ages 14-25.

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About KEM Hospital Research Centre and ICRW's Adolescent Reproductive Health Program in India

The KEM Hospital Research Center is a part of KEM Hospital, a large tertiary care teaching hospital located in Pune city. KEM has been doing community health work in several hundred villages around Pune since the 1970s. This feasibility study was initiated in response to earlier community-based research on married adolescents (1996-1999). It was part of a broader multi-partner program, led by the International Center for Research on Women (ICRW), aimed at improving girls' reproductive health. That research program, the Adolescent Reproductive Health Program in India, was funded by the Rockefeller Foundation.