

Pushing Boundaries by Engaging Adolescent Girls and Communities

Evidence from Evaluation of the PanKH Program in Rajasthan, India

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India has more than 253 million adolescents,¹ accounting for almost 21 percent of its population and making it one of the countries with the largest adolescent population in the world. Further, around 47 percent of this population is female. Adolescent girls in India continue to experience early and child marriage (ECM), early and repeated pregnancy as well as discontinuation/dropout from secondary schools.² There exists a wide interstate variation in the status of adolescents with respect to education and ECM, however, adolescent girls continue to remain marginalized in almost all states.

There have been conscious efforts on part of the government and other stakeholders to reduce ECM and improve school education of adolescent girls across nine³ focus states in India, including Rajasthan. However, Rajasthan continues to have a high proportion of adolescent girls who are illiterate and ranks third across the country.⁴ The state also has the fourth highest rate of women marrying before the legal age of 18 years.⁵

There exists a strong interconnection between little or no schooling and ECM for adolescent girls. Early marriage is linked with poorer health outcomes, economic insecurity, gender inequality and experiences of domestic violence, including intimate partner violence. Physical mobility and decision-making ability of girls who are married as adolescents are also likely to be more restricted than others.⁶ It also affects the mental health of young women, increases risk of lifetime and current psychiatric disorders, risks of malnutrition, isolation and depression for young brides, and results in higher rates of suicidal ideation and attempts.⁷

The district of **Dholpur, Rajasthan**, has a population of 1.2 million, with approximately 100,000 adolescent girls in the age group of 12-19 years. The district shows high prevalence of child marriage and low knowledge of sexual reproductive health (SRH) among the adolescent girls and was thus identified as one of the high priority districts under the National Health Mission, Government of India. It is also listed as one of the aspirational districts identified by NITI Aayog⁸ for accelerating development on several indicators, including health, nutrition and education.

Status of Adolescent Girls (10-19 years) (in percent)

Indicator	India	Rajasthan	Dholpur
Illiterate**	11.8	17.9	13.2
Women aged 20-24 years married before legal age***	26.8	35.4	35.4
Women aged 15-19 years begun childbearing***	7.9	6.3	8.7

Census of India, 2011; *NFHS 4, 2015-16.

*Formerly affiliated with the respective organizations mentioned above.

†Formerly PRADAN, Dholpur

¹ As per the Report of the Advisory Committee for the International Youth Year (A/36/215 annex), the United Nations understands adolescents to include persons aged 10-19 years for statistical purposes without prejudice to other definitions by member states.

² Census of India, 2011; NFHS-4, 2015-16; National Institute of Educational Planning and Administration, 2017.

³ The nine focus states are Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Odisha, Rajasthan and Assam.

⁴ Census of India, 2011

⁵ National Family Health Survey 2015-16 (NFHS-4).

⁶ Economic Impact of Early Child Marriage, International Center for Research on Women, 2018.

⁷ Le Strat, 2011; Nour, 2006; Khanna, 2013; Godha D., 2013.

⁸ The National Institution for Transforming India is a policy think tank under the Government of India.



Adolescent girls in Dholpur face highly restrictive gender norms, which manifest in gender-based discrimination and domestic violence.⁹ Given this context, the **International Center for Research on Women (ICRW)** implemented the **Promoting Adolescents' Engagement, Knowledge and Health (PAnKH)** program in Dholpur.

This brief summarizes the findings from the evaluation of the **PAnKH** program.

About the Program

PAnKH was implemented between years 2015 and 2018 in Dholpur, and engaged unmarried and married adolescent girls and their communities. The aim of the program was to improve outcomes related to marriage, educational attainment and SRH for adolescent girls. The program was led by the ICRW, with **Professional Assistance for Development Action (PRADAN)**¹⁰ as the implementing partner and technical support from the Institute for Fiscal Studies (IFS) and **United Purpose**.¹¹

The program objectives were:

- To develop and test an integrated model to engage unmarried and married adolescent girls aged 12-19 years, their parents, men and boys, schools, health systems and other key stakeholders in their communities as compared to a girls-only intervention and standard government initiatives;
- To support research uptake and policy advocacy to strengthen ongoing programs for ending ECM, improving educational attainment and SRH of adolescent girls.

Intervention Design

The program intervention spanned over 18 months and reached out to approximately 6,600 girls (aged 12-19 years) through group educational activities (GEAs) and sport sessions of *kabaddi* across 60 intervention clusters¹² (30 from the girls-only arm and 30 from the integrated arm). The program was implemented by village-level female and male mentors, who were young women and men from the communities where they worked, guided by a female and male field facilitator, respectively.

Intervention Design		
	<i>Objective: Creating a safe space (physical and mental) for adolescent girls to discuss issues, strengthen peer networks and spend time in public space</i>	
Control Group 30 clusters <ul style="list-style-type: none"> • Standard government programs or other initiatives 	Girls-Only Model 30 clusters <p>Groups of up to 30 adolescent girls met twice every week for:</p> <ul style="list-style-type: none"> • Sports : <i>Kabaddi</i> sessions, and annual village-level, inter-village and district-level <i>kabaddi</i> tournaments • GEAs: Graded curriculum*, using a 'gender-transformative approach*'; on issues of gender, marriage, education, violence, body and sexuality, SRH of girls and boys • A total of 31 GEA sessions for girls aged 12-14 years, and 28 for girls aged 15-19 years 	Integrated Model 30 clusters <p>Girls-Only Program+</p> <ul style="list-style-type: none"> • Community Engagement Activities: Monthly 'Call for Action' event(s) led by girls, boys and mentors to take up issues with families and the wider communities • Spot meetings with boys at popular hang-out places (aged 15-18 years): Fortnightly; led by male mentors using a summarized version of the graded curriculum* used with girls

*Basic (11 sessions – 60 minutes each), Intermediate (12 sessions – 60 minutes each) and Advanced (8 sessions for age group of 12-14 years; and 5 sessions for age group of 15-19 years – 90 minutes each).

*The gender-transformative approach lays emphasis on creating spaces for people to engage in critical reflection, and examine, question and change rigid gender norms and imbalances of power to end gender-based discrimination as well as increase gender equality.

⁹ No Country for Daughters?: Confronting Patriarchy in India's Heartland, Philipose, 2013.

¹⁰ PRADAN's Dholpur initiative culminated in 2018 and it was merged into a newly-formed organization, Manjari Foundation.

¹¹ Earlier known as Inspiration International.

¹² For the study, a cluster has been defined as a village or group of villages with a total population of less than or equal to 1,000. The overall population across the intervention clusters was 90,000.

Study Design, Sample & Analysis

A three-armed randomized control trial (RCT) was designed to evaluate the overall impact and to disentangle the effects of program components that target only girls from those that engage with both the girls and their communities. The study was conducted in 90 clusters in the three blocks (Bari, Baseri and Dholpur) of Dholpur district. The clusters were randomly allocated to one of the three arms – the integrated arm, the girls-only arm and the control arm. Two rounds of data collection were undertaken – one before the implementation of the program that served as baseline (October – December 2015) and the other post the completion of the intervention, which served as endline (December 2017 – March 2018).

All girls (aged 12-19 years) residing in program villages were eligible to participate in the PAnKH program. Within the age range, the girls were then further segregated under three groups – (1) younger adolescent girls (12-14 years); (2) older, unmarried adolescent girls (15-17 years); and (3) married adolescent girls (12-19 years) – assuming that the program impact on these groups would be different from each other.

The baseline sample covered a total of 7,577 girls (aged 12-19 years) both married and unmarried with following distribution – 3,096 unmarried girls aged 12-14 years; 2,827 unmarried girls aged 15-17 years and 1,654 married girls aged 15-19 years.* A small proportion (7 percent) of married girls participated in the program. Thus, at the time of endline, we did not follow up with them as the sample was not sufficient to measure the impact of the program on this subgroup. Instead, a qualitative study was undertaken to understand their experience and perception around different outcome indicators.

At endline, out of the targeted 5,921 girls, we were able to interview 5,150 girls (87 percent of the sample), as the rest had migrated to other districts or outside the state for work, education or due to marriage. Table 1 highlights the details of the sample covered under the three arms.

Table 1: Sample Size, Attrition Rate and Reasons for Attrition (By Arms)

	Girls-Only	Integrated	Control	Total
Sample at baseline (unmarried girls)	1919	1966	2036	5921
Sample at follow-up/endline	1665	1704	1781	5150
Attrition rate	13.2%	13.3%	12.5%	13.0%
Reasons for Attrition				
Moved to an area difficult to reach or out of Dholpur	141	128	134	403
Death/demise	4	6	9	19
Household not located	9	11	15	35
Refusal	43	37	24	104
Unavailable after three visits	57	80	72	209

As the evaluation used an RCT design, there was no significant difference in baseline values of the indicators in both the intervention arms and the control arm. In the current analysis, we highlight the results from endline data comparing control with the intervention arms after controlling for baseline factors.

Findings

Profile of the Respondents

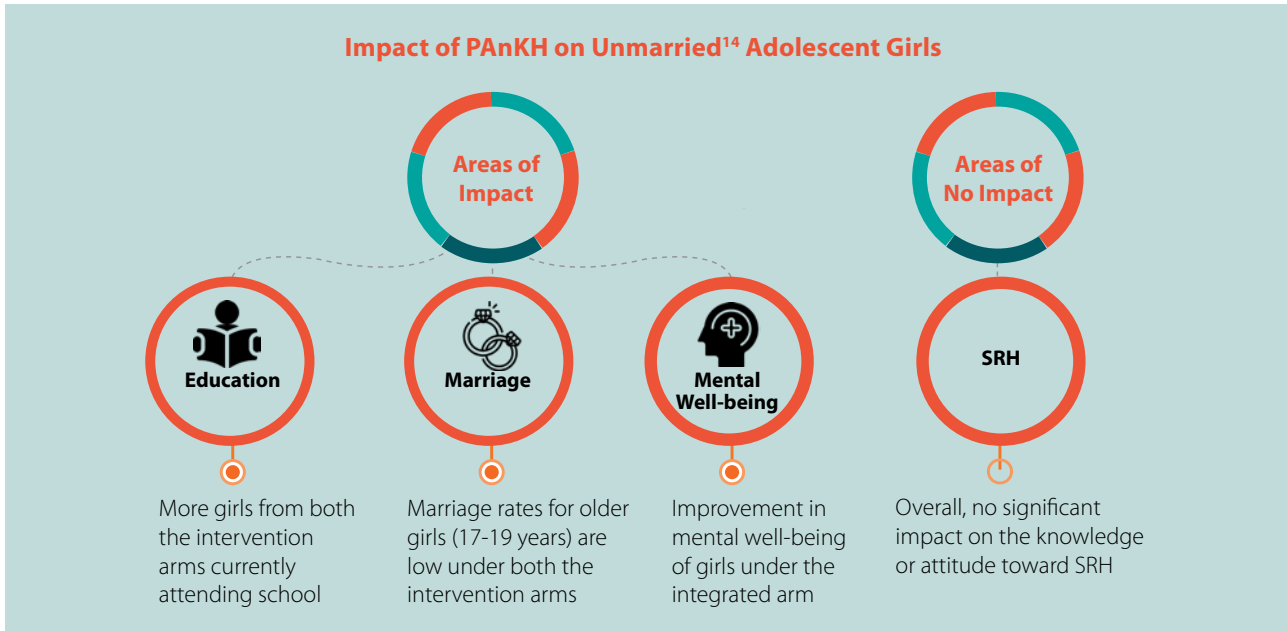
The mean age of adolescent girls who participated in the program was 16.3 years under both the intervention arms and the control arm. More than half of them were attending formal education at the time of endline. Most of the unmarried girls (90 percent) interviewed at the time of baseline remained unmarried at the time of endline under all three arms.

Caste composition¹³ of participating girls indicated that more than half of the girls from girls-only arm were from the OBC category as compared to 40 percent under the integrated arm and 43 percent under the control arm. One-fourth of the girls from control arm were from the General category as compared to 13 percent under the girls-only arm and 21 percent girls under intervention arm. There was no significant difference observed in the household asset index under the three comparison arms.

* There were no girls under the age of 15 years who reported as married.

¹³ Caste, even though considered officially abandoned in India, remains one of the strongest social determinants of health. Caste has been shown to be the most appropriate household characteristic for identifying poor and disadvantaged households. Socially disadvantaged groups including the Scheduled Castes (SC) and Scheduled Tribes (ST) and Other Backward Classes (OBC), are not only distinguished by economic poverty but also by their marginalization and seclusion from the rest of the society, having different traditions and living in the most economically disadvantaged areas. Refer to Social Exclusion, Caste and Health: A Review based on the Social Determinants of Health Framework, Nayar K.R., 2007.





Education

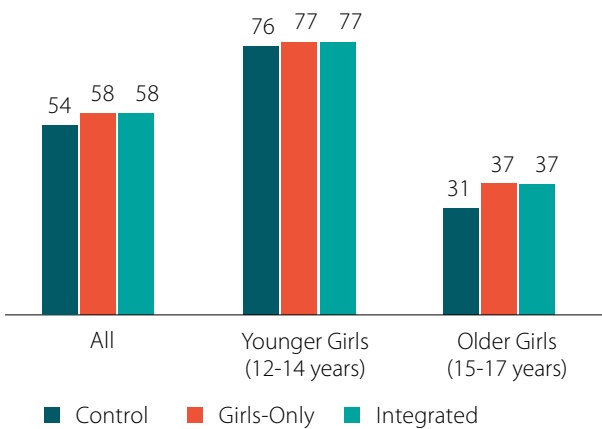
To understand the impact of the program on education, we measured the probability of still being at school. Girls in both the intervention arms were more likely to be attending school than girls in the control arm. This was driven by girls who were in the age group of 15-17 years at baseline. During the program,

- Around 7 percentage points increase in the proportion of older girls (aged 15-17 years at baseline) attending school under the intervention arms as compared to the control arm.
- There was no additional impact on education under the integrated arm over and above the girls-only arm.

a small proportion of girls re-enrolled in schools, but the overall impact was driven by girls who continued their education since baseline (see Figure 2). Older girls (aged 15-17 years at baseline) under the integrated arm (currently in school) exhibited significantly higher agency (had a big say or acted on their own) with respect to decisions on continuing education as compared to the girls under the control arm. However, there was no significant difference observed in the girls-only arm as compared to the control arm on agency with respect to decision-making on continuing education.

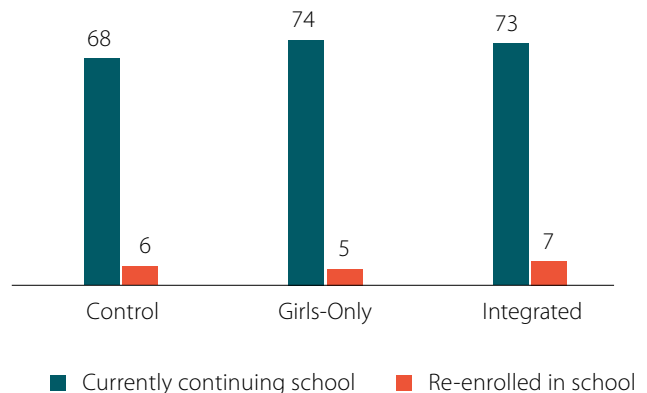
Absenteeism from school was significantly low under both intervention arms (2.7 days/month) as compared to the control arm (3.5 days/month). One of the major reasons for missing school across all the arms was due to household work (75 percent).

Figure 1: Girls currently attending school (by age) (in percent)



Note: The percentages have been adjusted after controlling for baseline characteristics.¹⁵ For educational attainment of girls, N is 5703 as we collected information for girls who had moved out of villages from their caregivers;
* The age of girls given in the graph is as at the time of baseline.

Figure 2: Girls continuing school (those who were in school at baseline) and re-enrolled (those who were not in school at baseline) (in percent)



Note: The percentages have been adjusted after controlling for baseline characteristics.

¹⁴ Unmarried at the time of baseline

¹⁵ Baseline controls – wealth index, caste, mother's education in years, full interaction between school attendance and age in years, caregivers' gender attitude, girls' intended age of marriage, and marriage fixed or engaged.



Marriage

Overall, there was no significant change observed in the proportion of adolescent girls married by the time of endline. However, the intervention had a significant impact on the rate of marriage among older girls (aged 15-17 years at baseline) under both the intervention arms.

Among younger girls (aged 12-14 years at baseline), there was no change in rate of marriage under the intervention arms and the control arm. The proportion of older girls married at the time of endline was around 3 percentage points lesser under both intervention arms (16 percent) as compared to the control arm (19 percent).

We found that parents are more likely to marry their daughter off if she had already dropped out of school or left education. It is likely that the decrease in the rate of early marriage was largely driven by girls remaining in school/continuing education.

- A decrease of around 3 percentage points in the proportion of older adolescent girls (aged 15-17 years at baseline) who were married under both the intervention arms as compared to the control arm.
- There was no additional impact on marriage under the integrated arm over and above the girls-only arm.

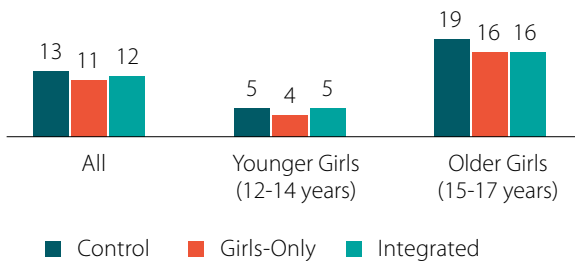
Existing literature suggests a score greater than or equal to 10 can be considered as an ideal cut-off point for screening moderate depression.¹⁸ An individual with a score of 8 and above is considered to have moderate anxiety.¹⁹ The intervention had a significant effect on reducing the rate of depression (cut-off score ≥ 10) among the girls under the integrated arm. However, there was no significant impact on the girls under the girls-only arm.

- The rate of moderate depression decreased by 5 percentage points among girls under the integrated arm, equivalent to a 25 percent relative reduction as compared to the control arm.
- The rate of moderate anxiety decreased by 2 percentage points among girls under the integrated arm, equivalent to a 29 percent relative reduction as compared to the control arm.

The intervention also significantly reduced the proportion of girls who showed symptoms of moderate anxiety under the integrated arm as compared to girls under the control arm. There was no difference in the proportion of girls who reported moderate anxiety under the girls-only arm and the control arm.

This clearly indicates that engaging with parents, men and boys as well as the larger communities to address the deeply entrenched harmful attitudes and behaviors around gender-based discrimination and marginalization is essential for fostering better overall mental health for adolescent girls.

Figure 3: Girls married at endline (in percent)



Note: For marital status of girls, N is 5635 as we collected information for girls who moved out of villages from their caregivers.

Mental Well-being

To assess the mental well-being of the adolescent girls, we measured the depression and anxiety score among them by using the Patient Health Questionnaire – 9 (PHQ – 9)¹⁶ and the Generalized Anxiety Disorder – 7 (GAD – 7)¹⁷ scale.

Cost-effectiveness

The impact of the PAnKH program was estimated as the average impact on all girls who were targeted or eligible to receive the intervention, regardless of whether they actually attended sessions (i.e., we estimate intention to treat). The PAnKH program costed INR 2,400 (USD 37) per eligible girl under the girls-only intervention and INR 3,200 (USD 49) per eligible girl²⁰ under the integrated intervention. The bulk of the costs were consumed in the salaries and training of frontline staff.²¹

Increasing the probability of a girl attending school by 1 percentage point cost INR 600 (USD 9) under the girls-only intervention and INR 840 (USD 13) under the integrated intervention. **These figures suggest increasing school attendance through such programs may be more cost-effective than through financial incentives.**

¹⁶ A brief version of the Patient Health Questionnaire, which is an instrument for diagnosing and assessing severity of depression symptoms.

¹⁷ A brief self-reported measure developed to identify cases of generalized anxiety disorder.

¹⁸ Ganguly, et al., 2013

¹⁹ Spitzer, Kroenke, Williams, & Lowe, 2006

²⁰ The number of girls aged 12-17 years under the girls-only arm was 3,056 and under the integrated arm was 3,207. This is based on the total girls listed for survey at time of baseline. These numbers are likely to underestimate the true number of eligible girls. This is because girls aged 18-19 and married girls were also eligible to participate, and, in practice, often girls from neighbouring areas, outside of the clusters, would also join and participate. Therefore, the true cost per eligible girl is likely to be less than what has been estimated here, implying that we underestimate the cost-effectiveness of PAnKH.

²¹ The cost was categorized into four broad categories – Program Administration: included salaries of key staff and some part of facilities (office) costs; Staff Training: included salaries of trainers, transportation and accommodation costs, materials, venues and food; Implementation: included field staff salaries (facilitators, mentors and PAnKH sakhis), transportation, materials, venues and food, education and sport sessions for girls, sessions for caregivers, boys and men, kabaddi tournament, and Call For Action events; and Monitoring: included costs incurred for visiting villages, gathering attendance data, and organizing meetings with field and office staff.

Insights for Policy

PAnKH is an evaluated program that shows enhancing life-skills, knowledge, agency and empowerment have a positive impact on girls' education and delaying their age at marriage. In India, most of the programs at the national and the state levels that focus on improving girls' education and delaying age at marriage have been driven more by financial incentives (such as the Dhanalakshmi,²² Apni Beti, Apna Dhan,²³ Kanyashree Prakalpa,²⁴ Mukhyamantri Bicycle Yojna²⁵ schemes). Only a few programs focus on the overall empowerment of adolescents (Kishori Shakti Yojana, SABLA,²⁶ Rashtriya Kishor Swasthya Karyakram [RKSK]) and steering change in behaviors/attitudes with respect to child marriage in communities.

The National Action Plan,²⁷ to prevent child marriage, emphasizes on strategies for changing mindsets and social norms, empowering adolescents, quality education and sharing knowledge, besides law enforcement. The PAnKH program brings forth critical evidence to inform government policies on prevention of ECM with feasible and cost-effective intervention strategies aimed at improving overall agency of girls and bringing about a change in social norms at the community level.

The PAnKH program was implemented within the framework of the RKSK initiative and had a similar approach (community-based) to improving educational, SRH and age-at-marriage-related outcomes for adolescent girls, led by village-level peer educators. However, programs such as PAnKH, RKSK and SABLA are quite dependent on the skills and capabilities of frontline staff, who are tasked with performing highly challenging duties, including mobilizing communities, forming groups of adolescent girls, leading GEAs and discussions about highly sensitive topics, and advising vulnerable young girls and women. Recruiting, training and supporting frontline staff to ensure that they have the confidence, knowledge and capacity to conduct engaging sessions is a significant challenge.

Despite significant efforts while recruiting frontline staff (village-level mentors aged 18-24 years) who were older than participating girls, offering competitive salaries, and with intensive training and support, many PAnKH mentors found the job highly challenging. The experience highlights the challenges in engaging young people to deliver crucial elements of girls' empowerment programs, such as skills, motivation and maturity, to perform their roles as intended. These learnings could also inform efforts to strengthen government programs such as RKSK or the school component of the Ministry of Health and Family Welfare's initiative, Ayushman Bharat.²⁸

This study lays strong emphasis on the fact that working with communities can substantially improve girls' mental health. While existing government programs such as RKSK do engage

adolescents at the community level through youth clubs or Nehru Yuva Kendras with the aim of improving mental health, PAnKH's evaluation suggests that structured engagement following the curriculum of GEAs was essential to giving all activities coherence. It also suggests that government programming may benefit from engaging the wider community in a more structured way than at present, which is an aspect that is not prioritized in existing program strategies at the national or the state levels.

Insights for Practice and Research

1) **Can creating safe spaces and opportunities for sports be as effective as standalone programs? What are the added benefits of a curriculum comprising components on life-skills, gender and SRH knowledge?**

Sports sessions were the most popular element of PAnKH interventions. Feedback from girls, mentors and supervisors suggested that sports sessions allowed the participating girls to challenge the unwritten norms related to girls occupying public spaces, helped them expand their social networks and gave them confidence. The sports component was relatively easy and economical to initiate and manage. Mentors required a fraction of training and support²⁹ as compared to what was required for the educational sessions. Future research should examine standalone community-based sports sessions for adolescent girls as a feasible and effective model for national policy, and the specific value addition of curriculum as one of the influencing factors.

2) **How can programs on empowerment of adolescent girls leverage existing community-based institutions mobilized for women empowerment?**

The program also suggests that layering the intervention for engaging adolescent girls on existing community institutions, such as the self-help group (SHGs) network in Dholpur, may be beneficial. Leveraging SHGs provided a greater impetus to community mobilization and helped build an early acceptance of the program, particularly in the backdrop of rigid patriarchal social norms. More studies and interventions are required to test the additional benefits and efficacy of interventions that converge initiatives for empowerment of women with those aimed at adolescent girls to bring about normative shifts at the community level.

3) **How can programs successfully engage with young married girls?**

The PAnKH program could not recruit married adolescent girls as envisioned. Even after multiple efforts for mobilization, which included intensive engagement³⁰ of

²² *Conditional Cash Transfers for Girls in India: Assessment of a Girl Child Promotion Scheme from Beneficiary Perspective*, T.V. Sekher & F. Ram, 2015.

²³ *Impact on Marriage: Program Assessment of Conditional Cash Transfers*, Nanda, P., Datta, N., & Das, P., 2014.

²⁴ *West Bengal's Successful Kanyashree Prakalpa Programme Needs More Push from State and Beneficiaries*, Sen, A. & Dutta, A., 2018.

²⁵ Education Department, Government of Bihar. For more information, visit: http://www.educationbihar.gov.in/About_us.aspx

²⁶ SABLA or The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls, Ministry of Women & Child Development, Government of India. For more information, visit: <http://wcd.nic.in/schemes/scheme-adolescent-girls-sag>

²⁷ *National Strategy Document on Prevention of Child Marriage*, Ministry of Women and Child Development, 2013.

²⁸ *Ayushman Bharat* program is also known as the Prime Minister's *Jan Arogya Yojana* (People's Health Scheme) and is focused primarily on reducing the financial burden on poor and vulnerable groups, and ensuring access to quality health services.

²⁹ Training and support was provided for explaining and familiarizing everyone with the rules and strategies of the game, fitness exercises and lessons, and implementation of ICRW's Child Safeguarding Policy and its provisions.

additional frontline staff from village-level SHGs along with female mentors, only 7 percent married girls attended any session. Major barriers to the participation of married girls were restrictions on their mobility and reluctance of their mothers-in-law as well as their husbands to give them permission to participate. In the qualitative survey we undertook with the married girls who participated in any session, they suggested specific activities targeted at married girls and greater negotiation with their parents-in-law and husbands

as essentials for future programs to ensure reach and participation. None of the major government programs engage with young married girls in a structured way and we anticipate that any attempt to expand existing programs to young married girls would face the same challenges.

Overall, the experience of PANKH suggests that different models of engaging with this particularly hard-to-reach group must be explored.

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³⁰ While unmarried girls were engaged by village-based female mentors (aged 18-24 years) under both intervention arms, for engaging married girls, additional efforts were put in by field facilitators, who had more expertise and experience than mentors, to negotiate with families and mobilize girls into groups. Besides, at least one active SHG member from every village was engaged to specifically focus on engaging married girls by undertaking home visits to provide information on key topics such as SRH. Another strategy was to engage married girls through home visits as well as group sessions on vocational skills. And finally, the last was to engage the mothers-in-law and married girls together on the sideline of monthly SHG meetings. These strategies were met with various challenges such as existing restrictive social norms on mobility and independence of married girls in the initial years of their marriage.





This brief is based on the research and evaluation conducted under the **PAnKH** program in Rajasthan, India. For further information, please visit our website: www.icrw.org/asia

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