



Implemented in three distinct phases, PRACHAR (meaning “promote” in Hindi) built local capacity to deliver comprehensive behavior change programming to delay the age of marriage and promote healthy timing and spacing of pregnancy (HTSP) among adolescents and young couples. Phase I was implemented from July 2001 to June 2005; Phase II from July 2005 to September 2009; and Phase III from October 2009 to September 2012.

Operating with a total budget of US\$ 9.3 million over 11 years, PRACHAR was almost exclusively supported by the David and Lucile Packard Foundation, with supplemental funding received from UNFPA in 2009 for Phase III.

PRACHAR: Advancing Young People’s Sexual and Reproductive Health and Rights in India

Between July 2001 and August 2012, Pathfinder International implemented the Promoting Change in Reproductive Behavior of Adolescents (PRACHAR) project to improve the sexual and reproductive health (SRH) status of adolescents and young couples in the state of Bihar in northern India. This brief summarizes the evolution of PRACHAR, describes the intervention model and key evaluation results that informed each phase, and highlights next steps for dissemination and advocacy based on 11 years of project learning.

Context

Bihar is the third most populous state in India—with 103 million people according to the 2011 census—and is one of eight states which together account for 46 percent of India’s total population of 1.2 billion.^{1,2} While India’s total fertility rate has declined over the past several decades to 2.7 children per woman, there is much variability among states—from 1.8 in Goa

in the south (below replacement level of 2.1) to 4 in Bihar in the north.³ India’s demographic future—whether the nation will reach the fourth level of demographic transition—depends largely on fertility trends in northern states.⁴

Bihar is predominantly rural and, similar to much of northern India, has high rates of poverty and fertility. While the contraceptive prevalence rate in Bihar increased from 22 percent in the

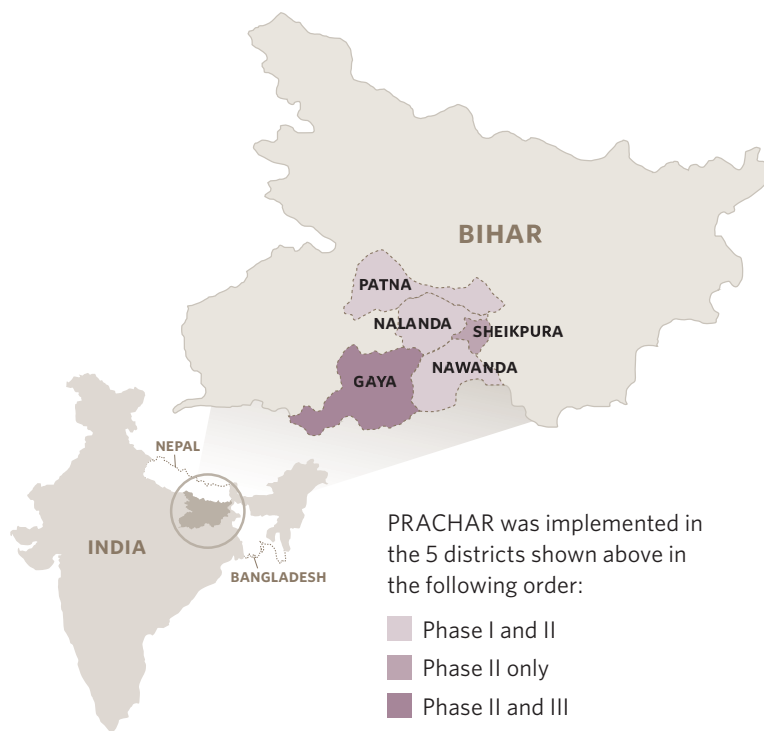


FIGURE 1: PRACHAR INTERVENTION AREAS

1998–99 National Family Health Survey (NFHS-2) to 29 percent in the 2005–06 NFHS-3, the majority of this rise is attributed to sterilization among women older than 35, whereas contraceptive use among women aged 25 or younger is negligible.⁵ These data highlight the common practice among Indian women of bearing two to three children by age 25, and then adopting a permanent contraceptive method. Unmet need for contraception among young married women remains high, however, at 31 percent among those aged 15 to 19, and 33 percent among those aged 20 to 24.⁶

Driving early and frequent childbearing are deep-rooted customs and values, gender inequality, and social norms that favor early marriage and hinder contraceptive use. The legal age of marriage for women in India is 18, yet, while early marriage has declined in recent years, the practice persists, particularly in rural, traditional areas. Among the Indian states, Bihar has the highest prevalence of women married before the age of 18 (at 63 percent) and 25 percent of adolescents 15 to 19 years old have begun childbearing.⁷ Young couples—especially young women—face extreme pressure from parents and relatives to conceive soon after marriage and cohabitation as a way to “prove” their fertility. Fears that the capacity for childbearing may decline with age, as well as persistent distrust of and misconceptions about contraceptives, create additional barriers to delaying and spacing births.

The effects of early marriage and childbearing are well documented. In addition to contributing to high fertility rates, the practice leads to significantly higher maternal morbidity and mortality rates, as well as higher infant mortality. A 2009 study in India further documented the link between early childbearing and poor fertility outcomes, including short birth intervals, and unintended and terminated pregnancies.⁸ Moreover, early marriage and childbearing have negative repercussions on girls’ education and mobility, which in turn inhibits a young woman’s access to social support, skills acquisition, and earning power—essential for overcoming poverty for herself and her family.⁹

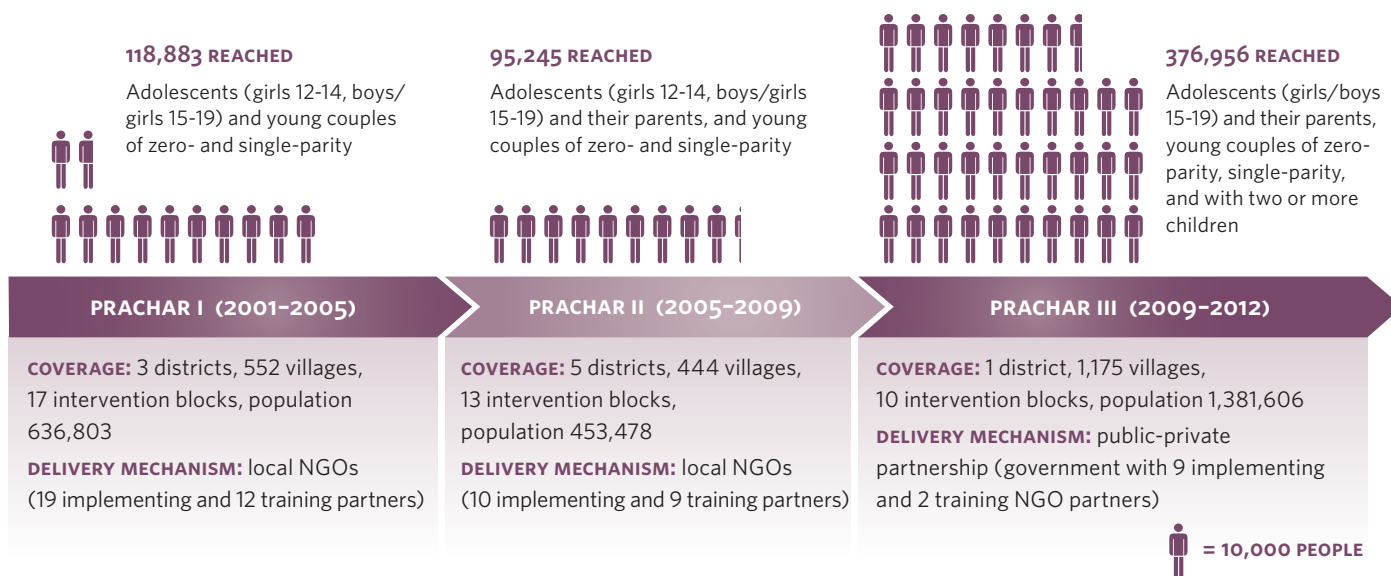
PRACHAR’s Inception

In 2001, Bihar faced a challenging political environment, contributing to a dysfunctional public health infrastructure and severe safety and security risks. While the government endorsed permanent contraceptive methods for limiting family size, there was little discussion of the need for contraception to delay and space births, and few nongovernmental organizations (NGOs) with the capacity to fill this gap were present. Adapting lessons from an urban adolescent health initiative supported by the Bill and Melinda Gates Foundation, Pathfinder designed PRACHAR to address the underlying barriers to sound SRH of young people aged 12–24 in Bihar. PRACHAR’s behavioral objectives were to delay the age of marriage until age 18 for women and 21 for men, delay the first birth until the mother is 21 years old, and space the second and subsequent births by at least three years. The project was implemented in three distinct phases over 11 years (see Figure 2).

PRACHAR Phase I: A Comprehensive Behavior Change Intervention

Prioritizing sustainability from the start, Phase I grounded its strategy in developing local NGOs’ capacity to design and manage adolescent and youth sexual and reproductive health (AYSRH) programs. Pathfinder placed a high value on partner selection and, after an extensive assessment, chose 19 implementing NGOs and 12 training NGO partners based on their relationships with local communities and their commitment to PRACHAR’s principles. Pathfinder not only built the capacity of these organizations to plan, implement, and monitor quality AYSRH programming, but also strengthened their overall institutional capacity for improved governance and management of financial and human resources. Phase I was implemented in three districts of Bihar: Nalanda, Nawada, and Patna (see Figure 1).

FIGURE 2: SCOPE AND COVERAGE OF PRACHAR PHASES I, II, AND III



AUDIENCE SEGMENTATION

PRACHAR's comprehensive Phase I model applied an audience-segmented approach to behavior change, engaging the entire community to shift norms and behaviors around early marriage and childbearing. First, barriers to behavior change were identified (e.g., parental and societal pressure to marry early, gender norms that value women mostly for their fertility, and myths and misconceptions about conception and contraception). Training programs and interpersonal communication (IPC) activities were then carefully structured to facilitate dialogue on these key issues. Educational topics, norm-shifting discussions, skills-building activities, and outreach methods were tailored to meet the specific needs, life stage, and roles of each group (see Figure 3).*

Phase I trained unmarried adolescents using developmentally appropriate SRH and gender-related curricula, with each sub-group trained separately (young girls aged 12–14, adolescent girls aged 15–19, and adolescent boys aged 15–19). Content and exercises focused on providing basic AYSRH education, as well as building agency and the communication and negotiation skills needed to make healthy decisions. For adolescents around the common age of marriage in Bihar (15 years old), training included discussion of the health, social, and economic benefits of delaying marriage and childbearing, birth spacing, and small family size. Training also equipped young people with strategies to resist societal pressures to marry and conceive at a young age.

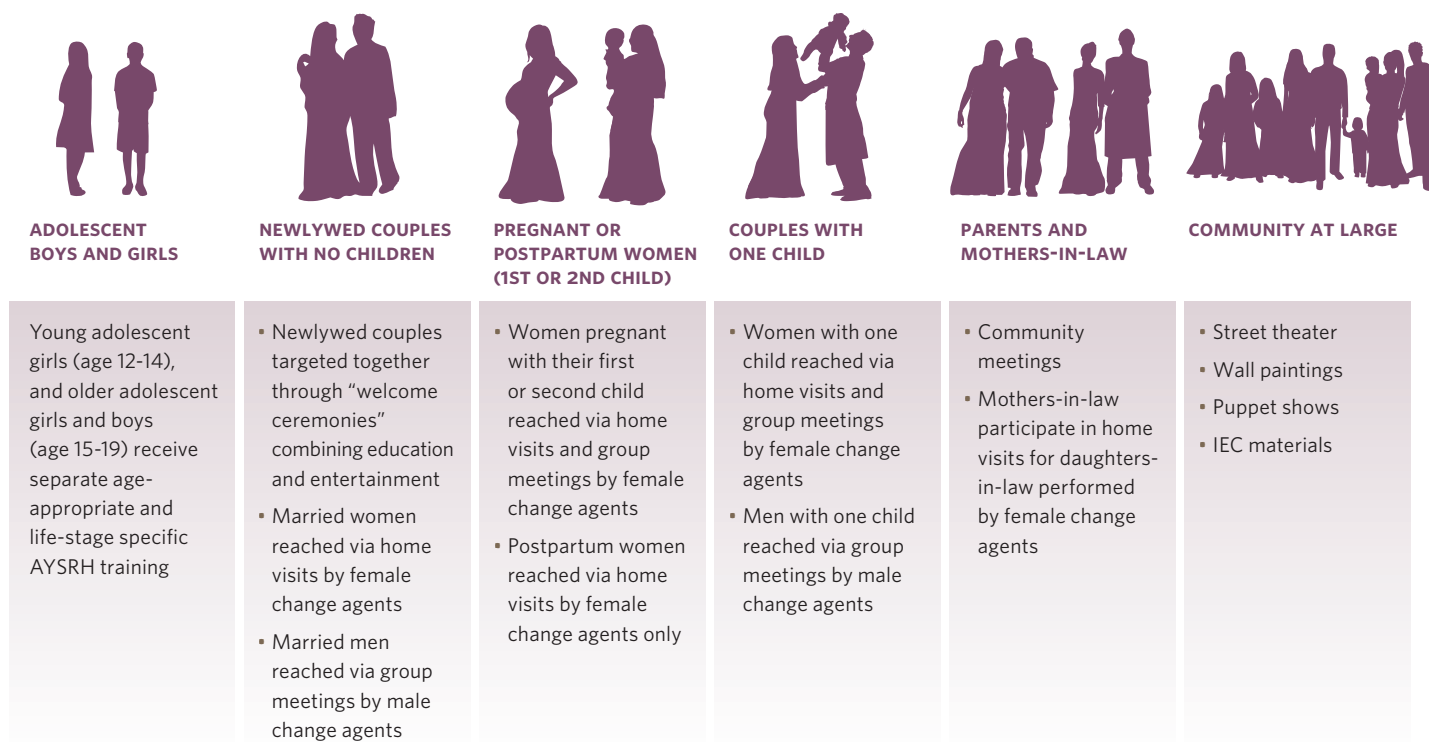
Young married men and women experienced the intervention in a variety of ways. Newly married couples participated in “newlywed welcome ceremonies,” combining education and entertainment to improve SRH knowledge, build life skills, and promote couples’ communication and joint decision making. Female change agents conducted home visits to young married women at various stages of pregnancy and parity to provide SRH education and counseling. Home visits created a space for one-on-one dialogue about contraception and related issues, and provided the social support necessary to nurture behavior change as a woman transitioned from one life stage to the next. Themes brought up in home visits were reinforced during group meetings, also held by female change agents with young women with one child, and those in their first or second pregnancy. Men were reached via male change agents who held group meetings focusing on SRH education and gender issues, encouraging male involvement and couples’ joint decision making.

DIALOGUE- AND NARRATIVE-BASED COMMUNICATION

In order to build community trust and support, change agents were selected locally and their capacity built to deliver information in a culturally sensitive manner. Change agents were trained to go beyond purely didactic methods of communication, employing dialogue to adapt information to individual needs and comprehension levels. Narrative was used to expand PRACHAR's communication approach. Technical staff created fictional stories based on

* For a more detailed description of Phase I, see *Promoting Change in the Reproductive Behavior of Youth: Pathfinder International's PRACHAR Project, Bihar, India* at www.pathfinder.org.

FIGURE 3: AUDIENCE-SEGMENTED APPROACH



identified behaviors and wove them into IPC activities, street theater, and wall paintings. Rooted in local realities, these stories allowed target audiences to identify with fictional characters and their journey through the stages of behavior change, thereby building the listener’s own self-efficacy.

GENDER INTEGRATION

Recognizing that traditional gender norms and gender inequality are strong underlying factors in early marriage and childbearing, PRACHAR implemented a range of gender-transformative activities. The purpose was to generate reflection and dialogue around the value society placed on girls and boys, as well as the importance of female empowerment and male involvement in ensuring the health of young people and their families. In addition to encouraging couples’ joint decision making, the project addressed several issues, such as the differences between sex and gender; gender-equitable norms within marriage; using nonviolent means to resolve conflict or negotiate decisions; discouraging son preference; empowering girls to delay age of marriage for health, education, and other benefits; and reproductive rights and responsibilities of both men and women. Gender-transformative efforts reached both men and boys and women and girls, engaging them to challenge harmful

constructions of masculinity and femininity for an overall gender-synchronized approach.¹⁰

ENABLING ENVIRONMENT FOR AYSRH

Recognizing the influential role of elder household members in young people’s decision making, PRACHAR intentionally engaged parents, especially mothers-in-law, through home visits and community events. Parents were encouraged to keep young girls in school and delay the age at marriage, and also to understand the equal “value” of both their daughters and sons. PRACHAR trained local reproductive health teams who engaged continuously with other “gatekeepers” (e.g., teachers, political and community leaders) to further support norm-shifting around early marriage and childbearing. Street theater, puppet shows, wall paintings, and information, education, and communication (IEC) materials reinforced themes raised through IPC, and created additional opportunities for discussion and dialogue. Lastly, PRACHAR provided support to strengthen community access to SRH services, through maternal and child health outreach clinics implemented with government auxiliary nurse midwives, training rural service providers in contraception and SRH issues, and collaborating with social marketing agencies to increase availability of contraceptives.

INTENSIVE OUTREACH, MONITORING, AND EVALUATION

PRACHAR depended heavily on the quality of communication and outreach activities for the success of the intervention, and therefore invested in comprehensive training, intensive outreach, and rigorous monitoring and evaluation. Consistent monitoring was not only critical for assessing project progress, but also allowed change agents to adapt activities to the needs of clients as they transitioned through various life stages. Pathfinder and partners ensured that each actor in PRACHAR—from project staff to NGO partners to change agents—internalized their roles, understood their importance to the project (including the relevance of the data they were collecting), which enhanced morale and overall performance. The Packard Foundation played an important consultative role to the project, particularly during evaluation planning and using data to inform strategic shifts, contributing to the strong technical oversight of the project.

PHASE I RESULTS

Baseline and Endline Comparison

After almost three years of implementation, PRACHAR conducted an evaluation of Phase I, consisting of surveys in both intervention and comparison sites of unmarried and married young people (under age 25) with no children, one child, or two children. Cluster sampling methodology was used to interview 1,995 women in the baseline survey (2002–03), and 2,080 women at endline (2004–05). Results pointed to positive effects of the intervention in improving SRH knowledge and attitudes, and especially in increasing contraceptive use for both delaying and spacing.

In the areas receiving the Phase I intervention, current use of contraception among young married couples increased from 4 percent at baseline to 21 percent at endline; whereas in the comparison area, contraceptive use only increased from 3 percent to 5 percent during the same time period. Analysis of results by parity shows that use of contraception by young women to delay the first birth increased from 3 percent to 16 percent in the intervention area, as compared to from 2 percent to 3 percent among women in the comparison areas. Finally, use of contraception to space the second child increased from 6 percent to 25 percent in the intervention area, versus only 4 percent to 7 percent in the comparison areas.¹¹ All of the increases in contraceptive use in the intervention areas were statistically significant, whereas none of the changes in contraceptive use in the comparison areas were statistically significant. Multivariate regression analysis found that young married women in the PRACHAR intervention area were

nearly four times as likely to use contraception as young married women in the comparison area (adjusting for age, parity, education, and caste).

Further inquiry into Phase I results suggests that a gender-synchronized approach, where both male and female partners are engaged, was associated with stronger results than working with only young men or young women. Results showed that couples in which both the respondent and their partner were exposed to PRACHAR had the highest odds of contraceptive use (3.7 among female respondents, 2.6 among male respondents), whereas couples in which only the respondent was exposed to PRACHAR had lower odds of contraceptive use (2.0 among both female and male respondents).[¥] See Figure 4.

Adolescent Follow-up Survey

To determine the effects of Phase I on age at marriage and childbearing, Pathfinder conducted an additional survey five years after exposure to the Phase I intervention. This 2008 survey sampled young people 19–24 years old in all three districts who had been exposed to PRACHAR Phase I and had participated in the three-day AYSRH training. At the time of the Phase I training, participants had been 15–19 years old, the majority unmarried. The sample of the 2008 survey included 613 young men and women who had been exposed to the Phase I intervention, and 612 who had not been exposed to any PRACHAR activities.

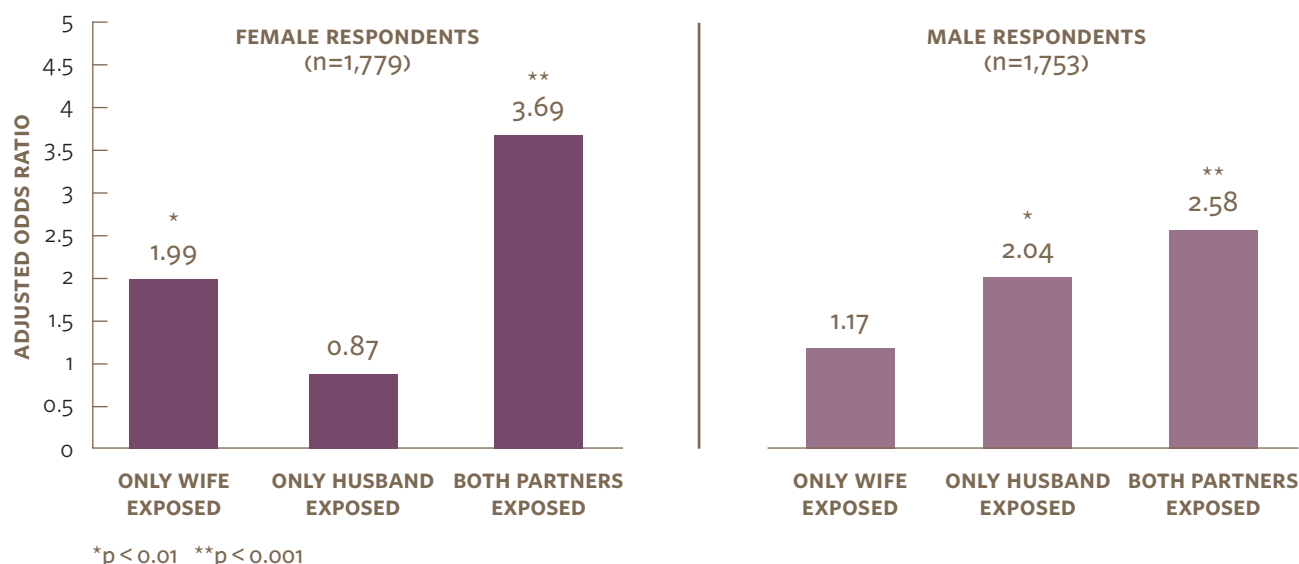
Results of this survey demonstrated that the young women exposed to PRACHAR and the AYSRH training were married about 2.6 years later (at age 22) than women who were not exposed (at age 19.4).[†] Adjusting for differences in education and caste, the study found that young women in the intervention area were 44 percent less likely to be married than young women in the comparison areas. Additionally, young women exposed to PRACHAR had their first birth 1.5 years later (at age 23.1) than young women who were not exposed (at age 21.6). Again controlling for differences in education and caste, the study found young women in the intervention area were 39 percent less likely to have had a child than young women in the comparison areas.¹²

PRACHAR Phase I demonstrated that culturally appropriate, community-based behavior change programming targeting young people and those who influence their decisions, can effect change in SRH knowledge, attitudes, and contraceptive use to delay and space pregnancies. Phase II, therefore, shifted the focus to scale-up and sustainability.

[¥] The reference group is couples in which neither partner was exposed. Results are adjusted for parity, women's level of education, and standard of living.

[†] Adolescents who were married at the time of the PRACHAR Phase I training were excluded from the analysis of age at marriage, but included in analysis of contraceptive use and age at first birth.

FIGURE 4: ADJUSTED ODDS RATIOS FOR EFFECT OF INTERVENTION EXPOSURE ON CURRENT USE OF CONTRACEPTION AMONG FEMALE (N=1,779) AND MALE (N=1,753) RESPONDENTS, PRACHAR PHASE II BASELINE



PRACHAR Phase II: Preparing for Scale

Phase II focused on identifying the most essential elements of the intensive PRACHAR Phase I model in order to develop a streamlined model that could eventually be adopted by the government's health delivery system. As such, Phase II was designed to: further explore some of the key outcomes of Phase I; evaluate different intervention components and their effects over varying lengths of time; and assess the sustainability of behavior change beyond the intervention period. Phase II added two new districts (Gaya and Sheikhpura) to its coverage and tested the effectiveness of different intervention models in increasing contraceptive use. Tested models included: the comprehensive Phase I model over two and five years, and "single intervention" models (such as the AYSRH training or home visits only), which were implemented alongside broader enabling environment activities.[§]

PHASE II RESULTS

Similar to Phase I, the evaluation of Phase II surveyed unmarried and married young people under age 25 with no children, one child, or two children in comparison and intervention areas. Among the two-year intervention models, women in the intervention areas for the "home visits only" model showed the greatest increase in current use of contraception from PRACHAR Phase II baseline

(2006–07) to endline (2008). This difference was statistically significant in the intervention areas, adjusting for age, education, caste, and standard of living index.

Combined results from Phases I and II demonstrated that home visits and engaging both male and female partners in a couple were most influential in increasing contraceptive use, and that AYSRH training of 15–19-year-olds (in combination with other PRACHAR activities) could influence age at marriage and childbearing. The results of these evaluations, as well as an additional scalability analysis, informed Phase III, which aimed to test scaling up a streamlined model through a public-private partnership between the government and the burgeoning NGO sector in Bihar.

PRACHAR Phase III: Testing Scalability

With joint support from the Packard Foundation and UNFPA, Phase III focused on scaling up a streamlined model of PRACHAR over three years in Gaya, the largest district in Bihar. In addition to providing technical assistance for quality implementation, Phase III aimed to determine whether a less costly, and less intensive, version of PRACHAR implemented by a hybrid government and civil society partnership was still effective in improving health outcomes. Phase III also planned to further investigate the effect of standalone AYSRH training for 15–19-year-olds, and to advocate

[§] For information on the arms tested in PRACHAR Phase II, see *Summary Report of Phase II Evaluation Findings* at www.pathfinder.org.

at state and national levels for the importance and feasibility of AYSRH programming.

The Indian government's 2005–12 National Rural Health Mission introduced several new schemes for health service delivery, including training Accredited Social Health Activists (ASHAs) in charge of maternal and child health outreach, who assumed the role of PRACHAR's female change agents. Local NGOs, most of which participated in Phases I and II, maintained responsibility for ensuring male engagement, through training and supervising male communicators who held group meetings with young married men with no children, one child, and two or more children. NGO partners continued training unmarried adolescents of both sexes ages 15–19, and maintained limited environment building activities (e.g., wall paintings and mobilizing gatekeepers to support adolescents' participation in training activities).

Pathfinder and partners endeavored to minimize the inherent risks of a pared-down model by working closely with the government and donors to strengthen the modalities of the intervention, reinforcing ASHA capacity and remuneration schemes, and developing systems for data collection and analysis. Public health managers and frontline workers were engaged at block, facility, district, and state levels through training and capacity building to enable the government to monitor, supervise, and manage the program, and support was provided to institutionalize key elements.

By the end of Phase III in September 2012, a training and supervision mechanism was embedded in the public health system, supporting 994 ASHAs to conduct home visits for women under 25 of zero- and single-parity, and group meetings with women with at least two children. The government of Bihar has an ASHA training resource center staffed with 22 master trainers, who are currently completing instruction to then train 87,000 ASHAs in districts statewide. Over the life of PRACHAR, several partner NGOs have become training resources for the government program, and are able to successfully receive and manage funds, and implement AYSRH programs independently. In May 2012, the government issued guidance that ASHAs will continue to collect data on home visits, as under PRACHAR Phase III, and will continue to receive incentives for promoting birth spacing.

An external evaluation conducted by the Population Council began in October 2012. The purpose of the evaluation is threefold: to measure the impact of the 11 years of investment against the project goal and objectives; to assess the effectiveness of the model for scale-up through the public-private partnership; and to evaluate the sustainability of behavior change achieved throughout implementation of all three phases. UNFPA has proposed to conduct a smaller survey of adolescents examining changes in



Female change agents conducting home visit to postpartum client

PHOTO: Karl Grobl

knowledge and attitudes in several intervention blocks. Pathfinder will also support further investigation into additional questions related to early marriage, the implications of scale-up, and the effects of specific intervention components.

Lessons Learned to Date

While the full spectrum of learning from PRACHAR will emerge with the results of the final evaluation, expected in May 2013, there are several key lessons thus far:

Employ a life stage-appropriate and audience-segmented approach: PRACHAR implemented targeted strategies to engage adolescents and young couples at various stages of life and parity, as well as their parents and parents-in-law, with specific activities tailored to their age, gender, and role in influencing behavior change.

Engage gatekeepers: In Bihar, young people have very little autonomy and decision-making power. PRACHAR therefore engaged parents and parents-in-law, as well as other community leaders, who greatly influence adolescents' future marriage and childbearing. Home visits, community meetings, and events stressed the importance of HTSP and delaying marriage for the health of young couples and their children, and particularly the rights of young people in SRH decision making.

Apply a gender-synchronized approach: Targeting both boys and girls, and husbands and wives, to challenge harmful and restrictive gender constructions that hinder health and wellbeing is critical for effective SRH programming. PRACHAR applied these lessons and

targeted young men and women—both separately and together as newlyweds—to improve knowledge, skills, and behaviors for HTSP.

Narrative and dialogue for effective IPC:

Dialogue between change agent and client, rather than delivery of prescribed messages, allows for more in-depth and contextually relevant communication, creating opportunities to pose and answer questions and ensure comprehension. Narrative is also a powerful tool for behavior change. Well-crafted stories based on identified behavioral barriers can help influence outcome expectations and risk perception, and increase self-efficacy.

Multiple overlapping channels spur and

reinforce behavior change: PRACHAR used a variety of activities and communication strategies acting at the individual and social levels, ensuring repeated exposure for adolescents, young couples, gatekeepers, and other community members. Allowing target audiences to experience diverse activities combining IPC and broader community-level events has a synergistic effect in changing social norms and behaviors.

Build trust and capacity for sustainability:

PRACHAR carefully selected locally based partner organizations, change agents, and trainers, thus fostering community commitment to project goals. Respecting sociocultural practices and values, such as conducting home visits with young married women in the presence of their mothers-in-law, also built trust, which ultimately allowed the project to challenge harmful social norms. Pathfinder placed particular emphasis on building the capacity of over 20 local partners and the Bihar government to enable scale-up and sustainability of key PRACHAR strategies well beyond the life of the project.

Moving Forward

Much of India's demographic future depends on fertility trends in northern states and, with the pressing need to improve access to reproductive health and rights for India's young people, scaling up efforts to promote increased

age at marriage and HTSP are critical. In the coming months, Pathfinder will use final evaluation findings to inform continued technical assistance to the Bihar government and to advocate with state and national government for evidence-based AYSRH programming. Best practices and lessons learned from PRACHAR are relevant for other countries in South East Asia and Africa where early marriage is common, populations are young, and adolescent fertility is high. Pathfinder is thus exploring ways to further cull lessons from the wealth of PRACHAR experiences and evaluation data, and adapt PRACHAR to other contexts, such as Pakistan, Ethiopia, and West Africa.

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COVER: Adolescent girls participating in AYSRH training

PHOTO: Karl Grobl

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