PRAGYA

Multisectoral, Gendered Approach to Improve Family Planning and Sexual and Reproductive Health for Young People:

A Research Study

Pathfinder International

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CONTENTS

ACRONYMS

AFS	adolescent follow-up study
CPR	contraceptive prevalence rate
FGD	focus group discussion
FP	family planning
HTSP	healthy timing and spacing of pregnancy
NFHS	National Family Health Survey
MDG	Millennium Development Goal
NGO	nongovernmental organization
SGBV	sexual and gender-based violence
SRH	sexual and reproductive health

I. EXECUTIVE SUMMARY

Public health experts have highlighted gender equality/women's empowerment as essential for equitable and sustainable development, and recommend that sexual and reproductive health (SRH) programs examine gender issues underlying health problems and address girls' and women's health needs throughout the lifecycle (USAID, 2009A and 2009B). Poor SRH outcomes across India are a result of low literacy, early marriage and childbearing, all of which are generally derived from the low status of females in Indian society, and particularly from cultural norms supporting early marriage and fertility (Lioon et al., 2009). In Bihar, as in the rest of India, gender inequality impacts women's SRH and choices.

Pathfinder initiated the PRACHAR project in 2001 to address SRH behavior change among young people aged 12-24 years in Bihar. Specifically, PRACHAR promotes delaying marriage and healthy timing and spacing of pregnancies (HTSP) among unmarried adolescents and newly married couples. The program was devised in three phases: Phase I (2002 to 2006), Phase II (2006 to 2008), and Phase III (2009 to 2011). PRACHAR's highly successful approach used intensive interpersonal communication for behavior change delivered through trained male and female change agents. The target audience was composed of unmarried female and male adolescents, young couples, their guardians (parents and in-laws) and influential community members. Although PRACHAR's main focus was on improving SRH outcomes of young people, the program design included gender accommodating and transformative elements. Rigorous evaluation of PRACHAR Phases I and II showed positive changes in SRH behavioral outcomes (e.g. increased contraceptive use by newlywed couples, and contraceptive use for spacing births).

To further examine the effect of PRACHAR's gender accommodating and transformative elements on SRH behavior changes, Pathfinder International conducted a research study entitled PRAGYA (Sanskrit for "insight") in 2010 in four districts (Gaya, Nalanda, Nawada, and Patna) of Bihar, India. The objectives of PRAGYA were to:

- Conduct retrospective analysis of PRACHAR Phase I and II data to develop a better understanding of the impact on FP/SRH outcomes and analyze possible trends in gender norms, attitudes, and practices related to SRH that may have changed over time as a result of PRACHAR.
- Conduct qualitative research (through focus group discussions) to explore possible linkages between intended SRH behavioral outcomes, multisectoral elements such as education, and PRACHAR's gender accommodating and transformative elements as well as how gender inputs could be made stronger to enhance gender outcomes.
- Develop and test an intervention model with significantly stronger multisectoral components and gender transformative approaches, and assess its impact on key SRH outcomes through a quasi-experimental study.

Due to budgetary constraints, PRAGYA ultimately focused on the first two objectives. The study consisted of quantitative and qualitative elements. For the quantitative element, secondary analysis was conducted using two data sets generated by PRACHAR: 1) PRACHAR Phase II baseline and endline data collected in 2006-07 and 2008, respectively, and 2) the Adolescent Follow-up Study (AFS) conducted in 2008, five years after PRACHAR Phase I trained adolescents in SRH. In addition, PRACHAR Phase I baseline (2002–03) data was used for selected analyses on educational status and contraceptive use.

Summary of quantitative findings:

- The active involvement of young men and women jointly was critical to young couples' use of contraception. Contraceptive use was highest among couples in which both spouses were exposed to PRACHAR communications, with condoms being the most popular method.

- Wife's participation in decision-making about contraceptive use increased significantly in the PRACHAR intervention areas from baseline to endline. Adjusted regression analyses showed that couples of zero and one parity were 1.5 and 1.2 times more likely, respectively, to use contraception when the wives participated in decision-making about contraceptive use.
- Young women and men who had participated in PRACHAR were much less willing to marry before the legal age of marriage, and more likely to talk with their parents about desired marriage age than those in the comparison group.
- Young women who had participated in PRACHAR were married an average of 2.6 years later and had their first birth 1.5 years later than women who had not participated in PRACHAR (both $p<0.001$). A significantly higher proportion of PRACHAR participants used contraceptives to both delay the first birth and space the second birth (23 percent) as compared to those not exposed to PRACHAR (5 percent).

In June-July 2010, Pathfinder collaborated with USAID and the Indian Institute of Health Management and Research (IIHMR), Jaipur to conduct the qualitative component of PRAGYA. The study was conducted in PRACHAR Phase I and II intervention districts of Patna, Nalanda, and Nawada. The purpose of the study was to identify underlying reasons and contributing factors for behavior changes observed among PRACHAR participants, particularly in agency and empowerment of girls. Twenty-one focus group discussions (FGDs) were conducted with 196 participants (adolescents, parents, field workers, trainers, and community influencers) who had participated in PRACHAR Phase I (2002–03). FGDs were conducted several years after the PRACHAR Phase I, and may have elicited general perspectives about community norms as opposed to individual-level attitudes or experiences of participants.

Summary of FGD findings:

- Most participants felt that the situation in Bihar is changing for the better in terms of education, delayed marriage and small families. Participants observed that there has been a significant change in girls' age at marriage, which some attributed to the PRACHAR program. Both boys and girls are staying in school longer, and parents are increasingly aware of the benefits of education and financial independence for their daughters. Women have been observed standing up to their parents and husbands on issues of education, marriage and childbearing.
- Gender roles and expectations are gradually changing. Women are increasingly seen as being able to carry out both household duties and outside work (often leading to a 'double burden' of responsibilities). When asked about aspirations for themselves or their children, participants' responses reflected a relatively gender-equitable perspective. Young women said that they wanted to achieve higher education and work outside the home. Parents wanted girls to study and work, in order to be self-sufficient.
- Although doors are opening for women in education and work, patriarchal norms are still deeply rooted. Some participants (particularly parents) indicated the persistence of patriarchal gender roles of men as the breadwinners and protectors. Deep-seated cultural norms about gender roles, marriage and childbearing remain a huge challenge. Women still have limited agency in making decisions about marriage and childbearing, particularly in disadvantaged castes and rural areas. Dowry, financial hardship and the lack of legal action against early marriage continue to be the main reasons that girls are married earlier than the legal age. Early marriage happens disproportionately among the vulnerable, disadvantaged groups (scheduled castes, impoverished families in rural areas), and continues to be associated with SGBV.

- PRACHAR appears to have played a role in changing community perceptions on girls' education, age at marriage, and SRH. Parents and trainers noted that PRACHAR created awareness about girls' education, delaying marriage, and the use of contraception for HTSP. Most young women and men could recall the topics covered in PRACHAR's training program, including the appropriate age of marriage for boys and girls and the benefits of delaying marriage.

Recommendations

The following are specific recommendations from PRAGYA for future interventions and programs:

Programs and interventions

- Conduct baseline and end line assessments of gender norms and behaviors, as well as RH/ FP behavior, at the individual and community level.
- Involve household- and community-level decision makers in programs targeting young women. Specifically: empower mothers and mothers-in-law; raise awareness of the importance of health and empowerment strategies for young women (and men); and raise parents' awareness of the importance and benefits of educating their daughters and avoiding early marriage.
- Strengthen delivery of gendered SRH interventions coupled with education and economic empowerment interventions. Specifically: increase girls' accessibility to education in local settings, including facilitation of school enrollment and retention; draw on role models in the villages and positively reinforce educational achievements; mandate life skills programs for girls in school curricula; and incorporate a livelihood skills-building module into SRH training.
- Implement developmentally appropriate SRH training for youth that emphasizes increased agency for girls in asserting and acting on aspirations for education, work, and marriage.
- Design program activities that respect cultural preferences and practices, gradually shifting from a gender accommodating approach to one that improves girls' rights, equity, and mobility.
- Create rights based programs for girls in rural areas, stressing that early marriage violates girls' and boys' rights, harms their health and hinders advancement. Promote programs that alleviate intergenerational poverty, which perpetuates the cycle of early marriage and poor health.

Policy

- Increase financial allocations to support programs to reach youth, in particular unmarried adolescents, and monitor these programs closely to ensure they reach intended target groups.
- Promote accountability measures within law enforcement to uphold legislation and enforce legal age of marriage. Strengthen community mechanisms to monitor and hold local governance bodies and individuals accountable.
- Support and encourage capacity building of civil society, media, and government to improve their understanding and commitment to addressing gender inequities.
- Develop and strengthen socio-culturally appropriate SRH policies and programs promoting women's empowerment and gender equality, cultivating political and administrative will to bring about improved gender outcomes.

Research

- Continue to invest in research to build evidence on SRH, education, and economic development, and their intersections and impact on young women.
- Develop operations research studies to plan, implement and evaluate gender-integrated multi-sector SRH programs for young people that include gender synchronized approaches to shift gender norms and power relations. Evaluate gender and SRH outcomes of these programs, including measurement of individual and community changes in gender norms and behaviors.

II. BACKGROUND

Gender is a key determinant of health, welfare and development of individuals, families and communities. Gender norms influence women's ability to make decisions about education, work, marriage and childbearing. Women's position in society also influences their ability to gain knowledge of sexual and reproductive health (SRH) and family planning (FP) issues, and to access the services they need. Gender inequality contributes to women's vulnerability to unintended pregnancy, sexually transmitted diseases, reproductive health-related morbidity and mortality. Male attitudes and notions of masculinity are linked to sexual and gender-based violence (SGBV). Ultimately, gender norms influence adoption of behaviors that can help or hinder healthy lifestyles.

The Millennium Development Goals (MDGs), the Beijing Platform for Action, and the Cairo International Conference on Population and Development Program of Action reflect a consensus that gender inequality undermines health, and that promoting gender equality and empowerment of women (MDG 3) can improve health outcomes. The priority strategies to achieve MDG 3 as described in *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*[1] include ensuring universal access and rights to SRH; involving men in reproductive health; improving health and well-being of girls and women by reducing exposure to SGBV and early marriage and facilitating their continued schooling; enabling women to participate in income-earning activities, governance, and their communities; linking women to livelihood interventions; and improving access to family planning.

Integrating gender into SRH programming

Public health experts have highlighted gender equality/women's empowerment as essential for equitable and sustainable development, and recommend that SRH programs examine gender issues underlying health problems and address girls' and women's health needs throughout the lifecycle (USAID, 2009A and 2009B). Gender is one of the most important factors to consider in designing and delivering SRH services, yet it may be the least understood in terms of how women and men's health needs differ, how those differences are best addressed, and how gender dynamics influence SRH attitudes and behaviors.

Rottach, Schuler, and Hardee (2009) report on various programs where integrating gender into programs proved worthwhile. The authors list five gender integrating strategies, which are also the approaches suggested by USAID and the Intergovernmental Working Group (IGWG): 1) increase gender equity, 2) address male norms and behavior, 3) reduce violence and sexual coercion, 4) increase income generation for women and girls, and 5) increase women's legal protection and property rights. Evidence shows that programs that do

Box 1. Gender-integrated approaches

Gender accommodating approaches acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them.

Gender transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers and traditional leaders.

Gender synchronized approaches intersect gender transformative efforts reaching both men and boys and women and girls. They engage people in challenging harmful and restricted constructions of masculinity and femininity that drive gender-related vulnerabilities and inequalities and hinder health and wellbeing.

Rottach, Schuler, and Hardee, 2009; Greene and Levack, 2010.

[1] www.unmillenniumproject.org/reports/srh

not address these issues may be less effective (Greene and Levack, 2010). Gender-integrated programs can be characterized as either "gender accommodating," "gender transformative," or "gender synchronized" (see Box 1). Long-standing SRH programs can be expanded to integrate gender issues and include linkages to education and vocational opportunities (Rottach, Schuler, and Hardee, 2009; Mehta and Shah, 2003; Bhide and Mehta, 2008). The issue of gender equity (i.e. equal distribution of opportunities, responsibilities, and benefits between men and women) and the strategies and processes used to achieve it (Rottach, Schuler, and Hardee, 2009) must be prioritized if interventions and programs for young girls are to yield true, lasting rewards.

Box 2. Elements of gender integrated programming include:

- Specific gender equity/equality objectives and indicators for measuring success
- Equitable participation and involvement at all levels
- Fostering equitable relationships
- Advocacy
- Coalition building
- Multisectoral linkages
- Community support for informed individual choice
- Institutional commitment to gender integration

However, implementing and sustaining gender-integrated programs requires challenging the historical hierarchies of gender, race, class, and caste. Persisting impediments to gender equality such as early marriage, lack of mobility, and substandard education are particularly difficult to eradicate. Women's and girls' empowerment requires use of behavior change communications interventions and linkages to SRH and other programs (Varkey, Kureshi, and Lesnick, 2010; Rocca, Rathod, Falle, Pande and Krishnan, 2009). Research studies conducted by different agencies have recommended that multisectoral interventions are necessary in order to effectively manage the problem of child marriage at the community level. (Malhotra 2011, UNICEF 2006, UNICEF 2005). Such interventions include strengthening educational infrastructure and facilitating girls' school enrollment and retention, increasing parents' awareness of the importance and benefits of delaying marriage, strict enforcement of legal marriage ages, and vocational guidance and livelihood training for adolescents.

Gender-integrated programs emphasize the equitable participation of women and other under-represented groups (e.g. ethnic minorities, adolescents, and people with different sexual orientations) in program design and decision making. Gender integration should be a core strategy in adolescent programs; however, across the spectrum of programs and services for women and girls, gender issues are not often at the forefront (Sinha, Peters, Bollinger, 2009; Rocca et al., 2009). Consequently, women and girls continue to be deprived of their sexual and reproductive rights and health.

Gender and SRH in India and Bihar

Poor sexual and reproductive health outcomes across India are a result of low literacy levels, early marriage, early childbearing, and closely spaced births, all of which are generally derived from the low status of females in Indian society, and particularly from cultural norms that place a high premium on early marriage and fertility (Lioon et al., 2009). Although the legal minimum age at marriage for girls and boys in India is 18 years and 21 years, respectively, the NFHS-3 shows that a sizeable proportion of young men and women (75% of women aged 20-24 and 49% of men aged 25-29) in rural areas of Bihar marry below their respective legal minimum ages (IIPS, 2008). A recent study conducted among 10,000 married women aged 20–24 years in India found that adolescent marriage is directly correlated with increased violence at home. The study revealed that 43 percent of underage married women (below 18 years) had been subjected to violence by either their husbands or in-laws, and severe life-threatening violence was experienced by 16 percent of underage married women compared to 6 percent of adult married women (Raj et al., 2010). This is not surprising, since both age and gender-related factors are compounded resulting in adolescent girls' diminished agency.

Discrimination against girls in the areas of health, nutrition, and education is heightened in adolescence. The onset of puberty decreases autonomy and mobility, with increasing restrictions on speech, appearance, conduct, and interaction with the opposite sex. Such barriers also impede access to and retention in schools. Most adolescent girls have little knowledge of menstruation, sexuality, and reproduction (CEDPA, 2001). For instance, only 5 percent of women aged 15–19 years know that a woman is fertile only during the middle of her menstrual cycle (Parusuram et al., 2009). Adolescent girls aged 15–19 years tend to rank lower in SRH indicators, health service use, knowledge of HIV, economic autonomy, school enrollment, and exposure to the media (Rani and Lule, 2004; Bhide and Mehta, 2008). Some segments of society outright deny adolescents, particularly young girls, the basic human rights to health, education, and opportunities in society (de Silva de Alwis, 2007).

In Bihar, as in the rest of India, hierarchical gender relations and unequal gender norms impact women's SRH and choices. Gender role differentials are pervasive from an early age, and structural factors such as poverty and caste system exacerbate inequities. Adolescent girls have limited autonomy and face significant constraints on their mobility and access to resources, including education. After marriage, a young woman is under the authority of her husband's family. She has little say in domestic decisions and little freedom of movement. Her fertility, particularly the number of sons she bears, is the only avenue to enhance her prestige and security in her husband's home. Women who have borne only daughters can be subjected to harassment, and childlessness can be grounds for divorce or abandonment. These gender inequities have significant implications for SRH. Gender norms that perpetuate the 'culture of silence' inhibit women from communicating a health problem or seeking prompt treatment, especially for gynecological and reproductive morbidity which is linked so closely to sexuality.

Despite several national and state programs to enhance the educational and health status of women, Bihar lags behind many states on these and other indicators (See Box 3) (IIPS, 2007). According to the 2005-06 National Family Health Survey (NFHS), gender disparity in health in Bihar is evident in all age groups, particularly among disadvantaged groups such as the scheduled castes and scheduled tribes.[2]

Box 3. Poor SRH outcomes are a result of early marriage and childbearing in Bihar

- Median age of marriage is 15 years among women aged 20-49 years. 68% of women aged 20–24 years are reported to have married before turning 18.
- Overall, one in four young women in Bihar aged 15-19 years has already begun childbearing. More than half (58%) of women aged 19 years are either mothers already or pregnant.
- Young women from lower castes, educational levels, and rural residence bear a disproportionate burden of early childbearing. In disadvantaged communities of scheduled and backward castes, 64% of women aged 15-19 years have begun childbearing. Women aged 15-19 with no education are twice as likely to have begun childbearing (35%) as those with 5-9 years of education (15%). Women aged 15–19 years in rural areas are almost three times as likely to have begun childbearing (28%) as those in urban areas (10%).
- The contraceptive prevalence rate (CPR) is 34% among women aged 15-49 years. However, CPR is only 4% among young women under age 20 years. Nearly half of men (48%) in Bihar agree that contraception is women's business and a man should not have to worry about it.
- Bihar has the highest total fertility rate in India of (4.0), and 63% of all births in Bihar occur at an interval of less than 36 months.
- 56% of women aged 15-49 in Bihar have experienced physical or sexual violence.

(Sources: IIPS, 2007; Parusuraman, et al. 2009; IIPS, 2008)

[2] Scheduled castes and tribes are groups the Government of India officially recognizes as socially and economically disadvantaged and in need of special protection from injustice and exploitation (IIPS, 2007).

PRACHAR

Pathfinder initiated PRACHAR to address SRH behavior change among young people aged 12-24 years in Bihar. Specifically, PRACHAR promotes both delaying marriage and healthy timing and spacing of pregnancies (HTSP) among unmarried adolescents and newly married couples. The program was devised in three phases. PRACHAR Phase I (July 2002 to March 2006), PRACHAR Phase II (October 2006 to September 2008), and PRACHAR Phase III (2009 to 2011).

Phase I aimed to improve the health and welfare of young women and their children and to change social norms surrounding early marriage and childbearing. Phase I interventions were implemented by nongovernmental organizations (NGOs) and included training of unmarried adolescent girls (aged 12–14 years) and unmarried adolescent girls and boys (aged 15–19 years) in separate trainings; home visits to young married women (zero and single parity) conducted by female change agents; group meetings with young married men conducted by male change agents; group meetings with parents, in-laws, and other gatekeepers; cultural programs (e.g. street plays) on SRH/FP issues; Nav Dampati Swagath Samaroh (meaning 'newlywed ceremony') for newly married couples; and increased access to SRH/FP services in collaboration with government health services, social marketing agencies, and local retailers.

After three years, PRACHAR beneficiaries demonstrated significant increases in SRH knowledge and contraceptive use as compared to the comparison group (Daniel, Masalamani and Rahman, 2008). To facilitate scale-up of PRACHAR, Phase II was designed to further explore some of project's key outcomes, distill the most effective interventions within PRACHAR's overall approach, and evaluate the effect of varying durations of programmatic inputs (2, 3, and 5 years) as well as the sustainability of behavior change beyond the intervention period. Under Phase I and II, PRACHAR reached a population of over one million youth (females and males), parents and community members, spread over 996 villages in three districts. The program not only involved young women and men (married and unmarried) aged 12–24 years, but also their guardians and caretakers, and others that may influence or make decisions on their behalf (Rahman and Daniel, 2010). Rigorous evaluation of the first two phases of PRACHAR showed significant changes in SRH behavioral outcomes (e.g. increased contraceptive use by newlywed couples, and use of contraception to space the second birth).

PRACHAR Phase III aims to effectively scale-up PRACHAR in partnership with the government of Bihar, using government appointed frontline health workers (called ASHAs) as change agents. The ASHAs conduct household visits with young couples, and mobilize unmarried adolescents to participate in SRH training. The intervention model retains only essential interventions based on the Phase II evaluation. NGO-recruited male communicators (change agents) reach men through group meetings and NGO-supported trainers will continue to train unmarried adolescent boys and girls. In contrast to the previous phases, there are minimal activities for creating an enabling environment, as these are not within the purview of the government public health approaches. See Annex I for details on the differences between PRACHAR II and III.

Table 1: PRACHAR's geographical coverage

Geographical coverage	***Phase I (2001 – 2005)***	***Phase II (2005 – 2009)***	***Phase III (2009-2012)***
Districts	3	5	1
Population of intervention areas	636,803	453,478	1,381,606
Primary target population covered	118,883 (19%)	95,245 (21%)	376,956 (27%)

PRACHAR's behavior change approach

PRACHAR's highly successful approach used intensive interpersonal communication for behavior change delivered through trained male and female change agents. These trained communicators reached females and males with lifecycle-based SRH information, including messages on HTSP. The target audience was composed of unmarried female and male adolescents, young couples, their guardians (parents and in-laws) and influential community members.

PRACHAR's behavior change interventions for deeply rooted sociocultural practices, such as age at marriage and HTSP, involved intensive efforts beyond mere dissemination of messages. First, existing barriers to behavior change (e.g. parental and societal pressure to marry early, gender norms that value women mostly for their fertility, myths and misinformation about conception and contraception) were identified. Training programs were then carefully structured to facilitate dialogue on these key issues. The training programs included developmentally appropriate content and exercises to build girls' agency as well as the communication and negotiation skills needed to make healthy SRH decisions. PRACHAR also included referral links to vocational and educational training and institutions. The hypothesis underlying program implementation was that if a critical mass of adolescents were reached with appropriate behavior change interventions, it would maximize the chances of changing the attitudes and behaviors of some adolescents. These adolescents would, in turn, ensure that the new attitudes and behaviors were sustained and continued to grow in the community.

Pathfinder's *Reproductive Health Guide for Educators of 15–19-Year-Old Adolescents* was used to help adolescents acquire the necessary knowledge and skills to make responsible SRH decisions as they transition into adulthood and marriage. Training activities were designed to empower adolescents to avoid unintended pregnancy and infection, and use FP to delay childbearing. The training program provided adolescents with essential SRH information and addressed key issues of concern at their stage of life. Specific health content included basic reproductive anatomy and physiology; conception and contraception; reproductive tract infections and HIV and AIDS; myths and misconceptions related to sexuality and reproduction; and availability and importance of FP/SRH services. The program also included discussion and reflection around gender roles, norms and power dynamics related to FP/RH decision-making and behavior change.

Because these adolescents were at the common age of marriage in Bihar (15), the training also included discussion of the health, social and economic benefits of delaying marriage and childbearing, as well as benefits of birth spacing and small family size. The training emphasized the dangers of early marriage and childbirth, and explained the benefits of a woman marrying after the legal age of 18 and postponing the birth of her first child until the age of 21. Discussion and exercises helped participants develop strategies to resist family and community pressures to marry and conceive at a young age. The training encouraged girls to exercise their agency in SRH decision-making, and for both sexes to address SGBV and participate equally in decisions related to their own lives and their families. Change agents guided and encouraged the trainees to make healthy SRH choices that were appropriate for their lives, and made regular household visits to young couples to reinforce the above concepts. Information on SRH was also disseminated through murals, street theater, posters, and leaflets to foster an enabling social environment and to promote norm changes consistent with HTSP and delayed age at marriage.

Deep-seated gender norms, sociocultural practices and beliefs hinder contraceptive use by newly married couples in Bihar to delay or space births. Newly married women are pressured by parents and in-laws to 'prove their fertility' soon after marriage and cohabitation. Many fear that the capacity for childbearing may decline with age and contraceptive use, and therefore believe it is wise to have children as early as possible. Pressure from influential household members who play a strong role in

decision-making, and lack of spousal communication further deter young couples from delaying and spacing births. To address some of these barriers, PRACHAR implemented a couples-centered activity,[3] Nav Dampati Swagath Samaroh. This "welcome ceremony" for newlywed couples was aimed at promoting spousal communication and joint decision-making on contraceptive use. Gender issues related to SRH were identified and addressed via games and simulations. Content focused on each spouse respecting the views and choices of the other; informed choice through improved inter-spousal communication and joint decision-making; and acknowledging and reinforcing women's SRH rights.

PRACHAR's gender approach

The main focus of PRACHAR was to improve SRH outcomes of young people. However, there was recognition from the outset that traditional gender norms and gender inequality were strong underlying factors in early marriage and childbearing. While the extent to which PRACHAR intentionally sought to shift gender norms is somewhat limited, the program did include a range of gender accommodating and transformative elements as described in Table 2. It is important to note that in the Bihar context, where gender inequality is deeply entrenched and pervasive, "gender accommodating approaches can provide a sensible first step to gender integration. As unequal power dynamics and rigid gender norms are recognized and addressed through programs, [such as PRACHAR], a gradual shift towards challenging such inequities may take place" (Rottach, Schuler, Hardee, 2009).

Table 2: Elements of PRACHAR's gender approach

Gender accommodating elements
• Trained male and female change agents reached young men and women separately with age and lifecycle stage-appropriate BCC on mutual respect for spouses' opinions and decisions; joint informed decision-making about RH/FP; and use of modern contraception to 1) delay the first birth until the woman attains 21 years of age and 2) space the second birth at least by 36 months. • Sensitivity to mobility restrictions faced by adolescent girls and newly married women; trainings for girls were held close to their homes and female change agents visited married women at home. • Parents of adolescent girls and boys were reached via group meetings on the importance of encouraging their daughters to continue to attend school/college. Parents were also encouraged to delay the age of marriage of daughter as well as son until the age of 18 and 21 years respectively.
Gender transformative elements
• Trainings for adolescent girls and boys included content on: o Differences between sex and gender; case scenarios reinforcing gender-equitable norms within marriage o Sex determination (to counter beliefs that women were responsible for the sex of their baby) o How girls and boys can take an active role in SGBV prevention (e.g., using non-violent means to resolve conflict or negotiate decisions, actions that can be taken to reduce the risk of sexual abuse) o Discouraging son preference o Girls' negotiation and assertiveness skills for decision-making on issues related to marriage and HTSP o Empowering girls to delay age of marriage for health, education, and other benefits. o Reproductive rights and responsibilities of both men and women, including spousal communication and joint decision-making on contraceptive use • Newlywed ceremony that used interactive methodology to improve couples communication and joint SRH decision-making. • Promotion of male involvement in SRH decision-making, including male condom use for family planning • Messages targeting parents and gatekeepers that reinforced the importance of girls' education and delaying age of marriage, as well as the equal 'value' of girls and boys.

[3] Heterosexual couple-centered programs target a relationship dyad to improve health outcomes, typically focusing on ways partners can communicate and support each other's SRH intentions. They usually consider the needs and communication dynamic of the couple, but do not necessarily explore individual beliefs about gender or challenge inequitable gender dynamics.

III. PURPOSE OF THE PRAGYA STUDY

Rigorous evaluation of PRACHAR Phase I and II showed significant changes in SRH behavioral outcomes (e.g. delay in age at marriage, increased contraceptive use by newlywed couples, delay of first birth, and contraceptive use for spacing a second birth). While there was some evidence to suggest that individual changes in gender attitudes and practices (e.g. girls communicating their opinions about age of marriage to parents, joint decision-making, and male involvement in contraceptive use) contributed to changes in SRH outcomes, the quantitative PRACHAR evaluation did not fully explore this. For example, it did not examine the extent to which interventions targeting adolescent girls and their parents and gatekeepers affected girls' mobility, or fully assess whether interventions on couples communication led to joint decision-making on contraceptive use to delay and space births. To further examine the effect of PRACHAR's gender accommodating and transformative elements and the behavior changes observed in PRACHAR, Pathfinder International conducted a research study, entitled PRAGYA (Sanskrit for "insight"), in 2010 in four districts (Gaya, Nalanda, Nawada, and Patna) of Bihar, India. PRAGYA also explored the need for an enhanced gender-integrated approach for improved SRH and gender outcomes.

The objectives of PRAGYA were to:

- Conduct retrospective analysis of PRACHAR Phase I and II data to develop a better understanding of the impact on FP/SRH outcomes and analyze possible trends in gender norms, attitudes, and practices related to SRH that may have changed over time as a result of PRACHAR.
- Conduct qualitative research (through focus group discussions) to explore possible linkages between intended SRH behavioral outcomes, multisectoral elements such as education, and PRACHAR's gender accommodating and transformative elements as well as how gender inputs could be made stronger to enhance gender outcomes.
- Develop and test an intervention model with significantly stronger multisectoral components and gender transformative approaches, and assess its impact on key SRH outcomes through a quasi-experimental study.

Due to budgetary constraints, the study ultimately focused on the first two objectives. Although PRACHAR did not directly challenge gender roles and norms outside the realm of SRH, the PRAGYA research questions focused on finding out what happened since PRACHAR Phase I and II in terms of attitudes towards gender roles and beliefs in the intervention areas. Additionally, PRAGYA focused on determining the extent (if any) to which PRACHAR's limited gender accommodating and transformative elements that were linked to SRH interventions had a spillover effect on overall gender attitudes and beliefs. These changes in perceptions were explored through qualitative analysis of focus group discussions (FGDs) with the beneficiaries of PRACHAR Phase I. In addition to looking in greater detail at PRACHAR's SRH behavioral outcomes (contraceptive use for HTSP, age at marriage, and first birth), PRAGYA explored PRACHAR participants' views on gender attitudes and beliefs, support for young women's autonomy and agency to make healthy SRH choices, women's mobility (work outside the home and access to resources), and tolerance for girls to marry at a young age.

The PRAGYA study consisted of quantitative and qualitative elements conducted over the course of one year in 2010. The findings were expected to inform and influence new project design, policies at state and national level in India and elsewhere, and raise questions for further inquiry, in addition to illustrating the importance of gender-integrated and multisectoral approaches to improving SRH behavior.

IV. QUANTITATIVE RESEARCH

Methodology and Study Design

For the quantitative element of PRAGYA, secondary analysis was conducted using two quantitative data sets generated by PRACHAR: 1) PRACHAR Phase II baseline and endline data collected in 2006-07 and 2008, respectively, and 2) the Adolescent Follow-up Study (AFS) conducted in 2008, five years after PRACHAR Phase I trained adolescents in SRH. In addition, PRACHAR Phase I baseline (2002–03) data was used for selected analyses on educational status and contraceptive use. For PRACHAR Phase II, a randomly selected sample of 23,400 respondents (primarily married women under age 25 years with zero or one child, with additional samples from target groups of young married men whose wives were under 25 years, unmarried adolescent girls and boys, mothers and fathers in-law, etc.) from intervention groups were studied at baseline and endline, along with comparison groups of 3,900 randomly selected respondents at baseline and 7,200 randomly selected respondents at endline. For the AFS, approximately 300 young women and men aged 19–24 years who had been exposed to PRACHAR interventions and an equal number from comparison areas were studied, with a total sample of 1,225.

Using SPSS, descriptive and regression analyses were conducted on selected gender outcomes (e.g. ability of young married women to influence decision-making about contraception) from PRACHAR Phase II baseline and endline studies, as well as the AFS. Analyses also investigated changes in gender norms, attitudes, and practices related to SRH, and access to SRH services and information for young people, especially young women, that may have changed over time as a result of PRACHAR interventions. In addition, analyses explored school enrollment and educational attainment in PRACHAR Phase II, as well as the link between women's educational status and ever-use of contraception, in order to better understand the factors influencing adolescents' reproductive lives that should be considered in future interventions. PRAGYA looked specifically at the AFS to assess whether exposure to PRACHAR interventions translated into positive behavior outcomes (e.g. reduced likelihood of marriage and first birth). These data and results are fully presented in different papers by Daniel et al. (2008) and in a yet-to-be-published manuscript (Daniel 2011); only the relevant results are summarized in this report.

Results

Couple's exposure to intervention and contraceptive use

Through its communications interventions, PRACHAR aimed to promote joint decision-making among couples about delaying and spacing births. In particular, PRACHAR sought to engage young men as active partners in using contraception. PRACHAR Phase II data were analyzed to determine the effect of PRACHAR communications on contraceptive use. Couples were grouped into four categories in terms of exposure to PRACHAR Phase I interventions: 1) neither spouse exposed, 2) only wife exposed, 3) only husband exposed, and 4) both spouses exposed (separately or together). Analyses were conducted separately by parity group, assessing contraceptive use to delay births among couples with no children and contraceptive use to space births among couples with one child.

The findings showed that contraceptive use was highest among couples in which both spouses were exposed to PRACHAR communications, with the greatest effect among couples with one child (Figure 1). Condoms were the most popular method used by couples in each exposure and parity group, and were used in the greatest proportion by couples in which both partners were exposed to PRACHAR interventions. This indicates that the active involvement of young men and women jointly, particularly supporting young men's willingness to use condoms, was critical to young couples' use of contraception.

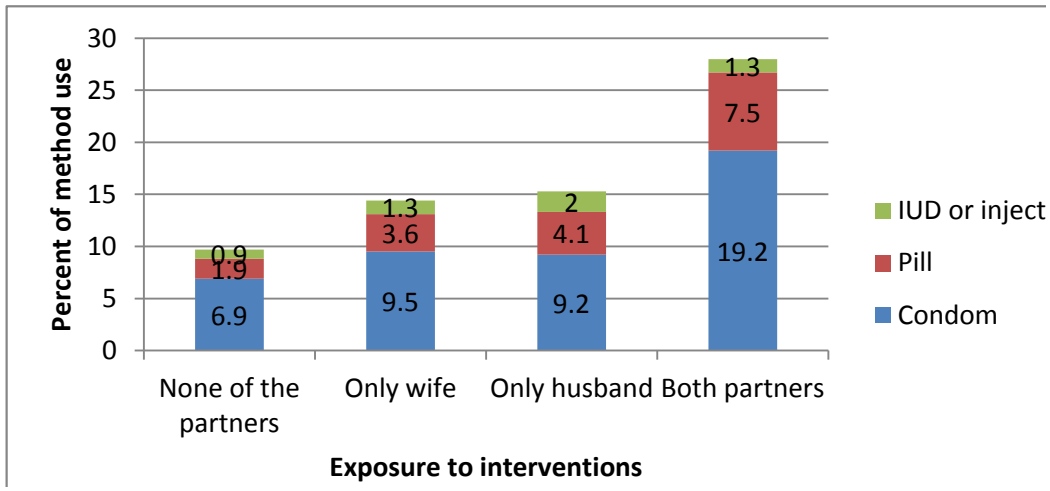


Figure 1: Use of contraceptive methods to space births among couples with one child, by exposure to PRACHAR communication interventions

Multivariate logistic regression analyses confirmed the importance of joint exposure to PRACHAR communications interventions on contraceptive use. After adjusting for parity, women's level of education, and standard of living index, the odds of using a contraceptive method were highest when both partners were exposed (OR=2.77; p<0.001) compared to when neither were exposed. The odds of contraceptive use were 1.87 times higher (p<0.01) among "only husband exposed" respondents and 1.28 times higher (p<0.05) among "only wife exposed" respondents, compared to "neither partner exposed." Joint exposure of young married couples to PRACHAR communications appeared to be more effective than exposure of men alone, suggesting that couples are more likely to use contraception when both are informed about contraceptive options and can make a joint decision. In looking specifically at condom use, the effect of joint exposure to interventions was even stronger; the odds of condom use were 3.41 times higher (p<0.001) among couples where both partners were exposed to PRACHAR communications interventions, compared to couples where neither partner was exposed. This reinforces the finding that engaging young men jointly with their wives may have the strongest effect on use of methods that require active participation of both partners (in this case, male condoms).

Wife's participation in decision-making about contraception and childbearing

In communities where young married couples are often strangers and communicate through in-laws, PRACHAR's gender accommodating approach and activities such as Nav Dampati Swagat Samaroh, the newly married couples' welcome ceremony,[4] encouraged spousal communication in general and communication about contraception in particular. Data on wife's participation in decision-making about contraceptive use from the baseline survey of Phase I (2002-2003) was compared with the end line study of Phase II (2008). The results indicate a statistically significant increase (as per chi-square test) in wife's participation in decision-making about contraceptive use in the intervention areas, from 19 percent at baseline to 52 percent at endline. A similar increase (22 percent to 45 percent) was observed in comparison areas.

The study further explored the impact of the wife's participation in decision-making on contraceptive use and age at first birth. Results of logistic regression revealed that after controlling for the effects of educational status, standard of living, knowledge about contraception, age and caste, couples without

[4] The program included activities such as games, skits , films, and couple activities that led to discussions of SRH, the elements of happy family life, the economics of raising children, and joint decision-making.

children were 1.5 times more likely to use contraception when the wives participated in decision-making about contraceptive use. Similarly, the odds of couples with one child using contraception increased 1.2 times when wives were involved in decision-making. The odds of a woman's not having had a first birth also increased (odds ratio 1.4) if she participated in decision-making about contraceptive use. These results indicate that increasing spousal communication and women's agency in reproductive decision-making is a significant factor in achieving SRH outcomes.

Effect of PRACHAR on desired age at marriage and first birth, and attitudes regarding women's agency in contraceptive use

Table 3 presents AFS analyses on selected indicators from respondents exposed and not exposed to PRACHAR interventions. The gender accommodating and transformative elements incorporated in PRACHAR's behavior change approach seemed to have been internalized by the participants who were exposed to the interventions (adolescent training and potentially other interventions that were part of the PRACHAR model). Young women and men exposed to PRACHAR were much less willing to marry before the legal age of marriage, and more likely to talk with their parents about desired marriage age than those in the comparison group. Young women who had participated in PRACHAR indicated in higher proportions that they wanted to delay (or had delayed) marriage because they were too young to marry, and/or wanted to complete education or find employment first. A higher proportion of adolescents exposed to PRACHAR expressed that 18–20 years is the appropriate age for girls to marry, and 21–24 years is the appropriate age for boys to marry. A lower proportion of adolescents exposed to PRACHAR agreed that women should not use contraception without permission of their husbands.

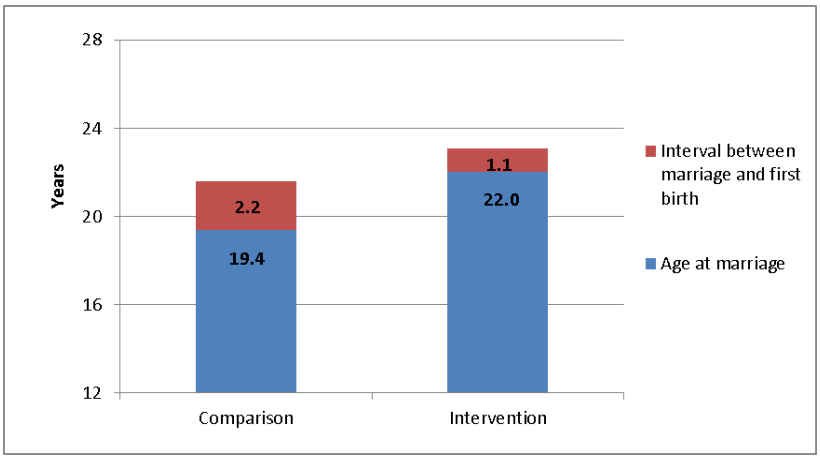
Table 3: Attitudes/behaviors of AFS respondents regarding marriage and contraception

Indicators	**Comparison** *Males=306 Females=306*	**Intervention** *Males=306 Females=307*	**Odds ratio [95% CI]**	**P value**
% willing to marry before legal age of marriage				
Males	16.3	10.1	0.58 [0.36-0.93]	0.023
Females	1.3	0.3	0.24 [0.03-2.22]	0.176
% expressed desire to parents on when to marry				
Males	30.7	36.9	1.32 [0.94-1.85]	0.104
Females	7.5	13.7	1.95 [1.14-3.33]	0.013
% agreed that women should not use contraception without husbands' permission				
Males	59.8	55.6	0.84 [0.60-1.16]	0.287
Females	57.2	39.7	0.49 [0.35-0.68]	0.000

Age at marriage and first birth

The AFS revealed that adolescents who were exposed to PRACHAR Phase I interventions were less likely to have married or had a child when surveyed five years later in 2008. Unadjusted estimates of median age at marriage and first birth (Figure 2) were significantly higher among those who had been exposed to PRACHAR (age 22.0 at marriage, age 23.1 at first birth), compared to those who had not been exposed (age 19.4 at marriage, age 21.6 at first birth) ($p<0.001$ for both comparisons). These findings were reinforced by life table analysis adjusting for education and caste (not shown), which suggest that young women who participated in PRACHAR interventions were 44 percent less likely to be married and 39 percent less likely to have had a first birth than those in the comparison groups when surveyed in 2008. These findings indicate that PRACHAR contributed to delaying marriage and first birth.

Figure 2: Women's median age at marriage and childbearing by area, AFS 2008



Ever-use of contraception for delaying and spacing births

The AFS asked respondents with no children about their use of contraception to delay first births, and respondents with one or more children about contraceptive use to space subsequent births. Analyses suggest that those exposed to PRACHAR were better able to plan their families. Among couples with no children, a higher proportion (21 percent) of those who participated in PRACHAR used contraceptives, compared to those not exposed to PRACHAR (10 percent). See Figure 3**.** A similar trend was observed among couples with one child: 38 percent of former PRACHAR participants used contraceptives, as opposed to 10 percent of non-participants. A significantly higher proportion of PRACHAR participants used contraceptives to both delay the first birth and space subsequent births (23 percent) compared to non-participants (5 percent) (data not shown). Logistic regression analyses found that after adjusting for education and caste, contraceptive use before the first birth was 4.95 times higher, and contraceptive use after the first birth 5.10 times higher, among PRACHAR participants than in the comparison group.

Figure 3: Use of contraceptives by couples of '0' and '1' parity

Knowledge and attitudes of adolescents about SRH and SRH-related gender issues:

The PRACHAR ASRH education program included detailed discussion on issues related to SRH and gender. The session on conception, contraception and abortion addressed issues related to sex selective abortion, son preference and gender stereotypes. For example, discussion about which partner is responsible for the sex of the child involved playing a game with beads that represented x and y chromosomes. The AFS included an assessment of knowledge and attitudes about topics discussed in the PRACHAR trainings. Respondents were asked whether they agreed or disagreed with a series of statements on SRH related gender issues, listed below:

- If a girl does not bleed during the first intercourse, she is not a virgin.
- If a woman wants an abortion, the law requires that she get the consent of her husband.
- Sex selective abortion is legal in India.
- The female partner determines the sex of the child.
- It is the husband's right to decide about matters such as when to have a child and whether to use contraceptive to delay childbearing.
- Women should not use contraception except with their husbands' consent.
- There is no harm if a boy teases a girl who is passing by—it is just a little fun.

Correct responses to each question were assigned a score of one, and incorrect responses a score of zero. A mean knowledge score was calculated for each respondent. The results showed that regardless of marital status or sex, the mean knowledge scores on gender-related SRH issues were higher among those who participated in PRACHAR than those who did not. After adjusting for the effects of control variables (education, caste, sex, and marital status), multivariate logistic regression analyses found that those exposed to PRACHAR had significantly higher SRH-related gender knowledge scores (odds ratio=1.7) than those not exposed to PRACHAR. Logistic regression analyses also showed that after adjusting for gender knowledge scores, contraceptive use to delay first birth was 2.6 times higher ($p<0.001$) among PRACHAR participants than those from comparison areas.

V. QUALITATIVE RESEARCH

Methodology and Study Design

Overview of Study

Using themes identified in the secondary analysis of quantitative PRACHAR survey data, Pathfinder International collaborated with USAID and the Indian Institute of Health Management and Research (IIHMR), Jaipur, to conduct the qualitative research for PRAGYA in June-July 2010. The study was conducted in the Phase I and II intervention districts of Patna, Nalanda, and Nawada in Bihar. The purpose of the study was to identify underlying reasons and contributing factors for behavior changes observed in PRACHAR, particularly in agency and empowerment of adolescent girls. Although PRACHAR did not aim to transform gender norms, PRAGYA's qualitative research aimed to better understand the interplay between gender roles and norms and SRH behavioral outcomes. The study was designed to elicit information on perceptions of gender roles in Bihar and the extent to which these roles have changed over the last five years, as well as factors enabling or hindering advancement of adolescent girls. The qualitative study was reviewed and approved by the Institutional Review Board of IIHMR.

Sampling

Focus group discussion (FGD) participants were recruited from the following populations: adolescents, parents, field workers, trainers, and community influencers (e.g. Panchayati Raj Institutions members,[5] teachers, opinion makers) who were exposed to PRACHAR Phase I interventions in 2002–3. Respondents from the 2008 AFS were re-contacted and screened for participation in the FGDs. Of the original AFS respondents, 196 were selected to participate in the FGDs. Participants were recruited by field workers (change agents) through NGOs that had been involved with PRACHAR trainings. Participants came from

[5]Panchayati Raj Institutions refer to elected committees and groups that are part of the village governance structure. Their members are regarded as people of influence in their communities.

51 villages across the three districts and intervention blocks (Patna 21, Nalanda 12, and Nawada 18). All efforts were made to include participants from the most vulnerable, hard-to-reach locations.

Methodology

Twenty-one FGDs were conducted with 196 participants (see Table 4). FGDs were segregated by sex, with the exception of the trainer FGD (composed of five women and two men). The young men and women were segregated into FGD groups according to whether or not they had exhibited positive behavior changes as measured in the AFS: 1) delayed age of marriage (18 for girls, 21 for boys); 2) use of contraception to delay first birth until age 21; and 3) use of contraceptives to space pregnancies. Parents were segregated according to whether or not their children were in the 'positive behavior group'.

Table 4: FGDs and participants

Population	Number of FGDs	Number of participants
Young women	6	59
Young men	6	55
Mothers	2	20
Fathers	2	20
Community influencers	2	19
Trainers	1	7
Field workers	2	16
Total	**21**	**196**

Each FGD group had a semi-structured interview guide with domains on gender and multisectoral factors, family relations and communication, education, work, support and aspirations, access to resources, and marriage and childbearing. Questions were open-ended and included probes. FGD guides for parents and community influencers were adapted to elicit attitudes and perceptions about young girls being educated, working and delaying marriage. Field worker (change agent) and trainer FGD guides were adapted to elicit views on training approaches and content. The FGD guides were field-tested, translated and back-translated to check interpretation and cultural/conceptual relevance. Each FGD had co-moderators, a note taker, and an observer (with checklist to capture non-verbal cues). All FGDs were audio-taped, transcribed by a bilingual Hindi and English speaker, and translated. The research teams debriefed each day; their observations contributed to refinement of the guides and analysis of the FGDs.

Data analysis

The analysis of FGDs was guided by grounded theory and content analysis approaches (Charmaz, 2006; Miles and Huberman, 1994). Using NVivo software, responses were grouped and categorized according to similarity and commonality, and patterns and recurring themes were noted. Categories with redundancy in their meaning were collapsed (Ryan and Bernard, 2003; Miles and Huberman, 1994). Themes were sub-divided by population demographics (i.e. age, gender, district, etc.) and grouped for comparison and collective reflection across all groups.

Limitations

The FGDs were conducted several years after PRACHAR Phase I, so there is a recall bias embedded in the study. This lag time may have exposed participants to other messages that influenced their views on gender issues, so it is not possible to directly attribute changes to PRACHAR. In addition, it was not possible to involve all prior participants in the qualitative study, so only a cross-section participated. Furthermore, the use of FGDs may have elicited general perspectives about community norms, as opposed to individual-level attitudes, practices, or experiences among the PRACHAR participants. The study team originally intended to conduct in-depth interviews with PRACHAR participants to elicit individual changes in gender attitudes and practices that may have contributed to changes in SRH behavior, but it was decided to conduct FGDs instead due to time and budgetary constraints.

Socio-demographic characteristics of participants

Prior to each FGD, and after securing informed consent, participants were administered a socio-demographic questionnaire that included questions on age, education, age at marriage, marital status, number of children, religion, and caste. These socio-demographic data confirmed that the young women and men who exhibited positive behavior (delayed marriage and first birth, contraceptive use) had higher levels of education, lower rates of marriage, and fewer children. Among the 30 young women who exhibited positive behaviors, 12 were married (18.9 mean age of marriage) and only 5 had children. Similarly, of the 28 young men who exhibited positive behaviors, 11 were married (22.2 mean age of marriage) and only six had children. In contrast, nearly all of the young women and men who did not exhibit positive behavior were married (16.7 and 19.4 mean ages of marriage, respectively), and most had children. On average, young women and men in the 'positive behavior' group had 2-3 more years of schooling than those who did not exhibit positive behaviors. For more details, see Annex II.

Key findings from FGDs

In this section, tables summarizing key themes that emerged during FGDs are presented. While the young male and female FGD participants were purposely segregated according to their behavioral outcomes as measured in the AFS, the positive and negative behavior groups did not vary in their perspectives and responses. This is in large part because participants were reflecting on overall attitudes, norms, and trends in their communities as opposed to their personal experiences. As there were no noticeable differences to highlight according to behavior group, the FGD findings are presented jointly for both behavior groups. Following the tables, responses of FGD participants are collapsed into five key themes: knowledge of contraception; changing trends in education, delayed marriage and small families; agency and decision-making; perceptions on gender roles; and SGBV. In addition, participants' reflections are included on the influence PRACHAR had on attitudes toward girls' education, age at marriage, and contraceptive use to delay and space pregnancy.

Table 5: Young women's themes (n=59, aged 16-27)

Changing trends	Young women discussed both positive and negative trends in gender roles and dynamics. Participants observed that there is more freedom for women and less taunting from boys. Yet preferences in the household remain traditional—women work inside, men go out and work. Trust and fear about letting the girls go out of the village was a major point of discussion.
Education	Making education accessible to young women is viewed as important, though most girls are limited to educational opportunities available in their village. Parents are motivated to send both daughters and sons to government schools in order to benefit from incentive programs.
Support	The girl has to tell her parents what she wants, but most of the time she does not. Mothers usually serve as mediators and communicate girls' aspirations to the father (assuming the mother is able to play this role). It is not up to the parents to support girls in their aspirations if they are poor.
Early marriage	Girls are marrying at a later age now, but the main contributor to this, from the point of view of young female participants, is parents' financial ability. The mandate to wait until the legal age of marriage (18 and 21 years) and fear of consequences have no bearing on the decision to marry off girls. It is the financial capacity that has the greatest bearing on this decision. Getting a match for a girl is seen as favorable, but it becomes a burden if she is *too* educated.
Gov't programs	Awareness of government programs was low overall among young female participants. Young women who knew about programs mentioned that accessing incentives associated with these programs was very difficult, due to the necessity of going outside of the village.

Table 6: Young men's additional themes (n=55, aged 19-33)

Changing trends	Young men perceive that things are changing in terms of women's education and mobility. There was a perception that only a few women do not know their rights, based on complacency on *their* part (i.e. they do not want to know). Some young men perceived that boys and girls are equal in abilities and roles, while others described more traditional gender roles.
Education	Some young men perceived girls as having increased opportunities for education, and attributed girls' lack of education to low motivation or outdated norms passed on from older generations. Other young men noted that boys' education is still favored because it improves family status (unlike girls, who give up the family name after marriage).
Gov't programs	The government encourages and provides support for education through incentive programs, but not everybody can access these programs. Young men were able to name Accredited Social Health Activists/Anganwadi workers (frontline gov't workers) and other programs with greater ease than the young women.

Table 7: Parents' themes (Mothers: n=20, aged 30-65; Fathers: n=20, aged 35-80)

Changing trends	Some parents noted that more girls are going to school and are marrying later, and families are now spacing "three years" in between children. Other parents felt that things were changing slowly or not at all; several expressed traditional gender roles regarding work outside the home.
Education	Parents noted that there is an increased interest in girls' education. Girls are not strictly kept at home as they were earlier. "We want that a girl, like a boy, should have the freedom to study and go out. However, they [the girls] are still watched more closely [by the family] than the boy." Some parents still questioned the benefit of educating girls, because the investment of time and money in a girl's education is lost when she gets married and goes to her in-laws'.
Marriage and education	Parents perceived that education is contributing to marriage taking place at the right age. Fathers want their daughter to study more. If the girl is educated than she can bring knowledge to the family ad make the family proud. They want her to be educated so she can be self-sufficient.
Support aspirations	From the point of view of parents, their children go to different people for support: friends, mother, father, and sister-in-laws (among girls). However, unanimously it was the mother who was given the main role of speaking on behalf of either son or daughter to the husband/spouse.

Table 8: Community influencers' themes (n=19)

Education	Community influencers made associations between higher education and having fewer children, as well as education and the cessation of dowry, if there is work and education.
Gov't programs	Participants were very knowledgeable about program and schemes. Primarily, they discussed the "lack" of programs and schemes that could support families' livelihoods.
Health	Delaying age of marriage and SRH issues easily surfaced. Participants also raised the persisting issues of domestic violence and alcohol.
Work	Unanimously, participants expressed positive views about financial improvement when both individuals in the family work.

Table 9: Trainers/field workers' themes (n=23)

Education	"In the village children would be grazing sheep, cattle, and working in the fields. In the past five years no child is seen grazing sheep. All the children go to school."
Self-confidence / role models	Participants expressed the opinion that young girls are gaining confidence and are not scared to roam in the village and be "teased." Women are seen as taking on work even when the husband is not present. Some participants noted an increased number of women participating in elections and taking on roles such as Sarpanch, District Counselors, and Ward members.
Seeking services	Participants perceive that more women are seeking FP services on their own. Only certain castes are unable to do this.
Negative perceptions	Participants expressed ongoing concerns about unsafe environments, alcohol use, and domestic and sexual violence against girls and women. They also expressed concerns about children not listening to parents and about a great number of them following the urban (modern) culture and not having good judgment.

Knowledge of contraception

According to the community influencers and trainers who participated in the FGDs, awareness of contraceptive methods and SRH has increased overall. The level of education among adolescents influences their awareness of SRH. Mothers of children with positive behavior outcomes pointed out that since the education level of girls has increased there has been a change in their health status. Women are now aware of health care, appropriate antenatal care, and spacing of pregnancy. These services are also more accessible now. Trainers noted that couples and adolescents now seek information on health-related issues from Anganwadi workers, Rural Medical Practitioners, and ASHAs (the village health worker who connects the community to government schemes and free services).

Perceptions of changing trends in equity in education, delayed marriage, and small families

Many participants shared the view that the situation in Bihar is changing in terms of education, delayed marriage (meeting the legal age of marriage), and small families. Previously, parents got their daughters married early, sometimes even before puberty. Now, participants observed that there has been a significant change in girls' age at marriage and that families are seen as happy now with only two (maximum three) children, even if they do not have a boy. Participants also linked delay in marriage to health benefits and childbearing; they were able to articulate that women and children are healthier if they wait until they are the "right age" to marry. Some participants attributed the changes in the age at marriage to the PRACHAR program.

> *Now parents get their daughter married at 18 years of age…Before, marriage would take place earlier than 18 years to get rid of the responsibility of marriage.* —Community influencer

> *There has been a change due to PRACHAR; earlier girls were married at an early age. Now, girls are married after they are 18 years old and boys after they are 21 years old. This has led to an improvement in health.* —Young male participant

Education was noted as a major catalyst for bringing about this transformation. Participants noted that the educational status of both men and women has shifted over the past five years, favoring advancement for women. Both boys and girls are now staying in school for longer periods than they did in the past. Girls are increasingly allowed to go out, attend school, and work outside the home.

A lot of change has taken place; girls want to study. Earlier she would not be allowed to study. Now she fights with her mother to study and she is allowed to study as well. So haven't changes taken place? —20-year-old married female participant

There has been a change, especially in education. If I have my education, I can take a job. Parents are encouraging for girls to stand on their feet. —Young married female participant

There has been a lot of change in 5 years. Earlier parents would not send their daughter out; the parents felt that she had to stay at home for the sake of honor/ dignity. Now [the daughters] go out openly. —Community influencer

Participants mentioned that education of girls can be an effective tool to fight against dowry and help girls become financially independent. Parents, especially those whose children exhibited positive behavior, said that they educate their daughters to enable her to get a good job and be financially independent, so that she can fend for herself.

They [the girls] *talk about studies, what kind of work they want to do according to their interests. If they have an interest in a particular work, then we advise them. All people in the family give advice and support. If you want to make* [them] *successful, then the responsibility is on everyone.* —Mother (of adolescent in positive behavior group)

One advantage of education is that marriages are taking place at the right age. When my daughter passed her matric I told her to study further, that is why it helped with the age of marriage. —Father (of adolescent in positive behavior group)

The PRACHAR program was credited with helping to raise awareness about the importance of girls' education. Some participants noted that young men have become advocates for girls' education.

Our society has put on a blindfold when it comes to women. To remove this blindfold, your organization [PRACHAR] *and the government have helped in bringing improvement, because of which there has been awareness among women. Their generation and their children will be educated as well.* —Young male participant

Both [boys and girls] are equal, but we have to change the thinking of the parents. Boys are given the freedom, but girls did not have this exposure. Now boys are changing the thinking of the parents to let the sister go [to school]… —Young married male participant

Participants shared their opinions on the role of existing governmental schemes in Bihar, such as the Sarva Shiksha Abhiyan[6], in girls' education. Some government schemes such as *Mukhyamantri Balika Cycle Yojana,*[7] *Kasturba Gandhi Yojana,*[8] *Mukyamantri Aksharanchal Yojana,*[9] and the National Program for Education of Girls at Elementary Level (NPEGEL)[10] provide incentives for educating girls. Participants pointed out that incentives offered by the state government have helped poor families educate their sons and daughters, although awareness of and access to these schemes are limited in some cases.

Participants noted that trends in education and age at marriage have associations with parental resources and socio-economic status. Parents with less education appeared to still favor sons' education

[6] *Sarva Shiksha Abhiyan (SSA) or* the *'Education for All'* Movement, is a flagship program of the government of India for universalization of elementary education as fundamental right, making education free and compulsory to children of ages 6–14.
[7] *Mukhyamantri Balika Cycle Yojana*, the Chief Minister's bicycle scheme for girls, was launched in 2007-08. The scheme entitled girls completing 8+ years of education to a free bicycle from the state or Rs. 2,000 to buy one.
[8] *Kasturba Gandhi Shiksha Yojana* is a program to establish residential schools for girls in districts with low female literacy rates.
[9] *Mukhyamantri Aksharancal Yojana* is a program in Bihar intended to make 4 million illiterate women literate in one year.
[10] NPEGEL was designed to provide additional support for elementary education of underprivileged and disadvantaged girls .

over daughters', but responses indicated that even among these families this trend is changing and is mainly influenced by financial need. Participants mentioned certain segments of the population in which they thought social change was slow. These communities were identified by their sub-caste and were economically deprived (e.g. Manjhi, Dome, Musahar, Chamar, and Pasi). Most individuals from these groups live in extreme poverty, are landless, and work as daily wage earners. These communities are perceived as lacking awareness, education and ambition, and slow to change in terms of gender norms.

> *[For] girls who are educated or families where there are educated people, the decision [about marriage] is taken by the girl. But in households where people are not educated… regarding marriage still decision is not taken [by the girl].* —Trainer

> *Changes have come in people from our strata but if you go in the interiors you will see that girls and boys are getting married at the age of 14 – 15 yrs.* —Community influencer

Agency and decision-making

Doors are opening for women in terms of education and work, but patriarchal norms are deeply rooted. Some participants noted that women still have little agency in marriage and childbearing; the wishes of the extended family prevail (predominantly her in-laws and husband). However, young women felt that with education, women's negotiating power and skills increase. Often an educated young woman can work around individuals in the family and gain access to contraception. Independently deciding the age of marriage was still difficult, but not insurmountable, for adolescent boys and girls (though less so for boys). Both young women and men said a positive trend was that prospective grooms and their parents preferred brides with some education.

Participants commented that adolescents are generally able to communicate their aspirations and concerns to parents or peers, depending on the issue. For example, if something about school or work is bothering them, they talk about it with their mother, father or a trusted adult. The mother is the central person through whom adolescents generally communicate with the father; she informs the son or daughter of the father's verdict on the matter under discussion. Young female participants pointed out that they feel comfortable communicating their aspirations or discussing sensitive issues with their mothers or elder brothers' wives (*bhabi*). Similarly, young married women also discuss issues related to health with their husbands. Some participants expressed the opinion that women are more courageous now—they stand up to their parents and spouses regarding education, marriage and childbearing.

> *I have seen many boys and girls who tell their father that they will not marry now. [They say] I have to study now…I will not marry till I stand on my feet.* —Father (of adolescent in negative behavior group)

> *We are ready to marry our girl, but she says no, I want to study further. She puts it off till B.A. and now she says that first she'll complete B.A. and then marry.* —Mother (of adolescent in positive behavior group)

> *I tell my mother-in-law that I have a son and a daughter; I will get myself operated [sterilized]. My mother-in-law says, 'have one more,' so I have told her I cannot take care of another child… these two are enough.* —Young married female participant

Despite the positive trends observed in girls' agency and decision-making, several participants commented that dowry, lack of education, and poor support from law enforcement agencies still prevent young women from deciding when to marry. There is a strong economic incentive for early

marriages, as less dowry is demanded. Individually speaking, young women and men both expressed a wish to marry at a later stage, but noted there that there are societal constraints. Young female participants added that communicating their wishes and exercising their agency becomes difficult when their parents are uneducated. For young men, lack of employment opportunities or poor health of a mother often pushes them to marry and thus get extra help with household and agricultural work.

Gender roles and responsibilities

Participants discussed their perceptions (not necessarily individual practices or experiences) on gender dynamics in and outside of the household. More specifically, the participants expressed their views on gender roles, responsibilities of women and men, and differences in aspirations for boys and girls. Both young female and male participants felt that women were capable of balancing domestic chores with pursuing higher education or working. Women are seen as being able to carry out both household duties and outside work, sometimes leading to a 'double burden' of responsibilities.

> *There is no work that a boy can do and a girl cannot and there is no such area where girls are not performing equally well.* –Young male participant

> *Nowadays girls are doing household work, but apart from that, in my community most of the girls are studying. We are studying, we do household work, and also take care of other responsibilities*. –Young female participant

However, many participants still viewed men as the primary breadwinners, protectors, and controllers of household finances. Parents of young women and men adhered to patriarchal notions of gender roles, indicating that women should cook and look after children and men should work and earn a living.

> *I have a shop, if I sometimes take care of housework and shut the shop, she says 'you look after the shop I will take care of the house work.'* –Married male participant

> *My family believes that a girl should do household work and a boy should go out for work. Boys cannot do household work.* –Young female participant

> *A son doing a daughter's work [domestic chores]? Never!* –Mother of participant

Participants indicated that there are still barriers to women working outside the home, including requirements for permission from husbands and in-laws. It is more acceptable for a single woman, whose husband has left her or died, to go out to work to provide for her children. Nevertheless, a young woman would not be allowed to shift residence in order to take up work.

> *People point fingers and say the family is living off the income of their daughter or daughter-in-law… A married woman can work only if she has the support of husband, mother-in-law, and other working women of the village like Anganwadi workers, who work in government-run childcare centers in the village.* –Young male participant

Interestingly, when asked about aspirations for themselves or their children, participants' responses reflected a more gender-equitable perspective. Young women said that they wanted to achieve higher education and work outside the home, and that both women and men should work. Young men shared similar aspirations for education and work, as well as marriage. Parents advocated for equal treatment for boys and girls; they wanted girls to study and work, to stand on their own feet and be self-sufficient.

Perceptions on sexual and gender-based violence

While PRACHAR's training did raise awareness of SGBV and actions that girls and boys could take to help prevent it (respecting their spouses' opinions and decisions; striving for informed, joint decision-making

that is mutually respectful and avoids confrontation), participants acknowledged that SGBV still persists in the community and that most of the physical violence occurs during alcohol use. Inferences on SGBV were made around women's inability to conceive or if she conceives more girls than boys.

> *Like if any woman conceives more girls then violence occurs, to prove her wrong...If a woman is incapable of conceiving, then violence takes place. Another woman is brought in her place and gets married to him. This happens here.* —Field worker

Participants mentioned that other harmful practices such as polygamy, dowry, and female feticide are still accepted. Across all groups, participants consistently noted a lack of accountability when an underage girl is married off. SGBV is thought to be highly prevalent in remote, interior areas where education is not available and girls lack agency and mobility. Participants mentioned that female feticide has decreased, but nonetheless is still happening, particularly among the lower castes.

> *It can be regularly seen in newspapers that a girl was killed or burnt for dowry. That is why we can see that people don't focus on marriage and instead focus on education so that she can take care of herself and she is independent and her in-laws cannot torture her. If she stands on her feet, nobody can bother her…So they believe that if she does her graduation, she need not listen to anybody.* –Young female participant

PRACHAR's role

Findings from the qualitative study suggest that PRACHAR did indeed play a significant role in facilitating a transformation in the perception of girls' education, age at marriage, and SRH among adolescents and other community members. Most young participants could recall the topics covered in PRACHAR's training program. Moreover, even after several years of being exposed to PRACHAR messages, participants were able to relate the appropriate age of marriage for young women and men and its positive impact on both sexes. They noted that messages also helped to diffuse discriminatory views against women (e.g. countering the preference for a boy child and ensuring nutritional access for a girl child). Parents and trainers also stressed that PRACHAR created awareness about girls' education, delaying marriage, and the use of contraception to delay and space pregnancy.

> *Earlier boys were given all the freedom. After the training, there has been some difference. Earlier they* [girls] *were only supposed to do housework. Only through PRACHAR they learned that both* [sexes] *are equal. Even now girls are studying.* —Young married male participant

> *There was a program [PRACHAR] that told about family planning and health according to age. It was quite good and it should be there for our boys and girls.* –Father (of adolescent in positive behavior group)

VI. DISCUSSION AND HIGHLIGHTS

The secondary analysis of PRACHAR Phase II and AFS data confirms significant behavioral changes in terms of delayed age of marriage and contraceptive use to delay and space pregnancies, behaviors that previously had been difficult to alter due to deeply entrenched social norms. Most of these changes were observed to be significant in the PRACHAR intervention group but not the comparison group, and persisted after adjusting for selected demographic and socioeconomic variables. This is a strong indication that the PRACHAR program contributed to these behavior changes. While the data collected under PRACHAR does not fully illuminate how shifts in gender attitudes and norms contributed to these changes, the limited data that was collected points to some promising shifts in terms of girls' agency.

These shifts include young women's ability to express desired age of marriage to parents, decreases in young women reporting the need to seek husband's approval to use FP, increased female participation in joint decision-making about childbearing, which was significantly associated with contraceptive use to delay the first pregnancy and space the second, and male involvement associated with increased condom use to delay or space pregnancy. Furthermore, PRACHAR participants' knowledge of SRH-related gender issues improved between baseline and endline of the project.

PRAGYA's qualitative research sought to better understand the contributing factors to these behavioral changes, specifically looking at changes in gender outcomes such as girls' agency, mobility, support of family, and increased access to education and social schemes. Due to limitations of the methodology, as noted earlier, we were not able to elicit individual changes in gender outcomes, but rather participants commented on general trends in their communities. This explains why there was little difference between the responses of participants' that exhibited positive and negative behaviors.

That said, the results of the FGDs overall offer a positive outlook on trends in young women's and girls' betterment in society, particularly in the area of education. Across all FGDs, the perception is that young women are advancing in education. Groups express the opinion that there is less discrimination against girls and that parents are more likely to see the benefit of young girls being educated and gaining financial independence. However, despite recognizable changes, deep-seated cultural barriers about gender roles, marriage and childbearing remain a huge challenge and are seen by some as unchangeable. Dowry, financial hardship and the lack of legal action against early marriage continue to be the main reasons that girls are married earlier than the legal age. Early marriage occurs disproportionately among vulnerable, disadvantaged groups (castes and tribal categories designated by the government as 'backward', impoverished families in rural areas, and others with limited resources), and continues to be associated with SGBV.

In comparing views between positive behavior and negative behavior sub-groups, both groups pointed to similar factors that hinder delay in age at marriage and attainment of higher education for girls. Both groups made reference to poverty and family or village pressures as the main reasons why girls marry early, which, in turn, prevented both daughters and, occasionally, their sons from pursuing further education. Overall, participants expressed positive views on the importance of educating young women and expressed more gender-equitable aspirations for girls and boys. This implies that PRACHAR perhaps indirectly transformed, to some degree, gender attitudes that support women—a step towards gender equality. Moreover, even several years after having had direct exposure to PRACHAR interventions, young women and men were able to articulate the legal age of marriage and its positive impact for girls and boys. SRH-related gender messages also provided direction in diffusing the discriminatory views against young women (i.e. countering son preference, improving educational access for girls, and participation of women in joint decision-making on FP).

These changing attitudes, however, contradict what young people and their parents actually do in some cases, especially those that are the poorest and least advantaged. In the village and surrounding areas, culture, poverty, and finances, still influence to a large degree what people do—women work in the house, and men go out and work. Traditional patriarchal gender roles are still entrenched across sectors. For example, women and men report that fathers or male guardians are the decision makers, as seen in numerous studies. Overall, women are still perceived to have very little authority in the household, but, when offered some level of power, they are the central person that serves as mediator, negotiator, and supporter of educational attainment, as has been demonstrated for health attainment (Maitra, 2003).

It is interesting to note that among the young women who exhibited positive behavior change, there seemed to be a stronger sense of self-confidence and ability to speak to the mother about her hopes and aspirations for education and work. Similarly, the parents showed openness and willingness to

listen; however, financial circumstances appeared to inhibit their ability to support their daughters' aspirations. Consequently, even among the young women who managed to delay marriage and space pregnancy, stopping school and work was generally accepted as a given.

Per this study, several issues need further attention. These include: 1) persistence of patriarchal notions of gender roles and responsibilities; 2) young girls and families excluded from opportunities due to geography and lack of access to information and services; and 3) lack of accountability on the part of local elected leaders to enforce laws and ensure access to programs. Both the secondary analysis and qualitative research also identified elements that should be considered in future programming:

- The inclusion of gender synchronized approaches, based on the results that showed the importance of reaching both sexes, to effect change in gender and SRH outcomes.
- Supporting multisectoral programs that prioritize girls' education as a path to delayed marriage, increased autonomy and agency, better FP/SRH outcomes, and a brighter future.
- The importance of reaching gatekeepers who have tremendous influence over young people's decision-making. In particular, programs and policy targeting young people should, ideally, inform the mother, as well as the men in the household. Trainers also suggested that *Pandits* and *Maulavis* (Hindu and Muslim priests) who perform wedding ceremonies and community elders be sensitized to issues related to early marriage so that they can put social pressure on families to stop early marriage and perhaps commit to not performing underage marriages.
- The use of influential role models who have completed school and can demonstrate the associated benefits, as a critical pathway to counter societal and familial pressures. For example, parents and influencers stated that they would refer to individuals who are going to school as precedents for supporting daughters to go outside the village.
- Increasing access for those most disadvantaged to government programs and schemes.

VII. RECOMMENDATIONS

Evidence shows that FP/SRH programs that enhance gender equity and equality are more effective at sustaining positive health outcomes. While it is not always necessary to define separate gender objectives, FP/SRH programs will benefit from making a commitment to gender equity and equality by addressing gender roles and identities in intermediate results and activities (Caro et al., 2003). In PRACHAR, the gender accommodating and transformative elements appear to have contributed to delayed age at marriage and specific SRH results, such as delaying and spacing pregnancies. Increased capacity of women to participate in decision-making, and male involvement in FP, were found to be significantly associated with increased contraceptive use. A gender-integrated and multisectoral approach that includes additional gender transformative or gender synchronized approaches and life skills would help sustain these positive SRH outcomes.

Stakeholders can apply PRAGYA's recommendations at various points in their work with women and girls, in particular in SRH interventions and programs that aim to delay marriage and establish multisectoral linkages. A multisectoral approach promotes synergy between different sectors, often combining health services with interventions that address women's economic empowerment, literacy, political participation and mobility. Through a multisectoral approach, many barriers can be addressed to confront women's disempowerment and the complex factors leading to poor SRH (Caro et al., 2003). The following are specific recommendations from this study for future interventions and programs:

Programs and interventions

- Conduct baseline and end line assessments of gender norms and behaviors, as well as RH/ FP behavior, at the individual and community level.
- Involve household- and community-level decision makers in programs targeting young women. Specifically: empower mothers and mothers-in-law, who often serve as mediators between children and their fathers; raise awareness of the importance of health and empowerment strategies for young women (and men); and raise parents' awareness of the importance and benefits of educating their daughters and avoiding early marriage.
- Strengthen delivery of gendered SRH interventions coupled with education and economic empowerment interventions. Specifically: increase girls' accessibility to education in local settings, including facilitation of school enrollment and retention; draw on role models in the villages and positively reinforce educational achievements (e.g. celebrating graduations); mandate life skills programs for girls in school curricula; and incorporate a livelihood skills-building module into SRH training.
- Implement developmentally appropriate SRH training for youth that emphasizes increased agency for girls in asserting and acting on aspirations for education, work, and marriage.
- Design program activities that respect cultural preferences and practices (e.g. in remote areas where it may not be acceptable for girls to attend program activities outside the home), gradually shifting from a gender accommodating approach to one that improves girls' rights, equity and mobility.
- Build capacity of staff to integrate gender into SRH and multisectoral programming.
- Create rights based programs for girls in rural areas, stressing that early marriage violates girls' and boys' rights, harms their health and hinders advancement. Promote programs that alleviate intergenerational poverty, which perpetuates the cycle of early marriage and poor health.

Policy

- Increase financial allocations to support programs to reach youth, in particular unmarried adolescents, and monitor these closely to ensure they reach intended target groups.
- Promote accountability measures within law enforcement to uphold legislation and enforce legal age of marriage.
- Strengthen community mechanisms to monitor and hold local governance bodies and individuals accountable.
- Support and encourage capacity building of civil society, media, and government to improve their understanding and commitment to addressing gender inequities.
- Develop and strengthen socio-culturally appropriate SRH policies and programs promoting women's empowerment and gender equality, cultivating political and administrative will to bring about improved gender outcomes.

Research

- Continue to invest in research to build evidence on SRH, education, and economic development, and their intersections and impact on young women.
- Develop operations research studies to plan, implement and evaluate gender-integrated multisectoral SRH programs for young people that include gender synchronized approaches to shift gender norms and power relations. Evaluate gender and SRH outcomes of these programs, including measurement of individual and community changes in gender norms and behaviors.

VIII. CONCLUSION

PRAGYA attempted to explore the extent to which PRACHAR's limited gender accommodating and transformative elements affected the SRH knowledge and subsequent behavioral outcomes of young women and men in Bihar. Findings from the quantitative and qualitative studies are encouraging and suggest that PRACHAR has indeed had both direct and indirect positive outcomes. PRAGYA found that in PRACHAR's intervention areas, adolescents' knowledge of SRH—particularly that of unmarried girls—had increased. Moreover, the study found evidence indicating that more girls are remaining in school, delaying marriage until 18 years of age, and having children at 21 years. The secondary analysis of data clearly establishes linkages between the SRH outcomes and gender accommodating approaches of PRACHAR, change in knowledge of SRH issues and SRH-related gender issues, access to schools and government schemes, and family and community support to beneficiaries to participate in the intervention programs. FGDs with community members, young men and women, and parents indicated that parents were more amenable to sending their daughters to school. Discussions with the participants also reflect the pivotal role of Bihar's educational policies in motivating and encouraging girls to attend school.

PRAGYA has expanded our understanding of how gender-sensitive programs like PRACHAR are effective in reaching adolescents and young married couples to achieve better SRH outcomes. Indeed, PRACHAR indirectly transformed, to some degree, gender attitudes that support women—a step towards gender equity and equality. However, realizing a fundamental change in gender norms and women's agency will require long-term, continuous gender-integrated and multisectoral programming. This would require a shift not only in programming but also in donor support and multisectoral coordination. Funding for SRH must include tangible support for integrating gender components into SRH programs and ideally extend funding cycles, as significant changes in gender norms are rarely achieved in a few years. In addition, efforts on the part of all stakeholders, including different sectors of government, funding agencies and implementing partners are needed to make sizeable progress toward reaching the MDGs.

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ANNEX I – Key differences between Phase II and III

Phase II	Phase III
Phase II tested several intervention approaches to determine the extent to which behavioral outcomes were linked to duration of intervention; impact of selected activities on behavioral outcomes through a.) home visits, b.) training, and c.) volunteers.	Based on evidence from Phase I and II, PRACHAR Phase III will use only the newly identified, most essential and effective approaches to youth fertility reduction and improved health status in terms of reduced maternal and infant mortality.
PRACHAR Phase I and II were implemented only by the NGOs and included: home visits to young married women conducted by female change agents; group meetings with young married men conducted by male change agents; training of adolescents conducted by NGO training partners; cultural programs (street plays) on SRH/FP issues performed by NGO performers and communicators; and capacity building of partner NGOs in SRH/FP programming. Access to SRH/FP services and products was improved in collaboration with government health infrastructure, social marketing agencies as well as with local retailers.	PRACHAR Phase III will test the PPP (public private partnership) model in Gaya district. Government frontline health functionaries – ASHAs will serve as change agents and conduct home visits to talk with young married women and to mobilize adolescents; male coordinators (NGO supported) will conduct group meetings with men; NGO supported trainers will train unmarried adolescent boys and girls
Evidence from PRACHAR Phase II was used to advocate for the PRACHAR model as an effective youth SRH/FP communication program to address the issue of population momentum.	Advocacy for Phase III was present from the outset. At the state level, through the Project Steering Committee chaired by the Executive Director of the Government's State Health Society, the project will engage key influential policy makers. At the national and international levels, in a series of forums, events, and presentations we will make the case for PRACHAR with policy makers, government agencies, and the general public, calling for urgent, increased attention to programs that address youth SRH and fertility, and to effectively allay the often expressed fears that youth SRH programs are neither effective nor scalable.

ANNEX II – Young women and men socio-demographic comparison by behavioral outcome

Young Women	**Positive Outcomes**	**Negative Outcome**
Age	Mean = 21.4 Range = 18 - 27	Mean = 20.8 Range = 16 - 26
Education	Mean = 7.6 Range = 0 - 15	Mean = 4.8 Range = 0 -12
Marital status Married Unmarried	 n = 12 n = 18	 n = 29 n = 0
Age at marriage	Mean = 18.9 Range = 15 - 21	Mean = 16.7 Range = 10 -20
Have children	n = 5	n = 21
Income/month	Mean = 83.3 Range = 0 – 1500	Mean = 69.9 Range = 0 - 2000
Total	n = 30	n = 29
Young Men	**Positive Outcomes**	**Negative Outcome**
Age	Mean = 24.9 Range = 20 – 32	Mean = 24.6 Range = 19 -33
Education	Mean = 11.8 Range = 0 - 15	Mean = 9.3 Range = 0 -18
Marital status Married Unmarried	 n = 11 n = 17	 n = 26 n = 1
Age at marriage	Mean = 22.2 Range = 21-26	Mean = 19.4 Range = 19 -23
Have children	n = 6	n = 19
Income/month	Mean = 1611 Range = 0 - 9000	Mean = 1889 Range = 0 - 12000
Total	n = 28	n = 27