Promoting Change in the Reproductive Behavior of Youth
Pathfinder International's PRACHAR Project, Bihar, India
For nearly 50 years, Pathfinder International has been a leader in bringing Reproductive Health and Family Planning (RH/FP) to poor and underserved communities around the world. Pathfinder believes that reproductive health is a basic human right and that when women and men are given control over their reproductive lives through knowledge and access to quality family planning, they gain the ability to significantly improve the health and welfare of their families and communities.

Pathfinder supports communities and individuals in learning to make responsible choices about their reproductive lives. Representing more than 50 percent of the developing world’s population, adolescents and youth are the focus of many projects, as their reproductive choices will influence coming generations. Pathfinder has always promoted maternal and child health care and works to prevent unsafe abortions by making sure that everyone has access to quality family planning methods.

Pathfinder in India

Pathfinder International has been working in India since 1999. Current programs are located in urban slums and rural areas of five states across India, including Delhi, Bihar, Rajasthan, Maharashtra, and Karnataka.

Promoting Change in Reproductive Behavior

In a culture with long-standing traditions of early marriage and childbearing, Pathfinder works to promote knowledge and understanding of the dangers of adolescent childbirth, the personal health benefits of delaying the first birth until a woman reaches age 21, and spacing subsequent children by at least 3 years through initiatives funded by the David and Lucile Packard Foundation and the Bill and Melinda Gates Foundation.

Combating HIV/AIDS

Pathfinder International integrates HIV/AIDS and sexually-transmitted infection (STI) prevention, care, and support with its reproductive health programs in India, focusing especially on high prevalence districts of Maharashtra. With the generous support of the Bill and Melinda Gates Foundation, this project prevents the transmission of HIV/AIDS and STIs through behavior change communication, STI treatment, voluntary counseling and testing, and supporting vulnerable groups to adopt safe behavior. Interventions address mostly sex workers and their clients.

Access to Safe Abortion

With support from an anonymous donor, Pathfinder works in selected districts of north Karnataka to improve access to safe abortion services. Primary care practitioners are trained in the use of manual vacuum aspiration and medical methods for first trimester abortions. Community-based communication activities for women increase their awareness of issues related to safe abortion and enable them to seek services early on from qualified providers.

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Executive Summary

In 2001, the David and Lucile Packard Foundation generously funded Pathfinder International to conduct a three-year project in Bihar, India, designed to significantly improve the reproductive behavior of adolescents and young adults. Called "Promoting Change in Reproductive Behavior in Bihar" (PRACHAR), the project took to scale successful approaches that had been developed in an earlier project funded by the Bill and Melinda Gates Foundation. PRACHAR was designed to reach a large proportion of the population in three districts of the state of Bihar and to change beliefs, attitudes, and practices among adolescents, young married couples, and parents and influential adult figures in these communities.

PRACHAR's long-term goal was to improve the health and welfare of young mothers and their children by changing traditional customs of early childbearing. By delaying the first child until the woman is 21 years of age and spacing subsequent children by three to five years, communities could benefit from a significant drop in maternal and infant mortality rates, and from improvements in the survival and general health of mothers and children after later pregnancies.

To achieve substantial cultural and behavioral change, a wide spectrum of the community had to be actively engaged in the conversation. They had to be reached with messages and information in culturally sensitive forms, and in language appropriate to local levels of education delivered by trusted and respected members of the local community.

Through a group of 30 local non-governmental implementing partners, Pathfinder conducted trainings, community group meetings, and events directed at the following:

- Adolescent girls between 12-14 years of age received training about puberty, menstruation, personal hygiene, and nutrition.
- Adolescent girls and boys between 15-19 years of age received information about reproductive health, family planning, sexually-transmitted infections (STIs), HIV/AIDS prevention, and the importance of delaying childbirth and spacing subsequent children.
- Newlywed couples, who had not yet had a child, received information about delaying and spacing children, as well as responsible planning for family life.
- Young couples with only one child received information about spacing subsequent children.
- Families of young couples, especially the mothers-in-law, received messages about the health and economic benefits for young couples who delay first births and space subsequent children.
- Respected elders and community leaders with influence received messages similar to those directed at families of couples.

In addition, villages were visited once every six weeks by Pathfinder-trained Cultural Teams, who presented plays, songs, and puppet shows dramatizing the hazards of early childbearing and promoting the advantages of family planning and child spacing.

Results: The program was widely accepted in the 452 villages where it was implemented. A rigorous monitoring system allowed Pathfinder to track the frequency and effectiveness of project activities and interventions, as well as key family events such as births, deaths, marriages, and pregnancies. It also enabled measurement of changes in contraceptive use. Extensive project data reveal:

- The PRACHAR Project has reached more than 90,000 adolescents and young adults with information on key issues in RH/FP.
Introduction

In July 2001, Pathfinder International/India launched Promoting Change in Reproductive Behavior (PRACHAR), a comprehensive project aimed at improving the reproductive health status of adolescents and young adults in Bihar, India, and the demographic situation related to youth. With the generous support of the David and Lucile Packard Foundation, this effort has succeeded in bringing about significant change in the knowledge, attitudes, and behavior of more than 90,000 youth and 100,000 parents and community members, reversing many practices in one of the poorest and most conservative communities in the country.

Pathfinder’s PRACHAR Project grew out of an earlier three-year project funded by the Bill and Melinda Gates Foundation, which had similar goals and provided many lessons for its successor. PRACHAR took the approaches and lessons learned in the earlier project to scale in Bihar, where it was launched in three phases over the course of nine months (July 2002–March 2003) in the districts of Nalanda, Nawada, and Patna. With each new phase, revisions and improvements were made in accordance with lessons learned.

Objectives

Despite acknowledged challenges involved in promoting social and behavioral change among youth, the scope of reproductive health problems among India’s burgeoning population under the age of 25 demands urgent action. Pathfinder designed the PRACHAR program to achieve a series of very specific objectives, which—if attained—would have a major impact on the overall long-term status of RH/FP in Bihar. These objectives were to:

• Change the beliefs held by young people between the ages of 12 and 24 regarding RH/FP, challenge traditional behavior patterns of early childbearing and inadequate spacing between children, and promote informed and healthy reproductive behavior.

• Change beliefs held by parents of adolescents and influential community adults about RH/FP, provide them with knowledge and education to discourage early marriage of their daughters, curb the pressure that they place on young couples for early childbearing, and encourage adequate spacing of subsequent children.

• Increase the use of contraceptives among young married couples, particularly to delay the first child until the mother is mature, and to space subsequent births by at least 3-5 years.

• Enhance the capacity of 30 non-governmental organizations (NGOs) in Bihar to design, implement, and monitor quality RH/FP programs.

• Enhance the quality of basic maternal and child care, reproductive health, and family planning services delivered by community-based traditional birth attendants (dais) and informal rural medical practitioners (RMPs).

The Intervention Approach

Bihar’s extreme poverty and high levels of illiteracy and unemployment reinforce a deeply conservative social system. The majority of the population has had little or no contact with the formal health care sector. Pathfinder realized that to have any significant impact on social norms, a number of factors had to be considered and addressed:

• All project staff would have to be thoroughly educated in reproductive health and issues of sexuality, to the point where they themselves were comfortable talking about them and could answer questions with expertise and authority.

• More than 100,000 parents and other community adults received similar messages aimed at building wide social acceptance for the ideas of delaying and spacing children.

• The percentage of the population (all respondents) who believe that contraception is both necessary and safe increased from 38.3 percent to 80.8 percent. Among unmarried adolescents, this figure increased from 45.3 percent to 90.5 percent.

• The interval between marriage and first birth for newlyweds increased from 21.3 months to 24 months.

• The percentage of newlyweds who use contraceptives to delay their first child more than tripled, from 5.3 percent to 19.9 percent.

• The percentage of newlywed adopters who began using contraception within the first three months of the consummation of marriage increased dramatically, from 0.1 percent to 20.8 percent.

• The percentage of first-time parents who used contraception to space their second child increased from 14 percent to 33 percent.

• 30 local NGOs in Bihar were provided with extensive training, supervision, and resources to attain new levels of capacity and sustainability, particularly in maintaining and developing programs in RH/FP.

• Basic RH/FP training of 1,398 traditional birth attendants (dais) and 447 rural medical practitioners (RMPs) has significantly improved both the quality of care provided by locally available practitioners in these rural areas, and the awareness of providers regarding RH/FP issues.

In addition to data from the monitoring system, data on project performance is available from baseline and endline surveys that measured changes in beliefs and attitudes about RH/FP issues over the course of the project. Acceptance by adults and young people in the community that early marriage and childbearing can be injurious to the health of both mother and child increased significantly. Adult recognition of the importance of spacing later children also increased.
The Challenge of Bihar

Of India’s 28 states and 7 union territories, Bihar is arguably one of the poorest and least developed. Lacking effective governance, the state is characterized by widespread poverty, high unemployment, high illiteracy, and limited health care. Among boys, only 14.6 percent in urban areas and 14.2 percent in rural areas have completed primary school, and only 14.8 percent of urban girls and 8.6 percent of rural girls have done the same.1 Health care provision in rural areas is limited to self-styled “doctors” or informal rural medical practitioners, traditional birth attendants (called dais), and some traditional healers. Only 11 percent of children aged 12-23 months have been fully immunized against childhood vaccine-preventable diseases by the government’s immunization program.2 Knowledge of reproductive health and related issues of sexuality is extremely limited. In traditional Hindu and Muslim villages of Bihar, women face extreme economic and social inequality. They are not allowed to make major decisions about their own lives. The median age at first marriage for women currently aged 20-49 was 16.9 in urban areas and 14.9 in rural areas—both well below the legally mandated age of 18. Parents, grandparents, mothers- and fathers-in-law, and neighbors all place enormous pressure on newlyweds to produce a child as soon as possible. In all of India, nearly half of currently married women age 15-19 have had a child,3 and only 13 percent of married adolescents have ever used contraception.4 Cultural norms pressure women to prove their fertility, or they may be abandoned and another wife chosen. Families fear that couples may fail to conceive if child-bearing is delayed. If the first child to arrive is a girl, a second is urgently sought in hopes of having a boy. Although many young couples express interest in delaying childbearing, they take no steps to do so in the face of so many pressures. Unlike most of modern India, communities in rural Bihar continue to maintain a strong identity with caste, which helps to hold the poorest citizens in poverty. About 80 percent of the total population of Bihar belong to the lower castes.5

Ms. Leela Kumari, Secretary, Mahila Vikas Samiti (Women’s Development Association), recounts, “The PRACHAR Project has had an especially big impact on the poorest people of the village—the those from the lowest caste who are all marginalized. They had never thought about the fact that many of their problems are related to reproductive health and sexuality. They always used to think that whatever happened was up to the grace of God, and it was not up to them to disturb His work. Now they realize that they can make real changes in their lives. Young adolescent girls in particular are demanding a better quality of life.”

• All staff working at the community level would have to be residents from that particular community, known and recognized as trustworthy and credible neighbors by target populations.

• Education and behavior change communications (BCC) would have to reach the parents of all adolescents targeted for the program, as well as community leaders and opinion-makers, because young people in this society are very much under adult control and supervision, and leaders carry considerable influence throughout the population.

• To break down resistance to change and establish new cultural norms, the project would have to succeed in changing the behavior of a critical mass of the community.

• Project BCC messages would have to be developed, tested, and repeatedly refined to produce a set of trainings and cultural presentations that address the real concerns and needs of the community in a manner that could be accepted and integrated into the lives of local villagers.

• The screening and hiring of project staff, from managers to community change agents, would have to be painstakingly rigorous to ensure that team members were comfortable with the content and committed to the process.

More than 30 percent of young men in Bihar7 leave families behind and migrate out of their villages to cities, or even out of the state, in search of work. When young men live alone for long periods of time, they are more likely to engage in high risk behavior than if they were at home. They could thus acquire HIV and bring it home to faithful partners when they return. Although the HIV infection rate in STI clinic attendees in Bihar is currently reported at only 1.2 percent8, 35 percent of all HIV/AIDS cases reported in India are among youth 15 to 24 years of age9. Because of the high rates of migration of young men in Bihar, the risks of HIV spreading in the state are serious.

Nearly 60 percent of adolescent boys ages 15 to 17 attend school in Bihar; however, only 34.7 percent of girls ages 15-17 attend school.10 Since most are not accessible through school programs, youth must be reached through community-based programs that are approved by their parents and village leaders. Pathfinder determined that the only way to inspire young men and women to make new decisions regarding RH/FP was to introduce entirely different ideas and information across the entire community. Once leaders, parents, in-laws, and teachers learned of the dangers of early childbearing and the importance to both mother and child of spacing children, the broad community would actively support the PRACHAR Project.

Lesson Learned

Given the limited level of knowledge about reproductive health and sexuality and the strict taboos against discussing these topics, Pathfinder expected to face enormous challenges in getting youth to participate in the PRACHAR program. That concern proved unfounded, for once community stakeholders were brought onboard, young people and adults alike received information about reproductive health that touched their personal lives, and natural human curiosity and the need to know overcame inhibitions. In fact, a profound thirst for knowledge was awakened in young and old alike, which proved to be of incalculable importance for reaching and informing the population in general.
Adolescent Reproductive Health in India—A Neglected Crisis

For more than four decades, the Government of India has actively promoted family planning and contraception, driven by legitimate concerns about population, the environment, and poverty. But for the most part, those efforts have sought to motivate women who have completed their families to end childbearing altogether. Little attention has been focused on the sizeable population of adolescents just entering their reproductive years. Young couples in their peak reproductive years, who need motivation to delay and space children, have not received much guidance on how to ensure planned, happy, and healthy families. In addition, FP programs have historically targeted women, neglecting the important role that men play in decision-making about having children.

Today, India is home to approximately 18 percent of the world’s youth between the ages of 10 and 24.11 Thirty-six percent of the population is below the age of 15.12 Among women between 15 and 19, 16 percent already have a child (and half of those who are married already have a child).13 Infant mortality in children born to adolescent mothers is 92.7 percent compared to 67.6 percent across all age groups.14 The high value placed on fertility reduces concern for the mother’s health, and this is evident in India’s tragically high maternal mortality rate of 540 per 100,000 births15.

The conservative culture of Bihar provides a false sense of security about sexual activity outside of marriage. With high rates of migration of young men to India’s urban centers, and given the high infection rate among young women, Pathfinder finds it essential to integrate HIV prevention training into all programs with adolescents and young adults.

Despite the fact that many young women die or lose a baby in childbirth, the connection between mortality and the physical immaturity of the woman is not easily drawn. As in many traditional cultures, people are fatalistic, attributing life’s events to God’s will or an evil spirit. Where life has changed little over the centuries, people feel no control over what happens to them—least of all over preserving life itself. The concept of allowing several years to pass between children is completely unknown and the connection not made between the time of the last pregnancy and the failure of mother and child to survive or thrive.

With government programs focused primarily on older women at the end of their reproductive lives, the true concept of “planning a family” is overlooked. PRACHAR programs introduced young couples to the concept of molding their own lives by working together to build a strong spousal bond and partnership at the beginning, planning their families, and building a financial base before taking on the responsibilities of childbearing. Armed with information about RH/FP and compelling reasons for delaying and spacing their children, they are prepared to withstand social and family pressures and take advantage of resources to prevent pregnancy.

Pathfinder has targeted adolescents in Bihar not only because of the absence of comprehensive RH interventions for this age group, but also because they represent an important opportunity for long-term, widespread development. If young adults delay their families to establish partnerships and save the resources needed for their children, they will launch their lives on a more secure footing than did previous generations. Their children will be healthier and their incomes more secure, giving them greater chances to move out of poverty.

PRACHAR—The Program

Changing the Behavior of a Critical Mass

Pathfinder sought to promote major attitude and behavior changes in youth—as well as their parents and influential community members—related to delaying a first child and spacing subsequent children. The hypothesis underlying program implementation was that if at least 80 percent of the members of each primary target group were reached with appropriate and understandable messages, it would maximize the chances of changing the beliefs and behavior of at least 20 percent of the members of these groups. The conversion of this critical mass would ensure that the new beliefs and behaviors would be sustained and continue to grow in the community.

By project’s end, this goal of coverage and conversion had been achieved, as a full 95.9 percent of the planned beneficiaries had been reached with specific messages, and an impressive 70.1 percent of targeted populations had undergone some level of training. The contraceptive use rate among young married women increased nearly four-fold, from 9.7 percent to 38.1 percent in three years. Although the project had been implemented throughout this period, the progress was achieved in an average of just 18 months per district.

Pathfinder developed the PRACHAR Project with the conviction that all members of the community—though conditioned to shun discussion of reproduction and sexuality—have a personal interest in learning more about their own reproductive lives and could see the compelling relevance of family planning and child spacing to their own lives. They could accept it and be supportive, if the information were presented to them in a respectful, appropriate, and credible way.

Lesson Learned

At the outset, project staff thought that adolescents, mothers-in-law, and others in the community would be offended by open discussion of human reproduction and sexuality. These fears were unfounded. Once the staff overcame their own inhibitions, and learned to initiate a conversation and effectively communicate on these issues, barriers melted. Staff did need extensive training, discussion, and role play before they acquired these essential skills; but were eventually able to speak about sexuality with clarity, comfort, and conviction. Their demeanor then set the tone for everyone else.

Structuring the Implementation Process

Phased program implementation began in Nalanda District in June 2002, followed by Nawada in September of that year and Parna in March 2003. These three districts were chosen for ease of access from Patna (where Pathfinder was located), their proximity to each other, and because they had a sufficient number of local non-governmental organizations (NGOs) with which Pathfinder could partner. These districts were no less needy than more remote districts, and Pathfinder anticipated that access and proximity would be key to ensuring close management and monitoring of the project. With strong monitoring and evaluation mechanisms in place from the outset, each launch was improved with lessons learned in the districts where implementation had begun earlier.

The overall population of the 452 villages where the project was implemented was 536,803, with a primary target group consisting of 96,241 adolescents and young couples. Community-
Manti Verma stands out among the women of her village as a role model for success and determination. She has always wanted to help her struggling neighbors. Married at 11 to an older man, she struggled herself to achieve enough independence to remain in school, get work with an NGO, and ultimately, start her own local NGO for women.

"Everywhere I go now," says Manti, "people are asking for more and more training. From government leaders to mothers to married couples, they all want to learn more about family planning and their own reproductive lives. I remember how hard it was to get mothers-in-law to come to meetings, but when they saw the large crowds, they began to listen." Village members of all ages now come to Manti for help and advice. The training and guidance she has received as the director of the PRACHAR-supported program in Bhita, Patna has opened many possibilities for her to expand her work for women in Bihar.

Capacity Building of NGO Partners and Training of Staff

Pathfinder International seeks sustainable results in all of its projects. Basic to that end is a system of partnering with and building the capacity of local NGOs, so that over the long term, they can maintain the gains achieved during the life of Pathfinder projects.

In selecting partners for the PRACHAR Project, Pathfinder initially reviewed documents of more than 165 NGOs, searching for those with experience in implementing RH/FP programs. Few organizations had experience in RH/FP, much less with working on such issues with adolescents. There was a clear need to establish capacity in the region to work with the growing youth population. Desk reviews were followed by site visits to 33 potential partners.

In a region of diminished resources, local NGOs had extremely limited technical and managerial experience. Pathfinder was challenged to choose partners from among the best of the organizations and then infuse them with the commitment, energy, and skills demanded by a project of this scope. Essential selection criteria required partner NGOs to be based in the villages where they proposed to intervene, and they had to have recognition and credibility in those villages. Finally, 19 were chosen to be NGO Implementing Partners (NIPs).

NGOs selected as partners held full responsibility for hiring and managing local staff and implementing community-based interventions. Another 11 NGOs were selected as NGO Training Partners (NTPs), responsible for training all primary target groups in the 452 intervention villages, and for training street performers and informal community-level health care providers.

In a typical village in Bihar, houses are made of a combination of mud, straw, and cow dung. Fewer than 18.2 percent of Biharis have electricity and only 65.7 percent have access to clean water within a walking distance of 15 minutes.16

Partnering with Local Non-Governmental Organizations

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![Manti Verma, Director of Mahila Bal Jyoti Kendra, Bhita, Patna District](image)

Ms. Manti Verma, Director of Mahila Bal Jyoti Kendra, Bhita, Patna District
Training enhanced the professional image of the NGO leaders.

Training on the finance and administrative systems has enhanced computer skills and increased transparency of their organizational systems.

Training on MIES helped to keep track of individual beneficiaries and show results, which enhanced the ability of partners to attract funding from donor agencies.

All NGO Training Partners sent their trainers out into the field every three months to observe and evaluate the performance of the NIP staff that they had trained, to provide on-site technical assistance and guidance, and to identify areas of continued weak performance and future training needs. This was true not just of the trainers who trained NIP staff and change agents, but of trainers of street theater groups and of dais.

Lesson Learned
When selecting partners and staff for an exacting social change project in a region of few resources, the process can be limited by availability of skilled partners and one must glean the best from available prospects. Training and trial field work must pass through many phases. Staff gradually acquired new levels of competence and motivation. Ultimately, those who were successful achieved comfort and commitment. This, when blended with their invaluable knowledge and understanding of community values and customs, made them powerful agents for change.

Recruitment and Training of Change Agents
Following partner selection and the hiring and training of Project Directors, Project Managers, and Project Accountants/Assistants, an intensive process of interviewing and hiring was conducted to identify and hire community members as change agents, who would become key communicators and village level representatives of the PRACHAR Project. One female was hired for every two villages and one male for every four villages for a total of 342 change agents.

Lesson Learned
More female than male change agents were hired in the expectation that one-on-one interviews would be conducted only with women. The need to meet with men individually was not fully appreciated at first, and more intensive coverage of men in the beginning of the project would have strengthened its overall success. Men remain the chief decision-makers in the family, and few women make the decision to use contraception on their own.

The interviewing and review process to hire change agents was again intensive, due to their important role in promoting community participation. Change agents had to be semi-literate, known, and respected. Most were nominated for consideration by local leaders. Building their capacity to learn RH/FP material and to communicate about these issues with sensitivity and cultural relevance was key to the success of the project.

Lesson Learned
The selection of the change agents was a crucial step in developing an effective team that could motivate and encourage villagers. Pathfinder left the hiring to NIP staff, but in hindsight, should have been more involved in helping the partner NGOs develop selection criteria and provide oversight so that rigor was maintained in hiring change agents. Poor change agents proved costly, as they failed to promote community participation and limited the reach of RH education. Behavior change suffered consequently. It was also politically extremely difficult to replace low-performing change agents, as they were nominated by village elders.

At the outset of the project, change agents did not have the skills necessary to lead group meetings with community leaders, parents, in-laws, and couples, and their immediate supervisors from the training partners ran these meetings. However, over time and with training, their skills improved, and many became excellent facilitators. The change agents were the backbone of the project at the community level, which greatly enhanced their community stature and led to wider leadership responsibilities. At the end of the project, the change agents remain as a pool of knowledgeable people—an ongoing resource for younger generations and others to consult.

Community Engagement and Assessment
Meeting with Village Leaders
A large community meeting launched the project in each village. District and village government officials, teachers, landlords, medical providers, and others with community stature—including religious leaders—were invited. Outside government leaders often attended, and in addition to the 70-75 invitees, approximately 150-200 villagers were generally in attendance. This ceremonial project launch, presided over by a district level government official and led by the head of the NIP and their project team, was an opportunity to inform the broad community of the goals of the project, placing special emphasis on the health improvement and long-term family welfare of community youth. The meetings were crucial to community acceptance of the project.

Vinay’s mother is in her 80s. She is very proud of her son and his work for the community, but she adds, “I don’t talk with my friends about family planning and all of that. We are too old!” But, she adds with a smile, “When he brings groups of newlyweds to our home for their meetings, I always bless them.”

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Vinay Kumar Singh, Change Agent in Paravu Village, Bihar, Purna District, with his mother.
Lesson Learned

Community Mapping

Following intensive training in community resource mapping, change agents surveyed the 25-30 villages of their districts covering a population of approximately 35,000 people. Through door-to-door canvassing, they introduced themselves and the project to the community and gathered the names, ages, and other specifics about members of targeted populations: adolescents, about-to-be-married young people, newlyweds, and young couples with one child. They started an ongoing database of births, deaths, marriages, and other significant community events, meeting weekly to consolidate and verify their data with others. This information was crucial for the eventual tracking and motivating of individuals to participate in project activities, as well as to track behavior change as individuals moved from one reproductive life stage and one primary group to another. At final evaluation, measurement of performance against key project indicators was made possible because of this recording and tracking of individual members of primary target groups. Such measurement would not have been possible through only baseline and endline surveys.

Lesson Learned

Familiar with government-conducted surveys, many villagers believed that project change agents were conducting yet another enumeration. This included questions about caste, to clarify their identity, make their role and purpose clear, and clearly separate themselves from government projects.

Lesson Learned

Rural Bihar society remains strongly organized according to the Hindu caste structure. Early efforts at attracting parents to meetings or to support activities soon showed that members of lower castes were strongly influenced by the reactions of higher caste members. Once the higher caste leaders approved of an activity or accepted an idea, others were willing to participate.

Programs with Targeted Populations

Newlywed Couples

A high priority was placed on immediate intervention with newlywed couples to promote their ability to make informed choices about the use of contraceptives to delay the first child until the wife reached the age of 21.

Taking advantage of the celebratory arrival of the new bride to the family and to the village, newly married couples were invited to a felicitation ceremony called “Nav Dampari Swagat Samarat” (NDDS), or “Newly-Married Couples’ Welcome Ceremony”. This new social experience drew important attention to the project and its goals, even as it provoked controversy in some quarters because it challenged local customs of keeping newly married couples out of the public eye. The program was developed by Pathfinder International staff and implemented by the training partner Centre for Communication Research and Development (CENCORED), which recruited and trained a staff and two teams of emcees, hosts, and actors, who worked together to entertain and educate the 8-10 couples at each ceremony. Over the course of the project, 48.1 percent of newlywed couples in intervention villages attended these events.

Initially, some families refused to allow their daughters-in-law to participate. Rumors hinted that the refreshments might be adulterated to affect fertility. Couples were uncomfortable attending an event undifferentiated by caste—coming themselves from a higher or lower caste than others and finding such mingling socially improper. Excuses were made about time constraints or distances to travel, and it was difficult to start events on time, because brides arrived under the escort of their mothers-in-law, while the grooms would show up some time later. Nevertheless, as events were held and reported on favorably by word-of-mouth, more and more couples began to attend with the willing support of their in-laws.

For many young newlyweds, the Welcome Celebration was their first experience eating together since their wedding. Activities attempted to generate new emotional connections. Short plays, games, and couple activities led to discussions of RH/FP, the elements of happy family life, the economics of raising children, and sharing in decision-making. One activity detailed all of the costs associated with having a new baby. Although information focused on health and economic reasons to delay first births and space children, couples also spent time learning to make decisions in a partnership. They were given cooperative tasks to perform together—in some cases their first experience of purposeful collaboration. Skits illustrated how to negotiate with parents or in-laws who pressure them on child-bearing.

A Demanding Job

The more than 340 change agents working on the PRACHAR Project put in demanding 6 day work weeks, often scheduling 100-120 visits per week. At any one time, a village might have 40-50 newlywed couples, 8-10 women with first pregnancies, and another 50-60 women who recently delivered a first child. Change agents were given detailed work schedules in their trainings, as well as careful guidance in how to document important data during each of their visits. They were given honoraria of 1,000 Rupees per month, and males received bicycles to facilitate their travel. Despite encouragement by project staff, most female change agents were not comfortable with traveling by bicycle; however, some women eventually borrowed bicycles from their male counterparts to use in their work.

A few daring women change agents have expressed a willingness to break with social constraints and travel to their villages by bicycle.
Finally, couples received a small lunch-box containing condoms and birth control pills to encourage immediate adoption of contraception. Careful explanations of the different kinds of contraceptives and their use were initiated at the welcome ceremonies and followed-up on in the coming weeks.

Over the course of the project, 3022 couples (63.6 percent of the estimated 4755 newly-married couples) attended the NDSS programs. Each event was attended by an average of 9-11 couples. Peak marriage seasons in Bihar occur in the summer months immediately after the harvest and again during the festival season between October and December, when migrant workers come home. Teams of trainers held 20 to 24 programs weekly over the course of the project.

As a follow-up to the NDSS event, NTP staff visited couples in their homes to present them with framed photographs and to discuss important elements of the messages one-on-one, particularly guidance on contraceptive use. On average, men are about four years older than their wives, and it is not unusual for a man to feel impatient to have children to prove his own virility and establish himself as a father. Male change agents organized group meetings with the husbands for additional discussion and motivation, addressing any lingering misgivings and concerns they might have.

**Pattern of Home Visits**

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Number of home visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly-married women w/o children</td>
<td>1st visit immediately after learning of marriage, 2nd visit two weeks later, 3rd visit four weeks after 2nd, once monthly thereafter until woman conceives or adopts contraception</td>
</tr>
<tr>
<td>First time pregnant woman; fathers w/ 1 child</td>
<td>At least 3 (immediately after learning of pregnancy, 4 weeks later, during 8th month of gestation)</td>
</tr>
<tr>
<td>Husbands of first time post-partum women</td>
<td>3 within 10 days of delivery, 20 days later, 4 weeks later</td>
</tr>
<tr>
<td>Married women with 1 child under 28 months old</td>
<td>Once a month until she conceives her second child or first child attains 28 months</td>
</tr>
<tr>
<td>Contraceptive users</td>
<td>1st visit two weeks after stating the method, 2nd visit two weeks after 1st, 3rd visit four weeks after 2nd, once monthly thereafter</td>
</tr>
</tbody>
</table>

**Pattern of Group Meetings**

<table>
<thead>
<tr>
<th>Target Group</th>
<th># meetings</th>
<th>Meeting objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly-married men</td>
<td>3</td>
<td>Delay first child; use FP consistently; STI prevention</td>
</tr>
<tr>
<td>Fathers-in-law</td>
<td>3</td>
<td>Not to demand early child-bearing; reinforce importance and support delaying first child</td>
</tr>
<tr>
<td>Husbands of first time pregnant women; fathers w/ 1 child</td>
<td>3</td>
<td>Understand need to space births; use post-partum contraception; care during pregnancy; STI prevention</td>
</tr>
<tr>
<td>First time pregnant women</td>
<td>5</td>
<td>ANC; two TT injections; exclusive breastfeeding; colostrum; importance of spacing; regular use of contraception</td>
</tr>
<tr>
<td>Mothers-in-law</td>
<td>3</td>
<td>Not to demand early child-bearing; reinforce importance and support delaying first child</td>
</tr>
<tr>
<td>Mother of 1 infant child (46 days to 28 months old)</td>
<td>4</td>
<td>Importance of spacing; regular use of contraception; avoid abortion</td>
</tr>
</tbody>
</table>

**Lesson Learned**

Isolation, poverty, illiteracy, and lack of access to health care all conspire to inhibit healthy lifestyle changes, even when knowledge has reached a population as a whole. PRACHAR would not have achieved significant success if it had provided information only. But it also provided people with tools: contraceptives and lessons on how to use them, couple and life skills training, follow-up refresher visits, and detailed knowledge about RH and sexuality. These efforts built confidence in the safety of contraception. By demonstrating the connections between FP and economic improvement, the project enabled the community as a whole to make positive decisions about family planning.

Young married women were invited to at least 3 group meetings run by female change agents, while their husbands were asked to attend three sessions run by male change agents. Sessions emphasized the great difference in the survival rate and health of children spaced at least 3 years apart, and pointed out the advantages a mother can offer her child if her attention is undivided during those important early years. The return of fertility and need for contraception within 90 days of delivery were embedded in messages to both husband and wife, as the men play such a crucial role in reproductive decision-making. Although the messages about contraception and its use were the same for both groups, husbands and wives were addressed separately in case sensitive issues surfaced.
Adolescent Girls and Boys, ages 15-19

With the onset of puberty and sexual development, adolescents of both sexes are eager for information about their own reproductive systems and their physical, emotional, and intellectual development. Based on the reproductive health, family planning, and how to make responsible decisions about reproductive health throughout their lives.

The incidence of premarital sex among adolescents has not been documented in Bihar, but the high incidence of HIV among 15-25 year-olds in India signals a need for preventive training. Pathfinder has integrated STI/HIV/AIDS prevention information into all of its older adolescent and young adult programs.

Given the right knowledge and skills, young people can move into their reproductive years fully equipped to plan their families according to their circumstances and preferences, delaying and spacing their children as they choose. This can be achieved through innovative and effective training of reproductive health educators, community leaders, and trainers. Some particularly articulate adolescents were often most helpful in convincing parents to let their daughters attend. With the passage of time, these objections receded considerably as the value of the sessions and project benefits unfolded.

Girls and boys were trained separately. Given the wide gap between girls’ and boys’ basic knowledge about RH, and the divergent roles they are expected to play in society, they brought very different problems, misconceptions, and questions to the training.

Numbers of Target Groups Trained

<table>
<thead>
<tr>
<th>Target Groups</th>
<th># trained</th>
<th># training sessions</th>
<th># 1st refresher</th>
<th># 2nd refresher</th>
<th># 3rd refresher</th>
<th>% of target group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls 12-14</td>
<td>18,641</td>
<td>787</td>
<td>970 (59 sessions)</td>
<td></td>
<td></td>
<td>97.4</td>
</tr>
<tr>
<td>Girls 15-19</td>
<td>17,451</td>
<td>761</td>
<td></td>
<td></td>
<td></td>
<td>111.8</td>
</tr>
<tr>
<td>Boys 15-19</td>
<td>16,136</td>
<td>767</td>
<td></td>
<td></td>
<td></td>
<td>41.5</td>
</tr>
<tr>
<td>Desi</td>
<td>1378</td>
<td>88</td>
<td></td>
<td></td>
<td></td>
<td>103.6</td>
</tr>
<tr>
<td>Cultural team</td>
<td>227</td>
<td>5</td>
<td>173 (3 sessions)</td>
<td>194 (5 sessions)</td>
<td>175 (4 sessions)</td>
<td>119.5 (1st refresher 91.1, 102.1, 91.1)</td>
</tr>
<tr>
<td>New AYURV (NDSS)</td>
<td>1886</td>
<td></td>
<td>317</td>
<td></td>
<td></td>
<td>48.1</td>
</tr>
<tr>
<td>RMPs</td>
<td>470</td>
<td></td>
<td>31</td>
<td></td>
<td></td>
<td>78.2</td>
</tr>
<tr>
<td>Young couples w/ 0 children</td>
<td>5263</td>
<td></td>
<td>657 meetings</td>
<td></td>
<td></td>
<td>60.5</td>
</tr>
<tr>
<td>1st time pregnant women</td>
<td>1525</td>
<td></td>
<td>305 meetings</td>
<td></td>
<td></td>
<td>62.3</td>
</tr>
<tr>
<td>Young couples w/ 1 child</td>
<td>6510</td>
<td></td>
<td>758 meetings</td>
<td></td>
<td></td>
<td>60.8</td>
</tr>
</tbody>
</table>

Note: At the start of the project when households were listed, all unmarried girls were counted. As the program progressed, even married adolescent girls asked to come to the program and were made welcome. Also, girls who were fourteen when the survey was conducted became eligible for training upon turning 15 the next year. The number who attended the program was thus greater than initially expected.

Young Adolescent Girls (12-14 yrs of age)

As girls enter adolescence and go through menarche, they need education on the physical and psychological changes they are experiencing, as well as information on menstrual hygiene, anemia, nutrition, and the connection between menstruation and conception. Traditionally, girls in Bihar learn about these things indirectly and piecemeal, much of the information laden with superstition and misconceptions based on beliefs passed down through generations. Studies show that 50 percent of female adolescents aged 12-15 residing in rural and slum areas of India did not know about menstruation until its onset.18

Gender discrimination in India begins before birth, with a high percentage of aborted females creating a sex ratio in favor of males. Traditionally, girls used to be married as young as 10 years old, but remained with their parents until they were considered mature enough to begin life with their husbands (“gauna”) and bear children. Though the custom of gauna is phasing out and the average age of marriage has increased, many of the rural poor are still married very young. The PRACHAR Project focused on this population to initiate a gradual process of empowerment of young women, giving them the knowledge and skills to develop a new level of control over their lives.

Two training partners conducted the training of young girls, including the Centre for Development and Mahila Chetna Kendra. In preparation for the training, parents and community leaders were invited to a series of group meetings to discuss the specific content of the trainings and to enlist their cooperation and support.

Two groups of 25 girls each were trained concurrently at the village level in two sessions of two and one-half hours each. Every week, six batches were trained by two teams of two women trainers. The sessions were based on Pathfinder’s Reproductive Health Guide for Educators of 12-14 Year Old Girls. 19

In the three intervention areas, a total of 18,641 girls were trained, representing 97.4 percent of all girls of this age.
Three training partner organizations were chosen to conduct the training among older adolescents. Association for Social Research and Action (ASRA) conducted training in Nalanda district, Association for Social Engineering Research & Training (ASSERT) in Nawada district, and Bihar Voluntary Health Association in Patna district. In each district, two teams of two female trainers trained the girls, while the two teams that trained boys each had one female and one male trainer. Women trainers were included in the boys’ sessions to provide a restraining influence and to encourage a culture of respect for girls and women.

Groups of 30 adolescents met for three 5-hour sessions. Staff were recruited by the NTPs but trained by Pathfinder using Pathfinder’s Reproductive Health Guide for Educators of 15-19 Year Old Adolescents. Over the course of the project, a total of 17,451 girls and 16,136 boys were trained, representing more than 60 percent of the total population of these groups in the community.

Because these adolescents are at the age of marriage common in India, training emphasized the dangers of early marriage and childbirth, as well as the importance of a woman postponing the birth of her first child until the age of 21. Stress was placed on couples spending time together, getting to know and enjoy each other’s company, developing an understanding relationship, becoming more emotionally mature, and on saving the money needed for children before taking on the responsibilities of childbearing. Discussion and exercises helped prepare them to resist family and community pressures to marry and conceive at a young age.

Special sessions on combating sexual abuse introduced both girls and boys to the fact that such abuse exists and that they can do something to protect themselves from it. Another session was devoted to STIs and HIV/AIDS awareness and prevention.

The training program addressed gender issues at every opportunity, helping both boys and girls to think about their own notions of the equality of men and women, about double sexual standards, about sexual harassment of women, and about whether or not women have a right to decide about their own bodies and participate equally in decisions related to their own lives and families.

PRACHAR seeks to establish whether or not education and open discussion of RH introduced at this stage of development can significantly affect the RH and family planning behavior of girls and boys through later adolescence and into adulthood. These adolescents were identified and documented by name. Many went on to participate in the programs for newlywed couples, and their behavior will be tracked on into marriage and early childbearing.

Lesson Learned
Experience drawn from Pathfinder International’s initial India project, Reproductive Health of Young Adults in India (RHEYA), conducted between 1999-2006 and funded by the Bill and Melinda Gates Foundation, led planners of the PRACHAR project to use adult trainers to facilitate RH education sessions. Youth reached by RHEYA consistently reported that they wanted reproductive health, family planning, and sexuality information from older, well-informed persons, with some life experience, who were comfortable talking about sensitive issues and could answer all of their questions with a high level of competence. The key to persuasive communication with youth on sexually-sensitive issues is quality training of trainers, so that they are totally comfortable with their topics and are sympathetic to the developmental realities of young people.

Cultural Teams and Folk Media
“First you have to show people that what is going on in their lives really is a problem, and then show that they can do something about it. They are crippled by fatalism.” This is the view held by Fr. Arun Ignatius, director of the Ravi Bharti Institute of Communication (RBIC) in Patna.

This NTP trained teams of actors, singers, and puppeteers, who spread out into PRACHAR villages to prepare people for new ideas about early marriage, childbearing, and spacing of subsequent children.

Folk Media offers a powerful forum in which ideas, customs, and traditions can be opened for public debate. When well done, live drama and puppet shows can confront people with the realities of their daily lives. Humor or tragedy can touch people emotionally and can force questions into the open about traditions and customs that may be harmful or controversial.

The selection and training of Cultural Teams was rigorous—particularly because team members had to be from the local community. After applicants were interviewed and tested, many were found lacking in commitment or performance skills. Twenty-five percent of the 200 trainees were illiterate. Finally, a total of 18 teams of 10 members each were chosen to participate in a 15-day residential training session. Each team included a few people who could play musical instruments, as well as those with good singing voices. With emphasis on team building, ten days were devoted to street theatre and five days to the art of making and using puppets. As local residents, many cultural team members were initially embarrassed to perform in front of their neighbors on topics related to reproduction or sexuality. As was the case in training trainers, comfort with the topics came with thorough knowledge and practice.

Cultural teams were charged with writing their own scripts for songs and plays. Trainers offered feedback, but left the teams to develop material appropriate to their cultural contexts. The scripts had...
to be emotionally compelling. “You cannot just tell people to change. You can only throw an idea or situation out there and encourage people to think about it,” said Mr. Virendra Kumar, a trainer from RBIC. “People in India keep their questions inside themselves, which you can only see through their body language.”

The impact of the Cultural Teams and their performances is hard to measure in absolute terms, but their appearance once every six weeks in every single village ensured exposure to family planning, delayed childbirth, and child spacing to virtually the entire population. The rigor and discipline of the training of Cultural Teams made them cohesive and professional. Given the difficulty they faced in broaching such sensitive topics, that professionalism was very important in putting their audiences at ease and enabling everyone to take the emotional messages seriously.

Training Leadership Groups for Sustainable Education

As the PRACHAR training process began to reach a wider segment of the population in intervention areas, groups who had not been part of the original plan began to come forward and ask to become involved. Older men, for example, asked for training, as they too wanted to understand about contraception and the appropriate timing of children. In the later stages of the PRACHAR Project, Pathfinder provided a series of trainings for older men and women, which included all of the basics of RH/FP, the details about delaying and spacing children, and the health and economic benefits of family planning. The goal of the trainings was to motivate participants to actively influence the RH practices of their families and communities. The workshops offered an opportunity for trainers to address concerns that continued to trouble members of the community.

Improving Access to Quality Reproductive Health Services

As project activities significantly increased demand for RH/FP services and products in intervention villages, Pathfinder worked with local government health administrators at the district and block levels, as well as with private providers, to improve the availability of local services. However, barriers to improvements in overall logistical supply systems remained challenges throughout the project. Initially, as in most parts of Bihar, government auxiliary nurse midwives (ANM) did not visit the villages to provide childhood immunization and antenatal care. It is not surprising then, that only 10-15 percent of children in Bihar have received all childhood vaccines. To make some basic RH/FP services available, NGO partners organized monthly maternal and child health (MCH) clinics at the village level. With constant communication with the primary health center and the district medical officer/civil surgeon, the ANMs began to visit the villages to immunize children and pregnant women at the monthly MCH clinics.

In the early months of the project, only 20 percent of these clinics were attended by an ANM. Towards the end of the project, attendance increased to 50 percent. However, the ANMs continued to limit their services to immunization. Antenatal and post-partum checks and family planning counseling had to be carried out by the project staff of the implementation partners. Project staff also carried out basic health checks for adolescents, who were invited to the clinics after their training programs.

In spite of efforts to assess the facilities of nearby private providers and negotiate special rates for project-referred clients, and even providing a list of doctors and clinics to whom project staff could make RH/FP referrals, these services were rarely used. Villagers continued to prefer to see local providers like the dai (traditional birth attendant) for deliveries, and self-styled rural medical practitioners (RMP).

Though the dai and RMPs have no formal training, they represent the community’s preferred first line of defense against illness at the village level, where they are known and trusted. This preference is based on a combination of factors, including easy access, privacy, affordability, payment and credit terms, and respectful treatment. Given the absence of formal alternatives, Pathfinder felt it extremely important to help these essential providers improve the quality of their work. Training not only promoted new knowledge and skills, but also sought to reduce harm by dealing directly with misconceptions, harmful beliefs and practices, suggesting alternative practices, and by encouraging timely referral to appropriate providers or centers.

In spite of the fact that training required absence from home and work, and that participants did not receive any compensation for work time lost, both dai and RMPs were enthusiastic about receiving training to improve their services.

Training of Traditional Birth Attendants (Dais)

In rural India, more than 80 percent of babies are delivered at home. Of these 35 percent are assisted by a dai. In Bihar, 66 percent have the aid of a dai; however, only 9 percent receive assistance from a formal provider (though generally not a doctor). Only 10 percent of pregnant women receive at least three antenatal check-ups, which is the strongest determinant for their seeking institutional delivery.

Dais are women of lower caste who earn a small amount of money or agricultural produce delivering babies and caring for the post-partum mother and baby. These women are generally illiterate and learn the skills of their trade from their mothers or mothers-in-law. Dais combine vast amounts of on-
Training of Rural Medical Practitioners (RMPs)

Every village has a person who is recognized as the village ‘doctor.’ This informal and usually untrained RMP has generally picked up whatever training he has by working for two or three years as an all-purpose assistant or office boy to a qualified doctor in town. Many of the RMPs have approximately 10 years of general schooling. They generally offer medication, injections, and treatments for a host of conditions, including ‘night emissions,’ masturbation (seen as a case of excessive hormones), irregular periods, uterine and vaginal discharges, prolonged labor, and minor ailments. With no formal training or certification, the quality of services provided by the RMPs depends on who they appren-
ticed with and the quality of the work of their role model.

Most RMPs offer “medical” services on the side, while farming or practicing a trade to earn their primary livelihood. To most people in the community, they are ‘doctors’ and are trusted sources of care. Due to their valued role in the community and access to women and others in need of health care, Pathfinder sees them as potentially effective conduits of information and as representatives who can educate the community about basic RH/FP issues. With proper training and supervision, both dais and RMPs can be encouraged to abandon those previous practices which were harmful to health and can become strong advocates for healthy practices.

RMP training provides these informal practitioners with knowledge of RH/FP conception, the importance of delaying first birth and spacing between births, and the advantages and disadvantages of all forms of contraception. They learn how to administer and correctly use emergency contraception as well. They are taught the dangers of medication for hastening labor and the need for timely referral of women with complications. Common knowledge suggests that some RMPs provide abor-
tion services, and therefore the training program dealt with the dangers of unsafe abortion and the need for preventing reliance on abortion by promoting contraception.

RMPs can be powerful voices for the elimination of popular myths and misconceptions about RH/FP and other medical issues, especially false impressions people commonly have about different kinds of contraception. They learn to identify common reproductive tract infections and STIs (through symptom recognition), and can teach people how to prevent them or make referrals to clinics when needed. Most importantly, the RMPs reported that the training put them much more at ease in talking with patients about the intimate subjects of RH and sexuality, and they vowed to discontinue harmful practices such as reusing disposable syringes or giving medication to patients before performing an examination or prescribing medication to hasten labor. At the end of the training, some RMPs expressed concern that if they changed their practice according to what they had learned, and did not treat masturbation or menstrual irregularities with medication, they might lose status in the community. They clearly have to work gradually to change age-old conceptions of illness and wellness.

The training needs of RMPs are many, but Pathfinder has emphasized those issues that would enable them to understand and serve the RH/FP needs of youth.

The dais is also called the village ‘doctor.’ This informal and usually untrained RMP has generally picked up whatever training he has by working for two or three years as an all-purpose assistant or office boy to a qualified doctor in town. Many of the RMPs have approximately 10 years of general schooling. They generally offer medication, injections, and treatments for a host of conditions, including ‘night emissions,’ masturbation (seen as a case of excessive hormones), irregular periods, uterine and vaginal discharges, prolonged labor, and minor ailments. With no formal training or certification, the quality of services provided by the RMPs depends on who they appren-
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### Key Project Performance Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Endline</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>% increase in median interval between marriage and first birth</td>
<td>Intervention Area</td>
<td>21.3 months</td>
<td>24 months</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>Data not available</td>
<td></td>
</tr>
<tr>
<td>% women using contraception for delaying first child</td>
<td>Intervention Area</td>
<td>5.3</td>
<td>19.9</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>4.2</td>
<td>7.9</td>
</tr>
<tr>
<td>% of newlywed contraceptive adopters using contraception from the consummation of marriage</td>
<td>Intervention Area</td>
<td>0.1</td>
<td>20.8</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>Data not available</td>
<td></td>
</tr>
<tr>
<td>% women using contraception for spacing second child</td>
<td>Intervention Area</td>
<td>14</td>
<td>32.6</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>9.6</td>
<td>20.3</td>
</tr>
<tr>
<td>% first time mothers using contraception who adopt FP within 90 days of delivery</td>
<td>Intervention Area</td>
<td>2</td>
<td>24.8</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>Data not available</td>
<td></td>
</tr>
<tr>
<td>% youth who believe that FP to delay the first child is necessary and safe</td>
<td>Intervention Area</td>
<td>40.1</td>
<td>82.9</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>39.3</td>
<td>72.3</td>
</tr>
<tr>
<td>% adults who believe that FP to delay the first child is necessary and safe</td>
<td>Intervention Area</td>
<td>32.1</td>
<td>73.9</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>36.1</td>
<td>71.7</td>
</tr>
<tr>
<td>% youth who believe that early child bearing is injurious to health of mother</td>
<td>Intervention Area</td>
<td>16.5</td>
<td>74.3</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>11.4</td>
<td>64.4</td>
</tr>
<tr>
<td>% adults who believe that early childbearing is injurious to health of mother</td>
<td>Intervention Area</td>
<td>22.4</td>
<td>80.2</td>
</tr>
<tr>
<td></td>
<td>Non-Intervention Area</td>
<td>172</td>
<td>69.1</td>
</tr>
</tbody>
</table>

Data from project records were reviewed each month to track planned activities and progressive coverage of demographic sub-groups through program activities. Similarly, specific records were maintained on the numbers of partner staff trained.

Pre- and post-training tests measured the effectiveness of training inputs. Of particular significance to the overall success of the project, feedback on the effectiveness of training programs was continuously incorporated into revisions of training modules. Over the course of the project, as preconceptions...
Conclusion

Family planning programs spread their attention over all eligible couples aged 15 to 49. Programs that focus selectively only on the reproductive behavior of young couples are rare. The mother’s age at first birth and the spacing of subsequent pregnancies are important to the health of mother and child during pregnancy, delivery, and early child rearing. And there are important economic and family welfare benefits that derive directly from that health benefit. This totally new way of thinking about FP has been Pathfinder’s unique contribution to reproductive health programming in India.

Since the International Conference on Population Development changed the population paradigm to reproductive health, programs have struggled to translate policy into action. Except for HIV/AIDS prevention education programs, little has been done to address the RH needs of youth. Pathfinder’s PRACHAR Project has demonstrated a methodology for improving both reproductive health and demographic indicators by focusing on adolescents and youth and serving their felt needs. It has shown how traditional FP indicators can be used to measure demographic change in age and parity specific subgroups, such as newlyweds and couples with one child. Contraceptive Prevalence Rate (CPR) is generally taken as the key variable of demographic change. This indicator has been adopted by PRACHAR, which has measured contraceptive use among young couples for delaying first child and for spacing the second child. Timing of contraceptive initiation has also been emphasized by PRACHAR—from consummation of marriage, and as early as possible post-partum (within 90 days).

There are few programs for youth that have attained scale. PRACHAR demonstrated that even in resource poor rural settings, scale can be attained with carefully constructed implementation structures, the development of human capacity, and close program monitoring. The PRACHAR methodology is proven, and with additional funding, this innovative approach could be further scaled-up to reach a larger segment of Bihar youth.

PRACHAR II—The Next Phase

The Packard Foundation has extended funding for a second phase of PRACHAR. In the new phase, Pathfinder plans to discontinue work in several Phase I areas with the intention of studying the extent to which changes brought about in Phase I are sustained after interventions end. A sample of adolescents trained in Phase I will be tracked to study whether the inputs that they received before marriage influence their reproductive decisions when they marry.

Interventions will continue in 6 of the 19 Phase I areas, and efforts will be made to determine whether changes that began in Phase I intensified or tapered off. The six Phase I partners who continue into Phase II will double their intervention areas and further develop their capacity for RH/FP programming. These sites will serve as demonstration sites where visitors can observe and learn from project approaches. In Phase II, PRACHAR will introduce youth RH programs in two new districts, widening PRACHAR’s presence and its potential for impact in the state of Bihar.

Other highlights of the results are:

- Median age of mother at first birth increased from 20 years to 21 years
- In newlyweds aged 17 and under, 34.4% had used contraception to delay the first child. As the age of the woman increased to 18-20 years, contraceptive use declined to 28.4%, and only 15.2% of couples with a wife over 20 used contraception to delay the first child. These high rates of use by couples with a wife under 20 show that the community has begun to act upon the message that early childbearing is injurious to the health of the mother.
- In both newlyweds and couples with one child, condoms were the contraceptive method of choice. 59.9% of newlyweds used contraception used condoms, as did 55.7% of couples with one child. Oral contraceptive pills were the second choice. Use of IUDs, and other methods, was insignificant. Men have actively participated in planning their families.
- Pregnancy rates in newlyweds declined from 24.3% at the start of the intervention to a six month average of 21.6% in the period July to December 2004. Pregnancy rates in those who had used contraception declined to 20.1% when compared with the rate of 36.3% in those who had never used a contraceptive method.
- Age specific fertility rates declined by 14.3% in the age group 15 to 19 years, and by 12.8% in the age groups 20-24 years.

A comparison of the changes that have occurred in intervention and non-intervention areas shows that social norms related to early child bearing in Bihar have begun to shift. Knowledge and attitudes have changed even in the non-intervention areas, as has behavior related to contraceptive use for delaying the first child and spacing the second. However, the degree of change in knowledge, attitudes, and behavior is markedly greater in the intervention areas. PRACHAR has clearly accelerated change. Regarding the difficult issue of delaying first birth, the PRACHAR intervention has made real inroads.
Acknowledgements

PRACHAR is the work of hundreds of people:

- selected village elders who supported project activities and helped resolve issues in the field
- supportive district officials and primary health care personnel who cooperated in providing services to the intervention areas
- trainers who worked to military precision in moving from village to village to execute training programs every day of every week for over 7 months, in 452 villages
- performers in street theater groups who set aside their inhibitions and acted out issues that their kith and kin were accustomed to being reticent about
- many fiery adolescent girls and boys who spoke up publicly on taboo issues
- the staff and change agents of Pathfinder’s 30 partners who became committed advocates for change
- the staff of Pathfinder International in Boston who provided technical guidance and back-stopping
- Pathfinder’s senior management whose visits to the field provided much needed cheerleading and moral support
- PRACHAR’s monitoring consultants who continuously and thoroughly gathered, input, and analyzed field records and service statistics, making measurement of results possible
- Pathfinder’s own staff in Patna and Delhi, without whose passion, pride of ownership, and perseverance none of this work would have been possible.

Pathfinder salutes them all.

This publication is the result of Jennifer Wilder’s enquiry into the purposes, methods and results of the project. She engaged us all in a dialogue about our work, pored over documents, searched in vain our archive of enthusiastic but completely amateur photographs for professional quality pictures for this publication, traveled into the field to meet villagers, to observe and learn first hand about their situation and needs, and to study their reactions to project sponsored street plays, adolescent training programs, home visits and group meetings, and meticulously put everything together to meet very short deadlines. Her fresh and empathetic mind and eyes helped us, who have worked so long on the details of this project, to see it afresh again, and we enjoyed that immensely.

Thank you, Jennifer.

To the David and Lucile Packard Foundation, its senior management, and India country team, our grateful thanks for understanding the problems of implementing a pioneering project in a difficult state, for having the patience and the faith to support us through this venture, for frequent visits and encouragement, and for the opportunity to make a difference.

Photo credits: Jennifer Wilder and Pathfinder International/India staff

List of Partner Organizations

NGO Implementing Partners (NIPs)

Nalanda:
- Binoba Arogya & Lok Shikshan Kendra
- Bureau of Rural Economic and Agricultural Development
- Gramin Evam Nagar Vikas Parishad
- Jan Jagraan Sansthan
- Nav Bihar Samaj Kalyan Pratishtan Kendra
- Nisha Bunai Silai School
- Young Men’s Christian Association

Nawada:
- Dalit Vikas Vindu
- Gram Nirman Mandal
- Indian Institute for Rural Development
- Janhit Vikas Samiti
- Lok Chetna Vikas Kendra
- Lok Prabhat
- Mahila Vikas Samiti

Patna:
- Arpan Gram Vikas Samiti
- Integrated Development Foundation
- Mahila Bal Jyoti Kendra
- Pragati Gramin Vikas Samity
- Swasthya Evam Jan Kalyan Samiti

NGO Training Partners (NTPs)

Aragami India
- Association for Social Engineering Research & Training (ASSERT)
- Association for Social Research and Action (ASRA)
- Bihar Voluntary Health Association (BVHA)
- Bihar Water Development Society /Sewa Kendra
- Center for Communication Resources Development (CENCORED)
- Center for Integrated Development (CIDEV)
- Kurji Holy Family Hospital
- Mahila Chetna Kendra
- Ravi Bharti Institute of Communication (RBIC)
- Tripathi Social Service Hospital
In 2001, the David and Lucile Packard Foundation funded Pathfinder International to implement a youth reproductive health project in Bihar, India, designed to significantly improve the reproductive behavior of adolescents and young adults. Called “Promoting Change in Reproductive Behavior in Bihar” (PRACHAR), the project has taken to scale successful approaches designed to reach a large proportion of the population in three districts of the state of Bihar. PRACHAR works to change beliefs, attitudes, and practices among adolescents, young married couples, and parents and influential adult figures in the community by changing traditional customs of early childbearing. By delaying the first child until the woman is 21 years of age and spacing subsequent children by three to five years, communities can benefit from a significant drop in maternal and infant mortality rates, as well as improvements in the survival and general health of mothers and children after later pregnancies.

Pathfinder International believes that reproductive health is a basic human right. When parents can choose the timing of pregnancies and the size of their families, women’s lives are improved and children grow up healthier. Pathfinder International provides men, women, and adolescents throughout the developing world with access to quality family planning and reproductive health services. Pathfinder works to halt the spread of HIV/AIDS, to provide care to women suffering from the complications of unsafe abortion, and to advocate for sound reproductive health policies in the U.S. and abroad.