Pathfinder INTERNATIONAL

SASHAKT

Strengthening Adolescent and Youth Sexual and Reproductive Health; an experience with Mahadalit Community in Bihar, India

PATHFINDER INTERNATIONAL is driven by the conviction that all people, regardless of where they live, have the right to decide whether and when to have children, to exist free from fear and stigma, and to lead the lives they choose.

Since 1957, we have partnered with local governments, communities, and health systems in developing countries to remove barriers to critical sexual and reproductive health services. Together, we expand access to contraception, promote healthy pregnancies, save women's lives, and stop the spread of new HIV infections, wherever the need is most urgent. Our work ensures millions of women, men, and young people are able to choose their own paths forward.

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FOREWORD FROM THE COUNTRY DIRECTOR

Pathfinder International in India has prioritized the sexual and reproductive health and wellbeing of young people and adolescents. This is an imperative given one in eight young people in the world live in India. Pathfinder believes all young people and adolescents are entitled to responsive sexual and reproductive health services provided without bias and discrimination, and the realization of their sexual and reproductive health rights. The Government of India has also prioritized the wellbeing and entitlements of young people through progressive policies and programs which prioritize their health, education, and economic opportunity.

Social, cultural, economic, and institutional marginalization has rendered young people and adolescents of the Mahadalit community, who make up ten percent of the population of Bihar especially vulnerable to their circumstances. The Mahadalit community does not own land and depends entirely on sharecropping, wage labor, remittances from migrants. Government programs prioritize adolescent and young Mahadalits the right to essential services and support, but provider bias often prevents them from realizing these entitlements. Of special mention is the inability of women, girls, and young people to access and use responsive sexual and reproductive health services.

The outcomes of this marginalization on the Mahadalit communities are grim… circumstances force migration of young men in search of wage labor; among Mahadalit communities there is an inordinate prevalence of early marriage of girls, teenage pregnancies, high levels of maternal and child mortality, and uncertainty and helplessness in the face of the future.

Pathfinder worked with Mahadalit communities and their households in 288 villages in Bihar over the past three years through the Sashakt project to improve opportunities for social, economic, cultural, and political opportunities. The focus of Sashakt were adolescent boys and girls who came together as peer groups and took part in activities which helped them understand their entitlements and rights, focusing specifically on their sexual and reproductive health. Peer educators selected from these groups continued to work with subsequent groups of adolescents to continue sharing information, knowledge, and addressing social norms which prevented positive behaviors regarding sexual and reproductive health.

The outcome of these efforts was adolescents championing for completing of secondary education, delaying marriage till at least the age of 18 for girls, promoting healthy timing and spacing of children among young married couples, and accessing of institutional sexual and reproductive health services. Sashakt implemented innovative approaches to make sure migrant boys participated in peer groups through effective timing of peer group meetings.

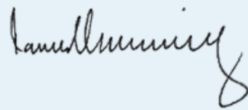
Sashakt also worked with frontline health workers, especially the ASHAs in creating awareness on restrictive social norms and biases which marginalized young Mahadalits and improving sexual and reproductive health outcomes. This work helped reduce service provider bias toward Mahadalit women and young people while improving the provision of institutional health services at primary facilities.

Sashakt has had an impact at District and State levels on promoting the health and wellbeing of Mahadalit youth. It has influenced thinking on the role of Sashakt peer educators in strengthening the delivery of the Rashtriya Kishore Swasthya Karyakram (RKSK) program, which has enrolled 15,000 RKSK peer educators in Bihar. Key stakeholders have recognized Sashakt as a trail blazing innovation to ensure Mahadalit youth take part in and benefit from India's exceptional economic and development gains.

Pathfinder is grateful to the Lucille and David Packard Foundation for their generous support in making Sashakt possible. We also gratefully acknowledge the support and cooperation of the State Government of Bihar.

Most importantly, we are thankful to the young people from the communities and their households for their trust and partnership in making Sashakt an extraordinary success story, and a model for adaptation and replication widely.

Thank you.



Daniel Sinnathamby

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ACRONYMS

ANM	AUXILIARY NURSE MIDWIFE
ASHA	ACCREDITED SOCIAL HEALTH ACTIVIST
AYSRH	ADOLESCENT AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH
BHM	BLOCK HEALTH MANAGER
BPC	BLOCK PROJECT COORDINATORS
ED	EXECUTIVE DIRECTOR
HTSP	HEALTHY TIMING AND SPACING PRACTICES
ICDS	INTEGRATED CHILD DEVELOPMENT SCHEME
IPC	INTERPERSONAL COMMUNICATION
MOIC	MEDICAL OFFICER IN-CHARGE
PHC	PRIMARY HEALTH CENTRE
PHED	PUBLIC HEALTH ENGINEERING DEPARTMENT
RKSK	RASHTRIYA KISHOR SWASTHYA KARYAKRAM
SHSB	STATE HEALTH SOCIETY BIHAR
SL	SUPPLEMENTARY LEARNING
SPO	STATE PROGRAM OFFICER
SRH	SEXUAL AND REPRODUCTIVE HEALTH
SRHR	SEXUAL AND REPRODUCTIVE HEALTH RIGHTS
WIFS	WEEKLY IRON FOLIC ACID SUPPLEMENTATION

EXECUTIVE SUMMARY

Investments in health and development of adolescent age group are critical to ensure that they progress as a healthy and productive adults as facts suggest that a large proportion of the disease burden and mortality is attributed to behaviors and factors associated with this age. Within health domain, Sexual and reproductive health amongst adolescents is an area where both services and outcomes have been far from satisfactory. Pathfinder is committed towards the cause of enabling the adolescents to realize their sexual and reproductive health rights and have greater autonomy over their lives.

Pathfinder International India harnesses the vast international experience in AYSRH projects that its parent entity brings in as well as learnings gathered from SRH projects running in India over more than a decade. PI adopts a holistic approach of working on the community systems and strengthening health systems. The Sashakt project was one such project that utilized learnings from AYSRH projects and evolved within the favorable context of growing political commitment and recognition for adolescent health.

Sashakt was conceptualised with an aim to improving knowledge and awareness as well as service provision through government health systems for Healthy Timing and Spacing Practices (HTSP) amongst the adolescents from Mahadalit community In three districts of Bihar. The interventions were aligned in view of the emerging challenges as these were identified during the baseline and the midline assessment.

The project was received well by the Mahadalit community- married and unmarried adolescents, parents and ASHA functionaries. The endline evaluation showed improvement in knowledge and attitudes of adolescents towards age at marriage and HTSP. It also led to positive change in attitudes of ASHAs towards the vulnerable community and subsequent improvement in outreach services provided by her through household visits to married couples. The positive outcomes are validated with the stakeholder perspectives gathered that reflect the value addition seen in the project. The absorption of project trained peer educators into the government's RKSK project is a testimony of the quality of interventions imparted through the project.

Re-strategizing and delivering the interventions in most appropriate and acceptable way for the community served as the guiding principle throughout the implementation phase. These iterations and challenges have culminated in valuable learnings that can be applied to any project designed for vulnerable adolescents for SRHR. One of the key learnings gained is that imparting knowledge does not necessarily translate into behavior change and positive outcomes and engagement of all stakeholders and decision makers is critical to create an enabling environment for adolescents to practice the knowledge gained. Another learning gained from project is that any intervention in project mode needs adequate government endorsement and collaboration to stay sustainable and also provide commensurate services to the demand generated. The gains made so far can be leveraged if the learnings gathered in the project are meticulously utilized to strategize the next phase of the project.

RATIONALE AND INTENTIONS

BACKGROUND OF SRHR FOR ADOLESCENTS IN INDIA

India is home to world's largest adolescent population and one fifth of the country's population is in the 10-19 years age group. The health of the future adults depends of the healthy behaviors adopted during adolescent age. About 33% of the disease burden and almost 60 per cent of premature deaths among adults are associated with behaviors or conditions that began or occurred during adolescence"[1]. The median age at first sexual intercourse for women is 19.0 years and about 39% of women (age 25-49) had sex before age of 18 reflects the dire need to address the Sexual and Reproductive Health for Adolescents.

The Government of India launched the National Adolescent Health Strategy and *Rashtriya Kishor Swasthya Karyakram* (RKSK) in 2014 acknowledging that health needs of adolescents need to be addressed to break the inter-generational cycle of poor health.

However, despite the initial strong focus on SRH, attention was later diverted to school health programs and nutrition supplementation components.

Several challenges such as lack of access and knowledge to sexual and reproductive health information and services, lack of agency and decision-making power, restrictive gender norms, prevalence of child marriages and adolescent pregnancy and maternal mortality call for attention and formulation of adolescent specific strategies and interventions to improve SRH outcomes for the adolescents.

PATHFINDER INTERNATIONAL AND SEXUAL AND REPRODUCTIVE HEALTH

> ***"Pathfinder is driven by the conviction that all people, regardless of where they live, have the right to decide whether and when to have children, to exist free from fear and stigma, and to lead the lives they choose."***

Pathfinder champions Sexual and reproductive health and rights (SRHR) worldwide and to work with communities in overcoming barriers and forging paths to a healthier future. Pathfinder envisions a world where **everyone** has access to contraception, where there are no new HIV infections, where no woman dies from preventable pregnancy-related complications, and where everyone leads a healthy sexual and reproductive life. In the above context and due to interlinkages with SRH outcomes, Contraception, Maternal health, newborn health, HIV and AIDS have been its core thematic areas. Further, cervical cancer prevention; population, health, and environment; and safe abortion care

are emerging areas of that have critical significance in SRHR.

Pathfinder is a global leader in high-quality contraception and AYSRH service delivery. PI works to improve SRH is fundamentally through improving both community systems and formal health systems by systematically integrating AYSRH across programmes. It has implemented over 120 AYSRH programs in over 40 countries and has delivered 15 innovative projects in India across States.

1. UNFPA. 2014. "India Launches National Adolescent Health Strategy." UNFPA India. 1 7. Accessed 3 11, 2020. https://india.unfpa.org/en/news/india-launches-national-adolescent-health-strategy.

One of the flagship projects of Pathfinder in India was the PRACHAR project launched in 2001 through support from the David and Lucille Packard foundation with an aim to promote Healthy Timing and Spacing Practices (HTSP) in young married couples through preventing early marriage and promotion of contraceptive use. Over 11 years of implementation, PRACHAR supported an audience-segmented behaviour change approach aimed at different cohorts of young people and influential gatekeepers, such as parents and religious leaders all of whom play a definitive role in influencing the reproductive decision-making of young couples. This generated a strong body of evidence on effective approaches to bring about improvements in SRH behaviours in populations at large.

The rich evidence from achievements and learnings from the PRACHAR project and an enabling political environment with launch of National Adolescent Health Strategy and RKSK and the thrust provided by government to meet the needs of the underserved and vulnerable populations resulted in the conceptualisation of the SASHAKT Project in 2015.

The project was launched in tandem with Bihar State government's priorities to focus on development of its most vulnerable population, the *Mahadalits*. Alignment with the state government plans and proposed project geographies provided increased opportunities for mutual learning and leveraging of resources.

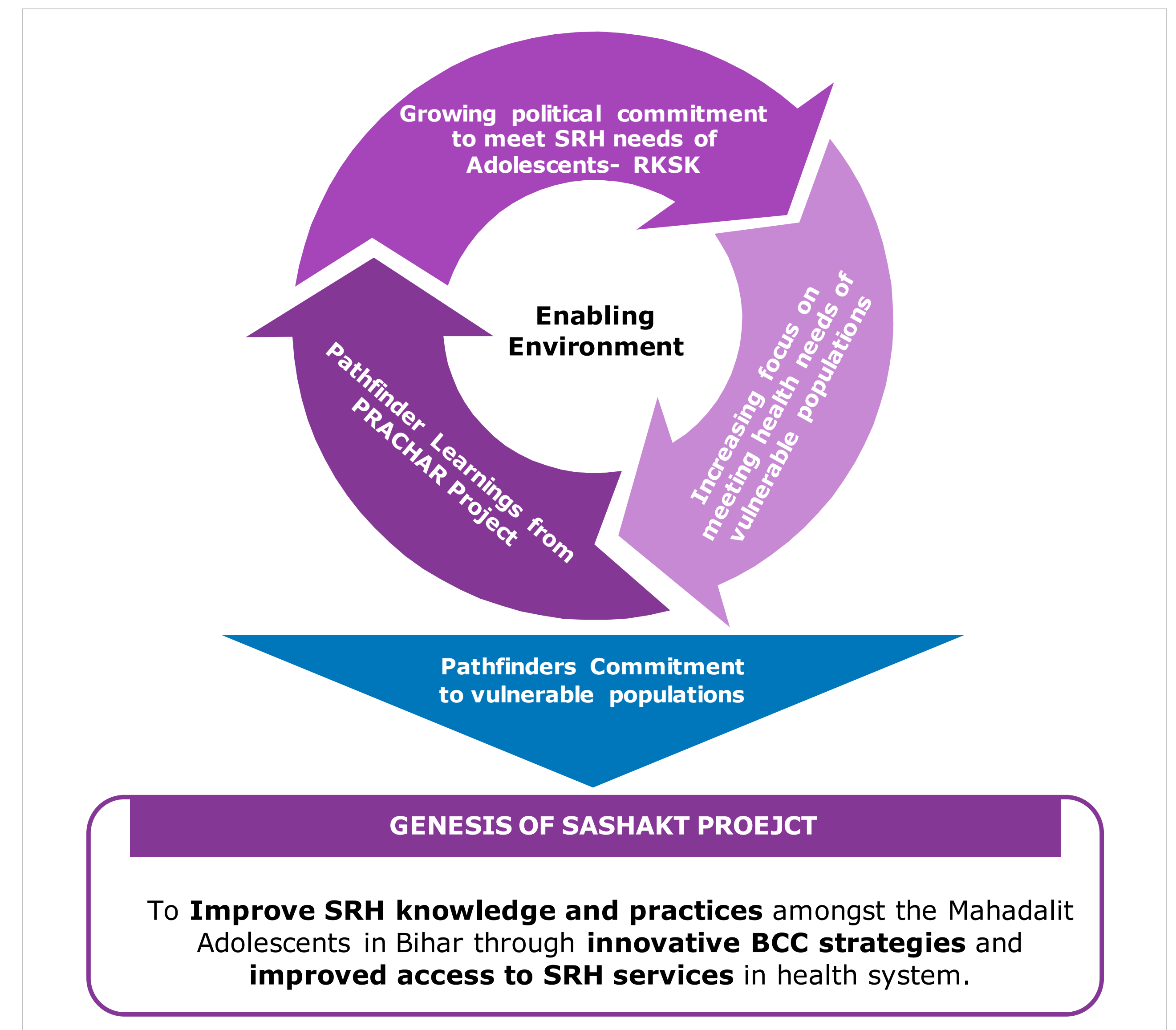

Exhibit 1: Evolution of Sashakt

SASHAKT – INTRODUCTION AND BACKGROUND

The *Mahadalit* **Community** was identified for the project based on the outcomes of a social and economic vulnerability assessment conducted by the State government in 2007. The assessment explored the *Mahadalit* community's restricted access to SRH services constrained by social, economic, and institutional discriminatory practices in the State. The community faced both physical and social exclusion with practices of untouchability, restriction on inter-dining, and endogamy ingrained in village norms. The community showed a high rate of early marriages, high school dropout rates and mostly restricted to daily wage labor. As adolescents from *Mahadalit* community faced multiple vulnerabilities owing to the lack of agency coupled with caste related stigma, married and unmarried *Mahadalit* adolescents (ages 15-19) were chosen as participants for the project.

Geography was decided based on concurrence with the State governments roll out plan for RKSK and covered 288 hamlets/villages spread across 67 *Panchayats* within six blocks in three districts (*Purnea, Katihar, and Araria*) of Bihar. Estimated *Mahadalit* adolescents (ages 15-19) population in the intervention areas of these six blocks numbered 22,000. To ensure the project reached the most vulnerable groups within this community, outreach was focused on geographical areas with highest concentration of the *Mahadalit* populations.

LONG TERM GOAL OF THE SASHAKT

To Increase comprehensive SRH knowledge and promote an enabling environment so that *Mahadalit* adolescents (15-19 years) can make informed decisions about whether and when to have children, thereby reducing drivers of adolescent pregnancy.

SHORT TERM OUTCOMES

1. **Improved Knowledge And Attitudes On Healthy Timing And Spacing Practices (HTSP)**, and demand for contraceptive services among *Mahadalit* adolescents, both married and unmarried, ages 15-19 years old.
2. **Improved Access** to contraceptive and maternal health services for married *Mahadalit* adolescent/couples (ages 15 -19).
3. **Strengthened Government Capacity** to deliver and sustain quality adolescent health programming for *Mahadalit* adolescents.

Adolescent peer group learning about various contraceptive methods and safe sex in a peer-group meeting led by peer educator

APPROACH

Sashakt developed a comprehensive programmatic approach with inclusion of all the relevant stakeholders playing a role in provision of and uptake of SRH services by adolescent men and women. It not only focussed on the knowledge and skills of adolescents on SRH, but also took cognisance of the fact that knowledge cannot translate into action until an enabling environment is created by commensurate efforts for reaching out to the all relevant stakeholders. (Exhibit 2)

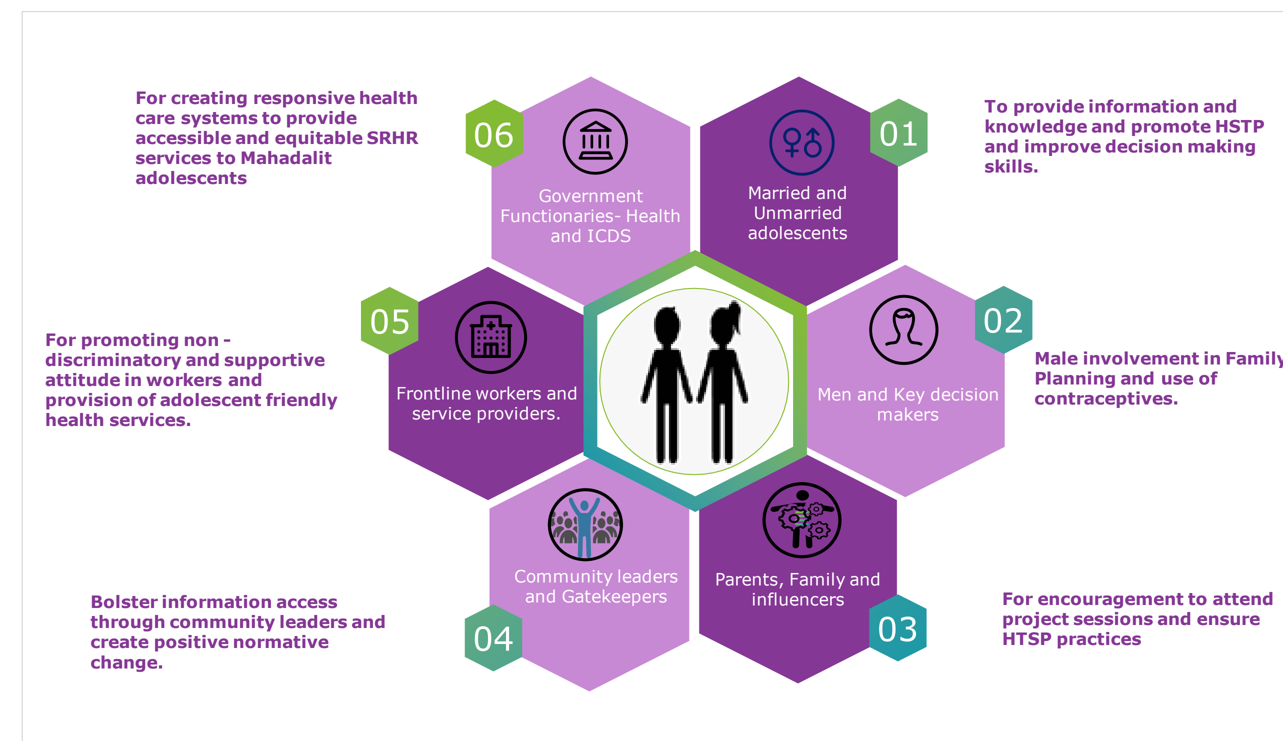

Exhibit 2: Multi Stakeholder Approach

SASHAKT STAKEHOLDERS

1. **Married And Unmarried Adolescents:** The most important group for imparting knowledge, encouraging and enabling decision making with respect to SRH.
2. **Men And Key Decision makers:** Most important to sensitize as the key decision makers for the adolescents.
3. **Parents And Influencers:** Adolescents have limited agency and family members make decisions on behalf of or for adolescents, especially with respect to marriage and HTSP.
4. **Community:** Cultural norms in any society play a central role in shaping a person's beliefs and behaviors and these beliefs include myths and misconceptions surrounding SRH services and act as barriers in the adoption of effective SRH practice. Community and religious leaders are trusted channels of information and can actively promote and encourage community members to access health services.
5. **Frontline Workers And Service Providers:** The attitude, knowledge of frontline workers of ASHAs are crucial to serve health needs and provide effective outreach services.
6. **Government:** Adequate SRH services cannot be provided in the absence of sufficient and AYRSH friendly infrastructure, FP supplies and provision of facility-based services. To close the loop of demand generation through all behavior change activities, the government health facilities need to be strengthened to cater to the demand generated through interventions with the community.

PROJECT STRATEGY

For reaching out and engaging the *Sashakt* stakeholders, a two-pronged strategy was designed to generate demand and uptake of SRH services by individuals and within communities and to improve access to equitable SR health services through the government health system. The approach and rationale for utilising segment specific strategies are mentioned on the exhibit below from the Sashakt Baseline Evaluation report.

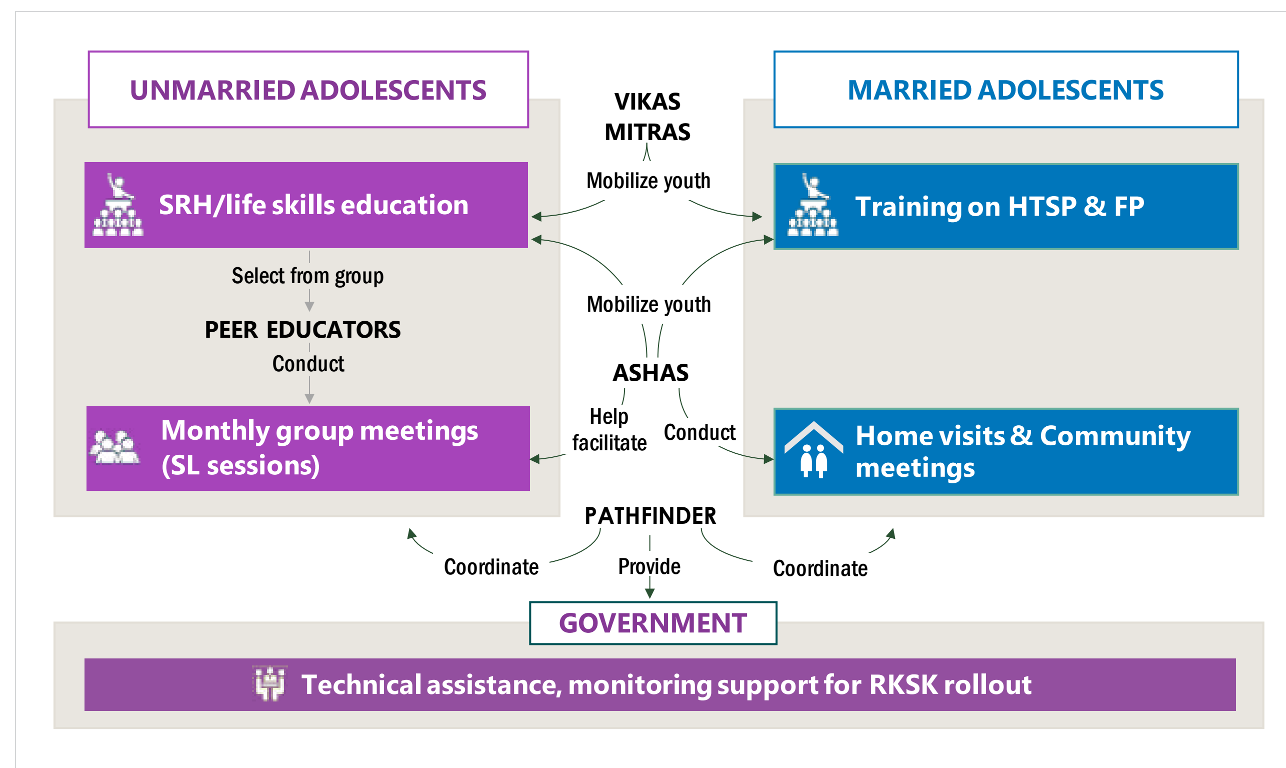

Exhibit 3: Segment specific communication (Source MPR Sashakt endline study)

Married Adolescents: Married adolescent couples were selected based on the age of wives aged 15-19 years, irrespective of husbands' age. The project conducted a one-day training for married adolescents on HTSP, which was reinforced with regular household visits to meet couples and the community meetings conducted for the all stakeholders including parents. ASHAs conducted home visits to provide customized Interpersonal Communication for HTSP and contraception options, with use of job aids provided.

ASHA using Sashakt IPC tools to explain contraceptives to a married adolescent during a home visit session

Unmarried Adolescents: Recognizing unmarried adolescents and youth are sexually active *Sashakt* designed and implemented a two-day SRH and life skills education course conducted in village schools, to discuss delaying marriage and information on contraception. This two-day training was supplemented by a 12-module curriculum being implemented through Peer Educators, who held monthly group meetings (Supplementary Learning sessions) for unmarried *Mahadalit* adolescents in their respective tola's. At these meetings, one module was implemented every month on SRH. Notably, these peer educators were selected and trained, with the objective of integrating *Mahadalit* peer educators into the government peer educator program under the *Rashtriya Kishor Swasthya Karyakram* (RSSK) at the conclusion of the project.

Peer Educators with Country Director, Pathfinder International, at State Level Dissemination in Patna

Community: ASHAs supporting the project conducted small group meetings with community members to change community perceptions on adolescents' age of marriage and SRH and create awareness about the importance of girl's education, delaying marriage, and the use of contraception for HTSP.

ASHA using Sashakt IPC tools to explain importance of spacing births during a home visit to a married adolescent

Males: To reach males as users and as key decision makers with respect to marriage, family planning and use of contraceptives, the project ensured their participation through trainings for both married and unmarried adolescents. Apart from this, community meetings and home visits by ASHAs were planned in accordance to the male migration patterns. With the help of a migration calendar tool, all ASHA's captured inward as well as outward movement of the men migrating from villages. ASHA's organized the community meetings in the village on HTSP one week prior to the men's arrival. The tool was useful for ASHA's for preparing women for contraception before men arrived.

A group of adolescent boys undergoing training on sexual and reproductive health

Parents, Family, and Influencers: During the home visits, key decision-making gatekeepers (e.g., husbands and mothers-in-law) were also engaged. To engage with community influencers including village elders, parents, brothers-in-law, and sisters-in-law to garner support for Supplementary Learning activities and create awareness on appropriate age of marriage and HTSP, small meetings were conducted.

These meetings were focused on specific topics that would fetch attention of the influencers and community at large.

Government: *Sashakt* provided technical, managerial, and monitoring support to the Government of India to roll out its National Adolescent Health Program (RKSK) in project-supported areas by integrating AYSRH with other programs areas such as nutrition, substance abuse, mental health, injuries and violence, and non-communicable diseases. To avoid creating parallel systems and to increase sustainability, the project built the capacity of existing Medical Officers (MOs), Block community mobilisers and ASHAs.

Frontline Workers: From the identified villages/ tolas, ASHAs were selected for training for mobilizing adolescents. The medical officers in charge (MOICs) of PHCs issued instructions for ASHAs working in the *Mahadalit* villages/tolas in the six blocks to attend the training being imparted by PII. 192 ASHAs were trained on:

1. **Enhancing IPC Skills** - this module covered effective listening skills, understanding problems and issues around SRHR effecting Mahadalit adolescents and effective counselling skills.
2. **Enhancing Technical Skills** on family planning methods and counselling, advantages and side effects of all FP methods, myths and misconceptions around the contraceptive methods and how to address them.
3. **Sensitization Towards** Migration and social exclusion of Mahadalits from access to family planning and health care services. Use of migration tool to effectively plan home visits and community meetings was also included.
4. **Job Aids for ASHA:**
    - **Picture Based Cue Cards** were developed for facilitation of home visits to ensure specific information was delivered to segments of the married couples based on their parity. Relevant contraceptive methods for each segment were given on cue cards to guide the ASHA while conducting home visits.
    - **Flipbooks For Facilitation Of Community Meetings** for keeping participants engaged and focused on difficult topics for ASHA. Picture and story-based posters were developed for topics on appropriate age at marriage, appropriate age at first pregnancy, spacing births, and role of men to break gender stereotypes related to use of contraception.
    - **Migration Calendar** to track migration affected families and plan the inward movement of migrating population and organized home visits and community meetings accordingly. ASHA's planned visits to the families based on information gathered and organised community meetings in the villages on HTSP one week prior to the men's arrival.

PROCESSES AND ACTIVITIES

SHORT TERM OUTCOME 1

Improved knowledge and attitudes on HTSP, and demand for contraceptive services among *Mahadalit* adolescents, both married and unmarried, ages 15-19 years old.

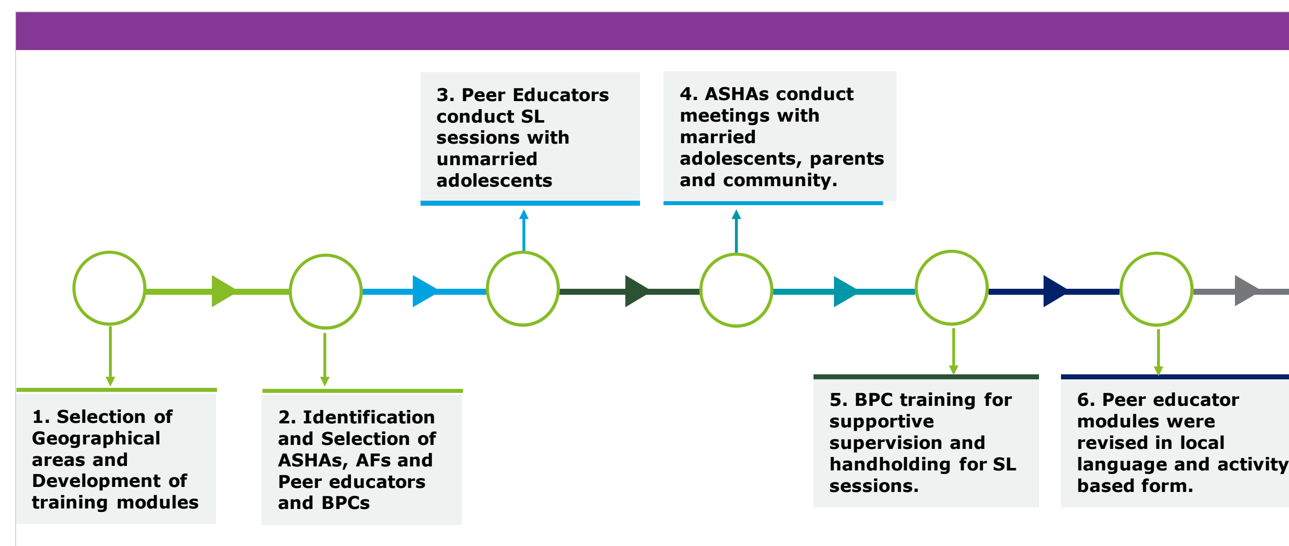

Exhibit 4: Short Term Outcome 1 interventions

Selection Of *Mahadalit* Village/Tolas: The districts were selected based on deprivation in terms of poor health, nutrition indicators. Within the selected districts, six blocks with the highest proportion of *Mahadalit* population as per Census data were identified, and a socio-demographic profile of the project area was developed. With this assessment, 12 additional primary health centers (PHCs) already implementing RKSK and villages/hamlets with a high *Mahadalit* population, were selected for implementation from 61 Panchayats.

Development Of Training Module: New Concept Pvt. Ltd developed training modules for married/ unmarried groups covering the following topics: Facilitation skills, Adolescent period transition, Reproductive and adolescent health, Marriage, Partnership and Family planning, Infections of Reproductive tract, STIs and HIV/AIDS, Addiction and substance abuse, Gender and Sex, Violence and Sexual harassment, and Role of peer educators (PEs). Modules for married couples included Family planning methods, Spousal communication, and Negotiation skills.

Selection And Training Of Master Trainers: Master trainers (13 females and 10 males) were selected based on interviews and trained for five days. The master trainers were oriented to Pathfinder International's work and the *Sashakt* objectives, mainly to ensure that all master trainers understood the program purpose.

The first three days of training were dedicated to imparting facilitation skills regarding different adolescent life skills and SRH topics, and the last two days were devoted to mock sessions.

Training Of ASHAs And ASHA Facilitators: From the identified villages/tolas, ASHAs were selected for training for mobilizing adolescents. The medical officers in charge (MOICs) of PHCs issued instructions for ASHAs and ASHA facilitators working in the *Mahadalit* villages/tolas.

In the selected six blocks, 266 ASHAs and 42 ASHA facilitators were trained on project goals/objectives and process of selection/mobilization of unmarried/ married adolescents.

Selection of PEs: Based on post-test results, two PEs were selected from each batch. The criteria also included Education, communication skill, leadership abilities, resourcefulness, and general awareness. During selection, priority was given to select PEs in the group aged 15 to 17 years to allow engagement with the project for one complete year.

Orientation Of Selected PEs On Incremental Learning: Orientation sessions were organized at the Block level from module one to module ten and mock session were conducted to internalize content learned The orientation focused on monthly incremental learning sessions, reviewing the roles/ responsibilities of PEs, ways to organize monthly incremental learning sessions, engagement with their adolescent peer group, record keeping, writing reports/minutes of meetings.

Mobilization Of Unmarried Adolescents And Married Adolescents Of *Mahadalit* Communities: Accredited social health activists (ASHAs) conducted home visits, during which parents/mothers-in-law were informed about the content and benefits of training. A training plan was developed based on the list generated by all ASHAs block wise. A final list of unmarried adolescents and married couples was prepared. For married couples, the age of wives aged 15-19 years was considered, irrespective of husbands' age.

Training Of Unmarried Adolescents: The peer educators (PEs) enlisted 5,941 adolescents, to form small groups in the villages with 5,874 adolescents participating in SL meetings. Peer educators (PEs) conducted 1,489 SL module sessions in 362 hamlets in 10 Panchayats. Adolescents underwent training in their village/ government schools for two days.

Training Of *Mahadalits* Married Couples: A list of married, adolescent couples (1,636 across six blocks) was prepared by ASHAs (based on the age of the wife under 19). Trainings were conducted in village government-run schools by one male and one female master trainer, assisted by ASHAs.

Development Of New Modules And Training Of Trainers: supplementary learning (SL) modules to facilitate small village meetings of unmarried adolescents through Peer educators based on insights from adolescent groups and ASHA's were collected. Based on these insights, new modules were developed in Hindi and, attempts were made to contextualize this by including local language and style so that the group could relate to the content.

MODULE THEMES

- Anaemia effect on adolescents health
- Depression as a common concern.
- Serious ill-effects of tobacco use.
- Benefits of delaying first pregnancy.
- Awareness on various modern contraceptive methods.
- Benefits of spacing between two births.
- Menstrual hygiene practices – for girls,
- Need for boy's and men's supportive attitude towards girls/women on menstrual hygiene.
- Risk preparedness (especially focusing on sexual/mental health) during migration/when away from home, HIV and AIDS.

Exhibit 5: Themes of revised modules for training PEs

Training of Block Project Coordinator and PE on Incremental Learning: Incremental learning modules on life-skills education are being used by PEs with their group members during meetings organized at villages. A four-day training of block project coordinators and 10 selected PEs was organized on incremental learning at *Purnea*. All the Block Project Coordinators and project manager underwent a training on the new SL modules as well as new ASHA curriculum to capacitate BPCs on building facilitation skills of the peer educators to improve the quality of SL sessions.

SHORT-TERM OUTCOME 2

Improved access to contraceptive and maternal health services for married Mahadalit adolescent/couples (ages 15 -19)

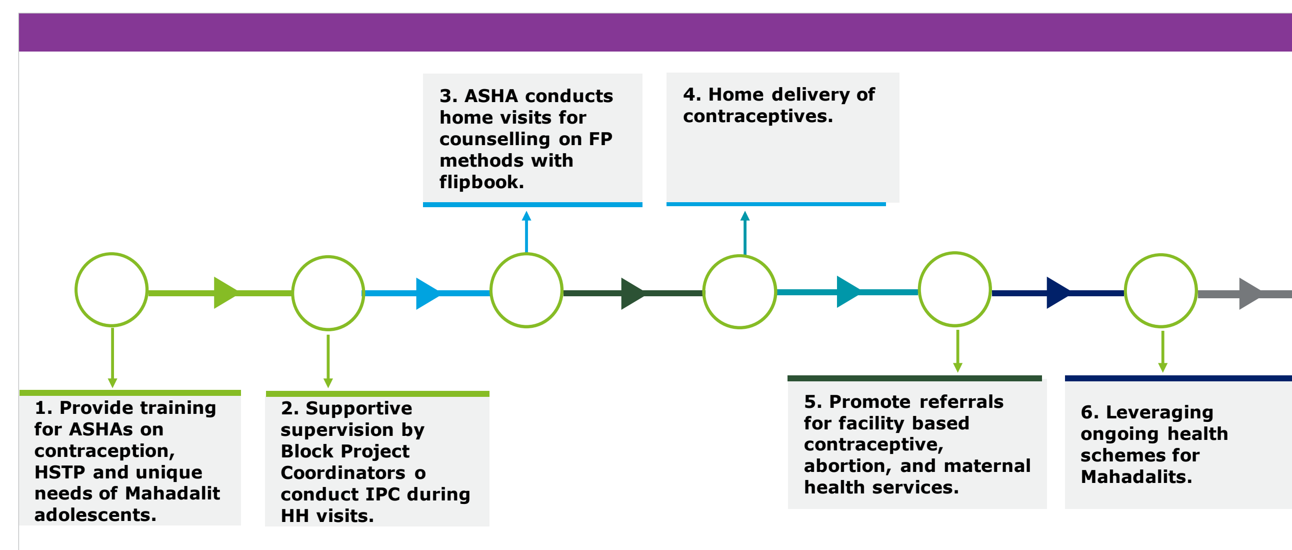

Exhibit 6: Short Term Outcome 2 interventions

ASHAs Training On Contraception, HTSP, And The Unique Needs And Conditions Of Married *Mahadalit* Adolescents: One day training was conducted for 160 ASHAs in six blocks on unique needs of adolescent population in *Mahadalit* community, adolescent health and the PE approach to change knowledge and attitude among adolescents around SRH. During this training, ASHAs were also trained using the IPC tool/flipbook, a FP counselling job aid developed by Pathfinder.

Undertake Supportive Supervision Visits For On-Site Support Of Ashas: ASHAs in the project area were provided with supportive supervision by Block Project Coordinators (BPCs) to conduct IPC during household (HH) visits. A list of eligible adolescent couples was created for each intervention site with the help of ASHAs. ASHAs conduct home visits to deliver messages on key HTSP behaviours and community-based distribution of contraceptives: Using the flipbook ASHAs conducted IPC to create awareness on all the FP methods. The eligible couple were also given the opportunity to decide on the method of choice and plan to start use with ASHAs.

Promote Referrals For Facility-Based Contraceptive, Abortion, And Maternal Health Services: Of the women visited by ASHAs, 527 were eligible for use of contraceptives. However, only 56 women were using a contraceptive method including four tubectomy cases, and 274 non-pregnant women expressed desire to have a child soon. Only 86 women were aware of contraceptive methods but were not currently using one while their husbands were migrated out of the village. A total of 98 women reported being unaware of contraceptive methods and did not know where to get one. Of those visited, 522 women opted for contraceptive and were referred to health centers.

Deliver Additional Training For ASHAs On Values Clarification Surrounding Contraception And HTSP For Mahadalit Adolescents: In this project phase, Pathfinder created additional modules with increased focus on enhancing IPC skills to promote non-judgmental attitudes, unbiased care, and empathetic interactions towards *Mahadalit* adolescents. These additional topics were considered in response to the baseline findings and learning workshop conducted with MPR, that married women's views about the ASHAs look down on them. Also, it was noticed that the ASHA's lack skill to communicate effectively on the contraceptives. Thus, a new curriculum for two days was developed for ASHA's.

Integration With The Existing Schemes For *Mahadalits*: Pathfinder facilitated the FP component in the training organized under *Mukhya Mantri Saat Nishchay Yojana* (Chief Minister's seven decision scheme) in *Araria* attended by a total of 227 *Vikas Mitras*. The training covered FP needs, methods, and rights based SRH services.

SHORT-TERM OUTCOME 3

Strengthened government capacity to deliver and sustain quality adolescent health programming for *Mahadalit* adolescents.

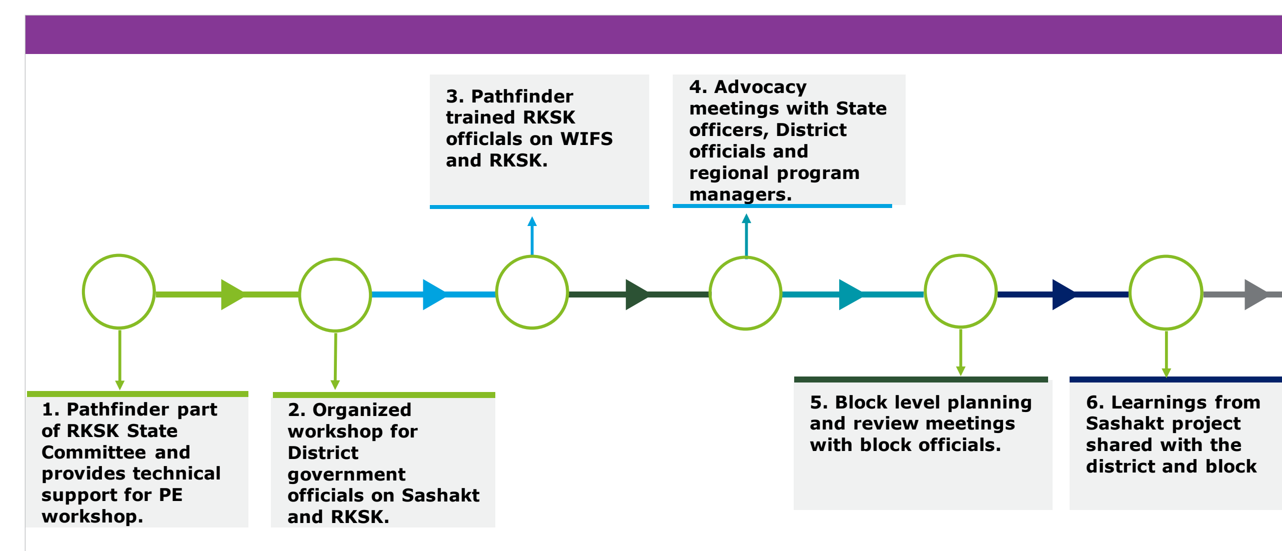

Exhibit 7: Short Term Outcome 3 interventions

Support The Government Through Technical And Managerial Assistance In The Rolling Out Of RKSK Program In The Sashakt Intervention Areas: Pathfinder participated in the RKSK State Committee and participated in the state-level meeting held January 16, 2018 at State Health Society.

Support In Trainings And Workshops: Pathfinder provided technical support during the PE dissemination workshop and five-day training of trainers of Auxiliary nurse midwives (ANMs). Additionally, *Sashakt* representatives from *Raniganj* and *Forbisganj* supported the trainings in their respective blocks.

Workshop For District Officials On *Sashakt* And RKSK: Requested by the district Magistrate *Arariya*, a one-day workshop was organized on December 23, 2017 for district-level officials from ICDS, PHED, Education, and *Panchyati* Raj for cross-learning between the *Sashakt* and RKSK programs.

Advocacy Efforts: Pathfinder's advocacy strategy, increased the engagement of government officials in the project and prioritization of RKSK activities at block and district levels. This catalysed officials' monitoring of the ASHAs'/ASHA facilitators' activities related to RKSK and *Sashakt* in *Mahadalit* villages during the review meeting at PHCs.

RKSK And WIFS Trainings: Pathfinder trained all RKSK block officials on Weekly Iron Folic Acid Supplementation (WIFS) program under RKSK in Katihar and Purnea.

Meet With Government Managers At Block, District, And State Levels To Share Project Progress: Meetings were conducted to inform the Executive Director, SHSB and SPO, and RKSK on project goals. Meetings were also conducted with the SPO and Executive Director of Bihar *Mahadalit* Vikas Mission to review the implementation of the *Sashakt* - II project and get permission to train and involve the *Vikas Mitras* in the mobilization of *Mahadalit* adolescents and married couples. In these meetings, learnings from selection of peer educators and capacity building of peer educators was discussed with government officials.

Garner Support From Government: The civil surgeons of three districts issued instructions to the relevant MOICs to extend their support for trainings of ASHAs and ASHA facilitators, and support for the *Sashakt* project. The training plan of ASHAs was disseminated to MOICs and block community mobilizers/block health managers by the block project coordinators through the district communication channel.

Joint Monitoring Visits With Government Officials: In all three-districts, joint review meetings were organized with RKSK nodal officers, District community mobilizers, MO in charge of the RKSK blocks and respective Block Community mobilizers. Government officials at the block conducted field visit to *Sashakt* intervention areas and provided feedback. Block community mobilizer's (BCM's), the nodal officers for RKSK at block visited eight locations, Block Health Managers (BHM) made three field visits whereas one visit with medical officer in charge (MOIC) was conducted. 83 meetings were conducted with block level officials including MOIC, BCM and BHM's. During these meetings monthly data and plans were shared. The meeting agenda included ASHA review, PE training, Availability of contraceptives, no. of married adolescent using contraceptive, Yuwa clinic, Telephone counselling services, RKSK PE validation, Adolescent Health Day planning and feedback under RKSK.

A peer educator leading a group session in her village

ACHIEVEMENTS AND OUTCOMES

Sashakt yielded several positive accomplishments in areas of intervention, and also bought fore challenges in some other areas leading to either innovations or realization of the project design limitations. This garnered valuable learnings for synthesizing effective strategies in any program designed for vulnerable adolescent population. The learnings have emerged from evaluation of the project through baseline, midline and endline.

The overall progress in the outcome indicators from baseline to endline does not necessarily provide the causal evidence of the impact of the Sashakt. The extraneous factors and limitations that may have changed outcomes are discussed in Challenges and Learnings section. The cumulative quantifiable achievements in terms of the key inputs, processes and outputs and reach of the project are summarized in the exhibit below.

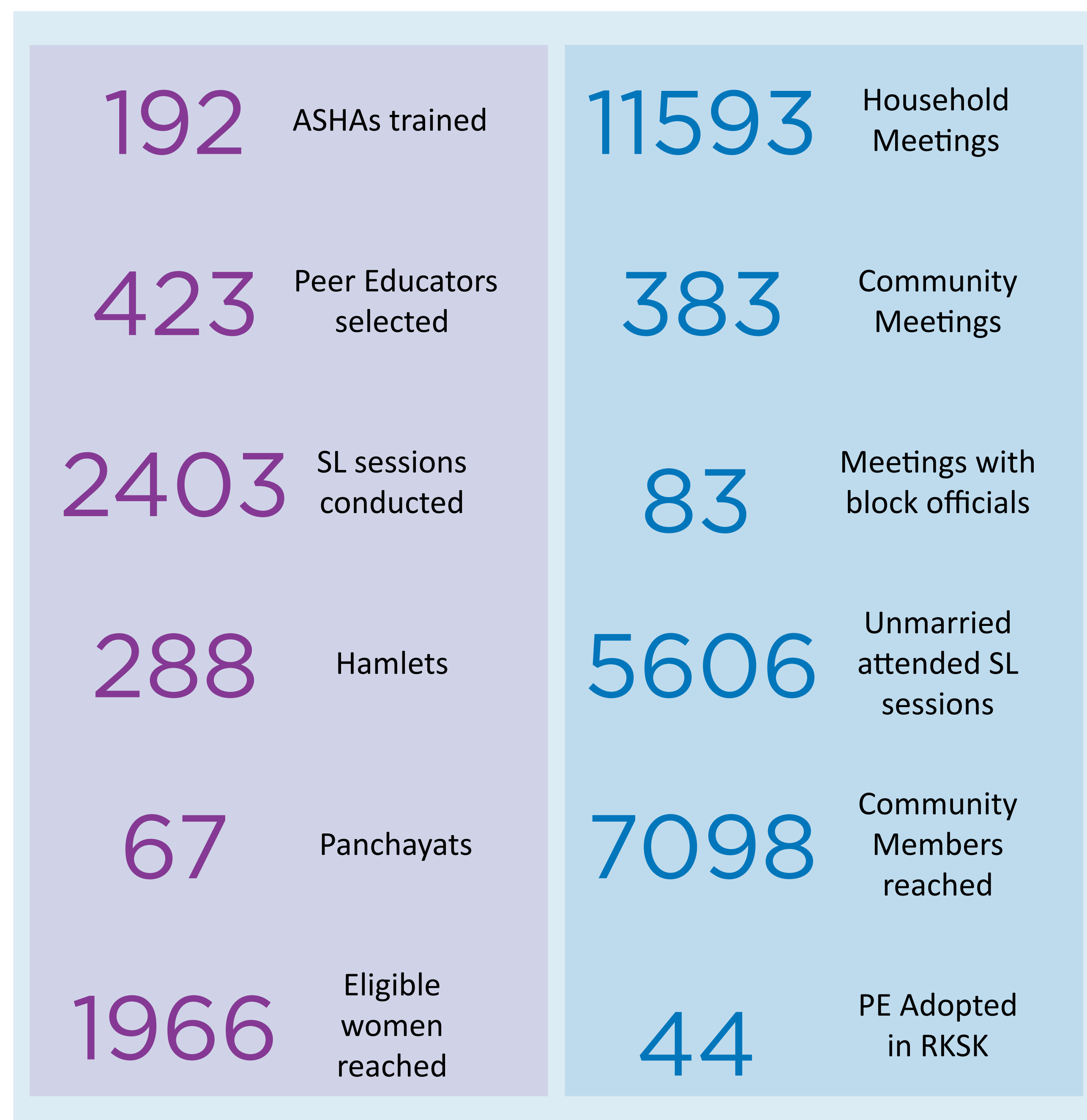

Exhibit 8: Output and Outcome Indicators

The overall outcomes of the project as assessed through the end line assessment to evaluate program uptake and stakeholders perspectives and shifts in project outcomes are as follows:

STAKEHOLDERS PERSPECTIVES

PROGRAM EXPOSURE:

Unmarried women segment had highest exposure to project activities while both married and unmarried women had limited exposure due to migration and opportunity cost involved in attending sessions. Competing priorities such as MR and MI campaign affected frequency of HH visits by ASHAs, therefore limiting married women's exposure to the project interventions.

PERCEPTION ABOUT SASHAKT ACTIVITIES:

All adolescent groups viewed trainings very useful. While Married women and men reported that ASHAs are very good at conducting sessions, the unmarried men and women found PE very good at conducting SL sessions.

FREQUENCY OF INTERVENTIONS:

Most groups of beneficiaries reported regular and frequent sessions from the project. About 90% of unmarried adolescents said the SL sessions were held monthly and 81% married women reported that community meetings were held monthly Despite ASHAs busy schedule most married women reported that they received two SRH sessions from ASHA in three months.

PEER EDUCATOR'S COMPETENCY:

This area had varying findings with the adolescents reporting the PEs were good at conducting sessions and answering questions and Peer Educators indicating that they did not always understand the intent and ways to conduct interactive activities integrated into modules. The female peer educators were still not very confident in their facilitation of SL sessions and relied on Pathfinder block program coordinators for support.

IMPROVEMENT IN SHORT TERM OUTCOMES

MARRIAGE RELATED CONCEPTS

- Unmarried women showed significant improvement in being able to cite any particular benefit to delaying marriage.
- Opinions around the role of girls in decisions about marriage timing has improved among unmarried women and men.
- Significant gains in adolescents reporting they would tell parents or have already told to delay marriage.
- Still, most adolescents did not believe they will be involved in decisions about their own marriages.

CONTRACEPTIVE KNOWLEDGE

- Contraceptive knowledge increased across all sub-groups, but joint decision-making around and use of contraception remained low.
- Knowledge of three or more contraceptive methods increased significantly for all groups except for married women.
- Proportion of married women reporting that contraceptive use should be a joint decision between a husband and wife rose significantly
- 40% of married men and women said that they plan to use a method in the next 12 months.
- Knowledge of where to get a modern method increased among men but did not increase significantly among women.

ATTITUDE TOWARDS HEALTHY TIMING AND SPACING

- Attitude about timing of first birth improved among all subgroups, except married men.
- Over 65% of women believe it is optimal to wait at least 2 years after marriage, while only around half of men share this belief.
- Desired number of children remains relatively unchanged.

INTENTION TO USE CONTRACEPTIVES

- Discrepancy between current use of contraception and intention to use among married adolescents.
- Intention to ever use contraception decreased significantly among married women
- Intention to use family planning to delay first birth changed among unmarried adolescents, with decrease by 11.6 PPT for unmarried women and increase by 17.4 PPTs for unmarried men. Intention to ever use contraception did not change for either group – remaining high for unmarried women at 90% and low for unmarried men at 50%.

ABORTION AWARENESS

- Abortion awareness increased from low baseline levels but remains low.
- Only 28 to 44% of adolescents were aware of abortion's legality at endline.
- Awareness of the risks of unsafe abortion rose significantly for unmarried adolescents from 59 to 70% at endline.
- Married adolescents had higher levels of knowledge of risk than their unmarried counterparts (69% of married men and 82% of married women).

ASHAS VIEWS OF MAHADALITS

- ASHA's no longer referred Mahadalits by derogatory terms, as they did during baseline and midline assessments.
- Interaction of pregnant or recently delivered women with ASHA increased from 2.0 at baseline to 2.5 at endline.
- Adolescents' perceptions of how they are treated by ASHAs has not improved as 22% respondents felt that the ASHA looks down on them at the endline as compared to 21% at baseline.

Adolescent girls participating in the sexual and reproductive health training and ASHA delivering family planning messages to a married couple during a home visit session

CHALLENGES AND LEARNINGS

The *Sashakt* project has generated a wealth of learnings and good practices. The most valuable learning comes from understanding and addressing the challenges encountered. The project ensured emerging challenges paved way to learnings and realignment of interventions. The learnings accumulated were bought forward from Baseline dissemination, Midline evaluation and the endline survey learning workshops and regular review meetings. The Implementation learning design involved collecting timely data for establishing a feedback loop that generates learnings and aids in decision making and re-strategizing.

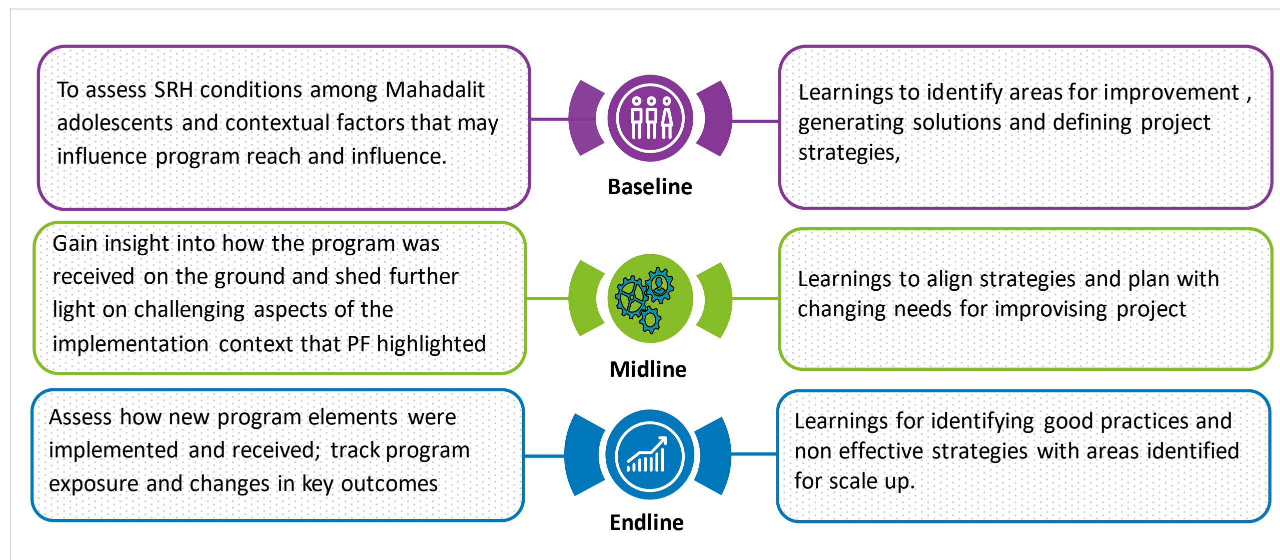

Exhibit 9: Implementation Learning design

This section pulls together the main challenges encountered, and lessons learnt in implementing *Sashakt.* It has developed a rich diversity of strategies to improve AYSRH services, demand and create sustainable models under circumstances constrained by conservative and religious environments.

CHALLENGES

The project encountered many anticipated and unanticipated challenges in delivering the interventions as well as the innovative approaches developed to improve the access and reach of project activities. These were related to involvement all the stakeholders including the adolescents, the community, ASHAs and ANMs, Peer educators and the health facility staff. From the operational aspect, these can be classified into the challenges encountered in mobilising adolescents for the sessions and the challenges in receiving services from health facilities. These are explained in detail below:

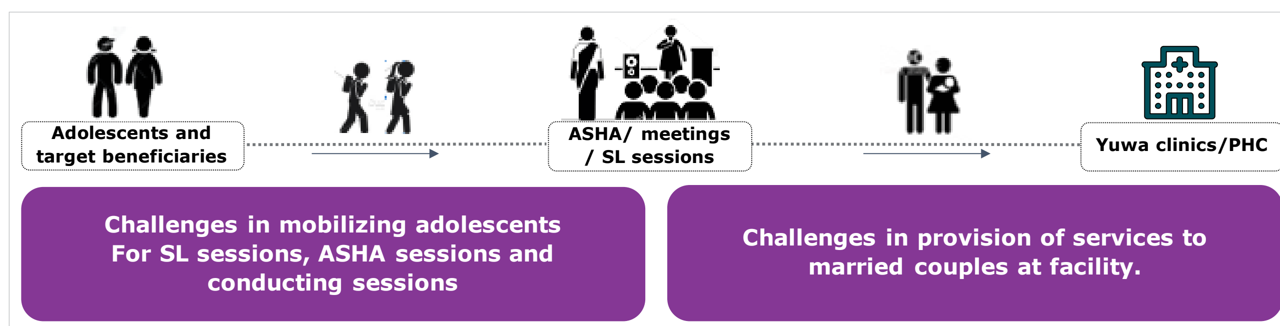

Exhibit 10: Project implementation challenges

MOBILIZATION AND ENGAGEMENT OF ADOLESCENTS

Seasonal Issues/Periodic Issues: The adolescents had increased personal engagements during certain seasons and phases such as elections, festivals, marriage, exams, sowing and harvesting season that affect their ability to attend Supplementary learning sessions. Further, household responsibilities, extreme summers, rains and flood hampered their participation in sessions.

Loss Of Wages: The participation of adolescents in sessions does involve opportunity cost, especially during agricultural seasons when *Mahadalit* community are engaged in wage labor. In such circumstances, parents were reluctant to send their children for a two-day training.

Migration: Adolescent males aged 15 to 19 years migrate to other parts of the country for work opportunities and are not available in the villages for a major part of year. In some Tolas, the entire adolescent groups migrated together. This created a major barrier in engaging with married, adolescent couples, as both husband and wife were rarely available at the same time for home visits and community meetings.

Gender Norms: Mobilization of married, adolescent girls was severely impacted by the prevailing gender norms such as the *Pardha* (veil) and taboos that restrict women's mobility and ability to freely engage in any public events with their husband.

Peer Educators competency: It was observed that, the educational qualification of the PE's need not necessarily reflect their ability to read and text heavy modules posed a challenge. Further, some concepts of life skills such as critical thinking, problem solving, and decision-making were difficult to comprehend and deliver even though modules consisted of activities and role-plays.

ENGAGING SERVICE PROVIDERS AND AVAILABILITY OF FACILITY-BASED SERVICES

Service Provider's Bias: Judgmental attitude, caste-based prejudices and discrimination among ASHAs and ANMs towards *Mahadalit* community emerged as a social hindrance in adolescents' access to information and services.

Competing Priorities For ANMs: The home visits and community meetings relied on ASHAs availability. However, the pre-existing commitments to strictly monitored national health programs and routine immunization, led to program officers reluctance to relieve ANMs for participating in project activities at the cost of the program indicators.

Inadequacy Of Contraceptives: Home delivery of contraceptives to married couples during home visits was one of the key project strategies. However, ASHAs relied completely on the supply of contraceptive commodities from the PHC and reported shortages of condoms and urine pregnancy testing kits. This emerged as a major challenge in use of short acting FP methods in view of the mobility restriction and lack of awareness amongst adolescents on how to purchase and use the UPT kit.

Lack Of Assured Facility Based Services: Married couples were referred to government health facilities, Yuwa clinics for long acting contraceptive methods by ASHAs during HH visits. However, these clinics were rendered non-functional either due to transfers of MOs and ANMs or preoccupation with labor room duty in Araria and Purnia. Thus, willingness to use IUCDs and injectable methods could not be translated to improved utilization.

LEARNINGS

Project implementation taught many valuable lessons about nuances, factors and challenges effecting implementation and outcomes over time. These insights were promptly used to redesign strategies to test effectiveness and discontinue activities that were proven ineffective. Project failures were analysed to determine where the project when wrong, what could have been done better and which areas need more attention in the next phase of the project. The key learnings accumulated over the project duration are described as under two heads, for the project and for the strengthening public health systems:

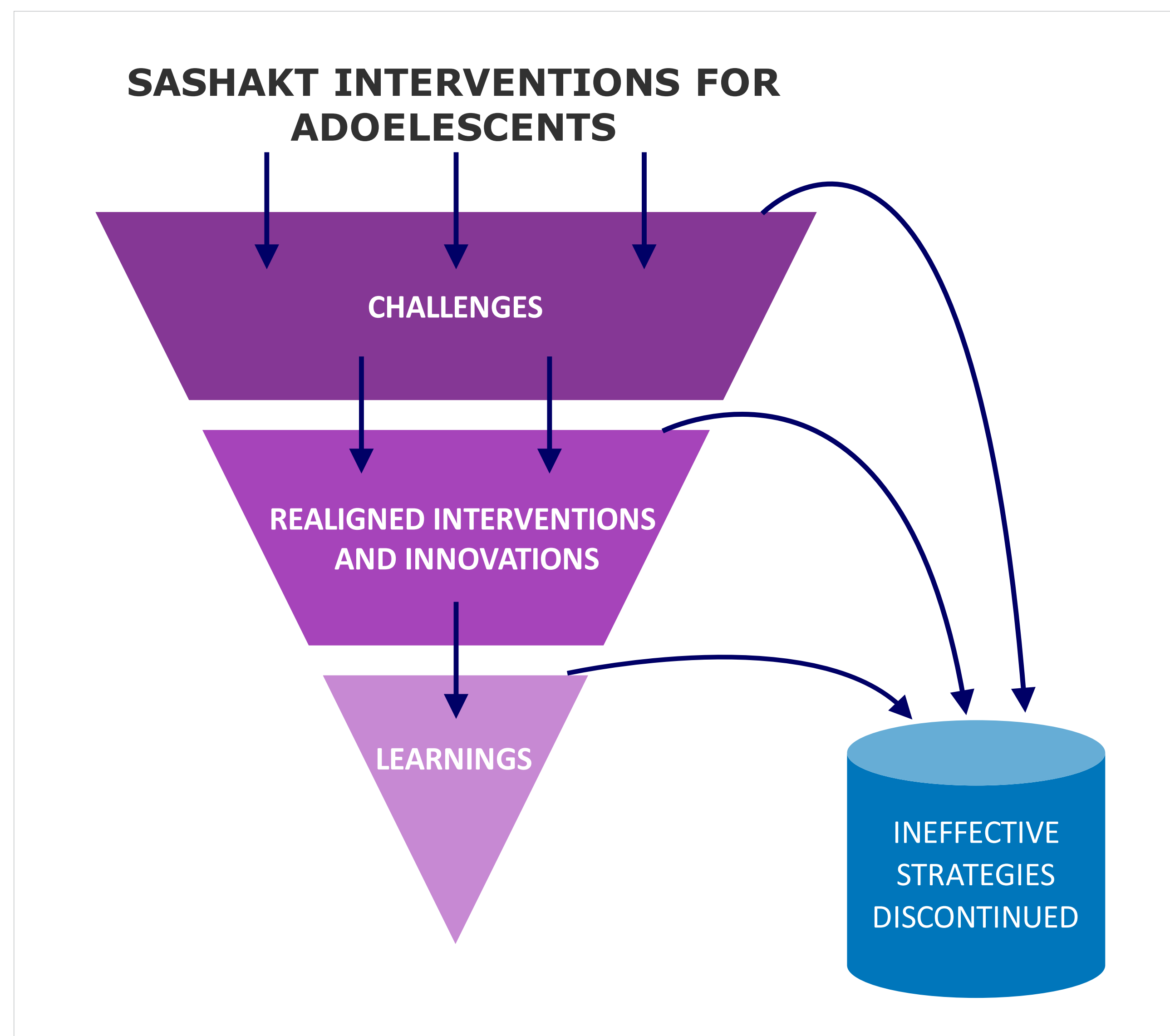

Exhibit 11: Learning Framework

Knowing The Demography Is Important as understanding the detailed profile of the target beneficiaries and their community helps know why knowledge and attitude changes related to marriage and contraception may not always lead to positive changes and decision making in SRH. The various determinants such as knowledge; social norms, economic considerations, inclusion in social opportunities and education that affect the behaviours and the SRH outcomes need to be addressed to achieve positive outcomes.

Peer Educators Have Great Potential to address the knowledge needs of *Mahadalit* adolescents, notably as majority of these adolescents do not attend school, have no reliable sources of information, and prefer receiving this info from family and peers. The PEs have good understanding of the common concerns and provide crucial insights in designing appropriate and acceptable strategies as they belong to the same group.

Peer Educators Are Instrumental to establish health care accountability mechanisms by acting as a link between adolescents and health care delivery systems through ASHA. They also help in address community based issues such as social norms around gender and marriage.

Training Modules Affect Learning Outcomes And sessions need to be Interactive in design as text heavy SL modules were low on engagement and made sessions a monologue with PE reading out the module. The revised SL modules based on suggestions from PE's, BPCs, ASHAs and adolescents were well received as they were interactive, simplified and contextualised with use of Hindi and Local language so that the adolescent group could connect with the content.

Criteria Of Selection Of Peer Educators needs to be decided carefully with consideration to several factors. The criteria of performance in the trainings, education, communication skill, leadership abilities, resourcefulness, and general awareness were found to be useful but not sufficient as other factors led to drop out or problems in acceptance in community.

A new set of criteria was developed to reduce the drop out. The new set of criteria included candidate from *Mahadalit* community, age of 15-19 years, ability to read and write, consent from the parents to volunteer, no addictions, no plans to marry or migrate, belonging to a family with good reputation within tola.

Sensitization Of Providers is essential to address bias, judgmental attitudes and behaviours that may interfere with equitable access to healthcare for *Mahadalits* as ASHAs are from high-caste background and may have prejudice towards *Mahadalits*. Constant engagement of field-level health workers helps dispel such prejudices against the *Mahadalit* women and adolescents, to some extent.

Provision Of Financial Incentives can play a key role in motivating ASHAs to provide outreach services to the otherwise socially excluded and neglected community needs and improve their commitment and quality and frequency of beneficiary interactions.

Skill Trainings Of Service Providers on counselling and communication skills to be able to effectively deliver appropriate segment specific message in a convincing way has great bearing on session outcomes. ASHAs receive many trainings on the technical content under the National health programs and often lack on this aspect.

Job Aids And Tools Are Effective means of improving facilitation skills and confidence in peer educators and ASHAs. Use of engaging and pictorial tools also helps in engaging the audience effectively and enhancing two-way communication. The job aids also need to be specific to audience such as cue cards and flipbook for adolescents and pictorial story based posters for community meetings.

Informal Teaching Style and interesting mediums of engagement such as drama, song, and music are more appreciated by the adolescents. Such mediums should be included for better participation and learning. Trainings conducted by external trainers enjoy more credibility and are more impactful in increasing knowledge.

Appropriate Timing Of Sessions and meetings is vital to ensure consistent presence of adolescents in SL classes. To improve attendance the meetings should be scheduled at a convenient time, mainly before working hours. In addition, catch-up rounds should be conducted to reach adolescents who could not attend previous meetings. A pattern of migration must be studied to devise an appropriate strategy to reach the maximum amount of married and working adolescents.

The Training Pace Needs To Be Optimal with repeated pre-test and post-test to gauge the previous session recall. Brainstorming and question-and-answer sessions are good way to reiterate the messages conveyed and the means of taking answers should ideally be objective answers than subjective that need writing.

Community Meetings Have Potential to disseminate knowledge and address the social and gender norms. They were instrumental to galvanize support from community and the parents, as they were able to relate to the topics discussed in the SL sessions and encourage their children to attend meetings. There is a need to explore some mechanism to act as compensation of wage loss to overcome reluctance in parents.

Segment Specific Communication is essential to ensure internalization of the knowledge imparted. The response to and the attendance in community meetings was good as only those topics were discussed that would fetch attention of influencers and is relevant to them such as appropriate age at marriage and first pregnancy, birth spacing, role of men in breaking gender stereotypes related to use of contraception. Similarly, the married adolescents were selectively given information on methods relevant and most appropriate for their own parity status.

Sustainability And Ownership of the project by government can be ensured through joint monthly meetings for review of project, adoption of peer educators of project in RKSK and passing administrative orders to extend support to the project. RKSK program and Yuwa clinics strengthening is important to cater to demand generated by the project with commensurate supply of services at facilities.

Positive Political And Administrative Environment plays a major role in successful implementation of any project. The State governments' commitment and efforts towards upliftment of the socio-economic status of *Mahadalit* communities and involvement of Vikas Mitras cadre meant for linking *Mahadalits* with welfare schemes provided an enabling environment for the project.

STAKEHOLDER PERSPECTIVES

Sashakt gave due importance to the key stakeholders involved in the effective service delivery of SRH services to the married and unmarried adolescents from Mahadalit community. It aimed at bridging the gap between the target beneficiaries and the service providers by transferring knowledge. The project strategically involved these groups for getting their inputs in planning and implementation of activities.

The close liaison of the project staff with the government officials was maintained to ensure the project activities complemented the existing services from government or developed a strong foundation for government adolescent health program to build on. Constant engagement with representatives from the adolescent group i.e., peer educators was maintained to redesign strategies and activities in accordance to felt need.

It is important to gauge and understand the value and benefit these different stakeholders perceive in the project and how they anticipate the project to evolve and better address their expectations. The following section gives a summary of these expectations and recommendations from the key stakeholders to build on the gains made:

Community Peer Educators: Representatives from the Peer educators asserted that while the project has led to an increase in self- esteem, knowledge and problem-solving capabilities the following interventions would add value:

- The Peer Educators should have an official recognition and authorized identity.
- Peer Educators can actively participate in the state government organized programs such as RKSK to create better demand for their services, to streamline service delivery and benefits for Mahadalit community.
- Peer Educators should be linked to other economic and social opportunities to motivate them to continue working as peer educators.

ASHAs undergoing training on social inclusion, and peer educators participating in monthly trainings on sexual and reproductive health modules

Sashakt block coordinator providing handhold support to a peer educator

State Government: The project depicted a workable model for RKSK in the districts and garnered a lot of learnings and good practices that can be instrumental in operationalising the RKSK programme. The State government representatives explicitly expressed on the following value addition bought in by the project:

- RKSK has been prioritized at the state level and is considered important to be implemented in all districts. The RKSK has potential to institutionalize Sashakt model for the expansion of RKSSK across all districts. (ED-SHS, Bihar).
- Sashakt project outcomes and learnings have the potential to ensure success of RKSK.
- More efforts would be made for peer Educators confidence and capacity building and Sashakt PEs have been identified as resources for building capacities of about fifteen thousand RKSK PEs.
- The project has done well in increasing age at marriage, health system needs to learn from the Sashakt experience and implement.

The different stakeholders' perspectives reflected commonalities in terms of the benefits accrued by the project and the need to further develop in areas. These include developing linkages of peer educators with other socio-economic opportunities, utilization of their skills in other programs including RKSK and developing new partnerships with organizations and communities to ensure scalability and continuity of Sashakt approach and interventions. Some of the insights from stakeholders have been conceptualized to be incorporated in the next phase of the project.

WAY FORWARD

One of the prime intentions of the Sashakt was to generate evidence and documenting lessons learnt to enable designing of future projects for the Mahadalit adolescents. The end line evaluation assessed progress of outcomes and beneficiary perspectives and bought forward several factors that affected the project implementation and need to be addressed to bring about desired behaviour change.

The evaluation results highlighted many strategies that bought about improvements such as sensitization of FLWs on social inclusion and provision of nominal financial incentives that played a role in motivating ASHA's to address information and service delivery needs of Mahadalit adolescents. However, even though there were improvements reported in ASHAs attitude towards beneficiaries, the progress is still far from desirable. More extensive sensitization workshops for rectifying ASHAs' existing discriminatory beliefs about Mahadalits are required to build on the positive effects achieved so far. Some strategies to strengthen financial incentives to ASHAs to improve ASHA outreach to Mahadalit adolescents could also be tried out for a larger impact.

The evaluation showed substantial changes in levels of knowledge and awareness amongst all group of adolescents and validated the approach of group meetings as a platform to ensure access to accurate SRH information amongst married and unmarried adolescents. However, it also showed that increase in the knowledge on SRH amongst adolescents does not necessarily lead to desired behaviour change as it is influenced by several other factors that need commensurate attention to improve in SRH and HTSP practices. Focussed efforts on tackling gender related social norms, participation and engagement of the men for improved couple communication and sensitization of decision makers is crucial in order to achieve intended outcomes. The project intervention therefore should expand the scope to Social Behaviour Change Communication (SBCC) from the previous model of information provision through trainings.

Since prevalence of seasonal migration, mostly by the able-bodied males, to nearby cities and towns makes reaching out to them in person a great challenge, there is a need to devise strategy to reach out to more adolescent including male migrants through intensified meetings/ group sessions with these beneficiaries when they return and are available through adoption of technology based platforms for increasing reach of SRH sessions amongst migrant men when not available.

To strengthen the Sashakt model further, it should be integrated with the governments' Rashtriya Kishor Swasthya Karyakram; for improvement in the access of the adolescents to non-SRH services such as nutrition supplementation and counselling services. As in the first phase, the project will continue to build capacity of Peer Educators under the RKSK program to increase referrals for service provision through strengthened coordination between Peer Educators, ASHA and ANMs and ins second phase will work more closely with government officials to address HR and supply chain issues that affected the facility based SRH service delivery. Focussed efforts would be made to improve the client provider interface and improving access to Family planning and Maternal health services amongst the community. The proposed model for adoption during upcoming phase of Sashakt is given below:

Sashakt proposes to adopt Social Behaviour Change Communication (SBCC) framework based on Socio-ecological Model (SEM) at community level, and Theory of Planned Behaviour (TPB) at individual level. The project will add a component of extensive community mobilization for creating an enabling environment for favourable shift in social norms and to complement and facilitate Peer Educators work as change agents to implement SBCC strategies at

individual level. The Socio-ecological enabled the project to create enabling environment by engaging with multiple stakeholders and the TPB model was instrumental in changing the behaviours influenced by peers and close community networks.

Sashakt utilised two-step model of behaviour change with first step aiming to move from adolescents from Apathy to Intent where critical factors at individual and social level affecting the adoption of desired SRH behaviours were identified and these factors were addressed through SEM and TPB strategies centred around the peer educators as change agents. The second step aimed at translating Intent to adoption of desired behaviour, which included providing necessary and enabling environment by reducing institutional barriers. The project worked closely with the health system and relevant institutions such as welfare department, ICDS and education to address the institutional barriers, build the capacities of the institutions to provide quality SRH services and create opportunities for marginalized adolescents to enjoy SRHR.

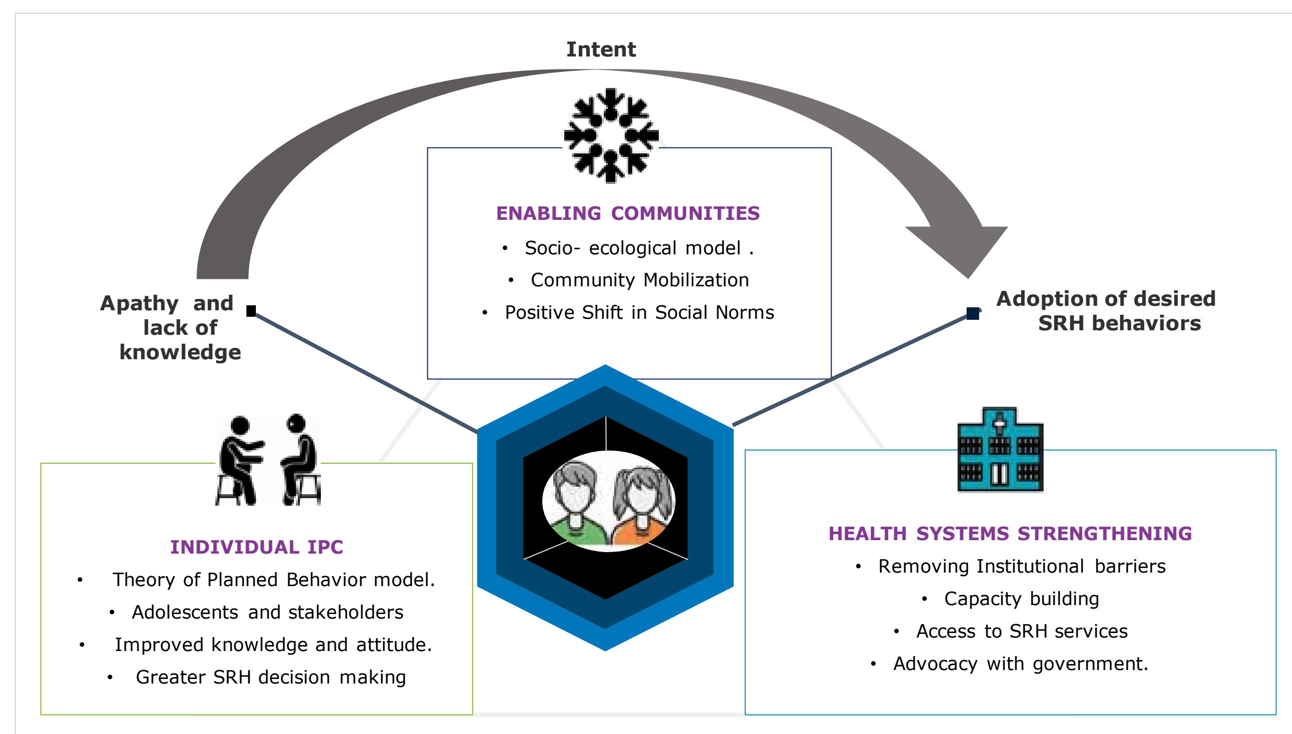

Exhibit 12: Theory of Change

As one of the prime reasons for attrition amongst peer educators attrition were the economic concerns such as wage loss, the future approach is also expected to look at developing incentive mechanisms and providing official recognition/identity to peer educators; motivating them to continue their work. PE would be trained as champions to be the facilitators to help Mahadalits to realize existing government services.

Exhibit 13 explains the pathways and intended outcome of the future model of Sashakt project.

Thoughts for the future

Innovations to address *capabilities of unmarried and married Mahadalit and other Scheduled Caste adolescents in 10 districts of Bihar to overcome social and institutional barriers which constrain/prevent their sexual and reproductive health choices, decisions and behavior.*

Focus on two Pathways

Communities and Individuals			Institutions	
Peer Education	Home based counselling	Community involvement and participation	Capability Development AYSRH Systems and Services	Partnerships to ensure continuity of and support PEs

Technology enabled communication approaches including options to reach migrant boys and men

Change Outcome 1

- Change in factors and social norms to promote intent in adopting effective SRH behavior; Peer Educators as change champions, FLW's to increased demand and uptake of SRH services among married and unmarried (ages 15-19),
- Favorable shift in underlying social and gender norms driving adolescent marriages and early pregnancies, increased male participation to improve couple communication and decision making around use of contraceptive services.

Address Institutional barriers, Social exclusion, quality RKSK services and new opportunities for PE's

Change Outcome 2

- Public health systems prioritize social inclusion, improved client provider interphase, confidential SRH service provisioning and improved access to contraceptive and maternal health services for married *Mahadalit*/Dalit adolescent/couples (ages 15 -19)
- New partnership to enable vulnerable communities (*Mahadalits*) to realize existing Government schemes and services and further handholding to link and benefiting them with appropriate schemes and services. PE could be trained as champions to be the facilitators.

Exhibit 13: Thoughts for the future

In light of the COVID-19 pandemic, physical distancing measures are likely to be in place for a while and it would be worth exploring mobile-based platforms for sensitizing and providing SRH information to Mahadalit adolescents, particularly men, including migrants. It would also be vital to test some innovative digital platforms for awareness-building and sensitization that are not reliant on community-level meetings. With high level of mobile penetration amongst men and majority returning from cities due to nationwide lockdown, there is a conducive environment to test the virtual approach in addition to intensifying and scaling up the existing strategies and accumulated leanings.

VIKAS KUMAR RAVIDAS

"Today, I can speak to anybody and at any platform for a good cause.

I have established my identity in the village and the community trusts and listens to me."

19 YEARS
A PEER EDUCATOR FOR
SASHAKT

Meet Vikas, the boy with the wide smile, born to a hard-working but partially paralyzed farmer in a Mahadalit community in a remote village of Bihar. With his family coping with his father's disability and the lack of opportunities in his rural, marginalized community, Vikas' future held only the bleak prospect of joining the migrant population as a taxi driver, like his brothers had.

Vikas' story took a turn when first he attended Sashakt trainings and was trained further to be a peer educator. Vikas not only turned his own life around but also stepped up to the challenge of changing norms within his community, one mind at a time. Overcoming initial mistrust from community members, he worked tirelessly to engage reluctant adolescent boys and their families on nutrition, adolescent health and the ills of early marriages. He attributes the changed fate of many in his village and an increased appreciation of the true value of education within the community to Sashakt.

Vikas is now a valued and respected change agent in his village who worked with government officials to prevent three adolescent marriages in the last year. A shining example for his peers, Vikas is now scripting a new future for himself as a student of Electronics and Machinery at the Industrial Training Institute in Purnea and supports his family by tutoring children in his village. Thanking the Sashakt program, he says. "I am determined to achieve my goal of becoming an engineer and making my father proud."

Pathfinder International implemented Sashakt project with support from the David and Lucile Packard Foundation.

AARTI KUMARI

"Shashkt has changed my life completely.

I am determined not to get married before 18 years."

18 YEARS
A MAHADALIT GIRL FROM PURNEA
SASHAKT

Aarti, a 16-year old Mahadalit girl, was fighting to keep her dreams of an education alive in the dire reality of being part of the ostracized and uninformed community. Casting aside her modest ambition, she had joined the workforce to help her family eke out a living. When she first came to Sashakt, Aarti was not only suffering from a severe infection brought on by unhygienic menstrual practices but was also fending off parental pressure to marry a much older man.

A ray of hope broke through the clouds when Aarti sought and received help from a Sashakt peer educator at a community meeting. She was encouraged to join the peer group to learn more about SRH and agreed in spite of opposition from her family, who considered the topic taboo. In fact, Aarti approached her peer educator for sensitizing her mother about the adolescent meetings and importance of Sexual and Reproductive Health (SRH), eventually succeeding in changing her mother's mind.

Aarti is now a staunch supporter of Sashakt and a strong advocate of SRH and the role it plays in forging a happy and healthy life for adolescent girls. She believes similar programs should be introduced to change the lives of more adolescents like her.

Pathfinder International implemented Sashakt project with support from the David and Lucile Packard Foundation.

UTTAM KUMARI

"I now feel well informed and the community respects me. Sashakt has not only provided me opportunities to learn but also helped me become who I am today."

19 YEARS
A PEER EDUCATOR FOR
SASHAKT

Uttam Kumari, a young girl from the Mahadalit community of village Katihar, had seen early marriages and frequent childbirths as a prevalent practice in her community. Growing up in a community that was severely marginalized, isolated and ignorant of the facts and hygienic health practices, this was the fate of many of its young girls. Menarche was considered an indicator of marriageability and came hand in glove with frequent infections and the notion of being impure.

Hearing about the Sashakt project from her local ASHA one morning transformed Uttam's life. She first started attending Sashakt trainings and later was chosen to be a peer educator. Uttam equipped herself with knowledge and played a pivotal role in spreading awareness about menstrual hygiene, adolescent SRH and combatting early marriage within her community. Through her discussions with other adolescents at school and monthly meetings, Uttam took the fight against taboos, socio-cultural restrictions, myths and misconceptions associated with menstruation right to the heart of her community.

Young Uttam capably shoulders the responsibility of disseminating knowledge to change long-standing norms within her community. She now works as a 'Master Resource Person' under JEEVIKA, an Initiative of Government of Bihar and is a beacon of hope for other girls in her village.

Pathfinder International implemented Sashakt project with support from the David and Lucile Packard Foundation.

Project Partner: Reach India Trust
Special thanks to RKSK division,
State Health Society Government of Bihar.

Pathfinder
INTERNATIONAL