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KIAWAH TRUST

The Kiawah Trust is a UK family foundation that is committed to improving the lives of vulnerable and disadvantaged adolescent girls in India. The Kiawah Trust believes that educating adolescent girls from poor communities allows them to thrive, to have greater choice in their life and a louder voice in their community. This leads to healthier, more prosperous and more stable families, communities and nations.



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DASRA

Dasra meaning 'enlightened giving' in Sanskrit, is a pioneering strategic philanthropic organization that aims to transform India where a billion thrive with dignity and equity. Since its inception in 1999, Dasra has accelerated social change by driving collaborative action through powerful partnerships among a trust-based network of stakeholders (corporates, foundations, families, non-profits, social businesses, government and media). Over the years, Dasra has deepened social impact in focused fields that include adolescents, urban sanitation and governance and has built social capital by leading a strategic philanthropy movement in the country.

For more information, visit www.dasra.org

FOREWORD

Adolescence is a critical time of transition – a developmental stage when children become adults. Lessons and behaviors learned at this stage determine their future. Adolescents in India can find themselves dangerously disempowered to shape their own lives, leaving them at great risk, especially when it comes to their reproductive and sexual health. An adolescent in India today contends with imposed early marriage, violence, exclusion, discrimination and disadvantage. Access to reliable and accurate information about their own sexual and reproductive health could go a long way in addressing these issues.

We know that investing in adolescents' sexual and reproductive health and rights delivers enormous economic, social and demographic returns. We need to empower India's adolescents to make informed decisions about their bodies, their health and their lives to protect their mental and physical health and well-being as well as their dignity. But the question today is - how do we ensure better health outcomes for India's adolescent population?

This report by Dasra is a timely effort to highlight the breadth and depth of this issue, identify gaps in the sector and offer solutions to many challenges. At the same time, the report presents a comprehensive landscape of work that is being done by non-profits in this area.

It is critical that the community of practitioners acknowledge that adolescents represent an enormously varied demographic. It is important that programs acknowledge the heterogeneity of India's adolescent population and the multiple levels of vulnerability that it faces. Among these different groups, we must make an effort to reach the most vulnerable, and to serve the traditionally underserved such as married girls, young adolescent boys, the poor and those from marginalized castes and communities.

At the same time, programs for adolescents need to speak first and foremost to adolescents. We need to give adolescents the opportunity to bring their voices, their perspectives, their needs and their solutions to the table. It is critical that programs begin to place adolescents at the center of programming – updating program designs to ensure they reach adolescents through channels they already use. At the same time we must acknowledge that adolescents cannot be change makers in isolation – we must also speak to the wider community, including gatekeepers, to ensure that the information and services we provide are normalized in society.

It is encouraging to see that programs are designing for scale. We must now collaborate to leverage what has already been done to improve these outcomes at scale. While much has been done, there is still a long way to go, to achieving a healthy, empowered and productive population of adolescents.



Anand Sinha,
Country Advisor,
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EXECUTIVE SUMMARY

Transitioning Challenges

Comprising one fifth of India's population, adolescents are a significant demographic transitioning into adulthood.¹ Adolescents making this transition experience rapid change and heightened vulnerability, particularly adolescent girls. The onset of puberty is a period wrought with challenges that impact an adolescent's sexual and reproductive health rights (SRHR):

- **Lack of knowledge:** One study found only 26% of adolescent girls knew that a condom should be used only once, and only 34% understood that oral contraceptive pills must be taken daily.²
- **Lack of agency and decision making power:** 64% of boys and 68% of girls reported that they only met their spouses on their wedding day.^{3,4}
- **Restrictive gender norms:** The NFHS-3 reports that 72% of men and 65% of women aged 15-24 years agreed that a woman should obtain her husband's permission for most things.⁵
- **Prevalence of child marriage and adolescent pregnancy:** A research study in Bangladesh found that husbands and mothers-in-law are often the key decision-makers regarding childbearing, sometimes overruling the wishes of a married adolescent girl, and leading to erratic use of contraception.⁶
- **Restricted access to services and affordable contraception:** Only 5% of young girls in rural Gujarat, 8% in rural Uttar Pradesh, and 14% in Bihar, Jharkhand, Rajasthan, Maharashtra, Andhra Pradesh, and Tamil Nadu reported that they could access a health facility alone.⁷
- **Prevalence of gender violence:** The Population Council found that one out of three girls reported sexual violence in their marriage.⁸

Landscaping Stakeholders

Dasra's report highlights the efforts of key stakeholders - including international development agencies, non-profit organizations, media agencies and the government - that employ varied approaches to mitigate barriers to adolescents' SRHR. For instance, the government implements several programs - in specific, the Adolescence Education Programme, Rashtriya Kishor Swasthya Karyakram and the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls - to enhance adolescents' access to SRHR information, services and resources. International development agencies and the media have also made strides to ensure that SRHR information and services for adolescents are available and accessible, at scale. By creating and implementing key programs and policies, funding best practices, and disseminating information, these stakeholders have improved SRH outcomes over the last 20 years - breaching topics in public schools that were previously unaddressed and challenging ingrained social norms.

A key insight that emerged from Dasra's research in the sector is that implementing organizations must account for the heterogeneity of adolescents as they design SRHR programs. Sexual and reproductive health outcomes are significantly influenced by geographical location, religious and cultural norms, socio-economic status, identity and age. Organizations that don't factor these variables into their program design run the risk of alienating several key audience segments among adolescents—and ultimately failing to achieve SRH outcomes.

Cornerstones

Dasra's report argues that immediate measures must be taken to address key SRHR barriers and associated challenges. Experts and stakeholders have

identified four key action areas that are pivotal to enhancing adolescents' sexual and reproductive health:

- **Innovate on outreach mechanisms to maximize vulnerable adolescents reached:** Where traditional channels such as school-based programs hit saturation roadblocks, technology holds the potential to make rapid advances that surpass such roadblocks and reach audiences in significantly larger numbers.
- **Customize programs to address the heterogeneity of the adolescent population:** While the umbrella group called 'adolescents' sees programs aimed mostly at 15-19-year old girls, this group also includes boys and young men, very young adolescent girls, tribal and disabled adolescents, each of which has distinct needs that are not best served by blanket solutions.
- **Collaborate and tap existing service delivery platforms:** Non-profits working to implement programs must leverage existing platforms for service delivery rather than create parallel delivery systems that duplicate efforts.
- **Include adolescents in program design and implementation:** As with any other exercise in communication, knowing your target audience is key to determining how much of your effort they will relate to and decide to absorb. For instance, adolescents are very well placed to offer perspective on what makes a program most accessible and appealing to young people.

At the Grassroots

Despite the challenges discussed, many organizations across India implement a range of interventions to meet adolescents' SRHR-needs. Dasra mapped 192 organizations that work to improve sexual and reproductive health outcomes in India, and profiled 22 organizations, whose work effectively represents the scope and breadth of the adolescent SRHR sector in India. Based on discussions with these organizations, Dasra identified the following key interventions that improve SRHR outcomes:

- Educating Adolescents on SRHR
- Enabling the Delivery of SRHR Education Programs
- Peer-Based SRHR Programs for Adolescents
- Strengthening Government Systems
- Strategic Behavior Change Communication
- Sensitizing Boys and Men
- Facilitating Adolescents' Access to SRHR Products and Services

Ripples of Change

The critical potential of the sector is reflected in the sheer spread of its implications - the consequences of poor SRHR awareness, attitudes and practice have spanned the entire gamut from child marriage, missed education and teenage pregnancy to HIV, domestic violence and billions in lost economic output. And it plays out across the spectrum of geographic escalation, from individual adolescents - boys and girls - at the household level, to rigidity and resistance at the community level, and social and economic costs at the national level.

Funders in SRHR are in a unique position to touch this one sector and set off ripples of empowerment, safety, equity and economic growth. Innovative and scale - oriented SRHR organizations have the potential to protect and prepare this huge, dormant demographic and plug it into an energized and more inclusive national engine.

CHAPTER

01

THE ISSUE & IMPACT

GROWING PAINS: TRANSITIONING INTO ADOLESCENCE

At India's last census, adolescents aged 10–19 years made up almost one fifth of the country's population - making one in every five Indians an adolescent, and giving India the largest share of adolescents in the world.⁹

Given the sheer size of this demographic, it is vital to improve the quality of life of India's adolescents. Adolescence is a critical age that acts as a bridge between childhood and adulthood, marking a time when many social and biological factors begin to change and setting the stage for adulthood. The arrival of puberty in early adolescence triggers an abrupt series of changes.¹⁰ In many countries globally, adolescents are viewed as adults with the onset of puberty. They are socialized into existing gender norms and made to accept more responsibilities towards their families, including childcare and income generation.¹¹ At the same time, they face physical, emotional, social, and cognitive changes such as growth spurts and maturation, a shifting identity, a need for emotional autonomy from their parents, and the beginning of sexual impulses and gender identities. Most young people experience sexual activity for the first time at this age, and are most vulnerable to sexual violence.¹²

This transitional period of rapid change and heightened vulnerability considerably influences adolescents' sexual and reproductive health and rights. In India, adolescents have a striking lack of knowledge, agency, self-efficacy and decision-making power—all critical measures of empowerment—that impact their sexual and reproductive health. For instance, a large majority of adolescents in India aren't aware of basic bodily functions like menstruation, let alone the specifics of contraception or family planning.¹³ Low decision-making power leaves several adolescents at risk for early marriage. Adolescent girls who marry early are more likely to experience violence, and bear their first child before their body is equipped to do so, often without the necessary maternal care.^{14, 15}

Out of all married adolescent girls (aged 15–19 years) surveyed under the NFHS - 3, only 15% participated in making major decisions for themselves. These include decisions regarding their own health, major household purchases, daily household needs and visits to family members or relatives. On the other hand, 46% did not participate in any of these four decisions.¹⁶



DEFINING SRHR

Image Credit - CREA

“A successful transition to adulthood with reference to sexual and reproductive health outcomes has seven attributes: attainment of at least a secondary school education; delaying marriage beyond childhood and free and full choice in the timing of marriage and selection of partner; exercise of the right to health, including access to friendly and sensitive health services and counselling; access to health-promoting information including on sexual and reproductive matters; acquisition of protective assets and agency, particularly among girls and young women, and promotion of gender equitable roles and attitudes; protection from gender-based violence; and socialization in a supportive environment.”¹⁷



Research findings from the top five most populated states in India with recently published data available* reveal that sexual and reproductive health indicators among adolescents including the age of marriage, age of first pregnancy, use of contraceptives and knowledge of HIV/AIDS – show need for improvement, across the country.

MADHYA PRADESH

- 30% of women and 40% of men aged 20-24 years were married before the minimum legal age.
- 7% of women aged 15-19 years were already mothers.
- 49% of married women did not use any contraceptives.
- 82% of women and 71% of men had incomplete or no knowledge of HIV/AIDS.

MAHARASHTRA

- 25% of women and 16% of men aged 20-24 years were married before the minimum legal age.
- 8% of women aged 15-19 years were already mothers.
- 35% of married women did not use any contraceptives.
- 70% of women and 56% of men had incomplete or no knowledge of HIV/AIDS.

TAMIL NADU

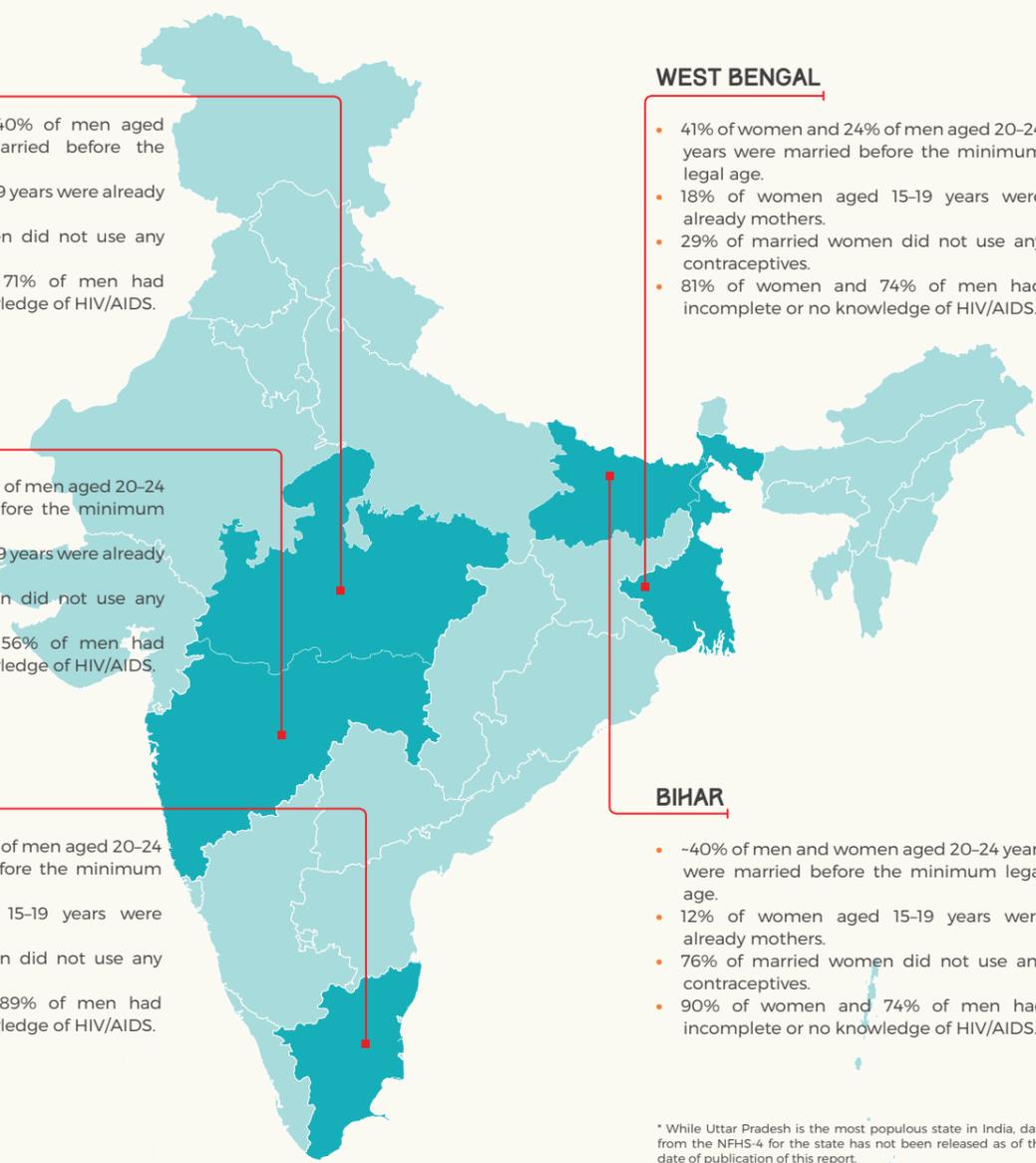
- 16% of women and 17% of men aged 20-24 years were married before the minimum legal age.
- 5% of women aged 15-19 years were already mothers.
- 47% of married women did not use any contraceptives.
- 84% of women and 89% of men had incomplete or no knowledge of HIV/AIDS.

WEST BENGAL

- 41% of women and 24% of men aged 20-24 years were married before the minimum legal age.
- 18% of women aged 15-19 years were already mothers.
- 29% of married women did not use any contraceptives.
- 81% of women and 74% of men had incomplete or no knowledge of HIV/AIDS.

BIHAR

- ~40% of men and women aged 20-24 years were married before the minimum legal age.
- 12% of women aged 15-19 years were already mothers.
- 76% of married women did not use any contraceptives.
- 90% of women and 74% of men had incomplete or no knowledge of HIV/AIDS.



* While Uttar Pradesh is the most populous state in India, data from the NFHS-4 for the state has not been released as of the date of publication of this report.

Investing in adolescents’ sexual and reproductive health and rights delivers enormous social, demographic and economic returns.

The income adolescent mothers forgo over their lifetime ranges from 1% - 30% of a country’s annual GDP, depending on the size of the economy.¹⁸

If girls in India wait until their early twenties to have children, the increased economic productivity would equal more than USD 7.7 billion.¹⁸

Doubling the current global investments in contraceptives and family planning, would reduce unintended pregnancies by an estimated two thirds - from 75 million to 22 million.¹⁹

In addition, investing in comprehensive sexuality education is linked to delaying sexual intercourse and increasing safe sexual behavior, which in turn reduces unwanted pregnancies and STIs, including HIV infections. Moreover, health gains have the potential to break intergenerational transmission of inequities.²⁰ India’s social and economic development depends on how well adolescents transition from childhood to adulthood, making it critical to address barriers to adolescents’ sexual and reproductive health.

BARRIERS TO ADOLESCENTS' SEXUAL AND REPRODUCTIVE HEALTH

Based on extensive research on the sector and conversations with experts and implementing organizations, Dasra has identified six barriers that hinder an effective transition from childhood to adulthood, and impact sexual and reproductive health among adolescents:

1. LACK OF AGENCY

2. LACK OF KNOWLEDGE

3. CHILD MARRIAGE AND ADOLESCENT PREGNANCY

4. LACK OF ACCESS TO CONTRACEPTION

5. VIOLENCE

6. RESTRICTIVE GENDER NORMS



1. LACK OF AGENCY

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Lack of agency, which manifests as a lack of self-confidence and self-efficacy, limits adolescents' decision-making power, mobility, access to resources and consequently, their long-term sexual and reproductive health, and exercise of related rights. For instance, adolescents in India have limited decision-making power over their choice of spouse - 64% of boys and 68% of girls reported that they only met their spouses on their wedding day. As a result, many respondents felt unprepared for marriage and almost 50% were scared and unhappy about their marriage.^{21, 22}

Feelings of fear and unhappiness regarding their choice of partner or preparedness for marriage have a long-term impact on adolescents' mental and emotional health, as well as their reproductive choices. A young girl unable to communicate with her husband is likely to be unable to negotiate for the use of contraception, and unaware of her right to do so and so, is vulnerable to early pregnancy.

Besides decision-making power, mobility is also curtailed at adolescence — with girls reporting many more restrictions than boys.

While most adolescents report relative freedom within their village or neighborhood, such as visiting a neighbor or a local shop, mobility outside the village is highly restricted. Access to health facilities is even more restricted and very few girls have the freedom to visit a health worker unescorted.^{23, 24} Moreover, her limited mobility, which includes curtailed visits to health facilities, restricts her access to information on family planning and antenatal care essential for a healthy pregnancy.

In a range of studies conducted on the issue, 4% of girls in rural Uttar Pradesh, 14% of girls in Gujarat and 25% of girls in Bihar, Jharkhand, Rajasthan, Maharashtra, Andhra Pradesh, and Tamil Nadu reported that they could go unescorted to visit friends or relatives outside the village. However, just 5% of young girls in rural Gujarat, 8% in rural Uttar Pradesh, and 14% in Bihar, Jharkhand, Rajasthan, Maharashtra, Andhra Pradesh, and Tamil Nadu reported that they could access a health facility alone.^{25, 26}

2. LACK OF KNOWLEDGE

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In addition to a lack of agency, adolescents also lack knowledge on sexual and reproductive health issues, including basic bodily changes at puberty, appropriate contraceptive use and sexually transmitted infections. For example, in a survey conducted across 11 cities by India Today, a leading news magazine, almost half of all young people interviewed didn't know enough to protect themselves from HIV/AIDS. Similarly, in a study in India, only 26% of adolescent girls knew that a condom should be used only once, and only 34% understood that oral contraceptive pills must be taken daily.²⁷ Another study by the All India Educational and Vocation Guidance Institute found that 42%–52% of young students in India feel that they do not have adequate knowledge about sex.

This lack of knowledge is cause for alarm, especially with health issues such as HIV/AIDS. The spread of the HIV/AIDS epidemic in India in the 1990s created a great shift in the way issues of sex and sexual health were discussed.²⁸ Yet, a dangerous lack of knowledge regarding HIV remains the key challenge to

completely eradicating the disease and other STIs. Findings from a study among youth in Bihar, Jharkhand, Rajasthan, Maharashtra, Andhra Pradesh, and Tamil Nadu indicate that while 91% of young men and 73% of young women had heard of HIV/AIDS, a much smaller percentage had comprehensive knowledge on the subject - 45% of men and 28% of women.²⁹ Limited knowledge about HIV/AIDS and other STIs highlights the need for awareness programs targeted at adolescents.

Unfortunately, social stigma perpetuates adolescents' lack of knowledge on SRH issues. Parents, teachers and other gatekeepers are unwilling to have a frank conversation with adolescents under their care about sex. In India, less than 1% of youth reported that a parent had discussed reproductive processes with them.³⁰ At the same time, the introduction of reproductive health education in schools can be controversial - for example, the Adolescence Education Programme (AEP) introduced by the National AIDS Control Organization (NACO),

that championed Comprehensive Sexuality Education (CSE) within schools, was banned in six states as soon as it was introduced in 2007.³¹ While the AEP has been revamped and reintroduced in school systems in many states, it is still banned in five states across India.³² This vacuum of safe and trusted sources of information often results in adolescents acquiring information about sex from unreliable and often inaccurate sources such as pornography,

the Internet, mainstream media, movies and television serials. As a result, adolescents ascribe to misleading notions of sex, sexuality, consent, relationships, gender norms, body image and pubescent changes. Pressing issues such as contraception, child sexual abuse, intimate partner violence and risks of early pregnancy are not discussed, leaving adolescents with several misconceptions about sex that severely impact their sexual and reproductive health.

3. LACK OF ACCESS TO CONTRACEPTIVES



Lack of knowledge and resultant misconceptions about sexual and reproductive health, in turn impact how adolescents access and use contraceptives. In 2014, 225 million women in the developing world had an unmet need for contraception. This need is greatest where the risk of maternal mortality is highest, and among the most vulnerable in society — adolescents, the poor, those living in rural areas and urban slums, and marginalized communities.^{33,34} Adolescent girls are less likely than older women to access sexual and reproductive healthcare, including modern contraception and skilled assistance during pregnancy and childbirth.³⁵

Social stigma attached to sex also limits access to contraceptives, particularly for unmarried adolescents. In 2011, the Government of India began an initiative that involved accredited social health activists (ASHAs) delivering minimally priced condoms, oral contraceptive pills, and emergency contraceptive pills to households within a modified supply chain that would avoid

stock-outs and delays. However, this initiative targeted only married women. This is especially risky, because the evidence shows up to 15% of boys and 5% of girls experience sex before marriage.³⁶ By leaving out adolescent girls, unmarried adolescents and men, the initiative ignores vital demographic segments with largely unmet contraceptive needs. Addressing this unmet need can help empower girls to delay pregnancy and take back decision-making power related to the number, spacing and timing of their pregnancies. Therefore, it is important that contraception distribution systems ensure that adolescents have easy access and that distributors are non-judgmental and maintain confidentiality. The government's recently introduced policy Rashtriya Kishor Swasthya Karyakram (RKSK) is intended to fill this gap by strengthening Adolescent Friendly Health Clinics (AFHCs) and providing counselling and curative services, as well as non-clinical contraceptives for adolescents through AFHCs.

4. CHILD MARRIAGE & ADOLESCENT PREGNANCY



Child marriage is another barrier to adolescents' sexual and reproductive health that has a measurable negative impact on the health and wellbeing of adolescent girls.³⁷ Previously discussed barriers including a lack of agency and knowledge among adolescents in India, contribute to the prevalence of child marriages across the country. For instance, a lack of decision-making power, curtails a girl's ability to stand up to familial and societal pressure to marry at a young age. A research study showed that 68% of married girls met their husbands for the first time, only on their wedding day.³⁸

It is within the confines of marriage that many girls experience sexual

activity for the first time, often at a very young age. A lack of agency and the inability to negotiate for their rights, leave adolescent girls susceptible to early pregnancies, a common occurrence in early marriages - the 2006 NFHS showed that one in five young women aged 20-24 years had given birth before the age of 18. A research study in Bangladesh found that husbands and mothers-in-law are often the key decision-makers regarding childbearing, sometimes overruling the wishes of a married adolescent girl, and leading to erratic use of contraception.³⁹ In another study conducted by the Population Council in Uttar Pradesh, as many as 20% of married girls want to delay their first pregnancy by two years,

but are unable to do so. As a result, two out of three married girls have a child within the first two years of marriage. This is alarming given that girls aged 15-19 years have a 28% higher risk of dying during pregnancy or childbirth, compared with those aged 20-24 years.⁴⁰

Violence is another issue that is endemic to child marriage. Married women and girls experience high levels of violence, but enjoy few legal protections. The Population Council found that one out of four girls reported marital violence (including both physical and emotional violence) and one out of three reported sexual violence in their marriage. This is corroborated by many studies that illustrate how child brides are more vulnerable to sexual and physical violence in their marital homes.⁴¹ In one study, a third of young women indicated that they had experienced physical or sexual violence in the 12 months preceding the interview.⁴² In 2013, lawmakers declined to criminalize the act of marital rape, claiming that to do so would weaken traditional family values.

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GIRLS AGED 15 AND 19 YEARS HAVE A 28% HIGHER RISK OF DYING DURING PREGNANCY OR CHILD BIRTH
”

5. VIOLENCE



As discussed, adolescent girls have very little agency over when they get married, whom they marry, whether or not to have sexual relations and whether to have children. Limited decision-making power impacts an adolescent's ability to take preventive measures against **sexual violence** and negotiate for consent and condom use within intimate sexual relationships.⁴⁷

In addition to sexual violence, **child sexual abuse** is also prevalent across the country. In a study commissioned by the Indian Ministry of Women and Child Development (2007) - that involved 12,000 children and over 2,000 young adults across 13 Indian states - over half (53%) of the respondents reported that they had been sexually abused as children, between the ages of five and 12. Mirroring global data, parents, legal guardians or close members of the family most often perpetrated this abuse, and more than half of all cases were not reported to the authorities. Child abuse can have far-reaching consequences on the sexual and reproductive health of victims. It places young children at risk of contracting HIV/AIDS and changes

Section 376 of the Indian Penal Code reads "sexual intercourse or sexual acts by a man with his own wife, the wife not being under fifteen years of age, is not rape."⁴³⁻⁴⁴ This not only legitimizes sexual violence within marriage, but also directly contravenes India's other laws governing consent — the age at which any girl is able to give consent for sex and marriage in India is 18 years. Thus, a girl between the ages of 15 and 18, who is by law considered incapable of consent, is denied legal protection against sexual violence if she is married.⁴⁵

Child marriage thus impacts the sexual and reproductive rights of adolescent girls, and limits their future prospects. Girls who marry young are thus more likely to drop out of school, live in poorer households, and are at greater risk of contracting sexually transmitted infections, including HIV/AIDS.⁴⁶

the way victims understand and approach sexual activity — resulting in risky sexual activity at one end of the spectrum, and a fear of physical contact at the other.

Human trafficking is another form of violence that impacts the sexual and reproductive health of adolescents. The Ministry of Women and Child Development reports that around 2.8 million people, mostly young girls and children below 18 years, are trafficked and forced into sex work every year.⁴⁸ Trafficking violates victims' right to life, liberty and freedom to chart their own life course, and subjects them to cruelty, torture, dangerous and degrading 'work,' unwanted pregnancies, and inhumane living conditions. Furthermore, it subjects trafficked women and children to sexual violence, and leaves them vulnerable to HIV and other STIs. Findings from a research study indicated that women and girls trafficked into sex work were more likely to have HIV than those who voluntarily joined the trade.⁴⁹ Thus, human trafficking severely impacts the sexual and reproductive health of trafficked victims.

S. RESTRICTIVE GENDER NORMS



Cutting across barriers of violence, child marriage, lack of agency and knowledge are restrictive gender norms that govern what is considered appropriate behavior for boys and girls. Gendered traditions, which define the roles of men and women in a family, impact a girl's ability to make decisions regarding her own sexual and reproductive health — such as, at what age to marry and conceive.⁵⁰ Adolescents in India are socialized from birth to accept gender norms that condone violence against women and limit women's agency. The NFHS-3 reports that 72% of men and 65% of women aged 15-24 years agreed that a woman should obtain her husband's permission for most

things. Similarly, 54% of young men and 58% of young women agreed with the statement that wife beating was justified if the wife was to decline sexual relations, disagree with her husband's opinion, if she was unfaithful or she went out without informing her husband.^{51,52} Gender norms also influence sexual behavior that increases adolescents' risk for STIs and HIV. One study found that gender stereotypes and expectations about the sexual behavior of boys compared with those of girls was linked to an increased risk of violence, substance abuse, and accidents among boys, and a higher degree of restricted mobility, limited agency and social hierarchy among girls.⁵³

Thus, these six barriers—violence, gender norms, child marriage and early pregnancy, lack of agency, knowledge, and access to contraception—severely impact adolescents' sexual and reproductive health and rights across the country.



54% OF YOUNG MEN AND 58% OF WOMEN BELIEVE THAT BEATING YOUR WIFE IS ACCEPTABLE UNDER SOME CIRCUMSTANCES.



CHALLENGES TO IMPLEMENTING SRHR PROGRAMS FOR ADOLESCENTS IN INDIA

There is a broad consensus among stakeholders that addressing barriers to improving sexual and reproductive health rights (SRHR) for adolescents in India is vital to their wellbeing and quality of life. However, there are longstanding challenges to doing so that implementing organizations, funders and policy-makers must grapple with. These include cultural, infrastructural and systemic challenges:

1. CULTURAL

Deeply entrenched stigma against SRHR education

Arguments that it is against Indian culture to discuss sex and sexuality, or that such discussions encourage sexual activity - are the most common assertions against educating adolescents about their sexual and reproductive health and rights (SRHR). Organizations implementing related programs face immense resistance and backlash from community members who perceive adolescent education programs as endorsing pre-marital sex and encouraging children to act immorally. As a result, many programs carefully regulate the language they use to discuss sex, and at times choose to leave out critical subject matter necessary for adolescents to be fully informed, that could provoke controversy.⁵⁴

2. INFRASTRUCTURAL

India's diversity makes scaling difficult

India's socio-political differences across states make it difficult for programs to adopt a one-size-fits-all approach. Implementing organizations often find that what works in one state or district, when it comes to working with relevant stakeholders, may not work in the next because the social and political context of each state can differ. Moreover, government schemes to improve sexual and reproductive health outcomes for adolescents are implemented by different government departments and ministries, across states, with different approaches and priorities. This makes scaling successful programs from one state to another difficult for non-profits in the sector.⁵⁵

3. SYSTEMIC

Public service delivery system faces challenges in providing SRHR services

India's public healthcare system faces systemic challenges in maintaining the quality of care, including challenges with health financing; maintaining a qualified health workforce; ensuring efficiency, standardization and quality of service delivery; ensuring the availability of essential medical products and technologies including necessary drugs and supplies; maintaining health information systems; and encouraging community ownership, awareness and participation. At the same time, SRHR service provision is often hindered by provider bias and inhibition - whether it is delivered by healthcare workers or teachers in schools.

DESIGNING PROGRAMS FOR HETEROGENEOUS ADOLESCENTS

Aside from mitigating cultural, infrastructural and systemic challenges, implementing organizations in the sector must customize programs to account for varied demographic differences among adolescents. These include:

- 1. GEOGRAPHICAL LOCATION
- 2. RELIGIOUS AND CULTURAL NORMS
- 3. SOCIO-ECONOMIC STATUS
- 4. IDENTITY
- 5. GENDER
- 6. MARITAL STATUS
- 7. AGE

Each of these factors influence the attitudes and actions of adolescents' sexual behavior and reproductive health norms. Programs that do not account for differences among adolescents and tailor their programs accordingly are likely to alienate their target audiences.



1. GEOGRAPHICAL LOCATION

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Discrepancies in the quality of public healthcare services and availability of resources across geographical locations in the country - specifically, urban versus rural locations - heighten SRHR challenges.⁵⁶ An example of such discrepancies is the availability of health practitioners. According to the Health Intelligence Bureau of the Ministry of Health and Family Welfare, rural areas record a substantial shortfall of health practitioners at many community health centers (CHCs) and primary health centers (PHCs).⁵⁷ Because of the shortage of service providers, rural adolescents in these areas are less likely to have access to quality health services, including,

but not limited to maternal health services and comprehensive information regarding their sexual and reproductive health and rights. Conversely, public health services in India's urban centers are able to attract and employ qualified health service providers, and adolescents in these areas have better access to SRHR information. Therefore, programs designed to enhance adolescents' knowledge of SRHR and access to related health services, need to account for the geographical discrepancies in urban and rural healthcare provisions for adolescents.

2. RELIGIOUS AND CULTURAL NORMS

2 ■ ■ ■ ■ ■ ■ ■ ■



Stringent religious and cultural norms dictate rigid gender roles and subsequently compound SRHR challenges. For example, the appropriate age of marriage for both girls and boys can often be linked back to religious norms or cultural traditions. Virginity and chastity are valued in most dominant religions and cultural traditions in India, and fears regarding chastity often lead to communities controlling girls' sexuality by placing limits on mobility and access to information.⁵⁸ As a result, in families with extremely conservative religious beliefs, girls' bodies are likely to be

heavily policed and many girls are unaware of basic bodily functions. For instance, cultural norms dictate that girls and women from certain communities are not allowed to participate in religious rituals, and face restrictions on their mobility while menstruating.⁵⁹ A study by Nielsen and UNICEF conducted in rural areas of Bihar and Jharkhand showed that 70% of girls felt they were 'completely unprepared' for their first period.⁶⁰ Consequently, organizations working among conservative communities need to adjust their programs so as to reach their target audience effectively.

3. SOCIO-ECONOMIC STATUS

3 ■ ■ ■ ■ ■ ■ ■ ■



The socio-economic status of an adolescents' family is a key determinant of the quality of life and the quality of healthcare an adolescent is able to access. Economic vulnerability is both a cause and consequence of poor health.^{61,62,63} Healthcare costs are often enough to send economically vulnerable families spiraling into debt. For example, a study in the Lancet found that 25% of Indians are unable to access healthcare services due to financial constraints and 35% of hospitalizations propelled families into poverty.⁶⁴ A recent report shows that India's public financing of health is among the lowest in the world at just over 1% of GDP. At the same time, out-of-pocket spending for healthcare

is among the highest in the world at around 3% of GDP. These inflated healthcare costs often mean that necessary sexual and reproductive health services, such as visiting a gynecologist, or accessing family planning and maternal healthcare for adolescents, is financially out of reach for many families.⁶⁵ While this gap is partially plugged by the provision of services through the public healthcare system, adolescents often prefer to access healthcare from private providers on account of enhanced privacy and quality of care. Therefore, organizations implementing sexual and reproductive health programs must make a concerted effort to reach those on the bottom-most rungs of the socio-economic ladder.

4. IDENTITY



Sexual and reproductive health (SRH) indicators across the board are worse off for Scheduled Castes, Scheduled Tribes, disabled persons and other marginalized communities. These identity markers represent centuries of discrimination that manifest in socio-economic disadvantages.

For example, 52.1% of Scheduled Tribes and 45% of Scheduled Castes do not currently use any form of contraception.⁶⁶

5. GENDER



There are very few programs designed to reach Indian boys. Those that are, often do not prioritize SRHR outcomes for boys as a primary program outcome, but instead reach out to men and boys to change gender norms that police girls' and women's behavior and bodies. It is vital to begin to include this demographic in SRHR programs, as their knowledge levels and attitudes largely influence the SRHR decisions of young couples. Girls are often unable to

use contraception without the knowledge and consent of their male partners — either because they are required to participate in using or accessing contraceptives, or because socio-cultural norms dictate that boys are the decision-makers. This is problematic given that most boys have very low levels of awareness about essentials such as how to use a condom, or how pregnancy can occur as a result of sexual intercourse.⁶⁷

6. MARITAL STATUS



Married girls under 19 years constitute the largest group of sexually experienced adolescents in this country, but at the same time, are extremely hard to reach through adolescent-focused programs. India's religious personal laws allow girls to be married before the age of 18. Once married, many young girls find their lives confined to the private sphere, with strict restrictions on their mobility. They are also often pulled out of school, are unable to access communal

spaces and have their social networks limited to their immediate family. They are less educated than their unmarried counterparts, don't have basic numeracy and literacy skills, and rarely have peer networks. In fact, in one study married girls (aged 15-19 years) scored worse than 10-14 year old respondents on numeracy and literacy tests. Thus, the social disadvantage and isolation of married adolescents is profound.⁶⁸

7. AGE



The SRH needs of adolescents vary greatly according to their age and life stage and can be broken down into two age brackets 10-14 and 15-19 years. It is important for programs to take a nuanced approach to adolescents based on their age differences.

A) 10 - 14 YEAR OLD ADOLESCENTS (VERY YOUNG ADOLESCENTS)

Most programs for adolescents in India focus on those aged 15-19 years. However, though the period of adolescence spans many years, it is during early adolescence that the bulk of transitions take place. In many countries, these transitions include "leaving school, entering the labor force, getting married off, and becoming a caretaker, parent, or worker."⁶⁹ These transitions coincide with physical, cognitive and emotional transitions that must be accounted for in programming, with a focus on imparting age-

appropriate information. Moreover, gender norms emerge at this time, and research shows that hierarchical gender norms become apparent as early as age 10, or even before, so it is important to promote egalitarian gender norms at this age.

The age of menarche has come down globally, averaging between ages 10 and 12, making this age group even more vulnerable—as post menarche, girls are exposed to greater SRH-related risks.⁷⁰ These risks include exposure to "HIV,

10-14 VERY YOUNG ADOLESCENTS

material deprivation, and political and social conflict, and erode traditional safety nets and increase vulnerability."⁷¹ Therefore, many experts indicate that starting SRHR programs for adolescents at age 15, leaves out the younger adolescents who are equally vulnerable (if not more) to negative influences and the loss of rights, though the effects of this may not be apparent till later in life.^{72, 73, 74}

The benefits of starting SRHR programming for adolescents as early as possible are clear – behaviors formed and the information received during this time period stays with them for life. Yet, adolescents in this age group are highly neglected. There is a lack of data available on the behaviors, habits and knowledge levels of this age group, and they are excluded from important government programs.⁷⁵ Hence, there is a need for funders and non-profits to invest in this group.

a. Needs of Very Young Adolescents:

- Very young adolescents (VYAs) are in a formative period in their lives and experience a variety of transitions on the way to adulthood. In many cases, they are no longer seen as children but are not old enough to be considered adults, resulting in an identity crisis of sorts. Consequently, VYAs benefit immensely from programs that help them navigate this tumultuous time by investing in personality and life skills development. It is important for programs to equip VYAs with:
 - Life skills such as decision-making skills, negotiation skills, and communication skills, aimed at improving self-confidence and self-efficacy;
 - Comprehensive Sexuality Education, that provides information about puberty, sex and changes to the body, including addressing the development of self and body image, and the use of contraception; and
 - Information that helps them identify and address violence by providing them with the language and resources to ask for help.

For example, talking to young people about a 'good touch' vs. a 'bad touch' gives them the language to identify perpetrators of child abuse and the language to reach out to adults who could help them.

b. Challenges in reaching Very Young Adolescents:

- It is often controversial to work with this age group in the Indian context, due to the stigma surrounding SRHR issues. They are considered too young to talk about sex, contraception and violence, and some non-profits working across the country have indicated that communicating openly with adolescents on these issues could lead to their legal harassment.⁷⁶
- There are systemic challenges in imparting this knowledge to VYAs. Teachers are not properly educated to provide counseling, and there are no counselors in public schools or in low-cost private schools. Similarly teachers, Aanganwadi workers, and other frontline workers are overburdened and overworked, and therefore unable to take on the additional burden of SRH education.⁷⁷
- Addressing gatekeepers is vital. Adolescents in this age group are not decision-makers for themselves. Instead they must be reached through parents, teachers, community leaders and religious heads. Yet many gatekeepers are unconvinced of the necessity to provide SRH information and services to this age group.⁷⁸
- Accessing the most vulnerable adolescents is extremely difficult – including those from Scheduled Castes, Scheduled Tribes, or disabled adolescents and sexual minorities such as transgendered youth – as this demographic segment is not easily reached through mainstream programming. Similarly it is nearly impossible to reach out-of-school adolescents.⁷⁹

15-19

YEAR OLD ADOLESCENTS

B) 15 - 19 YEAR OLD ADOLESCENTS

Adolescents are already seen as adults when they turn 15 and are expected to take on significant responsibilities at home, including contributing to the family's income. It is during this period that the impact of gender differences begins to grow even more extreme, and further social distinctions begin to manifest in the form of marital status. Adolescents in this age category are even harder to reach given that many of them are out of school, and girls who are married are isolated from their social and peer networks, and confined to the domestic sphere.⁸⁰ While there are significant overlaps with the needs of 10-14 year olds, it is critical that programs address the fact that adolescents at this age are closer to adulthood and are often seen as adults in their communities and families.

a. Needs of 15 - 19 year old adolescents:

- As adolescents get older, it is vital to continue to provide Comprehensive Sexuality Education to address myths and misconceptions attached to sexual and reproductive health and rights issues, as well as to restrict the spread of incorrect information through unreliable sources.
- Family planning, contraception and reproductive health services also become critical as adolescents get older, especially in the context of India's high rates of child marriage. Services must be accessible, affordable and acceptable.
- Mental health continues to be critical for a successful transition to adulthood, and yet depression remains the leading cause of health-related disabilities among girls. At the same time, for adolescent girls and boys aged 15-19 years, suicide is the leading cause of mortality.⁸¹
- In order to resonate with this demographic it is vital that implementers approach this age group with comprehensive programs that respond to adolescents' needs, including economic empowerment through life skills training, vocational training, financial literacy and mentorship.

- It is also important to address the issue of violence, including sexual violence, in relationships. Girls, who marry younger, are at a higher risk of domestic violence. They also face violence from their own family members, including male siblings. On the other hand, boys face societal pressure to demonstrate their masculinity by exhibiting violence and by protecting the honor and chastity of female relatives.⁸²

b. Challenges in accessing 15 - 19 year old adolescents:

- This age group is difficult to reach, as many of them have already dropped out of school. It is common for girls in this age bracket to live closer to home, and for boys to migrate for work. For this reason, school-based programs have limitations, making it necessary to reach adolescents through employers and community-based platforms.⁸³
- Recent legislature has created stricter frameworks around sexual violence and sexual activity with minors. This is regarded as a positive move by activists. However, some have indicated that stricter laws can also have the unintended side effect of criminalizing sexually active adolescents.⁸⁴
- There is a lack of public spaces for boys and girls, or young men and women to interact with each other.
- There is a strong stigma associated with adolescents accessing SRH services.

CONCLUSION

This chapter outlines key barriers to adolescents' sexual and reproductive health rights including a lack of knowledge and agency among adolescents, restrictive gender norms, the prevalence of child marriage and adolescent pregnancy, challenges in accessing services and affordable and acceptable contraception, as well as the prevalence of violence in Indian society. It also explores the cultural and infrastructural challenges associated with addressing these barriers. Details of various demographic considerations that implementing organizations must keep in mind as they design programs for adolescents include geographical location, religious and cultural norms, socio-economic status, identity and age. This chapter argues that immediate measures must be taken to address key SRHR barriers and associated challenges. Subsequent chapters in this report provide a roadmap for how concerned stakeholders might engage with these issues.



STAKEHOLDERS

STAKEHOLDER 1: THE GOVERNMENT OF INDIA
STAKEHOLDER 2: INTERNATIONAL DEVELOPMENT AGENCIES
STAKEHOLDER 3: THE MEDIA

Approaches to Addressing Adolescents' SRHR

As illustrated in chapter one, adolescents in India face intrinsic challenges in accessing quality and comprehensive sexual and reproductive health (SRH) education, resources and services. Multiple stakeholders—including international development agencies, non-profit organizations, media agencies and the government—employ varied approaches to mitigate these challenges. For instance, while some non-profits implement programs that ensure access to SRH services for adolescents, the government works to strengthen legal provisions that safeguard adolescents' rights to these services. Similarly, certain international development agencies fund advocacy efforts to generate public discourse on the issue of SRH for adolescents, whereas a few media agencies broadcast SRH-educational programs, to the same end. This section highlights the work undertaken by these key stakeholders to address adolescents' sexual and reproductive health, and showcases a variety of approaches to achieving SRH-related outcomes.

STAKEHOLDER 1: THE GOVERNMENT OF INDIA

As a critical stakeholder in the sector, the Government of India works to improve SRH outcomes by passing laws, delivering services through policies and programs and working with non-government organizations to expand its outreach. The government's involvement began as early as 1929 with the Child Marriage Restraint Act- one of the first legal provisions to address a social reform issue at a national level.⁶⁵ While the legislature at the time did not envision the law as having an impact on specific SRH outcomes, today its passage is considered a lesson in petitioning the government to create laws that reflect the demands of the people, and marks the beginning of the government's effort to improve SRH indicators.

Legal Provisions that Safeguard Adolescents' SRHR

Following from there, the Government of India has played a significant role in improving adolescents' education, health, and welfare – by creating a legal framework to address SRH barriers or by investing in related development programs. For example, the Right to Education Act makes education a fundamental right of every child aged 6-14 years, thereby increasing attendance in public schools. Consequently, government programs including the

Adolescence Education Programme that implement reproductive and sexual health education in public schools are able to facilitate the dissemination of accurate and relevant SRHR information to youth across India. Similarly, many laws and government programs aim to counter sexual and gender-based violence in India by punishing perpetrators of domestic violence, sex discrimination and sexual violence. For instance, the Protection of Children from Sexual Offences Bill (2012) creates a legal framework to persecute abusers and upholds the safety and sexual rights of children through enforcement and punishment.⁶⁶

Other laws are the manifestation of efforts to compensate for a culturally inherent, gender imbalance in India. The Preconception and Pre-natal Diagnostics Techniques Act (1994) aims to prevent female feticide and arrest the declining sex ratio by banning prenatal sex determination. This was necessary with the arrival of ultrasound techniques in the 1990s, which led to increased female feticide due to an inherent preference for sons in India and the resultant social discrimination against girls.⁶⁷ By recognizing this gender gap and emphasizing gender equity, laws advance the reproductive and sexual rights of women and girls.



The timeline below outlines the progression of government laws and policies to improve adolescents' sexual and reproductive health outcomes, between 1929 and 2016.

POLICIES

The National Population Policy

A holistic policy that strengthens reproductive health services by promoting 20 years as the right marriageable age for girls, and integrates and converges Indian systems of medicine and social sector programs to include reproductive health services more completely.

2000

The National AIDS Prevention and Control Policy

Aims to prevent the further spread of HIV/AIDS by increasing awareness of its implications, how to protect oneself from infection, and providing services and care for people living with AIDS

2005

2005: National Rural Health Mission (NRHM)

Establishes a fully functional, community owned, decentralized health delivery system with convergence at all levels to ensure action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

2009

LAWS

1929

Child Marriage Restraint Act

1961

Dowry Prohibition Act

1994

Preconception and Pre-natal Diagnostics Techniques Act

2002

2002

Medical Termination of Pregnancy Act, (amendment to 1971 act)

2005

2005

Protection of Women from Domestic Violence Act

2006

The Immoral Traffic (Prevention) Amendment Bill

Prohibition of Child Marriage Act

2009

The Right of Children to Free and Compulsory Education Act

2011

The Protection of Children from Sexual Offences Bill

2013

Sexual Harassment at Workplace Act

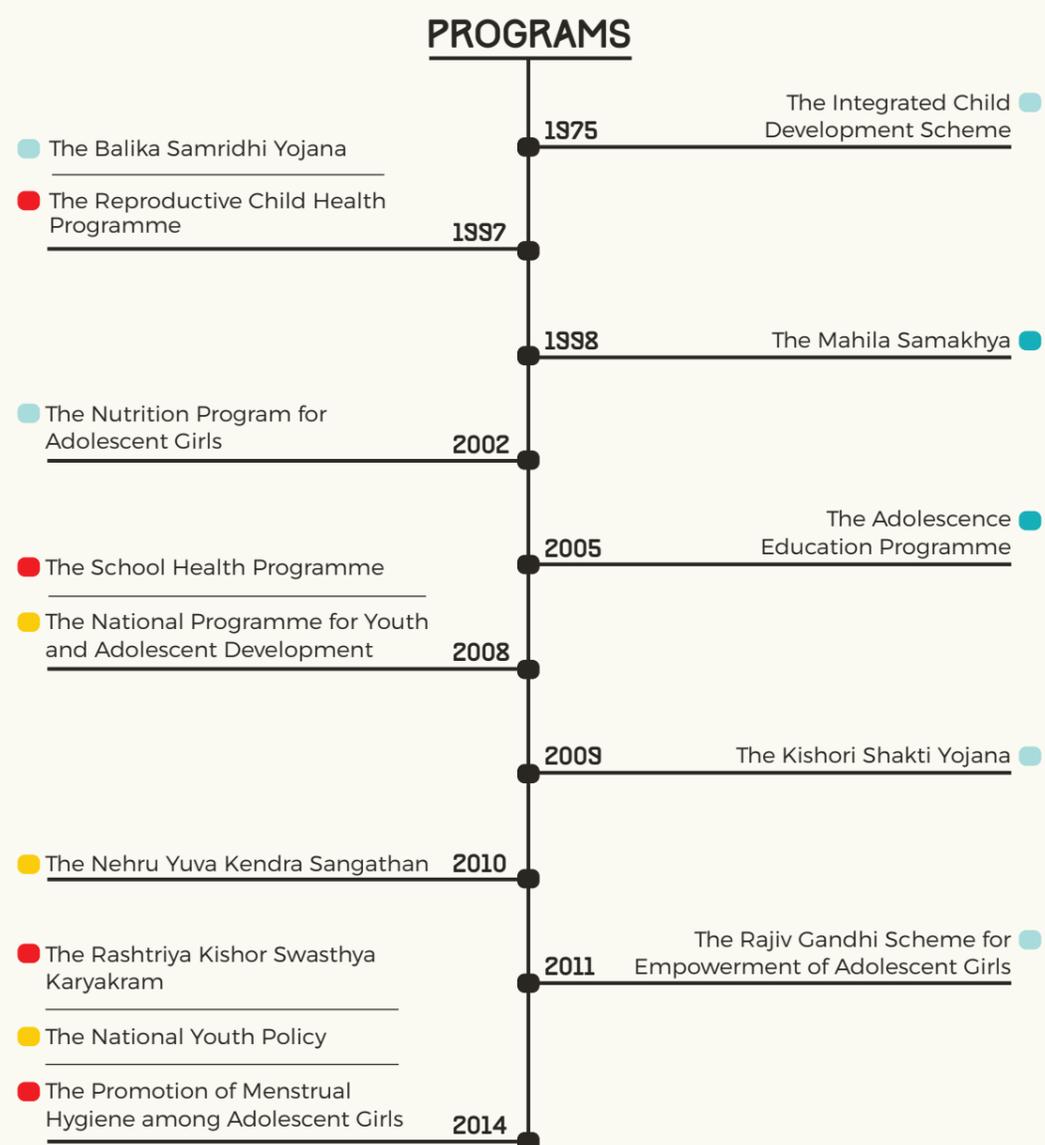
GOVERNMENT PROGRAMS THAT DELIVER SRH OUTCOMES FOR ADOLESCENTS

Aside from these legal provisions that uphold and enhance adolescents' sexual and reproductive health and rights (SRHR), the Government of India also implements several related programs at a national and state level. Government ministries – including the Ministry of Health and Family Welfare, Ministry of Human Resource Development, Ministry of Youth and Sports, and the Ministry of Women and Child Development – run SRH programs for adolescents that fall under their jurisdiction. These ministries collaborate with each other whenever required, and even combine and consolidate programs and policies to enhance the delivery of SRH-related services.

SRH-Related Programs

The timeline below outlines the progression of government programs to improve adolescent sexual and reproductive health outcomes, implemented across ministries:

- The Ministry of Health and Family Welfare
- The Ministry of Human Resource Development
- The Ministry of Youth and Sports
- The Ministry of Women and Child Development



THE MINISTRY OF HEALTH AND FAMILY WELFARE



The Reproductive Child Health Programme (1997) is a comprehensive, sector-wide, flagship program under the umbrella of the Government of India's National Health Mission that addresses major causes of mortality among women and children.⁸⁸

The School Health Programme (2008) is an intervention under the National Rural Health Mission that improves in-school adolescents' awareness of sexual and reproductive health, hygiene, and nutrition - by including related information within school curricula.⁸⁹

The Promotion of Menstrual Hygiene among Adolescent Girls (2014) is an initiative that increases adolescents' awareness of menstrual hygiene and creates access to menstrual hygiene management products. The program encourages usage of menstrual hygiene products in rural areas through the distribution of sanitary napkins by Accredited Social Health Activists (ASHAs) across villages.⁹⁰

The Rashtriya Kishor Swasthya Karyakram (2014) or the National Adolescent Health Strategy aims to create a more holistic health model based on a continuum of care to comprehensively address the needs of and meet SRH outcomes for India's adolescents.⁹¹

THE MINISTRY OF HUMAN RESOURCE DEVELOPMENT



The Mahila Samakhya (1998) works to educate and empower women at a grassroots level - as outlined by the objectives of the National Policy on Education of 1986 - by providing information on reproductive health, building capacity and ensuring equal participation.⁹²

The Adolescence Education Programme (2005) aims to empower young people with accurate, age appropriate and culturally relevant information on SRH, promote healthy attitudes and help them develop skills to enable them to respond to real life situations in positive and responsible ways.⁹³

THE MINISTRY OF YOUTH & SPORT



The National Programme for Youth and Adolescent Development (2008) acknowledges adolescents as a distinct sub-group among youth and addresses the need for their agency, teaches leadership, personality development and teamwork.⁹⁴ It is a merger of four centrally funded programs, and is designed to reduce multiplicity across programs with similar objectives, as well as to ensure uniformity in funding patterns and implementation mechanisms.

The Nehru Yuva Kendra Sangathan (2010) is an autonomous organization created to provide disadvantaged rural adolescents with avenues to participate in nation building activities and avail opportunities for personality and skill development.⁹⁵ The program is implemented through a network of village-based youth clubs, and uses existing resources from various government departments and national- and state-level institutions.

The National Youth Policy (2014) empowers youth to achieve their full potential in priority areas of education, skill development, health, community engagement, and participation in politics and governance.⁹⁶

THE MINISTRY OF WOMEN AND CHILD DEVELOPMENT



The Integrated Child Development Scheme (ICDS) (1975) aims to raise health and nutritional outcomes for children under six, provides preschool education, and combats gender inequality by providing girls with the same resources as boys.⁹⁷ These services are provided from Anganwadi centers established mainly in rural areas and staffed with frontline workers.

The Balika Samridhi Yojana (1997) aims to change negative family and community attitudes towards the girl child and her mother, improve enrolment and retention rates of girls in schools, increase the age at marriage for girls, and assist them in undertaking income-generating activities.⁹⁸ It is implemented through the ICDS infrastructure in rural areas and through representatives of the health department in urban areas.

The Nutrition Program for Adolescent Girls (2002) provides under-nourished adolescent girls, pregnant women and lactating mothers with food-grains through the Public Distribution System, according to their weight, so as to address their nutritional needs.⁹⁹

The Kishori Shakti Yojana (2009) improves the nutritional and health status, and awareness of 11-18 year old girls by providing literacy and numeracy skills training, improving their decision-making capabilities and taking measures to delay the marriageable age.¹⁰⁰

The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (2011) is a program that uses Aanganwadi centers to deliver nutritional, health, and SRHR education services to adolescent girls aged 11-18 years in 200 districts, to improve their health and education outcomes.¹⁰¹

A CLOSER LOOK AT KEY GOVERNMENT SRHR PROGRAMS

ADOLESCENCE EDUCATION PROGRAMME (AEP):



Image Credit - NIOS

RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK):



Image Credit - CREA

As illustrated, the government implements several programs to improve adolescents' sexual and reproductive health and rights (SRHR), and enhance access to SRHR education, services and resources. Dasra conducted an in-depth analysis of three significant government SRHR programs — the Adolescence Education Programme, Rashtriya Kishor Swasthya Karyakram and the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls.

The AEP provides adolescents with accurate, age-appropriate and culturally relevant information that enhance their sexual and reproductive health behavior. The curriculum enables adolescents to respond to real life situations in positive and responsible ways. By imparting knowledge on reproductive and sexual health concerns, promoting positive attitudes, and developing appropriate life skills for responsible behavior, the AEP aims to develop informed and responsible students and teachers, and through them parents and communities.¹⁰² AEP is implemented by different agencies at various levels. At the national level, the program is coordinated by the National Council of Educational Research and Training (NCERT), implemented in partnership with the Ministry of Human Resource Development (MHRD) and United Nations Population Fund (UNFPA) with the help of three implementing agencies. NCERT is also the coordinating agency on behalf of MHRD across 30 states and union territories.¹⁰³

Although, the UNFPA found that the AEP contributed positively to improving young people's attitudes on sexual health, abuse and even HIV, the program was banned in 12 states in 2007.¹⁰⁴ Teachers, parents and policy makers objected to the content of the AEP, which was criticized for promoting risky behavior among adolescents, containing graphic pictorial depictions and degrading Indian values.¹⁰⁵ One Member of Parliament warned that the program would "promote promiscuity of the worst kind, strike at the root of India's cultural fabric, corrupt Indian youth and lead to the collapse of the education system."¹⁰⁶ Over time, the AEP was reinstated in most states, though five states continue to ban the program till date.¹⁰⁷

The closest the Government of India has come to comprehensive sexual and reproductive health and rights education is through the Ministry of Health and Family Welfare's National Adolescent Health program RKSK. Launched in 2014, the program targets adolescents aged 10-19 years, and covers issues of concern for this age group including nutrition, sexuality, reproductive health, and substance abuse. RKSK also includes topics such as participation and leadership, equity and inclusion, and gender equality activities.¹⁰⁸

RKSK strives to enable significant SRH outcomes including delaying the age of first pregnancy, decreasing teenage pregnancies and meeting contraceptive needs of adolescents. To this end, the program acknowledges the strength of Adolescent Friendly Health Clinics (AFHCs) and uses this channel to provide counselling and curative services, such as iron and folic acid tablets, non-clinical contraceptives, counseling on contraception, emergency contraceptives and reversible contraceptives. AFHCs prevent unwanted pregnancies among adolescents, and delay teenage pregnancies. Pregnant adolescents receive guidance on early antenatal registration and access to institutional delivery, in order to prevent antenatal and postnatal complications.¹⁰⁹

RKSK is unique in the way it realigns the existing curative approach to adolescent health with a more holistic approach that views adolescent health and developmental needs as a continuum. It converges similar programs within and across government ministries — including programs under the Ministry of Women and Child Development, the Ministry of Human Resource Development and the Ministry of Youth Affairs and Sports. RKSK has inbuilt quality assurance through a system of checklists, scorecards and regular visits from government workers. Though it is too soon to quantitatively measure the extent of impact the program has had in India, and difficult to attribute improvements in nationwide health indicators to the RKSK program — initial qualitative reviews feedback from implementers have already noted a positive impact of RKSK in many states.¹¹⁰



RAJIV GANDHI SCHEME FOR EMPOWERMENT OF ADOLESCENT GIRLS (SABLA):

SABLA has a nutritional, SRH and skills-training component. The nutritional component aims to increase the nutritional intake of girls aged 11-18 years by supplementing their meals, while the SRH component gives out-of-school adolescent girls access to health checkups, health education counseling, education on SRHR and life skills. At the same time, SABLA provides 16-18 year old adolescent girls with access to vocational training services. SABLA is implemented through collaborative efforts of the Ministry of Health and Family Welfare, the Ministry of Youth Affairs and Sports, and the Ministry of Human Resource Development. For example, SABLA uses Aanganwadi centers to disseminate health and education services, allowing both in-school and out-of-school adolescent girls a safe space to meet and learn about reproductive and sexual health, raise awareness and discuss important issues that impact their lives.¹¹¹ From 2014 to 2015, SABLA reached over 10 million adolescent girls, across 205 districts, through a budget of INR 6.1 billion. Based on this success, many states have sent proposals to the Government of India to include more districts under the scheme. Although this expansion has not been possible due to budget constraints, the numerous applications indicate the effectiveness and success of the program.¹¹²

STAKEHOLDER 2: INTERNATIONAL DEVELOPMENT AGENCIES

International Development Agencies promote SRH programs by working closely with government and non-government organizations to fund initiatives for adolescents. Through grant-making, circulation of knowledge, best practices and increased accountability, international development agencies in India have been successful in strengthening health and education outcomes for adolescents in their areas of operation.

MacArthur Foundation:

The MacArthur Foundation was the earliest entrant into adolescent and reproductive health program funding in India. Since 1990, the Foundation has funded population and reproductive health work at the national level, with a special focus on efforts in Rajasthan, Maharashtra, and Gujarat – states that have a significantly high unmet need for reproductive health information and services. Furthermore, the foundation has several research networks on SRH issues, including Transitions to Adulthood, Adolescent Development and Juvenile Justice, and Youth and Participatory Politics.¹¹³

The David and Lucile Packard Foundation:

The Packard Foundation's funding for SRHR initiatives supports efforts to expand access to and improve the quality of comprehensive sexuality education, voluntary family planning or contraception. In India, the foundation has heavily invested in women and girls from marginalized communities in Bihar and Uttar Pradesh, who bear the greatest burden of poor sexual and reproductive health and rights, due to their disadvantaged social status and limited educational and economic opportunities. Their efforts have contributed to improving access to services, mobilizing political and financial commitment, and increasing women and girls' agency in decision-making. Through their funding, they hope to see more young girls and women start to make informed decisions about the age at which they marry and conceive, as well as the number of children they plan to have.¹¹⁴

United Nations Population Fund (UNFPA):

UNFPA has been assisting the Government of India since 1974 to provide family planning and health services, advance reproductive health and rights and improve maternal health. For its current grant cycle (2013-2017), UNFPA is supporting the Government of India to focus on young people's sexual and reproductive health, and improve opportunities for vulnerable women and girls. UNFPA also supports research, advocacy and government policies, and programs to advance gender equality and reproductive rights, family planning and population dynamics. UNFPA implements programs through offices in Bihar, Madhya Pradesh, Maharashtra, Odisha and Rajasthan.¹¹⁵

United States Agency for International Development (USAID):

USAID works in India to contribute to global efforts to solve specific worldwide development challenges. Adolescent Sexual and Reproductive Health and Rights (SRHR) is one of USAID's key focus areas to achieve sustainable results in the area of public health and contribute to the demographic dividend in India. USAID is transitioning to a new strategic approach, which, while continuing to provide targeted assistance for SRHR interventions, is increasingly adopting methods focused on multi-stakeholder cooperation. Accordingly, USAID will be engaging more directly with local partners, co-financing instead of fully funding agreements on its own, and developing platforms and alliances to generate SRHR outcomes through multiple organizations and increase impact for adolescents in India.

STAKEHOLDER 3: THE MEDIA

The media plays an integral role in the widespread dissemination of accurate information related to reproductive and sexual health and rights for adolescents. Consequently, the media, more specifically TV and radio, is as an important tool to influence adolescents' SRH outcomes. As a critical stakeholder the media broadcasts programs on SRHR-related topics that facilitate public discourse, challenge cultural norms, and shape collective understanding of reproductive and sexual health and rights.

For instance, Doordarshan, an Indian public service television network, collaborated with the Population Foundation of India to broadcast a unique television serial 'Main Kuch Bhi Kar Sakti Hoon (I, a Woman, Can Achieve Anything)' in March 2014. The serial uses entertainment as a means of education in order to influence and alter deeply entrenched social norms and promote the health and agency of women. Specifically, the serial aims to change the attitude of youth towards child marriage, sex selection, closely spaced pregnancies and nutrition, and improve their access to contraception – thus contributing to better planned and healthier families. Through its script and strong female lead, Main Kuch Bhi Kar Sakti Hoon creates realistic and relatable scenarios in each of its episodes to challenge age-old

social norms that hold women back. By providing a medium for the widespread dissemination of behavior change communication through a television serial, Doordarshan is educating its viewers and moving towards achieving SRHR outcomes.¹¹⁶

In addition, radio programs on sex, sexuality, and sexual and reproductive health and rights of adolescents also play a role in challenging restrictive cultural norms. Radio technology is easily accessible and low cost for the consumer, especially in rural areas in India. Programming can also be easily adjusted for regional diversity and language differences. For example, Health and Family Welfare programs are regular broadcasts of All India Radio, the national public radio broadcaster of India, and one of the largest radio networks in the world. Regional and local radio stations produce and broadcast these programs in their respective regional languages and cover issues like raising age at marriage, delaying the first child, spacing between children, pregnancy-termination methods, maternal care, child survival, promotion of inter-spouse communication and male responsibility, neutralizing male preference syndrome, and managing reproductive-tract infections and sexually transmitted infections.¹¹⁷

CONCLUSION

This chapter illustrates how the Government of India, international development agencies and the media have made strides to ensure that SRHR information and services for adolescents are available and accessible, at scale. By creating and implementing key programs and policies, funding best practices, and disseminating information, these stakeholders have improved SRH outcomes over the last 20 years –breaching topics in public schools that were previously unaddressed and challenging ingrained social norms.

CHAPTER

03

CORNERSTONES

Areas for Action

Previous chapters have illustrated the importance of improving sexual and reproductive health (SRH) outcomes for adolescents in India. While there has been some progress on achieving these outcomes, it is critical to bring increased and sustained investment to the sector to allow non-profits to scale programs that have a proven positive impact on SRHR indicators. Through secondary research and expert consultations, Dasra identified four key priority areas for action that deserve the attention of funders and other stakeholders. These include key principles to consider when creating programs and interventions to enhance adolescents' SRHR:

- 1.**
USE INFORMATION & COMMUNICATION TECHNOLOGIES TO REACH VULNERABLE ADOLESCENTS
- 2.**
CUSTOMIZE PROGRAMMATIC APPROACHES TO ADDRESS THE HETEROGENEITY OF THE ADOLESCENT POPULATION
- 3.**
ENSURE PROGRAMS CAN BE DELIVERED THROUGH EXISTING DELIVERY PLATFORMS
- 4.**
INCLUDE ADOLESCENTS IN PROGRAM DESIGN AND IMPLEMENTATION

1. USE INFORMATION & COMMUNICATION TECHNOLOGIES TO REACH VULNERABLE ADOLESCENTS

1 ■ ■ ■ ■

Traditional SRH outreach mechanisms - such as school-based SRH educational programs or community health centers - are resource intensive and challenging to scale, often failing to reach vulnerable adolescents, who have limited mobility, visibility and agency. These include married girls, very young adolescents and out-of-school adolescents. Rapid technological advancements like the Internet and mobile technology, allow organizations to leverage Information Communication Technologies (ICTs) to reach a larger number of adolescents, including these vulnerable adolescents. ICTs refer to a broad range of technologies used to gather, store, retrieve, process, analyze and transmit information. While these technologies are not a silver bullet for all outreach challenges with adolescent programming, they provide a relatively affordable means to disseminate knowledge on a wide scale, as well as a fast and consumable way to access information.¹¹⁸

In India, mobile phone usage has increased dramatically in the last decade. According to the Telecom Regulatory Authority of India's 2016 subscription data, India has 81.35 mobile phone connections per 100 citizens, up from 37.94 connections per 100 citizens in 2009.¹¹⁹ Additionally 43.3% of mobile phone

connections in 2016 are found in rural areas.¹²⁰ Mobile phones are also increasingly used to access the Internet - already, 35 million users browse the Internet through their phones.¹²¹ This means that ICTs can cost effectively support the provision of information to a large audience of adolescent boys and girls. Stakeholders in the sector therefore encourage ICTs as an important medium for young people to access information. Rashtriya Kishor Swasthya Karyakram, a government program, leverages telecom-based platforms and two-way, communication-based technology interventions for greater dissemination of SRHR information.¹²²

Apart from being an effective tool to disseminate accurate and relevant information in an accessible and cost-effective way, technology interests adolescents who are likely to engage with technology-based interventions to receive information.¹²³ There is a level of anonymity in mobile-based interventions, such as interactive voice response systems (IVRS), which allows young people to ask the questions they have without embarrassment or fear. Text-based messaging, social networking services and other forms of audio-visual messaging have proved to be popular and attractive mediums to capture young people's interest.

Besides appealing to adolescents, ICTs are also useful for tracking patient history and providing health-related information in rural and otherwise inaccessible areas. For instance, the Kalam-Raju tablet, a low-cost, India-manufactured mobile tablet developed in 2012 by APJ Abdul Kalam and Dr. B Somaraju, has helped frontline healthcare workers like doctors and Anganwadi workers to record and access important

information.¹²⁴ These tablets store medical information and patient medical history, making important treatment procedures and diagnostic tools available in remote areas, thus empowering Anganwadi workers when physicians are unavailable. Consequently, ICTs can be used to cost-effectively disseminate information to otherwise hard-to-reach audiences across geographies.

Despite their affordability, the privacy that they offer, and their inherent appeal to adolescents and reach across geographies - there are also limitations to using ICTs that constrain the scope of interventions employing ICT-based outreach methods. For instance, access to ICTs is gendered, with girls and wives having less access to technology due to parental or familial control over information.¹²⁵ Also, over 70% of parents expressed concern about their children's use of the Internet on mobile phones to access inappropriate sites.¹²⁶ This can sometimes result in the complete restriction of adolescents' use of the Internet on phones, rather than parental involvement in content filters or other ways to protect access to undesirable content. While these constraints may limit the appropriateness of ICT interventions, they are not enough to write them off entirely. ICT interventions are relatively low cost and have large potential for reach. It is possible to reach many adolescents across India effectively with programs that use ICT dissemination methods. By reaching as many adolescents as possible using this low cost technology, we would free up resources to target more vulnerable groups. Therefore, when choosing ICTs as a mode of content delivery, it is important to consider technology appropriate for the audience an intervention is targeting.



CASE STUDY 1

CREA: KAHI ANKAHI BAATEIN

CREA, in partnership with Gram Vaani, TARSHI and Gurgaon ki Awaaz, launched a mobile-based infoline Kahi Ankahi Baatein (Speaking the Unsaid) in 2016. The infoline is a safe and anonymous platform for young people to get essential SRHR information in Hindi. It is a unique, round-the-clock, mobile-based technological solution that uses an Interactive Voice Response System (IVRS) to reach out to a diverse range of audiences across geographies and age categories. The content is packaged in a creative and engaging format and covers important SRHR themes including menstruation, relationships, contraception, consent, violence and disability.¹²⁷ Kahi Ankahi Baatein also gives listeners an option to record their feedback and queries, as well as access previously aired content. CREA, Gram Vaani and TARSHI partner with colleges, universities, community radio networks and other civil society organizations to publicize Kahi Ankahi Baatein offline.

The infoline successfully taps the potential of ICTs to reach young people in urban, peri-urban and rural areas. Over 37% of callers are below 18 years, 40% are between the ages of 19-25 and 39% are women and girls. Although the percentage of male callers is higher because of their primary access to mobile phones, it is encouraging to see that the reach of the infoline is expanding among adolescent girls and women.

2. CUSTOMIZE PROGRAMMATIC APPROACHES TO ADDRESS THE HETEROGENEITY OF THE ADOLESCENT POPULATION



Organizations working to enhance adolescents' sexual and reproductive health must account for identity differences within this demographic and customize programs to meet a diverse range of needs. While the information provided in SRH programs should be the same for all adolescents (while accounting for the age group), the heterogeneity of adolescents may require different approaches and forums to effectively target, engage and disseminate information to ensure retention. As outlined in Chapter 1, there are many factors that contribute to the heterogeneity of adolescents: geographical location, religious and cultural norms, socio-economic status, identity, gender, marital status and age. Of these factors, married adolescent girls, very young adolescents (aged 10-14 years) and boys are particularly underserved by SRH programs. While the different factors that create heterogeneity among adolescents make scaling successful programs across India more difficult, local organizations that have a finger on the pulse of the demographic they serve are able to consider the specific requirements of adolescents to an extent. However, some groups remain underserved.

For example, adolescent boys are an especially vulnerable demographic when it comes to SRHR programming, as there are an extremely limited number of programs designed to reach them. Most SRHR-focused programs traditionally aim to achieve positive sexual and reproductive health outcomes for girls. And yet, it is just as critical to reach adolescent boys, who have distinct reproductive and sexual health needs, and who go on to play key decision-making roles as brothers, husbands and fathers in girls' lives.

Research findings corroborate the need to address both girls and boys in SRH programs. Studies published by the International Center for Research on Women (ICRW), and its partners in India, investigated strategies to improve or address SRHR for adolescents between 1999 and 2005. They found that reaching men and boys to improve their own sexual and reproductive health, as well as to improve their participation in young women's health decisions, was critical to improving overall SRHR outcomes.¹²⁸ Another research study by the Foundation for Research in Health Systems (FRHS) in rural Maharashtra found that young men chose a different set of topics in health education sessions than the young women in the program. Men were interested in topics like sexually transmitted infections (STIs), including HIV, sexual performance, the effects of multiple sexual partners on performance and fertility, and drug abuse.¹²⁹ While it is critical that the content of the information provided through SRHR education is the same for both boys and girls, programs for adolescent girls may not necessarily satisfactorily address these particular subjects and position these topics in a way to draw adolescent boys' interest

and engagement, or provide a safe space for adolescent boys to feel comfortable asking questions they might have. Data thus emphasizes the need to customize SRHR programs to address the distinct needs of young men.

In addition to recognizing and addressing young boys' questions, concerns and needs, it is important for programs to engage boys in discussions on gender equality, masculinity, and domestic violence, so as to improve their participation in young women's health decisions. Programs that encourage boys to reflect on the origins and consequences of gender norms and inequalities not only help them turn into responsible adults, but also subsequently improve adolescent girls' health outcomes. Given the grave impact of gender-based violence, gender-based restrictions and discrimination, organizations that address violence and vulnerability with both boys and girls have an indirect, but critical, role to play in improving SRHR outcomes. Thus, engaging boys in programs that have meaningful and relevant content could significantly improve both, adolescent girls' and boys' agency and health outcomes.



CASE STUDY 2

ECF: ACTION FOR EQUALITY

Action for Equality is an action research program by the Equal Community Foundation (ECF) that engages boys and young men with the objective of reducing violence and discrimination against girls and women. The program operates in 20 low-income communities in Pune. Action for Equality is an intensive 15-week course, designed for adolescent boys, that uses interactive and participatory sessions to discuss gender issues and build knowledge on human rights and women's rights. The course is split into three stages - the first stage is foundational and includes sessions on the impact of masculinity and patriarchy. The second stage imparts communication skills, builds knowledge of women's rights and gender equality, as well as fosters peer-support networks through interactive and participatory sessions. The last stage enhances leadership potential by building boys' persuasion and campaigning skills. Boys emerge as ambassadors of gender equality in their communities.

By giving boys a space and opportunity to understand the roles that patriarchy, masculinity and gender play, ECF hopes to influence their beliefs and actions. For example, ECF has observed that post their participation in the program, boys display stronger support for gender equitable norms, demonstrate increased levels of participation in the domestic sphere and vociferously speak out against gender violence.

3. ENSURE PROGRAMS CAN BE DELIVERED THROUGH EXISTING SERVICE DELIVERY PLATFORMS

■ ■ ■ 3 ■ ■

SRHR interventions are more successful and scalable when they use existing platforms for program delivery. Considering the limited resources of time, capital and manpower — advancing adolescents' health and agency at a large scale can only occur by building on existing work and using proven successful modes of service delivery. Non-profits working to build new programs must be aware of existing programs, including their successes and challenges; rather than create parallel systems of delivery that duplicate effort and unnecessarily expend limited resources. Scalable and sustainable programs use existing infrastructure to reach adolescents, whether it is a school-based intervention that works with in-school adolescents, a training program that supports Anganwadi workers, or an organization that supplements resources in community and primary health centers. When programs are designed to build upon existing platforms, they converge with work already being done and move the sector forward.

In addition to using existing platforms, organizations need to collaborate with each other to achieve common outcomes in the SRHR landscape. Each organization has something unique to bring to a partnership. This could include specific knowledge of their area of coverage or distinct insights based on their experiences. By working together, organizations can share best practices and benefit from a support system for organizations of all sizes, thus conserving resources. There can also be a division of labor among cooperating non-profits as to who targets what area of a population, to ensure that a diverse range of adolescents' needs are addressed efficiently. Indeed, when organizations fail to communicate or collaborate, it creates silos and rivalry in a sector where competition has no place. Thus, organizations should use existing channels and leverage each other's strengths to optimize the reach and impact of their programs.



CASE STUDY 3

NATIONAL INSTITUTE OF OPEN SCHOOLING (NIOS)

The Ministry of Human Resource Development established the National Institute of Open Schooling (NIOS) in 1989 as an autonomous organization. In addition to general academic courses, the NIOS provides a number of vocational, life enrichment and community-oriented courses at the secondary and senior-secondary level.

In collaboration with UNFPA, NIOS integrated the Adolescent Education Programme (AEP) into its existing curriculum. Instead of offering the AEP as a stand-alone course, NIOS included AEP modules within the top five subjects taken by secondary school students — thus ensuring 100% student coverage. By incorporating the AEP within its curriculum, NIOS demonstrated how to leverage an existing service delivery platform to disseminate SRHR information. Moreover, NIOS courses are designed for those who cannot keep up with the school system on account of learning disabilities, physical handicaps, limited mobility or other reasons. NIOS is therefore best positioned to reach the most vulnerable, marginalized adolescents who have limited access to SRHR information.

4. INCLUDE ADOLESCENTS IN PROGRAM DESIGN AND IMPLEMENTATION

■■■ 4

Most often, adolescents aren't invited to discussions on policies and programs that directly affect their lives. They are usually included only at the later stages of a program, either during the actual implementation period or during post-program evaluations.¹⁵⁰ However, in order to create more appropriate and relevant programs, adolescents must be included in the decision-making process. It is important to first sensitize adolescents by providing them with context, ensuring that they understand the scope of the program and the range of opportunities available to them before asking them to weigh-in on program design and implementation. This ensures that their feedback is valuable and relevant for the effectiveness and uptake of SRHR programs. Inputs from adolescents should be brought in at an early planning stage, and programs must evolve based on their feedback. This will ensure that a program creates meaningful impact and will limit the didactic approach to adolescent reproductive and sexual health rights.

By considering adolescents' feedback, educators, community decision-makers and implementers could gain important insights into specific implementation challenges and accordingly design more effective programs.¹⁵¹ Adolescents can also provide perspective on components that make a program more accessible and acceptable to young people, a perspective that adults and program planners sometimes lack.¹⁵² Without this input, it is less likely that a program will be tailored to fit the target population. By including adolescents in the decision-making process, it is possible that appropriate attention will be given to problems that might otherwise go unnoticed by adults. It is therefore essential to involve adolescent health consumers in program planning and operation. Increased representation of adolescents in the planning and implementation process improves the quality and relevance of SRHR programs.



Image Credit - Restless Development



CASE STUDY 4

CHILD IN NEED INSTITUTE'S (CINI) WORK IN WEST BENGAL

Non-profit organization CINI works with the West Bengal Government to strengthen the implementation of the Rashtriya Kishor Swasthya Karyakram (RKSK) – a government program that enhances SRH outcomes for adolescents between the ages of 10 to 19. CINI emphasizes that adolescents are critical stakeholders in their own empowerment and ensures that they play a major role in any program that works to improve their development outcomes. CINI educates adolescent peer leaders from target geographies on their rights and entitlements, and promotes their active participation in local governance efforts. Peer leaders then inform adolescents in their communities about their rights and act as their representatives in local government meetings and child protection committees.

CINI also recognizes that working with adolescents would be futile if their community and environment were not supportive and adolescent friendly. The organization therefore also facilitates bi-monthly meetings, held at various community centers across their target geographies, to bring together adolescents and their gatekeepers – parents, teachers, government service providers and Panchayat members – to analyze the risks and vulnerabilities experienced by adolescents (for example, the risk of child marriage, limited access to health and education) and develop and implement action plans to improve their circumstances. These meetings help adolescents become empowered change makers within the community. Through CINI's outreach, about 16,733 stakeholders and 2,585 health service providers have been sensitized on adolescent development issues and trained to create a more enabling environment for adolescents.¹⁵³

CONCLUSION

As discussed, Dasra's research highlights four cornerstones that have the potential to optimize funding and deliver SRHR outcomes. These include using innovative methods such as ICTs to reach young people, customizing programs to meet the needs of all demographic segments among adolescents, including boys, collaborating to deliver programs through existing platforms and including adolescents in program design and implementation.

04

A LANDSCAPE OF SRHR INTERVENTIONS FOR ADOLESCENTS

There are considerable socio-cultural and systemic challenges associated with delivering programs in the field of sexual and reproductive health and rights (SRHR) for adolescents. Despite these challenges, many organizations across India implement a range of interventions to meet adolescents' SRHR needs. Dasra conducted a comprehensive mapping of the sector in India and identified 192 organizations that work across a spectrum of SRHR interventions. Of these, Dasra shortlisted 50 organizations implementing scalable or innovative interventions that cater to adolescents. Based on discussions with these organizations, Dasra identified the following key interventions that improve SRHR outcomes:

1. EDUCATING ADOLESCENTS ON SRHR
2. ENABLING THE DELIVERY OF SRHR EDUCATION PROGRAMS
3. PEER-BASED SRHR PROGRAMS FOR ADOLESCENTS
4. STRENGTHENING GOVERNMENT SYSTEMS
5. STRATEGIC BEHAVIOR CHANGE COMMUNICATION
6. SENSITIZING BOYS AND MEN
7. FACILITATING ADOLESCENTS' ACCESS TO SRHR PRODUCTS AND SERVICES

1. EDUCATING ADOLESCENTS ON SRHR



Overview

Entrenched social stigma and norms related to sex and sexuality in India have created a silent vacuum within which SRHR information and services aren't easily accessible to youth. Given these cultural barriers, a shocking 75% of young adolescents remain poorly informed about—and in some cases completely unaware of their own sexual and reproductive health and rights. The ensuing social silence perpetuates an absence of reliable channels to increase adolescents' awareness, as well as the disbursement of incomplete or wrong information among peers. To address this lacuna in accurate and available SRHR information, various stakeholders run SRHR education programs for adolescents that cover gender, sexuality, rights and health-related issues. SRHR education programs are referred to, interchangeably, as comprehensive sexuality education, family life education, sex education or adolescent education programs.

OBJECTIVES

- a. Provide holistic information on sexuality and reproductive health that includes body changes, sexual health, gender rights and gender sensitivity.
- b. Go beyond awareness generation and address adolescents' concerns and doubts regarding their health and sexuality.

Implementation Challenges

Securing Community Buy-In: Community members, parents, school management and health workers often impede adolescents' access to SRHR information and services. Therefore, in order to reach adolescents and engage with them on sensitive issues, it is essential to directly involve community gatekeepers and frontline health workers. However, organizations find it challenging to work with community members, given the inherent social stigma attached to sex and sexuality.

Implementing Organizations

a. Love Matters

Love Matters is a bilingual online resource for information on reproductive and sexual health education for young people, teachers and peer educators. The content of the website is user-generated whereby the audience determines what content to showcase, how this content should be packaged and which dissemination channels to use. In this manner, Love Matters prioritizes the needs of end-users. Furthermore, it gives adolescents a judgment-free space to discuss intimate issues and thereby eliminates the shame and stigma attached to conversations about sex. The website is easily accessible from mobile phones.

b. Vacha

Vacha works with adolescents as a preventive measure against vulnerabilities faced by women due to a lack of education, exposure and opportunity. It enhances adolescents' knowledge about SRHR-related issues through sessions on health, gender and life skills. Participants in Vacha's programs are also exposed to information through workshops, educational visits, film screenings, and group discussions - and have access to a library with a collection of books and resources in seven Indian languages.



Image Credit - Love Matters



Image Credit - Vacha

2. ENABLING THE DELIVERY OF SRHR EDUCATION PROGRAMS



Overview

In order to educate adolescents on SRHR issues, organizations work to design comprehensive curricula, train school teachers and community facilitators, as well as create safe spaces within which SRHR information can be delivered to vulnerable adolescents. These interventions form the building blocks of SRHR education programs and enable their delivery.

a. Developing Curricula: Non-profits use their technical expertise to develop curriculum for SRHR education programs for adolescents. Curricula modules cover a range of SRHR issues including gender and sexuality, fertility, contraception, sexual violence, HIV and AIDS, safe motherhood and reproductive health services. Furthermore, organizations include modules such as nutrition and life skills that don't fall under the purview of SRHR education, but are nonetheless associated with improved SRH outcomes.

b. Training School Teachers or Community-Based Facilitators: Non-profits partner with state governments to train school teachers to deliver SRHR programs to adolescents. They also implement their own programs at scale by training community-based facilitators who understand the local context. Organizations training school teachers or facilitators are typically involved in:

- Preparing training material;
- Conducting workshops or training sessions to build the capacity of school teachers or community-based facilitators to educate adolescents on SRHR issues; and
- Monitoring, assessing and evaluating implementation results and using insights to improve the curriculum.

c. Creating Safe Spaces: Organizations are also directly engaged in service delivery and educate adolescents on SRHR in safe spaces or adolescent centers. These interventions are particularly relevant for vulnerable, at-risk adolescents (especially girls) from marginalized communities who are not reachable through school systems and are left out of typical youth-based programs. These interventions involve:

- Extensive community-based outreach;
- Delivery of SRHR curricula by a trained facilitator; and
- Provision of a safe physical space for adolescent groups to obtain information, develop life skills and create social networks.

OBJECTIVES

- a. Enable the delivery of quality SRHR education programs for adolescents.
- b. Ensure that those delivering SRHR education programs-school teachers and community health workers - are well-trained and equipped to do so.
- c. Create safe spaces where vulnerable and otherwise inaccessible adolescents can access SRHR information.

Implementation Challenges

a. Sustaining Government Engagement: Adolescents have only recently been recognized as a distinct demographic with unique health and information needs. Although the Government of India has acknowledged the importance of providing targeted information on sexual and reproductive health to adolescents, non-profits still find it challenging to secure government support. Government representatives are hesitant to support programs that address sex and sexuality, as the general presumption is that this could lead to increased promiscuity. Organizations also find it difficult to find and sustain champions within the government as officials are transferred frequently or governments change, and consequently, agreements and memoranda of association have to be renegotiated.

b. Contextualizing Curricula: Across India, sex remains a sensitive topic, and discussions related to sex and sexuality are often brushed under the carpet. For many program participants, discussing sex, menstruation and sexuality is not only considered inappropriate but also immoral and unacceptable.

Consequently, non profits that deliver SRHR education programs find it valuable to remain sensitive to prevalent cultural norms. However, this presents a challenge when they seek to scale their work, as adapting SRHR curriculum to varied social contexts requires a significant investment of resources.

c. Identifying Universal Standards: Experts highlight the need to identify critical topics that all SRHR-education curricula for adolescents should cover (such as inequality, violence and sexual abuse) so as to meet certain quality standards. However, India lacks platforms or collaborative networks for organizations to come together and collectively identify universal standards for SRHR-education programs. In the absence of identified quality indicators, many existing SRHR-education programs fail to educate adolescents on their basic rights and critical health information

Implementing Organizations

a. CREA

CREA is a women's rights organization that partners with community-based organizations (CBOs) to advance SRHR for adolescent girls using sports. It

- develops an SRHR curriculum that includes issues such as gender identity, contraception and information about adolescents' bodies; and
- trains CBO facilitators to deliver sports-based SRHR sessions through girls' collectives.

CREA also monitors sessions conducted by its partner CBOs and assesses improvements in girls' self-efficacy and SRHR knowledge.

b. Centre for Catalyzing Change (C3)

Across its SRHR programs that are aimed at different adolescent sub-groups such as in-school or married adolescents, C3:

- develops life skills based SRHR curriculum to improve adolescents' agency and SRHR knowledge;
- trains and builds the capacity of government school teachers and frontline workers to provide adolescent-sensitive health information and services.

c. Talking About Reproductive and Sexual Health Issues (TARSHI)

TARSHI has been conducting training programs for SRHR practitioners who engage with adolescents since 2003. It has developed a training manual that provides tools and methods to effectively address SRHR issues with adolescents. It also trains practitioners to select or adapt suitable exercises for their classes and tailor information modules to a specific group's requirements.

3. PEER-BASED SRHR PROGRAMS FOR ADOLESCENTS



Overview

Adolescence can be a vulnerable and isolating period, and adolescents are naturally hesitant to talk about personal, sexual health related issues with adults. Consequently, they may feel more comfortable discussing sex and sexuality-related questions with their peers, and are more likely to rely on information from these informal sources. Experts interviewed through this study also recommend that it is easier to reinforce best health practices and SRHR messages, as well as access at-risk, marginalized adolescent groups – through peer-led initiatives. Therefore, one mechanism through which organizations provide SRHR information to adolescents is by:

- Identifying peer representatives or leaders from a particular group of adolescents;
- Educating them on SRHR issues; and
- Training them to actively inform the rest of their peer group.

OBJECTIVES

The key objective of peer-based SRHR programs is to encourage adolescents to not only learn about SRHR, but also communicate related needs to trusted peers and mentors. It allows adolescents to access SRHR information and provide feedback on the kinds of resources they need, thereby enabling non-profits to tailor their interventions accordingly.

Implementation Challenges

a. Recruiting Peer Leaders: It is challenging to identify and recruit motivated and mature adolescents with the skills required to discuss SRHR, as peer leaders. Furthermore, it is difficult for peer leaders or educators to challenge other adolescents to develop critical thinking skills and question cultural norms or social stigma. This is because young peer leaders often lack leadership, communication skills and the capacity to drive social change within their communities.

b. Altered Peer Relationships: Peer-based programs could actually change the dynamics of peer relationships, creating a social divide between selected peer leaders and their peers. Peer leaders may be perceived as being favored by teachers or program staff members, and this in turn might negatively influence trust levels within peer groups.

c. High Costs: Peer leaders are volunteers who cannot be retained, and there is rapid turnover as peer leaders grow older. Consequently, there is a constant need to train new recruits. Furthermore, youth require more handholding, training and supervision than adults, and subsequently, there are higher costs associated with implementing peer-based SRHR programs.

Implementing Organizations

a. Child In Need Institute (CINI)

CINI takes an integrated approach to improving development outcomes for children in Eastern India. As technical advisor to the Government of West Bengal for the implementation of the Rashtriya Kishor Swasthya Karyakram, it

- promotes youth-led selection of peer leaders;
- trains government school teachers to enable peer leaders to reach out to their networks; and
- encourages youth representatives to raise their concerns at village-level meetings attended by local government authorities.

b. NAZ Foundation

Naz Foundation works on sexual health issues including HIV and STI awareness. Since 2006, Naz Foundation has implemented Goal, a 10-month-long program for girls aged 12-20 years, in urban slums and government schools. The program includes bi-weekly sports sessions to provide life skills training and SRHR information. One participant (out of 30) is selected as a peer leader and trained in providing SRHR information to peer groups. One peer leader (out of 10) is then selected as a community-sports coach and trained to conduct the Goal program for new participants.



4. STRENGTHENING GOVERNMENT SYSTEMS

4

Overview

Non-profits strengthen government systems so as to improve the efficacy of government-led initiatives that promote adolescents' sexual and reproductive health (SRH). They do so by advocating for better SRH policies or by building the capacity of government teachers and health workers.

a. Advocacy: While the Government of India has developed policies and programs to improve SRH outcomes for adolescents, there are various design and implementation gaps that need to be addressed. Non-profits play a critical role in identifying these gaps in policy and programs, and using their experience and expertise to advocate for change. Organizations also use evidence from their work with adolescents to advocate for modifications in government-led SRHR initiatives, so as to enhance service delivery.

b. Capacity Building of Government Workers: Non-profits support the government's implementation of SRH programs by facilitating workshops and training sessions for government workers, including school teachers and health workers. Non-profits provide government workers with the curriculum, tools and techniques to deliver SRH programs to adolescents. They strive to build the capacity of these government workers to engage with all stakeholders, including reluctant community members and gatekeepers.

OBJECTIVES

a. Use research findings to advocate for better implementation of existing government programs as well as to recommend more effective programs.

b. Build the capacity of government workers to effectively deliver SRHR programs for adolescents.

Implementation Challenges

a. Evidence-Based Advocacy: Government-initiated policies and infrastructure do not necessarily translate into strong programs on the ground. The intended outcome of a particular program often differs from what is achieved post implementation. Non-profits work to bridge implementation gaps by advocating for policy changes. However, they face a challenge in collecting strong evidence for recommended modifications. Evidence-based advocacy to influence government policies and programs is often a lengthy and expensive process that requires rigorous data collection and research.

b. Ensuring Effective Outreach by Government Workers: Government workers are often ill-equipped to address issues such as gender and sexual rights. This reduces the effectiveness of government-run SRH programs. Although organizations work to build the capacity of government workers through training programs, they lack the authority to hold them accountable for poor implementation of programs. Consequently, organizations are challenged to ensure that government workers effectively deliver SRH programs.

Implementing Organizations

a. CREA
CREA is a New Delhi-based women's rights organization that challenges popular perceptions regarding gender and sexuality. It supports activists, organizational representatives, policymakers, and others working on gender, sexuality and SRHR to advance the sexual and reproductive rights of women. CREA aims to influence global and national policies by advocating for changes in laws, policies and practices that violate the rights of women, young girls and other marginalized communities.

b. Institute of Health Management, Pachod (IHMP)
IHMP works with adolescent girls, community members and other stakeholders to prevent child marriage and early pregnancy, in rural Maharashtra. One of IHMP's key interventions involves training frontline government health workers to: (i) conduct monthly health needs assessments of married adolescent girls; (ii) provide needs-based counseling to married adolescent girls and their families; and (iii) actively link adolescent girls to government healthcare providers and health centers.

c. Himalayan Institute Hospital Trust (HIHT)
HIHT builds the capacity of government health workers to deliver SRH services at the district, state and national level. It uses a 'training of trainers' model to educate health workers on SRH issues. The training provided by HIHT includes modules on lifestyle changes, mental health, gender, violence and reproductive health. It is one of six organizations in India that serves as a national training partner to the Government of India and works across seven states to strengthen government systems.

5. STRATEGIC BEHAVIOR CHANGE COMMUNICATION

5

Overview

Strategic Behavior Change Communication (SBCC) refers to a set of well-defined intervention strategies that non-profits deploy to influence positive changes in beliefs and practices. These interventions incorporate varied media formats to alter the sexual and reproductive health (SRH) behavior of adolescents. These formats include mass media (press and television), community-level activities (street theater), information and communication technologies and new media (Internet).

Comprehensive SBCC-based interventions include the following steps:

- Identifying harmful behavior as well as barriers to adopting positive behavior;
- Identifying and segmenting target audiences;
- Outlining desired behavior change outcomes;
- Designing and pre-testing communication solutions in accordance with identified objectives; and
- Implementing, monitoring and evaluating interventions.

OBJECTIVES

SBCC-based interventions provide information that can affect a positive shift in SRH-related attitudes and corresponding behavior. Through cumulative efforts, SBCC interventions aim to influence a change in beliefs, practices and norms related to the sexual and reproductive health and rights of adolescents.

Implementation Challenges

Going Beyond SBCC: Individuals and communities are more likely to act on information that is coupled with easy access to products and services necessary to improve outcomes. Consequently, a lack of access to SRH products, services and infrastructure often limits the impact that an organization can make through its SBCC interventions. For instance, young married couples are more likely to use contraception, if information on related benefits comes with easy access to medical facilities, family planning services and products. SBCC interventions, therefore, cannot be implemented as stand-alone interventions and organizations are challenged to provide communities with access to critical services and products that are acceptable and affordable.

Implementing Organization

Population Services International India (PSI India)

PSI is a global health organization working on HIV/AIDS prevention, family planning, maternal and child health, and violence. PSI's SBCC interventions are designed and managed in partnership with national and international experts and community-based organizations. PSI conducts extensive research to gather data on barriers to SRHR outcomes among youth aged 15-29 years. This research is used to design programs and campaigns to bridge identified gaps in information and to influence behavior change. Information is disseminated through hoardings, TV commercials, street theater, as well as trained community volunteers, who provide door-to-door information to households with women at reproductive age, and encourage the uptake of family planning services. PSI uses qualitative and quantitative approaches - such as formative assessments, Management Information Systems (MIS) and scientific research surveys - to measure behavior change and evaluate the performance of its programs.



Image Credit - Vishakha & PSI India

S. SENSITIZING BOYS AND MEN



Overview

Boys and men, often hold more power than girls and women over decisions regarding sexual and reproductive health (SRH) in relationships. However, limited access to opportunities that could help them develop gender-sensitive attitudes often lead boys and men to make decisions that violate women's sexual and reproductive health and rights (SRHR). Working with this demographic is therefore pivotal to improving SRHR outcomes for girls and women.

Organizations working with women recognize this demographic as a critical stakeholder and often include fathers, fathers-in-law, brothers and husbands in their workshops and counseling sessions for girls and women. Some organizations also run separate interventions focused specifically on working with young men and boys. These interventions are based on the idea that young men's participation and cooperation is critical to reducing gender-based inequality and improving SRH outcomes for girls and women.¹⁵⁴

Specific components of these interventions include training modules and workshops that bring young men into conversations that challenge sexual violence, promote equitable decision-making regarding family planning and contraception, and defy gender stereotypes.

OBJECTIVES

- Educate and sensitize boys and men on SRHR-related issues.
- Facilitate gender-equitable reproductive and sexual health practices.

Implementation Challenges

Lack of Donor Support: Donors aren't aware of the vital role that adolescent boys play in achieving favorable SRH outcomes for girls. Consequently, most funders, within the SRH sector, only support programs that are designed for and involve adolescent girls. Non-profits implementing programs for boys and men therefore struggle to secure funding for related activities, and need to build evidence on the benefits of engaging men across interventions.

Implementing Organizations

a. Equal Community Foundation (ECF)

ECF was founded in 2009 to enable boys to participate in India's 'Ending Violence Against Women' campaign. Through its program, Action for Equality, ECF delivers a 15-week course to boys and men. The course material includes three SRHR-focused modules that are structured on the premise that limited information about SRHR is an important cause of high-risk behavior among boys. ECF's curriculum provides SRHR information to boys and addresses issues such as gender-based violence and shared domestic responsibilities.

b. Vatsalya

Vatsalya works in Uttar Pradesh to improve health outcomes for children and women. Amongst other SRHR issues, it works to promote safe menstrual hygiene practices. Vatsalya partners with mobilizers within communities and village Panchayats to actively engage men and boys, and encourage a shift in their attitude towards sanitation and menstruation. It conducts these sessions using interactive information education and communication methods such as stories, rudimentary board games, theatre and puppet shows.



7. FACILITATING ADOLESCENTS' ACCESS TO AFFORDABLE SRHR PRODUCTS AND SERVICES

■■■■■■■ 7

Overview

Many young Indians from disadvantaged backgrounds struggle to access critical sexual and reproductive health and rights (SRHR) information, services and products. Insufficient knowledge about health services, ineffective implementation of government schemes, unapproachable and ill-trained healthcare providers and deep-rooted cultural and gender norms impede adolescents' access to critical SRH services. Non-profits address these barriers by providing adolescents with:

- Accurate information on sexual and reproductive health and rights;
- Effective, affordable and safe methods of contraception;
- Services that ensure healthy pregnancy and safe delivery for young mothers;
- Facilities that diagnose and treat sexually transmitted infections and diseases;
- SRHR-related counseling services; and
- Referral services to prevent and respond to sexual violence.

OBJECTIVES

To provide adolescents with access to information, services (such as treatment for STIs) and products (such as contraceptives or sanitary napkins) to meet their SRH needs effectively.

Implementation Challenges

Ensuring Utilization of Products and Services: Facilitating access to products and services does not necessarily lead to actual service utilization. Often services and products are not acceptable or affordable. For example, service providers are rude or judgmental, and while there are affordable public services that are free or low cost, people often prefer private providers who are considered to be safe or confidential sources. Organizations often struggle to include an accompanying SBCC component that can affect attitude and behavior change needed to increase the uptake of products and services.

Implementing Organizations

a. Pathfinder

Pathfinder works in partnership with the Government of India to provide critical SRH-related information and services to marginalized groups. Its program 'Promoting Change in the Reproductive Behavior of Adolescents' worked with girls (aged 15-19 years) across Bihar to delay the age at marriage and first pregnancy. Additionally, it promoted healthy timing and spacing of pregnancies among adolescents and young couples. Pathfinder employs multiple interventions to ensure utilization of SRH products and services. These interventions include individual counseling services for young women, women's group discussions on SRH issues, group meetings with married men, fathers and fathers-in-law that are led by male counselors, and infotainment programs for newlywed couples.

b. Population Services International India (PSI India)

PSI India's Project Pehel leverages the potential of the private sector to provide affordable contraceptive products and services to adolescent girls and young women in Uttar Pradesh, Rajasthan and Delhi. It has trained over 1,100 doctors in the private sector and provided them with high-quality contraceptive products such as condoms, oral contraceptive pills and IUDs at subsidized rates, which are then distributed to clients in PSI's project intervention areas.



Image Credit - Pathfinder



Image Credit - PSI

CONCLUSION

Based on an analysis of various SRHR programs for adolescents across India, Dasra has identified three key enablers that allow organizations in the sector to work at scale.

a. Government Engagement

Non-profits across the board emphasize the importance of working in partnership with the government, which has the resources to scale SRHR programs. Organizations with long-term experience in the sector are able to leverage government support by:

- Acting as technical advisors to state or local authorities to further national health policies and programs, such as the Rashtriya Kishor Swasthya Karyakram (RKSK).
- Entering into Memoranda of Understanding (MoUs) with state, national or district level authorities to train: (i) frontline, government health workers to provide quality SRHR services to adolescents; or (ii) government school teachers to educate adolescents on SRHR through the school curriculum.
- Implementing SRHR programs that they have managed to successfully pilot and generate evidence at a state or national level.

b. Community Support

It is not possible to improve SRH outcomes within a community unless non-profits work to change prevailing social attitudes regarding adolescents' sexual and reproductive health. Community members, parents and school management act as gatekeepers and impede adolescents' access to related SRHR information and services. Even non-profits that work directly with adolescents need parental support at the outreach stage to enroll participants in programs.

Furthermore, adolescents can only apply what they've learned through SRHR programs with the support of their gatekeepers. For example, a girl may know that the legal age for marriage is 18, but she is often powerless to use this knowledge if her parents want to marry her off at the age of 15. Consequently, community support is critical to implement sustainable and effective SRHR programs.

c. Collaboration Among Non-Profits

As this chapter indicates, there are a large number of non-profits working in the sector, and each of these organizations has its own area of expertise and success. However, there is also a lot of unnecessary duplication of effort within the sector. For instance, non-profits working on SRHR education often create their own curricula, despite the existence of material that can easily be modified and used to suit their social context. Consequently, collaboration is a critical enabler to streamline the SRHR sector. It would also enable non-profits to collectively advocate for policy change. Organizations that leverage each other's strengths could ensure standardized and quality SRHR program delivery at scale, across India.

CHAPTER

05

THE CHANGEMAKERS

During the course of this research, Dasra mapped 192 organizations working to improve sexual and reproductive health outcomes in India. This chapter profiles 22 organizations, whose work effectively represents the scope and breadth of the adolescent SRHR sector in India.

The table below maps these organizations to the interventions discussed in the preceding chapter.

	Organization	Educating Adolescents on SRHR	Enabling the Delivery of SRHR Education Programs	Peer-Based SRHR Programs	Strengthening Government Systems	Strategic Behavior Change Communication	Sensitizing Boys & Men	Facilitating Adolescents' Access to SRHR Products and Services
1.	Aangan Trust	●	●		●		●	
2.	Breakthrough	●	●			●	●	
3.	Centre for Catalyzing Change (C3)	●	●	●	●	●	●	●
4.	Child in Need Institute (CINI)	●	●	●	●	●	●	●
5.	CREA	●	●		●			
6.	CRHP	●	●				●	
7.	Dr. Shambhunath Singh Research Foundation	●	●					●
8.	Equal Community Foundation	●	●				●	
9.	Himalayan Institute Hospital Trust	●	●		●			
10.	IHMP	●	●	●	●	●	●	
11.	Love Matters	●				●		
12.	MAMTA Health Institute for Mother & Child	●	●		●	●	●	●
13.	National Institute of Open Schooling	●						
14.	Naz India	●	●	●				
15.	Pathfinder	●	●	●	●	●	●	●
16.	Population Services International				●	●	●	●
17.	Restless Development	●	●	●		●	●	●
18.	SNEHA	●	●				●	
19.	Swasti	●	●		●	●	●	●
20.	TARSHI		●				●	●
21.	Vacha	●	●				●	
22.	Vatsalya	●					●	



AANGAN TRUST

www.aanganindia.org

Founded: 2002 | **HQ:** Mumbai, Maharashtra | **Coverage:** Assam, West Bengal, Rajasthan, Odisha, Uttar Pradesh, Bihar, Maharashtra | **Full Time Staff:** 60
Organization budget (2015-16): INR 6.8 crore (USD 1 million)



Overview

Aangan Trust builds protection systems to keep most vulnerable children safe from occurrence or recurrence of serious harm – child trafficking, child marriage, hazardous work and exploitation. It works with communities and the Government to ensure a collaborative and coordinated approach to child safety in 'hotspots', where the incidence of child harm is high.

Leadership

Suparna Gupta, Founder & Director

Partners

- Partners include State Ministries of Women & Child Development and the Police in three states.
- Funders include LGT Venture Philanthropy, Azim Premji Philanthropic Initiatives, Goldman Sachs, EMpower and Epic Foundation.

Program Overview

Coverage: 6 states including Rajasthan, Uttar Pradesh, Maharashtra
Program budget (2015-16): 1.4 crore (USD 209,000)

Aangan conducts targeted interventions for adolescent girls (Shakti) and adolescent boys (Chauraha), building peer support, empowerment and resilience to harm as well as increasing access to education, support and protective services. It mobilizes and trains mothers to be barefoot child protection workers in urban and rural communities with a high incidence of child harm. In each of these locations, families are supported to recognize and prevent risks such as unsafe migration, running away and financial crises. Consequently, adolescent girls are supported by adults and can resist pressure to drop out of school, marry or be sent away for trafficking and work. It works in partnership with state authorities to ensure that destinations of harm are well-equipped to provide treatment and care. It also works with the state to strengthen care and rehabilitation systems so that a child who leaves a government home is safe from recurrence of harm.

Impact Evaluation

A study conducted in 2014-15 found that girls who participate in Shakti have greater confidence and ability to negotiate for their choice, both at home as well as with government service providers.

Key Highlights

By training and empowering mothers, communities and government to keep children safe, Aangan has designed and implements a unique and sustainable approach to child protection.



BREAKTHROUGH TRUST

www.inbreakthrough.tv

Founded: 1999 | **HQ:** New Delhi | **Coverage:** New Delhi, Uttar Pradesh, Jharkhand, Bihar, Karnataka, Haryana | **Full Time Staff:** 70 | **Organization budget (2015-16):** INR 10.7 crore (USD 1.6 million)



Overview

Breakthrough is a global human rights organization working to prevent violence against women and girls by transforming the norms and cultures that enable it. Through innovative, relevant multimedia campaigns, tools and programs, Breakthrough enables a critical mass of changemakers to stand for human rights in their own spheres and beyond.

Leadership

Mallika Dutt, Founder, President & CEO

Partners

- Partners include Ministry of Women & Child Development, Government of India, Pratham and Save the Children.
- Funders include Ikea Foundation, Packard Foundation, UNICEF, United Nations Trust Fund, Google and Oracle.

Program Overview

Coverage: Uttar Pradesh, Bihar, Jharkhand, Haryana | **Program budget (2015-16):** INR 7.4 crore (USD 1.1 million)

Breakthrough's Adolescent Empowerment Program (AEP) aims to ensure rights and agency for adolescents and helps them to demand equity in health and education in their homes and community, for themselves and others. This includes reducing the incidence of early marriage and gender-based violence among adolescent girls and increasing the age at first pregnancy. The program has two components: in-class curriculum and stakeholder sensitization. 30 modules on topics such as gender equity, health and education are delivered in government and low-income private school classrooms. Simultaneously, key stakeholders such as families, teachers, public health workers, education officers and local government officials are engaged through communications and outreach (including community radio and video vans) to provide a supportive environment to these adolescents.

Impact Evaluation

- For AEP, a mixed methods baseline has been conducted and a formal endline evaluation will be conducted once the current cohort of participants graduates in early 2019.
- Two RCTs are being conducted to evaluate the most cost-effective intervention to increase age of marriage and bring down cases of gender-biased sex selection.
- Since its inception, Breakthrough's in-person work including in-depth training and school-based programs has reached over 300,000 people. Its community mobilization work has reached over 15 million people and its mass media (TV, radio and print) PSAs have reached over 349 million people.

Key Highlights

Breakthrough has effectively involved men and boys in the conversation on violence against women and girls, set a benchmark for excellence in using audio-visual media and successfully cultivated partnerships for scale.



CENTER FOR CATALYZING CHANGE (C3)

www.c3india.org

Founded: 1987 | HQ: New Delhi | Coverage: Bihar, Jharkhand, Delhi | Full Time Staff: 42
Organization budget (2015-16): INR 9.16 crore (USD 1.4 million)



Overview

Center for Catalyzing Change (C3) formerly CEDPA India, works to mobilize women and girls to achieve gender equality. Its focus areas include gender equity, governance, reproductive health and rights, girl education and youth development. C3's core belief is that achieving gender equality is essential to development, democracy and global progress.

Leadership

Dr. Aparajita Gogoi, Executive Director

Partners

- Partners include the Departments of Education, Women & Child Development, and Health & Family Welfare, Government of India and White Ribbon Alliance India.
- Funders include MacArthur Foundation, Ford Foundation, Packard Foundation, UNFPA and Bill & Melinda Gates Foundation.

Program Overview

Coverage: Bihar, Jharkhand, Delhi | Program budget (2015-16): INR 3.35 crore (USD 500,000)

C3 seeks to improve sexual and reproductive health (SRH) outcomes at scale for adolescents aged 11-19 with the support of state governments. It implements the following tailor-made programs - Udaan for in-school adolescents in Jharkhand, Tarang for in-school adolescents in Bihar, Sabla for out-of-school adolescent girls in Jharkhand and Delhi, Swanirbhar for adolescent girls in Bihar and YouthLIFE, a digital, interactive curriculum for adolescents. Across these programs, C3 broadly carries out the following activities:

- Delivers life skills based sexual and reproductive health and rights (SRHR) programs at scale by leveraging available platforms such as schools and anganwadi centers to improve adolescents' agency and awareness.
- Trains government schools teachers on SRHR and assists government health workers to mentor and train peer educators on SRHR.

Impact Evaluation

Measurement indicators for C3's programs include: (i) change in perception of gender and equality; (ii) increased understanding of SRHR information; (iii) increased leadership skills; and (iv) an improved ability to deal with violence. In 2015-16, C3 reached over 9,00,000 adolescents across all its programs.

Key Highlights

- Successful partnerships with Governments of Bihar, Jharkhand and Delhi to improve SRH outcomes.
- Use of technology to impart life skills and SRHR education to 30,000 adolescents in Delhi and Jharkhand.
- Udaan, one of the largest in-school adolescent education programs in India, selected as a replicable practice and innovation in public health care systems by Ministry of Health and Family Welfare, India in August 2016 and chosen by the WHO Geneva as a 'first generation innovative adolescence program' with lessons for scaling, sustaining and replicating.



CHILD IN NEED INSTITUTE (CINI)

www.cini-india.org

Founded: 1974 | HQ: Kolkata, West Bengal | Coverage: West Bengal, Jharkhand, Odisha
Full Time Staff: 1500 | Organization budget (2015-2016): 32 crore (USD 4.8 million)



Overview

CINI has over 40 years experience improving life outcomes for vulnerable children, adolescents and women in eastern India. CINI adopts a community-based convergence approach for sustainable development in health, nutrition, education and protection. It fosters government-community partnerships to improve development outcomes for women, adolescents and children.

Leadership

Dr. Samir Chaudhuri, Founder Director & Secretary

Partners

- Partners include Ministries of Health & Family Welfare, Women & Child Development, local governments in West Bengal & Jharkhand.
- Funders include MacArthur Foundation, UNICEF, Tata Trusts, Bill & Melinda Gates Foundation and the Government of India.

Program Overview

Coverage: West Bengal, Jharkhand | Program budget (2015-16): INR 11 crore (USD 1.6 million)

CINI has established an Adolescent Resource Center to promote and protect sexual and reproductive health and rights (SRHR) for young people. It has also partnered with state governments to implement the Rashtriya Kishor Swasthya Karyakram (RKSK) program, wherein it trains:

- Government medical officers, school teachers and counselors to impart life skills & SRHR education.
- Peer leaders to inform their peers on SRHR issues, partners with the community through targeted outreach and shares SRHR materials at local community centers.
- Public health workers to provide adolescent-friendly services at health clinics.

Impact Evaluation

A third party evaluation of CINI's support to the Government of West Bengal's implementation of RKSK shows that it has improved SRH and other outcomes for 1,36,153 adolescents and trained 4,811 peer educators. Indicators measured include (i) increase in SRHR knowledge; (ii) increased consumption of iron and folic acid tablets (iii) openness within the community to discuss SRHR issues; and (iv) implementation of a peer-based vigilance system to support child protection.

Key Highlights

CINI creates wide-scale impact across eastern India by leveraging its technical expertise to support state governments to improve SRH outcomes for adolescents. It adopts a convergence approach to its government engagements by facilitating collaboration between different state departments.



CREA

www.creaworld.org

Founded: 2000 | HQ: New Delhi | Coverage: Pan-India | Full Time Staff: 28
Organization budget (2015-16): INR 5.9 crore (USD 881,000)



Overview

CREA is a feminist women's rights organization that works at the grassroots, national, regional and international levels to challenge popular perceptions of gender and sexuality. It partners with a diverse group of human rights organizations to build feminist leadership, advance women's rights and expand sexual and reproductive freedom across the developing world.

Leadership

Geetanjali Misra, Co-founder & Executive Director

Partners

- Partners include community-based organizations (CBOs), Sexual Rights Initiative and Action Plus.
- Funders include Ford Foundation, EEmpower, Comic Relief Foundation and Oxfam.

Program Overview

Coverage: Bihar, Jharkhand, Uttar Pradesh | Program budget (2015-16): INR 1.6 crore (USD 239,000)

CREA partners with 12 CBOs to implement the It's My Body (IMB) program to advance sexual and reproductive health and rights (SRHR) across rural districts and urban areas of Bihar, Jharkhand and Uttar Pradesh. The organization:

- Has developed SRHR, life skills and sports curriculum that includes 22 sessions divided into three clusters: (i) Understanding and Questioning Norms (ii) Saying Yes and No (iii) Demand and Exercise Rights.
- Trains facilitators at partner CBOs to deliver 30 sports-based SRHR sessions to adolescent girl groups over 10 months and conducts awareness generation events to obtain community buy-in.
- Monitors IMB sessions and assesses improvements in participants' agency and knowledge on SRHR issues.

Impact Evaluation

CREA evaluates qualitative indicators such as improvements in SRHR knowledge and self-efficacy. It conducted an evaluation study in 2016 which found a 20% increase in consumption of iron tablets and 45% increase in awareness about laws against sex-selection in IMB participants.

Key Highlights

CREA's IMB program not only provides girls with safe spaces to discuss SRHR issues but also helps them widen their social networks by mobilizing and collectivizing them. Anecdotal evidence suggests that a collective identity is critical to girls' empowerment as it enables them to unite and stand up for their rights.



COMPREHENSIVE RURAL HEALTH PROJECT (CRHP)

www.vatsalya.org.in

Founded: 1970 | HQ: Jamkhed, Maharashtra | Coverage: Maharashtra | Full Time Staff: 47
Organization budget (2015-16): INR 1.7 crore (USD 254,000)



Overview

CRHP works with the rural poor and marginalized to empower people and communities to eliminate injustice through integrated efforts in health and development. CRHP's comprehensive approach to community-based primary healthcare, known as the Jamkhed Model, has been introduced to communities worldwide.

Leadership

Ravi Arole, Director

Partners

- Partners include Public Health Foundation of India, University of Melbourne and Elon University.
- Funders include Freedom From Poverty Foundation and World Diabetes Foundation.

Program Overview

Coverage: Maharashtra | Program budget (2015-16): INR 12 lakh (USD 18,000)

CRHP works with adolescent girls and boys to create healthier and more equitable communities. Its Adolescent Girls Program (AGP) is a six-month program for unmarried adolescent girls aged 12-18. The curriculum covers topics such as sexual health, nutrition, sanitation, self-esteem and gender equality. In its Adolescent Boys Program (ABP), which works with boys aged 12-18, CRHP also covers topics such as peer pressure, substance abuse, gender-based violence and leadership.

Impact Evaluation

- Since being founded in 1970, CRHP has demonstrated significant improvements in health indicators including the infant mortality rate (IMR), the number of women receiving prenatal care, safe deliveries and child immunizations. For instance, the IMR in CRHP's project area has decreased from 176 deaths per 1000 live births in 1971 to 18 deaths per 1000 live births in 2011.
- CRHP seeks to influence outcomes such as completing secondary education, delaying age of marriage, delaying age of first pregnancy and increasing time between pregnancies.

Key Highlights

CRHP has contributed to improved health indicators in its project area through a community-led approach to health and development. CRHP integrates this philosophy in all its programming, ensuring that it is responding to the needs of the community and building their capacity to own and implement programs.



DR. SHAMBHUNATH SINGH RESEARCH FOUNDATION (SRF)

www.srf.ngo.in

Founded: 1989 | HQ: Varanasi, Uttar Pradesh | Coverage: Uttar Pradesh | Full Time Staff: 63
 Organization budget (2015-16): INR 2.3 crore (USD 343,000)



Overview

SRF works in 7 districts of Uttar Pradesh for community development, child rights, women's empowerment, human rights and urban poverty. It aims to establish a society which is exploitation-free, educationally, socially, culturally and environmentally enriched and which inspires the next generation.

Leadership

Rajeev Kumar Singh, Chief Functionary

Partners

- Technical partners include CEDPA, Child Helpline International and Credibility Alliance.
- Funders include UNICEF, Plan India, CRY, Action Aid and Ministry for Women and Children Development, Government of India.

Program Overview

Coverage: Uttar Pradesh | Program budget (2015-16): INR 21.5 lakh (USD 32,000)

SRF works at the grassroots to improve sexual and reproductive health outcomes for adolescent girls by:

- Conducting community outreach and conducting sexual and reproductive health and rights (SRHR) education for girls in rural and urban areas.
- Training peer leaders on SRHR and setting up vigilance committees to monitor sex trafficking across 34 villages in Aurai and 9 slums in Varanasi.
- Providing referral and counselling services to victims of abuse and trafficking and connecting them to legal aid as a part of its child protection activities.

Impact Evaluation

SRF conducts quantitative impact assessment of its projects. Under its child protection efforts, SRF identified and referred 50 cases of child abuse and trafficking to the district police officer, for further action.

Key Highlights

SRF is part of the Child Welfare Committee and District Child Protection Committee under Government of India's Integrated Child Protection Scheme (ICPS). ICPS aims to provide a secure living environment for vulnerable children by providing them access to emergency outreach services, foster care and shelter. SRF's membership in these committees allows it to more effectively protect children from abuse and trafficking and connect victims of such violations to support services.



EQUAL COMMUNITY FOUNDATION (ECF)

www.ecf.org.in

Founded: 2009 | HQ: Pune, Maharashtra | Coverage: Maharashtra, West Bengal
 Full Time Staff: 26 | Organization budget (2015-16): INR 1.2 crore (USD 179,000)



Overview

ECF implements behavior change programs for boys and men to end violence and discrimination against girls and women. In order to achieve scale, it builds the capacity of partner organizations to work with boys and men. It also conducts research and builds evidence to demonstrate that empowered men are a positive resource for women's empowerment.

Leadership

Rujuta Teredesai Heron & Will Muir, Co-founders & Directors

Partners

- Partners include CINI, Sanlaap and Praajak.
- Funders include Hummingbird Foundation, Global Fund for Children and NoVo Foundation.

Program Overview

Coverage: Maharashtra | Program budget (2015-16): INR 90 lakh (USD 134,000)

Action for Equality is an action research program that equips adolescent boys aged 13-17, from low-income communities with knowledge, skills and peer support to challenge discriminatory social norms that contribute to gender-based violence. It comprises of 15 weekly sessions covering seven thematic areas - human rights, gender, boyhood to manhood, sexuality, relationships, violence and taking action.

Impact Evaluation

4,493 young men have enrolled in Action for Equality, of which 2,348 have graduated. ECF has commissioned third party evaluations that have shown improvements in:

- Willingness to take up domestic chores.
- Ability to question and prevent violence against female family members.
- Ability to hold discussions on reducing violence and discrimination against women.

Key Highlights

In 2014, ECF initiated Project Raise that over a period of five years, will build the capacity of 100 organizations across India, to engage boys and men to end violence and discrimination against girls and women. In the first phase of this initiative, ECF is partnering with 12 organizations in West Bengal. These efforts will contribute to the prevention of trafficking of girls and women.



HIMALAYAN INSTITUTE HOSPITAL TRUST - RURAL DEVELOPMENT INSTITUTE (HIHT-RDI)

www.hihtindia.org

Founded: 1989 | **HQ:** Dehradun, Uttarakhand | **Coverage:** Pan-India | **Full Time Staff:** 50
Organization budget (2015-16): INR 7.6 crore (USD 1.1 million)



Overview

HIHT conducts research and community-based outreach to improve health and education outcomes. It focuses on serving communities in the hard-to-reach Himalayan Garhwal region. It seeks to develop integrated and cost-effective approaches to healthcare provision that meet the needs of local populations and serve as a replicable model.

Leadership

B. Maithili, Director, HIHT - RDI

Partners

- Partners include Wipro and State Health Department, Government of Uttarakhand.
- Funders include WHO and Population Foundation of India.

Program Overview

Coverage: Pan-India | **Program budget (2015-16):** INR 75 lakh (USD 112,000)

The Rural Development Institute (RDI) at HIHT works with communities and the government to improve sexual and reproductive health (SRH) outcomes for adolescents. Specifically, it engages in:

- **Community Outreach:** Working with adolescents to improve knowledge, attitudes and behaviors related to general health and hygiene as well as reproductive health practices. It addresses mental health, gender issues, violence, nutrition and reproductive health through peer learning programs, health check-ups and counseling services.
- **Capacity Building:** Conducting training for public health providers at district, state and national levels on a variety of subjects which include adolescent SRH, nutrition and violence. Over the years RDI has worked with over 50 NGOs and trained public health providers including medical officers, child development project officers, auxiliary nurse midwives and anganwadi workers.

Impact Evaluation

RDI uses baseline and endline studies to track SRH outcomes for adolescents that participate in its community outreach program. Outcomes tracked include age at marriage and age at first pregnancy.

Key Highlights

It is one of six organizations in India that acts as a Regional Training Partner to the Government of India, conducting Training of Trainers for the Ministry of Health and Family Welfare's national adolescent health program, Rashtriya Kishor Swasthya Karyakram.



INSTITUTE OF HEALTH MANAGEMENT PACHOD (IHMP)

www.ihmp.org

Founded: 1978 | **HQ:** Pachod, Maharashtra | **Coverage:** Maharashtra | **Full Time Staff:** 72
Organization budget (2015-16): INR 2.32 crore (USD 346,000)



Overview

IHMP works with marginalized communities in rural and urban Maharashtra to improve the sexual and reproductive health (SRH) of girls and women. It trains public health workers to effectively engage adolescents and improve their health-seeking behavior. It also conducts research studies to assess the effectiveness of its programs and advocate for policy improvements.

Leadership

Dr. Ashok Dyalchand, Founding Director

Partners

- Partners include National Rural Health Mission, Government of Maharashtra and Global Giving.
- Funders include MacArthur Foundation, Johns Hopkins, Oxfam, UNFPA and Tata Trusts.

Program Overview

Coverage: Maharashtra | **Program budget (2015-16):** INR 1.94 crore (USD 290,000)

IHMP runs an integrated program to empower adolescent girls and protect them from the consequences of early marriage. It works with:

- **Unmarried adolescent girls:** Provides life skills education with a focus on cognitive and practical skills, to improve self-esteem and self-efficacy and thereby delay age at marriage.
- **Married adolescent girls:** Conducts behavior change communication and counseling on SRH to improve treatment-seeking behavior, delay age at first pregnancy and supports the health delivery system to reduce vulnerability to maternal and neonatal morbidity.
- **Boys and young men:** Delivers gender sensitization workshops to reduce sexual and domestic violence.

Impact Evaluation

Between 2003 and 2009, baseline and endline studies indicate that IHMP's program with married adolescent girls led to increase in:

- Median age at first birth from 15.8 to 18 years.
- Mean interval between marriage and first conception from 6.6 to 10.7 months.
- Percentage of girls using contraceptives from 10.9 to 30.4.

Key Highlights

IHMP has developed a monthly health needs assessment system to enable universal health coverage with services. It has designed a needs-specific behavior change communication system, which is a paradigm shift in health communication. IHMP has also developed a locally-contextualized scale to measure self-esteem and self-efficacy in adolescent girls. This scale allows IHMP to identify the most vulnerable girls in the community, measure the impact of its program and thereby build evidence for the effectiveness of its interventions.



LOVE MATTERS

www.lovematters.in/en

Founded: 2011 | HQ: New Delhi | Coverage: Pan-India | Full Time Staff: 11
Organization budget (2015-16): INR 2.33 crore (USD 348,000)



Overview

Love Matters is a bilingual online resource for young people and peer educators to access relevant information about reproductive and sexual health education. It provides a safe space to talk about sex in an open and non-judgmental manner and produces content suited to the Indian context.

Leadership

Vithika Yadav, Head, Love Matters, India

Partners

- Partners include Family Planning Association India, TARSHI, YP Foundation, CREA and The Humsafar Trust.
- Funders include The Dutch Foreign Ministry, Ford Foundation, Packard Foundation and AmplifyChange.

Program Overview

Coverage: Pan-India | Program budget (2015-16): INR 2.33 crore (USD 348,000)

Love Matters creates user-centric content that is easily accessible online and from mobile phones to pay special attention to the needs of its audience of young people. It uses focus groups to determine what topics to cover and how information should be packaged - from videos and images to blogs and discussion forums. Love Matters gives young people a judgment-free space to discuss intimate issues with the aim of eliminating the shame and stigma associated with conversations about sex.

Impact Evaluation

Love Matters performs extensive qualitative analysis on the conversations, content on message boards and comments left by users on the website. This analysis shapes the form of future content on the website. It has had 15 million views, with viewers spending an average of eight minutes on the website. On a monthly basis, the website receives over 2 million views. Love Matters' Facebook page has 1 million followers.

Key Highlights

Love Matters works towards breaking down the stigma and taboo associated with talking about sex in Indian culture. Its material and content is 'pleasure positive', aims to normalize discussions about sex and make talking about natural needs and urges a less embarrassing or shameful experience.



MAMTA HEALTH INSTITUTE FOR MOTHER AND CHILD

www.mamta-himc.org

Founded: 1990 | HQ: New Delhi | Coverage: Pan-India | Full Time Staff: 665
Organization budget (2015-16): INR 29.6 crore (USD 4.4 million)



Overview

MAMTA works in the areas of maternal and adolescent healthcare and communicable diseases and non-communicable diseases through program implementation, advocacy, training and research. The organization works with the Government of India and various corporates to provide health services across India.

Leadership

Dr. Sunil Mehra, Executive Director

Partners

- Partners include apex national and international institutions and the Government of India.
- Funders include the European Union, Azim Premji Foundation, MacArthur Foundation and Philips India.

Program Overview

Coverage: Pan-India | Program budget (2015-16): INR 20.1 crore (USD 3 million)

MAMTA works across the country to improve adolescent sexual and reproductive health (SRH). Notably, it:

- Creates safe spaces to facilitate discussion and awareness generation around SRH. Adolescent boys and girls participate in group activities and learning modules on sexual health, puberty, violence and gender rights.
- Develops curriculum for SRH education programs for young women aged 11-25, covering both gender and health-related aspects. It develops customized, need-based content for its partners, including state and national government bodies and partner non-profits.

Impact Evaluation

MAMTA works with two age groups of adolescents to improve specific SRH outcomes:

- Ages 10-14: Increase in knowledge on SRH and changing attitudes towards restrictive gender norms, measured through assessment tests.
- Ages 15-19: Increase in age of marriage and age of first pregnancy.

Key Highlights

MAMTA has fostered a strong relationship with the Government of India and several state governments, working closely with various ministries that implement programs to improve adolescents' sexual and reproductive health and rights. This enables it to leverage and improve government service provision and advocate for policy-level change.



THE NATIONAL INSTITUTE OF OPEN SCHOOLING (NIOS)

www.nios.ac.in

Founded: 1989 | HQ: Noida, Uttar Pradesh | Coverage: Pan-India | Full Time Staff: 235
 Organization budget (2015-16): INR 181 crore (USD 27 million)



Overview

An autonomous institution established under the aegis of the Ministry of Human Resource Development (MHRD), Government of India, NIOS caters to the educational needs of socially and economically disadvantaged students, drop-outs and out-of-school children. Students enrolled in NIOS can flexibly work towards completing their education and access over 100 vocational training programs.

Leadership

Dr. C.B. Sharma, Chairman

Partners

- Program partners include the Ministry of Human Resource Development, Government of India.
- Funders and technical partners include UNFPA.

Program Overview

Coverage: Pan-India | Program budget (2015-16): INR 28.2 lakh (USD 42,000)

MHRD's Adolescence Education Programme (AEP) aims to empower young people with accurate, age-appropriate and culturally-relevant information to promote healthy attitudes and behaviors. NIOS has integrated AEP curriculum into five subjects offered at the secondary level - Science and Technology, Social Science, English, Hindi and Home Science - as well as into study material resources, in order to give out-of-school learners access to life skills education as well as sexual and reproductive health (SRH) information. It has also made relevant resources available at 3,830 NIOS study centers and created an Interactive Voice Response platform to effectively disseminate AEP content along with academic and administrative content.

Impact Evaluation

NIOS incorporates life skills education and AEP content into examination questions. It also plans to undertake qualitative analysis of study materials and Tutor Marked Assignments to assess how much AEP content has been absorbed by students.

Key Highlights

- NIOS ensures that all its students are exposed to AEP content, since it is integrated into language classes which are mandatory for all students. Consequently, almost 700,000 adolescents have been exposed to AEP content since it was launched in 2013-14.
- By weaving this content into existing curriculum, NIOS has found a non-controversial way to deliver SRH information to adolescents across the country.



THE NAZ FOUNDATION (INDIA) TRUST

www.nazindia.org

Founded: 1994 | HQ: New Delhi | Coverage: New Delhi, Maharashtra & Tamil Nadu
 Full Time Staff: 30 | Organization budget (2015-16): INR 3.42 crore (USD 510,000)



Overview

The Naz Foundation (India) Trust sensitizes the general population on the prevalence of HIV, highlighting issues related to sexuality and sexual health. It works with marginalized populations using a holistic approach that includes care and support services, information, capacity building and advocacy.

Leadership

Anjali Gopalan, Founder & Executive Director

Partners

- Partners include Women Win, Dasra, Netball Australia, Thozhamai, SNEHA and Manitham Charitable Trust.
- Funders include Standard Chartered Bank, Comic Relief and Bank of America Continuum India.

Program Overview

Coverage: New Delhi, Maharashtra and Tamil Nadu | Program budget (2015-16): INR 2 crore (USD 299,000)

Goal is a 10-month long school and community-based sport (netball) and life skills program. Adolescent girls and young women facilitate sessions for their peers aged 12-20. Goal provides girls with a safe space to play, thereby providing a reason to attend sessions and learn from peers. The life skills sessions address a range of topics including communication, self-confidence, reproductive health, gender, gender-based violence and financial literacy. Participants are also provided with opportunities to become peer leaders and community sports coaches (CSCs), thereby nurturing their leadership potential.

Impact Evaluation

A third-party qualitative evaluation of Goal, conducted in 2016, found that:

- It has played a significant role in enhancing self-esteem, leadership and communication skills of Goal participants, peer leaders and CSCs and enhanced the decision-making power of CSCs.
- 85% of participants stated that their lives have transformed through their participation in Goal and as a result of access to sports, they experience improved mobility, enhanced confidence, increased friendships, improved relationships with parents, awareness of one's body and knowledge on how to be safe.
- Since inception, Goal has reached more than 40,000 adolescent girls and young women.

Key Highlights

Naz India's sports-based approach enables experiential learning, gives girls a safe space to express themselves, challenges gender stereotypes, and increases their confidence. Through Goal, Naz is building the capacity of partner organizations with an aim to create centers of excellence for adolescent girl interventions.



PATHFINDER INTERNATIONAL

www.pathfinder.org

Founded: 1963 | HQ: New Delhi | Coverage: New Delhi, Bihar, Haryana, Rajasthan, Madhya Pradesh
Full Time Staff: 39 | Organization budget (2015-16): INR 5.9 crore (USD 881,000)



Overview

Pathfinder International is an international non-governmental organization that removes barriers to critical sexual and reproductive health (SRH) services. Founded globally in 1957, Pathfinder has been working with local governments, communities and health systems in India since 1999 to expand access to contraception promote healthy pregnancies and stop the spread of HIV.

Leadership

Matthew Joseph, Country Representative, India

Partners

- Partners include UNFPA.
- Funders include The David and Lucile Packard Foundation, Bill & Melinda Gates Foundation and MacArthur Foundation.

Program Overview

Coverage: Bihar | Program budget (2015-16): INR 1.62 Cr (USD 250,000)

The Promoting Change in Reproductive Behavior of Adolescents (PRACHAR) project is a USD 11 million project that was implemented from 2001 and 2012. The project, aimed at promoting Healthy Timing and Spacing of Pregnancy (HTSP), worked with local governments and community-based organizations to provide SRH counseling for young women and men, life skills education for adolescents, 'infotainment' programs for newlywed couples and behavioral change programs for the broader community. Based on evidence and the results of the PRACHAR project, Pathfinder designed the Sashakt project to reach the socio-economically marginalized Mahadalit communities with SRH information and services.

Impact Evaluation

Evaluations of the PRACHAR program found a notable impact on women's SRH:

- Median age at marriage was 2.6 years older for young women in intervention areas.
- Young women using contraception to delay their first pregnancy rose from 3% to 16% in the intervention area (vs. 2% to 3% in comparison area) and young women using contraception to space second pregnancy rose from 6% to 25% in the intervention area (vs. 4% to 7% in comparison area).

Key Highlights

Pathfinder International works with local governments to ensure that their programs can be adopted into existing government service delivery channels and therefore adopted by the government.



POPULATION SERVICES INTERNATIONAL (PSI)

www.psi.org.in

Founded: 1988 | HQ: New Delhi | Coverage: Pan-India | Full Time Staff: 196
Organization budget (2015-16): INR 122 crore (USD 18 million)



Overview

PSI is an international organization with a country office in India. PSI India partners with public and private sector organizations to provide health-related products and services at-scale, to vulnerable populations. Its areas of intervention include family planning, maternal and child health (MCH), tuberculosis, HIV/AIDS and non-communicable diseases.

Leadership

Pritpal Marjara, Managing Director

Partners

- Program partners include Federation of Obstetric and Gynaecological Societies of India (FOGSI).
- Funders include Bill & Melinda Gates Foundation and USAID.

Program Overview

Coverage: Pan-India | Program budget (2015-16): INR 62 crore (USD 9 million)

PSI India draws on its global expertise to provide health care services and products to achieve large-scale impact on young people's sexual and reproductive health. Its programs provide communication services focused on improving behaviors and achieving positive health outcomes among young people. PSI also engages in international and in-country advocacy efforts focused on building an environment that enables young people to access high quality sexual health products and services.

Impact Evaluation

PSI uses Output Tracking Surveys (OTS) as a tool to monitor its behavior change communication (BCC) activities. OTS is a small sample sized survey conducted to determine recall of BCC activities and pace of the program through description of any movement in knowledge, attitude, beliefs or behaviors. OTS provides actionable findings to help decision-makers make necessary programmatic decisions.

Key Highlights

PSI's project Wahood seeks to improve reproductive, maternal, adolescent and newborn child health outcomes by contributing to the reduction of gender based violence (GBV). It works with NGO partners, community members and policy makers to build a comprehensive response to GBV in India. The organization also directs funds to NGOs in Delhi, Haryana, Odisha and Madhya Pradesh, to enable them to work with young men to change gender based attitudes and behaviors. PSI's family planning project connects young men and women with affordable and high quality contraception services. In 2013, PSI trained over 1100 doctors to provide intrauterine devices (IUDs) to low-income clients in Uttar Pradesh, Rajasthan and Delhi.



RESTLESS DEVELOPMENT

www.restlessdevelopment.org/India

Founded: 1986 | HQ: New Delhi | Coverage: Delhi, Bihar, Jharkhand, Odisha, Tamil Nadu
Full Time Staff: 30 | Organization budget (2015-16): INR 5 crore (USD 746,000)



Overview

Restless Development is an international organization that champions youth-led development. It works to ensure that young people have a voice, are able to earn a living, have sexual rights and are leaders in preventing and solving the world's challenges. In India, it focuses on enabling access to gainful employment, ending child marriage and improving sexual and reproductive health.

Leadership

Nalini Paul, India Country Director

Partners

- Program partners include local community-based organizations, panchayats in program villages and other civil society organizations.
- Funders include Bill & Melinda Gates Foundation, SRHR Alliance and DFID.

Program Overview

Coverage: Bihar | Program budget (2015-16): INR 24 lakh (USD 36,000)

Restless Development's program, United For Body Rights (UFBR) addresses gender-based discrimination, child marriage and adolescents' lack of information on sexual and reproductive health and rights (SRHR) through comprehensive sexuality education with young people aged 12-18 in schools and communities. It also works with families and community members to create a youth-friendly environment that empowers adolescents. It has reached 232,000 adolescent girls and boys. Restless Development has also developed a mobile application named M-Sathi to supplement its programs. M-Sathi educates users about SRHR and the services available to girls and women in India's villages. It covers a broad range of topics, including puberty, anatomy, menstruation, sexual rights and responsibilities, conception, contraception, HIV/AIDs and resources to address gender-based abuse.

Impact Evaluation

Restless Development tracks a comprehensive set of indicators for all its programs. A mid-line assessment of the UFBR program conducted in 2013, showed that, among other things:

- 44% of young people indicated they did not want to get married before the age of 22, compared to the 31% of young people that did so in the baseline study.
- Number of girls with knowledge on how to prevent pregnancies increased from 49% to 66% halfway through the program.

Key Highlights

- Restless Development advocates a wholly youth- and community-led approach to development, thus ensuring that programs are need-based.
- It uses technology to supplement its programs and optimize resources.



SNEHA

www.snehamumbai.org

Founded: 1988 | HQ: Mumbai, Maharashtra | Coverage: Maharashtra | Full Time Staff: 395
Organization budget (2015-16): INR 16.5 crore (USD 2.5 million)



Overview

SNEHA improves health outcomes of women and children in Mumbai's slums, through its interventions in maternal & newborn health, child nutrition, adolescent health, sexuality and empowerment and prevention of violence against women and children. It works with communities to cultivate positive health-seeking behavior and with government to support the delivery of quality health services.

Leadership

Vanessa D'Souza, CEO

Partners

- Partners include Lokmanya Tilak Municipal Hospital and Mumbai Municipal Corporation.
- Funders include Ford Foundation, Siemens, HDFC Bank, Cipla, WHO, Wellcome Trust and Comic Relief.

Program Overview

Coverage: Mumbai | Program budget (2015-16): INR 1.15 crore (USD 172,000)

SNEHA's program EHSAS (Empowerment, Health and Sexuality of Adolescence) works with adolescent girls and boys aged 10-19 in Mumbai's slum communities to equip them with the knowledge and ability to make informed choices about their health and well-being. Trained facilitators conduct sessions on health, life skills education and vocational training at community-based youth centers, known as Arogyamitra Kendras. EHSAS works with 55 youth groups across these communities. The program also builds the capacity of select youth (2 per 1,000 residents) to develop as peer leaders and draws on them to mobilize youth from the community to participate in EHSAS.

Impact Evaluation

Through EHSAS, SNEHA has provided health and life skills education to over 10,000 adolescents and vocational training to over 5,000 adolescents. SNEHA uses baseline and endline assessments and a participatory qualitative evaluation framework to track:

- Awareness on sexual and reproductive health, gender rights and violence.
- Attitude shifts and gender sensitivity.
- Enhanced health and well-being

Key Highlights

EHSAS employs a gender-transformative approach that aims to transform gender roles and promote more gender-equitable relationships between men and women. SNEHA believes that it is equally important to work with girls and boys and has received an overwhelming response from the community to this approach, which has allowed for rapid expansion of the program across four communities.



SWASTI

www.swasti.org

Founded: 2004 | HQ: Bangalore, Karnataka | Coverage: Pan-India | Full Time Staff: 120
Organization budget (2015-16): INR 27.8 crore (USD 4.1 million)



Overview

Swasti is a health resource center focused on improving public health outcomes for poor and marginalized communities. It believes that health and well-being are best addressed when behaviors, systems and social determinants are addressed together. Interventions have a significant focus on communities and employ a multitude of approaches, combining research and practice.

Leadership

Shiv Kumar, President & Founder Director

Partners

- Partners include Azim Premji University, WHO, National AIDS Control Organisation and Ministry of Health and Family Welfare, Government of India.
- Funders include Bill & Melinda Gates Foundation, UNDP, USAID and WaterAid.

Program Overview

Coverage: NCR/Gurgaon, Andhra Pradesh, Telangana, Maharashtra, Karnataka & Tamil Nadu
Program budget (2015-16): INR 23 crore (USD 3.5 million)

Swasti's work in sexual and reproductive health and rights (SRHR) including prevention of HIV has been with the vulnerable and marginalized communities of urban and rural poor, factory workers, women in sex work, gay men, transgender people as well as people living with HIV. With each community, the SRHR focus is nuanced to meet immediate needs, while building the community's capacity to work with immediate stakeholders (family, employers, service providers) and the larger ecosystem (government and others). Swasti has also pioneered life skills based SRHR curriculum for factory workers, especially women, with a view to facilitating their professional and personal growth through life skills training. It is now refining this curriculum to meet the needs of adolescents and adults of other vulnerable communities.

Impact Evaluation

Evaluations by ICRW and the Universities of Michigan & Harvard have assessed a 49-150% improvement in self-esteem, self-efficacy, 3X faster career and income growth and a 100% increase in social and financial inclusion as a result of Swasti's interventions.

Key Highlights

Swasti reaches vulnerable adolescents and adults with comprehensive and inclusive services to improve health and well-being, at scale. It reached 2,20,000 people in 2015-16.



TARSHI (TALKING ABOUT REPRODUCTIVE AND SEXUAL HEALTH ISSUES)

www.tarshi.net

Founded: 1996 | HQ: New Delhi | Coverage: Pan-India | Full Time Staff: 7
Organization budget (2015-16): INR 1 crore (USD 149,000)



Overview

TARSHI works towards expanding sexual and reproductive choices in people's lives to enable them to enjoy freedom from fear, infection and reproductive and sexual health problems. It takes an affirmative and rights-based approach to its work which includes training, consultation, research, public awareness and technical support for advocacy initiatives.

Leadership

Prabha Nagaraja, Executive Director

Partners

- Partners include CREA, Naz Foundation and Nirantar.
- Funders include International Women's Health Coalition and Human Capability Foundation.

Program Overview

Coverage: Pan-India | Program budget (2015-16): INR 1 crore (USD 149,000)

TARSHI leverages two decades of experience of working on sexual and reproductive health and rights, to build the capacity of service providers, by offering a range of services including:

- Training and Consultancy:** On counseling skills, gender, sexuality and rights-related issues that can be tailor-made to suit the needs of individuals and organizations.
- eLearning Courses:** On topics such as Comprehensive Sexuality Education (CSE). These courses are offered in three modes - moderated, self-paced and blended.
- IVRS Infoline:** That provides information in English and Hindi on a range of topics related to sexual and reproductive health, HIV, contraceptive choices, violence, safety and pleasure in a pre-recorded format.

Impact Evaluation

TARSHI does not directly engage with adolescents and hence relies on self-reported, anecdotal evidence from participants 3-6 months after a program is implemented by a partner organization. It focuses on measuring change in knowledge levels and use of sexual and reproductive health information.

Key Highlights

TARSHI works on sexuality from an affirmative and rights-based perspective, which is distinct from an approach that views sexuality from a disease prevention, violence against women or minorities framework.



VACHA CHARITABLE TRUST

www.vacha.org.in

Founded: 1987 | HQ: Mumbai, Maharashtra | Coverage: Gujarat, Maharashtra
Full time staff: 20 | Organization budget (2015-16): INR 1.56 crore (USD 233,000)



Overview

Vacha, which loosely translates into 'speech or verbal expression' in several Indian languages, is a resource center for women and girls. It addresses issues faced by women and girls through educational programs, resource creation, research, training, campaigns and networking.

Leadership

Medhavinee Namjoshi, Executive Director

Partners

Funders include EMpower, Star of Hope Foundation, Friedrich Ebert Stiftung (FES India), RPG Foundation, Global Giving and EdelGive Foundation

Program Overview

Coverage: Maharashtra | Program budget (2015-16): INR 1.24 crore (USD 185,000)

Vacha implements two programs that work with marginalized adolescents in urban locations:

Urja: Adolescent girls aged 10-18 attend sessions on health, gender, life skills such as communication, self-efficacy and negotiation as well as 21st century skills such as spoken English, computer literacy and photography. These skills enable girls' participation in civic life when combined with opportunities to speak in public, produce newsletters, advocate for their rights and organize community-based events.

Tejasvi: Adolescent girls and boys aged 15-20 attend life skills sessions together, learning to work collaboratively and engage in civic issues. Participants in this program have initiated youth groups that address issues in their neighborhoods such as safety of girls and women.

Impact Evaluation

Internal studies conducted by Vacha find that:

- 96% of girls enrolled with Vacha have completed education till the 10th grade.
- 96% of girls and boys enrolled with Vacha have been trained to use digital technology such as cameras and computers, as compared to 39% of their peers

Key Highlights

Vacha is innovative in its use of technology and civic participation to equip adolescent girls with the skills they need to negotiate restriction and patriarchy in their lives.



VATSALYA

www.vatsalya.org.in

Founded: 1995 | HQ: Lucknow, Uttar Pradesh | Coverage: Uttar Pradesh
Full Time Staff: 61 | Organization budget (2015-16): INR 5.12 crore (USD 764,000)



Overview

Vatsalya improves health and social development outcomes of communities, with a focus on women and girls. It achieves this through research, advocacy, program implementation, training and capacity building of community based organizations (CBOs). It works on issues such as nutrition, child rights protection, child survival and sanitation.

Leadership

Dr. Neelam Singh, Founder

Partners

- Program partners include the Government of Uttar Pradesh and Water Aid.
- Funders include Bank of America Merrill Lynch, Action Aid, UNICEF and Plan International.

Program Overview

Coverage: Uttar Pradesh | Program budget (2015-16): INR 2.3 crore (USD 343,000)

Vatsalya works in communities and schools to increase the awareness of girls, women, boys, men and government workers on menstrual hygiene management (MHM) issues. Vatsalya helps women shopkeepers become change agents that sell sanitary napkins and serve as MHM experts for girls, alongside public health workers.

Impact Evaluation

Internal impact evaluation studies conducted by Vatsalya show that its programs have resulted in:

- 79% of girls reporting that the sessions have changed the way they manage menstruation.
- 40% decrease in girls missing school due to menstruation after participating in the program.

Anecdotal evidence also shows that the program has led to improved mobility and agency for girls and greater dialogue and participation of men on MHM issues.

Key Highlights

The program aims to break the culture of shame and stigma that surrounds menstruation, which in part arises from the ignorance and lack of involvement of men and boys. Vatsalya's mobilizers actively engage groups of men and adolescent boys to influence changes in attitudes around menstruation and MHM.

CHAPTER

06

RECOMMENDATIONS

Adolescents stand at the threshold of adulthood. At this vulnerable age, a variety of influences can shape the trajectory of their lives and have a significant impact on development indicators, defining India's place in the world. It is therefore vital for multiple actors to come together to improve information and services for adolescents' sexual and reproductive health and rights (SRHR). Through research and conversations with experts and practitioners, Dasra has the following recommendations for stakeholders in the sector:

-
1. ADDRESS ADOLESCENTS' SPECIFIC AND DIVERSE NEEDS
 2. DRIVE CONVERGENCE AMONG STAKEHOLDERS
 3. DETERMINE PROGRAMMATIC STANDARDS
 4. INCREASE FUNDING FOR MEN AND BOYS
 5. INCREASE FUNDING FOR LONG-TERM PROGRAMS
 6. GENERATE DATA TO FACILITATE EFFECTIVE DECISION-MAKING
-

1. ADDRESS ADOLESCENTS' SPECIFIC AND DIVERSE NEEDS

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Adolescents are a heterogeneous group, with many diverse identity markers. The most significant of these is age – SRHR interventions for those aged 10-14 years, are very different from those appropriate for older adolescents. It is important for practitioners, funders and the government to ensure that programs are designed to meet the diverse needs of these groups:

Recommendations for programs aimed at 10 to 14 year olds:

- Further innovate to find more creative ways to engage this demographic. If designed properly, technology, media, sports programs and community radio have additional untapped potential to deliver SRH programs to very young adolescents in India.
- Build an ecosystem around very young adolescents. Gatekeepers often resist SRHR programs for very young adolescents because they do not understand the importance of such programs. Therefore it is important to involve stakeholders and gatekeepers such as teachers, parents, panchayat leaders, and the media, and help them understand the necessity of SRHR education for very young adolescents.
- Implementing organizations must share resources and key insights amongst themselves, to increase efficiency, create comprehensive data sets for decision-making and advocacy, and develop a common standard of easy-to-read and easy-to-use material for teachers and frontline workers.
- Focus on building an experienced cadre of training experts who can work to educate teachers, frontline workers and community leaders on SRHR issues and their importance.

Recommendations for programs aimed at 15 to 19 year olds:

- Provide adolescents with access to sexual and reproductive health services, such as contraception and family planning. Services provided must be affordable, acceptable and accessible and delivered confidentially. Moreover, service providers must be trained to be non-judgmental when providing services.
- Reach out-of-school adolescents through alternative avenues, such as community-based and workplace programs.
- Identify agents of change for neglected demographic segments, such as adolescent boys in this age category. While ASHAs and Anganwadi workers provide SRH services to girls, they are often unable or unwilling to do so for boys. It is important to innovate on ideal methods and identify people to reach men and boys, such as male mentors and informal healthcare providers, including pharmacists.
- Ensure community support before reaching out to adolescents, so as to create an enabling environment within which adolescents are able to act on training received. Specifically, reach out to and work with boys and men, and showcase positive deviances from restrictive gender norms, thus providing boys and men with effective and relatable role models.
- Create safe spaces for both men and women in communities and institutions, where they are able to candidly address and openly discuss barriers to improving their own SRHR outcomes.
- Enhance adolescents' understanding of laws and entitlements that protect their sexual and reproductive rights through awareness campaigns.
- Provide knowledge about reproductive health and family planning services to the couple instead of just the women.

In order to drive change at a large scale, it is vital for stakeholders, including implementing organizations, funders, multilateral agencies and the Government of India to begin working together effectively. Non-profit organizations can do this by sharing resources, data, and training material amongst themselves in order to leverage each other's work. Funders also have a vital role to play through publishing their insights, sharing data, and most importantly, encouraging implementing organizations to leverage the government's resources and reach. Furthermore, non-profits must use their programming expertise to advocate for better policies and programs, and where possible, align their outreach with government initiatives.

2.DRIVE CONVERGENCE AMONG STAKEHOLDERS

■ 2 ■ ■ ■ ■ ■

3. DETERMINE PROGRAMMATIC STANDARDS

■ ■ 3 ■ ■ ■

Stakeholders across the board have emphasized the need for a common understanding of what must be covered when teaching Comprehensive Sexuality Education (CSE), while simultaneously stressing that any curriculum must leave room for customization to a local context. Many have also articulated the importance of covering components beyond sexuality education, including, but not limited to, gender norms, nutrition, mental health and substance abuse. At the same time, they have expressed concern that CSE is increasingly limited to safe topics due to the stigma attached to several subjects discussed in the curriculum. Stakeholders must therefore arrive at an understanding of non-negotiable aspects of CSE and agree to include issues like changes at puberty, gender, sexuality, sexual identity and contraceptives.

4. INCREASE FUNDING FOR MEN AND BOYS

■ ■ ■ 4 ■ ■

Over and over again, research has demonstrated the importance of investing in programs that target men and boys. These programs must address the specific and unique SRHR needs of adolescent boys, and sensitize them to gendered privileges and patriarchal norms. However, despite widespread consensus, there is extremely limited funding available for such programs. In order to effectively reverse this trend, it is vital for funders to recognize that investing in boys is critical to advancing gender equality and to improving SRH indicators in India.

5. INCREASE FUNDING FOR LONG-TERM PROGRAMS

■ ■ ■ ■ 5 ■

The issues that sexual and reproductive health programs are working to address - for example, child marriage, early pregnancy, halting the spread of HIV, altering gender and sexuality norms - are long-term, intergenerational issues. It is often impossible for programs to demonstrate significant behavior change during the course of a one - to two-year program. Therefore, many programs pick proxy indicators that point towards shifting norms, to track the real impact of a given intervention. It is therefore vital for donors to provide long-term, sustainable funding and support to SRHR interventions, or programs - in a single geography, over five- or even ten-year periods.

6.GENERATE DATA TO FACILITATE EFFECTIVE DECISION-MAKING

■ ■ ■ ■ ■ 6

Due to the pervasive stigma related to sex and sexuality, most data collection activities avoid questions about sexual activity and contraceptive use with certain demographics. For example, India's National Family Health Survey refrains from asking unmarried girls about contraceptive usage. However, this hampers effective decision-making for government and program implementers, as it leaves them with an incomplete picture. Working with communities—to collect representative data and create more substantive, evidence-based literature—will help funders, implementers and policy makers to understand which interventions work and which do not. Furthermore, non-profits that engage with communities can use evidence to improve programs in real time and effectively meet specific community needs as a result.

CONCLUSION

This report on adolescents' sexual and reproductive health and rights draws on Dasra's own research, as well as a wide range of international and national studies, to examine existing barriers. This report underlines the urgency of addressing SRHR barriers and highlights pivotal interventions and best practices. It also provides a landscape of non-profits doing commendable work to improve SRHR outcomes for adolescents in India. Dasra urges funders and other stakeholders to use this information to lend their voices and influence, and to support non-profit organizations working to empower and protect adolescents' sexual and reproductive health and rights.

APPENDICES



APPENDIX I

Dasra would like to extend its sincere thanks to all sector experts that have made invaluable contributions to its research and this report. In particular, Dasra would like to acknowledge:

Expert	Organization
Swati Parmar	Centre for Catalyzing Change
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Nilima Achwal	Iesha
Priya Nanda	International Center for Research on Women (ICRW)
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Rajesh Singh	MAMTA Health Institute for Mother and Child
Murari Chandra	MAMTA Health Institute for Mother and Child
Kalyani Subramanyam	Naz Foundation (India) Trust
Mahesh Srinivas	Pathfinder International
Callie Simon	Pathfinder International
Poonam Muttreja	Population Foundation of India
K.G. Santhya	Population Council
Shireen Jejeebhoy	An academic and formerly associated with Population Council
Nalini Paul	Restless Development
Dr. Jaya	United Nations Population Fund (UNFPA)
Medhavinee Namjoshi	Vacha Charitable Trust
Dr. Venkatraman Chandra-Mouli	World Health Organization (WHO)
Manak Matiyani	YP Foundation
Vinita Sahasranaman	YP Foundation

APPENDIX II

Dasra followed a two-step process to identify organizations working to improve sexual and reproductive health (SRH) outcomes for adolescents in India.

Phase I – Sector Mapping

- The process involved an exhaustive sector mapping, leading to the compilation of a list of 192 non-profits working to improve adolescents' SRH outcomes in India.
- Based on secondary research, references from previous experience and inputs from sector experts, the work carried out by the non-profits identified was categorized under different approaches to improving SRH outcomes.
- Non-profits with were shortlisted from this universe on the basis of criteria such as program focus, outreach, budget, scale, impact and innovation.

Phase II – Identification of Key Players

- Dasra identified 50 non-profits fitting these criteria that work to improve SRH outcomes for adolescents in India and had telephonic conversations with senior leadership of 30 organizations to gain a better understanding of their work.
- This was followed by a shortlisting process that identified 22 non-profits whose work effectively represents the scope and breadth of the Indian SRHR sector.
- These organizations have been profiled in this report. Each profile briefly describes the organizations' approach, their impact evaluation efforts and innovations and/or enablers adopted to improve SRH outcomes.
- These profiles have been prepared on the basis of information shared by senior leaders at each organization. To the extent possible, we have relied upon documents and records shared by the organizations. Where such documents or records were not available for review, we have relied upon the veracity of statements made by senior leaders at these organizations.

APPENDIX III

Dasra's Use of Data – how reliable are official data sources on sexual and reproductive health?

Reliable data on demographic and sexual and reproductive health indicators is hard to find, and constitutes one of the biggest challenges that the government and non-profits in the sector face. Key issues include:

1. Sample Demographics: Official data that includes SRHR indicators (including the 'National Family Health Survey' and the 'District Level House Survey') doesn't survey children and adolescents under 15, and uses retrospective data for adolescents aged 15-16. While the Census of India does survey those under 15, it does not include data on sexual and reproductive health. This means that the SRHR challenges of adolescents aged 10-14 years are largely invisible.

2. Timeliness and Age of Data: The 10-year gap between national level surveys means that organizations are rarely able to access up-to-date information. The last Indian Census was done in 2011, and the last complete set of data from the NFHS (NFHS-3) was released in 2006. While the Indian Institute for Population Sciences (IIPS) has begun releasing data from the NFHS-4 conducted in 2015-16, only limited data sets for 18 states have been released thus far. In addition, due to frequent migration, it is nearly impossible for these numbers to remain up to date.

3. Availability of Data: National surveys do not typically include performance on all cornerstones and best practices. In addition, there is a paucity of information of the effectiveness of government schemes that aim to improve SRHR indicators.

4. Conflicting Data Sources: There are massive discrepancies in official data and non-profit and academic sources. Where possible, Dasra has tried to use official data so as to provide a basis for common understanding and cooperation between the government and non-profits.

ACRONYMS

AEP	Adolescence Education Programme
ANM	Anganwadi Worker
ASHA	Accredited Social Health Activist
CHC	Community Health Center
CSE	Comprehensive Sexual Education
ICDS	Integrated Child Development Services
ICT	Information and Communication Technology
IDAs	International Development Agencies
IVRS	Interactive Voice Response System
MNCH	Maternal and Child Health
NACO	National Aids Control Organization
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
PHC	Primary Health Center
RKSK	Rashtriya Kishor Swasthya Karyakram
SABLA	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
SC	Scheduled Caste
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
ST	Scheduled Tribe
STIs	Sexually Transmitted Infections
UNICEF	The United Nations Children's Emergency Fund
VYAs	Very Young Adolescents
WHO	World Health Organization

GLOSSARY

Accredited Social Health Activists (ASHAs) are community health workers instituted by India's Ministry of Health and Family Welfare as part of its National Rural Health Mission.

Anganwadis are day-care centers set up under the Integrated Child Development Services.

Anganwadi Worker is a health worker chosen from the community and given four months of training in health, nutrition and childcare. She is in charge of an Anganwadi or daycare center for children.

Auxiliary Nurse Midwife is a trained health care provider who conducts outreach and provides services to women and children in the community.

Community Health Center is the third tier of the network of rural healthcare institutions, required to act primarily as a referral center for the neighboring PHCs for patients requiring specialized health care services.

Primary Health Center (PHC) is the first point of contact between individuals and a qualified medical doctor. Each PHC is linked to approximately six sub centers (a population of approximately 30,000) and is typically a single-doctor clinic with about six inpatient beds as well as facilities for delivery, family planning (including sterilizations), minor surgeries, and limited laboratory testing.

The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls or SABLA, is a scheme by the Ministry of Women and Child Development that uses Anganwadi Centers to deliver nutritional, health, and SRH education services to 11 to 18 year old adolescent girls in 200 districts in order to improve their health and education outcomes.

The Rashtriya Kishor Swasthya Karyakram is a scheme by the Ministry of Health and Family Welfare that targets adolescents aged 10-19 years and covers nutrition, reproductive health, substance abuse education, as well as adolescent participation and leadership, equity and inclusion, and gender equality activities.

The Adolescence Education Programme is a program run by the Ministry of Human Resource Development that aims to empower young people with accurate, age-appropriate and culturally relevant information that promotes healthy attitudes. It develops skills to enable them to respond to real life situations in positive and responsible ways.

APPENDIX IV

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