Process Evaluation

Adolescent Empowerment Program intervention under Dasra Adolescent Collaborative in Jharkhand

Submitted to
Dasra

Submitted by
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AEP	Adolescent Empowerment Program
AFC	Adolescent Friendly Club
AFHC	Adolescent Friendly Health Clinic
AHD	Adolescent Health Day
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist (also referred to as Sahiya in Jharkhand)
AWW	Anganwadi Worker
BPM	Block Program Manager
BSUC	Bal Sansad cum Udaan club
C3	Centre for Catalyzing Change
DAC	Dasra Adolescent Collaborative
IRB	Institutional Review Board
MOIC	Medical Officer In-Charge
MRC	Medical Research Council
NT	Nodal Teacher
PE	Peer Educator
PRI	Panchayati Raj Institution
RKSK	Rashtriya Kishore Swasthya Karyakram
SMC	School Management Committee
SRH	Sexual and Reproductive Health

1. Executive Summary

Adolescents in India remain a vulnerable and marginalized group. Adolescents face vulnerabilities in key aspects of their lives including sexual and reproductive health, education, nutrition among other aspects facing challenges such as early marriage, early pregnancy, child labor, trafficking, sexual abuse, substance abuse and lack of agency (Population Council & UNICEF 2013)[1]. Dasra has taken an initiative to create a network of adolescent-friendly organizations under the '10to19: Dasra Adolescents Collaborative (DAC)' with an aim to transform the lives of adolescents across health, education, employability and agency.

One of the interventions under DAC is Adolescent Empowerment Program (AEP), which is being implemented by Centre for Catalyzing Change (C3) in Gumla and Lohardaga districts of Jharkhand. An integrated district level model, C3's Adolescent Empowerment Program leverages existing scalable platforms to impact and improve agency, health, education and employability of adolescents, especially girls through a comprehensive approach. This comprehensive approach attempts to target all adolescents through two government programs; (1) Udaan program which gives life-skill based education to school going adolescents in grades 6-11 and (2) RKSK program which focusses on empowering non-school going adolescents along with school going adolescents in age group 10-19 years and strengthens health systems to respond to adolescent needs.

This study is aimed at undertaking evaluation of processes under Adolescent Empowerment Program. Process Evaluation helps in informing the effectiveness of the intervention through detailed analysis of the activities and processes within it. In order to do this, mixed method research design was adopted with major focus on qualitative findings from the field supplemented by programme data, wherever available. Study was conducted in two of the twelve working blocks in Gumla district. Four villages and four schools (two village and two schools in each selected block) were visited to conduct in-depth interviews, focus group discussions and non-participant observations with different stakeholders (programme team, Udaan master trainer, nodal teacher, BSUC member, ANM, Sahiya, Anganwadi worker, AFHC counsellor, and adolescents in & out of school). Total 24 interviews, 7 FGDs and 8 NPOs were conducted across these stakeholders. Data was collected and analyzed by adopting Framework method. It was interpreted based on MRC Guidance. Major findings that emerged from these discussions and observations are discussed below:

Out-of-school component: Under the out-of-school component, the study found that at some places, PEs were conducting sessions involving adolescent boys and girls, while some PEs were still being undergoing training. PE selection, retention and motivation emerged as a challenge. Adolescents that participated in the sessions perceived their awareness increasing around health practices. There were others, however, who could not participate due to competing work priorities. NPOs also reveal that the sessions could be organized in a better way at more appropriate places.

Strengthening of health systems: C3 also organized refresher trainings of FLWs. Interviews with FLWs suggested that these were useful in making them aware of their role in RKSK program and performing adolescent related activities in a better way. Some interviews also revealed the FLWs enforcing their moral prejudices over adolescents, which may deter adolescents from sharing their issues. The study found that AHDs were being conducted in campaign mode (two rounds of AHDs in a year in January-February and April-June months in all revenue villages). This led to timing conflicts and fewer adolescents attending AHDs. C3 also facilitated strengthening of AFHCs. While AFHC counsellors (charge found to be with ANMs) were happy with the support provided by C3, competing work priorities of ANMs made the AFHCs open for very limited time. It was found that very few FLWs actually referred adolescents to AFHCs.

In-school component (Udaan): The in-school Udaan component lacked reach and quality of implementation. Udaan sessions were not being conducted in middle schools. Adolescents had low awareness of Udaan and the delivery of sessions also faced challenges. Stakeholder accounts indicated that interactions between teachers

[1] Adolescents in India: A desk review of existing evidence and behaviours, programmes and policies. 2013. New Delhi: Population Council & UNICEF

and students were not open enough to allow adolescents to share sensitive issues. It appeared that nodal teachers as well as adolescents were hesitant and uncomfortable in discussing sensitive issues in Udaan sessions. The sessions had too many students, hence chaotic, and mixed gender participation leading to limited delivery of sensitive topics. Udaan clubs had been merged with Bal Sansads in schools. However, despite its lacunae, adolescents indicated some improvement in knowledge and awareness due to the sessions.

Recommendations:

Out-of-school component: The study findings suggest that the selection process of PEs did not follow all guidelines from RKSK in some places indicating a need to standardize the process. Our study findings indicate that in spite of mixed findings around the PE selection process, they were found to be acceptable among most adolescents that took part in the session. The PE led sessions were found useful by the adolescents due to the innovative methods of transacting information and were perceived to have led to improvement in health behaviours among adolescents. The quality of the PE led sessions was perceived to be satisfactory though there was a need for practical and demonstrative sessions that was suggested by the participants. Frequent mentoring of PEs from the C3 team could be helpful in this regard.

However, the program was also grappling with motivation as well as retention of PEs, particularly for male PEs. A model that provides incentives to PEs in the form of recognition in the community or engaging them in government skilling programs and other vocational activities for future employments may motivate them in transacting sessions regularly. This may involve C3 to be actively advocating around the role of PE and methods to retain them in addition to the training program that they are currently facilitating.

The participation of adolescents in the sessions was an issue, which was more pronounced for boys than girls. In addition, not having an appropriate and private place to conduct these adolescent sessions was possibly another barrier for good participation. The program would need to continue its adaptation of holding sessions post 4 pm and on Sundays to engage more adolescents. Creating awareness in the community about the unique needs of the adolescents and the utility of these sessions for development of adolescent can help nudge parents to send their children in these sessions and improve reach of the intervention. Engagement with community members through various platforms (such as SHG and gram sabha meetings) should be continued. A well-planned community engagement exercise with gate keepers that starts with identification of a clean, comfortable and private yet safe place for conducting sessions may further improve the acceptance and attendance of the sessions.

Strengthening of health system: FLWs also found their trainings (conducted by C3) helpful in making them aware of their roles and responsibilities that helped them with better engagement with adolescents. However, enforcement of FLWs' moral prejudices was found to be a concern. The trainings of FLWs should increase emphasis on building non-judgemental attitudes and positive messaging on sensitive issues, particularly related to SRH, to eliminate any biases they hold that deter adolescents in sharing their health problems.

C3 was proactive in improving the systems including in strengthening AFHCs through better reporting and maintaining the required commodities. Stakeholders also believed C3's effort had led to better reach of AFHCs with improvement in footfall. However, there were systemic issues with the AFHCs, which led to AFHC opening on fewer days and restricted reach among adolescents. The C3 should continue to strengthen AFHCs and advocate for trained counsellors that are present at all times in these AFHCs. The linkage between AFHC and the community needed strengthening. There is a need to create more awareness within community around the existence and need of AFHCs. Intensity of AHDs as well as participation in AHDs also needed further improvement for adolescent and community engagement.

In-school component: The in-school Udaan component was not taking place as envisaged. Intensity of sessions in middle school was sporadic as training of nodal teachers was ongoing, but it affected reach. Although, some students indicated perceived improvement in knowledge and awareness through the sessions, hesitancy of teachers and adolescents around sensitive issues might lead to poor awareness on some of the

issues discussed in the session. Too many students and mixed gender participation also led to limited delivery of sensitive topics in Udaan sessions. Capacity building of nodal teachers should focus on helping them engage better with adolescents and create an environment of learning. There is a need to focus on breaking the myths around sexuality and bringing openness in discussing sensitive topics. Refresher trainings with teachers can help with this. Moreover, C3 may need to increase their engagement with nodal teachers and adolescents in the sessions. Systemic issues did not allow to have separate Udaan clubs and integration of Udaan Clubs with Bal Sansads still needed to take off appropriately. C3 should continue to push for this integration activity and bring in more clarity about the role of BSUC members.

Conclusion:

It is important to engage adolescents in and out of school to improve their agency, health and educational outcomes. Adolescent empowerment program in Jharkhand seemed to have certain positive and negative aspects around its implementation towards achieving these outcomes. Overall, it was perceived to be an appropriate and acceptable intervention for adolescents in and out of schools. However, it has yet not been delivered as intended. The program needs to improve mobilization of adolescents in the community. Training of nodal teachers and FLWs must focus on non-judgemental interactions with adolescents and focus on improving knowledge and attitudes towards health behaviours of the adolescents. In addition, service delivery through AFHCs needs to be strengthened through better community and facility linkage for better outcomes.

2. Introduction

Adolescence is a phase of transition towards adulthood and characterized by rapid growth and development during which physical, physiological, psychological and behavioural changes take place. The demographic transition of the past few decades has led to highest proportion of adolescents aged 10 to 19 years than ever before in human history. Adolescent population across the world is more than 1.2 billion, in other words, nearly every sixth person is an adolescent (UNICEF 2012)[2]. However, the majority of these adolescents in the world are growing up in contexts of widespread poverty, rapid urbanization, limited educational opportunities, globalization, and increased access to worldwide information through the internet and social media. These factors may have far ranging implications for the health and wellbeing of youth thereby, affecting the ability of the nations to garner their 'demographic dividend' (United Nations Population Fund and Population Reference Bureau 2012)[3].

India, one of the youngest countries in the world, has a huge young demographic with adolescents comprising around 21% (about 253 million) of the total population (Census, 2011)[4]. Even though there have been considerable improvements in health, nutrition and education outcomes among adolescent in the last decade, adolescents in India remain a vulnerable and marginalized group. Adolescents in India face vulnerabilities in key aspects of their lives including sexual and reproductive health, education, nutrition among other aspects facing challenges such as early marriage, early pregnancy, child labor, trafficking, sexual abuse, substance abuse and lack of agency (Population Council & UNICEF 2013)[5]. In addition, these vulnerabilities and challenges are exacerbated particularly for girls, who face gender disparities in education and nutrition, early marriage and discrimination. Especially, those belonging to socially excluded caste and tribes are at a higher risk of such vulnerabilities and poor health and nutritional outcomes[6].

There are encouraging signals from Central and State governments in India to recognize some of the vulnerabilities faced by young people. Policies and programmes that reflect commitment towards promoting adolescent development needs and protecting adolescent rights have been initiated. Under education, the Draft National Education Policy 2019 aims to achieve access and participation in free and compulsory quality school education for all children in the age group of 3-18 years by 2030. It also aims to provide foundational literacy and numeracy for every student in Grade 5 and beyond by 2025 (Ministry of Human Resource Development 2018)[7]. Under health, Rashtriya Kishor Swasthya Karyakram (RKSK) envisions enabling all adolescents in India to take informed and responsible decision related to their health and well-being and by accessing the services and support they need to do so. It aims to improve nutrition, sexual and reproductive health, mental health, prevent injuries and violence, prevent substance misuse and address non-communicable diseases (Ministry of Health & Family Welfare 2018)[8]. However, efforts by the government are fraught with issues such as limitation in resources, difficulty in reaching the target population, and insufficiently trained personnel among others.

Non-governmental organizations in tandem with the Central and State Governments in India are trying to address the above issues by working with the affected population. In one such effort, Dasra has taken an initiative of creating a network of adolescent-friendly organization under '10to19: Dasra Adolescents Collaborative' (DAC) with an aim to transform the lives of adolescents, across health, education, employability and agency, and help India achieve its Sustainable Development Goals. For this, Dasra has set four priority

[2] http://www.unicef.org/publications/files/Progress_for_Children_-_No._10_EN_04232012.pdf
[3] United Nation Population Fund and Population Reference Bureau. 2012. "Status Report on Adolescents and Young People in Sub-Saharan Africa: Opportunities and Challenges " In.: UNFPA.
[4] Census 2011, Office of the Registrar General & Census Commissioner, India, Ministry of Home Affairs, Government of India
[5] Adolescents in India: A desk review of existing evidence and behaviours, programmes and policies. 2013. New Delhi: Population Council & UNICEF
[6] https://www.unicef.org/sowc2011/pdfs/India.pdf
[7] Ministry of Human Resource Development, Government of India. 2018. Draft National Education Policy 2019.
[8] Ministry of Health & Family Welfare, Government of India. 2018. Implementation Guidelines Rashtriya Kishor Swasthya Karyakram (RKSK)

outcomes, viz. completion of secondary education, delaying age at marriage, increasing agency and delaying age of first pregnancy/ birth. Some of Dasra's efforts fall have synergies with existing government programs such as Rashtriya Kishor Swasthya Karyakram (RKSK). Their efforts would help achieve the broad mandate of government in improving health and education outcomes for adolescents. Dasra is trying to achieve its objectives of improving the state of adolescents in Jharkhand with its partners, Aangan Trust, Centre for Catalysing Change (C3), Child in Need Institute (CINI) and Quest Alliance, implementing DAC as a three-year intervention.

Although, a number of adolescent development programmes, to address education, health, skill development and employment generation, have been implemented in different states within India, only a select few have been soundly evaluated. There is scant literature and documentation around promising practices, evidence on what works and what does not work around interventions aimed at adolescent development. In order to fill this gap, Dasra has commissioned a process evaluation study to gain insights about key processes and distill what works and what doesn't with respect to delivery of such processes under the four interventions in DAC. Process evaluations of the interventions within DAC would be useful in informing the effectiveness of an intervention by investigating how it was implemented, the mechanisms by which it achieved its effect, how the intervention interacted with the context in which it was implemented and whether the process and outcomes of the interventions can be sustained over time (Haynes, et al., 2014)[9]. The Process evaluation study would help Dasra take learning back into program delivery and take steps towards course correction, if required.

The primary objectives of this process evaluation exercise are listed below:

- Document key processes and activities within it;
- Assess the quality of implementation of identified processes;
- Develop an understanding of interaction between the intervention and its key beneficiaries.

The next sections in this report delves into the details of Adolescent Empowerment Program (AEP) intervention being implemented by Centre for Catalyzing Change in Gumla and Lohardaga districts of Jharkhand and detailed findings from the process evaluation with respect to core activities envisioned under AEP.

3. About Adolescent Empowerment Program (AEP)

An integrated district level model, C3's Adolescent Empowerment Program in Jharkhand leverages existing scalable platforms to impact and improve agency, health, education and employability of adolescents, especially girls through a comprehensive approach. This comprehensive approach attempts to target all adolescents through two government programs, Udaan program which covers school going adolescents in grades 6-11 and RKSK program which captures non-school going adolescents along with school going adolescents in age group 10-19 years. Currently, AEP is being implemented by C3 in 12 blocks of Gumla district - Basia, Bherno, Bishunpur, Chainpur, Dumri, Ghaghra, Gumla, Kamdara, Palkot, Paramvir Albert Ekka, Raidih, Sisai and 7 blocks of Lohardaga district Bhandra, Kisko, Lohardaga, Senha, Kuru, Kairo, Peshrar in Jharkhand.

[9] Haynes, A., S. Brennan, S. Carter, D. O'Connor, C. H. Schneider, T. Turner, G. Gallego and C. Team (2014). "Protocol for the process evaluation of a complex intervention designed to increase the use of research in health policy and program organisations (the SPIRIT study)." Implementation science: IS 9: 113-113

The project works through six core strategies outlined in the Figure below -

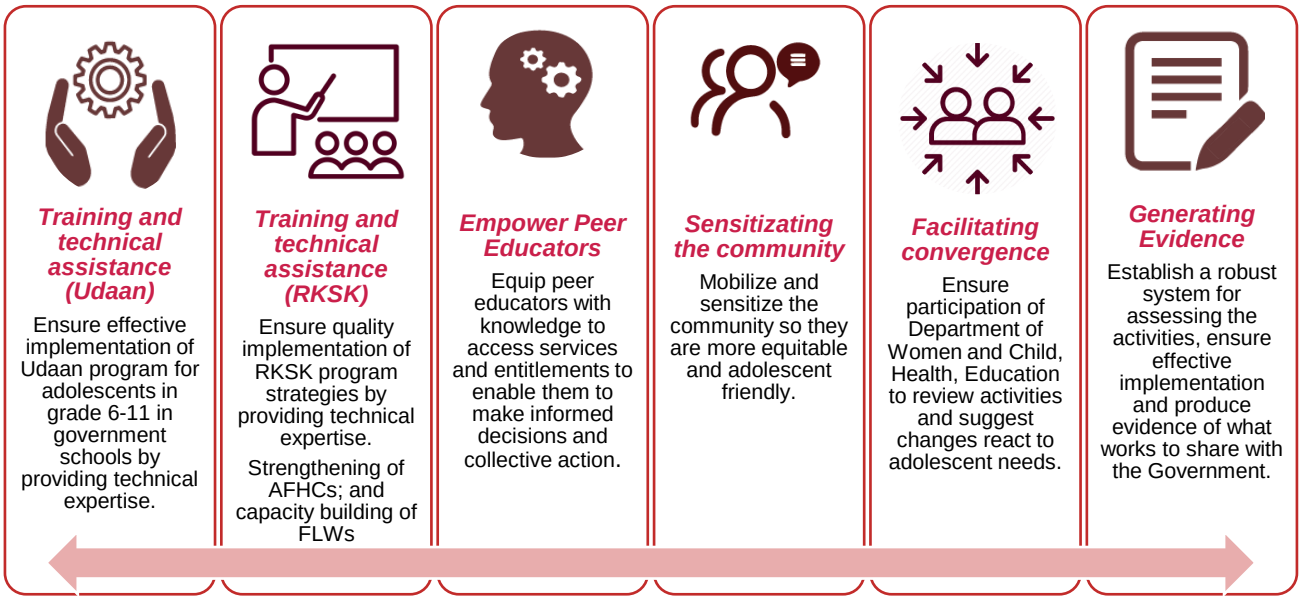


Figure 1: Adolescent Empowerment Program Approach

The various intervention activities under the program are as follows-

1. **Training & technical assistance (Udaan):** To empower adolescents with SRH and life skills education, C3 has focussed on ensuring quality implementation of Udaan program in government schools for adolescents in grade 6-11. C3 provides training to master trainers from the project blocks who then provide training to identified nodal teachers from each school. They also support nodal teachers in conducting Udaan sessions and activities with adolescents at school level. Bal Sansad cum Udaan Club (BSUC) members are identified in each school to support Udaan club activities.

2. **Training & technical assistance:** To strengthen the implementation of RKSK strategies, C3 is conducting trainings for service providers, front line workers and PEs. Apart from imparting trainings, C3 is also providing monitoring and handholding support to these frontline workers in activities such as collectivization of adolescents, selection of PEs, organization of adolescent sessions and submission of reporting formats. C3 is also engaged in strengthening Adolescent Friendly Health Clinics (AFHC) to provide treatment and referrals to adolescents facing health issues.

3. **Empower Peer Educators:** To enable PEs under RKSK to make informed decisions and take collective action, C3 is facilitating **s**election of PEs from the communities, facilitate their trainings and resource kits, supporting transactions of sessions, providing handholding support and refresher trainings.

4. **Sensitization the community:** To transform the social environment to be more positive towards girls completing education and preventing early marriage, C3 engages with the community and sensitizes them. The activities include ensuring formation and strengthening of School Management Committees (SMCs), developing app/checklist for tracking vulnerable girls, implementing school development plans and orienting PRI members, SMCs on adolescent rights, laws, entitlements and schemes.

5. **Generating Evidence:** To contribute to evidence generation and learning agenda for scalable designs and approaches on issues related to girls, C3 is conducting research studies, collating case studies and other data and documenting processes. C3 will also be disseminating evidence collected through these channels for a large-scale outreach.

6. **Facilitating convergence:** C3 is putting efforts to encourage coordination and convergence among the departments of Health, Education and Woman and Child. For this, C3 organizes regular review and orientation sessions with all key stakeholders from various departments and District level convergence meetings with key departments, Block and Panchayat level members.

4. Methodology

4.1. Study design

A mixed methods study design was adopted for this process evaluation study. Qualitative approach was primarily adopted for data collection and quantitative programme monitoring data was utilized wherever available.

4.2. Study approach

We adopted a stepwise approach for carrying out the evaluation. The exercise was carried out in the following phases:

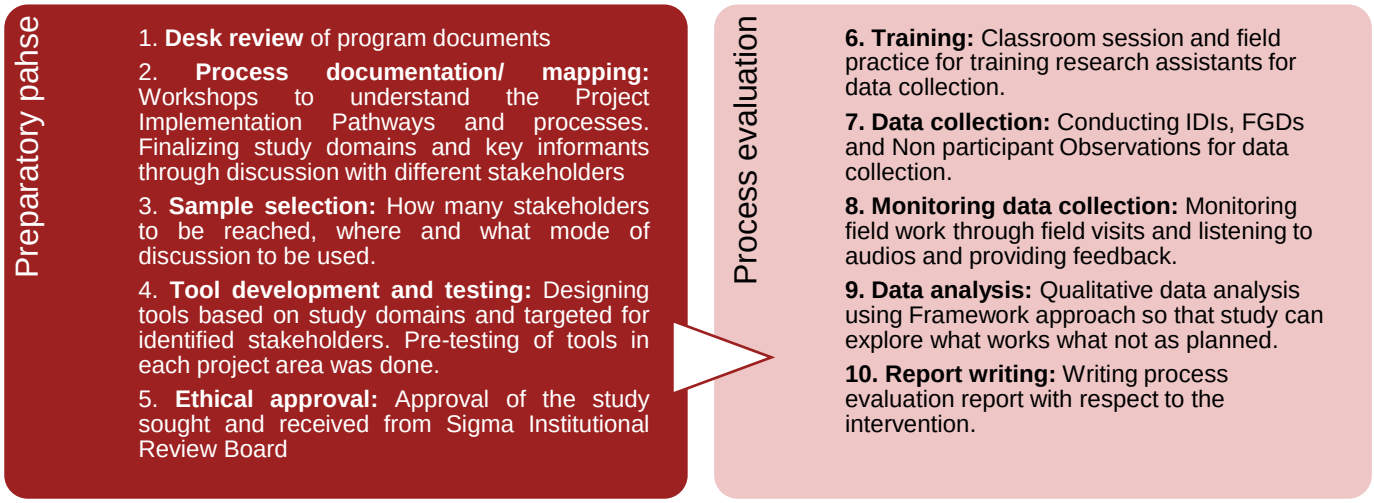


Figure 2: Study approach

These phases are discussed in detail in the next sections.

4.2.1. Desk review and Process documentation

Sambodhi reviewed program documents to get a theoretical understanding of the programme and underlying processes. This gave preliminary understanding of the processes. Discussions were held with the program staff and Dasra team to refine the understanding of the processes. These discussions also helped in identification of relevant stakeholders for the evaluation. Process maps were created following the discussions outlining the implementation pathways. The process map that emerged from the discussions is provided in **Annexure 1**. Some processes were excluded from the evaluation based on mutual discussion. The processes around 'sensitization the community', 'education enrichment', 'facilitating convergence' and 'generating evidence' components in the process map were excluded from the scope of evaluation. Additionally, some processes that were part of the scope could not be studied in detail as they were either one-off processes or did not take place during the data collection phase.

4.2.2. Qualitative data collection methods used in the study

A qualitative approach was adopted to collect primary data for the study. Among different types of In-Depth Interview (IDI) techniques (structured, semi-structured and unstructured), **semi-structured IDI** suited the purpose of the study as it helps in get answers to the issues under lens and still have leeway to secure responses which were not anticipated earlier. The IDIs are useful in assessing people's perceptions, their experiences, description of situations and construction of reality and hence were chosen as methods of data collection[10]. **Focus Group Discussions (FGDs)** were chosen as another mode of data collection for their

[10] *Somekh, B and Lewin, C. 2005. Research Methods in the Social Sciences. London: SAGE.*

capability to provide group perspectives and validating responses acquired in IDIs. FGDs were conducted primarily with adolescents (in addition to IDIs with adolescents), as they are the beneficiaries under the intervention and most important source of information. In addition, **Non-Participant Observations (NPOs)** were also conducted to observe various trainings and adolescent sessions being conducted as part of intervention activities.

4.2.3. Sample selection

We have adopted purposive sampling in this study. Purposive sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest (Palinkas et al. 2015)[11]. The variety of participants **(Table 2)** was purposively drawn from different settings to enable us to study contextual variations. This was done to capture maximum essence of the intervention and thus helps provide better feedback to Dasra on program implementation.

For selection of blocks and villages within the selected blocks, following criteria were chosen to achieve maximum variation:

a. Vulnerability of the overall population (presence of marginalized communities)

b. Any known issues with adolescents (such as high incidences of child marriage, teenage pregnancy, school dropout etc.)

c. Old and new intervention villages

d. Challenging or smooth in terms of the rollout of our programs

e. Geographical differences (distance of village from block HQ and school from the village)

f. Good performing and low performing schools/ villages

Based on the above criteria, two blocks (Basia and Gumla) were selected from a total of twelve blocks where the intervention is being implemented in the district. Further, using the given criteria, C3 provided a list of 10 villages in Basia and 10 villages in Raidih block. The list was further refined by Sambodhi using the same criteria to arrive at 2 villages in each block for the purpose of data collection. In two villages, nearest high school was selected and in other two villages, nearest middle school was selected. This is tabulated below **(Table 1)**:

Table 1: Sample selection of block, village and school

Block	Village	School
Basia	Ramjhari	Kumhari High School
Basia	Banai	Govt. Upgraded Middle School, Ghunsera
Raidih	Bargidandh	SS High School
Raidih	Semartoli	Middle School

Another level of sampling was done at the level of respondents. They were targeted based on the following selection criteria methodology for each type of respondent:

Under out-of-school intervention, in each sampled village visited, interview was conducted with one PE and a focus group discussion was done with a group of adolescent boys or girls. For PEs, preference was given to those who had received PE training the earliest and those who had transacted adolescent group sessions.

[11] *Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and policy in mental health and mental health services research, 42(5), 533-544.*

Despite revisits, male PEs were unavailable as they were away for work, hence, only female PEs were interviewed in three villages. For FGDs with adolescents, two were done with girls and two were done with boys. Around 6-10 adolescents of different ages from 10-14 years and 15-19 years, who had attended PE led sessions were included in group discussions. Attempts were made to include at least two non-school going adolescents in the discussion.

In each block, one ANM, one Sahiya and one AWW were interviewed. Attempts were made to include those who had received RKSK orientation from C3 during project period. There was some oversampling in case of interviews with frontline workers. AFHC counsellor from each block was interviewed.

For in-school intervention, high school or middle school nearest to the sampled village was approached. In each school, attempts were made to interview one trained nodal teacher, one BSUC member along with conducting an FGD with girl or boy students from class 6-8/9-11. But many these interviews and discussions could not be conducted in each school due to unavailability of respondents and on-going exams. In each block, one Master trainer who had received training for Udaan program in project period was interviewed.

NPOs of activities that were conducted during data collection period were done. These included observations of training of nodal teachers, training of PEs, peer led sessions, AFHCs and AHD. In all, 24 in-depth interviews, 7 focus group discussions and 8 non-participant observations were conducted. The final sample size and data collection methods for stakeholders are provided in the table below **(Table 2)**:

Table 2: Sample selection across stakeholders

Centre for Catalyzing Change (C3)		
Target respondents	**Sample size**	**Data collection method**
Project officials (implementation team)		
State level	1	IDI
District level	1	IDI
Block level	4 (2 per block)	IDI
Sample distribution among Stakeholders involved in out-of-school activities		
Peer educator/Saathiya	4 (1 per village)	IDI
Adolescent girl and boy participants (out-of-school)	4 (1 FGDs per village)	FGD
Stakeholders involved in school activities (Udaan)		
School nodal teachers	4 (1 per school)	IDI
Students (both girls & boys) in class 6 to 9	4 (1 per school)	FGD
Bal sansad cum Udaan club member	4 (1 per school)	IDI
Master trainers for Udaan program	2 (1 per block)	IDI
Other stakeholders		
ASHAs/Sahiya	2 (1 per block)	IDI
AWWs	2 (1 per block)	IDI
ANMs	2 (1 per block)	IDI
AFHC counsellors	2 (1 per block)	IDI
Non-participant observations		
Training of male and female peer educators	2 (1 per block)	Non-participant observation (NPO)
Group sessions for girls, boys	4 (1 per village)	
In school sessions provided by nodal teachers (Udaan session)	4 (1 per school)	
Bal Sansad cum Udaan club activities	4 (1 per school)	

Orientation of ASHAs/AWWs/ ANMs to implement RKSK effectively	2 (1 per block)
Training of nodal teachers	2 (1 per block)
Training of Master trainers (Udaan program)	1
AHD session	4 (2 per block)
Visit AFHC facilitated by C3	2 (1 per block)

4.2.4. Tool development and pre-testing

In accordance with the methods identified for data collection, research tools were developed to guide discussions with different stakeholders and observe various activities. Tools focused mainly on understanding the processes implemented on the ground, interaction among various stakeholders and involvement of the program teams. Revisions to the study tools were also made following feedback from Dasra team and program staff. The tools, thus developed, were translated to Hindi as it is commonly understood by the identified stakeholders in Jharkhand. Translation of tools from English to Hindi was done by a professional translation firm. Data collection tools developed for the study were pre-tested in the field to ascertain their suitability to actual field conditions. The research team members carried out the pre-testing exercise in non-sampled project areas. Based on the experiences from pre-testing, the research instruments were further revised and finalized before submitting them for ethical approval as the next step.

4.2.5. Ethical approval

Ethical approval for the study was sought from Sigma Institutional Review Board (IRB). Research documents, pre-tested tools along with other required documents were submitted to the IRB. Feedback received from the IRB meeting was incorporated in the research tools. Following this, ethical approval was received for the study.

Following protocols were adhered to, in order to maintain ethics in the study.

1. **Informed consent:** Any discussion with a respondent was initiated only after they agreed verbally and in writing for the same. Respondents were informed in advance about the purpose of the study, nature of information required from them, risks & benefits of the study among other aspects.

   In case a respondent interviewed was minor (i.e. below 18 years of age), informed assent was taken from the respondent and informed consent was taken from his/ her guardian. In case such respondent belonged to a school, consent forms were sent to his/ her parents at least a day prior to the discussion after explaining all the contents of the consent form to the adolescent. Only those adolescents who came back with a signed consent form from their parent were included in the discussion. In case minor respondents being interviewed were out of school, the field team approached their parents and sought consent.

   In case of non-participant observations, written consent was taken from the person in-charge of the activity. For examples, for observing morning assembly, informed consent was taken from the school principal.

2. **Confidentiality:** All measures have been taken to keep the information provided by respondents during data collection strictly confidential. This information has been used only for research purposes. Personal identifiers of respondents will be kept confidential from anybody other than the project team.

3. **Privacy:** While conducting interviews and focus group discussions, privacy of respondents has been maintained. No external person was present during the discussions beyond the project team and the programme staff.

4.2.6. Data collection

The field team comprised of three Research Assistants who were trained on the Dasra Adolescent Collaborative, AEP intervention, nuances of conducting interviews, focus group discussion and non-participant observations and the relevant tools to be administered in detail through two trainings. Each training consisted of theoretical classes and field work practice. First training was organized for 4 days with 3-day classroom sessions and 1 day of field practice. Second training (refresher training) was conducted for 3 days followed by data collection and monitoring of data collection. The RAs worked closely with the Research Manager at Sambodhi and the field team of the implementation organization throughout the data collection process.

Field notes were taken during the interviews, and IDIs and FGDs were audio-recorded. During the IDIs and FGDs, questions were asked according to the interview and discussion protocol, thus prompting interviewees to provide further details until each line of inquiry was sufficiently covered. The average length of an interview was about 40 minutes. It is to be noted that all attempts were made that a male respondent is interviewed by a male person while a female adolescent is interviewed by a female person.

Certain challenges were encountered during the discussions. The time of the data collection coincided with harvesting of paddy. This led to lesser number of people available at home. Hence, the interviewers had to make multiple visits in a community to find relevant respondents. Further, festivities and election affected the flow of the work. A few discussions could not be carried out as anticipated for reasons such as activities itself not taking place and unavailability of eligible respondents.

4.2.7. Data analysis

Organization and analysis of data has been carried out by adopting Framework method (Gale et al. 2013)[12]. This helped generate a framework of codes and code categories based on pre-decided themes. Major steps involved in developing analytical framework under Framework method included:

- **Transcription and translation**: The audio recordings collected during data collection were transcribed and translated verbatim by the RAs. Random samples from these translations of transcriptions were checked by research managers and feedback was given to RAs at this stage.
- **Familiarization with the interviews:** Members of the research team thoroughly read and re-read each transcript and listened to audio-recorded interviews to become familiar with the dataset. This process of familiarization is essential as the researchers analysing data are not present during the discussions.
- **Developing coding frame:** Data so collected is structured using codes and code categories. Responses from all IDIs and FGDs were coded by the principal researchers using R as a commercial, qualitative data analysis program. The adapted framework method of Gale et al. directed the list of codes under predetermined themes to specifically assess quality of implementation, context and mechanism of action as directed by the MRC framework. The principal researchers decided upon the most representative quotations to reflect the respective themes.
- **Developing framework:** A framework of codes and categories was developed using a few transcripts. Once it was developed, we checked and compared each frame with the rationale behind it. The structuring and generation of the coding frame was done using a combination of two strategies:
    - In a concept driven way; i.e. based on what the researchers already knew from the literature review and field insights.
    - In a data driven way i.e. by letting the categories/ dimensions emerge from the collected data.

  The combination of these two strategies enabled us to incorporate both deductive and inductive processes. The developed framework of codes and categories was used to code other transcripts.

[12] Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC medical research methodology, 13(1), 117.

- **Interpreting data:** Based on the emerging framework of codes and categories, other transcripts were coded and reviewed. Among many approaches to interpreting data we adopted MRC guidance (Moore et al. 2015)[13]. Evaluation findings are weaved together by adopting MRC Guidance. MRC guiding document helps in planning, designing, conducting, reporting and appraising process evaluations of complex interventions. It breaks the key functions for process evaluation of an intervention under implementation (how is delivery achieved and what is being actually delivered), mechanism of impact (how does the delivery intervention produce change) and context (how does context affect implementation and outcomes).

The study focuses on certain core strategies decided in consultation with Dasra. Findings are structured as per the major components of Adolescent Empowerment Program to be studied and the evaluative findings with respect to each studied component is informed by MRC guidance.

4.2.8. Limitations

- The study adopted purposive sampling to get in-depth understanding of perspectives of the stakeholders and situations. However, the findings are not generalizable.
- Purposive sampling was adopted with certain inclusion and exclusion criteria, but this may still have led to creeping in of selection bias.
- Some processes were excluded from the scope of the evaluation based on mutual discussion with C3 and Dasra. Some of the processes, that were part of the scope, could not be studied in detail as they were either one-off processes or were not scheduled to take place during the data collection phase.

5. Key Findings

C3 leverages existing government programs to impact and improve agency, health, and educational outcomes among adolescents in Jharkhand. C3 is working to improve implementation of RKSK in select blocks of Jharkhand as well as mainstream Udaan sessions as part of in-school activity for classes 6-11 in government schools. In order to strengthen implementation of RKSK and Udaan, C3 is conducting training of service providers including ANM, ASHA, AWW and nodal teachers in public schools across Gumla and Lohardaga districts in Jharkhand. C3 staff, including their district, block and cluster coordinators, also provide handholding support to the Government functionaries mentioned above and engage in monitoring their activities at ground level. In addition, they also facilitate the selection process of Peer Educators (PE), otherwise known as Sathiyas in the villages, who are supposed to lead the group sessions with adolescents as per RKSK program guidelines. The C3 also sensitizes community through various community level platforms (such as AHD and AFHC) and engaging with community level committees (such as Village Level Child Protection Committee and School Management Committee). C3 engages with nodal teachers in public schools and occasionally with students in the school with respect to ongoing Udaan sessions. These processes are detailed out in process maps included as **Annexure 1**. This following section presents the thematic analysis of the IDIs and FGDs with stakeholders as well as findings from the NPOs of the various activities of the intervention that were conducted as part of the study.

5.1. Out-of-school component

A major component of the RKSK program, known as the Peer Educator component, is being facilitated by C3. This component involves PEs, who are recruited from the community as volunteers to establish adolescent groups, conduct participatory sessions with adolescents on RKSK themes, and facilitate referrals to AFHCs. The

[13] *Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., ... & Baird, J. (2015). Process evaluation of complex interventions: Medical Research Council guidance. bmj, 350.*

RKSK program envisages that ASHA workers, also known as Sahiyas, and AWW mobilize adolescent girls and boys to form adolescent groups. Once the groups are formed, PEs are to be selected from the group. Under the RKSK, ANMs of respective villages should act as mentors for PEs and should conduct Adolescent Friendly Club (AFC) meeting every month with PEs, ASHA and AWW to discuss and resolve issues in implementing RKSK strategies at the village level.

Total four PEs ought to be selected from a population of 1000 in a revenue village. Male and female peer educator are supposed to form a group of about 15-20 boys and girls respectively from their community and conduct weekly 1-2 hour interactive sessions. Among these four PEs, one male and one female PE are to be selected from school going adolescents and one male and one female PE are to be selected from out-of-school adolescents. These PEs are provided training to conduct participatory sessions on RKSK themes with their respective adolescent groups. The training of PEs is conducted with the help of ANMs, who is trained as the master trainer for these training sessions. Around four to five ANMs in each block trained by C3 staff, and other government resource persons are selected as master trainers for PE training. PEs also receive an adolescent resource kit during training which consists of books and other information, education and communication (IEC) materials for conducting sessions with adolescents. These sessions should be held twice in a month and include discussion on topics like nutrition, sexual and reproductive health (SRH), mental health, substance abuse, and life skill, among others.

The facilitation of the PE component of the RKSK program is being implemented in phases. As part of the study, we chose two sampled villages where implementation of RKSK was ongoing from a longer time as compared to the other two villages sampled in the study. All PEs had been identified but their training was not yet complete. The PE led adolescent sessions were being held in the villages, but in some areas, PEs were attending training during the course of data collection. Hence, observations of PE led sessions could not be done in those areas. Some of these sessions were taken by Sahiyas in the absence of PEs. Description regarding PE sessions is given below.

Issues around PE selection and retention

In accordance with the RKSK norms, PE selection was mainly guided by ASHA workers in the villages. C3 facilitated PE selection process and helped distribute resource material (PE kit) to the PEs after taking due approvals from relevant authorities. FLWs highlighted that the selection process of PE on the field first involved a meeting of adolescent boys and girls wherein three-four adolescents who were in the older age group and who could speak confidently were nominated. Adolescents were then asked about the suitability of nominated candidates. Those selected were retained as PEs. However, interviews with stakeholders highlighted conflicting accounts of PE selection process. While FLWs suggested a more RKSK guideline-driven method, some PEs suggested that it was arbitrary, and they were chosen without following any standard process and even without their knowledge. This may influence the acceptability of the PEs among different groups of adolescents in the community.

'She (Sahiya) came to my house and told me I had been selected…. I did not know that I will be selected earlier. But one day, there was meeting and I did not know, my friend told me later, I had gone to college…..Sahiya didi knew me so she came and told me' – IDI, Peer educator

'Sathiya (PE) was selected in which ANM, C3 staff and village head got an announcement made in the village that today is the selection of Sathiya. Then adolescent girls and boys came to the meeting and selected, discussing amongst themselves that this girl is good in speaking and explaining ideas…based on this, adolescent girls selected a girl and adolescent boys selected a boy.' – IDI, Frontline worker

'Sahiya didi asked me to come for training and then in training, I was told that I had been selected as Sathiya.' – IDI, Peer educator

C3 has identified 5950 PEs and aimed to train 2500 of them PEs in Q3 of 2019. They could only reach to 1962 owing to delays in getting the PE kits from the government. This meant that that PE sessions were not always taking place as planned and some of these sessions were taken up by ASHA workers instead. This was observed in the field and had implications about acceptability and expected outcomes from these sessions as detailed in the findings section below (refer to section on 'Issues around reinforcement of moral prejudices and negative messaging' under Strengthening of Health System component). The PM data does not provide the details on the number of male and female PEs though our study and field observations indicate that male PEs are less in number. Our study found an active male PE in one village while in another village the male PE stayed in the district headquarter for studies but came to take sessions every month. The observations and discussions indicate that there are multiple reasons for fewer numbers of active PEs in comparison to what is envisaged in the program. Some of the common reasons for low retention of PEs that were highlighted include migration for work and studies among males and marriage among females. Majority of the stakeholders including PEs themselves also highlighted the need for better incentives for PEs to continue working.

'PEs also change. For example, assume that someone (female PE) has got engaged, we don't want that peer educator to change because she has been trained and has done work for many days, if new one is selected, she won't be able to do so much, it will take time.' – IDI, Frontline worker

'There was one boy (PE) but he went away for work, he never took any session. He only attended the training and after that he went away. Now he stays there only. Both the boys (PE) are like that.' – IDI, Peer educator

'XX and XX were selected as PEs for boys. They are not there at present.' – IDI, Frontline worker

'If possible then Sathiya should also get something as the work that they are doing, they don't want to do it for free. When they come to meetings, they have to pay from their own pocket. They leave work and go there.' – IDI, Frontline worker

'There are people with different mind-sets. Sometimes a Sathiya may think that going to some place is just a waste of time if I would have gone to some other place then I would have earned some money. Alternatively, sometimes their guardians may think that he or she is just wasting four hours. Therefore, it would be better if this kind of thinking is reduced. When they do their weekly meetings and we have something for them also then they would be more enthusiastic.' – IDI, Frontline worker

Quality of Training of PEs

In two of the sampled RKSK villages, PEs had already been trained and sessions were conducted regularly over the past year. In the other sampled village, older PEs had dropped out and new PEs were receiving training during data collection. The training for the pool of newly joined PEs (as old ones had left) in old RKSK villages and in new intervention villages, was delayed as per plan because PE resource kits were not ready. Systemic barriers of such kind appear to be a challenge for proper implementation of PE model due to delays in PE training that have an effect on conducting the adolescent sessions in the community.

The PE training was originally envisaged as a six-day training to be conducted by ANMS at the block level. However, PEs have to attend school or college during weekdays. Hence the PE trainings, were divided into 2-day modules conducted over three subsequent weekends, an adaptation implemented by C3 to improve attendance of the selected PEs. In our observation of a PE training session, we found that the trainers covered the topic (nutrition and anaemia) at an appropriate pace and encouraged discussion among participants. A group activity was also conducted on nutrition within different groups in the training session. However, it appeared that the trainers (ANMs) were not well prepared as they referred to the book frequently and discussed amongst themselves. Although participants responded to questions, they did not ask any questions themselves. In general, female PEs responded to questions more actively. Sahiyas, who were also receiving training along with the PEs, were less active in the session. In addition, some PEs could not participate in the training session due to exams or needed to carry out their usual household chores. However, our interviews with PEs indicate

that these trainings were found to be informative by majority of PEs, though they felt that more training was required. The PEs also felt that resource and training material that was provided for adolescent sessions was not enough as it could not cater to all the queries.

'Like for teaching there should be one more book, the book we have got is insufficient. We get such questions that we also do not know about it. (I feel) there is lack of information.' – IDI, Peer educator

'It would have been better if information was given using (video) footage. We could understand through video and there would be no problem in explaining (to others) as well.' – IDI, Peer educator

Overall, the intensity of PE training was found to be low because of systemic barriers (unavailability of training resource). This could be a major bottleneck when PEs go on to deliver sessions among adolescents. Unpreparedness of ANMNs was also a hindrance to desired quality of training of PEs. Timing of the sessions is an equally important issue that needs to be taken into account. Hence, it appeared that both intensity and quality of the training delivered to PEs was not up to the mark.

Perceived quality of PE led sessions

Adolescent group sessions were being conducted in all the villages on various topics such as changes in adolescence, SRH issues like menstrual health, nightfall, substance abuse, and nutrition, among others. Apart from these, discussions also revolved around relevant social issues for adolescents such as child marriage, adolescent pregnancy, gender discrimination, human trafficking, elopement, and sexual and domestic violence.

'…Discussion takes place on changes in height, weight, mental state. Also, how people discriminate between boys and girls on gender basis.' – FGD, Male Adolescent

'We take sessions with adolescent girls and boys and explain them, discuss with them and give them information (on issues) like child marriage, elopement, human trafficking, about health, menstruation, Yuva Maitri Kendra (AFHC).' – IDI, Peer educator

One of the group sessions observed was led by a female PE (male PE was absent) and facilitated by an ASHA. The session highlighted that the PE was confident, enthusiastic and was able to engage adolescents. The PE used a flipbook to deliver the session and used question and answer method to elicit responses from adolescents. The PE kept encouraging the adolescents to participate and interact. However, the interaction of PE with the adolescents was tepid.

Interviews with PEs suggest that over time they had gained confidence in taking sessions and they were able to talk openly about sensitive issues. Besides disseminating knowledge about various issues, the various methods of transacting information such as role plays, group discussions, flipbook presentations and Sathiya mobile app were also found useful by both PEs and adolescents. Most adolescents, during the FGDs, also indicated that they were comfortable in engaging and discussing most topics with the PE.

'Everyone comes in the meeting, so I used to hesitate earlier but now there is none. Since we went there (training), that time we had to speak sometimes in front of everyone then slowly I lost all hesitation.' – IDI, Peer educator

'Initially I used to feel shy but now I don't feel it, after having gone there (training), I came to know that if you have any problem, you should talk about it, otherwise it causes many problems later on.' – IDI, Peer educator.

'We have downloaded Sathiya mobile app, we use that to teach, sometimes we read it at home and then talk about it here.' – IDI, Peer educator

'They (PEs) talk to everyone and we like them. We feel they are knowledgeable and whatever we ask they

reply to it. They discuss about gender discrimination, cleanliness etc.' – FGD, Male Adolescent

Majority of adolescents felt that the adolescent group sessions were good because they were informative. Many adolescent girls and stakeholders also perceived that awareness and practices around issues such as menstrual hygiene practices have improved and attributed that to the sessions in particular. They also felt comfortable to socialise, discuss, and support each other on most issues in the adolescent group, which they could not discuss with parents.

'We cooperate among ourselves and help each other to solve our problems. At times we are in condition when we cannot share our problems with our parents directly, we do share with our friends among the group and our issues are addressed. This is the reason why I joined the group.' – FGD, Female Adolescent

'I was not aware of these talks before. It may sound weird but these things are important in everyone's life. In such meetings, we come to know what are the do's and don'ts we should follow. We might be missing something or doing some mistakes. So, coming here discussing with friends we get to know about such problems and the practices to tackle them' – FGD, Female Adolescent

'The program is beneficial for us. We take whatever knowledge is given to us.' – FGD, Male Adolescent

While the program is too young to reflect any actual change among adolescents and this study was not designed to assess that, there were some accounts of change that seem to be attributable to the PE sessions. A change that a lot of stakeholders discussed was around the use of sanitary napkins instead of cloth, a behaviour change among many adolescent girls, to prevent infections. Apart from that, a few stakeholders also indicated around increase in consumption of Iron and Folic acid (IFA) tablets by adolescent girls. There were also some accounts of girls refusing to marry early by FLWs, but it is difficult to say whether it was a direct effect of the program.

'We never knew about periods and definitely not how to handle them. We were taught to use pads properly. If we use cloth, then we should use cotton cloths. Then before cleaning we should dry the cloth under the sun. We never knew this. Pimples use to worry us a lot before. Now we know its normal part of growing up.' – FGD, Female Adolescent

'We get regular Iron tablets now whether at school or Anganwadi. Previously we only got 3 packets of iron tablets before the (C3's) program.' – FGD, Female Adolescent

'Earlier they used to marry off (girls) at 16-17 years, but now girls refuse to marry before 18 years of age. In nearby village, marriage was fixed for a girl who was younger than 18 years of age, she directly went to police station and stopped the marriage and said she wanted to study, she was in 9th class at that time. Due to this program only, girls are aware. Earlier they used not take iron tablets, now they do.' – IDI, Frontline worker

A few adolescents, during FGDs, also indicated that sessions could be made more interactive through practical demonstrations, games and competitions.

'Yes, there should be practical…..meaning we should actually try and see….nothing will happen by just talking about it…..one should try it actually.' – FGD, Female Adolescent

'No, we are not satisfied. They conduct only exam. No games and activities are involved. More competitions must be conducted.' – FGD, Male Adolescent

'Feels good but it has only studies, it would have been better if it had something more like practical studies, they try to show it practically like what to eat.' – FGD, Male Adolescent

As block coordinators an cluster coordinators are not able to visit all the PE sessions, some adolescents and PEs highlighted the need for the frequent interactions with C3 staff during and between sessions for mentoring and active feedback on ways to conduct the sessions in a better way.

'XX and XX visit from C3. They share their insights in the discussions. We are now aware of many things." – FGD, Male Adolescent

'No, we are not able to talk to Sathiyas every week. We have trained them in a way that if we tell them we can't make it to the meeting they conduct the meeting themselves.' – IDI, Cluster Coordinator

'No, but sometimes they (C3) won't come in 1 month but if they miss second week meeting, we would like to have them on our fourth week meeting and guide us.' – FGD, Male Adolescent

'They (C3) should give trainings frequently to improve our knowledge. In between a few sessions and frequently as we have received only one training so far.' – IDI, Peer Educator

The NPOs indicate that the sessions could be organized in a better way. Sessions were held at Anganwadi centres, one of which was cramped and dirty. The other one did not offer auditory privacy. The majority of interviews with PEs also indicated a lack of suitable space with privacy to hold these sessions that may also result in poor and irregular participation of adolescents.

'We don't like teaching (conducting sessions) in this place. This place is always dirty, we don't feel like (taking sessions). When we asked for another place, we were told that it would not be possible. We can do it in school, here there is a middle school.' – IDI, Peer educator

'We conduct here in Anganwadi. There will be Sunday market and the noise from the vehicles causes disturbance.' – FGD, Adolescent

Mobilisation of adolescent for PE sessions is a challenge

Ensuring good attendance in the sessions regularly seemed to be an issue, especially during data collection for this study as it was the harvesting seasons and the entire family along with children go to work in the fields. Other than agricultural work, adolescents also indicated lack of time to attend PE sessions as they have to attend school, are engaged in household chores, and other labour work to supplement family income. To counter this and improve attendance, C3 was trying to conduct meetings after 4 pm to cater to students going to school (from 10 AM to 3 PM) and was also organizing these meetings on Sundays so that their staff is able to visit more than one meeting.

One of the main reasons for not coming to current meetings is harvesting of crops. In this season, we cannot conduct continuous meetings because harvesting of crops is a long process, and this is the only means of livelihood (for them). – IDI, Program staff

'Reasons for not coming are like household chores, someone goes to school faraway and by the time they return it is 5 or 6 o'clock.' – IDI, Program staff

"Most of the kids go to school. Finding the right time to hold meetings is a challenge. Saturday and Sunday are official holidays. Though there is work happening on Saturday, conducting meeting is difficult. So, we have asked our cluster coordinators to take meetings on Sunday and alternatively take off some other day." – IDI, District Coordinator

The stakeholder interviews and FGDs with adolescents also indicated lack of motivation to attend these sessions. The FGDs with adolescents particularly highlighted challenges like long distances, staying hungry and thirsty during the session and need for incentives to improve and regularise the participation in PE sessions.

'We are girls, we do not have money all the time, sometimes we do, sometime we do not, so within the meetings if there could be any monetary benefits that will help us.' – FGD, Female Adolescent

'We get but not where teenagers assemble, some even come from faraway places or come without having food, it would be helpful if they get nutritious food….Some sports equipment and some food and drinking water should be there near the meeting (venue).' – FGD, Male Adolescent

The interviews with program staff and NPOs suggested that there were more girls in the adolescent groups than boys. Mostly, sessions of adolescent boys and girls were held together due to lack of active male PEs. The stakeholders involved in implementing the program also indicated participation of boys as a major challenge as it was difficult to mobilise boys and bring them to group meetings despite efforts. The facilitation and engagement of PE sessions particularly with older adolescent boys was found to be difficult. However, taking sessions together cropped up the challenge of discussion on sensitive topics (such as SRH, STIs, physical relationships etc.), which could not take place as openly as it would in separate sessions.

'Yes, it is challenge to mobilize boys, girls come but boys are a little fickle, even if they come, they create a racket….we tell them that we will talk on issues important to you first and then we will have fun. Then they hear us. Even then, in a group, there would be 5-6 boys for 20-22 girls.' – IDI, Program staff

'Earlier, we did not use to take sessions of boys; male PEs would take sessions with boys and I with girls. But now, very few boys come, so we take the sessions together.' – IDI, Peer educator

There is difficulty in explaining things to boys, male PE is also not able to explain them sometimes and boys also do mischief, they ask whatever they want (awkward questions).' – IDI, Peer educator

The NPOs and IDIs indicate that the married adolescent girls are not part of the PE sessions. It is difficult to mobilize married adolescent girls to participate in adolescent sessions, but the program staff is trying to capture them through Adolescent Health Day and other meetings at Aanganwadi centres. One account suggested that the number of married adolescent girls itself was less and hence their participation was low in the PE sessions.

'Married girls come to AHD; if we call them then they come.' – IDI, Frontline worker

'Married girls are less in number. They are not much involved as the number is very low.' – IDI, Block Coordinator

In addition, the stakeholders including adolescents themselves highlighted the importance of parental engagement around the unique needs of the adolescent and benefits of attending such sessions in order to mobilise adolescents and improve attendance in PE led sessions in the community. C3 is also engaging with parents in the community to encourage them to send their children to meetings as they would learn useful things there. They also engaged with women in SHGs to send their children to these meetings.

'Like they don't send us to graze cows and goats, they understand that it's more beneficial to send us here. Whatever we learn here we go back home and tell them, so they wish that we learn more and hence they do not tell us anything, especially on Sundays when everyone has a holiday, nobody asks us to do any household chores.' – FGD, Male Adolescent

'They (Parents) say that our girls are becoming smart now, earlier they used to be quiet.' – IDI, Peer educator

'Yes, we take meeting with parents as well. We have SHG meeting weekly. we conducted 4-5 meetings a month. And there we put this forward. we urge them to send their children especially boys. Because now a days it easy to fall into the trap of addiction (substance abuse).' – IDI, Block Coordinator

5.2. Strengthening of health systems

The interviews with C3 staff suggest that the program has been positively pushing the agenda for adolescent health in the state amongst competing priorities of maternal and child health and family planning programs.

'RKSK has never been a priority program for state government. We had to put in a lot of efforts to convince them and get their support for RKSK. It took us a very long time to convince them and get support.' – IDI, Program staff

C3 has been focusing on building capacities of frontline workers, namely, ANM, ASHA and AWW to improve delivery of RKSK program. For that, C3 conducts training and re-orientation of frontline workers on interfacing with adolescent boys and girls to ensure delivery of services to them. Along with trainings, C3 also puts efforts towards monitoring and handholding of FLWs in implementing RKSK activities. The program also facilitates organization of Adolescent Health Day (AHDs) in villages.

Trainings and reorientation of FLWs on RKSK

The role of FLWs is central to the RKSK. ANM plays an anchor role for the program by being a mentor and master trainers to PEs. ASHA workers implement RKSK strategies on ground including mobilizing and establishing adolescent group and helping PE in taking certain adolescent sessions. AWW plays a supportive role in RKSK implementation helping ASHA workers in mobilizing adolescents for sessions and AHDs.

The interviews with stakeholders suggest that capacity building of ANMs, ASHA and AWWs was done by C3 through one-day refresher training on RKSK for each group at block level. In addition, field level handholding and mentoring of FLWs along with monitoring support is also provided by C3. These orientation sessions focused on training frontline workers on engaging and counselling adolescents on issues of adolescence, referral mechanisms for adolescents with health issues, their roles and responsibilities under RKSK, and monitoring and reporting systems. In addition to conducting trainings and reorientations, the program staff also engages with the FLWs through regular interactions to discuss their progress and hindrances and understand if any assistance is required. The interactions also serve the purpose of monitoring, providing feedback, and solving field level issues with FLWs. The program monitoring suggests that C3 conducted refresher trainings (reorientations) of 239 ANMs and 1684 ASHA in Q3 out of a target of 760 and 2,850 respectively. All AWWs were trained in Q2 itself. Rest of the ANMs and ASHA will be trained in Q4 of 2019-20.

'When we organize our meetings that time they come and see, explain (things) to us and help us, when we meet (C3 staff) we ask them whatever we don't understand. They keep coming everywhere. (C3 staff) is also present in club meetings and keeps asking us (about the status and progress) whenever they come.' – IDI, Frontline worker

While trainings and review meetings were not observed, interviews with FLWs suggest that the trainings and reorientations were useful in making them aware of their role in RKSK program and adolescent related activities at the village level.

'*We were told about RKSK program that is going on under which (we learnt) what is anaemia and how to prevent it, violence, deaddiction, use of cloth during menstruation by girls and what diseases it causes, where to get tablet for anaemia, when to take and how to take, then we talk about these things in sessions.' – IDI, Frontline worker*

'Some change was there earlier; we have been working since many days. We came to what is Yuva Maitri Kendra (AFHC) after C3 training, we didn't know before that, now we know.' – IDI, Frontline worker

'We get a lot of knowledge. We did not know this much before. But after RKSK training, we got a lot of knowledge. Even talking with adolescents, interacting with them, the way they talk to us, it feels like our own

children.' – IDI, Frontline worker

A few FLWs also expressed the need for increasing the frequency and improving the quality of the trainings through increased engagements with ANM master trainers.

'Those were festival days, so training happened in haste. We got 3 days training (in Year 1, 2018-19, of the C3 program) then for training this time, there was not much told so don't remember. Training given to us is fine, we like the training. But if it was given from time to time then it would be better.' – IDI, Frontline worker

Issues around reinforcement of moral prejudices and negative messaging

The FLWs need to discuss various issues that include sensitive topics like physical changes in adolescents, menstruation, nightfall, and sexually transmitted diseases among other SRH issues with adolescents. The majority of FLWs indicated that they were comfortable discussing these issues. However, we observed an ASHA led peer session in one of the villages, as the female PEs who had been volunteering, had dropped out recently. An ANM was also present in the session. A total ten females and ten males were present in the session. The discussion in the session was focused around different topics including HIV, nutrition and child marriage. The observation of that session indicated that the session seemed ineffective in engaging adolescents due to inadequate preparation and delivery of the content by the facilitator. The communication in that session was found to be one-sided as none of the participants asked any questions on their own.

In addition, interviews with few adolescents and FLWs indicated that discussions around sensitive issues led to reinforcement of moral prejudices of FLWs. The interviews with a few FLWs indicated judgemental attitudes and messaging that may be enforcing social norms and moral judgments. Although, many FLWs openly and positively explained sensitive issues to adolescents, yet the consequences of any judgemental messaging, even from only a few FLWs, are far reaching as they not only reinforce existing social norms and stigma around such sensitive topics but might also deter adolescents from sharing their problems openly.

'We don't get many (abortion) cases but by chance, one or two come, like (girls) who go outside to earn, they come like this, locals don't come like that. – IDI, Frontline worker

'Initially when RKSK was implemented, girls used to come here wearing small skirts, but now everyone comes wearing long slacks…..Now no girl comes wearing a skirt, they wear only leggings because we didn't like that they were wearing (only) skirts, we explained them that whenever you wear, wear skirt over leggings.' – IDI, Frontline worker

'She told us that at this age we should not do anything wrong. We should not have any physical relationship.' – FGD, Male Adolescent

Facilitating the strengthening of AFHCs

Interviews with health workers suggest that C3 is playing a significant role in strengthening of AFHCs in both our sampled blocks. C3 was facilitating strengthening of AFHCs by identifying gaps in availability of supplies and infrastructure at the clinics, ensuring these gaps were addressed by engaging with Medical Officer In Charge (MOIC) and Block Program Manager (BPM) and providing IEC materials and other resources where required. Observation of two AFHC clinics was done based on RKSK supervision checklist. Findings showed that in general, materials and resources required in AFHC were available in both the facilities. Both AFHCs had separate rooms in the hospital building where auditory and visual privacy was maintained. One AFHC was open six days a week. It had IEC materials available only for nutrition, SRH and mental health, and not for gender-based violence, non-communicable diseases and substance misuse. While it maintained information about the clients, it was not detailed enough to be captured in all the required reporting registers separately. Consolidated reports did not have details regarding what issues the adolescent came up with and how these were treated/

managed. The other AFHC had all the IEC material available on all topics such as nutrition, SRH, gender-based violence, mental health, non-communicable diseases and substance abuse. It maintained information in all the required reporting registers. Consolidated report of the last quarter was available with information as per the standard format. But it was open only for 6 hours on two days of the week. The C3 staff also conducts monitoring and supervision visits at AFHCs once in 7-15 days to support the AFHC counsellor in her work. C3 keep following up with the AFHC counsellor on outreach visits from time to time. AFHC counsellors were positive regarding the support received from C3 in making the AFHC functional.

'Yes, we get (feedback) because if they see any shortcoming somewhere and if I am facing some problem in making report then they help. – IDI, Frontline worker

Gradually our Yuva Maitri Kendra is becoming intact with the support of C3. It was not fully functional before but now it is fully functional. When C3 officials visit they check everything, our maintenance, our keeping of service register, everything. – IDI, Frontline worker

Systemic Issues in making AFHC functional

In all the observed AFHCs, ANMs were appointed as in-charge of AFHC counsellors. The C3 program staff is engaged in capacity building of ANM (239 out of 760 completed by December 2019) to ensure service delivery to adolescents. Interviews with ANMs indicated reduced time for RKSK program and AFHCs due to competing work priorities of other health programs. In our visits to one of the AFHCs, it was observed that it remained open for 6 hours on 2 days in a week as ANM had other duties to perform.

'I am the only counsellor and I am available only twice a week because of which we are not able to reach sufficient number of adolescents and carry our responsibilities satisfactorily. If there would have been a special counsellor then he or she would have provided better services. One more reason is that adolescents are still hesitant about their problems. Even after coming here, they do not come to Yuva Maitri Kendra.' – IDI, Frontline worker

According to the C3 program staff, recruitment of counsellors has been delayed due to unwillingness of qualified counsellors to work at low salary. Efforts are being made by C3 to urge the government to increase the salaries or relax the norms for eligibility and provide them with appropriate training.

Poor Linkages between Community and AFHCs

AFHCs receive adolescent clients through walk-ins, referral from within the hospital and most importantly, referrals from the community through FLWs and PEs. One of the counsellors also believed that with the help of C3 staff, the number of adolescents approaching the AFHC had increased and outreach visits had also begun.

'Earlier when we used to report, the number of adolescents was less but now when we report the number of adolescents is more. Earlier we were not able to provide medicines but now we have facilities and we provide medicines. Earlier we did not do outreach but now with the help and suggestion of C3 we do outreach and get hold of many adolescents and provide them services. Because of C3, there have been lots of changes in our Yuva Maitri Kendra and positive changes.' – IDI, Frontline worker

However, our interviews indicate that the linkages of adolescents with AFHCs directly and indirectly through FLWs and PEs was still lacking. Chain of referral in the field begins with the PE to ASHA workers to ANM and finally to AFHCs. We observed that while all mediators were aware of AFHCs and their function, very few had actually referred anyone to the AFHCs. This might, however, also be because the adolescents were not reaching out enough to PEs and FLWs with their health concerns.

'We will go in the village and explain (to others), if there are any issues (faced by anyone) then we can send

them to AFHC……Like sometimes when (adolescents come) with itching in private parts, I explain them about maintaining hygiene and then I refer them if I don't have any medicines.' – IDI, Frontline worker

'If someone faces any problem, we will go (to AFHC). But no girl has come with any problem till now.' – IDI, Peer educator

The procedure says to refer adolescent with issues to Yuva Maitri Kendra, but I have not yet received any such problem.' – IDI, Frontline worker

There were mixed responses among adolescents regarding awareness of AFHCs and their function. In most cases, adolescents had only heard of AFHC and were not aware of its purpose. Some adolescents knew about the AFHC through second-hand accounts of their friends and spoke about accompanying their friends to the AFHC.

'We have heard (of AFHC) from here but do not know what it is.' – FGD, Adolescent

'I know about 'Yuva Maitri Kendra' but have not met Didi personally, I have seen her though. I know where the hospital is but never been there. In case any problem comes, I will visit there.' – IDI, Peer Educator

'We have heard about Yuva Maitri Kendra but have no clue as to what happens there. We have never been there. We have heard about it but can't recall from whom.' – FGD, Adolescent

'I visited with a friend. She was having a problem that needed to be checked.' – FGD, Female Adolescent

Adaptation to conducting AHDs

The C3 program staff also plays an important role in facilitating AHDs in all the villages twice every year. The interviews with FLWs indicated that C3 staff namely block coordinators are helping ANMs in drawing up micro-plans for AHDs including dates and activities to be conducted during AHDs, assisting in, mobilizing adolescents for the same and conducting some awareness sessions with adolescents on AHDs. These AHDs also see attendance of a few parents. FLWs check BMI and haemoglobin of the participating adolescents and play games and quizzes in the event.

'They help us whenever we have any problem, we call C3 and they come. Like if we are celebrating AHD and we are alone then it is difficult to mobilize (adolescents), we take help of C3. They bring their poster used in training and they also explain some (things).' – IDI, Frontline worker

AHDs are supposed to be held every six months in each revenue village as per the government directive. As one ANM caters to multiple villages in her panchayat, AHDs were being organized in different villages throughout the year. However, AHDs could not be organized as per schedule. As a result, since the last year, AHDs were implemented in campaign mode every six months, i.e. they were being organized in all revenue villages in January-February and April-June months only. One round of AHDs had been conducted in villages in the last year in April-June 2019. The second round of AHDs were planned to be held in the January-February 2020. But organizing AHDs in campaign mode cropped up another challenge. Under this mode, it is not possible to arrange for AHDs on Sunday in every village, leading to conflict with school timings, and fewer adolescents attending AHDs. Thus, fewer number of AHDs in a year and scheduling conflicts may result in underutilisation of this platform for engaging adolescent and community.

'We face the challenge of selecting a holiday for kids. They are at school at the time of AHD and it is not possible to fix a Sunday for every village. Therefore, we are not able to get hold of the kids. Therefore, we get to meet less students.' – IDI, AFHC counsellor

Adolescents were found to be aware about AHDs and its purpose. Some adolescents had heard of the AHDs but had never participated; others mentioned they participated in one long back and a few had participated

recently. While awareness seemed to be good, the intensity for adolescent engagement on such a platform seems low and enhancing participation in an AHD was still an area for improvement.

'It was conducted three years ago when we must be in 5th or 6th standard. Sorry I don't remember properly.' – FGD, Male Adolescent

'Yes, we have heard (about AHD) and went there this year. Not all boys and girls from the village come though. Around 29-30 come. The rest who have work to do don't come.' – FGD, Female Adolescent

'We have heard of it but do not know much about that.' – FGD, Female Adolescent

5.3. In-school component (Udaan)

C3 supports implementation of Udaan program in government and aided schools for classes 6-11 where students are taught about issues such as life skills, SRH, mental health as well as contemporary issues such as cyber bullying, and road safety among others. Two Udaan sessions are envisaged to be conducted per week. Two nodal teachers, one male and one female are identified in each school, who impart the Udaan curriculum to students. Training of nodal teachers is carried out by master trainers in each block. These master trainers are in turn trained by C3 staff at the state level. Master trainers are also involved in monitoring and supervision of the program. Master trainers to be trained from each block are identified by the government. Each master trainer and nodal teacher is given a curriculum book to refer while taking trainings or sessions. Training of nodal teachers for classes 9-11 had already taken place in the last year (2018-19) and hence, Udaan sessions for higher classes (9-11) were being organized regularly. Program monitoring data for Q3 of 2019 suggests that training of nodal teachers for classes 6-8 was ongoing (completed for 88% nodal teachers). Some nodal teacher trainings could not be completed due to the teachers being busy in post-election duty. These trainings were planned for the next quarter. Further, as per a government order, in-school Udaan program is to run for 6 months, from June-December. Hence, the Udaan sessions for middle classes (6-8) are scheduled to be conducted in a proper manner from June-December 2020. However, as training of many nodal teachers had been conducted for classes 6-8 this year, Udaan sessions were being conducted for middle classes in some schools as well with low intensity.

The observations of two nodal teacher trainings indicated that their trainings were organized as planned. Master trainers carried out the trainings with facilitation from C3 expert trainer and C3 field staff. They used different methods such as presentation, story-based group discussions, group presentations, and role plays. For training of nodal teachers of middle school, topics such as menstrual health, changes in adolescence, and life skills were covered. For nodal teachers of high schools, most topics were similar to that of middle school but also included some additional topics such as HIV-AIDS. The interviews with nodal teachers indicated that the content was appropriate and acceptable. However, nodal teachers felt that sessions for students in senior secondary classes could include contraception to inform them about delaying early pregnancy after marriage. Master trainers pointed to the fact that nodal teachers were hesitant about discussing issues such as menstruation initially but were able to discuss openly by the end of trainings.

'On day one of the interaction, we ask them (nodal teachers) about their expectations. They write down their expectations and then we understand that they have knowledge but are unable to present it. They are unable to open themselves up on sensitive topics like menstruation. As a trainer, we are trained well on how to initiate topics. We are also trained on how help participants open up and discuss about these issues. So, both male and female trainers have shown 100% participation and they put 100% efforts. We did not face any problems despite them hesitating initially.' – IDI, Master trainer

'We are living with them (students) for a long time, so they hesitate a bit in talking about these things (sexual health related) in front of us. But when madam (C3 staff) comes from outside, they are comfortable in talking.' –

IDI, Nodal teacher

'Both trainings are almost of similar type. The only difference is that children in ninth to eleventh standard are taught about AIDS and the ones in Raidih (middle classes), they are taught about menstrual cycle of girls, the changes in body of adolescent boys and girls, life skills and details about them. Both trainings were similar in my point of view.' – IDI, Nodal teacher

Perceived improvement through Udaan sessions yet limitations in reach and quality of implementation

There were awareness issues among adolescents in school about the Udaan sessions. The FGDs with adolescents suggested that they had more awareness of C3's out-of-school intervention under RKSK program as compared to their in-school component on Udaan sessions. A few adolescents who participated in the Udaan program in their school, were also part of the adolescent groups (under out-of-school component) in their villages. They confused between the two programs as they were similar in nature. A few adolescents also suggested better planning, regularisation and increasing the frequency of these sessions for further improvement in their knowledge around topics pertaining to adolescent development. FGDs with adolescents also suggested that Udaan session could be organized better as there were too many students, too much disturbance, and mixed gender participation leading to limited delivery of content of sensitive topics.

'We want more deep information about all the topics we discussed, Classes should be conducted at least 4 days a week.' – FGD, Female Adolescent

'This program (Udaan) should have to be fixed dates in a week. They (nodal teachers) come sometimes and sometimes not, so it should be fixed. If the dates are fixed, it would be good.' – FGD, Male Adolescent

'Everybody doesn't attend class regularly. But around 80-90 students attend.' – FGD, Adolescent

Another challenge is that of the quality of sessions may suffer due to limited interaction between the teachers and students, particularly on sensitive topics. Even though the nodal teachers indicated that they shared a good rapport with students, and students could approach them with their problems, the other stakeholder accounts suggest that interactions between teachers and students were not open enough to allow adolescents to share sensitive issues. It appears that nodal teachers as well as adolescents were hesitant and uncomfortable in discussing sensitive issues in Udaan sessions.

'Teacher doesn't talk much about these things (periods related) when boys are there….. In front of boys they don't talk about periods or any other sexually related topics…...' – FGD, Adolescent

'Yes, also we got a book but many students don't want to listen because they feel shy in front of us. When 'didi' comes from outside to teach them they participate properly ask doubts and answer their questions, but it is not the case with us.' – IDI, Nodal teacher

'When nodal teacher teaches, boys do not ask questions because they feel shy. They only ask a bit about AIDS. They ask something to the teacher and some other things they ask me. – IDI, BSUC Adolescent

'If someone has a problem such as stomach ache and is not getting periods on time, do you talk to your teacher?....No' – FGD, Adolescent

One of the interviews with a nodal teacher, however, indicated that myths around discussing sensitive topics such as sexuality still existed. In one instance, a nodal teacher felt that giving information to adolescents on SRH issues could have negative impact on adolescents. Such thinking runs the risk of perpetuation of stereotyping and wrong information among adolescents that may affect the expected outcomes around knowledge, attitudes and behaviours around SRH among adolescents from Udaan sessions in school.

'*Yes, there could be (difficulty in organizing sessions) in future like if we tell them these things, boys and girls will get attracted towards each other then what we will do.' – IDI, Nodal teacher*

However, even with the limited reach and quality of implementation of Udaan sessions in schools, adolescents who participated indicated perceived acceptability and usefulness of the sessions. A majority of the students in the FGDs and interviews indicated that the sessions had led to some perceived improvement in knowledge and awareness around various RKSK themes as well as adolescent issues in the local context.

'Yes, change has come, I got information about everything. During menstruation, I could not take many (precautions), I used cloth every time. My friends also did not know much, they also learned. During (menstruation), we should bath every day and if something remains dirty, then (we) get diseases.' – IDI, BSUC member

'It was interesting to hear about human trafficking. We shouldn't fall under any traps.' – FGD, Male Adolescent

Lack of clarity around role of BSUC members

As part of the in-school program, Udaan Club is to be formed in each school and few Udaan Club members are to be selected from among the students. An adaptation was done to the program strategy regarding the formation of Udaan Club. As per mandate of the Government, there can be no parallel structure to Bal Sansad[14]. Hence, Udaan Club has been merged with Bal Sansad, which are already in place in all schools, to form Bal Sansad cum Udaan Club (BSUC).

'Bal Sansad is in school for a long time, it fulfils RTE Act 2009. As per that, you should have Bal Sansad in a school, and we have been ordered by the department that we cannot have any team parallel to this. Udaan Club is there but it is not parallel to Bal Sansad. So, we try to form the Udaan Club with the help of Bal Sansad members.' – IDI, Udaan stakeholder

BSUC members are positioned as a link between students and nodal teachers. They are supposed to assist in conducting any activities under the Udaan curriculum and help students bring forward their concerns. Selection of BSUC members is done by nodal teachers and students. However, we found that only one of the high schools among the sampled schools had a BSUC member. This member also did not have much role in Udaan curriculum apart from resolving the queries of students. It was observed that none of the stakeholders had clarity regarding the role of a BSUC member. This may also be because no trainings have been conducted yet for BSUC members.

'Don't know, we just have to make students as members of Udaan Club. We do not understand any motive behind it.' – IDI, Nodal teacher

Whatever madam tells us is our responsibility, whatever we understand, we discuss among friends and among ourselves….. we don't do anything during the Udaan session.' – IDI, BSUC member

C3 block coordinators were interacting with the nodal teachers in the schools and ensuring that they were submitting reports on time. They also mentioned that they interacted with students occasionally. From the discussions with master trainers, it was found that they had a role in monitoring of Udaan activities along with Udaan Mitra, appointed at district level. However, this monitoring had not started yet. A strategy regarding monitoring of the program activities still needed to be formulated. The lack of monitoring oversight may have led to the program not being given much priority at school level.

[14] An elected body of students in a school that identifies issues, initiates problem solving approaches and drives impactful changes in their school

Seemingly, the Udaan component lacked intensity in middle schools and hence its reach was affected. The IDIs and FGDs also indicated concerns with the quality of the Udaan sessions in high school. This component seemed like it was not being prioritized as much as the other components in the program. The component needed improvement to be implemented as envisaged.

6. Discussions & recommendations

C3's approach to improving adolescents' agency, health, education and employability involves building up on two government programs; helping implement Udaan program in Jharkhand that targets in-school adolescents and strengthening implementation of RKSK that captures both in-school as well as out-of-school adolescents. The findings of the study were categorized under three components, viz. out of school, health system and Udaan. The discussion and recommendations in this section are also arranged around these three components.

Out-of-school component: The study findings suggest that the selection process of PEs did not follow all guidelines from RKSK in some places indicating a need to standardize the process. Our study findings indicates that in spite of mixed findings around the PE selection process, they were found to be acceptable among most adolescents that took part in the session. The PE led sessions were found useful by the adolescents due to the innovative methods of transacting information and were perceived to have led to improvement in health behaviours among adolescents. The quality of the PE led sessions was perceived to be satisfactory though there was a need for practical and demonstrative sessions that was suggested by the participants. Frequent mentoring of PEs from the C3 team could be helpful in this regard.

However, the program was also grappling with motivation as well as retention of PEs, particularly for male PEs. A model that provides incentives to PEs in the form of recognition in the community or engaging them in government skilling programs and other vocational activities for future employments may motivate them in transacting sessions regularly. This may involve C3 to be actively advocating around the role of PE and methods to retain them in addition to the training program that they are currently facilitating.

The participation of adolescents in the sessions was an issue, which was more pronounced for boys than girls. In addition, not having an appropriate and private place to conduct these adolescent sessions was possibly another barrier for good participation. The program would need to continue its adaptation of holding sessions post 4 pm and on Sundays to engage more adolescents. Creating awareness in the community about the unique needs of the adolescents and the utility of these sessions for development of adolescent can help nudge parents to send their children in these sessions and improve reach of the intervention. Engagement with community members through various platforms (such as SHG and gram sabha meetings) should be continued. A well-planned community engagement exercise with gate keepers that starts with identification of a clean, comfortable and private yet safe place for conducting sessions may further improve the acceptance and attendance of the sessions.

Strengthening of health system: FLWs also found their trainings (conducted by C3) helpful in making them aware of their roles and responsibilities that helped them with better engagement with adolescents. However, enforcement of FLWs' moral prejudices was found to be a concern. The trainings of FLWs should increase emphasis on building non-judgemental attitudes and positive messaging on sensitive issues, particularly related to SRH, to eliminate any biases they hold that deter adolescents in sharing their health problems.

C3 was proactive in improving the systems including in strengthening AFHCs through better reporting and maintaining the required commodities. Stakeholders also believed C3's effort had led to better reach of AFHCs with improvement in footfall. However, there were systemic issues with the AFHCs, which led to AFHC opening on fewer days and restricted reach among adolescents. The C3 should continue to strengthen AFHCs and advocate for trained counsellors that are present at all times in these AFHCs. The linkage between AFHC and the community needed strengthening. There is a need to create more awareness within community around the

existence and need of AFHCs. Intensity of AHDs as well as participation in AHDs also needed further improvement for adolescent and community engagement.

In-school component: The in-school Udaan component was not taking place as envisaged. Intensity of sessions in middle school was sporadic as training of nodal teachers was ongoing, but it affected reach. Although, some students indicated perceived improvement in knowledge and awareness through the sessions, hesitancy of teachers and adolescents around sensitive issues might lead to poor awareness on some of the issues discussed in the session. Too many students and mixed gender participation also led to limited delivery of sensitive topics in Udaan sessions. Capacity building of nodal teachers should focus on helping them engage better with adolescents and create an environment of learning. There is a need to focus on breaking the myths around sexuality and bringing openness in discussing sensitive topics. Refresher trainings with teachers can help with this. Moreover, C3 may need to increase their engagement with nodal teachers and adolescents in the sessions. Systemic issues did not allow to have separate Udaan clubs and integration of Udaan Clubs with Bal Sansads still needed to take off appropriately. C3 should continue to push for this integration activity and bring in more clarity about the role of BSUC members.

7. Conclusion

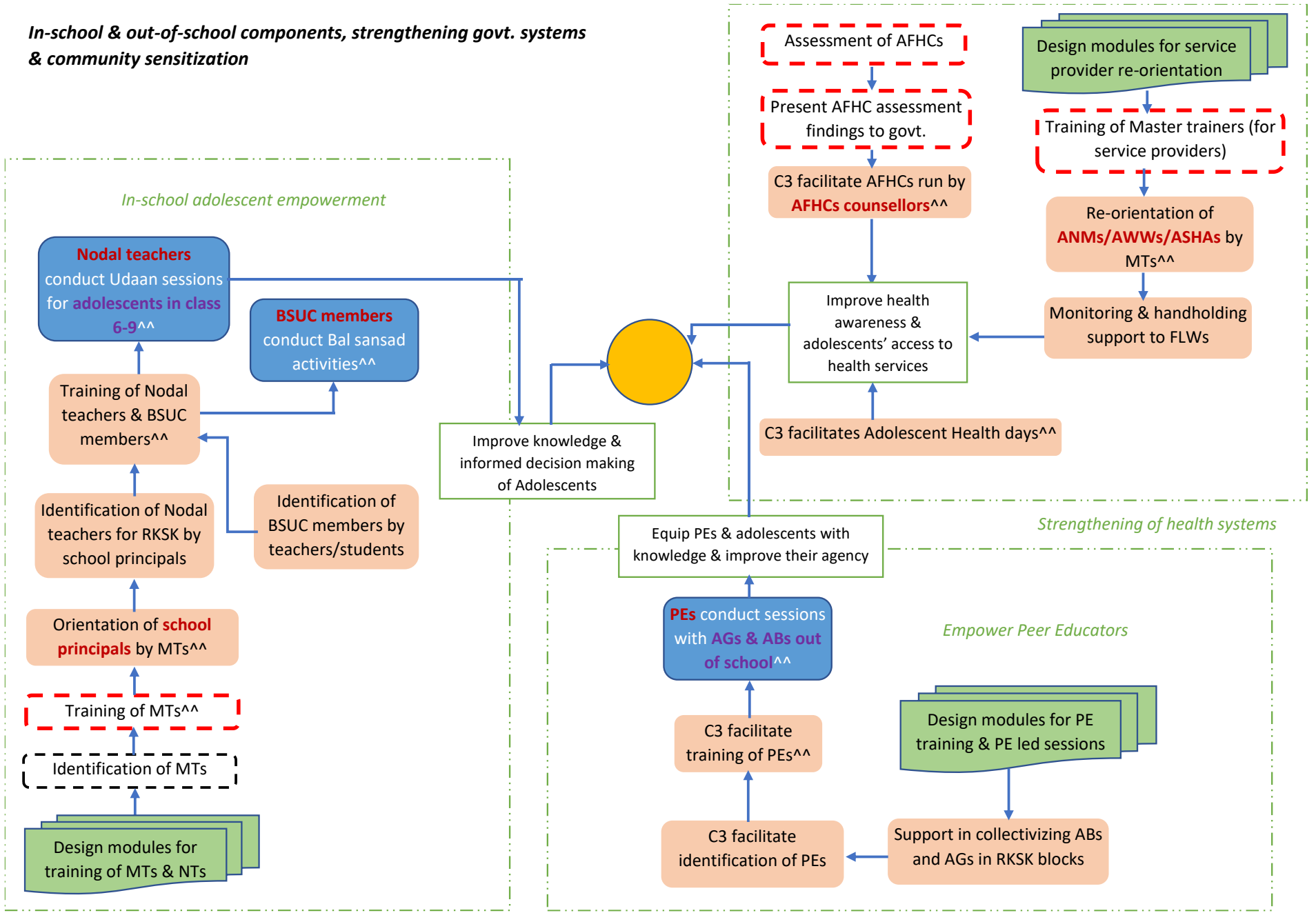
It is important to engage adolescents in and out of school to improve their agency, health and educational outcomes. Adolescent empowerment program in Jharkhand seemed to have certain positive and negative aspects around its implementation towards achieving these outcomes. Overall, it was perceived to be an appropriate and acceptable intervention for adolescents in and out of schools. However, it has yet not been delivered as intended. The program needs to improve mobilization of adolescents in the community. Training of nodal teachers and FLWs must focus on non-judgemental interactions with adolescents and focus on improving knowledge and attitudes towards health behaviours of the adolescents. In addition, service delivery through AFHCs needs to be strengthened through better community and facility linkage for better outcomes.

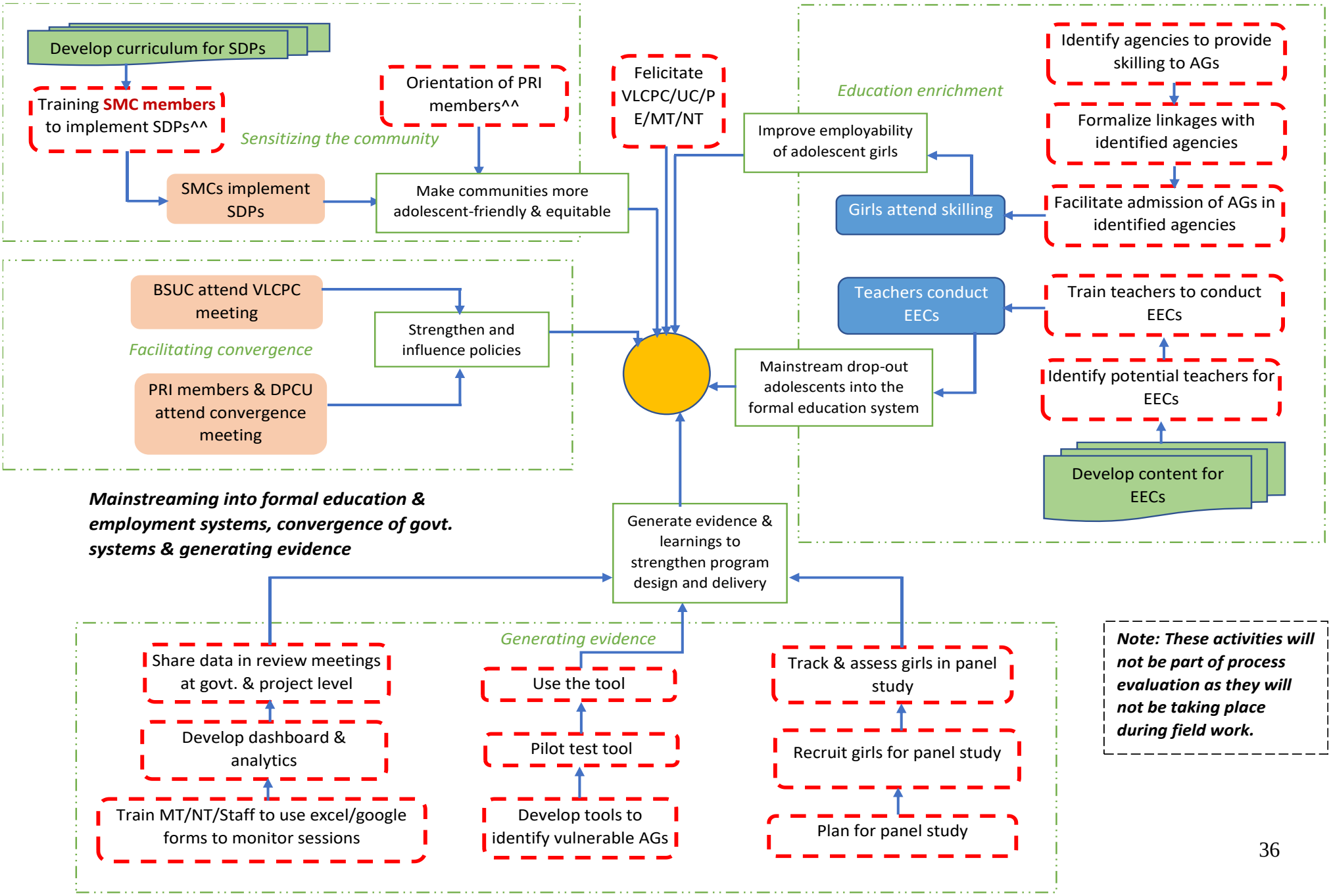
Annexure 1: Process Map

Key to processes

	Key documents/materials prepared for primary AEP intervention
	Process carried out by C3 team
	Process facilitated by C3 team
	Final goal envisioned by C3
	Process carried out by government machinery
	Process carried out by change agent
	Intermediate goal of the intervention
^^	Activities to be observed through non-participation observation
Stakeholders	Stakeholders to be interviewed in-depth
Stakeholders	Stakeholders who Focus Group Discussions will be conducted

In-school & out-of-school components, strengthening govt. systems & community sensitization




Develop curriculum for SDPs
Training SMC members to implement SDPs^^
Orientation of PRI members^^
Sensitizing the community
SMCs implement SDPs
Make communities more adolescent-friendly & equitable
Felicitate VLCPC/UC/PE/MT/NT
Education enrichment
Improve employability of adolescent girls
Identify agencies to provide skilling to AGs
Formalize linkages with identified agencies
Girls attend skilling
Facilitate admission of AGs in identified agencies
BSUC attend VLCPC meeting
Facilitating convergence
PRI members & DPCU attend convergence meeting
Strengthen and influence policies
Teachers conduct EECs
Train teachers to conduct EECs
Identify potential teachers for EECs
Develop content for EECs
Mainstream drop-out adolescents into the formal education system
Mainstreaming into formal education & employment systems, convergence of govt. systems & generating evidence
Generate evidence & learnings to strengthen program design and delivery
Generating evidence
Share data in review meetings at govt. & project level
Develop dashboard & analytics
Train MT/NT/Staff to use excel/google forms to monitor sessions
Use the tool
Pilot test tool
Develop tools to identify vulnerable AGs
Track & assess girls in panel study
Recruit girls for panel study
Plan for panel study
Note: These activities will not be part of process evaluation as they will not be taking place during field work.

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