Process Evaluation

Child in Need Institute (CINI) intervention under Dasra Adolescent Collaborative in Jharkhand

Submitted to
Dasra

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List of Abbreviations

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)

ASS Adolescent Safe Spaces

AWC Anganwadi Centre

AWW Anganwadi Worker

CINI Child In Need Institute

DAC Dasra Adolescent Collaborative

IEC Information Education Communication

FGD Focus Group Discussion

HSC Health Sub-Centre

IDI In-depth Interview

IRB Institutional Review Board

MRC Medical Research Council

NPO Non-Participant Observation

PE Peer Educator

PF Panchayat Facilitator

RKSK Rashtriya Kishore Swasthya Karyakram

SRH Sexual and Reproductive Health

VLCPC Village Level Child Protection Committee

WIFS Weekly Iron Folic Acid Supplements

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 that of Child in Need Institute (CINI), which is being implemented in Simdega and Saraikela Kharsawan districts of Jharkhand. The intervention aims at building technical skills of government health workers, building health related knowledge and awareness among adolescents and empowering them to have increased agency, and bringing in innovation in service delivery. The intervention is also working towards engaging community members through forming and functionalizing necessary community level groups and organizing community level events.

This study is aimed at undertaking evaluation of processes under CINI's intervention in Jharkhand. 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 Kolebira and Gamhariya blocks in Simdega and Saraikela districts respectively. Four villages and four schools were visited to conduct in-depth interviews, focus group discussions and non-participant observations with different stakeholders (program team, ANM, Sahiya, Anganwadi worker, AFHC Counsellor, and adolescents part of peer group sessions). Total 28 interviews, 8 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:

Peer Educator (PE) led sessions were being conducted by the PEs with handholding from Panchayat Facilitators (PF) when and where required. PEs were not yet trained on all modules, yet, they found acceptability among adolescents who participated in the sessions. Innovative methods were being used in PE sessions and exposure visits to banks, post office and police station were also conducted for some of the groups. The sessions were a good platform for adolescents to come together and discuss around health, life skills and education related issues. Session were perceived to be helpful in increasing adolescents' knowledge and awareness and building their self-esteem. However, some adolescents suggested introduction of practical topics such as working on computers, and more extracurricular activities in the sessions to make sessions more engaging.

There were issues around discussing sensitive topics such as sexual and reproductive health (SRH), physical relationships, sexual diseases etc. in the sessions. PEs as well as FLWs, to some extent, found themselves constrained while discussing such topics. This has led to bifurcation of sessions for male and females separately while discussing sensitive topics. Further participation of male adolescents was found to be low in most activities as well as in the peer group sessions. Program implementors from CINI and government staff believed mobilization of male adolescents was a challenge.

Awareness among PEs towards Adolescent Friendly Club (AFC) meetings was found to be low, hence there were participation issues in AFC meetings. Awareness levels of adolescents towards Adolescent Health Days (AHD) as well as Adolescent Friendly Health Clinic (AFHC) was also found to be mixed. While organization of AHDs is being regularized, it missed the target marginally. Number of adolescents visiting AFHCs in case of need seemed to have increased from before, yet the low availability of resources with AFHCs and larger distance of an AFHC from villages, made visiting it inconvenient. CINI has been able to make certain headway (but below target) in terms of forming Village Level Child Protection Committee (VLCPC) in a few villages. However, intensity of orientation of VLCPC members was low and their meetings

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

needed regularization. Training of health system members including Accredited Social Health Activists (ASHA workers), Auxiliary Nurse Midwife (ANMs) and Anganwadi workers (AWW) on better implementation of RKSK and effective engagement with adolescents also needed a push.

Recommendations:

Adolescents enjoyed the exposure visits conducted as part of the PE sessions. More such visits should be planned and facilitated in future. In addition, the content of the PE led sessions can be developed in discussions with the adolescents. Including some of the age appropriate skills building modules in the curriculum like computer applications or other vocational training skills may help in increasing attendance and engagement among adolescents.

The existing trainings of PEs and FLWs can increase focus on developing innovative and interactive methods to engage adolescent on sensitive topics. In addition, existing platforms like AFCs should be organized as per the target so that engagement with PEs is increased. This would require mobilisation and improving attendance of PEs on these platforms that may also help in cross learning among PEs on ways to overcome issues around discussions on sensitive topics. CINI can advocate and push for appropriate utilization of these platforms. The Adolescent Safe Spaces being created in the study area may be useful in encouraging discussions around sensitive topics for they provide privacy, confidentiality and safety to adolescents and should be encouraged going further. They may gradually break societal norms among adolescents. Intervention should focus on meeting the target of creation of ASS and attempt to increase their usage among adolescents.

There may be merit in continuing separate male and female sessions and having a male PF and male PEs in a male only session to help reduce shyness of adolescents. Low participation of male PEs can be countered by borrowing a male PE from a neighbouring village or panchayat to reach male adolescents and facilitate discussions with them.

At the same time, the community should be engaged more through existing platforms and made aware of the importance of improving knowledge and behaviour of adolescents on all topics for healthy development. The awareness and engagement with community should continue through interactive methods such as dramas, village level meetings, workshops etc. to break societal norms and stigmas within the community. With respect to mobilization of all adolescents in the sessions, responsible PEs, ASHA workers and PFs should together be tasked with mobilizing them in the sessions. Incentivization of adolescents, who attend PE sessions consistently and exhibit improvement in knowledge, and engaging them in extracurricular activities can also be thought of to encourage better participation. In addition, community level activities and events under RKSK including PE sessions, AHD, AFHC, safe spaces and village level committees provide platforms to have discussion, cross-learning, address health issues and develop solutions for child safety. These platforms can also be utilized to orient different participants and break taboos and myths around sensitive topics. The intervention needs to continue advocacy amidst decision-makers to facilitate timely formation, functionalization and regularization of all the above entities.

Conclusion:

The intervention has made headway in terms of engaging adolescents through group sessions led by PEs. This seemed to be improving awareness around health behavior and life skills among participating adolescents. However, low engagement of male adolescents and male PEs is leading to limited reach of the intervention. Existing societal norms, taboos and myths were persistent across the study area which led to restricted discussion around sensitive issues such as SRH, STIs, physical relationships, physiological changes etc. Some adaptations and measures were being taken to improve engagements with adolescents on sensitive topics but with limited success. Building appropriate capacities of FLWs and PEs is also required to improve their awareness and utilization of the available community level platforms. The limited intensity and low awareness around some of the existing platforms (such as AFC, AHD, ASS, village level committees) that could help with better reach and discussion with adolescents and community needs to be improved upon to augment engagement with adolescents and community members and facilitate discussion around child safety and improved behaviors for adolescent development.

2. Introduction

Adolescence is a phase of transition towards adulthood and characterized by rapid growth and development during which physical, physiological, psychological and behavioral 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 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

[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)

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 Child in Need Institute (CINI)'s intervention in Simdega and Saraikela-Kharsawan districts of Jharkhand and detailed findings from the process evaluation with respect to core activities envisioned under the intervention.

[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

3. About CINI's intervention

CINI's intervention aspires to improve access to social networks, create awareness and knowledge around health systems for adolescents; innovate practices in service delivery and in engaging with adolescents; strengthen systems for effective implementation of RKSK across relevant stakeholders. This comprehensive approach attempts to target all adolescents in the age bracket of 10-19 years through strengthening RKSK scheme. Currently the intervention is being implemented in 4 blocks and 60 gram panchayats of Simdega and Saraikela Kharsawan districts in Jharkhand.

The project works through the core strategies outlined in the figure below -

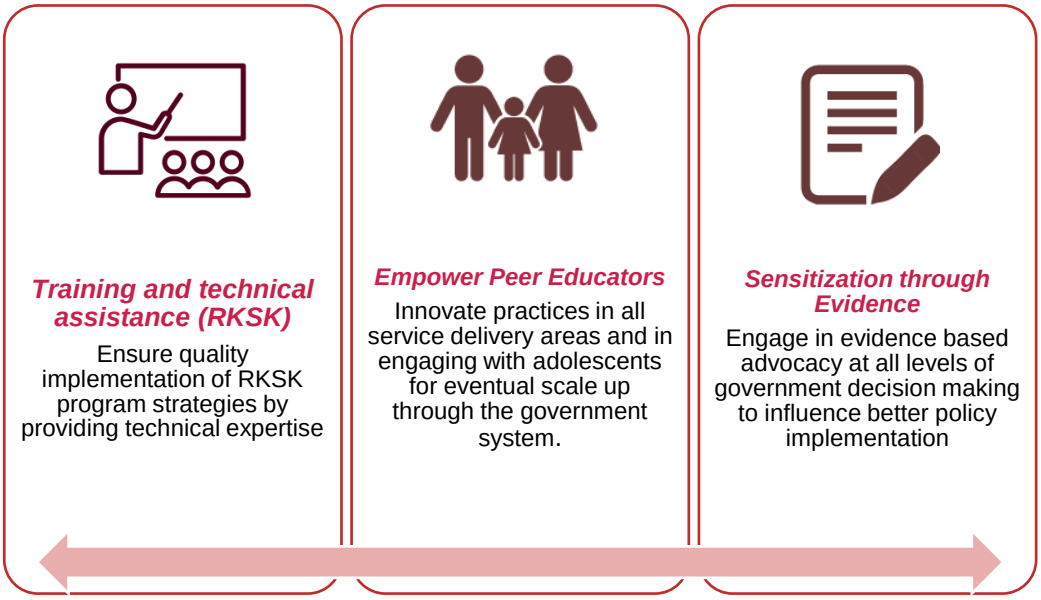


Figure 1: CINI intervention's Approach

The various intervention activities under the program are as follows-

1. **Training & technical assistance:** To strengthen the implementation of RKSK strategies, CINI is conducting trainings for service providers, front line workers and PEs. Apart from imparting trainings, CINI is also providing monitoring and handholding support to frontline workers in activities such as selection of PEs, organization of adolescent sessions and conduction of community level events. CINI is also engaged in strengthening Adolescent Friendly Health Clinics (AFHC) and the referral chain, and influencing for improvement in supply chain of materials in AFHC as per RKSK norms.

2. **Innovation and empowerment:** To enable adolescents under RKSK to make informed decisions and take collective action, CINI is facilitating selection of PEs from the communities, providing them trainings and necessary resources, supporting transactions of sessions through innovative and interacting mechanisms. Frontline health workers (FLWs) are also being trained to create village level safe spaces for adolescents.

3. **Sensitization through evidence:** CINI intends to fill the data gaps in presenting adolescent issues. Through the intervention, it engages in evidence-based advocacy with government stakeholders through regular meetings. CINI is working to strengthen village level committees to transform the social environment to be more child friendly. They are also engaged in identifying and addressing vulnerabilities among adolescents.

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:

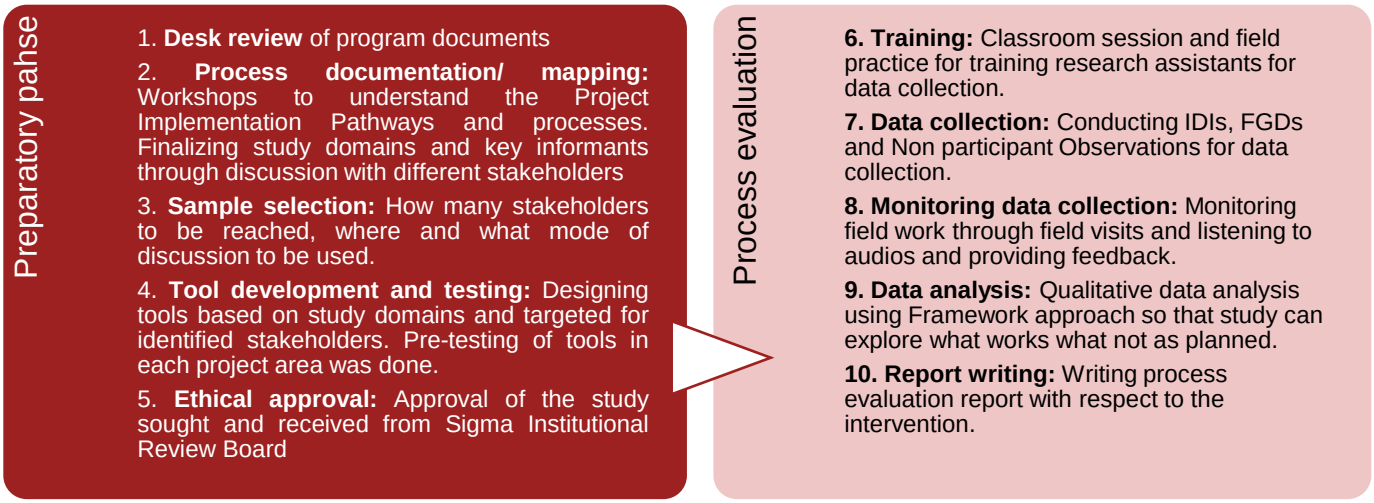


Figure 2: Study approach

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 and outlining the scope of the 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 through evidence' component and the processes around remedial coaching centres and vocational skilling 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 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)**

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

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 (Kolebira and Gamhariya) were selected from a total of 4 blocks where the intervention is being implemented in the two districts. Further, using the given criteria, CINI provided a list of gram panchayats in these blocks. 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. This is tabulated below **(Table 1)**:

Table 1: Sample selection of block and village

Block	Village
Kolebira	Lachragarh
Kolebira	Keyondpani
Gamhariya	Narayanpur
Gamhariya	Beltand

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 the intervention, in each sampled village visited, interviews were conducted with two PEs (one Male and one Female PE) in each village and focus group discussion was done with a group of adolescent boys and girls separately in each village. Those PEs preference was given to those who had received PE training the earliest and those who had transacted adolescent group sessions. For FGDs with adolescents, four were done with girls and four were done with boys. We undertook FGDs with adolescents of different age groups. Attempts were made to include at least two non-school going adolescents in the discussion.

In each block, one ANM, one ASHA worker and one AWW were interviewed. Attempts were made to include those who had received RKSK orientation from CINI during project period. AFHC counsellor from each block

[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.*

were interviewed. One IDI each with an adolescent boy and a married adolescent girl were conducted in each block. Panchayat Facilitator from each village was interviewed.

NPOs of activities that were conducted during the data collection period were done. These included observation of training of PEs, PE led sessions, AHD, training of service provider (PF) and two audits of AFHC. In all, 28 IDIs, 8 FGDs and 8 NPOs were conducted. The proposed sample size and data collection methods for stakeholders are provided in the table below **(Table 2)**:

Table 2: Sample selection across stakeholders

Child in Need Institute (CINI)		
Target respondents	**Sample size**	**Data collection method**
Project officials (implementation team)		
District level	2 (1 per district)	IDI
Block level	2 (1 per block)	IDI
Sample distribution among Stakeholders involved in out-of-school activities		
Peer educator (Saathiya)	8 (2 per village)	IDI
Adolescent male and female (participants of peer group sessions)	8 (2 FGDs per village)	FGD
Married female adolescent	2	IDI
Married/ unmarried male adolescent	2	IDI
Other stakeholders		
ASHAs (Sahiya)	2 (1 per block)	IDI
AWWs	2 (1 per block)	IDI
ANMs	2 (1 per block)	IDI
AFHC Counsellor	2 (1 per block)	IDI
Panchayat Facilitator	4 (1 per village)	IDI
Non-participant observations		
Training of PEs	2 (1 per block)	Non-participant observation (NPO)
Peer leader imparting training to the group	4 (1 per village)	
Training of health service providers and FLWs	2 (1 AFHC counsellor & 1 FLW)	
Training of master trainers - ANMs - 1-day training	2	
Adolescent Health day	4 (1 per village)	
Visit to AFHCs	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 analyzing 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.
- **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 CINI's intervention 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.

[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.

[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.*

- Some processes were excluded from the scope of the evaluation based on mutual discussion with CINI 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

CINI aims to improve agency, education, health and child protection outcomes in order to facilitate healthy and safe transition to adulthood among adolescents in Jharkhand. CINI is currently working with state government to strengthen implementation of RKSK in Jharkhand through promotion of healthy behaviors among adolescents and by fostering better engagement with community members. As a part of this intervention, CINI is trying to build capacities of FLWs including ASHA workers, also known as Sahiyas in Jharkhand, ANMs and AWW on better implementation of RKSK. The CINI staff, in particular, the PFs, are handholding the FLWs to create village level safe spaces for adolescents, and strengthen AHD, as well as refer more adolescents to AFHCs and mobilize PEs to AFCs. The CINI staff, including the PFs, are also involved in the selection of PEs and in handholding them to conduct sessions on RKSK PE module with adolescents on life skills, child protection and education. In addition, CINI is also engaging community members to ensure child safety in the villages. These processes are detailed out in process maps included as **Annexure 1**. The 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.

Panchayat Facilitator as a key mediator in implementing the intervention

The PFs play a pivotal role in community engagement and facilitating some ground level RKSK activities like selection process of PEs, organising and handholding PEs in delivering sessions to adolescents, and facilitating regular organization of AFCs for the PEs. The PFs, along with other CINI staff, help organize and facilitate AHDs and attempt to ensure that the AFHCs formed at Community Health Center (CHC) and run by the AFHC counsellor, meet the designated norms of RKSK. PFs also assist FLWs with their work, which includes mobilizing adolescents, creating awareness and monitoring distribution of iron supplements in and out of school, and engaging with community stakeholders about adolescent health. They also identify and facilitate creation of safe spaces for adolescents in the community. The program monitoring data suggests that a total 60 PFs needed to be placed at gram panchayat level and currently 55 PFs were on roll and filling in for the work of 5 vacant posts.

The PFs are trained on the intervention, aspects of RKSK, their role, PE modules and the project MIS. Their training is a continuous process and is taking place in phased manner. A training of PF on life skills and sessions on creativity, emotional management etc. was observed as part of the study. Session was attended by 20 PFs and training was imparted by CINI staff that included district training coordinator, block coordinators, and other programme officers. The session was lively with both trainers and participating PFs being highly enthusiastic. The PFs were engaged in the training through games and activities. The trainers provided feedback after every activity. The trainers encouraged discussion among participants and participants seemed to enjoy the sessions.

The interviews with PFs suggest that they found their training useful and appropriate to help them with their routine work. They, however, noted that their trainings could have been of longer duration. They believed that current duration of the training was not sufficient to cover the plethora of information that was being imparted during their training. Delays in getting the relevant resource material was also another issue according to the PF. They highlighted the need for resource materials during the sessions itself to understand training topics in detail and have more informed discussions.

"Training method was really good. Project team (CINI) told a lot of things and they conveyed it well." – IDI Panchayat Facilitator

"The training was interactive. They taught us through games. There were group exercises. We kept our shyness apart and learnt a lot. However, I feel if it was extended for a few more days it would have been

better." – IDI Panchayat Facilitator

"Perhaps the training period could have been extended for two or more days. We were all new to this and first time we were to a new place, so I could not gather much in the initial days." – IDI Panchayat Facilitator

"If we are given material related to those points on the same day, it will be useful. Material is given to us after 2-4 days. If it is given on the day of training, we can look at the topics right there. We can contribute in the discussion as well and have more concentration. It would be good." – IDI Panchayat Facilitator

It was found that PFs were contributing to all the activities discussed above in the section. They initially faced difficulties in engaging the different stakeholders including community members, health workers, and school personnel, but with time and sustained engagement they managed to find acceptability with majority of these stakeholders. The community members, adolescents, and health workers appreciated their support and were of the belief that the activities in the intervention that were facilitated by the PFs has been able to bring some positive developments with respect to health in the community.

In addition, the PFs handheld PEs during group sessions and contributed when required, such as on bringing in technical details on various topics and discussion on sensitive issues that PEs hesitated to discuss. They encouraged adolescents to participate in these sessions and be open in discussing their issues with the group and with the PE. Adolescents as well as PEs appreciated PFs efforts in bringing them to sessions post school hours and encouraging them to be frank and open in discussing about any of their issues. This is also corroborated through interviews with PEs and FGDs with adolescents.

"Initially we used to sit quiet in meetings and then few of the girls said you are PE tell us about some topic or make us understand and I was like I don't know how to start with but then Didi (PF) told us to observe and learn from her and I learned from Didi… then I started asking them if you face any problem you can discuss with me or you are being pressurized to perform anything you can share with me." – IDI Peer Educator

"I meet PF in the adolescent meetings two times in a month and in Anganwadi. It feels good, we talk like friends." – IDI Peer Educator

"When we have our meetings, that time only she asks to call everyone to gather." – FGD Female Adolescent

"He encourages us to be open …yes, we talk anything with him in a friendly way." – IDI Male Adolescent

"We openly discuss all topics with her... We talk to her in private for any sensitive issues." – FGD, Female Adolescent

The PFs also monitored community activities including AFCs and AHDs and attempted to ensure that events take place at appropriate intervals by also being part of the sessions. They supported FLWs in performing their work effectively. PFs are working to spread awareness in the study area to improve health by guiding adolescents and community members through frequent interactions. Selection of PFs from the community helped with their acceptability and well-organized trainings enabled PFs to perform the tasks as envisioned by CINI.

"She helps us whenever we need her, she works equivalent to us." – IDI AWW

"We, ANM didi and PF make their families understand. Then families send their children." – IDI ASHA

Some of the activities and platforms discussed above are elaborated below with findings around the barriers, facilitators, benefits and challenges faced in the implementation of the intervention.

Perceived acceptability of PEs but issues around capacity building of PEs

CINI is supporting empowerment of adolescents by facilitating the Peer Educator (PE) component of RKSK program. This component of the intervention includes selection of one male and female PEs, from the community for a population of 500 in a village. These PEs are supposed to conduct two sessions every month with male and female adolescents in their village to create awareness on healthy behaviors and importance of education and attending schools.

Although a standard process of selection of PE was not observed, the process was still found to be democratic and based on merit. In most cases, the PE selection was found to be based on the views of adolescent group members, and in one case, based on quiz competition conducted among the adolescents. In certain cases, where there were limited nominations for the role of PEs, PFs and ASHA workers themselves chose the PEs. PFs as well as ASHA workers facilitated the process of PE selection.

"Quiz was organized in which those who answered most questions correctly were selected and other adolescents were then also asked to select among them … other adolescents in group and our PF also proposed my name for PE." – IDI Peer Educator

"At a few places we (PF and ASHA workers) selected the volunteering candidates and where there was voting, we selected the one with higher number of vote counts." – IDI Panchayat Facilitator

"We (adolescents) only elected her (PE) here through elections." – FGD, Female Adolescent

The choice and selection process of PE culminated with approval from adolescents in most cases. Hence, the PEs found acceptability among the adolescents, which may be essential for a better interaction in the sessions.

"She (PE) is nice. She explains us at everything. She even tells stories and guide as at every point by explaining things. I was afraid initially, but not now." – FGD Female Adolescent

"We feel good and like to attend sessions and group meetings. PE explains things very well. They belong to our village so there is no fear. We share our problems with the PE but not with each other." – FGD Male Adolescent

"He is knowledgeable. He is aware of each and every topic discussed." – FGD, Male Adolescent

CINI is facilitating the PE training as building capacity of PEs is essential for them to perform their role effectively in adolescent sessions in the villages. As per the program monitoring data, 697 PEs from the total 1200 PEs were trained in the in the last quarter (Q3). The remaining PEs are supposed to be trained in the next quarter and next year while the CINI staff, particularly PFs, also facilitate AFCs that are meant to be learning platforms for PE throughout the year. The training of PEs on life skills was conducted by CINI program team in presence of PFs. As per RKSK, the PE training are supposed to be conducted by the ANMs. However, CINI is currently conducting these trainings as the ANM training was ongoing. Going forward, ANM master trainers, trained by CINI program staff, will undertake training of PEs on RKSK themes.

The interviews with the PEs indicate that they found their trainings informative and interactive. An NPO of a PE training session also corroborated the finding around perceived quality and acceptability of the training session among PEs. Half-day of the 2-day PE training was observed. The trainer for the session, a program officer from CINI in this training session, seemed confident and actively involved in sessions. The trainer delivered the session using interactive methods such as group discussion on emotional changes during adolescence, group activity of writing letters to relevant authorities on issues such as child marriage, sanitation and mid-day meal, demonstration of nutritious food items (tomato, green leafy vegetables, rice, pulses, wheat) required for growth and development. The participants seemed engaged during the sessions, as they responded to the questions posed by the trainer, although the number of questions or clarifications raised by them were less. The female PEs seemed more attentive towards the sessions than male PEs.

"The training was good. We were told about life skills including self-awareness, sympathy, mutual relationships, communication, decision taking, problem solving." – IDI Peer Educator

"They told us about Hemoglobin and iron tablets. Yes, the training was useful, I got to know about intestinal worm infestation and its medication. They also told us about our rights. The quality of training was good." – IDI Peer Educator

Organization of Adolescent Friendly Club (AFC) meetings, one of the community-based approaches under RKSK, brings together PEs from nearby villages under one roof. Hence, these meetings encourage cross-learning and motivate PEs to discuss their issues and get resolution from the ANM. These meetings may

also be a good platform to enable the PEs to learn around methods of engaging adolescents on all topics including discussions on sensitive topics. The interviews with FLWs and PEs suggest that ANMs conduct AFC meetings once in a month at HSC or AWCs which is as per protocol of RKSK. The IDIs with PF indicates that they facilitated the AFC meetings while CINI program staff like block training coordinator, DCs, district training coordinator (DTC) attended the meeting whenever possible. The interviews with PEs reveal that while most PEs had participated in the AFC meetings, there were a few PEs who were not aware of AFC meetings. While the FLWs along with the PFs made efforts to mobilize PEs for the meetings, they faced challenges in mobilizing them as PEs were often preoccupied. They had to go to work and attend school among other tasks.

"In club meetings, we have games and discussions over health, nutrition and sexual and reproductive health, we hold meeting for not more than 2 hours and once in a month." – IDI Peer Educator

"We undergo Anaemia and Haemoglobin testing, height and weight check at the AFC meeting." – IDI Peer Educator

"No, I haven't heard about AFC. I have not attended any AFC meeting." – IDI Peer Educator

Perceived quality and issues around PE led sessions

As per the program monitoring data, 535 PE groups were active in CINI's intervention area till Q3 of 2019, with regular group meetings being conducted as per the activity plan. CINI had been able to reach out to about 40,000 adolescents across project villages through these group meetings and other activities, platforms and forums (such as AFC, AFHC, AHD etc.). PEs lead the group sessions with adolescents. These sessions were being supported by ASHA workers, facilitated by PFs from CINI, and occasionally joined by ANMs, who talk on specific issues. The PE led sessions included discussions and information around various topics prescribed under RKSK, including hygiene, safety, substance abuse, cleanliness, safe sex; and life skills.

The NPOs suggest that the gender composition of the PE led sessions was based on the topic of discussion. Two of the PE sessions were taken together for male and female adolescents and discussion included life skills, nutrition and substance abuse. One session was organized only for female and discussed on menstrual cycles and menstrual hygiene. However, the male PE was present in only one of the sessions. Attendance in the three sessions ranged from 8 females in female-only session to maximum 20 adolescents in one session. PEs made use of flipbooks, black board and interactive activities to make the sessions more engaging. The participants seemed attentive and appeared to enjoy the sessions. However, the PEs should also encourage adolescents to speak up and ask questions to promote two-way communication in discussions. Female only session deliberated over physical maturation in a female and good practices in terms of hygiene that should be followed during menstruation.

Majority of adolescents who participated in the peer group sessions had positive things to mention about the PEs and the sessions. The FGDs with adolescents suggested that adolescents found the peer group sessions interactive as innovative methods were used to conduct sessions such as storytelling, games, role-play etc. Adolescents also found the peer group sessions helpful in increasing their knowledge and awareness and building self-esteem. These adolescent sessions were described as a suitable platform for socializing among adolescents of the village. In addition, incentives like receiving sports material on some occasions, increased motivation among adolescents to attend the sessions.

"It feels good attending the group sessions. Things which are not discussed at home are discussed in these meetings when we gather here. We discuss regarding menstruation, intoxication, nutrition, right age of marriage." – FGD Female Adolescent

"Yes, the self-confidence has been increased. Notions and wrong perceptions are also vanishing after attending sessions these sessions." – FGD Male Adolescent

The FGDs also revealed certain innovative processes were being facilitated by CINI through PEs for engaging adolescents in the community. An example of such a process was an exposure visits for a certain

group of adolescent boys and girls were organized to a post office, a bank and a police station to make them understand about their functioning and giving them a general worldview.

"We have been taken for exposure visits to old banks." – FGD Male Adolescent

"They have taken us to a post office. The postmaster had given us information regarding how to get a good job and salary." – FGD Female Adolescent

"Yes, we find them interesting. We do not even feel how the time passes and sessions come to end." – FGD Male Adolescent

However, a few FGDs indicated the need to improvise on the existing content of these sessions. Some adolescent girls indicated their desire to learn about operating computer and filling up forms online, while boys also seemed to be inclined towards extracurricular activities along with education; suggesting their inclusion would improve the sessions.

"Yes, I feel knowledge of computer – how to switch it on and turn it off – could be added more in the module. Also, if we are informed about some forms and how to fill them up that would be better." – FGD Out of school Female Adolescent

"More topics should be added, like children are interested in studies as well as sports, so that can be added. Some are also interested in acting and plays." – IDI Male Adolescent

The issue of engaging adolescents on sensitive topics in PE led sessions emerged as a particular area of concern. The Interviews with PFs and FGDs with adolescents revealed that some adolescents and PEs found it uncomfortable to discuss sensitive issues. Any discussion on sensitive topics particularly pertaining to Sexual and Reproductive Health (SRH) such as physical relationships, contraception, sexually transmitted infections etc. led to awkwardness among the participants. Both, male and female adolescents found it uncomfortable to discuss sensitive issues in presence of the opposite gender.

"We find sexual and reproductive health a difficult topic to understand. We usually keep our doubts to ourselves on SRH." – FGD Male Adolescent

"We ourselves will not ask any such issues (SRH) before the boys, we will ask later in privacy." – FGD Female Adolescent

They (male adolescents) don't even discuss SRH with male PE. They hesitate. They do have issues (such as nightfall, unsafe sexual relationships etc.), but they keep it to themselves and don't share." - IDI Panchayat Facilitator

"Whenever I try to discuss on this topic children become silent and it seems that they are very shy. I tell them that these changes are very normal in teenage and it should you openly discussed. If you shy, the problems would not be solved it would increase." - IDI Panchayat Facilitator

"They hesitate a little, also out of shyness they are not able to discuss openly about such topics. Some are fluent they talk openly but some still feel shy to speak up. Like the girl educators are quite open and they talk about menstruation frankly now which was not the case earlier. We discuss these topics quite openly but some of the boys hesitate a little when it comes to such discussions over sexual health topics." – IDI Panchayat Facilitator

The intervention had made an adaptation by taking separate sessions for male and female adolescents in case the issues discussed were sensitive to encourage better participation of adolescents. Although, we still observed low levels of interaction between adolescents and PEs even in case of separate sessions, adolescents were found to be more attentive in separate sessions. However, discussion on sensitive issues can't be side-lined if it comes up in sessions taken together with male and female.

In addition, CINI is also actively engaged in identifying and facilitating formation of Adolescent Safe Spaces (ASS) at the level of revenue village that could also help in interaction among adolescents and encourage discussions on all issues among adolescents (both male and female) within the village. ASSs were also equipped with Dropboxes to cater to any questions, or complaints from adolescents regarding any topics including any sensitive information and maintain anonymity. These boxes provide opportunity to adolescents

to ask questions anonymously that they would otherwise hesitate to ask openly. These were then then taken forward by PEs to ANMs for resolution. These spaces while providing privacy to adolescents were also approachable to PEs. At some places, the community hall in the school was designated as a safe space whereas at other places, an area in Aanganwadi Centre was identified as a safe space. These spaces were provided with stationaries and sports equipment to engage adolescents in creative activities and games. These ASS had drinking and washroom facilities as well. This addresses issues for adolescents who want to get their queries resolved but ensuring anonymity. It was found that PF and block coordinators helped in identifying these spaces, which were ultimately provided by the community. The program data indicates that 122 such spaces against the target of 200 were identified and made functional and helping adolescents engage with each other. During data collection, we were not able to get the details of usage or perception of ASS.

"We did an arrangement of complaint box at every safe space. We call it Dropbox. In that Dropbox, they (adolescents) can put questions and complain about anything like health or education. If the issue is related to health, then we forward it to ANM Didi. PE educator gives these questions or complaints to ANM in AFC meeting. Then ANM didi tries to solve those problems." – IDI Block Coordinator

Issues of limited reach among male adolescents through PE sessions

The RKSK program in general saw less participation of male adolescents in the villages. Engagement of male adolescents was found to be low across activities including in leading a peer group session, participating in peer group session, or visiting AFHC. Interviews suggest that one possible reason for this could be that they had to engage in livelihoods activities to sustain their families or migrate out of village to study or work. Male adolescents were also found to be engaging less during mixed peer group adolescent sessions conducted in the villages. Male adolescents found it particularly inconvenient to discuss SRH, even with the male PEs. Further, it was found that there were lesser number of male PEs in some areas and female PEs were taking sessions with boys, which is possibly leading to male adolescents being hesitant in discussing SRH. Another reason is disinterest among male in these sessions. They preferred playing games rather than attending these sessions. Less participation of male adolescents is leading to low reach of the intervention, which is making headway mostly through female participation.

"They (male) came when elections were held. Now they don't come. On telling that they will get snacks, they came once or twice. Now they don't come. They must be feeling weird about what we teach them." – IDI ANM

"Usually the number of boys are less in the gatherings but the participation from girls is quite good." – IDI, ANM

"I don't get the time to attend sessions because I have to run a grocery store." – IDI Male Adolescent

"Since boys and girls both remain present in the sessions, we cannot talk freely." – IDI Male Adolescent

"Boys are usually less frequent to approach. Usually boys from 15-17 years of age are less approaching. Smaller kids from 10-11 years do come. Girls of all the age till 19 approach us." – IDI AFHC counselor

"We generally organize the meeting after school at 4 pm or on Sunday morning so boys were indulged in playing games like cricket, football or badminton, they have not much interest in group meetings." – IDI Block Coordinator

Need for capacity building of Frontline Workers (FLWs)

In order to address discussing sensitive issues, training of FLWs along with PEs becomes essential. One round of training of FLWs had been conducted previously. CINI has planned for further orienting service providers (including ANM, AWW, ASHA workers and nodal teachers) on elements of RKSK and engaging with adolescents. This requires orienting 1200 ASHA workers, AWWs and teachers (for a day) and 150 ANM master trainers (3-day training). So far, while all ANM master trainers were trained, only 180 ASHA workers from two blocks could be trained as required government permission was received only for their training. Orientation of more ASHA workers, AWW and teachers is scheduled to be done over the next quarter.

Those who got trained felt the trainings were useful in engaging better with adolescents. However, the envisioned number of trainings could not be completed.

"We definitely feel that our knowledge has improved, and we feel good after sharing this information with adolescents. Previous trainings (non-CINI) were also useful, but this one helped us communicate effectively with adolescents." – IDI ASHA worker

"Initially we were not comfortable in talking openly in front of children, we also used to feel shy in talking. We were told openly during training and we got confidence that we can also go and talk comfortably in meetings. Then we tried and it happened just like that. We got self-confidence about talking openly." – IDI AWW

"Yes, changes are there. Initially, even I used to feel hesitant while talking with the children. I did not have much knowledge. The children were also reluctant. But now the scenario has changed. I talk to them more freely. Now all are trained, including the ANMs who conducts the meeting for adolescent girls and boys. These changes have occurred due to training. It is better than before." – IDI AFHC Counsellor

"Training was good and I feel good after attending it. It is helping me now." – IDI AFHC Counsellor (ANM)

FLWs felt hesitant and shy in discussing sensitive issues with adolescents, in particular with male adolescents. This hesitation was also because of the fear of backlash from the community as their messaging went against the existing social norms. This may be indicative of the existing societal norms and stigmas attached to sensitive topics such as sexual health among adolescents as well as among community members. Thus this lack of intensity of FLW trainings had potential effects with respect to mobilization and reach of adolescents and engaging adolescents and parents in the community, particularly on sensitive issues.

"Being a female, it becomes difficult for me to answer every question, especially to the males… Questions related to topics like sexual diseases or wrong habits and practices of children. In such cases it becomes a little difficult. I face difficulties with the males only. For the females I call the girls and adult females and discuss with them but discussing these with the adult males becomes a little problematic." – IDI ANM

"I feel shy, I think that what will they think that what didi is saying." – IDI AWW

"We are also afraid sometimes telling sensitive things to adolescents, we have to face their parents in villages. They would scold us for telling their children unwanted things. But our duty is to inform them despite all possible results. Finally, I gather courage and ask girls, but they still don't speak up." – IDI ANM

I had gone to the other village, there was a sahiya didi there, I ask her to bring children, but their parents said that why were we teaching bad things (particularly SRH)? So they had a little argument with the Sahia. I didn't like that at all but what can be done. Later, a meeting was held and it was good but his child did not come. – IDI, Panchayat Facilitator

Issues around reach and platforms for community engagement

In order to spread awareness in community on health and to mobilize more adolescents, in particular male adolescents, CINI staff engages with parents in the community to send their children to PE sessions and to school, if the children are not enrolled. Some parents are engaged through one-to-one interactions by PFs in every village. Parents are also made aware about child protection issues through these interactions and encouraged to send their children to group sessions. CINI, through another agency, conducted events such as Q&A sessions and street plays in 20 villages to spread community awareness around child vulnerability issues. Program monitoring data suggests that they have been able to reach up to 16422 parents against 18000 to be reached in the first three quarters of 2019 (this could however include reaching out to same parents). Engaging community members can be helpful in increasing adolescents' attendance in sessions and introducing openness in discussing sensitive topics.

"With parents and committee members my main aim was that in an adolescents' group there is less participation from the boy's side. In a group of 20 people, the number of boys present in it was 5 to 6 only. We convince the parents that you are sending the girl child in the meeting also send your boy. Because the boy's attendance is very less. We also inform them about child marriage." – IDI Block Coordinator

AHDs are events celebrated at village level (usually at Aanganwadi centre or other community space) with the aim of increasing awareness among adolescents and community regarding adolescent health. Peer educators are supposed to work with FLWs to organize AHDs as per RKSK guidelines. During an AHD, information on RKSK themes is provided to adolescents using different modes including lectures, posters, games, plays, activities etc. PEs, ASHA, AWW and CINI staff mobilize adolescents and parents from the community AHDs bring together adolescents for health check-ups, puts up relevant IEC material, provides counselling & provides commodities (such as sanitary pads, certain medicines etc.).

The adolescents, who participated, seemed to be enjoying the event. The FGDs with adolescents suggest that games and quizzes were organized in AHDs and prizes were distributed to winners. One of the AHDs observed had participation of 49 adolescents, 2 male PEs, 3 female PEs, 1 ANM and 2 ASHA workers. The PF took the responsibility of explaining health related topics to adolescents. She used posters to convey messages on child marriage, substance abuse and health in general. ANM and ASHA were performing BMI screening and Haemoglobin test. Adolescents seemed to be enjoying the exercise of measurement of their weight and height. In our observation, the AFHC counsellor was not present in the event however the interviews suggested that AFHC counsellors were always present in AHD. PF and FLWs conducted the event as planned making use of appropriate resources and informing adolescents over various health related topics.

"Yes, we celebrated Kishor Swasthya Divas once. It was in January. Games and programs were conducted." – IDI Peer Educator

"AHD is celebrated in Panchayat. Last time, a comic play was organized on domestic violence, gender inequality, girls not allowed to study etc. Sports, drawing and some activities were organized as well. – FGD Out of School Female Adolescent

As per RKSK protocol the AHDs are to be organized quarterly. However, in Jharkhand, they were being organized twice in a year following State's order. The program monitoring data suggested that 175 AHDs were conducted against the plan of 200 AHDs by Q3 of the year 2019-20. The IDIs with PFs reveal that AHDs were being conducted twice in a year at HSC (Health sub-centre) or AWC. The ASHA workers were tasked with mobilizing adolescents and community members for the event. The PFs encouraged parents to send their children to AHDs for free health check-ups. ANM was assisted by the CINI Block coordinator in planning for the AHD. Various stakeholders were found to be attending the event including ANM, ASHA, AFHC Counsellor, PFs, PEs (male and female), adolescents and their parents. Our study indicates a mixed finding with respect to the awareness levels of adolescents about AHDs. Thus, the lack of intensity of AHDs coupled with sub optimal awareness around AHDs means that only few adolescents can be reached through this platform, and community engagement also suffers due to this low intensity.

"No, I don't know about health day celebration (AHD)." – IDI Male Adolescent

"No, in case it (AHD) has happened, we are not aware of that." – FGD Male Adolescent

Improving awareness but low usage around AFHCs

An AFHC acts as a referral unit for adolescents in villages on issues around nutrition, substance abuse, mental health, gender-based violence, SRH, non-communicable diseases, among others. The program monitoring data suggests that CINI had planned to strengthen 4 AFHCs, which they were able to do by availing required IEC material and other resources. The two AFHC audit conducted in the sampled blocks as a part of the study revealed mixed findings. Both AFHC had separate rooms for the clinic and maintained all aspects of privacy as outlined in AFHC guidelines. But the drugs and supplies were different in both AFHCs. One of them had all essential drugs and necessary equipment while the other AFHC had no sanitary pads and lacked some drugs. This second AFHC was open only for four days a week.

"Sanitary pad was available there some time ago in the year 2017-18, but now not. Because we haven't received it." – IDI AFHC Counsellor

Both the clinics had availability of IEC materials and registers for record keeping. The clinics were maintaining the required reporting formats (such as client registration register, service provision register, stock register etc.). Service providers at the AFHC included medical officers and ANMs, one of whom was in-charge of the AFHC. The interviews suggested that the PFs, most PEs and FLWs referred adolescents to AFHC for health-related concerns that could not be resolved at their end.

"I ensure that any adolescent facing problems, reaches AFHC and receives all the facilities available for them. I advise adolescents to reach out to AFHC for any issues, counselling & support free of cost. I also took some adolescents to AFHC many times. ANM is there to guide regarding right age of marriage, pregnancy etc. – IDI Panchayat facilitator

"ANM and ASHA bring the girls to the centre or they come by themselves. The adolescent boys visiting the AFHC talk about their bodily changes." – IDI AFHC Counsellor

"If any adolescent among the group seek us for any health-related matter, then we take him/her to AFHC. Only we must do it, right! Else if PF is asked then he/she can also take the adolescent to the clinic." – IDI Peer Educator

The AFHC Counsellors spoke of CINI's intervention being useful in increasing awareness among adolescents on health issues. AFHC Counsellors were appreciative of the mobilization efforts made by CINI in the villages to send adolescents to AFHC for health issues. They believed that more adolescents were visiting AFHCs because of CINI's efforts. Most adolescents also mentioned that they were informed regarding AFHCs by the PF and in some cases by the FLWs. The counsellor, however, also pointed that large distance was a major barrier for adolescents to visiting AFHCs. An AFHC is located at community health centre and adolescents from many villages found it far away.

"The number of girls approaching AFHC is growing. Initially the girls were not approaching. But these people (CINI) have conducted many meetings in the villages and have also trained the Sahiyas, who keep referring girls to me." – IDI AFHC Counsellor

"Through CINI's efforts, there has been an increase in the number of children visiting AFHCs, also an increase in awareness of children." – IDI AFHC Counsellor (ANM)

"This AFHC is far. Not all girls and boys can reach out to me. There should be one more AFHC." – IDI, AFHC Counsellor

Interviews and FGDs with adolescents revealed that very few adolescents had visited AFHCs. A few adolescents indicated that they were aware of AFHCs and its purpose. In other cases, adolescents had not even heard about AFHCs. Some adolescents who knew about AFHC from second-hand accounts, were aware of their importance, but had not visited an AFHC themselves. An interview with an AFHC Counsellor also revealed that boys were less frequent in using the services of an AFHC.

"Yes, we are aware of Yuva Maitri Kendra but we have never been there. We were informed that in case of any problem we can go there." – FGD Out-of-school Female Adolescent

"I have heard about it but have not visited. Many girls from here have visited there." – IDI Peer Educator

"A girl told her problem and she was taken to Yuva Maitri Kendra." – IDI Peer Educator

"We have not heard of AFHC (Yuva Maitri Kendra)." – FGD Male Adolescent

"Boys are usually less frequent to approach. Usually boys from 15 or 16 or 17 years of age are less approaching. Smaller kids from 10-11 years do come. Girls of all the age till 19 also approaches us." – IDI AFHC Counsellor

The study results indicate that while awareness and footfall may have increased at the AFHCs as compared to previous years, there is still scope for increasing awareness levels around existence of AFHCs, when to visit them and services that were available in these clinics.

Formation and attendance of Village Level Child Protection Committee (VLCPC) a challenge

Under the Integrated Child Protection Scheme (ICPS) of Government of India, every village should have a VLCPC in order to create and promote a child-friendly and safe environment wherein children's well-being, safety and rights are protected. CINI is making efforts to activate VLCPCs where they don't exist and ensuring their proper functioning as per government norms, where they exist. Each VLCPC shall include two child representatives, one Anganwadi worker, two SMC members, one SHG member, one NGO member, one elected member/ gram pradhan and one ASHA worker[14]. The Committee in the sampled area was working towards ensuring protection and safety of children who needed support, for example orphans, those who were migrating, and re-enrolment of out of school children in sampled area. Program monitoring data suggests that the intervention had planned to orient 1580 VLCPC members in the first three quarters of 2019, of which only 1107 (about 70%) could be oriented. Strike by AWW had hampered the orientation of VLCPC members.

Interviews with district and block coordinators revealed that they were trying to strengthen VLCPCs through regular meetings. CINI engages AWW, who is the member secretary of the VLCPC, to encourage them to form these committees. Then they work towards organizing their monthly meetings regularly. While they have been able to call up the monthly meeting at certain places, attendance was still a major issue. This is possibly due to preoccupations of the members and difficulty in finding a mutually agreeable date for the meeting.

"That committee (Village Level Child Protection Committee) is still not formed; it will be constructed soon." – IDI AWW

"VLCPC is not formed in every village. According to the government it needs to be formed in every village. What we are doing is that if they are formed then we are regularizing its monthly meeting. We are working on them." – IDI Block Coordinator

"Now we are calling meeting every month but when I go to the meeting it's not happening. If nine members have to attend the meeting, then only three are coming. In December and January there was Christmas season, marriage season so there were issues in timetable and challenges in conducting meetings." – IDI District Coordinator

[14] As per information provided by CINI

6. Discussions & recommendations

The study findings suggest that PFs are able to carry out their activities as intended with quality. The selection of PFs from the community and their sustained engagement has contributed to their acceptability and created a rapport with adolescents and different stakeholders in RKSK program. The trainings imparted to them by CINI have also led to increased awareness and skills among PFs to be able to conduct their activities. A seemingly merit-based selection process coupled with capacity building trainings on RKSK associated activities from CINI has enabled PEs to lead and engage adolescents in sessions on most topics. The findings also suggest that the adolescents were appreciative of the sessions and enjoyed the interactive nature of the sessions. They particularly enjoyed the exposure visits and more such visits should be planned and facilitated in future. In addition, the content of the PE led sessions can be developed in consultations with the adolescents. Including some of the age appropriate skills building modules in the curriculum like computer applications or other vocational training skills may help in increasing attendance and engagement among adolescents.

The discussion on sensitive topics (such as SRH, physical changes in adolescents, physical relationships etc.) was an area of concern. PEs, FLWs as well as participating adolescents found themselves in quandary over discussing these issues openly in the sessions. In addition, limited capacity building trainings of FLWs due to systemic barriers had potential negative effects with respect to engaging adolescents and parents in the community, particularly on sensitive issues. The limited engagement of adolescent on sensitive topic is exacerbated due to fear of backlash from the community on discussing such issues as it went against societal norms.

The PFs from CINI try to facilitate sessions with sensitive topics more actively, but in the wake of the limited capacity of FLWs and PEs, this may also lead to sustainability challenges as FLWs and PEs may not be ready to engage adolescents on these topics when PFs are not around. The existing trainings of PEs and FLWs can increase focus on developing innovative and interactive methods to engage adolescent on sensitive topics. In addition, existing platforms like AFCs should be organized as per the target so that engagement with PEs is increased. This would require mobilisation and improving attendance of PEs on these platforms that may also help in cross learning among PEs on ways to overcome issues around discussions on sensitive topics. CINI can advocate and push for appropriate utilization of these platforms. The Adolescent Safe Spaces being created in the study area may be useful in encouraging discussions around sensitive topics for they provide privacy, confidentiality and safety to adolescents and should be encouraged going further. They may gradually break societal norms among adolescents. Intervention should focus on meeting the target of creation of ASS and attempt to increase their usage among adolescents.

The intervention had already been trying a few mechanisms to improve discussion around sensitive themes. They have separated male and female sessions when the topics to be discussed are sensitive to encourage better participation of both genders. There may be merit in continuing this adaptation as having a male PF and male PEs in a male only session would help reduce shyness of adolescents. Although, male adolescent as well as male PEs participation was seen to be low in the intervention and that may create an issue of continuing single sex PE sessions. The program can try to fix this issue through having a male PE from a neighbouring village or panchayat to reach male adolescents and facilitate discussions with them.

At the same time, the community should be engaged more through existing platforms and made aware of the importance of improving knowledge and behaviors of adolescents on all topics for healthy development. The awareness and engagement with community should continue through interactive methods such as dramas, village level meetings, workshops etc. to break societal norms and stigmas within the community. With respect to mobilization of all adolescents in the sessions, responsible PEs, ASHA workers and PFs should together be tasked with mobilizing them in the sessions. Incentivization of adolescents, who attend PE sessions consistently and exhibit improvement in knowledge, and engaging them in extracurricular activities can also be thought of to encourage better participation. In addition, community level activities and events under RKSK including PE sessions, AHD, AFHC, safe spaces and village level committees provide platforms to have discussion, cross-learning, address health issues and develop solutions for child safety. These platforms can also be utilized to orient different participants and break taboos and myths around sensitive

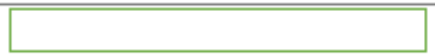
topics. The intervention needs to continue advocacy amidst decision-makers to facilitate timely formation, functionalization and regularization of all the above entities.

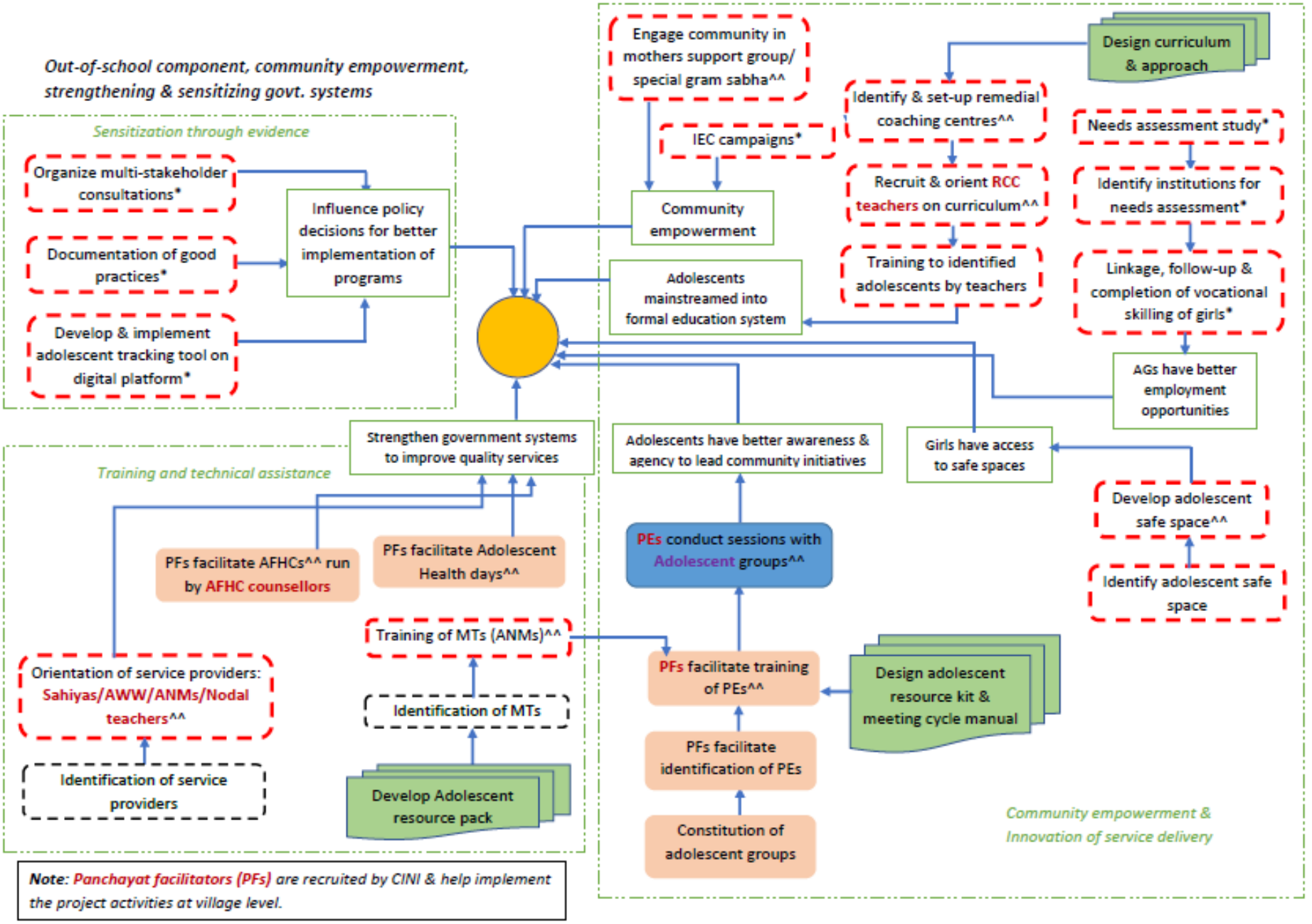
7. Conclusion

The intervention has made headway in terms of engaging adolescents through group sessions led by PEs. This seemed to be improving awareness around health behavior and life skills among participating adolescents. However, low engagement of male adolescents and male PEs is leading to limited reach of the intervention. Existing societal norms, taboos and myths were persistent across the study area which led to constricted discussion around sensitive issues such as SRH, STIs, physical relationships, physiological changes etc. Some adaptations and measures were being taken to improve engagements with adolescents on sensitive topics but with limited success. Building appropriate capacities of FLWs and PEs is also required to improve their awareness and utilization of the available community level platforms. The limited intensity and low awareness around some of the existing platforms (such as AFC, AHD, ASS, village level committees) that could help with better reach and better discussion with adolescents and community needs to be worked upon to augment engagement with adolescents and community members and facilitate discussion around child safety and improved behaviors for adolescent development.

Annexure 1: Process Map

Key to processes

	Key documents/materials prepared for primary ARC intervention
	Process carried out by CINI team
	Process facilitated by CINI team
	Final goal envisioned by CINI
	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
*	Activities that are not part of the process evaluation as they would not coincide with field work


Out-of-school component, community empowerment, strengthening & sensitizing govt. systems
Sensitization through evidence
Organize multi-stakeholder consultations*
Documentation of good practices*
Develop & implement adolescent tracking tool on digital platform*
Influence policy decisions for better implementation of programs
Engage community in mothers support group/ special gram sabha^^
IEC campaigns*
Community empowerment
Adolescents mainstreamed into formal education system
Identify & set-up remedial coaching centres^^
Recruit & orient RCC teachers on curriculum^^
Training to identified adolescents by teachers
Design curriculum & approach
Needs assessment study*
Identify institutions for needs assessment*
Linkage, follow-up & completion of vocational skilling of girls*
AGs have better employment opportunities
Strengthen government systems to improve quality services
Adolescents have better awareness & agency to lead community initiatives
Girls have access to safe spaces
Develop adolescent safe space^^
Identify adolescent safe space
Training and technical assistance
PFs facilitate AFHCs^^ run by AFHC counsellors
PFs facilitate Adolescent Health days^^
PEs conduct sessions with Adolescent groups^^
Training of MTs (ANMs)^^
Orientation of service providers: Sahiyas/AWW/ANMs/Nodal teachers^^
Identification of MTs
Identification of service providers
Develop Adolescent resource pack
PFs facilitate training of PEs^^
Design adolescent resource kit & meeting cycle manual
PFs facilitate identification of PEs
Constitution of adolescent groups
Community empowerment & Innovation of service delivery
Note: Panchayat facilitators (PFs) are recruited by CINI & help implement the project activities at village level.

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