DRAFT REPORT

Evaluation of a Youth-Focused Intervention: An Exploratory Qualitative Study in West Bengal

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LIST OF ABBREVIATIONS

ASHA- Accredited Social Health Activist

ANM- Auxiliary Nurse cum Midwife

AGP - Adolescent Girl Participant

AGNP - Adolescent Girl Non Participant

CHI - Community Healthcare Intermediary

IUCD - Intra Uterine Contraceptive Device

PHC - Primary Healthcare Centre

YWP - Young Woman Participant

YWNP - Young Woman Non Participant

SALIENT FINDINGS

OVERVIEW OF IMPACT ACROSS BOTH PARTICIPATING YOUNG WOMEN AND ADOLESCENT GIRLS *(in contrast to non-participants).*

The following section offers an overview into the impact of the intervention across all age groups of girls and women, identifying the inputs from the intervention and the type of impact they have had in terms of awareness & knowledge, comprehension, agency or application to their own realities. *This impact has been explained with the help of comparisons between the experiences of intervention participants with those of non-participants.*

1. COMFORT IN NAVIGATING & ADDRESSING SRH ISSUES - Destigmatizing of SRH topics and increased comfort in addressing SRH issues due to safe, confidential interactions

Adolescent girls and young women express and demonstrate increasing confidence & ability to discuss issues related to SRH. The opportunity for participation in open discussions, along with the availability of safe, non-judgmental spaces have helped in **destigmatizing and normalizing the topic of SRH. This has helped in dissociating from 'taboo' status attributed to openly discussing SRH issues.**

Nearly all intervention participants expressed substantial comfort in being able to discuss SRH topics. Even during interviews for this research, participants took significantly less time to open up and speak freely about SRH. Meanwhile, a large proportion of nonintervention participants continue to express a combination of embarrassment and hesitation throughout the discussion.

2. KNOWLEDGE & COMPREHENSION OF SRH ISSUES -

Enhanced ability of young women and adolescent girls to connect back SRH knowledge to their own context and situation, due to tonality and method of engagement. This is leading to greater ability to monitor and identify SRH issues they experience.

Adolescent girls and young women report that **in-depth explanation/demonstration as well as two-way discussions** have led to a thorough technical understanding of SRH issues pertaining to their lives. A **safe and controlled platform for conversation** provided by the intervention has also led to adolescent girls and young women participants being more **receptive** to technical information related to their own SRH issues or concerns. This also aids participants in developing more meaningful associations and therefore, a more comprehensive understanding of SRH issues.

Accessibility of technical knowledge related to SRH issues due to repetition and reinforcement of content material and administration of content by a singular, consistent and familiar source.

In case of intervention participants, knowledge regarding various SRH issues including but not limited to menstruation, preparedness for motherhood, RTI/STI, contraception and abortion etc. is reported to be received from **a single, concentrated source (Youth Leader)**, leading to focused assimilation of information related to SRH issues. Especially when contrasted to non intervention participants, it emerges that since they have multiple and fragmented sources of information on multiple SRH topics, their technical understanding becomes scattered and in some cases, incomplete.

In many cases, participants are able to use the relevant terminology, biological understanding, associated issues and noteworthy symptoms for various SRH issues while referring to them in conversation, owing to the

repetition/reinforcement of the same during the meetings, more so in the case of the age group of **young women.**

3. CONFIDENCE & ABILITY TO APPLY KNOWLEDGE ON SRH:

Participants evaluate their comprehension in terms of their ability to utilize their SRH knowledge to educate others around them. In case of intervention participants, (especially) young women have reported the comfort of not only applying knowledge to their own lives, but also being able to share their experiences of SRH issues, and sharing this knowledge with peers, family members who may need it.

In the absence of this reinforcement and access to information, it is seen that non-participants express feeling pressured by various members in their ecosystem - family members, neighbours, peers etc. That is, they are uncomfortable and/or unable to prioritize issues related to their own health due to lack of knowledge, comprehension or support.

Greater reported confidence in individual identification of issues and decision-making related to SRH

Being equipped with vocabulary and technical context of various SRH issues, results in greater confidence and ability to identify one's own health issues along with the confidence to seek assistance for it. Having a space available to them where they can discuss issues about their lives has aided in developing the individual desire and aspiration in decision making - be it household, motherhood, or finances. Women who participated in the intervention assigned a **higher priority to personal well-being and aspiration** across topics of discussion or concerns. Whereas, in case of women who did not participate in the intervention presented a tendency to prioritise the needs and wants of members of the household, their family members, or the considerations of other parties.
NOTE: This was observable in both the age groups but slightly higher in the young women age group.

4. ACCESS & UTILIZATION OF SRH SERVICES

Familiarization and comfort building with health infrastructure

The intervention serves as a **starting point** for utilization of healthcare services entering the young woman's individual consideration. This is a significant departure from the typical dependence seen in non-participants on other members of the family to recognize, seek help for and consistently monitor SRH.

Creation of pathways to access services to navigate SRH issues with the introduction of Youth Leader as a medium to engage with providers/healthcare intermediaries

The presence of the Youth Leader as an individual who acts as medium for participants to engage with the healthcare system, helps to create pathways in the minds of participants - starting from individual understanding of SRH needs, to identification of issues, followed by reaching out for information and/or services to the Youth Leader, who then connects them with the relevant healthcare provider.

SRH TOPICS THAT HAVE HAD THE GREATEST INTENSITY OF RESPONSE DURING THE INTERVENTION ACROSS BOTH TARGET GROUPS

Menstrual Hygiene

Intervention participants (both young women and adolescent girls) exhibited knowledge of menstrual hygiene and health practices with greater intensity. While, the broad understanding of the utility of sanitary napkins for menstrual hygiene is present amongst both participants and non-participants; the following responses from

participants help understand the incremental impact of learning of and discussing these topics during the course of the intervention:.

- ➔ Intervention participants distinctly express an advanced level of knowledge of **menstrual hygiene needs** such as in-depth knowledge of duration of napkin use and disposal; as well as the significance of periodical change and requisite intervals of use of 2 sanitary napkins. Further, participants are able to establish a clear, direct association between menstrual hygiene and extended use of sanitary napkins, highlighting the possibility of infections
- ➔ **This knowledge was spontaneously expressed indicating salient presence in intervention participants**

Infections - RTI/UTI/STI

There is an incremental understanding amongst participants as compared to non-participants across multiple SRH issues. However, RTI/STI stands out as a topic where in all aspects from input till attribution are extensively covered. Some of the following points capture the degree of understanding and comprehension of **intervention participants, when it comes to infections (RTI/STI/UTI).**

- ➔ Clear understanding of **symptoms** of RTI and UTI, commonly called white discharge in the community; preventive/precautionary measures, **course of action** for diagnosis and consultation from healthcare provider

- ➔ Importance and practical application of precautionary measures [most commonly, avoiding bathing in pond water], products and practises to be used to ensure prevention, ability to identify symptoms and knowledge of method to reach out to healthcare providers

- ➔ Ability to communicate symptoms to healthcare providers in case of medical emergency [often accompanied by family members, usually mothers], and ability to share information with other women requiring assistance

- ➔ Repetition of information leading to lasting retention of facts along with increasingly establishing significance of the issue, offering assistance preemptively at meetings

Contraceptives/Motherhood

In terms of preparation for motherhood, whilst the young women (aged 15-24 years) are able to directly correlate the need for timely pregnancy and the impact of an early pregnancy on the physical and mental health of the woman; the young adolescent girl participants understand this concept in more theoretical terms.

- ➔ For young women, they appear to have developed a glossary of terms that help them navigate contraception altogether.
- ➔ They are aware of the various methods of delaying pregnancy that are available by name, and with all technical information; and are able to make informed decisions on their preferred method

- ➔ They have the confidence to navigate the conversation around delaying/preventing pregnancy within their homes, as they feel the confidence to navigate the conversation, with substantial knowledge available to them

Abortion

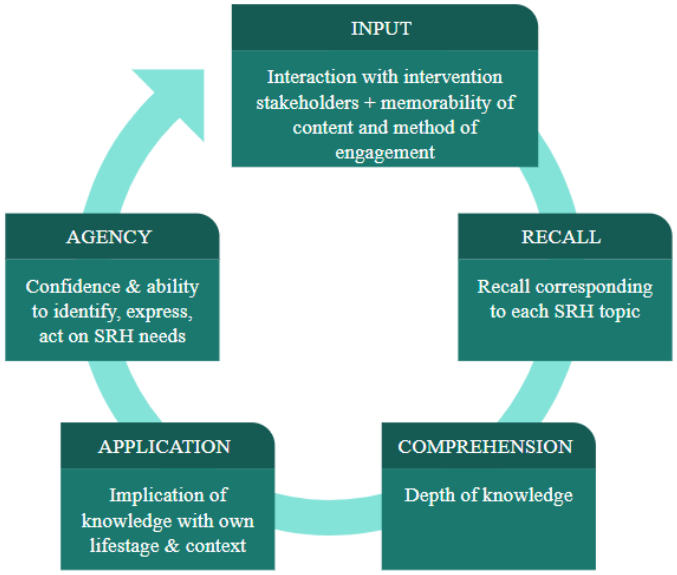
As a topic, abortion is only touched upon with the young women (15-24 years). The participants engaged in this research reported a clear, and simple understanding that:

- ➔ It is legal to have an abortion for an unintended pregnancy over the age of 18 years
- ➔ There are of medicines available for abortions, and one can simply consult a doctor to proceed with a procedure like this
- ➔ If they are to be in such a situation, they would be comfortable approaching a healthcare provider for this assistance.

TOOLS THAT HAVE ENABLED THE INTERVENTION IN ACHIEVING IMPACT

- **A singular, focused channel of information** helps participants to filter out clutter typically caused by multiple active and passive sources of information such as elder women, peers, neighbours, multiple CHIs. Provision of knowledge and guidance related to SRH issues in a holistic, comprehensive format from a single dedicated source has led to higher retention of information shared as part of the engagement, and application of knowledge.
- **Two-way conversations, with group participation from participants** around SRH topics has led to greater clarity of understanding. This has equipped the women with defined pathways to follow in case of any issue related to SRH.
    - These pathways haven't been defined for non-intervention participants due to scattered and inconsistent knowledge about the subject. Their source of information about the subject matter seems to be a combination of various sources, immediate family members and peers leading to incomplete/overwhelming information
- **Simple, direct and repetitive content:** The meetings held as part of a way of reinforcement of SRH content, have equipped the participants with knowledge in a form that can not only be retained but also applied due to continuous repetition across several meetings.
- **Presence of a relatable, reliable source of information in the form of the Youth Leaders:** Greater approachability of similarly aged youth leader (like a peer) has led to greater comfort in the community, enabling higher interaction; as well as due to a greater tendency amongst participants to continue engaging with the YL.

ASSESSING THE OVERALL IMPACT FOR ADOLESCENT GIRLS AND YOUNG WOMEN BY TOPIC



The above framework represents the parameters on the basis of which the impact of the intervention has been assessed in this qualitative study. Namely, it captures the 'impact' based on the following parameters:

1. **Input -** The interaction of the target groups with the intervention since inception by way of engaging with youth facilitators, healthcare providers and CHIs associated with the intervention, content and platforms used to engage the intervention participants
2. **Recall -** Recall corresponding to each topic upon which the participants have been engaged
3. **Comprehension -** The depth of knowledge and understanding of each SRH issue
4. **Application -** The understanding and application of the knowledge gained from the intervention to the participant's own life and lived reality
5. **Agency -** The belief, confidence and ability therefore, to identify, express and act on SRH needs

CHANGE REPORTED IN - YOUNG WOMEN	
Menstrual health and hygiene knowledge and practices	Maximum change
Preparedness for motherhood, ideal age for marriage and childbirth,	Maximum change
Contraceptive knowledge and use	Moderate change
Abortion - legal aspects, process	Moderate change

White Discharge/ Infections - STI/RTI/UTI	Maximum change
	Maximum change
Utilization of SRH services & Experiences	Moderate change
Overall belief, confidence, ability to deal with SRH needs	Maximum change

TOP ISSUES RANKED IN DESCENDING ORDER OF RETENTION AND ASSOCIATION WITH INTERVENTION - ADOLESCENT GIRLS	
Menstrual health and hygiene knowledge and practices	Maximum change
White Discharge & Infections - STI/RTI/UTI	Moderate change
Family Planning/Right age for marriage	Moderate change
Utilization of SRH services & Experiences	Moderate change
Overall belief, confidence, ability to deal with SRH needs	Maximum change

The body of the report helps to understand the quality and intensity of the change/impact of the intervention on the participants.

CHAPTER 1:BACKGROUND & STUDY DESIGN

1.1 STUDY BACKGROUND

1.1.1 Sexual and Reproductive Health and COVID '19

Over a few decades, approaches to enhancing the Sexual and Reproductive Health (SRH) as a human right of the citizens have gained more traction. According to India's most recent census, young women aged 15–24 years made up almost one-fifth of the country's female population - making one in every five Indians a youth and giving India the largest reservoir of young population in the world. Given the magnitude of this demographic cohort, it is imperative to improve the quality of life of India's youth. Young women in India constitute 30% of total maternal mortality in the country. The highest maternal deaths (34%) in India are also recorded for young women ages 20-24 years (RGI 2019). This situation can only be improved by empowering young women and girls to improve their ability and agency to exercise SRH rights and services. Majority of young women in India are not aware of basic SRH issues.

To address this problem, ***Ipas Development Foundation (IDF) has been implementing a youth-focused intervention in selected rural clusters of South 24 Parganas (Health District Diamond Harbour) to improve the ability and agency of young women and girls (10-24) in selected districts of West Bengal.***

About the intervention: A multi-pronged intervention model has been adopted by IDF for improving the knowledge and agency of young women and girls. On the one hand, IDF has strengthened the public health system to make youth-friendly services available and accessible by equipping facilities with the required infrastructure, and working with health providers, counsellors, and support staff to be more youth-responsive. On the other hand, IDF undertook community outreach activities to improve SRH related awareness among adolescents (10-14 years) and young women (15-24 years) and other key community influencers.

In West Bengal, in addition to doctors and nursing staff, Anwesha Counsellors are appointed at Primary Healthcare Centres as to provide counseling and medical facilities to the adolescents related to menstrual and reproductive health, puberty, pregnancy, mental health concerns amongst others. Anwesha counsellors were also engaged as part of provider outreach, in this intervention.

1.1.2 Capturing all existing information on the intervention:

Before we initiated the primary data collection process, the research team was oriented with the planning, activities and content to arrive at a thorough understanding of the intervention. This included briefing sessions with the IDF team, briefing with the on-ground intervention team to understand the intervention design and implementation timeline, due diligence with all intervention content and materials.

1.2 OBJECTIVES AND SCOPE OF WORK

The specific objectives of this cross-sectional evaluation were:

- To assess the awareness and knowledge on SRH-issues including contraception and abortion and perceived transition due to the intervention
- To understand the perceived feelings on the preparedness of motherhood from the lens of SRH (perceived ideal age at marriage and childbirth) and perceived transition due to the intervention
- To understand the exposure to SRH-related activities, and information and message recall – including

effectiveness of different communication activities

- To explore agency / self-efficacy among adolescents and young women
- To understand the utilization of SRH services and experience of accessing services
- To assess the menstrual hygiene practice and perceived transition due to the intervention
- To explore the association (if any) between intervention exposure and transition in desired behavior including, service utilization, menstrual hygiene, seeking information on SRH, and SRH related awareness
- To assess the impact of COVID-19 on access to SRH information and services

1.3 STUDY COVERAGE

A cross-sectional qualitative study among adolescents and young women and a few select stakeholders in West Bengal was proposed to assess the effects of community outreach and facility-based interventions in improving knowledge, self-efficacy, and utilization of sexual and reproductive health (SRH) services.

In the absence of a baseline community assessment, this qualitative evaluation assessed the potential association between **youth intervention and transition in knowledge, agency, and the ability of young women and girls to access SRH information and services and care and transition in MHH (menstrual health and hygiene) behaviour.**

1.3.1 Detailed Areas Of Information may be found in the Appendix - 1.

1.3.2 Focus Areas for Each Participant Segment for the Qualitative Study

STUDY PARTICIPANT	AREAS OF INFORMATION
Adolescent Girls (10-14 Yrs) AND Young Women (15-24 Yrs)	• Assess knowledge, feelings, ability, confidence practice when it comes to dealing with SRH, and experience of utilizing SRH services • Determine the reported and implied transition in practices from the pre-intervention period. • Arrive at detailed insights on the challenges faced during the pandemic to access information and services pertaining to SRH.
Community Healthcare Intermediaries AND Facility Providers: *(Doctors, Nursing Staff, Anwesha Counselors)*	• Understand their viewpoints and a holistic picture of the community • To determine their understanding of the uptake of services by the community (as a result of the intervention) • To get a community context on the disruption caused in access to healthcare (SRH) information/services due to COVID'19.

1.4 THE METHODOLOGY

To have a holistic picture of subject matters of enquiry along with ensuring maximum safety of everyone involved, the team undertook a combination of an online and offline approach to conduct in-depth, one-on-one interviews -

Step 1: Qualitative primary data collection

1. In-depth interviews conducted online and offline (50:50) with adolescent girls and young women
2. Telephonic interviews with local healthcare providers like ASHA workers, ANMs, doctors, and nurses

Step 2: Workshops with Adolescent Girls & Young Women

Additionally, we conducted an interactive workshop to explore the experiential aspects of programming that may have had a significant impact on target beneficiaries. This contributed to the possibility of systematizing intervention components that have been successful in achieving desired impact, and to help improve those elements that may not have been memorable and/or left an impact on the minds of beneficiaries.

1.5 THE TARGET GROUP DEFINITION

The target audience for this study were as follows:

1) *Adolescent and young women (Married and unmarried)*
   - Segmented into 10-14 years and 15-24 years
   - **Mix of exposed and unexposed to IDF intervention**
   - If Married:
     - Mix of Parity - 0, 1, 2+ (Parity is the number of pregnancies resulting in childbirth)
     - Currently cohabiting with spouse for at least 2 months
     - To achieve a representative sample, we recruited a mix of users and non-users of modern contraceptive methods
     - Primary education to ensure substantial articulation
   - Unmarried:
     - Currently living in maternal home
     - Primary education and upwards to ensure substantial articulation
2) *Facility Providers (doctor and counsellor):*
   Doctors and Anwesha counsellors available at the facility in the intervention villages from where adolescent and young girls were recruited for the research, preference was given to those who have been exposed to the intervention
3) *Community intermediaries:*
   ASHAs and ANMs stationed in the intervention villages from where adolescent and young girls were identified for the research, preference was given to those who have been exposed to the intervention

1.6 CENTRES FOR RESEARCH

The study was conducted in the existing intervention areas of youth focused intervention in South 24 Pargana (Diamond Harbour Health District) in West Bengal. **Three** villages were selected to identify the target respondents - those who have been and have not been exposed to the intervention. Further, these villages were mapped to the corresponding PHC where the intervention activities were conducted with the provider

Intervention villages where research was conducted - Village Santoshpur, RH Kulpi; Village Moraripur, RH Mathurapur and Village 24 No. Lat, RH Raidighi

1.6.1 SAMPLE ACHIEVED

	Moraripur	Santoshpur	24 No Lat	TOTAL
Adolescent Girls (10-14 years)	**3**	**3**	**3**	**9**
Young Women (15-24 years)	**5**	**6**	**5**	**16**
Facility Providers (Doctors & Counselors)	2	**1**	**2**	**5**
Community Intermediaries (ANM & ASHA)	1	**1**	**1**	**3**
Workshop with Young Women (15-24 years) - 7-10 members				**1**
TOTAL UNITS				**33 + 1 = 34**

1.6.2 Location & Physical Presence:

- The **local field team was present on ground for recruitment** and obtaining initial consent from respondents was required to visit the field and were **trained to take various safety precautions for self protection and protection of the respondents**

1.6.3 Recruitment Process

Identification & Recruitment Strategy for Target Audience:

Given the current scenario to utilize the physical space of respondents in most optimized way with all safety standards for research purposes, we followed the following methods of interacting with various target groups:

1. **Screening and recruitment of respondents:** An experienced and trusted field partner (with prior experience in development sector projects - specifically sensitive issues related to women sexual and reproductive health) was appointed to take all requisite safety precautions, and visit the location to screen and identify potential respondents meeting the requisite criteria (detailed in the sample above).
2. **Extensive project briefing and training for field partners and research teams:** All members involved in the process of recruitment underwent extensive project training prior to the commencement

of the study.

3. **Snowballing through known contacts:** IDF helped the research team with details of locations where the intervention has been implemented. Additionally, the field team was introduced to the on-ground IDF program teams as well as intervention **youth leaders,** who aided the identification of villages wherein facility access and therefore access to counselors and doctors was a possibility.

4. Further, the teams assisted the PARI field teams to identify geographical clusters from which participants and non-participants (adolescent girls and young women) were recruited to participate in the study.

Considerations & Protocols For Recruitment may be found in Annexure - II

1.7 LIMITATIONS OF THE STUDY:

- COVID-19 cases were on the rise at the time of conducting the study. As fieldwork was conducted, safety and sanitizing requirements were required to be put into effect including distancing, and therefore limited contact with the community. Thus, a combination of offline and online research was implemented.

- Non-availability of healthcare providers due to increase in workload (COVID-19) - Due to the workload and safety considerations, surrounding COVID-19, the research team was unable to physically access healthcare facilities (PHC) and thus did not have physical interaction with them. Thus, interviews with this part of the sample were carried out via telephonic interviews.

- The study was carried out in three villages in one district, as per the RFP, this does not aptly represent any other geographies in the country as a whole. Thus, the interpretations and learning from the research cannot be safely generalized for other states / districts in India.

- Limitation of qualitative analysis: Qualitative is limited to a small universe in terms of sampling and cannot be utilized to arrive at quantitative or statistical generalizations about a target group.

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CHAPTER 2: RESEARCH FINDINGS

NOTE: This detailed report will first delve into the key findings from young women (15-24 years). We have incorporated the point of view of the providers on the impact of the intervention with respect to this cohort in **2A** itself. The findings from our study among adolescent young girls (10-14 years) will be covered under **2B.**

Both 2A and 2B will have the following sub-sections

1. **Awareness and knowledge on SRH-issues including the point of view of Providers**
2. **Exposure to and effectiveness of different communication activities**
3. **Exploring Agency and Efficacy among Young women**
4. **Understanding the utilization of SRH services and experience of accessing services for intervention participants**
5. **Perceptions around menstrual hygiene**
6. **Perceptions around SRH with respect to Motherhood and relevant related and age appropriate topics such Motherhood, Contraceptives, Abortion, STI**

2.A IMPACT OF YOUTH FOCUSED INTERVENTION ON YOUNG WOMEN - 15-24

2.A.1 AWARENESS AND KNOWLEDGE ON SRH-ISSUES

- **Young women are seen to have not only a descriptive, but a technical understanding about SRH issues** including menstruation, puberty and changes accompanying it, STI/RTI, contraceptives and abortion. This understanding includes identification of symptoms, implications on the female body, methods to manage symptoms including information seeking and reaching out to health care providers in case of an escalation.

"Talking about physical problems, some women have diseases: Many have infections in the urinary tract, and here some women die while giving birth, giving birth to a dead baby, white discharge, burning feeling while passing urine." ***- Married YWP, Santoshpur***

- Intervention participants expressed and demonstrated **high recall and detailed understanding with respect to various** SRH topics discussed with them during meetings with youth leaders -
    - This includes understanding of various SRH issues as well as being equipped with terminology and confidence to share the knowledge with women[family or peer circle] facing issues related to SRH who might not have had access to meetings.

"It (pad) is given in the sub-center. You should use a clean pad every 4 hours, I don't take bath in the lake water." ***- Married YWP, Village - 24 No. Lat***

    - Non intervention participants expressed an overall hesitation due to consideration of discussion on SRH as a taboo and not being able to express their thoughts due to a lack of knowledge of technicalities and terminology

"I am aware about periods but am not comfortable discussing all these. All the polluted blood goes out from the body, by periods. I heard from my mother that due to this we can have a baby." ***- Unmarried YWP, Baribhanga***

- There is a systematic break-down of superstitious belief associated with SRH issues for participants as they become acquainted with the physical/biological understanding behind the various aspects of SRH. **Non participants share questions and doubts about the detailed implication of menstrual hygiene practices and attention to reproductive health.**
    - *The recognition of the role of menstruation in the female body has seen to lead to breaking down of superstitions related to it such as 'period blood being bad or impure blood'*

"We had wrong perceptions about menstruation like don't go out, don't touch boys, can't go out, these perceptions have been changed. Girls are not weak. I have to take responsibility, I have to study and look after my family." - ***Unmarried YWP, Village - 24 No. Lat***

    - Although fewer in number, some young women display an understanding of the psychological impact of physical changes that a woman undergoes as she achieves puberty in the process of experiencing events like menstruation and the resulting discomfort. This is in contrast to the limited awareness about the same in non-intervention participants.

"At the age of 10, the breasts will increase in size, there will be growth of hair on intimate parts of the body, I think her monthly periods will begin slowly, and then mental issues like she won't be able to focus on her studies or while on her periods. Actually, during the periods there is a lot of stomach ache, because of that, there is mental stress about what will happen or not happen or the mind becomes a little different." - ***Married YWP, Baribhanga***

FOCUS ON CONTRACEPTION AND ABORTION:

- Awareness of existence of contraceptives in general, different types of contraceptives available, side-effects associated with each method, safety measures to be taken with different methods
    - In case of intervention participants the knowledge was detailed and they were aware of several nuances. With non-intervention participants, their awareness about the topic was limited to fewer details with a lack of clarity about the nuances like the options available in the market, and biological understanding of the working of the products.

"To not have any more babies I used to take a medicine called Suvida. I buy it from a shop and don't know whether health workers keep it or not as I have never visited them. I used to have this medicine since my marriage as my husband also knows about it and he used to bring it for me. Suvida has an instruction paper in it which mentions the details of usage. Convenience is birth control, and I can do menses as per my wish. If any puja or function is coming up and you want to postpone the menses, having 2-3 tablets together postpones the menses to a few days. Also if you want to prepone the menses, stopping the tablets 2-3 days prior will start the flow." - ***Married YWP, Santoshpur***

- Participants demonstrate high and precise knowledge of choices available in terms of variety of contraceptive methods available for preventing pregnancy [IUCD, Copper T, Condoms, Pills], brands with respect to convenience, price [Mala D, Mala E, Suvidha]

"There are so many contraception methods like Mala-D, condom, Copper T, Subidha." - ***YWP(Workshop), Moraripur***

- Further, they exhibit an understanding of specific information such as dosage details in case of pills/medicine of any type and course of action for implementation for other methods like Copper T, IUCD, etc.

"There are so many contraception methods like Mala-D, condom, Copper T, Subidha. If you do the miscarriage after 19 days, that will be risky for mother and baby both. There is no problem. If you want to take a baby then 8 to 19 days are the possible time to get a baby. If you want to be a mother then you need to know the possible time to get a baby. So, if you do intercourse with your husband during that time the possibility of being a mother is high. Other times you may or may not be pregnant. It would not be any problem for the baby if one becomes pregnant at another time." ***- YWP(Workshop), Moraripur***

- Participating in the intervention has led to de-stigmatising the use of contraceptives, especially the use of medicines/pills and birth control devices like IUCD (which typically have myths and apprehensions associated with them). This is due to the reinforcement from youth leaders as well as CHIs, as part of group or individual meetings.

"She told us contraception methods like she told us to use Mala-D, Chaya, copper T, condom and internal injection." ***- YWP(Workshop), Moraripur***

- Participants demonstrate clarity about the need for recourse like contraceptive products in family planning and are able to tie it to the implications of lack of family planning. They appear to have an understanding of the role of contraceptives as a product to delay pregnancy (or avoid pregnancy till intended) and being able to ladder the utility of the contraceptive products to their subsequent perceived benefits of preventing financial and health implications of unplanned/early motherhood.

"At this age I have come to know that many who have intercourse with their husbands take medicines, but I don't take one. They take medicine so that they don't conceive. She said that since you have pain, don't take any medicines. Instead use other protections like condoms." ***- Married YWNP, Baribhanga***

ABORTION

- For intervention participants, there is now a clear understanding of the legality associated with abortion *[girls below 18 need to be accompanied by a guardian, abortion can be done before 24 weeks]*, conditions under which it should be adopted [risk to mother's health, accidental/unintentional pregnancy which is going against family planning], reasons to adopt along with benefits laddered
    - Several non-intervention participants expressed a lack of clarity about the legality associated and considered abortion against the law. They showed a high dependence on knowledge passed through generations and superstitions.

"About abortion, if you conceived, whether you to want to have the baby or not. Within 20 weeks you can abort the baby, beyond that you cannot and if you still want to abort then you need to consult a certified doctor, or meet with Aanganwadi sister and go to Government hospital and consult a certified doctor. Before that it can be done with medicines also. We got it in Kulpi hospital. XX didi (youth leader) does not have it. They say if we are not able to consult a doctor, then we can connect with Aanganwadi sister and they will take us. She told us if we have to abort a child, how can we abort. I mean for what reasons you can abort a child - Suppose you got to know that the child within you is handicapped, you can choose to abort. Another case is while using a condom, it tore because of which it goes to your stomach, then you can abort. And she said after 18 years if you want to abort a

child, you can go and do it on your own. If it is before that, then you will need a guardian to go along with for signature." - ***Married YWP, Santoshpur***

- Participants attribute **altering of misconceptions associated with abortion** being incorrect, illegal or, a taboo, among other concerns related to the practice, passed on through generations of women in the family

"She told us when we can do abortion. I now know it can be done till 20 weeks or 4.5 months we can do abortion and we should do it from government hospital." - ***YWP(Workshop), Moraripur***

- Participants demonstrate a **clear understanding of the course of action** to be followed in case of need for abortion, following their participation in the intervention. This includes reaching out to youth leader/ASHA worker along with knowledge of the possible plan of action followed by them - i.e. a referral to hospitals/doctors and/or assistance in getting procedure done

"She told us within how many days we can do abortion and whether it is legal or not. From where we should do it, to know if you are pregnant you should go to the sub center. So, about these topics she played a game like she made two teams like A and B. The right things were kept in A team and the wrong things were kept in B team." - ***YWP (Workshop), Moraripur***

APPLICATION:

- Participants report increased usage of contraceptives as compared to the remaining women in the village. In some cases, young women cite lower dependence on traditional methods of withdrawal and abstinence as a form of contraception due to the understanding of high risks involved

AGENCY:

- Whilst even non participants express the desire to delay pregnancy, the participants cite their ability to be vocal about **their choice of contraceptive** in the basket of options available. They mention their ability to communicate their choice of contraception to husband and/or take a decision in consultation/discussion, with a clear understanding of wanting to delay pregnancy.

"For not having any more babies I take a medicine called Suvidha. I buy it from a shop and don't know whether health workers keep it or not as I have never visited them. My husband also knows about it and he brings it for me." - ***Married YWP, Santoshpur***

- Non intervention participants, whilst expressing a similar view on the right age for motherhood (later in her marriage) **attribute the control and decision-making to a supportive family**, rather than having the confidence or knowledge to decide or choose the method to prevent pregnancy on their own.

"At 30 years old is the right age to become a mother. If she will mix with the new family well, then if she will have her baby then all the family members will take care of her. It will be very much beneficial for her. She will be able to manage her family well and then can have her baby. She will be mature enough to handle the baby." - ***Unmarried YWNP, Baribhanga***

- Young women who participate report lower dependence on common knowledge as received from female family members and state that there is a greater ability to differentiate between correct and incorrect facts. Meanwhile non participants rely on a combination of familial and social sources of information on

contraceptives and family planning, which may or may not be inconsistent. In most cases, they do not lead to concrete decision making.

"I knew about periods. I knew that some problems were happening while pregnant but I didn't know the problems after the pregnancy. I know some of these methods. Family members have said this like elder sisters, my sister-in-law told me. Now I have a baby already so I should use something so that I don't have a baby later one. There are contraceptive pills also. That's something that we can have daily and then whatever boys are using also. She said those. my sister-in-law told me." - ***Married YWNP, Santoshpur***

- Intervention participants express an ability to share information related to SRH issues with confidence and conviction with other individuals of the community lacking access to the intervention and in need of assistance

"2 years ago I did not know about health issues but now I know about it. I came to know all these things from xx when she had a meeting and she has explained all these things to us.

Now I know about: 1) You have to be clean during menstruation. 2) Physical Changes and about Pregnancy" - ***Unmarried YWP, Moraripur***

- Ability to communicate needs and wants in terms of resources and practises with family members, especially spouse to prioritise health, convenience and comfort

"To prevent having a child, a woman can get an injection - Mala or Antara. She would reach out to her husband to do this." **- *Married YWP, Moraripur***

STATED AND IMPLIED TRANSITION DUE TO INTERVENTION:

- Ability to use appropriate methods to tackle physical discomfort as a result of prioritizing SRH has been a stated transition that has occurred amongst intervention participants

"During her periods many women just bear it silently, some use a hot compress on their pelvic region to soothe the pain, nutritious foods, and consumption of lots of water. Then to prevent odour, washing of the bathrooms. Then about how we should dispose of our pads, we can either burn them or bury them deep underground. It's not good to just discard them out in the open" **- *Married YWP, Moraripur***

- Participants report that there is an observable enhancement in ability to identity issues(includes side effects of contraceptives or SRH issues in general) and knowledge of when and how to reach out to health-care providers including sub centre doctors, ASHA workers, either on their own or through a youth leader. This is attributed to the intervention itself.

"I've come to know a lot of things like now there are IPAS meetings, previously such meetings never used to take place and I did not know anything and I never used to go to such meetings and had no idea about it. Now after attending the meetings I got some ideas. First is about menstrual periods. Then regarding contraceptive and abortion. After knowing all these things I can take a lot of precautions which I never used to take before. I'll give you an example about my marriage life regarding contraceptives so I am able to take precautions. Before the age of 20 there can be problems if we have childbirth, so regarding that there are discussions, so I came to know about all these." - ***Married YWP, Santoshpur***

- Intervention participants express a heightened tendency to promote hygienic practises for women in their close vicinity - family members, peers, etc who might not have/had access to this information.

"She will have to use a sanitary pad after every 4 hours. If she uses cloth, she has to wash it well, dry it in the sunlight. She had to eat nutritious food. She can have problems if she does not follow these things." ***- Married YWP, Village - 24 No. Lat***

PROVIDER POV

OPINION ON IMPACT CREATED

1. Providers were of the opinion that there has been a significant change in the level of agency indicated by greater ability to articulate issues or concerns related to SRH with the use of accurate terminology and providing a detailed description of their concerns.

    - In case of married women, most commonly in the age group 18-24, there is lower hesitation in describing symptoms to the doctor or at healthcare facilities as compared to other age groups. A decrease in hesitation was noted by the providers with an increase in age.

    - Women in the age group 15 to 18 seem to prefer to visit PHCs alone or sometimes with the company of a friend who has been exposed to the procedure of utilising healthcare services earlier. Additionally, although they exhibit a hesitation to communicate with male doctors, as noted by all the providers, their sense of comfort was much higher with nurses or Anwesha counsellors present at the facility. They continue to believe that discussing SRH issues with a male is a taboo. Moreover, they possess an ability to provide an articulate description of their concerns which is increasing over time.

    - The providers also directly attribute this change to the intervention. They are of the opinion that gamification of SRH issues has piqued the interest of the community in this topic, ensuring incremental awareness.

"People were very shy before. We take meetings in their colony now so they don't feel shy now. They are aware of these problems. If I go to take a meeting, I try to cover each and every problem. It is not possible to talk about everything in detail but try to discuss everything." ***- Anwesha Counsellor, Kulpi RH***

"The women are becoming more aware and takes interest because the things are explained with the help of games and quizzes" ***- ASHA, Moraripur***

"Female doctors are not present here much. They don't want to talk freely with male doctors. Suppose, her aunt or mother came and told that this is the problem, that the girl will not talk about her problems freely. Some girls who are educated will tell their problems smartly but still there is hesitation in telling each and everything clearly. Below 18 like 14 or 15 mainly, they don't talk freely. We usually send one lady to talk with them. Sometimes, their problems will be different but won't be revealed. They don't talk about menstruation and all, they avoid it." ***- Doctor, Raidighi RH***

2. As per the observations of the providers, the increased awareness about SRH issues, sufficiently attributed to the intervention, doesn't directly imply behavioural changes in several aspects. Doctors were of the

opinion that there has been minimal impact on the age of marriage and motherhood, and early pregnancies are still quite prevalent in the area.

"If this program will run properly, teenage pregnancy and teenage marriage will be reduced. They have started counseling on the fields related to abortion care. They should maintain hygiene. Patients are told to maintain hygiene which will avoid disease. We tell them about contraceptives. We do counseling to use this and that. These things have been modified. There are some patients who have awareness of these things." ***- Doctor, Raidighi RH***

3. A key impact attributed to the intervention by the providers is the greater preparedness of the women for several SRH issues due to greater awareness about the symptoms generated by the meetings and establishment of the seriousness of the issues.

"Maybe it hasn't affected the younger girls aged between 10-14 years as much. But in the case of newly married women who don't want to conceive have benefited from this. Risks associated with abortion has also decreased. The risks associated with life have decreased. There is some impact but it hasn't reached that place yet. We counsel the women who come to us." ***- Doctor, Raidighi RH***

ATTRIBUTION OF THE IMPACT CREATED

1. It was also brought to notice that meetings around SRH topics are also conducted by ASHA workers and ANMs in these villages. These meetings are higher in frequency and according to providers, greater ease in communication with ASHA workers and ANMs was observed for the women.

2. Behavioural changes like increased use of sanitary napkins due to laddering to infections was attributed to meetings conducted by ASHA workers and ANMs and not the intervention.

3. Providers attributed much of the behavioral changes to the meetings conducted by them due to greater frequency of the meetings and increased ability of women to communicate with them without hesitation.

"Every month, Asha Didi conducts meetings. I see lots of changes. When I joined, they were not able to pronounce white discharge well, I did not understand the problem that time. I asked Didi about it, and she told me about it. I have been working for 12 years, and they did not know the name of the problems which they are having. Now, meetings are conducted, they go to school, and now they have learnt things properly." ***- Anwesha Counsellor, Kulpi RH***

"Asha didi from the rural areas send these cases as referrals. This is a part of public health so they're doing it for that, not IPAS." ***- Doctor, Raidighi RH***

COMMON SRH ISSUES WHICH REQUIRE ASSISTANCE

There are limited number of visits to the PHCs, usually limited to the purpose of abortion or delivery. In case of unmarried women, the visits were even fewer and limited to menstrual issues or infections due to a lack of hygiene.

"Unmarried girls come very less. They come with the problem of not maintaining hygiene. They come with the problems of menstruation. They are referred to by Asha Didi from the sub-centre. They call me up and tell me this patient is going. Patients for delivery and abortion generally come here." ***- Doctor, Raidighi RH***

Across providers interviewed, the most common SRH issues observed in the habitants of the area were infections, most commonly UTIs, PID[pelvic inflammatory disease], and menstrual issues like excessive dysmenorrhea, or polymenorrhea and low blood pressure.

- Issues related to menstruation like PCOS, polymenorrhea, oligomenorrhea weren't common earlier but cases have started to rise in recent years according to providers citing a need for greater awareness about these issues.

- For women between the ages of 20 and 24, issues related to unsuitability of contraceptives are also common.

"Girls from 14-19 years of age come, they come with white discharge problems mostly. They come with the problems of rashes in private parts, problems related to taking bath in a lake. About white discharge, rashes there, delay period, frequent menstruation, many girls have their first menstruation and continue for many days, some girls have immense menstruation, these are the problems mainly." ***- Doctor, Mathurapur RH***

"They mostly visit for dysmenorrhea which is common between the ages of 14-19 years. Painful and Polymenorrhea. Another common issue is Polycystic Ovarian Syndrome patients with PCOS have a higher degree of Polymenorrhea and also have Oligomenorrhea. These weren't this common before and are increasing nowadays." ***- Doctor, Raidighi RH***

- Early marriages precisely between the age 15 to 18 are common in the area, most often due to family pressure leading to subsequent early pregnancies. On visiting the PHCs, these women are often counselled into getting an abortion and using a method of contraception on a regular basis.

"Some girls at the age of 12 come for the abortion, we motivate them. Some girls at the age of 12 or 13 have got married. We went with them, got abortion done, got ICT done. After 5 years, you can go for it again." ***- Nursing Staff, Kulpi RH***

2.A.2 UNDERSTANDING THE EXPOSURE TO SRH-RELATED ACTIVITIES, AND INFORMATION AND MESSAGE RECALL – INCLUDING EFFECTIVENESS OF DIFFERENT COMMUNICATION ACTIVITIES

INTERVENTION LOGISTICS

1. FREQUENCY: Although the time period between 2 consecutive meetings is unclear, they appear to be scheduled consistently enough in order to conserve the memory of all elements of the intervention and the relation shared between youth leaders and participants.

    - The frequency has also been instrumental in creating a balance between revision of old knowledge(to facilitate greater comprehension and retention) and introduction of new knowledge(to ensure engagement without monotony)

2. DIVERSITY IN LOCATION OF MEETINGS: It was observed that meetings were conducted at different

locations on different occasions allowing a variety of participants to attend subsequent meetings in case one faced issues with the location of the meetings. This further appears to maximise attendance.

3. MEETINGS AT SAFE SPACES: Locations for meetings chosen are also observed to be common spaces trusted by women like primary schools and sub centres. This reduces hesitation in attending meetings and contributes to maximising attendance.

"Best thing about the meeting is they are making us aware and well informed. It's important to know all this. If not us, we can help our friends come out of these problems. They tell us about the unplanned pregnancies which result from having an intercourse. They say that they can be avoided by using protections. They tell us about different medicines. All this I have come to know." - ***Unmarried YWP, Santoshpur***

MEDIUM OF ENGAGEMENT

1. Personalised information of schedule for meetings by the youth leader has been effective in continuous interaction of participants with the youth leaders. This seems to not only facilitate establishing incremental trust and comfort for the participants but also appears to minimize absence due to the presence of a personal touch.

2. HOME VISITS: Visits by youth leaders to the homes of the participants has helped build rapport with the families of the participants and hence, the community as a whole - the youth leader is perceived as a trustworthy figure by most members of the community and not just the women. Building trust with the family seems to have reduced their hesitation associated with the women of the house attending meetings hence ensuring the greater participation

"Rupali Didi, along with 2-3 more Didis came to my house and conducted a meeting. 4-5 girls around my house were called. I talked to her about my problem directly." - ***Unmarried YWP, Santoshpur***

3. REFERRALS: Referrals have been instrumental in ensuring a higher number of women have access to the existing healthcare facilities by removing the barriers of lack of knowledge and confidentiality. Due to the high sense of trust in the youth leader, women seem to be much more comfortable with the idea of reaching out to healthcare professionals with the company of the youth leader. Although there were only a few citations of referrals being availed, there was no negative sentiment associated with it.

POINT OF CONTACT - YOUTH LEADER

1. Participants view youth leaders to be highly approachable leading to ease in reaching out in case of any medical issue or even concerns otherwise. Additionally, participants had an option of being in touch with the youth leader via call or messaging during periods of inactivity. This indicated that the youth leader was also sufficiently accessible creating greater trust among the participants.

"I would like to come to a meeting and my family members will definitely allow me to go there. After going there, if you have any problem will you be able to tell that freely to those Didi. After going there, if I have any problem I will be able to tell that freely to those Didi. Nothing happened in my life that I will feel shy about. When I get married, I will think about that." - ***Unmarried YWNP, Baribhanga***

2. As the youth leader had been introduced to the community by the ASHA worker, a well-respected figure for the community, she automatically gained trust, confidence and the respect of the community due to

her association with the ASHA worker. She came to be perceived as an individual who is part of the peer group or the community and not an intruder by the women.

3. The training provided to the youth leader appears to be effective because participants did not particularly cite negative sentiments towards the youth leader and appear to have satisfactory experiences on all occasions they reached out to the youth leader for medical assistance in the form of counselling or appointment for a diagnosis.

"Didi showed us 2,3 types of medicine to prevent conceiving a child. Showed us condoms and showed us copper T and said if you want you can come with me or Asha didi. All these things will be arranged free of cost for you." ***- Married YWP, Santoshpur***

4. Additionally, the youth leader is perceived as a source for awareness for all issues and a destination for all concerns related to SRH as participants didn't express having witnessed hesitation and judgement from the youth leader. Instead, they viewed the youth leader as a resource that they could confide in without any judgement, ensuring satisfaction of participants from any experience of interaction with her by making them feel empathised and leading to high trust and comfort with her.

"I like how Xx Di explains everything. My son is very naughty so that is why I am not able to go there. I want to go there but can't go." ***- Married YWP, Moraripur***

"Didi says that if you face a problem that you cannot tell anyone, you can tell that to us and we will take you there. Also, if you are in some mental stress, and if it is worsening slowly and you cannot get out of it, also if there is some issue we can go there. I like those who conduct the meeting, xx sister is nice" ***- Unmarried YWP, Santoshpur***

"What she says is very clear. Plus if you don't understand something you can always go over to her and ask her separately." ***- Married YWP, Moraripur***

TOOLS AND TECHNIQUES

1. LIVE ITERATION: Repetition of information around SRH issues has been one of the most effective communication techniques leading to high retention and comprehension. Participants also exhibited greater attribution to constant reminders about correct practises associated with female hygiene to the intervention.

"They discussed urinary tract infection in meetings. Many women when having periods did take a dip in the pool which may cause infection or the pad that she uses, if it is more than 6 hours then that may cause infection, or the cloth that she is using, if it is not clean then infection can happen from there . What they informed me was needed. I didn't know about contraceptives and now I have come to know about this from them." ***- Married YWP, Santoshpur***

2. FREQUENCY: Regular interaction has had several positive programmatic effects -

    a. Increasingly establishing the importance of SRH issues and concerns

    b. Enhancing comprehension of SRH issues over time due to doubt clearance activities, and greater two-way discussion of issues faced by women in the community on a daily basis

c. Increase in trust allowing greater number of women to voice their concerns over time

d. De-stigmatisation of discussion of SRH issues

"In the second meeting, she explained the same thing properly. About periods. She said the female body contains a lot of eggs. Every month a egg is released and when it doesn't fertilize with a sperm it moves through the fallopian tube and into the uterus where it is shed with the uterus lining as periods. It felt good to know things I didn't know previously." - ***Married YWP, Moraripur***

3. PRESENCE OF DROPBOX: It was also brought to attention that a drop box is placed at the meeting location allowing women to have an option to voice their concerns or get an answer to their issues/queries, confidentially. This appears to allow greater participation in terms of interaction and clarifying issues leading to higher participation and incremental assurance of creation of safe and comfortable space for women.

"During pregnancy what all things are right and what is not right, they explained all that by making us play coin games. It's written in a circle, a woman becomes pregnant at 18, is this right? If no, then she puts the coin in "no". If it's right, she puts it in "yes". Sisters told us about a drop box. If anyone has any problem and is shy to share or ask, they can write it on paper and put it in a drop box."- ***Unmarried YWP, Santoshpur***

4. VISUAL DEMONSTRATION: Drawing or demonstrating pre-drawn diagrams as an activity during the meeting seems to be effective in facilitating a higher degree of interaction with the participants.

   Visual demonstration by drawing diagrams during the meeting exhibited a good recall value in terms of a communication method but slightly lower retention value of the topics explained through the method was observed leading to low effectiveness.

   Pre-drawn diagrams on the other hand seemed to be more effective for this age group.

"There was some writing/drawing on pink paper we had to flip them over and see, you know right? See people know what the external genitalia looks like but aren't too sure about the inner genitalia. So she showed us all the parts and spoke about their roles. The diagrams were on the pink cloth, she flipped through them explaining for us." - ***Married YWP, Moraripur***

5. DEMONSTRATION OF TANGIBLE PRODUCTS, ESPECIALLY CONTRACEPTIVES: This communication method involved demonstration of products like contraceptives including IUCD, condoms, pills, etc during the meeting. The practical aspect seems to have drawn attention of the participants and added a sense of practicality to the discussion leading to much higher retention of the concept indicated by thorough understanding of contraceptives among maximum intervention participants.

"She showed us many things and told us about many things. I didn't know about Copper-T. She told us about it and showed it to us. Then told us about contraception pills like mala, Chaya. I only knew of condoms, she showed me the rest. Showed us the medicines." - ***Married YWP, Moraripur***

6. DISTRIBUTION OF BOOKS AND/OR LEAFLETS: As a communication method, participants displayed efficient recollection of use of books and leaflets. But in case of the information shared through these leaflets and books, the recall was low making the effectiveness of this method questionable. Though,

one of the advantages of this method included participants being able to easily share their learnings with women in their family or peer group who might not have access to meetings.

"I got a book on menstruation, abortion and pregnancy from the meeting which i took home and read." - ***Married YWP, Village - 24 No. Lat***

"We got a leaflet on how to maintain hygiene during menstruation, about RTI and STI, birth control precautions, symptoms of being pregnant. I took it home and my mother and I read it." - ***Unmarried YWP, Village - 24 No. Lat***

7. GAMIFICATION: Explanation of SRH topics through gamification has been effective in ensuring greater interaction during the meetings along with easy comprehension of objective knowledge.

"We played a game related to abortion. There was one big circle. There were some coins, many things were written there. You have to read the things and tell which is correct and which is wrong. We also got to know about maintaining hygiene during menstruation. Didi played one game with us. She told us what to do during menstruation and what not to do." - ***Unmarried YWP, Village - 24 No. Lat***

"I learnt many things from the meeting. About abortion for unmarried girls, I did not know about these things. I can make use of it if I have any problem in the future. I did not change in that much time. xx Di told me to change the pad after every 5 hours." - ***Married YWP, Moraripur***

"Problems discussed in the meeting: *To keep hygiene at the time of white discharge and even menstruation. Disscussion on when abortion needs to be done and when you should not."* - ***Unmarried YWP, Moraripur***

"I had wrong information about Copper-T. Now, I have the correct information. Muscle in the stomach becomes thick. I did not eat it because it hampers health. How is the baby is born? What is the reproductive system? I did not know about it before, I know about it now. I had the wrong perception. I don't have those wrong perceptions now." - ***Married YWP, Village - 24 No. Lat***

"If in my village I get information about women's health and reproductive health it would be good. We would get to know so many things.I don't get the full knowledge from anyone. In the case of everything, whatever I know is not enough I think." - ***Married YWNP, Santoshpur***

2.A.3 EXPLORING <u>AGENCY / SELF-EFFICACY AMONG YOUNG WOMEN</u>

<u>MANIFESTATIONS OF AGENCY</u>	*<u>ROLE OF INTERVENTION - LATENT OR AND ATTRIBUTION</u>*
Increasing confidence to be vocal about family planning **and to assert choice of contraceptive method** - Non Intervention: Mostly at P1 stage - Intervention: Earlier, at P0	- At P1, women have had access to ASHA workers leading to slight increase in agency due to awareness about - a. Utility of family planning b. Significance of discussing/coordinating

- For intervention women already at P1, there is an intention to delay subsequent pregnancies owing to the incremental ability to communicate the utility of family planning to other family members especially, spouse.	family planning with spouse - At P0: Women attributed to being motivated by the youth leaders to assign greater importance to family planning and enhancing communication about the same with family members especially spouse - Programmatically, having access to a safe to discuss issues and and resolve concerns appears to have increased ability to be vocal about contraceptives and abortion as well as established the utlity of the products and the perceived benefits laddered by it.
Ability to identify and communicate the utility of family planning in terms of financial and biological implications - not only to spouse and family members but also women in peer group who might not have access to this knowledge	- Attributed to being aware of the utility of family planning and benefits laddered in enhanced health and finance
Displayed higher self confidence and greater belief in personal decision making	- The intervention has equipped its participants with a course of action to manage any health emergency providing them an overall greater level of confidence and belief in themself - It has also provided them a resource like the youth leader who is attributed to be extremely approachable to all the intervention participants for all kinds of concerns, including mental health issues
Capability, and confidence to share learnings from meetings with women who might or might not be in the need but haven't attended the meetings	a. Intervention has equipped them with information in a form that could be retained, comprehended, and shared due to repetition, doubt clearance and 2 way discussion leading to greater confidence b. Participants also realise the value of greater awareness about SRH issues and attribute it for observable changes in life. The observation of the impact on their personal lives has led to the tendency to share learnings.
There is significant prevalence of gender discrimination in the village, whether it be with intervention participants or non intervention	The behavioural changes related to identifying gender discrimination are minute and there is negligible direct attribution to the intervention.

participants. The difference lies in their attitude towards its occurrence. Intervention participants deem common gender discrimination practises inappropriate. They also displayed a tendency to ensure there are behavioural changes in their immediate family members. Non intervention participants displayed a tendency to justify these practises, deeming them as a need due to various circumstances.	But the overall increase in agency due to the intervention seems to have aided the intervention participants in deeming traditional practises as outdated and a cause of gender discrimination. This heightened awareness is absent in non-intervention participants.

"If I have some small issues then I can solve that by myself. If I am not feeling well then I will sit for some time and then again I will start working. That's as much as I have. If I see that I cannot do that at all then I would ask my mother in law for help." - ***Married YWP, Santoshpur***

"Firstly, with my husband then mother-in-law. Then I will discuss it with my mom and dad. They will tell me to consult a doctor if there is any problem." - ***Married YWP, Moraripur***

"Mostly I resolve my issues on my own. I will try to resolve it myself. I mostly don't tell anyone. If at all I have to share then I tell my friend, then she advises something and that's how I manage. I don't have much problem. Just like normal people spend their lives, my life is also going on normally, I did not get into any big problem yet. For small issues, I tell her and feel light." - ***Unmarried YWP, Santoshpur***

"I am able to solve the problem on my own. If I feel something bad I will cry alone. When I was small, If I used to feel bad for anything, I used to cry and go to my mother. I don't do it now. If I feel bad about something, I cry alone. I had a fight with my best friend. I was crying alone in one room. if i would like before i would have gone to my mom and told her everything about the fight with my best friend." - ***Unmarried YWP, Moraripur***

"If there is any physical problem, then I tell my mother, if there is anything related to studies, then I talk to my father. Which form to be filled and what to study. He never restricts me for anything, I can go anywhere and take any tuition, but then also I tell my father everything. There are some who decide on their own, may be with friends, but I am not like that. If I have to speak to someone, I speak in front of everyone, I generally speak with all, I do not discriminate. I am like an open book, I don't hide anything from anyone. I don't have any problem till time." ***-Unmarried YWNP, Santoshpur***

"When I was in 8-9 my mother had dengue and my sister was young and my mother n was ill so I had to do all the cooking I couldn't do but I tried. Grandmother was at home and mother teaches me now also and Jethima helped me." ***-Unmarried YWNP, Baribhanga***

2.A.4 UNDERSTANDING THE UTILIZATION OF SRH SERVICES AND EXPERIENCE OF ACCESSING SERVICES

- The knowledge of reaching out to healthcare providers like ASHA workers to access proper diagnosis

during medical emergencies or any SRH issue is top of mind for both participants and non participants.

- For intervention participants, the pathway to access SRH services is more clearly defined and the intervention has also equipped them for early detection of issues.
- The awareness of the course of action followed by ASHA workers or youth leaders is more detailed in intervention participants leading to greater preparedness for medical issues, and **far greater comfort in being able to approach youth leaders/CHIs for help**.

- Participants attribute the higher level of preparedness to -

    - **Constant pre-emptive reminders by the youth leaders to reach out in case of any emergency - medical or otherwise building a sense of trust in the community**

Thorough knowledge of steps taken by youth leaders and/or ASHA workers to relieve women in need of assistance due to repeated, two-way discussion during meetings.

- Provision of products like sanitary napkins, and contraceptives at sub centres is leading to easier access, something directly cited by the participants. *I*ntervention participants display significant satisfaction from the experience of accessing services.

- Participants consistently cite their appreciation for the friendly nature and approachability of youth leaders leads to lowered hesitation in communicating medical concerns, especially those related to SRH. This results in greater comfort in approaching the youth leader for access to SRH services and thus, more familiarization of the participant with the healthcare provider ecosystem.

- Intervention participants are aware of being able to avail the option of presence of youth leaders (as a safety blanket) throughout the process accessing healthcare services - always feeling like there is due recourse available, in case they should feel the need. Due to the inherent trust of the participants in the youth leaders, and assurance of confidentiality, there appears to be a greater confidence as well as higher satisfaction in the experience of accessing SRH services.

"If her child has some physical problems, she will take the child to a doctor or Asha Didi because Didi looks after all the problems from pregnancy to childbirth and all problems of the child. Asha didi will be able to say, she will be able to say a lot of things or she will contact the government hospital so she will go to her even for problems regarding menstrual periods." - ***Married YWP, Santoshpur***

"I can get help from doctors. Doctors are available in Kulpi hospital. People here generally don't go much to Asha didi. Everyone goes to Kulpi Hospital. People did not go to Asha Didi, they went to Kulpi Hospital as it is nearby." - ***Married YWP, Santoshpur***

"She has health problems and after Didi's suggestion and husband's approval, she went to the sub- centre and got an injection. It is taken twice. Second injection will be given after 15 days or 1 month" - ***Married YWP, Moraripur***

"My baby was born by cesarean. I haven't wanted a child for 10 years. I take an injection for birth control in the sub- centre every 3 months, and have taken it twice." - ***Married YWP, Village - 24 No. Lat***

"The Asha sisters of the sub-center also helped me. They told me what I should do when, how long I should sleep, and what all I should consume. They told me all these. They are the Asha sisters of the sub-center where I used to go. I used to go there to get my son. So, that time they used to tell me these. When I was pregnant that time they told me how I should take care of myself. After the birth of my child they asked me whether I wanted a second baby or not. They told me about contraception but they didn't say how and why." - ***Married YWNP, Santoshpur***

2.A.5 ASSESSING THE MENSTRUAL HYGIENE PRACTICES AND PERCEIVED TRANSITION DUE TO THE INTERVENTION

OVERALL KNOWLEDGE, ATTITUDE, BEHAVIOUR WRT MENSTRUAL HYGIENE AND HEALTH

- Participants express emphasis on need for menstrual hygiene with a clear correlation drawn to the possibility of contracting infection

"Pad is sanitary, there won't be doubt in the mind. In the case of cloth, if you don't wash it well, you can have rashes in the private parts. If you don't maintain hygiene and follow precautions, you may fall ill. If you are not clean, you take bath in lake water, if you use dirty cloth then you will fall ill." - ***Unmarried YWP, Village - 24 No. Lat***

- Young women participants also demonstrate the ability to share knowledge about the subject related to practises to maximise hygiene - avoiding pond water, minimising cloth use, in case of cloth usage washing it regularly, etc.
- They also showcase application of this knowledge of menstrual hygiene as well as SRH issues:
    - Undertaking the practice of storing packs of sanitary napkins by purchasing in advance to facilitate continued usage to maximise hygiene.
    - Ability to communicate sanitary napkin needs to spouse and/or other family members(usually, female if not spouse), often purchasing several packs at a time

"If we use clothes then we have to wash it and dry it in sunlight. If you give it in some isolated corner, then you might see that some insect or something is climbing on it. But we can use and throw it away." - ***Married YWP, Santoshpur***

"Use of clothes and pads. See it's advised not to wear the same pad for more than six hours. In the case of cloth we can't keep reusing it every month, we have to use new cloth every month. I rarely used cloth and mostly used pads only. I used a cloth only a couple of times."- ***Married YWP, Moraripur***

"We can't throw cloth away. We wash clothes well then again use it. If I am using it this month, I will use it next month if it is clean otherwise throw it away. We burn the clothes. I use it for 2 months maximum." - ***Married YWNP, 24 number lat, Tatipara.***

SOME CALL-OUTS:

- It seems that some of the women participants are inclined to overstate usage of pads (beyond what is physically and economically feasible). This could be a - using but not following complete practices
- Feeling the need to narrate correct practice - Theoretical understanding is sound

- With slightly older women of the young women age group, there has either been a partial or complete shift from usage of cloth to sanitary napkins. With the younger generation, usage of sanitary napkins since menarche is common.

"Switched to pad instead of cloth after marriage" ***- Married YWP, Santoshpur***

"I used cloth because the pad was unavailable. Date of the pad expired. I had to use cotton cloth that time."- ***Unmarried YWP, Moraripur***

"I always use a pad after marriage. Before marriage, I had used cloth." ***- Married YWNP, 24 number lat, Tatipara.***

STATED AND IMPLIED TRANSITION DUE TO THE INTERVENTION

- Intervention participants appeared to have become aware of the nuances of menstrual hygiene very recently, directly attributing to the meetings. Participants attribute this incremental understanding to repeated reminders at the meetings about significance of menstrual hygiene norms and laddering to possibility of an infection.

- Opting hygienic practises during menstruation or more likely, a combination of previously used practises and hygienic options in order to prevent infection

- Tendency to promote hygienic practises for women in their close vicinity - family members, friends, etc who might not have/had access to this information

"Still some of my friends are using cloth, so I tell them to use pads, as it is convenient. But many don't find it convenient; they are comfortable with cloth only. They say pads move away from the place or get stained. I tell them I don't face any problem. If we use it properly, it's good." ***- Unmarried YWP, Santoshpur***

"My periods were irregular. It didn't happen on the predicted dates, I sometimes missed an entire month, that's why I went to didi. She said there was nothing to worry as I was missing my period because my body was weak. It is normal for women to skip 1-2 months of their periods sometimes." ***- Married YWP, Moraripur***

"I was using cloth and I am using pad. Doctor said I had some infection. Doctor suggested that I use pad instead of cloth."- ***Unmarried YWP, Santoshpur***

"Previously cotton clothes were used but now sanitary napkins are used which is very good. I started using sanitary napkins through Asha Didi"- ***Unmarried YWP, Moraripur***

2.A.6 UNDERSTANDING THE PERCEIVED FEELINGS ON THE PREPAREDNESS OF MOTHERHOOD FROM THE LENS OF SRH (PERCEIVED IDEAL AGE AT MARRIAGE AND CHILDBIRTH) AND PERCEIVED TRANSITION DUE TO THE INTERVENTION

RETENTION

- Thorough understanding of biological mechanisms of pregnancy leading to awareness of the health implications of pregnancy

- Risks associated with pregnancy, symptoms of risks, ability to detect symptoms and opt for assistance of healthcare facility to access proper diagnosis

COMPREHENSION AND APPLICATION

- Ability to realise and communicate implications of pregnancy on one's own health, and assigning greater significance to the same.
- Understanding and adopting methods to avoid subsequent pregnancies - abortion and contraception
- Acquiring information about alternative course of action to be adopted to ensure no further parity - reaching out to youth leaders/ASHA workers and awareness about potential steps followed by them

AGENCY/CONFIDENCE

- Ability to communicate and discuss aspiration of parity with family members, especially spouse
- Ability to communicate needs in terms of practises, and/or products with family members, especially spouse, to avoid pregnancy subsequent to desired parity
- Increasing ability to be vocal about family planning - desired gap between subsequent pregnancies, choice of contraceptive methods

PERCEIVED TRANSITION

- For non-intervention participants, the understanding of appropriate age for motherhood is based on the aspirations of family members and expectations of the society/community(what is deemed appropriate by the community).
    - Intervention participants exhibit a thorough understanding of technical/scientific reasoning behind appropriate age for motherhood and are able to tie it to its tangible implications on the mother's health.
    - This knowledge is also directly associated with being made aware by the youth leaders, hence, attributed to the intervention.

"It was my decision and also our village Asha didi comes every month and tells me not to have a child before 20 years. It was mainly my decision. But the right age to bear a child is after 20 years". ***- Married YWP, Santoshpur***

"At the age of 21yrs is the right age for having a child" ***- Married YWP, Moraripur***

"I know that one can become a mother after the age of 21. People do this a lot. Because at this age the developments that happen in our body are almost completed. Because the private parts do not take proper form and shape till 21, that's why. Then maybe she can give birth to a child. Who will be completely healthy or will not have any problems may be". ***- Unmarried YWP, Santoshpur***

"21 is the perfect age to marry, have a kid at 22 years of age. If a child comes at an early age, there will be problems for mother and baby. If she becomes a mother at a very young age, the baby can't be born healthy. Because if she is not physically strong, how will her baby be healthy" ***- Married YWP, Village - 24 No. Lat***

"21 is the right age to become a mother. Because she will have physical strength in this age to give birth to a baby". ***- Unmarried YWP, Village - 24 No. Lat***

*"After marriage 25-26 is the age for becoming mother R: 25-26. My family members say that at that age the body develops".****-Unmarried YWNP, Santoshpur***

*"I think after 22, 23 – 24 a girl can become a mother, I have seen so and in the hospital also it is written that girls should be mothers after 21 years of age".****-Unmarried YWNP, Santoshpur***

"If she is 19 years old it's not right to marry before 18 and 19 years of age and it's good to marry after 21 and have a baby because if mens is not there it can be a problem for the baby. The baby can die and many people cannot save the baby. I think at the age of 22-23 years. She will be good in that age or else she can get handicapped. And those who marry at that age don't have nutrition on the body". ***-Unmarried YWNP, Baribhanga***

"I think one should take a baby after 20 years old which we read in the book. Before 20 years the body limbs of a girl don't get developed properly". ***- Married YWNP, Santoshpur***

"At 19 years of age. is the perfect age to become a mother. There will be no problem with the baby's health. There will not be any problem with my mother's health. Babies can be weak at start. Baby can have health issues. Baby is not healthy. If the baby is born at the perfect time, there won't be any problem. If she becomes a mother at the right age, there won't be any health". ***- Married YWNP, 24 number lat, Tatipara.***

2.B IMPACT OF YOUTH FOCUSED INTERVENTION ON ADOLESCENT GIRLS - 10-14 YEARS

2.B.1 AWARENESS AND KNOWLEDGE ON SRH-ISSUES

SPONTANEOUS AWARENESS

- Adolescent girls who have participated in the intervention demonstrate thorough, **nearly bookish** knowledge of SRH issues (includes identifying characteristics, management techniques, biological understanding behind it, along with visual demonstration) especially **physical and mental changes accompanying adolescence and the psychological implications of SRH issues**

"The changes that happen between the ages of 10-14 years are some start their periods and some don't. The skin/body becomes soft and oily. In girls the hips widen and for boys their shoulders widens. The muscles become harder in boys, their voices drop (get lower) and for women their voices get higher." ***-Unmarried AGP, Moraripur***

- They also demonstrate the understanding of bodily mechanisms associated with menstruation, forms of manifestation, along with details like **duration of menstrual cycle, involvement of hormones, and significance of menstruation in the female reproductive system (as a precursor to fertility)**

"I had thought that as everyone had said, periods last for 3-4 days. But initially I used to bleed for 5-6 days and I still do. So I asked Priyanka didi if I was bleeding too much. She told me the number of days varied from 3- 7 days and it wasn't any issue." ***- Unmarried AGP, Moraripur***

- Adolescent girls also demonstrate a thorough understanding of hygiene requirements related to SRH, along with a clear view of the absence of hygiene leading to the possibility of contracting infections in its absence

"If we take bath in the lake, white discharge problem occurs. You should change pads regularly, not take bath in the lake." ***- Unmarried AGP, 24 No. Lat***

- Subsequently, there is a clear understanding of symptoms associated with lack of menstrual hygiene, along with understanding of symptoms to detect infections, followed by the course of action needed to resolve them

"Debasmita Didi has even said that if there will be any health problems, meet Anwesha Didi. If you have white discharge problem, meet her." ***- Unmarried AGP, 24 No. Lat***

DEPTH OF KNOWLEDGE:

- There is some depth of knowledge that may be inferred from the level of anticipation and preparedness towards the potential discomfort accompanying physiological changes associated with SRH - such as requirement of adequate nutrition, needing iron supplements during menstruation, planning for management of menstrual cramps etc. Although, it must be noted that this is substantially less extensive than what is seen with the young women age group due to **limited practical application of the knowledge (by way of limited experience).**

"Didi told us about the iron tablet and she gave it to me but I did not consume it from that time, i used to keep it in the house. But Asha Didi and even Rakhi didi explains to us its importance. It helps in circulating blood. Due to periods, blood goes away from the body. Iron tablets help in generating blood. then start consuming it." ***- Unmarried AGP, Santoshpur***

- **Participant adolescent girls exhibit a sense of gratitude towards greater awareness of SRH issues, specifically menstrual hygiene**. They express an urgency to share their knowledge with family and peer groups due to the importance of heightened awareness in terms of their own health. On the other hand, in cases where non-intervention participants possess preliminary knowledge about certain issues, the importance of this awareness is low.

"My friend also went there because of white discharge problem. I had asked her to go" ***- Unmarried AGP, 24 No. Lat***

- Intervention participants not only display retention of theoretical knowledge of menstrual hygiene and symptoms of infections but also exhibit practical understanding of issues. This is indicated by use of appropriate practices and knowledge of process to access proper care in case of a medical emergency.

"Any mental health issues like depression, then any physical ailments like white discharge or stomach pain, irregular periods I will go to Anwesha Clinic." ***- Unmarried AGP, Moraripur***

- There is a some retention of theoretical aspects of contraceptives present but this largely is characterized by rote learning as they lack the understanding of biological implications and practicality indicating much lower comprehension. **Low comprehension seems to be owed to the information being age inappropriate making grasping the concepts difficult**

"Periods are related to the reproductive system. Germs which are there come out through blood. If it comes in contact with sperm, the baby is born. Through blood flow, it goes away. 10-19,the growing age, many changes come in the body mentally and physically. How to maintain hygiene during periods and about growing age. What should you use for birth control. Didi told us about a condom, Chaya." ***-Unmarried AGP, Village - 24 No. Lat***

CURSORY EXPOSURE TO CONTRACEPTIVES/FAMILY PLANNING

- Intervention participants exhibited a basic, theoretical understanding of contraceptives which includes its utility or role in preventing pregnancies. In contrast, non-intervention participants lacked awareness of contraceptives altogether. **This is likely because the participants have had some secondary exposure to content around contraception/abortion in intervention meetings, leading to some basic familiarization.**

"She got to know about periods, pregnancy, abortion from xx didi. She got to know about keeping herself clean and healthy during periods, what should be eaten, now she is more careful and follows all rules during and before periods." ***- Unmarried AGP, Moraripur***

- Correlation is primarily with 'the right age of motherhood.' Preliminary understanding of the importance of contraceptives in order to ensure that a woman becomes pregnant only when the female body is prepared for motherhood leading to lower risks during motherhood

"If someone has a baby at the age of 18, the mother or the baby may face some problems. She had a baby at that age because she didn't use any form of protection/contraception or did use it and it didn't work." ***- Unmarried AGP, Moraripur***

Stated And Implied Transition Due To Intervention:

- Thorough understanding of the health implications of SRH issues leading to **adoption of healthy** menstrual practices including use of appropriate products, early detection of any potential infection, and knowledge of reaching out to health care facilities, usually through family members like mother or sister

"If didi does not have pads then we buy pads from shops or use cloth. After 4-6 hours, we have to wash clothes well, dry them in the sunlight.sunlight kills germs which are there on the cloth." ***- Unmarried AGP, Santoshpur***

- Adolescent girls express the absolute a newfound for the compulsory use of hygienic methods of management during menstruation and opting for resources and practices specifically to ensure the same due to the awareness about possibility of infection

"I used to take bath in the lake even during menstruation but now, I don't take bath during menstruation. I eat nutritious food. These things stop white discharge. I follow these things so white discharge don't come." ***- Unmarried AGP, 24 No. Lat***

- Intervention participants also report now having the knowledge of possible course of action to be adopted in case of medical emergency associated with SRH, which includes reaching out to either female family members or youth leaders or ASHA workers

"I did not know about the changes in the body of a girl before. Menstruation comes, it is good and not bad. During menstruation, you should eat nutritious food, change pad after every 4 hours, and don't take bath in the lake. Clean your private parts well" - ***Unmarried AGP, Village - 24 No. Lat***

AGENCY

- For participants, there is a systematic de-stigmatisation and normalisation of the discussion of SRH issues - especially menstruation, bodily changes, prospect of marriage, pregnancy etc.

"xx didi spoke, initially I felt a little embarrassed and initially or you can say the introduction starts with the problems of periods but then I was comfortable." ***- Unmarried AGP, Moraripur***

- Ability to communicate characteristics of SRH not limited to superficial physical aspects that can be identified visually. But, the understanding of issues is often theoretical because of low relatability owing to age hence the practical aspects are often absent

"Body Changes: Voice changes, pimples come on the face. Height increases, breast growth, stomach changes. ".- ***Unmarried AGP, Santoshpur***

- Ability to share needs and wants in terms of resources and practices with family members(usually mother or sister), to ensure hygiene and prioritising own health, comfort and convenience during menstruation

"I get it from my mother and I don't go to buy pads, mother goes and purchases it for me." ***- Unmarried AGP, Moraripur***

- Possessing the confidence to reach out to family members(most often women) and/or youth leaders and ASHA workers in case of medical emergency associated with SRH

"If I face any problem, first I will tell my mother, then I will tell ASHA didi." ***- Unmarried AGNP, Baribhanga***

PROVIDER POV

OPINION ON IMPACT CREATED

1. Girls in this age group exhibit a high tendency to visit PHCs with family members like mother, or any other senior female member of the family - this in itself isn't a metric of their agency. But, they exhibit considerable hesitation in expressing symptoms or issues on their own.

"Young girls are there who feel shy" ***- Health assistant, No. 24 lat, sub-centre***

2. For girls in this age group, there is a much higher tendency to treat the discussion of SRH issues, especially menstruation with males, as a taboo.

3. A greater ease in communication is observable with the Anwesha counsellors due to the lack of female doctors in PHCs. Additionally, girls receiving formal education exhibit a clear ability to articulate their issues with greater clarity. But, a sense of hesitation and feeling of stigma towards SRH issues is omnipresent in this age group.

"Female doctors are not present here much. They don't want to talk freely with male doctors. Suppose, her aunt or mother came and told that this is the problem, that the girl will not talk about her problems freely. Some girls who are educated will tell their problems smartly but still there is hesitation in telling each and everything clearly. Below 18 like 14 or 15 mainly, they don't talk freely." ***- Doctor, Raidighi RH***

4. Girls in this age group also exhibit a greater need for counselling from doctors regarding the proper management of their concerns related to SRH and to reduce stigma towards the issue. A greater need for sensitization of the family was also noted by doctors for this age group.

"The 10-19 age group is our target group, girls and boys, they can be unmarried or married, we try to solve their health problems, be it physical or mental, they come to the clinic in the hospital. Our clinic runs 4 days in a week, Monday, Wednesday, Friday and Saturday. We have to make field visits on Tuesday and Thursday. We visited the sub centre, and we went to the camp of mothers and babies. We meet boys and girls of that age group. Whatever they want to know, we give information to them. We give proper information to them. We discussed several topics. Suppose, girls who have got married before 18 years of age, we call them up, we meet with them, and we meet with their family members. Asha Didi will come to the hospital, we will explain to them about contraception. We talk about sexual problems." ***- Anwesha Counsellor, Kulpi RH***

ATTRIBUTION OF IMPACT

1. Similar to the young women age group, providers attributed much of the observable change in behaviour to meetings conducted by the ASHA workers and the interaction of the adolescents with the ASHA workers and ANMs.

"Every month, Asha Didi conducts meetings. I see lots of changes. When I joined, they were not able to pronounce white discharge well, I did not understand the problem that time. I asked Didi about it, and she told me about it. I have been working for 12 years, they did not know the name of problems which they are having. Now, meetings are conducted, they go to school, and now they have learnt things properly." ***- Anwesha Counsellor, Kulpi RH***

2. They were of the opinion that intervention meetings appear to have led to a change in agency but haven't directly implied into behavioural changes and the behavioural changes visible in the community weren't often attributed to the intervention.

"If you will see the record here, teenage pregnancy and marriage is very high. It has not been controlled. We try to counsel patients, take public meetings but still there is no improvement. At 16 years of age, the family gets their daughter married. There can be pregnancy, they come to do abortion. Without telling anyone, girls may take medicine from outside. After some days, they come with problems." ***- Doctor, Raidighi RH***

COMMON SRH ISSUES THAT REQUIRE ASSISTANCE IN THIS AGE GROUP

1. As compared to the young women age group, visits of adolescents to PHCs are much lower and usually due to menstrual issues like dysmenorrhea, polymenorrhea, menorrhagia, etc.

"10-14 year olds generally come to the hospital with their mothers. The most common reason being Polymenorrhea, when there is pain during the menses. They mostly visit for dysmenorrhea which is common between the ages of 14-19 years." ***- Doctor, Raidighi RH***

2.B.2 UNDERSTANDING THE EXPOSURE TO SRH-RELATED ACTIVITIES, AND INFORMATION AND MESSAGE RECALL – INCLUDING EFFECTIVENESS OF DIFFERENT COMMUNICATION ACTIVITIES

A common observation for this age group is that communication methods involving greater degree of engagement of the participant always led to higher effectiveness of communication, like repetition during meetings, visual demonstrations, and one-to-one discussions.

LOGISTICS

Logistic designs of the intervention that helped increase attendance, hence effectiveness -

1. FREQUENCY: As with the young women category, frequency of meetings was unclear yet consistent. Here, due to the younger age of the women, frequency had a greater impact in ensuring higher recall of different elements of the intervention like preserving the relationship shared between the participants and the youth leaders as well as proper memorisation of the theoretical knowledge which was more prevalent in this age group.

"I wont be able to say how many meetings have happened till date. Nowadays I go for tuitions and I can't miss it as I am in class 10 and there is a lot of pressure. So till date I have attended 4-5 meetings." ***- Unmarried AGP, Moraripur***

2. DIVERSITY IN LOCATION OF MEETINGS: Considering the lower age of the participants for this group, the significance of diverse locations for meetings was higher here and allowed a variety of participants to attend meetings in case a particular location was inconvenient for a set of participants.

"There is a school - the meetings are either held there or at a ladies' home here." ***- Unmarried AGP, Moraripur***

3. MEETINGS AT SAFE SPACES: For the adolescent girls age group, assurance of meetings being conducted at safe locations reduced the hesitation of family members and built a sense of confidence in the community.

"Didi had seen me and she asked me to attend it as they were discussing these things. My mother also asked me to attend as this according to her was a good meeting." ***- Unmarried AGP, Moraripur***

MEDIUM OF ENGAGEMENT

1. Personalised information of schedule for meetings by the youth leader not only facilitated establishing incremental trust and comfort for the participants but also their families. Additionally, it seemed to play a role in getting a larger number of young participants under the purview of the intervention by personal communication with the participant as well as the family.

"They go to houses, talk with different people, then they come to the school and a meeting is conducted." ***- Unmarried AGP, Santoshpur***

2. HOME VISITS: Home visits conducted by the youth leader in case of adolescent girls created a greater sense of familiarity for the participants. It aided in visualisation of the youth leader as a family member or like an elder sister leading to greater comfort of the participant in confiding in her.

"I went to xx didi. She used to come to our house before. She used to talk about giving injections and all. She stays in Gram Panchayat. She gives lectures in the meeting. She gives instructions and guides well. She talked in the meeting." ***- Unmarried AGP, Santoshpur***

3. REFERRALS: The experiences of referrals were fewer in this age group because adolescent girls appear to prefer reaching out to their mothers or female family members in case of an emergency. However, the knowledge of the existence of healthcare facilities has led to a greater number of girls opting for a proper consultation from a doctor at early stages of manifestation of symptoms.

"Then I asked my sister that at this age you have the problem of menstruation, She told me no. A person can seek help from XX Didi also. I discuss with my mother. I can also talk with ASHA Didi or XX Didi then consult a doctor ultimately." ***- Unmarried AGP, Santoshpur***

POINT OF CONTACT - YOUTH LEADER *(IN ADDITION TO THOSE HIGHLIGHTED FOR YOUNG WOMEN)*

1. With the adolescent girls age group, the youth leaders appear to have an even gentler approach. This has helped in building trust and ensuring greater approachability.

"They explain everything very well. They are very polite and nice to everyone." ***- Unmarried AGP, Santoshpur***

2. Preemptive nudges from the youth leader to the participants to approach them in case of any issue or concern related to overall health has been instrumental in the participants being more vocal about issues and a greater depth of interaction.

"That if we have any problems we don't have to worry. We can tell didi about our problems and she can help us with it" ***- Unmarried AGP, Moraripur***

3. Of all the points of contact in the intervention, adolescent girls appear to have the most comfort in approaching the youth leader, followed by the ASHA and then the Anwesha counselor. There were very few adolescent girls who mentioned interaction with Anwesha counselors.

"It was good. I am satisfied with whatever xx Didi tell me and I don't go to Anwesha Didi." ***- Unmarried AGP, 24 No. Lat***

TOOLS AND TECHNIQUES *(IN ADDITION TO THOSE HIGHLIGHTED FOR YOUNG WOMEN)*

1. LIVE ITERATION: Across issues, there was a high level of memorisation of factual knowledge about SRH issues with direct attribution to repetition by the youth leaders - live iteration has been effective in high retention of objective knowledge.

2. VISUAL DEMONSTRATION: Participants had a clear recall of being explained certain elements about menstruation via visual demonstration that included either youth leader drawing diagrams during the meeting or demonstration through a pre-made diagram. For this age group, greater interaction facilitated by drawing diagrams during the meetings seems to have facilitated greater retention. Visual demonstrations were not only enjoyed by the participants but also viewed as an effective communication tool.

"They draw and demonstrate or tell us in the form of stories. They explain with the pictures given in the books, they have never shown a cartoon video." ***- Unmarried AGP, Moraripur***

3. DISTRIBUTION OF BOOKS AND/OR LEAFLETS: Participants in this age group cited fewer instances of having access to a booklet or leaflet. Additionally, there was low clarity about the contents of books - books and leaflets appear to widen the scope of awareness in the community but aren't effective in establishing the significance of the awareness.

"How these things happen, there are stories about this in the books and pamphlets and I listen to them, if we want to read those books they let us take it back home sometimes." ***- Unmarried AGP, Moraripur***

4. GAMIFICATION: There was higher recall of games like the coin game for this age group although the **variety** of games mentioned was low. However, the focus seemed to shift to the game itself, while the retention of topics taught through the method was low. Additionally, participants were unable to mention a variety of games. Hence, diversity in terms of different techniques for the communication method can be introduced to increase the recall of the topics taught through it.

"We played a game where right things were to be put in green, wrong things were to be put in red.I like playing games there." ***- Unmarried AGP, 24 No. Lat***

2.B.3 EXPLORING DEVELOPMENT OF AGENCY / SELF-EFFICACY AMONG ADOLESCENTS

INDICATORS OF PRESENCE OF AGENCY	*ATTRIBUTION TO THE INTERVENTION*
Incremental understanding of the utility of motherhood at a biologically appropriate age in order to reduce health risks associated with pregnancy at an earlier age.	Participants directly attribute this understanding to being made aware by the youth leaders at meetings - repeated discussions of health risks associated with maternity has led to increased retention of these aspects.
"Marriage should be at the age of 18 or 20 years and then not get pregnant before 21-22 years of age. See if you get married at an early age and have a baby. It can be harmful for the baby and the mother. There are also high risks of giving birth to handicapped babies." ***- Unmarried AGP, Moraripur***	
Ability to connect the importance of avoiding early marriage with appropriate age of motherhood, and ensuring greater education and possible prospects for a career	Participants expressed being reminded of the significance of higher education and being motivated towards it along with career prospects by the youth leaders at meetings. As the youth leader is viewed in a respectful yet friendly light, participants have a greater tendency to retain suggestions/advice from them.
"If someone has a baby at 23 - I can't say about the educational qualifications, maybe after her higher secondary she went to college and completed her education. She understands everything and takes care of her health. She is independent/ responsible and takes care of herself." ***- Unmarried AGP, Moraripur***	
Development of a 'sense of self' that is based on their own self awareness; which tends to	Intervention participants have had access to meetings where they have observed discussions and

otherwise be absent in non-intervention participants whose perception of themselves is based on the opinion of others in their family and sometimes, peer group (in the absence of a concrete opinion of their own).. Note: The level of self awareness for the intervention participants is lower in this age group as compared to the participants in the young women age group	perspectives held by others in a similar age group. This appears to have widened their own perspective allowing greater self awareness and a more balanced perception of their own life.
When asked about their good and bad traits - *"I can make everyone laugh. If somebody's mood is off, I can say something funny about them or something that will make them laugh. I get angry quickly/suddenly. Nowadays I also argue a little with my mother, so she also scold me for that. I think to myself that this is a character flaw but I cannot help myself."* ***- Unmarried AGP, Moraripur*** *"I am a shy person."* ***- Unmarried AGNP, Moraripur***	

2.B.4 UNDERSTANDING THE UTILIZATION OF SRH SERVICES AND EXPERIENCE OF ACCESSING SERVICES

- The utilisation of SRH services is limited to approaching youth leaders and ASHA workers for counselling and trace examples of issues related to menstruation.

"Asha didi gives us a packet of pads 1or 2 as per our requirement or sometimes we buy from the shop." ***- Unmarried AGP, Santoshpur***

- There is a stark difference in awareness about the presence of SRH services between the intervention participants and non-intervention participants. Intervention participants are aware of symptoms of various SRH issues allowing an early detection along with thorough knowledge of getting access to healthcare services through the youth leader or ASHA worker. In case of non intervention participants, the awareness about accessing SRH services or the course of action to be followed in case of any health issue is not as detailed.

- The utilisation of SRH services is minimal and usually through or with the company of family members, often mother or sister or a female relative due to a higher tendency to reach out to family members first in case of a medical emergency owing to age.

"Not faced any problem related to health but some complaints for stomach ache go to Anwesha Clinic with xx didi. Any mental health issues like depression, then any physical ailments like white discharge or stomach pain, irregular periods I will go there. Going to Anwesha clinic or to xx didi as we feel free and comfortable in talking to them." ***- Unmarried AGP, Moraripur***

- Family members of intervention participants in this age group high a higher sense of trust with the youth leader. Additionally, the intervention participants too, view the youth leader as someone whom they

could easily reach out to and is approachable. In this age group, there seems to be a higher sensitisation of families viewing the youth leader as a trustworthy resource for SRH services and counselling as compared to the young women age group.

- For the limited number of women who have accessed SRH services, there seems to be no negative sentiment towards the experience.

- Programmatically, as the youth leader was introduced through the ASHA worker, who is a well-respected figure in the community, the youth leader still seems to be viewed as, in association with the ASHA worker. This has aided in building trust and confidence in the community and aided in a greater number of women accessing the services of the youth leader.

2.B.5 ASSESSING THE MENSTRUAL HYGIENE PRACTICE AND PERCEIVED TRANSITION DUE TO THE INTERVENTION

OVERALL KNOWLEDGE, ATTITUDE, BEHAVIOUR WRT MENSTRUAL HYGIENE AND HEALTH

- With this age group, it is a common observation of usage of sanitary napkins since menarche - across both categories. With intervention participants, the knowledge of hygiene is more detailed with a thorough understanding of the significance of menstrual hygiene, laddering to the possibility of an infection. It includes the knowledge of the requisite time period between change of sanitary napkins, reduced use of alternatives, and the symptoms of infection allowing early detection.

"You should not take a bath in a lake. Eat healthy food, maintain hygiene. Clean your body with soap, use a pad. Wash your clothes or dress very well. You can't use cloth more than twice. You should dry it in heat. Throw it after using it." ***- Unmarried AGP, Village - 24 No. Lat***

- With intervention participants, there is a greater awareness of the role of menstruation in the female body.

- In case of intervention participants, when asked about menstruation, there is a direct association with the sanitation practises around menstruation with faint theoretical knowledge present as well. On the other hand, for non-intervention participants, the tendency is to associate menstruation with the superstitions passed on through generations of women in the family, even though there is slight knowledge of hygiene practices in the category.

"My mother told me how to use the pad. She asked me to stay away from my brother and father. She did not go to the Puja room. We cannot go to the puja room, stay away from brother and father, can't sleep with father. I sleep with my mother. When the pad is full, I need to change it. I keep them in one place, when the period gets over, my mother burns it off. I bath regularly, but I don't use soap at that time. My mother asks me not to use soap." ***- Unmarried AGNP, 24 No. Lat***

- There is also a faint awareness of nutritional supplements like iron tablets in intervention participants.

"Didi told us about the iron tablet and she gave it to me but i did not consume it from that time, i used to keep it in the house. But Asha Didi and even xx didi explain to us its importance. It helps in circulating blood.Due to period, blood goes away from the body. Iron tablets help in generating blood. then start consuming it." ***- Unmarried AGP, Santoshpur***

STATED AND IMPLIED TRANSITION DUE TO THE INTERVENTION

- Participants report placing greater emphasis on/attention to hygiene than before owing to numerous mentions of possibility of infection, during the meetings
- With non-intervention participants in this age group, the consideration of menstrual health as a taboo is highest as compared to any other age group. On the other hand, there has been a de-stigmatisation of menstruation among the intervention participants.
- Intervention has not only been attributed in decreasing the significance of superstitions to a minimum but also instilled the significance of hygiene maintenance associated with menstruation.
- Across categories and age groups, there is an awareness regarding the need for a nutritional diet during menstruation, but the seriousness is higher with intervention participants, potentially due to discussion about the same during meetings and its repeated mention by youth leaders, and ASHA workers.

2.B.6 UNDERSTANDING THE PERCEIVED FEELINGS ON THE PREPAREDNESS OF MOTHERHOOD FROM THE LENS OF SRH (PERCEIVED IDEAL AGE AT MARRIAGE AND CHILDBIRTH) AND PERCEIVED TRANSITION DUE TO THE INTERVENTION

- In this age group, there was an increased awareness of the harmful implications of elopement associated with being advised and warned against it(eloping) by the youth leaders because of its consequences in an early pregnancy. Additionally, early pregnancies were identified to occur due to the following reasons only -
    - Unstable financial state of the family hence daughters are married off early leading to early pregnancies
    - Family pressure (related to previous point)
    - Conceiving accidentally

"It is not good to get pregnant at a young age. If someone gets pregnant at less age, then that would be a problem." ***- Unmarried AGNP, Baribhanga***

- A theoretical understanding of the right age for motherhood was also observed across categories. The reasoning supporting the statement was slightly more scientific and biologically based for intervention participants, clearly associating to the discussion in meetings.
    - Parallely, an argument based in desire or agency or psychological preparedness to reason an appropriate age for motherhood was absent.

"The right age of having a baby is21 yrs. At 21 years of age, she will be mature enough to handle a baby. I don't know the reason but it is the right age. Body is strong at this age." ***- Unmarried AGP, Village - 24 No. Lat***

- Although a general understanding of the appropriate age for motherhood is present, girls in this age group, across categories often only have superficial knowledge of the issue. It is ingrained well in the intervention participants because of how the right age of motherhood seems to be treated as a rule of thumb at meetings.

"After 21 years of age is the right age to become a mother. Baby will be healthy, and the baby will get nutrients. Health of the mother will be good." ***- Unmarried AGP, Village - 24 No. Lat***

- Perceived Transition: Several intervention participants mentioned having been counselled and motivated by youth leaders on a regular basis to finish studying at the least before opting for marriage and subsequent motherhood, and avoiding elopement at all costs. Youth leaders' approachability is also high in this case.

- Biologically appropriate age for motherhood, reasons behind it with a incremental scientific understanding and implications of breachment of this age on the health of the mother and child

"The right age to have a baby is 21 yrs. She may be studying in college. Baby will be healthy and good."- ***Unmarried AGP, Santoshpur***

- In case of maternity, only theoretical knowledge seems to be present and provided, and there is minimal practical understanding observed which might be a result of lower age of this group.

- Role of early marriage in early motherhood and laddering to implications of elopement

RETENTION AND COMPREHENSION

- Although there was an objective understanding of the appropriate age for motherhood and its significance - it was superficial and limited to factual knowledge. Intervention participants expressed minimal understanding about the legal and biological explanation behind it and the implications associated with motherhood before the age or any perceived benefits of motherhood after the age.

"The girl herself can understand her health and since the girl is 21 years of age, she can conceive and she will have that level of maturity as to how she should be prepared. Because one can keep a child after 21 years of age." ***- Unmarried AGP, Santoshpur***

- Non intervention participants exhibited minimal objective knowledge and their understanding was based on knowledge passed through generations of women in the family and hence assigned greatest importance to the aspirations of family members.

- Delayed motherhood and prevention of early marriage was often laddered and associated with the aim of education upto graduation and sometimes even job prospects.

APPLICATION/AGENCY/CONFIDENCE

- Since the knowledge is superficial, application is minimal although observable in the aim for completion of education and possible career before having children - hints of family planning

PERCEIVED TRANSITION

- The implications of elopement and the perceived benefits of delayed pregnancy was directly attributed to the intervention due to the recall of having been instructed about it by the youth leaders.

- Objective knowledge of appropriate age for motherhood appears to be almost memorized. Additionally, for this age group, most of the intervention participants' knowledge of this issue is attributed to the

intervention. Hence, it appears that high retention of the objective knowledge is due to the repetition of this topic and several reminders regarding risks of early marriage and elopement during meetings.

"Marriage should be at the age of 18 or 20 years and then not get pregnant before 21-22 years of age." - ***Unmarried AGP, Moraripur***

2C. IMPACT OF COVID

The data collection for the study was conducted at the time when the entire country was reeling under the impact of the second wave of COVID 19. Therefore it becomes imperative to capture the perceived impact of the pandemic on SRH related issues.

IMPACT OF COVID-19 ON ACCESS TO SRH INFORMATION AND SERVICES

Menstrual Hygiene:

ISSUES

- Supply of sanitary pads getting exhausted at point of purchase, due to pandemic

"Shops were opened here, pads were available. If pads won't be available, have to use cloth." - ***Married YWNP, Moraripur***

- Temporary interruption in distribution of subsidized packs by ASHA workers during Covid

"On asking why she doesn't take cheaper sanitary napkins from ASHA workers: I don't come or when they come I am not at home. Or they are giving to 18 years old. They don't always come also, so I may go somewhere." - ***Unmarried YWNP, Santoshpur***

PRACTICES ADOPTED:

- Leveraging own access to source of procurement and positive relationship with provider, to ensure that stock is pre-secured (pre-emptive action)

"There is a shop near my shop, so I get pads from that. We have requested that the shop owner keep pads and from then they were keeping them and it was selling well also. When Covid had just started we requested the shop owner." - ***Unmarried YWNP, Baribhanga***

- Purchasing and stocking own supply of sanitary napkins (pre-emptive action)

"I buy pads from a shop. Most of the time I get it but if I tell my husband he also gets it for me. I don't usually face any problems. I always bring it in advance" - ***Married YWP, Santoshpur***

- Due to unavailability or irregular supply of the subsidized packs, purchasing more expensive brands

"M: I have heard health workers give pads at a cheaper price? R: Yes, but they do not give in every month." ***- Unmarried YWNP, Santoshpur***

- Outsourcing responsibility of procurement to spouse, from a different location where supply is available

"We do have a shop close by and I get from there or else when I ask my husband then he gets this for me. I don't have to ask my husband because my sisters are there. Now the shop is close by. Earlier I didn't have this shop here so I asked my sister and she used to get it from the market. Now I get it from the shop also." ***- Unmarried YWNP, Santoshpur***

Consultation/Counseling (Information Needs)

ISSUES:

- Inability to reach the right resource in case of a medical emergency

"Maybe it will be an emergency, maybe the pain is too much, that they will not be able to contact ASHA didi, they cannot wait that much and have to go to the doctor immediately." ***- Unmarried YWNP, Baribhanga***

- Health issues like white discharge or menstruation related issues, in case of young women - exceptional side effects of contraceptives

"I used to take bath in the lake even during menstruation but now, I don't take bath during menstruation. I eat nutritious food. These things stop white discharge. I follow these things so white discharge don't come." ***- AGP, Village - 24 No. Lat***

PRACTICES ADOPTED:

- Communication with youth leaders and ASHA workers(more so, former) via calls in case of absence of meetings or face-to-face outreach - exchange of contact information done beforehand

"There was not much problem because of Covid. Sisters came and recently there was a meeting. Right now the situation is very bad, but we did not have much problem. We could go to the sub center and take pads. And now it's not like if I don't see you for 10 days, we won't talk. Now we have mobile phones, if there's a problem, I will find out the solution. We talk on the phone" ***- Unmarried YWP, Santoshpur***

- Visits to ANWESHA clinic for consultation, often with the company of the youth leader.

"I have not faced any such problem till now, but anyway the sisters tell us during meetings, if we have any other issue, not just physical but even mental issues we can tell them. They will take us to Anwesha sisters. Their work is not just limited to physical but even mental wellbeing of all women." ***- Unmarried YWP, Santoshpur***

CHAPTER 3 - CONCLUSION & WAY FORWARD

The youth-focused intervention by IDF has had a multi-layered impact across its set of stakeholders. The qualitative assessment has resulted in evidence that includes:

- ➔ Awareness and knowledge of SRH issues
- ➔ Preparedness for motherhood
- ➔ Self efficacy and ability to seek information/assistance for SRH issues
- ➔ Utilization of SRH services and access to providers

The role of the youth leaders complemented by the CHIs and PHC staff has played an instrumental role in enabling adolescent girls and young women alike - to be exposed to substantial information, be engaged with a variety of tools and techniques, be given the space to engage safely and seek redressal for their concerns, and to be confident of taking decisions regarding their own sexual and reproductive health.

The palpable shift in the approach and attitude towards SRH issues, needs and services amongst the younger women as well as adolescent girls is both perceived through their response, as well as stated by them with the understanding that participation in the intervention has benefited them.

3A. BEST PRACTICES - APPROACH THAT MUST BE RETAINED

- Dependence on youth leaders due to regular interaction and feeling of safe space: In case of intervention participants - due to the regular interaction in a space where they are treated with utmost care, empathy, and comfort, ASHA workers and youth leaders are seen as resources that they can depend on as much as they depend on female family members.
    - Comfort induced by common link: In case of non-intervention participants, one reason for reaching out could be referrals, ie, some acquaintance would have mentioned reaching out to these resources leading to the level of comfort to reach out to the workers.
- Prior experience of assistance, information, and guidance: In case of younger women[both adolescents and unmarried women in the 15-24 category], the fact that ASHA workers and youth leaders have been a reliable source of information and SRH resources like contraceptives(available at sub centres), pads, etc, has led to the comfort level required to reach out in case of emergency.
    - With intervention participants, several of them have experiences of youth leaders being patient with their concerns - girls/women have returned to them with questions or concerns post meetings to clarify things a second time and they have received a satisfactory response. This response has aided in building a sense of comfort and the idea that they would be treated satisfactorily in case they reach out to them in times of need.
    - This is especially true in the case of adolescents - **the friendliness and patience from the youth leaders has been a major factor in building trust in the community.**

- Reinforcement of accessibility: Women have claimed that they are continuously reminded during meetings that they are supposed to come to the workers or youth leaders in case of emergency. The reinforcement enables them

- For 15-24 year old women, since the source of information for the meetings was the ASHA workers - a resource with a pre-existing trust with the community, the women had minimal hesitation in attending the meetings the first time.

- Flexibility in sharing issues, with the option to reach out in social settings, individually or anonymously: Multiple mentions of the benefits of a drop box allowing them to discuss issues bothering them without the compulsion of having to disclose their identity.

3B. RECOMMENDATIONS FOR THE INTERVENTION

1. **Tackling the barrier to participation:** One of the critical concerns that non-participants seem to experience in being able to attend the intervention is the clash of meeting timings with their (unavoidable) domestic responsibilities. In some cases, the youth leaders have devised a mechanism to set timings for meetings in consultation with the women of the village. Further, some of the youth leaders also change the venue of the meetings to different locations in the village, so as to be accessible on a rotational basis. This may be replicated to ensure that the maximum number of women are able to participate.

2. **Family counselling/sensitization to enhance participation:** It is seen that a key reason for non participation by young women and adolescents is the resistance of family members. Especially in the case of minors (adolescent girls), family members tend to be unwilling to allow girls to visit the 'safe spaces' on their own. The accompaniment of girls/women to these spaces is a deterrent to sharing and discussing issues related to SRH comfortably. It is critical to thus engage and manage the expectations of family members, and further to consider sensitizing them to the same issues, so that they may offer support to girls/women when the need arises.

3. **Segregating age-appropriate content:** This is required to ensure that topics discussed are not only retained but the girls can also **apply** the knowledge gained due to the factor of relatability, ie, knowledge provided should be age appropriate. For instance, some young women express some discomfort in being able to discuss topics like contraception or abortion when they feel that 15 to 17 year old, unmarried girls are present in the same space. This can be resolved with the creation of sub-groups based on age and/or marital status.

4. **Incentivizing attendance and participation**: Several young women state that if the intervention were to distribute sanitary napkins free of cost, this would most likely increase attendance. Though this may not be feasible, the program may consider incentivizing participation in the form of milestones - such as receiving some items/services related to SRH upon achieving milestones of participation

5. **Need for greater sensitization & familiarization of providers and counselors:** Due to the complete unfamiliarity, girls and young women find themselves at unease with the providers, in spite of a robust referral system being championed by the youth leaders. It may help to have the PHC staff for a designated location, visit the field occasionally in order to build rapport with the community. Further, since most doctors tend to be male, the topic of addressing SRH with male doctors requires systematic destigmatization. On the provider end, doctors feel that young women are more likely to visit a counselor

than a doctor, even when the latter is required. It may help to extend private spaces for doctor consultations.

APPENDIX

PROVIDER EXPERIENCE & ROLE IN THE INTERVENTION

The study had also included some interactions with Providers as well as Community Healthcare Intermediaries to understand their perspective. The relevant portions have already been added in the sections with the Young Women (**2A)** and Adolescent Girls (**2B).**

A very detailed report on the Provider perspective is being provided below to help the programme understand the context of these stakeholders better and if necessary investigate this further since the following findings are based upon a very small sample size.

2.D.1 COMMUNITY HEALTHCARE INTERMEDIARIES ASHA/ANM (based upon 3 in-depth interviews)

- **Perceived Role versus Role in Intervention**
    - The main focus of the work of ANMs is antenatal and postnatal care along with infant care, family care and a focus on vaccinations. In case of ASHA workers, the range of work is broader, inclusive of the entire village with a focus on issues of women in the village.
    - **For the intervention,** ASHA workers expressed handling the logistics of the intervention which included coordination with participants to ensure maximum attendance, along with coordination with others involved in the conduction of the meeting like the youth leaders and sometimes the ANMs.
    - ASHA workers also play a key role during the meeting - **as noted by other service providers**, they are involved in counselling for psychological issues associated with hormonal changes along with mental health issues across age groups.
    - The division of duties between the youth leader and the ASHA worker for the conduction of meetings and ensuring interaction with young women is not very clearly demarcated. Healthcare Providers (doctors, nursing staff) are of the opinion that meetings are organised as well as conducted by the ASHA workers.

"We have to do all kind of work in some we have to give more time and some we have to give less. As per the action plan I go to a village and I have to do vaccination but I cannot go to another village at that time to complete it so at that time xxdidi goes to that village to complete it." ***- ANM, Santoshpur***

"We do multi-purpose work.We have to take responsibilities of look after pregnant lady, children, family planning. In our sub-centre, we give elementary medicines.For fever, loose motion, cough and cold, cuts" ***- ANM, No. 24 lat, sub-centre***

"Before Asha workers were recruited, I used to go house to house and do field visits and tell them. Also by gathering them I used to do meetings also. After that my work as increased because I have to go and also do monitoring all the work, and load of work has increased" ***- ANM, Santoshpur***

- **ASHA/ANM's Experience of the Intervention**
    - ASHA/ANMs displayed a high sense of enthusiasm towards the work associated with the intervention - they considered it a part of their responsibility towards the community they were already looking after.
    - ASHA workers and ANMs realise the potential of the intervention in creating impact in terms of awareness generated hence leading to better overall health of the community. Hence, their responsibilities associated with the intervention weren't viewed distinctly and instead viewed as one of the duties assigned to her as an ASHA worker or an ANM.
    - ASHA workers and ANMs expressed receiving detailed training before the beginning of the intervention - they received booklets and leaflets for reference.
    - The training also involved a detailed explanation of SRH issues including decorum involved while discussing and educating other girls and women about SRH issues. This part of the training was appreciated by providers because they felt better equipped to carry out their duties.

"I have to call all of them and gather them in one place and then organize the meeting and after that explain to them. No matter what we feel this is our work and we have to do it and we are committed to that. If we have any irritation about it then we will not be able to do this work because we work in the field and we cannot have any irritation or problem about it. We work as everyone's mother. Some people may say something that we may not like but we have to explain it to them like a mother. If you get angry you cannot work in a public place because the responsibility of explaining it is ours. As much as possible we are trying our heart and soul to explain to them to make improvement in their life, so that they become aware" ***- ASHA, Moraripur***

"I was also involved in the meeting as young women feel shy so to make them talk to us or to Asha Didi or to yy didi." ***- ANM, No. 24 lat, sub-centre***

"As much as possible we are trying our heart and soul to explain to them to make improvement in their life, so that they become aware" ***- ASHA, Moraripur***

- **ASHA/ANM's understanding of community and stakeholder comfort/response with intervention**
    - ANMs feel that girls don't have so much time to attend meetings and they are much more frank with ASHA workers than the youth leaders

"The girls between the age of 15-19 visit us more with the problem of menses along with headache." ***- ASHA, Moraripur***

"Mostly who come on their own are the pregnant women in the 20 to 24 age group because they know one thing that they have to take tetanus. The girls below 20 years also come on their own when they need a sanitary pad." ***- ANM, Santoshpur***

- **Perceived impact of intervention on the target stakeholders (with anecdotes)**
    - ASHA workers and ANMs expressed that there has been significant impact of the intervention and their perception of impact of the intervention was greater than that of doctors and Anwesha Counsellors.
        - Noting that ASHA workers and ANMs have greater interaction with women and girls at the ground level - they appear to have observed the change in agency and behaviour in greater depth.

"Women become more aware and able to tell their problems to others. They tell the problems to us and then we take them to Anwesha Clinic for treatment." **- *ASHA, Moraripur***

- The impact of the intervention can be perceived in the greatest proportion in the change in agency - women across age groups increasingly display greater ability to articulate SRH issues using proper terminology with hesitation decreasing over time. ASHA workers and ANMs also attribute it to the intervention for the gamification of SRH issues piquing the interest of the community.

"Women are becoming more aware and taking interest because the things are explained with the help of games and quizzes." - **ASHA, Moraripur**

- The change in agency hasn't directly contributed to behavioral changes which is where ASHA and ANMs see greater potential for impact by the intervention.
- ASHA workers and ANMs attribute the behavioural changes in the community to the meetings conducted by them instead of the intervention - there seems to be a lack of clarity in distribution of duties between these two entities.
- The increase in caution towards infections including change in menstrual hygiene habits is attributed to the meetings conducted by the ASHA workers and ANMs due to higher frequency of meetings, distribution of sanitary napkins by ASHA workers and greater ability of the women to communicate with ease with them.

"Like they are using pads, and even if they are not getting from us, they are buying it, then they have understood the importance of that. When they are not getting pads from the government but they are taking money from the parents and buying it, then they have understood There have been changes in the mind-set like we understand when we ask questions like what do you do or maintain during the menstrual period. Then if they can answer then we understand that there is a change in mind-set" **- *ANM, Santoshpur***

"Some regressive people blame us that we are discussing things openly so children are running away and getting married. They are obviously not happy with our work" **- *ANM, Santoshpur***

"Previously women used to feel shy but now after speaking regularly on this it has reduced. They say like when we were small we used to use clothes then why are you giving all these things. Then we have to explain to them that auntie, in clothes there may be many bacteria whereas in this it is use and throw, so there is no fear of bacteria, so lot of improvement has taken place after explaining like this" **- ANM, Santoshpur**

Recommendations made by CHIs for the Intervention

1. ASHA workers and ANMs noted that for the muslim community, which has a significant presence in the area of operation of the intervention, IUCD which is most prevelant in the state is considered a sin. Hence, promotion of IUCD to the women of this community led to major backlash. They recommended increasing the emphasis on condoms and pills or other contraceptive methods along with increasing awareness about these methods specifically to help women of this community.

2. ANMs also recommended a deeper look into the emergency contraceptive pills because they knew of cases where women conceived even after taking the emergency contraceptive pill. They seem to expect a source of generation of greater awareness among the community as well as among CHIs about the topic.

3. ANMs and ASHA workers emphasised on the importance of sensitization of entire families instead of just women in this age group multiple times. They believed that even if women had access to the information related to SRH issues, they weren't able to take action because of lack of support from their families, especially from their spouses or mothers-in-law in case of abortion and contraceptives.

    - Several points of change in awareness that could have been transformed into behavioural changes, haven't taken place due to the lack of family sensitization and CHIs believe that the scope of impact could be widened with the introduction of family sensitization.

4. CHIs also believe that involving a greater number of people in the logistics of the intervention would heighten the impact. To put it into context - currently, there is 1 youth leader working with the ASHA worker. But, CHIs believe that if the community could witness 4-5 people making regular home visits in order to increase awareness about SRH issues along with a senior level participant being involved with these youth leaders - there would be greater impact due to the following reasons -

    - Increase in significance of these issues in the minds of people
    - Greater coverage in terms of number of homes covered and the frequency of home visits

    The impact then created would then involve behavioural changes along with the already present change in agency.

5. The number of meetings conducted should be increased. The CHIs are of the opinion that the intervention meetings are conducted once in a few months and increasing manpower, as mentioned earlier, could lead to an increase in the number of meetings that can be conducted.

6. CHIs also recommended methods to increase participation and attendance in the meetings

    - Providing a small meal or snack during the meeting could directly lead to greater participation.
    - Greater use of games and quizzes could lead to increased interaction in the meetings generating interest in the topic.

"More meetings to be conducted to explain them more. Some competitive methods to be adopted like quizzes and multiple choice questions that will create an interest and people will visit the meetings more in number." ***- ASHA, Moraripur***

"As I told you sometime back that if more of us can gather together and go then it would be better, means more manpower. If xx goes alone, then things will not work faster." ***- ANM, Santoshpur***

"Awareness was very less before. Girls did not come before but now, it is developed. Napkins are useful to them. Family planning methods, we don't have the right amount of supply, they have to buy things, supply should be good. Condoms, OP are unavailable, there should be a good supply of these things. Tiffin should be arranged in the meeting." ***- ANM, No. 24 lat, sub-centre***

"We are taking meetings but we need support, and can't do so much work. They help us in giving more output." ***- ANM, No. 24 lat, sub-centre***

"The improvement needed is that as xx is doing the program alone with Asha, if someone on the senior level does the monitoring, then it would be good. I feel that the community wants more people to come. If there are 4 or 5 people who visit their home, then that creates a better impact then they give more importance to it." **- ANM, Santoshpur**

2.D.2 DOCTORS & NURSING STAFF at PHC…(based upon 5 interviews)

Role in intervention

- Doctors expressed much of their workload involved an emphasis on the issues of pregnant women, new mothers, and babies. Additionally, their responsibilities were noted to be mostly outdoors. Doctors also noted a lack of distinction in space between male and female in the emergency ward leading to greater inconvenience for women to express their concerns.
    - A significant proportion of their workload also include sterilization most often rooted from a referral attributing to the intervention.
    - The role of doctors in the intervention also involved meetings with the field staff and coordination with ASHA workers.
- Anwesha Counsellors described their role as dealing and resolving issues of women in the age group of 10-19 years, not limited to physical issues but also psychological issues related to mental health.
    - Their responsibilities involved field visits, meetings with new mothers and children at camps and visits to the sub centres.
    - Responsibilities in terms of counselling involved providing appropriate information, conducting discussion on relevant SRH issues - most often, contraception and a larger umbrella of sexual problems.
    - Anwesha Counsellors also often found themselves dealing with nutritional issues common in the age group for women hence, explaining significance of proper diet and prescribing iron tablets. Much of the change in behaviour towards dietary supplements and the increasing awareness of proper nutrition is owed to Anwesha Counsellors' work.

- One of the most significant responsibilities of the nursing staff included the promotion of IUCD by counselling women to get it implanted and facilitating the procedure. Their duties included making women aware of the utility of IUCDs along with procedural details, etc.
    - Hence, in turn, they also look into cases of abortion which require counselling. They often directly receive referrals from the field or encounter women who would need assistance in this area. Nurses are then responsible for motivating women to opt for an abortion, facilitating the procedure through the doctor and counselling through the Anwesha Counsellors, following which nurses also motivate these women to opt for an IUCD - there is a clear distinction in responsibilities in the PHC regarding abortion and accidental pregnancy cases.
    - The nursing staff also play a key role in antenatal and postnatal care facilities - they provide information to new mothers regarding diet, medication, vaccination, etc. Additionally, they also motivate new mothers to immediately opt for an IUCD or other birth control methods by informing them of the basket of options available to them.
- Several providers in the PHCs spend significant amounts of time in counselling young women against early marriages and subsequent early pregnancies. There is also an emphasis on mental health issues as providers feel that suicide is quite prevalent in the area. Lastly, Anwesha Counsellors and nursing staff also look into filing FIRs when dealing with sexual harassment cases.
- Across providers, there was no negative sentiment towards the youth leader. If asked, they were appreciated for their conduct at work and were considered friendly.
- Doctors expressed sharing a close relation with ASHA workers at the workspace - one of the most significant duties of doctors included maintaining constant communication with the ASHA worker in order to clarify doubts related to SRH issues, ensuring proper coordination in provision of services or meetings, and providing consultation regarding birth control devices. This coordination mainly took place over call due to greater hesitation of people to come to hospitals due to Covid-19. Doctors also expressed an ease in communication with ASAH workers and presence of efficient coordination.
- The nursing staff and Anwesha counsellors expressed a high level of satisfaction from the work they were doing for the intervention. This is because they were of the opinion that they were making a quantifiable impact by helping people who were in need of assistance.
    - Due to high satisfaction levels, they viewed their duties of intervention as a part of their usual work and would ensure separate allocation of a few hours of their day to fulfil these duties.
    - High enthusiasm of the nursing staff and Anwesha counsellors can be attributed to their greater degree of interaction with women at an on ground level. Closer contact with beneficiaries of the intervention seems to have led to greater empathy towards them along with an understanding of the significance and need for it.
- Doctors on the other hand displayed much lower enthusiasm towards the work of the intervention. This was indicated by low effort in fulfilling duties of the intervention along with an absence of a specific management tactic that they use to balance the work - this indicated a low significance of intervention

duties among all the work they were responsible for. They also displayed an ambiguity about time commitment towards the intervention duties.

- Across providers, a significant increase in workload was noticed and attributed to increase in responsibilities with an absence of proportionate increase in manpower. But, they displayed no negative sentiments about this occurrence.

- Providers also informed of receiving formal training attributed to the IPAS team before the official beginning of their duties associated with the intervention. They also informed of the presence of regular supervision of paperwork done and records maintained by the team. Moreover, there was a comprehensive understanding of the role and work of IPAS attributed to the training received.

- The nursing staff particularly expressed that the training was helpful to them as they noticed a lack of awareness about specificities of SRH issues. They observed a greater ability to motivate and counsel people due to the training received. Moreover, doctors also expressed acquiring advanced practical knowledge due to the training that they weren't aware of before.

"I have different categories of patients. Lots of mothers with their problems come to me. Whatever is required, I give them enough time." ***- Doctor, Mathurapur RH***

"I mainly take care of incomplete abortions." ***- Doctor, Raidighi RH***

"Till 24 years of age, patients come to us. They work in sub centres in the village basically. They refer to us sometimes and may be Asha Didi. Basically, they work in sub centres, I go with them sometimes. Currently, we see patients for contraception, pregnancy, abortion in majority. We take meetings for young girls." ***- Anwesha Counsellor, Kulpi RH***

"People are aware about IUCD now. Before, 10-13 numbers used to come before 3 years, 5 have come maximum but number 7 or 8 or 9 did not come before, there is change." ***- Nursing Staff, Kulpi RH***

"I do outdoor, there are different categories in outdoor like diabetic outdoor, hypertensive outdoor, chest clinic, I look after these. There is an emergency, I look after my family, sterilize work, girls related problems, one doctor gives training, she helps, her name is Shabnam Rahman." ***- Doctor, Mathurapur RH***

"I am a second medical officer here. I have to look after the administration and officials in the hospital. I attend a public meeting. I have to coordinate with other medical officers." ***- Doctor, Raidighi RH***

*"I treat the emergency patients in the hospital. I practise anaesthesia, I don't give anaesthesia in the emergency department. I practise emergency medicine in emergency and I am in charge of the maternity unit. I look after the incomplete abortion cases."****- Doctor, Raidighi RH***

"General ward, male ward, female ward, everything we have to handle. There is lots of rush.. We have to do counselling to mother. Didi of Ipas are very good, they have given good training. Mothers from 16-21, we motivate them. One mother will come, we check after she goes to the bathroom, we motivate them. Our work is to motivate them, do ICT, that is our work basically. There is xxDidi, dropbox is allotted, we tell mothers to drop problems in the drop box. We are not there with them all the time. We will be there for that period of time. When an active level patient comes, will they get motivated or reduce pain? One mother will be there in the field, it is very good. We motivate them". ***- Nursing Staff, Kulpi RH***

- **Understanding of community and stakeholder comfort/response**

Doctors

- Doctors observed an increase in utilisation of SRH services by adolescent girls. Since a sense of hesitation is omnipresent, the number of visits by girls to the PHC are still minimal. But, girls increasingly opt for consultation with doctors through other means.
- The number of younger girls visiting and utilising services of PHCs still remains low. They were observed to be accompanied by parents or family members on their visits to the PHC. Additionally, doctors noticed a need for greater counselling before treatment in this age group.
- Unmarried women opting for abortion due to accidental pregnancies often chose to come to PHCs alone to ensure confidentiality. The increased comfort of women to reach out to get an abortion seems to be due to the greater caution and delicacy with which these cases are dealt. Doctors mentioned taking extra care to assure patients of confidentiality and providing greater counselling for such cases.
- For women above the age of 18, the target group approaching doctors usually include newlyweds or women married for a small period of time only.
- Doctors also noted that due to the lack of female doctors or minimal privacy for women in the hospital, a large number of women were still hesitant to visit PHCs. The main issues with which doctors were approached included menstrual issues and infections. But, issues related to contraception still remain lower than expected.

Anwesha Counsellors

- Anwesha Counsellors suggested that their main target group included girls between the ages 10 to 19 who utilised their services for issues related to adolescence, like menstruation issues, unwanted pregnancies, hormonal changes,psychological issues like depression, etc.
- There is a high sense of trust of individuals in this age group with the Anwesha Counsellors. This was indicated by girls approaching Anwesha Counsellors through calls or other means when the clinic was closed for several months during the lockdown in the previous year.
- Among adolescents, Anwesha Counsellor is viewed as an individual who could listen to issues and resolve them for the adolescents making them highly approachable and trustworthy.

Nursing Staff

- The nursing staff, as mentioned earlier, deal with a large scope of population with a focus on women and girls. They cater to diverse categories in terms of issues and services utilised.
- Girls below 18 were observed to reach out to the nursing staff for menstrual issues and infections whereas those above 18 usually need assistance with pregnancies.
- Nursing staff play a key role in facilitating abortions and counselling women to opt for contraceptive methods especially IUCD.

- Referrals were specifically appreciated by providers because it seemed to have reduced the inconvenience patients often have to endure by visiting one doctor after another and being diagnosed and treated in a variety of ways. Referrals streamlined the available healthcare facilities maximising the utilisation of available resources by the women of the community. The process for opting for medical assistance became increasingly convenient due to streamlining of information about services available.

- Since referrals were provided by ASHA workers, they were often attributed to the public health care system instead of the intervention. Additionally, there were negligible mentions of youth leaders handling referrals or facilitating the journey of a patient in the process of a referral.

- Providers attributed the increase in utilisation and accessibility of healthcare services especially hospitals, to the intervention

"Mothers visit here more, they come with their baby's problems" ***- Doctor, Mathurapur RH***

"Young age people come mainly starting from 18-19 till 30-35 years of age" ***- Doctor, Raidighi RH***

"10-19 age group, this is our targeted age group, not below that age, not above that age. We counsel them basically." ***- Anwesha Counsellor, Kulpi RH***

"From 10-45 years of age, both men and women come" ***- Nursing Staff, Kulpi RH***

- **Perceived impact of intervention on the target stakeholders with anecdotes**

- **The intervention was directly associated for the increase in abortion cases. Providers expressed that it was due to the intervention that there was an increase in number of patients approaching for abortions and also greater facilitation of abortion procedures. Very few patients were observed to approach PHCs for an abortion without any involvement of the intervention.**

    - The number of women agreeing and opting for contraceptive devices like IUCDs have significantly increased too and this was attributed to the intervention.

    - Doctors, however, felt that there has been only minimal impact of the meetings and counselling on the prevalence of early/teenage marriages and subsequent early pregnancies. Awareness about the financial and health implications about early pregnancies hasn't directly translated to behavioural changes.

        - It must be noted that the decision of marriage and pregnancy in this demographic is not of the woman solely and there is an immense significance of family pressure in these decisions. Hence, although there is significant awareness of the implications of early marriage and subsequent early pregnancy in this age group, lack of awareness about the same on the family or household level has prevented the translation of change in awareness into change in behaviour.

    - Nurses and Anwesha counsellors were noted to have a greater degree of interaction with the women and girls and expressed noticing changes in agency and communication skills over time. This was indicated by -

        - Decrease in hesitation and embarrassment in communication of SRH issues

- Greater use of appropriate terminology to articulately describe their concerns
- Providing an in depth description of their symptoms allowing easier diagnosis and better treatment

These changes were attributed by the nurses and Anwesha Counsellors to the awareness generated by the intervention.

"Training which adolescent girls and women, 10-18 years of age get, they are getting sexual education in the meeting. Menstrual problems are the big problem. They have a good response about these things. They have got mentally prepared.They are coming but we had to show them things outdoors, stand in the queue, they can't talk freely, they hesitate talking outdoors" ***- Doctor, Mathurapur RH***

"Young women and adolescent girls are benefitting. If this program will run properly, teenage pregnancy and teenage marriage will be reduced. They have started counseling on the fields related to abortion care. They should maintain hygiene. Patients are told to maintain hygiene which will avoid disease. We tell them about contraceptives. We do counseling to use this and that. These things have been modified. There are some patients who have awareness of these things." ***- Doctor, Raidighi RH***

Provider Recommendations for Intervention

- According to providers, a large number of misconceptions about IUCDs and contraception devices were still prevalent. ASHA workers and nurses provided adequate counselling and guidance before women opt for the procedures, but they face backlash from the families.
    - Hence, providers are of the opinion that there is a need for family level sensitization or at the least, sensitization of spouses regarding use of contraception. Although the responsibility of utilization of contraceptives often falls on the women, sensitization of spouses and in-laws would help in decreasing the inconveniences faced by women to implement contraception.
- Providers, especially doctors, felt a need for privacy in emergency wards for women - they felt that if there was a distinction between males and females for consultation in the emergency ward or if private spaces were available where women could consult doctors, the level of hesitation would decrease and the number of women opting for birth control devices and/or abortion would increase.
    - Even for consultation during visits outdoor, the lack of privacy has reduced the impact created from the potential impact that could be created.

"They don't go to hospitals as much. It's not that they don't visit me, they don't visit the hospitals as much. See in our hospital we don't have a setup that can maintain privacy. I see patients outdoors, so they tell me their problems there." ***- Doctor, Raidighi RH***

- Providers also feel that the intervention should cover a larger span of area and include a greater number of sub centres in order to multiply the impact quickly. Providers also suggested an overall scaling of the intervention through greater frequency of meetings, increased manpower in order to efficiently multiply the impact.

- Due to backlash faced for use of contraceptive devices by the Muslim community, providers also feel a need and potential for strategies designed to generate awareness and utility about contraception specifically for this community.

- Providers felt a need for emphasis on overall sex education. They observed a greater stress on awareness and education about menstrual issues but they feel that the intervention possesses the potential to multiply impact if there could be an emphasis on the larger umbrella of sex education instead of awareness of menstrual issues.

- Across provider groups, people felt that everyone could benefit from regular training sessions covering newer techniques that could be used and advanced practises that could be implemented. It would also keep the interest of facility members involved, intact.

"Our area has a population of 3 lakhs. Some people go to hospital, some ladies have to travel a long distance to come here. These are some of the problems. Vehicles can be arranged for them. Counseling is done, how many have been picked up, came along, we got all the sets together, this will be positive." ***- Doctor, Mathurapur RH***

"I am alone here in Raidighi Hospital. It is a big area. One more person is trained, he does not come regularly. I have lots of load. All the patients call me up, I have to go every time. One trained person was there, that person does not come, and takes a test once or twice in a month. I have to take most of the tests. This is the big challenge for me. They should give training to us in a regular interval of time. They should have discussions with us on new things and new changes." ***- Doctor, Raidighi RH***

"If the training can include lower level staff from the sub centres, then it would be more impactful." ***- Doctor, Raidighi RH***

"They should be covered with more population. They should take the issue of teenage pregnancy. They should work in this matter as well. If child marriage can't be stopped, pregnancy should be stopped because mother dies due to pregnancy, mother dies at the time of delivery." ***- Anwesha Counsellor, Kulpi RH***

"After delivery, IUCD should be given. They come after 1 or 2 years. Some ladies give birth even after taking IUCD. IUCD is not applied well sometimes. It should be done properly." ***- Nursing Staff, Kulpi RH***

APPENDIX

APPENDIX - I - KEY INFORMATION AREAS FOR THIS RESEARCH:

Variables of interest

- ***Awareness and knowledge on SRH-related topics including abortion.***
  - *Basic awareness on the legal aspects of abortion*
  - *Awareness on menstrual hygiene*
  - *Other SRH issues like body changes (particularly for unmarried), menstruation and heighten risk of pregnancy (high risk period),*
  - *Awareness of modern contraceptive methods*
  - *Sources of these knowledge (any recall for IDF intervention)*
- ***Perceived feelings on the preparedness of motherhood from the lens of SRH (perceived ideal age at marriage and childbirth)***
  - *o Ideal age at marriage and childbirth*
  - *o Perceived utility of avoiding early marriage and teenage pregnancy.*
  - *o Opinion on changes in age at marriage and childbearing in the community and transition in thoughts among young generation*
- ***Exposure to SRH-related activities, and information and message recall – including effectiveness of different communication strategies.***
  - *Exposure to IDF activities*
  - *Most effective strategies for awareness generation and knowledge improvement from respondent's lens.*
  - *Types of information received: Relevance and likability from the context SRH related information needs among young women.*
  - *Future intention to receive similar information and unfulfilled needs*
- ***Self-efficacy/agency among young girls and women***
  - *Views/perspectives which reflect their ability, belief, and confidence to deal with the SRH needs in terms of collecting information and utilizing SRH related services, contacting ASHAs, approaching doctors or health care providers for their SRH needs.*
- ***Utilization of SRH services and experience of accessing services.***
  - *More from the context of health system and government facilities*
- ***Menstrual hygiene and practice***
  - *What they are using and transition in their practices and potential influencers (IDF's role)*
- ***Impact of COVID***

APPENDIX - II - Recruitment of specific target groups

Given the current scenario to optimize utilization of the physical space of respondents with all safety standards, we followed the following methods of interacting with various target groups:

1. **Women & girls (Age- 10-14 & 15-24)**
   The key respondents i.e. the girls and women aged between 15 to 24 years were recruited using a purposive sampling approach.

- **A minimum level of articulation was checked to ensure the understanding of beneficiaries' to the**

utmost level.

- Female local recruitment partners were appointed to ensure the ease of reaching out to female beneficiaries
- Moderators were trained in child safety & training practices before interacting with any of the adolescents (10-18 years).
- Ultimately, the selection of the beneficiary was done on the basis of their **availability and willingness to participate in the research.**

2. ASHA Workers and ANM [snowballing via known acquaintances]

- Under this strategy, the recruiter was already in touch with a few FLWs. The recruiter through them met the potential respondents and explained to them the objective of the study. Later, they needed to gain their confidence by explaining to them the need for privacy and sensitivity and their consent was taken before interviewing them.