End line Evaluation of GARIMA Project in Uttar Pradesh (2013-2016)

Evaluation Report

Volume I

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<td>MH</td>
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<td>WIFS</td>
<td>Weekly Iron Folic Acid Supplementation</td>
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Structure of the Evaluation Report

The evaluation report is divided into seven chapters each of which contains relevant sub-sections. Chapter 1 provides a description of the GARIMA project across the three districts of Uttar Pradesh (UP), namely Jaunpur, Mirzapur and Sonbhadra. It further presents the context with regard to Menstrual Hygiene Management (MHM) at the national, state and district level at the inception of the project. This context highlights the need for a Social Behaviour Change Communication (SBCC) strategy to achieve the overarching goal of adequate MHM. Given this context, the chapter explains the need for implementing the GARIMA project and reviews the expected outcomes. Finally, the implementation of the GARIMA project is described in detail.

Chapter 2 describes the purpose, objectives and scope of the evaluation.

Chapter 3 explains the approach and the design adopted for the evaluation. Guided by a human rights, equity and gender perspective, the evaluation focuses on the OECD-DAC criteria to draw lessons for upscaling and replication of the GARIMA project across other districts in the state. The evaluation design includes: the key areas of enquiry; the methodology adopted for data collection; the tools used for data collection and the key sources of project data; the sample size and sampling methodology for the primary survey; and an evaluation matrix that summarises the design. The chapter concludes by describing the limitations of the evaluation, as well as the ethical standards and quality control mechanisms that were followed throughout the process.

Chapter 4 describes the socio-demographic profile of the participants - as reported by the participants themselves - who took part in the implementation of the MHM project and the process of evaluation.

Chapter 5 presents the findings of the evaluation. It also addresses the relevance of the project, its effectiveness in achieving the goal of adequate MHM, the impact and the efficiency of the project, and, finally, its long-term sustainability. The project’s contribution with regard to MHM has been assessed based on (a) the direct effects on MHM behaviour among adolescent girls; (b) the indirect effects such as knowledge, attitude, social support, social network, social norms and restrictions; and (c) the effect on other cross-cutting issues such as Water, Sanitation and Hygiene (WASH) and nutrition.

Chapter 6 details out the key findings of the evaluation based on the detailed evaluation findings presented in section 5.

Chapter 7 presents the conclusions and the lessons learned during the evaluation.

Chapter 8 presents recommendations that may be helpful for the upscaling or replication of the project in other districts or states.
Executive Summary

Menstrual Hygiene Management (MHM) is defined as the "use of clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required and having access to facilities to dispose of used menstrual management materials."  

A baseline assessment conducted by Nielsen India Private Limited in the three project districts in September 2012 highlighted certain impediments that fettered MHM among adolescent girls such as feelings of ‘impurity’ and ‘shame’, stemming from existing social norms and a prevalent culture of silence. This was further compounded by absence of functional sanitation facilities and difficulty in finding places to dispose of the menstrual absorbents, necessitating the need for an intervention to address the same.

About the GARIMA Model

The aforementioned conclusions led to the emergence of GARIMA model, which aimed to empower adolescent girls and their immediate influencers in three districts of Uttar Pradesh, with MHM serving as an entry point. Situated within the larger paradigm of equity, gender and human rights, the communication strategy used in the GARIMA project aimed at removing the culture of intergenerational silence around menstrual hygiene, enhancing knowledge and initiating dialogue around MHM within the family and, more broadly, at the community level, to create an enabling environment for adolescent girls to practice optimal MHM with dignity.

The GARIMA project was initiated in September 2012 and implemented in rural areas of three districts (Jaunpur, Mirzapur and Sonbhadra) in Uttar Pradesh. The total budget was 3.9 million, funded primarily by the IKEA Foundation, with partner Non-Government Organizations (NGOs) contributing six per cent of the total budget allocated to them. The project was implemented in two phases, with the first phase covering the district of Mirzapur in 2012-13. Incorporating lessons learned from the experience of the first phase, the project was subsequently scaled up during the second phase to cover Jaunpur and Sonbhadra districts.

The Implementation Model

The primary target audience of the project were adolescent girls and their mothers, while fathers, frontline health workers and school teachers formed the secondary target audience. To augment communication around MHM at the family and community level, groups of adolescent girls, mothers and fathers, with the active facilitation of Peer Educators (PEs), Field Facilitators (FFs), Frontline Workers (FLWs) and school teachers were formed.

Within the selected villages, the FFs appointed by partner NGOs formed groups of 15-20 adolescent girls mandated to meet once every month. The level of engagement with the parents differed from what was envisaged as the parents, especially fathers, were found to be reluctant discussing issues related to menstruation. It was also difficult to mobilise fathers on a regular basis, given their unavailability. As a result, discussions with fathers were largely limited to highlighting the importance for adolescent girls of nutrition, education and access to WASH

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facilities. Similarly, the frequency of the mothers' groups meetings was reduced from once every month to once every two months.

A baseline assessment highlighted that the adolescent girls in the three project districts were uncomfortable discussing issues related to menstruation with FLWs. In addition to the prevalent cultural norms, this was also due to the fact that FLWs lacked basic knowledge of menstruation and the requisite skills to engage with adolescent girls. Keeping this in mind, partner NGOs organised training sessions for FLWs, enabling them to facilitate group meetings with the girls and the mothers.

**About the Evaluation**

NRMC was engaged by UNICEF to conduct an end line evaluation assessing the **relevance, effectiveness, efficiency and sustainability** of the GARIMA project, and to identify the challenges and the lessons learned during its implementation. The results of the evaluation, undertaken between July 2017 and April 2018, covers the period from 2012 to 2016 for the district of Mirzapur and 2014 to 2016 for the districts of Jaunpur and Sonbhadra.

The evaluation, which used **OECD-DAC criteria**, looking at the relevance, effectiveness, efficiency, impact and sustainability of the GARIMA project, was guided by the **socio-ecological model**. It is noteworthy that activities addressing the related issues of education, WASH, nutrition and gender were intermittent. In the absence of a sufficient focus in the baseline on education, WASH, nutrition and gender, these aspects have been assessed under effectiveness and not as impact.

The evaluation methodology entailed a two-pronged approach for data collection; namely, a desk-based review and a primary survey (both quantitative and qualitative). It also adhered strictly to United Nations Evaluation Group (UNEG) norms, standards and ethical guidelines. **The research instruments used for the evaluation and the protocols for ethical standards have been reviewed and approved by a certified Institutional Review Board (IRB).**

**Assessing the Relevance of the GARIMA Project**

The existing context of the three project districts demonstrated the **poor status of knowledge and awareness, and the presence of misinformation and myths**, with respect to MHM. In addition, the project districts also displayed **negligible dialogue and communication, poor menstrual hygiene and disposal practices** and existence of **menstrual taboos and restrictions**. The project through its SBCC strategy has addressed the **need for effective social dialogue across stakeholders**, something that did not previously exist. In light of this context, the interventions of the GARIMA project aimed to encourage correct hygiene practices and effect behavioural and attitudinal change, to address restrictions and alter existing societal norms around menstruation.

The project has created channels towards improving MHM through monthly Adolescent Girls’ Group (AGG) meetings and engagement with mothers and fathers in the community. Supported by the FFs and FLWs trained under the project, the potential of PEs in the community was used to improve IPC, communication and other life-skill based outcomes for the girls. Moreover, the project has, through its convergence with government initiatives, highlighted and addressed MHM and other cross-cutting issues that include WASH, nutrition, education etc.

The **project further complements existing government policies** (geared towards infrastructural development to support MHM)- such as Rashtriya Kishor Swasthya Karyakram
(RKSJ), Swachh Bharat Mission (SBM), Sarva Shiksha Abhiyan (SSA) and Rashtriya Madhyamik Shiksha Abhiyan (RMSA) [now known together as the Samagra Shiksha Scheme] by bringing in behavioural change and capacity-building aspects that aid the practice of adequate MHM.

Hence, given the contextual factors within each district, the project has established its relevance to the prevailing scenario and created a supportive environment that enables adolescent girls to practice adequate MHM with dignity.

Assessing the Effectiveness of the GARIMA Project

The effectiveness of the GARIMA project was measured by examining how the initiative both directly and indirectly (mediated by knowledge, attitudes, interpersonal communication, social norms and restrictions) influenced adequate MHM behaviours among Adolescent Girls (AGs) and other project participants.

Direct effects were measured by examining the relationship between exposure and adequate MHM wherein a robust measure of encoded exposure was created by classifying the comparison site participants as ‘not being exposed’ and categorising intervention participants into ‘low’, ‘medium’ and ‘high’ exposure (based on a composite measure using 10 questions, including exposure dose and recall). MHM was measured as a 3-point categorical variable, distinguishing ‘inadequate’, ‘somewhat adequate’ and ‘adequate’ MHM. The MHM measure combined absorbent preparation use and disposal, while also considering personal hygiene during menstruation and access to privacy to change absorbents. The overall level, a quarter of the AGs fell into the inadequate group (24.5 per cent) and just a slightly higher number (27.6 per cent) practiced adequate MHM. Almost half of the AGs were categorised as practicing somewhat adequate MHM behaviours (48 per cent).

Both quantitative and qualitative data collected during the evaluation showed significantly higher levels of adequate MHM among intervention participants. The bivariate analysis shows a significantly higher practice of adequate MHM among intervention AGs when compared with comparison AGs, a trend that continues in the multivariate analysis after controlling for social demographic and social economic variables.

Indirect effects were measured by first examining the impact of exposure on key mediators and subsequently the impact of these mediators on MHM behaviour.

Knowledge: Levels of knowledge among all categories of participants was higher in intervention villages as compared to comparison villages. AGs knew more about puberty, reproductive body parts and appropriate use of menstrual absorbents, but mothers knew more about managing pain and discomfort, possibly due to their longer experience with menstruation.

Attitudes: Overall, menstruation continues to be associated with pain, negative emotions and physical symptoms across both intervention and comparison villages. More messaging is needed to normalise menstruation. On the one hand all intervention participants displayed more positive attitudes towards menstruation, absorbents, restrictions and gender. On the other hand, the lower overall levels of positive attitudes among adolescent girls, mothers, and fathers point to the need for additional SBCC addressing attitudes. Project implementers unsurprisingly had the highest levels of positive attitudes, indicating that the GARIMA project has been somewhat successful in shifting the attitudes of project implementers, who play a critical role in fostering community-level changes to break the silence surrounding menstruation.
Social Support: Mothers appear to be the primary source of social support in both intervention and comparison villages, followed by FLWs. Levels of social support are consistently higher in intervention villages, especially so for FLWs. It could be that the capacity-building activities in the project have made the FLWs more responsive and forthcoming to the needs of AGs.

Social Networks: On the whole, both intervention and comparison participants talk to the same people about menstruation. However, in intervention areas the discussion addresses more issues surrounding menstruation and takes place primarily at the family and peer levels. The GARIMA project appears to lag behind with respect to its goal of increased “community dialogue”. In comparison areas a higher proportion of dialogue is initiated by girls themselves, but in intervention girls areas the girls had more avenues for discussion, as such conversations were also initiated by members of their family and the community.

Social Norms: Two sets of norms were measured: norms around menstruation, and issues surrounding menstruation. The data showed a consistent discrepancy across all behaviours between levels of approval and actual practice, reinforcing the need for future programming to narrow this gap. For practices where almost universal approval does not correspond to universal practice (e.g. use of sanitary pad), it is important to explore personal and structural reasons that impact practice. Conversely, behaviours that have lower levels of approval followed by even lower levels of practice (e.g. interaction with boys after menarche) require both behaviour and social change interventions. Significantly higher levels of approval and practice across all norms were measured in intervention areas, providing some evidence that the GARIMA project was able to influence social norms. However, the fact that participants are unable to clearly articulate reasons for key behaviours, or specify their rewards and benefits, indicates a high level of internalisation of behaviours.

Restrictions: Restrictions as a whole cut across food, clothing and mobility domains. Surprisingly, comparison villages had a significantly lower proportion of social restrictions versus intervention villages. One interpretation might be that due to their exposure to the GARIMA project, intervention AGs are better able to articulate social restrictions. Additionally, AGs in intervention villages reported not following social restrictions in significantly higher proportions. This may indicate a higher level of confidence among intervention girls.

Nutrition: Consumption of green leafy vegetables during menstrual cycle is significantly higher in intervention areas. The trends are reversed for consumption of dairy products and non-vegetarian food. It is critical to control for social and economic variables while analysing nutritional intake. There was no difference between intervention and comparison AGs on decisions related to nutrition intake.

WASH: At an overall level there does not appear to be any major difference in the presence of household and school toilet facilities across intervention and comparison villages. The presence of a ‘space for changing clothes’ is significantly higher among intervention areas, which could be explained by the focus of the GARIMA project on promoting the construction of temporary structures for changing clothes. Both household and school toilets in intervention sites appeared to have more amenities than those in comparison sites, which again could be due to the project’s WASH messaging.

Gender: Gender-based outcomes for AGs were gauged through their learning of issues around sexual harassment, child marriage and education, and the subsequent actions taken. While
learning for the AGs and PEs largely revolved around the criticality of continuing education and reporting cases of child marriage and sexual harassment, the actions taken primarily included discussing these issues with immediate family members and important community level functionaries such as FLWs and the village Pradhan.

Bivariate analysis comparing encoded exposure with mediators showed significantly higher scores across all mediators for intervention AGs when contrasted with their comparison counterparts. The only exceptions were positive attitudes towards gender and the initiation of discussion. Multivariate analysis controlling for background variables illustrated that AGs in the high encoded exposure group had significantly greater odds of having higher knowledge about puberty and reproductive parts, and of having some experience of discussion and dialogue. A multivariate examination of the relationship between mediators and adequate MHM showed that the mediators which were significantly better among those practicing adequate MHM included higher knowledge levels (regarding puberty, reproductive parts and absorbent use), interpersonal communication and social norms.

The GARIMA project was an integrated SBCC effort which successfully achieved its objectives by generating both direct and indirect effects. These results suggest that the project was effective in changing behaviours and the key mediators of behaviour change. As such these results lend validity to the conceptual model that guided the project design.

**Impact of the GARIMA Project**

The impact of the project was assessed in terms of changes seen in knowledge, attitudes and beliefs between baseline and midline, as well as a comparison of differences between intervention and control sites. The analysis demonstrated higher levels of knowledge, more positive attitudes, improved MHM practices, greater degrees of interpersonal communication about absorbent use, and higher levels of school attendance during menstruation amongst intervention girls as opposed to baseline and end line comparison girls, indicating the positive impact of the GARIMA project on these key mediators. However, at end line, intervention AGs reported higher levels of social restrictions when compared with their comparison and baseline counterparts, possibly indicating that even when the project may not have fully addressed restrictions, it may have enabled girls to better articulate the imposition of restrictions during menstruation.

**Efficiency of the GARIMA Project**

The GARIMA project was implemented by multiple partner NGOs, each working in different regions and allotted appropriate budget on the basis of their yearly or periodic targets. While the overall approach and activities were designed by UNICEF and were standard across partners, some partners innovated or converged with the district and block administration to achieve greater efficiency.

A cost analysis, based on the expenditure data shared by UNICEF and partner NGOs, reveals Almost three quarters of the project expenditure was spent at the partner level, which seems appropriate for efficient implementation. While there is no reference cost available to compare it with, the low cost of USD 0.8 per month per adolescent girl or USD 28 for engagement with them during the whole project period of 35 months looked reasonable in order to achieve the intended outcome.
Given the nature of the project (i.e. the focus on behavioural change) at the partner level most of the financial resources (67 per cent) were allocated to technical support (which included salary and direct costs related to the core members). The overall resources available for the project were more or less sufficient. The partner organisations also contributed 6 to 9 per cent of their total cost in the project, which evidences their ownership in the project.

The project was implemented in a highly standardised and structured way ensuring quality delivery of capacity-building, communication outputs and better monitoring. Some of the good practices enabling better efficiency have a synergy with the child rights project, selection of FFs from the neighbouring villages and successfully managing attrition at the last mile connect.

**Sustainability of the GARIMA Project**

Sustainability of the GARIMA project was assessed in terms of continuation of the project outcomes beyond the duration of the project along with sustenance of outputs produced and strategies and processes adopted by the project. It could be observed that the outcomes generated by the project - especially in terms of knowledge enhancement around MHM and effecting positive changes with regard to attitudes and behaviour associated with menstruation - have been sustained one year after the closure of the project. The intervention has been particularly successful in terms of enhancing confidence levels and self-efficacy amongst AGs who participated in groups formed under the project who voice demands beyond MHM, such as WASH, nutrition, education etc.

**Institutionalizing the project** through the recruitment and training of PEs and capacity-building of the FLWs, has created a repository of knowledge regarding MHM in the community. This, coupled with the creation of a 'social movement' around MHM through the formation or strengthening groups of AGs, mothers and fathers was seen as necessary for sustainable social change.

The integration of issues around MHM with government initiatives - such as ICDS, RKS, SABLA etc. - highlight the project’s method of addressing menstrual hygiene in a holistic manner. Additionally, this approach also provides an opportunity to expand the project across the state, and possibly to other states as well.

Despite the in-built measures to ensure suitability, challenges associated with engaging FLWs as facilitators need to be addressed before scaling up or replicating the project elsewhere. Similarly, advocating with government departments for the efficient use of financial resources reserved for adolescent-oriented schemes is central in driving forward the shared goals of the project, as well as the government’s programmes pertaining to MHM.

**Conclusions and Recommendations**

The following could be summarized as key conclusions that have emerged during the course of the evaluation:

**a) Initiation of dialogue and voicing demands beyond MHM**

In contrast to the earlier scenario, the project has fostered dialogue around menstruation wherein, mothers, daughters, other female members of the family as well as FLWs in the
community have become more open to engaging in conversations around menstruation. Furthermore, the project has also sensitised fathers on their daughters' needs that encompass WASH, nutrition, education etc. Through its engagement with adolescent girls, the GARIMA project has also enabled them to make demands that go beyond MHM such as addressing issues around WASH, nutrition, education, sexual harassment and child marriage.

b) Improved knowledge and behaviour

The project has contributed towards better knowledge among adolescent girls and mothers around puberty and management of pain and discomfort during menstruation. It has also resulted in a higher proportion of respondents from the intervention villages practicing adequate MHHM behaviour vis-à-vis comparison villages.

c) Addressing social restrictions and taboos

Bending norms and restrictions around menstruation is in the nascent stage. While family members and the community in general display greater willingness in easing restrictions pertaining to diet, mobility and disposal of menstrual absorbents, religious restrictions are meticulously followed to a great extent.

Recommendations

Based on the lessons learned, the following recommendations are proposed:

Recommendations for the Government

- Findings from the evaluation demonstrate that the PE model coupled with necessary investments in training and handholding of PEs, capacity building of PE mentors along with communication and training package developed under the project, creates avenues for adolescent girls in the community to discuss MHM. Given that programmes such as RKSK promote menstrual hygiene through facility based services such as clinics and counselling, it is recommended that government considers replicating and scaling up the PE model. It is further recommended that the communication and training packages be used in similar contexts with adequate investment in handholding of PEs as well as periodic refresher trainings for on ground implementers comprising FLWs.
- Systematic budget analysis to determine allocation and utilization of funds to adolescent programmes is recommended, with funds specifically earmarked for the delivery of such programmes.
- Inter-departmental convergence remains of utmost importance in the formulation and implementation of MHM policies and programmes since the subject of MHM itself is marked by several cross-cutting involving nutrition, WASH, education and gender. Establishment of synergies between concerned departments and ministries for prioritization of policies, resource allocation and programming is therefore suggested for fine-tuning MHM interventions.
- Social capital created under the project, such as AGGs and PEs, the field facilitators, can be linked to programmes such as RKSK, ICDS, and NSS etc. Few ways in which this could be accomplished are as listed below:
  - Under RKSK, Ministry of Health and Family Welfare and concerned state departments can utilise AGG members and PEs towards mobilization of adolescent girls and awareness generation around menstrual hygiene and safe
disposal practices during Adolescent Health Days (AHD) organised at the village level and through Adolescent Friendly Health Clinics (AFHC) and counselling services established at the block level under RKSK.

- Under ICDS, Ministry of Women and Child Development and Health Department, along with AWWs, ASHAs and ANMs can seek support from the PEs and AGG members in utilising village level platforms such as VHSND to give out MHM related information to adolescent girls with a focus on out of school adolescents.

- Similarly, NSS student volunteers can be utilised by the central government (Ministry of Youth Affairs and Sports) to bring together student peers and community members in raising awareness around MHM by integrating training sessions on MHM into NSS events and camps.

**Recommendations for UNICEF/ NGO Partners**

- In future projects with similar focus on MHM and adolescent girls, it is recommended that the national and state programme teams of UNICEF and concerned partner organizations brand MHM in broader terms as normal part of womanhood through the following ways:
  - Positively influencing the attitudes of family members, especially mothers and fathers to address regressive gender norms and taboos.
  - Addressing social norms pertaining to MHM at the community level through conceptualisation MHM within gender transformative norms through promotion replacement behaviours and attitudes with regard to MHM and gender that are both desirable as well as rewarding.
  - Towards addressing prevalent social norms and restrictions around menstruation, future projects should also utilise community dialogue forums through mobilization activities such as theatre performances, nukkad-natak, video-vans etc; and leveraging community level platforms such as Self-Help Groups (SHGs) for creation of a supportive environment for MHM in the community.
  - Community level activities such as these should also be utilised for focused interventions with fathers on aspects around their role in ensuring adequate nutrition, provision of safe spaces and other resources for adequate MHM since reaching out to fathers at the family level remains challenging especially in Uttar Pradesh that reports high levels of migration amongst menfolk.

- One of the needs recognized by the project was the requirement of career counselling as expressed by adolescent girls. In future projects, especially those with adolescent girls, career counselling and age appropriate skill/vocational training should be used both as a topic for gaining entry into the community as well as meeting the needs of adolescent girls. Resource centres like those in GARIMA project should be used as spaces for career counselling and vocational training for adolescent girls through provisioning of necessary resources.

- Considering the usefulness of the SBCC model developed by the GARIMA project, it is recommended that the project/similar projects links itself with various government programmes besides RKSK such as SBM, ICDS etc. to utilise potential avenues built within these programmes that endorses MHM. While drawing such linkages, UNICEF should also pitch with those government programmes which have some degree of outcome-based similarity, adequate resources and remain top priorities for the government. One such programme could be SBM wherein integration of AGGs as members of surveillance
committees under SBM provides evidence for the scope and potential of such convergence.

- Addressing restrictions around MHM solicits a two-pronged approach that differentiates between personal (clothing) and social (mobility, diet) restrictions. While the former would require a behaviour change focus, the latter requires a norm-based approach. Before restrictions can be addressed programmatically, it is recommended that SBCC interventions under projects such as GARIMA focus on building confidence and efficacy of adolescent girls to enable them to articulate such restrictions.

- It is recommended that in future projects of this nature (communication/ SBCC) and scale, an online MIS system that can generate real time reports for managers at different levels should be designed and implemented. The MIS must collect and use data at the basic unit level i.e. at the project participant level so that the data validity as well as its usefulness can be improved.
1. Object of the Evaluation

1.1. Introduction

UNICEF India has engaged Drexel University and NR Management Consultants India Pvt. Ltd. as the technical assistance partner to carry out the "End line evaluation of GARIMA project in Uttar Pradesh." The current evaluation aims to assess the effectiveness of the Social and Behaviour Change Communication (SBCC) strategy in improving MHM within three rural districts of Uttar Pradesh (UP), as well as to examine how far the project has facilitated adequate MHM practices and impacted cross-cutting issues including education, WASH, nutrition and gender.

The Girls’ Adolescent and Reproductive Rights: Information for Management and Action (GARIMA) project was implemented by UNICEF from 2013 to 2016, with financial support from IKEA Foundation. The project largely used a SBCC model to expand the knowledge base and build confidence amongst adolescent girls to improve their menstrual hygiene practices, in line with the Government of India’s (GoI) Rashtriya Kishor Swasthya Karyakram (RKS) and menstrual health (MH) project. The project covered the districts of Mirzapur, Jaunpur and Sonbhadra in UP.

1.2. Setting the Context of the Intervention

1.2.1. Social Landscape: Gendered Realities and Inequities

While women and girls constitute a large proportion of India’s population, gender disparities in India remain a critical issue. Prevalent gender biases and imbalances negatively impact female education, health and workforce participation. Literacy rates for women (55 per cent) are significantly lower compared to their male counterparts (78 per cent), and women in India earn only 56 per cent of what their male colleagues earn for performing the same work. In 2015, the United Nations Development Programme’s (UNDP) Human Development Report ranked India 130 out of 155 countries in the Gender Inequality Index (GII).

Gender inequality and prejudices vary across states in India. While states such as Mizoram, Kerala, Meghalaya, Goa and Sikkim present equal opportunities for progress and improvement for both genders, research and the census data indicate that the states of Uttar Pradesh and Bihar, followed by Rajasthan, perform poorly on these indicators. Although girls are largely at a par with boys up to adolescence, with the onset of puberty consequences for girls diverge with increasing restrictions placed on their mobility and agency. For example, in India, while the per centage of out-of-school boys and girls in the age group 6–10 years stands at 5.5 per cent and 6.8 per cent respectively, for the adolescent age group 11–13 years the per centage of out-of-school children is much higher among girls (10 per cent) than boys (6.5 per cent). Adolescent girls are

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2 Adequate MHM is defined as the “use of clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required and having access to facilities to dispose of used menstrual management materials” Sommer M, Sahin M. Overcoming the taboo: Advancing the global agenda for menstrual hygiene management for schoolgirls. Am J Public Health. 2013; 103(9): 1556-9


particularly vulnerable in UP and Bihar, with over half of all adolescent girls married before the age of 18, up to 95 per cent dropping out of schools and over 50 per cent facing domestic violence.5

Existence of such disparities could be attributed to misplaced prioritisation of gendered expectations in the community, wherein girls are expected to help with domestic chores, learn to undertake household responsibilities and prepare themselves for marriage. Also, gender roles and behaviours rooted in narrow beliefs, perceptions and attitudes take a more definite form when the adolescent girl reaches puberty and menarche.

1.2.2. Status of Menstrual Health and Hygiene

For girls and women to lead healthy, productive and dignified lives, MHM is an essential aspect of their sexual and reproductive health. Various human rights and development agenda goals have MHM as a crucial part of their fulfilment agenda. It is thus a very important facet of rights associated with health and sanitation. Predictably, MHM issues are also linked with the Sustainable Development Goals (SDGs), specifically Goals 3, 4, 5 and 6, which include good health and well-being, quality education, gender equality, access to clean water and sanitation. These are crucial preconditions to ensure equality for girls and women in all walks of life.

MHM is defined as the “use of clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required and having access to facilities to dispose of used menstrual management materials.”6 MHM in India is challenged by:

a. **Lack of awareness**: 200 million girls in India lack awareness of menstrual hygiene and associated healthcare practices.7

b. **Unavailability of menstrual products**: 88 per cent of menstruating women in India use home-grown alternatives such as old fabric, rags, sand, ash, wood shavings, newspapers, dried leaves, hay and plastic.

c. **Lack of access to facilities**: 63 million adolescent girls live in homes without toilet facilities.

d. **A cycle of neglect** or social and mobility related restrictions that are intergenerational.8

A baseline study conducted in the three project districts in September 2012 illustrated various constraints for management of menstrual hygiene faced by adolescent girls.

- Feeling of ‘impurity’ amongst adolescent girls - engendered by social norms around menstruation - during their menstrual cycle.9
- Lack of private space for bathing/changing/washing menstrual cloth.10
- Inconvenience in finding a place to throw or burn used menstrual absorbents.

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7 Dasra. Spot on: Improving menstrual health and hygiene
8 Ibid
9 While 44 per cent of adolescent girls reported feeling ‘impure’ during menstruation in Jaunpur, 32 and 15 per cent of adolescent girls reported feeling similarly in Mirzapur and Sonbhadra.
10 While this was most striking for Jaunpur, where 73 per cent respondents reported non-availability of private space to wash their menstrual absorbents, in Mirzapur and Sonbhadra it was 60 and 28 per cent respectively.
The baseline assessment reported that nearly one-fourth of adolescent girls did not attend school during menstruation due to lack of access to toilets and safe changing spaces in schools. **Absenteeism during menstruation**, which emerged as a key cause of concern, could have been one of the factors causing adolescent girls to drop out of school in these three districts.

This illustrates that adequate MHM is only attainable in a society which views menstruation as a “natural” process. While having the right knowledge and information is a crucial prerequisite for practicing adequate MHM, free dialogue and smooth communication is equally important. In addition to this, access to clean water, sanitation facilities, and the privacy to change and clean, or dispose of, used cloths or sanitary pads are also important prerequisites for adequate MHM.

### 1.2.3. Toward an Enabling Environment for Adequate MHM

Over the years there has been an increased drive from donors, governments and the private sector to address menstrual health issues. While the key focus has largely been on products and expanding their availability and accessibility, in the recent past the fulcrum of engagement has moved towards improving awareness, especially among girls.

Several interventions have been implemented at the national, state, district and school levels across the country. The National Health Mission (NHM)\textsuperscript{11} steered by the Ministry of Health and Family Welfare is a flagship national programme launched to address various issues concerning different sections of the society, including adolescents. NHM provides two sets of interventions which focus on adolescent health: RMNCH+A (Reproductive, Maternal, Newborn, Child and Adolescent Health) and Rashtriya Kishor Swasthya Karyakram. While RMNCH+A aims to reduce anaemia in adolescent girls and boys and decrease the proportion of total fertility contributed by adolescents, RKS K and the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) or SABLA cater to issues faced by adolescent girls concerning their reproductive health. RKS K focuses on promotion and enablement of adequate MHM. Under the SABLA scheme *Kishori Samuhs* and *Sakhi Saheli* networks were created to reach out to girls on various adolescent related issues of which MHM remained a key aspect.

Under RKS K, a Menstrual Hygiene Scheme (MHS) for the promotion of menstrual hygiene among adolescent girls in the age group of 10–19 years has been implemented. The scheme operates predominantly in the rural areas as part of the ARSH component in the Reproductive and Child Health II (RCH II) programme. The objectives of the scheme include:\textsuperscript{12}

- Increasing awareness of menstrual hygiene among adolescent girls.
- Increasing access to and use of good quality sanitary pads among adolescent girls residing primarily in rural areas.
- Ensuring safe disposal of sanitary pads in an environmentally friendly manner.

MHS was initially implemented in 2011 in 107 select districts across seven states. In this phase a pack of six sanitary napkins under NRHM’s brand “Freedays” was provided to rural adolescent girls at Rs.6 per pack. From 2014 onwards, funds were devolved to respective states and Union Territories under the National Health Mission to facilitate decentralised procurement and distribution of sanitary pads in rural areas. Under the scheme, Accredited Social Health Activists

\textsuperscript{11} Earlier known as the National Rural Health Mission

(ASHAs) were mandated with the distribution of sanitary pads in lieu of an incentive of Rs.1 per pack sold and a free pack of napkins every month for their personal use. They were further assigned the responsibility of convening monthly meetings at Anganwadi Centers\textsuperscript{13} (AWC), which served as platforms for adolescent girls to discuss menstrual hygiene and other relevant issues. Besides this, a wide range of Information, Education and Communication (IEC) material – including audio, video and reading materials for adolescent girls and job aids for ASHAs and other field level functionaries – were developed to aid the process of awareness and knowledge creation around safe and hygienic menstrual health practices.

Several interventions have been spearheaded at the state level as well, where the focus has primarily been on building capacities of stakeholders to support the GoI flagship programs, promoting menstrual hygiene practices, and increasing outreach of communication packages as well as menstrual support programs.

While the aforementioned policies and programs situate themselves in a macro perspective in addressing the subject of menstrual hygiene in the country, there are also immediate prospects to leverage the national impetus in India to improve menstrual health, particularly for adolescent girls. Priorities include strengthening facilitator capacity to deliver awareness training, improving the reach and quality of low-cost pads and better targeting of influencers.

1.3. About the GARIMA Project

1.3.1. Objectives of the GARIMA Project

The project aimed to effect change with regard to the exercise of rights by adolescent girls pertaining specifically to MHM through capacity-building, community dialogue and interpersonal communication. The project attempted to empower adolescent girls and their immediate influencers in three districts of UP with MHM as an entry point. As well as influencing practices around MHM, the project worked on the specific objectives of addressing the inadequate understanding of the physiological reasons for menstruation, embarrassment and lack of conversation on the issue and poor hygiene in the management of the menstrual period.

Because menstrual hygiene has an impact on a broad array of women and girls’ rights, the entire GARIMA project was situated within the broader framework of human rights, gender and equity. Access to clean sanitation facilities and menstrual supplies is fundamental to living a life of dignity and realising many human rights, such as rights to education, work and health. A lack of safe and clean sanitation facilities in schools often results in dropouts and absenteeism, especially for girls, thereby adversely impacting their education. This makes it imperative to target change around the way menstruation and menstruating girls and women are perceived, and in many instances isolated, causing an infringement of their fundamental rights and dignity. Through its communication strategy aimed at replacing the culture of intergenerational silence around MHM with one of dialogue, communication and correct information, the GARIMA project also sought to create an enabling environment for the adolescent girls to practice optimal MHM with dignity.

1.3.2. Geographic Scope and Coverage of the GARIMA Project

The implementation of the GARIMA project began in September 2013 in the three rural districts of Mirzapur, Jaunpur and Sonbhadra in UP. It was completed in December 2016. The project was

\textsuperscript{13} Aanganwadi is a rural mother and child care centre in India. They were started as part of the Integrated Child Development Services (ICDS) programme to combat child hunger and malnutrition.
carried out on a budget of 3.9 million Euros from IKEA Foundation and the partner NGOs also contributed around 6 per cent of the budget allocated to them.

For the GARIMA project, the villages selected in the three districts were those in which the Child Rights Project funded by IKEA Foundation had previously been implemented by UNICEF. As the communities in these villages were already mobilised around issues of child rights, the GARIMA project leveraged existing social capital and networks in the villages, partnering with the same NGOs that were involved in the earlier IKEA Foundation-funded project. The first phase of the GARIMA project was implemented in 2013–2014 in Mirzapur district. The second phase of implementation started in April 2014 when the project expanded to cover Jaunpur and Sonbhadra, building on the experiences and lessons learnt in Mirzapur. The project eventually came to a close in December 2016.

The project covered a total of 1,974 villages across the three districts and reached out to 200,000 adolescent girls in the age group of 10–19 years. Furthermore, it aimed at interventions with around 65,000 women and 5,000 FLWs to equip them with the knowledge and interpersonal communication skills necessary to catalyse behavioural change amongst the primary stakeholders, i.e. adolescent girls.

1.3.3. Theory of Change for the GARIMA Project

The Theory of Change (ToC) essentially identifies the nature of the intervention and the activities undertaken with each stakeholder. It links these activities and the intended behavioural change with the broader domains of nutrition, WASH and education. Figure 1 is a graphic illustration linking the activities of the project to its goal of ensuring adequate MHM.

![Figure 1: Theory of change for the GARIMA project](image)

NRMC
Drexel University
Kempner School of Public Health
As mentioned earlier, the SBCC model was the pivot for achieving the project objectives. The model was focused on key primary, secondary and tertiary groups and on the stated objectives of social and behavioural change. The groups and the changes sought in each group were as follows:

A. **Primary audience:** Adolescent girls and mothers
   - They would know why menstruation happens.
   - They would understand the importance of maintaining hygiene.
   - They would talk freely and confidently, without embarrassment about menstruation.

B. **Secondary audience:** Fathers, teachers and frontline workers
   - They would know why menstruation happens.
   - They would understand the importance of maintaining hygiene.
   - They would be positively disposed to discussing the issue.

C. **Tertiary audience:** Networks, collectives, programme managers and media
   - They would provide a conducive environment and infrastructure for MHM.

The intervention's multimedia communication package worked to increase interpersonal communication of adolescent girls amongst themselves, as well as with PEs and FLWs. It also worked to generate community dialogue by engaging girls’ groups, mothers’ groups, fathers’ groups, key influencers (e.g. teachers) and NGOs. As a final step, the intervention endeavoured to build capacity and required skills through training for FLWs, PEs and NGO functionaries.

These efforts addressed cognitive, emotional, social and normative factors related to MHM. It was envisaged that these factors would positively impact broader crosscutting issues of WASH, nutrition and education, which would work toward making prevalent practices more hygienic, help increase girls’ agency and enhance their confidence.

In order to achieve the objectives of the project, SBCC strategy and its implementation were crucial. This strategy is described in the following section.

**1.3.4. The Social and Behaviour Change Communication Strategy**

Since convergence with government programs and departments was also one of the focal points of the GARIMA project, existing training and communication materials on menstrual hygiene and management under different government and non-government programs were collated to avoid replication of materials. The SBCC strategy devised for implementation comprised the following elements:

a) **Interpersonal communication:** Regular meetings of adolescent girls’ groups (AGGs) facilitated by peer educators (PEs) to educate girls on MHM and empower them on adolescent rights, as well hold activities based on life skills; also, monthly meetings of mothers’ groups for their sensitisation and capacity-building to support their daughters in exercising their rights.

b) **Group communication using multimedia:** AGGs and mothers’ meetings using interpersonal communication videos on menstrual hygiene and adolescents’ issues.

c) **Capacity-building:** For FLWs, teachers and PEs on interpersonal communication on MHM.
d) **Mass media:** To create a conducive environment to enable behavioural change.

e) **Advocacy:** With a broad range of stakeholders to establish interlinkages and establish MHM as a cross-sectoral issue.

1.3.5. Implementation of GARIMA Project

The process of reaching out to adolescent girls began with the formation of AGGs in the intervention villages. The adolescent girls were reached Field Facilitators (FFs) appointed through partner NGOs who covered 10 villages and where they held meetings. The project and its objectives were explained to the adolescent girls. Interested girls were chosen to be part of the project; emphasis was laid on adolescent girls from marginalised hamlets.

The implementation envisioned two AGGs per village (comprising 15–20 members each) with the objective of meeting at least once a month to discuss issues centred on menstrual hygiene. The remaining adolescent girls’ population were covered through home visits undertaken by FFs, occasionally accompanied by PEs. The FFs were mandated to conduct five home visits per month per village along with two successive follow-up visits. These visits also provided an opportunity to engage with the parents and other family members of households containing adolescent girls. Based on the recommendations from the first round of concurrent monitoring, the number of home visits was reduced to two per month in order to ease the burden on FFs and improve their effectiveness.

Parents, especially mothers, emerged as critical stakeholders for championing the cause of adequate MHM. Therefore, project activities also included regular monthly meetings with

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**Figure 2:** Stakeholders, activities and geographical coverage
mothers. Initially it was envisaged that the project would engage with the parents of the girls who were part of the AGGs. However, various constraints emerged over time. Therefore, the coverage was expanded to also include parents of those girls who were not part of AGGs. During the initial phase of the project, one meeting per month was proposed for the fathers and mothers’ groups, to be conducted by the FFs supported by the PEs. However, the strategy failed to materialise as envisaged. Parents, especially fathers, did not seem very eager to discuss the issue and, given that they had other engagements, it was difficult to hold their interest in the meetings. Therefore, as a mid-course correction, it was decided that the mothers’ group meetings would be conducted once every two months in each village while the fathers would, through occasional interactions, be given information on the importance of nutrition, education and access to WASH facilities for girls.

The first phase of the project, implemented in Mirzapur district between 2013 and 2014, was rolled out comprehensively through folk tales such as Chandamama ki Kahani, Ekta Main Bal and Burhe Kisan Ki Kahani, as well as thematic meetings to foster a democratic structure and create a sense of need and ownership amongst the adolescent girls. The second phase of implementation between January 2014 and December 2015, expanded to also cover the districts of Jaunpur and Sonbhadra, creatively incorporated standardised communication packages based on an ‘edu-tainment’\(^\text{14}\) approach such as Paheli ki Saheli, Ammaji Kehthi Hai, Adha Full, etc. in order to sensitize the community. Furthermore, this phase of the GARIMA project saw the convergence or creation of linkages with government departments and programs such as Village Nutrition and Health Days, Kasturba Gandhi Balika Vidyalaya and Kishori Shakti Yojana.

1.3.6. Stakeholder Coverage and Roles

The key stakeholders of the GARIMA project included:

a) Primary stakeholders that included adolescent girls and mothers.

b) Secondary stakeholders that included fathers, teachers and FLWs.

c) Tertiary stakeholders that included networks, collectives and media.

Beyond family, the female teachers, who carry the potential to be sources of consistent and correct information at the school, and whom the girls feel comfortable approaching with questions about menstruation or menstrual health management, also assumed importance as stakeholders. They have the ability to advocate for and ensure the presence of separate toilets and washing spaces for girls at school. Not having such facilities was often a cause of embarrassment for girls, due to which they avoided changing, resulting in infection, absenteeism and eventually dropping out from school.

FLWs, such as ASHAs and Anganwadi workers (AWWs), were also important stakeholders as they work at the grassroots level in the villages, engaging directly with communities in promoting healthy behaviours. Improving the interpersonal communication skills of the FLWs, as well as their knowledge of information around menstrual health and hygiene, was envisaged as a means to facilitate a sustained engagement with the adolescent girls.

Media and other networks also played an important role in creating a more facilitative environment in terms of policy formulation, advocacy and flow of information within which issues of menstruation and menstrual hygiene could be discussed. The GARIMA project focused

\(^{14}\) Edutainment = Education + Entertainment
on aligning its approach as well as its activities with other government programs. It aimed at the incorporation/re-emphasis of issues pertaining to sanitation and adolescent rights in the curriculum of Kasturba Gandhi Balika Vidyalayas and the Bal Swasthya Guarantee Yojana.

Refer to Annex 1 for more detailed information regarding the activities and processes adopted while engaging with the aforementioned stakeholders.

Organisational Structure of the GARIMA Project

![Organisational structure of the project](image)

Figure 3: Organisational structure of the project

The above schematic represents the organisational structure of the GARIMA project at the field level. UNICEF had contracted 10 NGOs to implement the project in the three districts; five NGOs in Mirzapur, three in Sonbhadra and two in Jaunpur. These organisations were responsible for carrying out the project activities with technical and financial support from UNICEF. A programme manager was appointed at the district level. At the block level, various villages were grouped together to form a cluster, and project support coordinators were responsible for the work undertaken in each cluster. Further, from each cluster of villages, around 10 villages were assigned to a FF who was responsible for carrying out the mandated activities in these villages. All FFs were females and were appointed by the NGO based on their familiarity with the area and their experience of working on similar issues. Most of the FFs, as it emerged from the discussions, were already working with the implementing NGOs and therefore did not need to go through a selection procedure per se. They were trained by the NGOs with support from UNICEF on aspects related to the project. FFs were mandated to conduct adolescent and mothers’ group meetings in each village. Additionally, they were to conduct five (later reduced to two) home visits per month, along with successive follow up visits.

With an overall budget of USD 5.08 million, the GARIMA project was implemented through three levels - national, state and partners. UNICEF provided technical assistance for capacity-building of all the stakeholders, including training and awareness on aspects related to menstruation, restrictions around menstruation and prevalent social norms, education, nutrition, WASH and child marriage. The UNICEF national level team also contributed to developing the SBCC package, including development of the Paheli ki Saheli package and Ammaji videos on MHM, and conducting a concurrent monitoring study. In addition to investing in training, the SBCC package and monitoring exercises, UNICEF contributed to developing and procuring MHM material, providing knowledge management and assisting partners.
2. Purpose, Objectives and Scope of the Evaluation

2.1. Purpose of the Evaluation

As per the Terms of Reference (ToR), the rationale for the end line evaluation of the GARIMA project was to assess the effectiveness of the SBCC strategy in promoting and improving MHM within three rural districts of UP. The evaluation also aimed to measure the impact of the project on adequate MHM practices amongst adolescent girls in the intervention districts, as well as on converging issues such as education, WASH, nutrition and gender.

Such an appraisal is useful because it provides crucial insights into the project to examine what does and does not work, and why. Moreover, these conclusions will be applicable to other projects designed to improve MHM for adolescent girls. The findings of the evaluation will provide UNICEF with required recommendation regarding the scaling up of the project in other districts of UP, as well as efforts to sustain and replicate the project in other parts of India. Similarly, the findings would also be particularly useful for Ministry of Health and Family Welfare and Ministry of Women and Child Development for designing and implementing programmes addressing menstrual hygiene and health.

Furthermore, the findings will also be pertinent for other UN organisations such as United Nations Development Programme, United Nations Population Fund, UN Women and World Health Organisation, donors, and government parties such as Ministry of Education and Ministry of Social Justice and Empowerment along with NGOs, both implementing partners and those working in the realm of menstrual hygiene and health.

The evaluation will help in assessing what adolescent girls, their families and communities know and understand about menstruation, the attitudes they hold, the level of communication and social support around menstruation, the social norms and restrictions that govern menstruation practices and how all of these relate to adequate MHM.

2.2. Objectives of the Evaluation

The evaluation objectives are listed below:

a) To understand how the project is suited and aligned to the needs of adolescent girls in UP.

b) To examine the direct impact of the project on menstrual health through a comparative analysis of data between baseline and end line.

c) To examine the concomitant impact of the project across multiple levels of the socio-ecological model, encompassing the effect on the personal and social lives of the adolescent girls, their families and their respective communities by comparing data between baseline and end line.

d) To review the efficiency of the project partnerships, strategies and the implementation process.

e) To analyse the sustainability and scope of replicability of the project in UP and other parts of India.
2.3. Scope of the Evaluation

The ToR proposed assessing the impact of the intervention, and a close assessment of the activities under the GARIMA project showed that a focused attempt was made by the project to change MHM practices. A result chain could be established as follows: Activities $\rightarrow$ Output $\rightarrow$ Outcomes $\rightarrow$ Impact. However, the activities designed to achieve outcomes and impacts on the converging issues of education, WASH, nutrition and gender were intermittent. In the absence of sufficient focus in the baseline on education, WASH, nutrition and gender, these aspects have been assessed under effectiveness and not as impacts. An analysis of the change in MHM practices in baseline and end line has been undertaken, as well as an analysis of counterfactuals in the end line.

Thus, the project has been evaluated within the OECD-DAC criteria of relevance, effectiveness, efficiency, and sustainability in promoting adequate MHM amongst adolescent girls. Additionally, the evaluation has looked at the potential impact created by the project with regard to its interventions surrounding MHM behaviour.

Specifically, the evaluation assessed what adolescent girls, their families and communities understood about menstruation, their attitudes toward it, the nature and intensity of communication regarding menstruation, and the social support received around the subject. It also looked at the prevalent social norms and restrictions that govern menstrual practices, and the manner in which all of these relate to adequate MHM practices.

The evaluation analysed qualitative and quantitative end line data from the intervention. It examined the consequences of the project and the difference it has made while exploring the counterfactual condition by comparing end line intervention with baseline data, as well as end line comparison site data. Measurements taken before and after the intervention, and comparisons of intervention and comparison sites, allowed the evaluation to measure differences in adequate MHM over time (baseline vs. end line intervention) and locations (end line intervention vs. end line control).

The evaluation provided crucial insights into what worked and what did not work, and the reasons why. The findings of the evaluation also provide UNICEF with recommendations that could be taken into account during the scaling-up of the project in other districts of UP, as well as pointers on how to replicate and sustain the project in other parts of India.

The findings are expected to be disseminated to UNICEF C4D staff in India, other UN organisations (UNDP, UNFPA, UN Women and WHO), donors, relevant government parties (Ministry of Health and Family Welfare, Ministry of Education, Ministry of Drinking Water and Sanitation, Ministry of Social Justice and Empowerment, and Ministry of Women and Child Development), and NGO partners (implementing partners and other NGOs working in the realm of menstrual hygiene and health) through PowerPoint presentations, a full report and an executive summary report. The findings will also be used as part of a doctoral dissertation, and several peer-reviewed journal manuscripts are also planned.
2.4. Evaluation Criteria and Questions

Besides assessing the relevance, effectiveness, efficiency, impact and sustainability of the GARIMA project, the evaluation also tested psychometric properties for Menstrual Health and Hygiene Management (MHHM) on a scale developed by the Drexel University team.\textsuperscript{15}

The key evaluation questions, given the criteria of relevance, effectiveness, efficiency and sustainability, are detailed as follows:

1. **Relevance**
   - Are the activities and outputs of the GARIMA project consistent with the overall goal and the attainment of its objectives?
   - To what extent is the GARIMA project suited to the needs of AGs in UP?
   - How relevant or aligned is the initiative to the Government of India’s priorities and strategies with respect to MHM? How is it aligned with UNICEF’s India programme and strategies?

2. **Effectiveness**
   - How does the initiative directly influence adequate MHM behaviours?
   - How does the initiative indirectly influence adequate MHM behaviours among AGs mediated by knowledge, attitudes, interpersonal communication, social norms and restrictions?
   - How does the intervention directly and indirectly influence mothers’, fathers’, frontline workers’ and teachers’ knowledge, attitudes, interpersonal communication, social support, social norms and restrictions related to adequate MHM among AGs?

3. **Efficiency**
   - To what extent has the GARIMA project used resources (financial, infrastructure, human resources and time) optimally to achieve its objectives? Were they adequate?
   - Were the resources allocated by the implementing partners appropriate to support the activities and achieve the objectives and were any best practices established during the implementation process? What were the bottlenecks in the implementation? How were they resolved, if at all?

4. **Impact**
   - What are the positive or negative, intended or unintended consequences of the project? How many people have been affected? What was the impact of intervention on education, WASH, and nutrition?

As mentioned earlier, while the impact of the project on MHM behaviours has been assessed, only effectiveness has been assessed for converging issues of education, WASH and Nutrition. This is largely because activities to achieve such outcomes and impacts were intermittent in nature. Additionally, the baseline study missed requisite indicators for capturing (and comparing) impact on education, WASH, nutrition and gender.

\textsuperscript{15} A note on the MHHM Scale and its measurement is given in Annex 13.
5. **Sustainability**

- Which components of the project are sustainable? What actions will be required for the outcomes to be sustained?
- What are the key factors that have and can influence further integration with GoI programming for AGs, specifically the RKSK programme?
- What good examples, practices or models emerged that can be documented for possible scaling up and replication? What did not work well?
- What factors need to be in place before the intervention can be scaled up across the state and possibly be replicated in other states?
3. Evaluation Framework

The evaluation is based on intervention-comparison for end line, which systematically assesses the difference in indicators around adequate MHM and cross-cutting issues of gender, education, WASH and nutrition, in intervention and comparison areas, within three project districts. We used a methodology that involved triangulating multiple methods, integrating findings from the quantitative survey with those of the qualitative module in the process.

This evaluation has been premised upon the OECD-DAC criteria that looks at the relevance, effectiveness, efficiency, impact and sustainability of the GARIMA project’s SBCC strategy. Given the emphasis of the project on addressing cognitive, emotional, social and normative factors related to menstrual behaviour, we focused on indicators related to: knowledge around MHM; attitudes and beliefs toward adequate MHM; prevalent MHM behaviours; dialogue, discussion and social support around MHM; and social norms and restrictions around MHM, along with cross-cutting issues of gender, education, WASH and nutrition.

3.1. Evaluation Approach

The evaluation undertook process and outcome assessments to understand the relevance, effectiveness and scope for replication of the model in other districts. It was guided by the socio-ecological model that measured the change in the project districts as a result of the intervention, establishing the linkages from the start to the end of the project. Besides facilitating the examination of several layers/levels of influence by various actors and networks, this model also provides a platform to identify the underlying causes of the issues and find the dynamics of change located within a community. This framework resonates with the National Guidelines on MHM of the Ministry of Drinking Water and Sanitation which is an integral part of the Swachh Bharat Mission Guidelines. It addresses three salient components of the guidelines:

- Access to knowledge and information.
- Access to safe menstrual absorbents and safe disposal infrastructure.
- Breaking social barriers and encouraging sustained dialogue around menstrual management in the community and society.

Detailed explanation for the evaluation approach and the evaluation matrix has been provided in Annex 2 and 3.

3.2. Evaluation Methodology

The evaluation methodology links various survey components together, interweaving the findings from the structured interviews with that of the qualitative discussions.

The ensuing sections describe the rationale for the methodology, types of tools used for data collection, sample size and sampling methodology, key information parameters, data analysis framework, and quality assurance mechanisms adopted by the evaluation, based in a gender, human rights and equity perspective.

3.2.1. Data Collection Methods

The evaluation followed a two-pronged approach for data collection, namely desk-based review and a mix of quantitative and qualitative methods including structured interviews, KIIs and FGDs.
Desk-based reviews of documents - including formative research reports, baseline project data for the three districts, annual reports, concurrent monitoring reports and documented case studies - was undertaken to understand the inception of the model and its implementation.

**Primary data collection** for the evaluation included both quantitative and qualitative methods:

- **Quantitative** survey consisted of structured interviews with adolescent girls, parents (mothers and fathers) of adolescent girls, key influencers in a village such as FLWs and teachers, as well as project implementers including PEs and FFs.

- **Qualitative** data was collected through FGDs and KIIs using interview guides, semi-structured KIIs and an FGD checklist. FGDs with adolescent girls gave insights into dialogues and conversation around menstruation, menstrual hygiene behaviours and social norms and taboos around menstruation. KIIs with the UNICEF project staff and NGO partners aided in understanding the implementation process of the MHM project in the three districts, the reasons for the outcomes achieved, the possibilities for replication, the contribution of the project toward ensuring adequate MHM and its impact on issues of education, WASH, nutrition and gender. Additionally, FGDs with adolescent girls helped in testing the psychometric properties of the MHM scale developed by Drexel University.\(^\text{16}\)

The structured interviews and FGDs used community-based participatory research (CBPR) tools to record views and elicit rich responses from the adolescent girls. The power of narrative, visual and numeric techniques was harnessed while engaging with the participants to acquire deeper insights into the data.

The quantitative surveys were conducted using Computer Assisted Personal Interviews (CAPIs). However, the responses for open-ended questions in the structured interviews were recorded manually on the recording sheets and coded thereafter for analysis.

### 3.2.2. Sample Size and Sampling Methodology (Quantitative)

- The minimum sample size came out as 384 per district, which has been rounded up to 400 for logistical purposes.
- At an aggregate level, a total of 1,200 interviews with adolescent girls were conducted across the three districts. Given that we have proposed a quasi-experimental design, there was a matching sample of 1,200 from comparison villages. Fixing a sample of 10 adolescent girls per village, 120 villages were covered in the intervention and the same number were covered in comparison areas.
- Apart from this, an additional sample of 12 intervention villages that were part of the baseline study were sampled. As a result, a total of 132 villages in the intervention area and 120 villages in the comparison areas were covered.

During the evaluation a total of 120 interventions and 120 comparison villages were sampled. The total number of AGs sampled was 2,400, divided equally among intervention and comparison villages. In addition, 12 villages covered under the baseline and the intervention were also added to the sample.

\(^{16}\) Drexel University has operationalised the behavioural outcome of adequate MHM, based on the definition in literature, in the form of an MHM scale.
Intervention was restricted to a limited number of blocks in the three districts and involved the majority of villages within the intervention blocks. As a result, separate blocks for sampling intervention and comparison were chosen to ensure minimal spill over and contamination across the two categories of participants.

Detailed sample size calculation and distribution can be found in Annex 11.

### 3.2.3. Sample Size and Sampling Methodology (Qualitative)

A total of 36 villages were chosen for conducting the FGDs. These included 18 intervention and 18 comparison villages, spread equally across the three districts i.e. 12 villages in each district (six intervention villages and six comparison villages).

One of the criteria for selecting a village for FGD in intervention areas was the number of AGGs in that village. On the one hand, given that structured interviews were also being conducted in these villages, it meant that 10 girls would have already been covered. The qualitative component, on the other hand, aimed to include in the FGDs those girls who had not been interviewed earlier (a minimum of six girls or a maximum of 12 girls). Assuming that one AGG comprised 10–15 girls, it followed that FGDs were conducted only in villages that had more than one AGG (or 15 girls) as per the data gathered during the listing survey in these villages. As per the ToR, 12 baseline + intervention villages and six other intervention-only villages were to be included in the qualitative survey sample across the three districts. However, out of the 12 baseline + intervention villages, only six villages (four in Mirzapur and one each in Sonbhadra and Jaunpur) were reported to have more than one AGG (Annex 12). Therefore, the sample was adjusted to include six baseline + intervention villages, 12 intervention-only villages along with 18 comparison villages spread equally across the three districts.

For the intervention-only villages, 12 villages out of the 120 sampled were selected for the FGDs (five each in Jaunpur and Sonbhadra, and two in Mirzapur) based on the number of girls associated with the project in that village (as per the listing data). The intervention villages in each district were arranged and thereafter selected randomly on the basis of the above-mentioned sampling criteria. The number of villages sampled from each category (representing age, religion, social category and school attendance status) was proportionate to the total number of villages within that category. The comparison villages were selected based on the number of suitable adolescent girls identified in the village during the listing survey. Thereafter, a similar approach was adopted to ensure representation across variables such as age, religion, social category and school attendance status. The complete list of villages from each district for the FGDs are included in Annex 12.

Following the above-mentioned criteria, the number of villages covered from each type in each district is given below:

<table>
<thead>
<tr>
<th>Village type/District</th>
<th>Jaunpur</th>
<th>Mirzapur</th>
<th>Sonbhadra</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline + Intervention</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Intervention only</td>
<td>5</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Comparison</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>
End line Evaluation of GARIMA Project in Uttar Pradesh (UP): Evaluation Report

In addition to FGDs, In-Depth Interviews (IDIs) were conducted with PEs, FFs and FLWs (ASHAs, AWWs and teachers) in non-sampled intervention villages. The villages were selected in consultation with the UNICEF programme team. Furthermore, KIIIs were also conducted with relevant government officials, UNICEF programme team staff and staff from partner NGOs (a detailed list is provided in Annex 19). Participants for KIIIs were also contacted with the help of the UNICEF programme team.

It is to be noted that the evaluation team faced difficulties in meeting with government officials at the district and block levels as the majority of them have now moved to different regions.

3.2.4. Data Analysis

The analysis for the study was conducted as per the following methods:

- **Quantitative Data:** Univariate and bivariate analysis has been conducted on the quantitative dataset for all six respondent categories, using SPSS and STATA software. For each indicator, possible top breaks were defined, and were included in the table structures for conducting univariate and bivariate analysis. In addition to this, multivariate analysis has also been attempted to study the relationship between MHM behaviour (dependent variable) with various independent variables.

- **Qualitative Data:** Detailed notes and charts were prepared for all qualitative activities. For all focus group discussions, a format for documenting responses was prepared, based on the inputs from Drexel University. The responses were later collated and coded, in accordance with the agreed method of analysis. Similarly, notes for in-depth interviews were used for identifying various thematic areas within the conceptual framework, and were further elaborated based on the responses provided.

3.2.5. Risks and Limitations of the Methodology

Limitations of the methodology faced during the evaluation, along with the mitigation measures adopted for each, are outlined below.

**Limitations as per the ToR include:**

- **Issue:** Since the baseline was done prior to the identification of intervention villages through random selection of villages, it was not possible to construct a panel of baseline villages for the end line evaluation.

**Mitigation Measure:** The baseline evaluation is representative of the state, which serves as a useful reference for extrapolating the effects of the intervention at a broader level. The end line includes findings from both the intervention and comparison villages, which highlights the difference between the two. The end line evaluation also comments on the change that has occurred in the intervention areas as a result of the project.

- **Issue:** Some of the girls from the older age cohort who participated in the intervention got married or moved to other locations, as it has been three or four years since the intervention took place.

**Mitigation Measure:** The evaluation focused specifically on girls who are currently in the age group of 12–19 years. This means that these girls would have participated in the intervention
since the beginning, thus allowing for better assessment of the effectiveness and impact of the intervention.

**Challenges during the evaluation:**

- **Issue:** Recollection of a few data points emerged as a challenge due to a time lag of more than six months between the completion of the project and its evaluation.

**Mitigation Measure:** The number of such data points in the structured interview tool was kept minimal. These questions mostly pertained to recalling numbers upon a positive response to the lead questions. Therefore, it was possible to evaluate whether a certain activity or process had happened, although the respondent may have found it difficult to recollect the exact number of instances the activity occurred. For example, the respondent may have been able to recall if she attended the group meetings, but not the exact number of meetings attended.

- **Issue:** Since the intervention adopted a saturation approach, nearly all villages in a block had been covered under the project. Hence, selection of comparison and intervention villages from the same block was not feasible.

**Mitigation Measure:** For selection of comparison villages, matching was done at two levels in order to create a perfect comparison group. At first, comparison blocks were matched with intervention blocks on the basis of certain socioeconomic and demographic characteristics such as caste composition, population and distance from the district headquarters. Thereafter, a similar exercise was undertaken for matching of villages. While doing this, adequate caution was exercised to map the exposure to any similar projects in the comparison villages.

- **Issue:** Certain questions for adolescent girls (questions on MHHM behaviour, social norms and restrictions etc.) did not elicit responses from pre-menarche girls.

**Mitigation Measure:** It was decided in consultation with UNICEF and Drexel University that the evaluation would exclude such girls (who are yet to experience menarche) from the sample size while analysing questions pertaining to MHHM behaviour, social norms and restrictions, as these sections were not applicable for pre-menarche girls.

- **Issue:** The evaluation design did not factor in the effect of access to education and technology (especially mass media) vis-à-vis any change in knowledge, attitude, practices, social norms and restrictions around MHHM in the intervention and comparison areas.

**Mitigation Measure:** The evaluation design was based on the assumption that factors such as education and access to technology, or any large-scale media campaign, would have had a similar effect in both intervention and comparison areas. The evaluation only demonstrated the contribution of the project and did not attribute any impact to the project.

- **Issue:** Lack of availability of MIS data.

**Mitigation measure:** In the absence of MIS data pertaining to identification of adolescent girls who participated in the intervention, the research team listed all the members of GARIMA AGGs within sampled intervention villages, along with the intensity of exposure (number of meetings attended), and also collected information regarding their exposure. Thereafter, a sample of adolescent girls was drawn from the listed data, and considered for main quantitative interviews.
• **Other Limitations:** As mentioned above, the study included IDIs with project implementers at the community level (PEs and FFs), NGO programme managers and NGO heads, and relevant government officials at state, district and block levels. Since the evaluation was conducted well after the completion of the project, it was observed that at the community level a number of PEs had got married and moved to other villages or towns, and hence could not be interviewed. Similarly, a number of NGO staff had moved to other organisations.

It is noteworthy that there was a change in state government in 2017, which led to a transfer of numerous officials. As a result, a number of officials associated with GARIMA project during 2013–2016 were not available for interviews in 2017–2018.

3.2.6. Quality Assurance

A comprehensive approach for quality comparison and assurance was followed throughout the evaluation. The senior team involved in the evaluation was engaged all along the course of the evaluation for quality comparison and assurance. The field research coordinator undertook timely visits to the field and back checked selected participants both in person and over the phone (for a detailed quality assurance protocol see Annex 16).

During the training and piloting phase before the commencement of the field work, all of the survey team members were briefed regarding ethical norms and considerations, which are detailed in the following section.

3.2.7. Norms, Standards and Ethical Considerations

The evaluation strictly adhered to the United Nations Evaluation Group (UNEG) Norms and Standards and ethical guidelines\(^\text{17}\) and the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (CF/PD/DRP/2015-001).\(^\text{18}\) The team engaged in designing, conducting and managing evaluation activities and endeavoured to produce high quality work guided by professional, ethical and moral principles.

Sensitive information derived from the FGDs and IDIs has been kept confidential. All the interviews were done with prior consent and/or assent of the participants. The design of the evaluation was guided by a human rights perspective, covering child rights, equity and gender, including disaggregation by sex, caste and disability.

Since the data collection involved children (adolescent girls below 18 years of age), consent from a parent and from the adolescent girl were obtained prior to her participation in the survey. Furthermore, the research instruments used for the evaluation and the protocols for ethical standards have been reviewed and approved by certified Institutional Review Boards (IRB) (Annex 18). Data collectors were further instructed to ensure the participants had an understanding of the study. Emphasis was placed on the voluntary nature of participation in the evaluation activities, including the fact that children could be permitted to withdraw at any stage of the evaluation. Privacy and confidentiality have been strictly maintained. This applies to the


\(^{18}\) UNICEF. UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis. 2015
information shared by a child and the person it was shared with, neither of whom are identified in any publication or dissemination of the findings.\textsuperscript{19}

Respecting the dignity of the children, their views and culture has been central to this evaluation. Children involved in the study were treated equally and no child was unfairly excluded from the study or discriminated against. The current evaluation has also sought to maximise benefits to children as a social group either during and/or as a consequence of the study.\textsuperscript{20}

NRMC's own detailed ethical norms followed during the course of the study can be accessed in Annex 17.

\textsuperscript{19} Accessed from http://childethics.com/ethical-guidance/
\textsuperscript{20} Accessed from http://childethics.com/charter/
4. A Closer Look at the GARIMA Project

This chapter predominantly gauges the extent and intensity of exposure to the project for the various stakeholders in terms of their engagement with the project and subsequent learning attained by virtue of being part of the project as either participants or implementers. Besides assessing exposure, the chapter also comments upon the training and capacity-building initiatives undertaken during the project period for the implementers, who include the PEs, FFs, FLWs and teachers, and also includes suggestions provided by the implementers regarding the improvement of the trainings and orientations organised under the project. These are as summarised below:

- More than 60 per cent of the participants and implementers named the project correctly and reported the meetings to have been held once a month. With regard to regularity of attending these meetings, the proportion of participants who reported having done so was considerably less compared to the implementers.
- Playing games, storytelling and prayer/motivational song were listed as the top three activities conducted during GARIMA meetings by the adolescent girls, mothers and the implementers. Besides these, among the activities conducted the implementers also mentioned a recap of the MHM process using aprons and home visits to adolescent girls. With regard to materials used, the Paheli ki Saheli book, film, diaries and aprons emerged as the materials used most in the meetings, as reported by the project participants and implementers.
- Across project participants and implementers, the FF was considered to play a crucial role in facilitating the GARIMA meetings.
- Learning for the participants and implementers primarily centered on knowledge regarding menstruation, hygiene management and the importance of adequate nutritional intake during menstruation. A significant proportion of adolescent girls and PEs ensured proper hygiene by using clean absorbents and properly disposing of them. However, in the case of mothers and fathers, a much lower proportion of participants reported having taken actions related to hygiene management through provision of clean menstrual absorbents, a focus on nutrition or the construction of toilets at home.
- The trainings held for the implementers were found to be useful and satisfactory in terms of knowledge enhancement around menstruation. Suggestions to improve these trainings included the use of videos and films for effective messaging, an increased focus on health and nutrition and the incorporation of vocational training to retain participation and interest.

The results on the socio-demographics (table A.1 in Annex 4) shows that the intervention and comparison samples were evenly matched across a majority of the key criteria. Among AGs there were several significant differences between groups. There was a higher proportion of SC/ST in the intervention group versus comparison group. The opposite was true with respect to other backward castes, where the proportion in the comparison group (43.7 per cent) was significantly higher than in the intervention group (37.2 per cent). A similar trend was true for mothers. Another significant difference was the type of house; a significantly higher proportion of intervention girls (51.6 per cent) lived in kuccha housing, compared to 42.8 per cent of comparison AGs. A similar trend was also true for mothers. At the overall level, it is possible to
hypothesise that the intervention girls were from a lower socio-economic status as compared to AGs from comparison villages. Among mothers there were also significant differences in educational qualifications with intervention mothers reporting lower levels of literacy than comparison mothers (illiterate or never attending: 14.3 per cent in intervention and 3.6 per cent in comparison). Unfortunately, there were substantial differences between the father samples across districts. Some of these differences could be attributed to challenges in finding adequate numbers of fathers to interview.

4.1. Exposure to the Project

Exposure to the project was measured through a number of questions intended to assess the awareness of the stakeholders about the GARIMA project, the frequency of the meetings organised and the regularity of attendance, along with questions regarding the activities and materials that formed part of these meetings.

Overall, between 90 to 100 per cent of the project implementers comprising the PEs, FFs, FLWs and teachers could name the project, while the proportion of adolescent girls, mothers and fathers who could name the project correctly ranged between 60 to 80 per cent.

With regard to the frequency of AGG meetings organised, 65 per cent of adolescent girls and 62 per cent of project implementers reported that the meetings were held once a month (refer to tables A.2 and A.3 in Annex 5). Similarly, 61 per cent of mothers reported that mothers’ group meetings were held once a month.

Likewise, as far as regularity of attendance in the meetings was concerned, while 37 per cent of adolescent girls and mothers reported having attended the meetings regularly (9-12 meetings in a year), about 61 per cent of the project implementers reported regularly attending meetings (refer to tables A.6 and A.7 in Annex 5).

Activities in Session and Materials Used

Participants were asked to list the activities that took place during meetings/sessions. Playing games, storytelling and prayer/motivational song emerged as the top three activities listed by the adolescent girls and mothers. Besides these activities, the implementers (PEs, FFs, FLWs and teachers) also mentioned other activities such as a recap of the MHM process using an apron, home visits to adolescent girls other than group members and discussion of iron-rich food recipes. Additionally, the FFs also mentioned among the activities that took place in the meetings the watching of FFL videos and the film Paheli ki Saheli.

With regard to materials used to share information or anchor discussions around MHM in the meetings, the Paheli ki Saheli book, films, diaries and aprons featured in the top four materials across all project participants. Besides these materials, a poster- Chup Mat Raho Khul Kar Bolo and a leaflet on menstruation were also reported as one of the materials most used by the implementers in the GARIMA meetings.

Facilitation of Meetings

The participants were asked to describe who conducted the sessions. Overall, 77 per cent of project participants (adolescent girls, mothers and fathers) reported that the FFs facilitated the GARIMA meetings. Interestingly, a higher proportion of FFs (92 per cent) reported that PEs served as facilitators when compared to the responses from the PEs themselves (only 36 per cent of PEs themselves reported they facilitated sessions). Furthermore, a higher proportion of project
participants and implementers (25 per cent and 34 per cent, respectively) than ASHA workers (18 per cent and 28 per cent, respectively) reported that AWWs facilitated the meetings.

Interactions with the PEs in the project districts further revealed the excessive dependence on the FFs to conduct the monthly meetings. The FFs played a central role in organising the adolescent girls and mothers, especially in the initial phase when the project was being rolled out. Similarly, it was also observed during the course of these discussions that most of the AGG and mothers’ group meetings in the villages were conducted at the Anganwadi centres, which could perhaps be the reason why the AWWs have been perceived as one of the facilitators, rather than the ASHA workers in the village.

4.2. Learning from the Project for the Participants and Implementers

Following the closure of the project, its impact on the participants and the implementers was evaluated in terms of the overall improvement in their understanding of menstruation and its various aspects, as well as the actions taken by the participants as a result. The components of the learning process are outlined in the following schematic:

While about 60 per cent of adolescent girls and PEs reported having taken the actions listed in Figure 4, the proportion of mothers and fathers who reported having taken actions was less than 20 per cent. The actions largely pertained to a focus on health and hygiene by arranging for clean menstrual absorbents, ensuring adequate nutritional intake and facilitating hygiene management through construction of toilets at home.

4.3. Training and Capacity-Building for the Implementers and Facilitators

Between 80 to 100 per cent of the project implementers comprising the PEs, FLWs, FFs and teachers reported having attended the trainings/orientations held under the GARIMA project. Even though there were variations in the number of trainings attended by the PEs, FFs, FLWs and

<table>
<thead>
<tr>
<th>Overall Learning around Menstruation</th>
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<tbody>
<tr>
<td>Project Participants</td>
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<tr>
<td>AG and Mothers</td>
</tr>
<tr>
<td>• Maintaining hygiene during menstruation</td>
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<tr>
<td>• Things to be done during menstruation</td>
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<tr>
<td>• Adequate nutritional intake during menstruation</td>
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<td>Fathers</td>
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<td>• Maintaining hygiene during menstruation</td>
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<td>• Adequate nutritional intake during menstruation</td>
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<td>• Knowledge regarding what menstruation is</td>
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<td>Project Implementers</td>
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<td>PE and Teachers</td>
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<td>• Maintaining hygiene during menstruation</td>
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<tr>
<td>• Maintaining hygiene during menstruation</td>
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<td>• Knowledge regarding what menstruation is</td>
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*Figure 4: Top three overall lessons and actions taken by participants and implementers*
teachers, almost 100 per cent of them were satisfied and found these trainings useful. The trainings were mostly conducted over a period of two to three days at nearby schools.

When asked about the aspects that were discussed during the course of these trainings, project implementers across districts most frequently mentioned:

a) Understanding what menstruation is about.
b) Importance of maintaining hygiene during menstruation.
c) Proper disposal of menstrual absorbents.
d) Understanding changes that occur during menstruation.

In addition, FFs in Jaunpur and Sonbhadra districts also mentioned that among the key discussion points during such trainings/orientations were problems faced by adolescent girls.

The main recommendations for improving the trainings/orientations, as suggested by the PEs, FLWs and teachers, were the use of videos and films for effective messaging, a greater focus on health and nutrition and the inclusion of vocational training activities.

4.4. Encoded Exposure

Encoded exposure aims to understand the degree to which participants have engaged with the project by creating a continuous variable with indicators covering exposure, dose, and recall. To measure encoded exposure, a composite variable was created using AGs and mothers’ data from the following questions:

- Can you name the project?
- Has GARIMA project been implemented in your village?
- How long ago did your GARIMA group form (in months)?
- How long ago did you join your GARIMA group (in months)?
- How often were adolescent girls group meetings held?
- How often did you attend these meetings?
- What was the duration of these meetings?
- What activities took place in each meeting?
- What materials were used at these meetings?
- Who facilitated these meetings?

A total of 1,812 AGs and mothers in intervention villages answered all ten questions. A total of 77 points were possible. AGs in intervention villages scored between 4 and 47 points, whereas mothers in intervention villages scored between 3 and 40 points. Based on the distribution of the data, three categories were created: low, medium and high.
As Table 2 shows, participants were evenly distributed among low, medium, and high categories. Another key finding is that the highest scores for AGs and mothers were considerably lower than the maximum score possible. There are several possible explanations for this data. The first was low recall, because participants were being asked to report on a project which had finished almost a year ago. Second, the project included menstruation-related content fairly early on and in later years expanded to include other gender issues such as sexual harassment and child marriage. Another issue could be related to short-falls in project implementation (e.g. inadequate attendance, irregular implementation of meetings, lack of integration with existing health and education services, frequent turnover of participants, limited use of materials etc.). These results may be a matter of concern with regards to sustainability of the project. Any future projects will likely need to have an overlap with the content of this project.
5. Adequate Menstrual Hygiene Management

The WHO/UNICEF Joint Monitoring Program (JMP) definition of MHM recognises that procurement, storage, privacy, frequency of changing the absorbent, hygiene and disposal are critical aspects that need to be taken care of in order to achieve adequate MHM. This chapter presents the findings of the evaluation and assesses the relevance of the GARIMA project’s activities, the effectiveness of the project in achieving the desired project outcomes, the impact created by it, the efficiency of the project and the sustainability of the project outcomes when external support is removed.

5.1. Assessing the Relevance of the GARIMA Project

This section aims to answer three critical questions concerning the relevance of the project, specifically:

a) Are the activities and outputs of the project consistent with the overall goal and the attainment of its objectives?

b) To what extent is the project suited to the needs of adolescent girls in Uttar Pradesh?

c) How relevant or aligned is the initiative to the Government of India’s priorities and strategies with respect to MHM? How is it aligned to the programme and strategies of UNICEF India?

The following section presents findings that establish the relevance of the project in relation to the context of the three districts and the larger policy environment in India.

The project has established its relevance to the prevailing scenario - characterised by a lack of knowledge and communication around MHM - through the creation of a supportive environment for adequate MHM in the following ways:

- The prevalent context in the districts revealed a glaring dearth of awareness and knowledge with regard to menstruation and hygiene management resulting in a malicious cycle of misinformation. This was further compounded by incorrect practices pertaining to hygiene management, stigmatisation and socio-cultural restrictions placed on menstruating girls and women, that reinforced gender inequity and exclusion. Through its SBCC strategy, the project has enabled effective social dialogue across stakeholders that did not previously exist. Given this context, activities were designed to encourage correct hygiene practices, which included the use, storage and disposal of the absorbents, and to address restrictions and norms that prevented adequate MHM.

- The project has created conduits towards improving MHM through monthly AGG meetings and engagement with mothers and fathers in the community. Supported by the FFSs and FLWs trained under the project, the potential of PEs in the community was used to improve IPC, communication and other life-skill based outcomes for the girls. Moreover, through its convergence with government initiatives, the project has brought forth and addressed MHM and cross-cutting issues that include WASH, nutrition, education etc.
The project complements government guidelines, policies and programmes around MHM by bringing in behavioural change and capacity-building aspects. These aid the practice of adequate MHM and provide a fillip to government policies that focus on infrastructure provision in facilitating MHM. Besides empowering the adolescent girls and other community members to demand facilities, the project has strived to effect behavioural and attitudinal change that enables them to use any such facilities at their disposal.

5.1.1. MHM: An Important Cog in Gender and Human Rights

Empowering and equipping women and girls to manage their periods with dignity is connected to the guarantee and realisation of a broad range of gender and human rights. Beyond the local community, addressing the issue is the shared responsibility of policy makers, NGOs and organisations working towards the promotion of adequate MHM.

The Universal Declaration of Human Rights states in its preamble that all human beings should be recognised for their inherent dignity. In this sense MHM links directly to the Sustainable Development Goals, which encompass healthy lives, inclusive and equitable education, gender equality, clean water and sanitation and inclusive economic growth.

Besides these elements, the United Nations Educational, Scientific and Cultural Organisation (UNESCO) also emphasises that access to health services, positive social norms regarding menstruation and effective advocacy and policies are enabling factors that facilitate hygiene management during menstruation, the absence of which poses significant barriers towards the exercise of gender rights and the attainment of gender equity.21

Through its design and implementation, the project has approached menstrual hygiene as a human rights concern that impacts not just health, education and sanitation but also other aspects such as dignity and gender equality.

5.1.2. Need for the GARIMA project: What Impedes Menstrual Hygiene Management?

Discussions with the project implementers (PEs, FFs and FLWs), along with insights drawn from the review of secondary literature, revealed the following context in the project districts pertaining to menstruation, hygiene management and attitudes and norms surrounding menstruation:

- **Limited knowledge of MHM:** Baseline and formative research carried out in Mirzapur, Jaunpur and Sonbhadra revealed a lack of information and preparedness before menarche amongst adolescent girls. Between 60 to 80 per cent of adolescent girls and mothers lacked knowledge about menstruation before menarche.22

The FLWs (particularly ASHA and Anganwadi workers) are by virtue of their training supposed to be cognisant of issues concerning adolescent girls in their respective

communities, especially with regard to health and hygiene. The baseline figures however revealed that awareness of why menstruations happens and the physiology of female reproductive organs was negligible among the FLWs in the community. Many girls also reported that they felt uncomfortable and hesitant in seeking information from FLWs.

- **Negligible dialogue and communication:** According to norms prevalent in the community, girls were not expected to know much about menstruation prior to its onset. Although discussions occasionally took place around what to do during menstruation, very few in the community felt the need to discuss why menstruation happens. These conversations seemed to happen only at menarche and largely revolved around the management of pain or discomfort. A pervasive culture of discouraging inquisitiveness also meant that few questions about menstruation were asked or encouraged.

In-depth interviews with the PEs, FFs and FLWs further revealed the stigma associated with the topic due to links between menstruation – particularly menarche - and sexuality. The elder female members of the households feared the consequences of being “found out,” which included not only humiliation and shame, but also a very real danger of sexual violation or other inappropriate behaviour, since the onset of menarche signifies attainment of sexual maturity.

- **Poor menstrual hygiene and disposal practices:** With regard to practices associated with menstruation, baseline findings suggest that most of the adolescent girls and women in the communities across the three districts re-used ‘old cotton cloth’ after washing it with soap and water. However, when it came to drying the cloth, they did so either inside the house or somewhere discreet, thus affecting hygiene.

Absence of proper disposal mechanisms was yet another issue that fettered MHM in the community. More than half of post menarche girls in the community wrapped the menstrual absorbent in plastic bags or newspapers and threw it in ponds and canals, raising serious environmental concerns. Since the burning of the menstrual absorbent was considered taboo, negligible numbers of girls in the baseline reported burning as a form of disposal. This was one of the restrictions in the community that the majority of the girls imposed upon themselves and that they believed in adhering to even after their exposure to the project.

- **Menstrual taboos and restrictions:** Of the many restrictions that were imposed on menstruating girls and women across the districts, not being allowed to enter the ‘puja’ room and kitchen during menstruation remained the most pronounced. Additionally, menstruating girls were also subject to strict dietary restrictions wherein they were deterred from touching or consuming foods like pickles, curd, tamarind etc. These restrictions were even more

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prominent in those households where the elders or grandparents lived with the family. One of the PEs from Sonbhadra whose grandmother was the AWW in the community reported that most of these restrictions were imposed on her by her grandmother, who often criticised education that encouraged girls to break away from their traditions.

Most women in the community, and sometimes even the adolescent girls themselves, did not consider these restrictions as discriminating or unfair. Even when mothers were positively disposed to addressing these restrictions, by virtue of sheer power dynamics and gender relations within the household they would often give in to social prescriptions, compelling their daughters to abide by these restrictions while also following it themselves.

5.1.3. How Relevant Were the Activities, Outputs and the Overarching Goal of the GARIMA Project?

The goal of the project was to address the issue of inadequate MHM by working on knowledge and the culture of silence and norms surrounding menstruation through initiating dialogue and sustaining conversation around the way menstruation is perceived.

The attainment of this goal was built upon three main pillars comprising capacity-building of the implementers, interpersonal communication and the initiation of community dialogue through AGGs, mothers’ and fathers’ groups and other key influencers such as teachers. Figure 5 maps the activities that were undertaken in each of these areas in order to achieve the goal of the project.

Knowledge and Attitudinal Shifts at the Individual Level

The baseline revealed that the girls felt most comfortable discussing menstruation with a trusted peer within their circle of friends. Hence, monthly thematic meetings of about 15-20 adolescent girls facilitated by a trained peer educator were organised under the project. These meetings
adopted a life-skill based approach which aimed to give the girls the required psychosocial and interpersonal skills by fostering critical thinking and problem solving abilities.

Likewise, mothers’ group meetings conducted during the course of the project contributed towards enhancing the mothers’ knowledge of menstruation and hygiene management. This resulted in open communication and the preparation of pre-menarche girls by the mothers, something that, as captured by the baseline, was barely the case before the project began. The family members, including fathers, were encouraged to build an enabling environment in terms of provision of adequate nutrition, education and the construction of toilets.

**Building Capacity and Skills of Frontline Worker**

To equip the FLWs with correct knowledge and understanding of menstruation and menstrual hygiene, capacity-building was carried out every quarter through refresher sessions held during sector meetings of ASHAs and AWWs. Sometimes the FFs also conducted meetings in the school, where they spoke to the teachers about the importance of having adequate sanitation facilities and well-functioning toilets for girls in order to minimise absenteeism and school drop-outs. As reported by the FF from Halia block in Mirzapur, these interactions at times proved useful and the teachers took the initiative to demand toilets from the village Pradhan. This represents a critical step towards improving educational outcomes for the girls.

**Challenging Attitudes and Social Norms: Community Dialogue and Advocacy**

To embolden people to voice their views and opinions, the project, through participatory theatre performances, envisaged the initiation of community-level dialogue with regard to menstruation, a topic often perceived as a ‘private’ issue. Furthermore, ‘edu-tainment’-based radio and television shows along with both fictional and factual stories were proposed under the project.

This was pivotal because, contrary to the individual and the family level, discussions around menstruation at the community level were deficient given the associated stigma. Hence, bringing the subject in to the public domain was extremely important to build a favourable environment in which menstruation would no longer be considered a taboo topic of discussion.

**5.1.4. MHM and the Policy Environment in India**

Despite the fact that adolescent girls and women form a major percentage of the country’s population, there is a dearth of comprehensive initiatives and strategies that facilitate MHM, which bears upon one of the most important aspects of their sexual and reproductive health.

Policies to improve MHM are led by multiple ministries in India, with each one bringing its own unique approach while addressing this cross-cutting topic. Although MHM has not been the exclusive priority for any of these ministries, it has often been a sub-set of other goals, such as improving health or education outcomes for women or adolescent girls. The table below summarises the focus of various policies and programmes related to MHM and other cross-cutting issues under particular ministries.
<table>
<thead>
<tr>
<th>Ministry</th>
<th>MHM-related Policy or Programme</th>
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<tr>
<td>Ministry of Health and Family Welfare (MoHFW)</td>
<td>The Rashtriya Kishor Swasthya Karyakram (RKS), India’s national adolescent health strategy, was launched in January 2014 to prioritise access to MHM information, support, and MHM products through Adolescent Friendly Health Clinics and counsellors.</td>
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<tr>
<td>Ministry of Drinking Water and Sanitation (MoDWS)</td>
<td>The Swachh Bharat Mission (SBM), India’s national cleanliness programme launched in October 2014, is run in rural areas by MoDWS and in urban areas by MoUD. It lays emphasis on sanitation infrastructure (e.g., individual and community toilets, solid waste management) and awareness programs for behavioural change.</td>
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<tr>
<td>Ministry of Urban Development (MoUD)</td>
<td>The Sarva Siksha Abhiyan (SSA, 2000-01) and Rashtriya Madhyamik Shiksha Abhiyan (RMSA, 2009) 24, which aim to provide elementary education for all and enhance access to secondary education, stress the building of sanitation infrastructure in schools as a way to improve attendance. Additionally, Swachh Bharat: Swachh Vidyalaya (SB: SV), India’s national guidelines for sanitation in schools, prioritises MHM facilities in schools (e.g., incinerators).</td>
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<tr>
<td>Ministry of Women and Child Development (MoWCD)</td>
<td>The SABLA program (2011), an integrated service to improve health, nutrition, and empowerment for girls, focused on improving awareness of MHM among adolescent girls through Anganwadi centres.予以提示。</td>
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In December 2015, the Ministry of Drinking Water and Sanitation (MoDWS) issued National Guidelines for MHM with support from UNICEF India. In a country with 355 million menstruating women, this was a welcome step that generated greater resolve for an integrated approach towards improved MHM for adolescent girls and women in India.25

The guidelines aim for state, district, block and school-level interventions and outline steps for all the ministries involved — Health, Rural Development, Human Resource, Women and Child and Tribal Development. Beyond the establishment and maintenance of infrastructure, that includes

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24 Now known as the Samagra Shiksha Scheme. The scheme subsumes three existing schemes— Sarva Shiksha Abhiyan (SSA), Rashtriya Madhyamik Shiksha Abhiyan (RMSA) and Teacher Education (TE) to treat school education holistically, as a continuum from pre-school to class XII

building toilets, provision of pads and installation of incinerators, indicators to measure success and outreach are closely linked to the development of life skills for girls and women that enable and empower them to access this infrastructure. These skills broadly comprise adequate knowledge, the feeling of being supported, and the development of capacities to experience a period free of guilt and shame. These guidelines have been further integrated into the national sanitation programme (Swachh Bharat Mission). In addition to targeting girls, it also emphasises the inclusion of boys and men in promoting adequate MHM, along with recommendations and standards regarding MHM education, MHM products and sanitation arrangements and the support required in schools and communities.26

5.1.5. How Does the GARIMA Project Augment Government Initiatives?

The focus of the aforementioned policies and initiatives is largely geared towards infrastructural development to support MHM and the boosting of accessibility and availability of MHM products and sanitation facilities. But little weight has been assigned to holistic solutions, of which behavioural change remains a decisive aspect.

RKS K is one of the few programmes that prioritises the provision of sanitary pads as well as sustained support and information on menstruation provided by counsellors. However, the nature of such information again largely hinges upon instructions on product use. Likewise, the recent MHM guidelines issued by the government urge the MoDWS to conduct awareness programmes to change community attitudes regarding access to sanitation during menstruation. However, in practice these efforts have centred on building toilets and not behavioural change.27

Since menstrual hygiene itself is characterised by several cross-cutting issues, effective MHM-related interventions require clearly defined roles and clarity on convergence across departments. This is particularly important as various policies and programs across different ministries overlap in their goals. RKS K and SABLA, for example, both prioritise creating awareness of MHM among adolescent girls. However, there is limited clarity on how a counsellor under RKS K’s Adolescent Friendly Health Clinics and an AWW under SABLA may complement each other’s efforts.28

Operationalising these existing polices remains challenging due to inadequate capacity on the ground. This is especially true with regard to FLWs and teachers, whose role as influencers in the community form the core of interventions that aim to reach out to adolescent girls and other community members. Although MHM programmes leverage community health workers and teachers in providing MHM education, their comfort in discussing the issue, particularly when talking to boys, remains restricted and is seldom addressed through training programmes and capacity-building measures.29 Additionally, as noted in the previous section, few adolescents and youths see health workers as a resource for such information or feel comfortable approaching them.

26 Ibid
28 Ibid
In the light of the policy environment discussed above, GARIMA becomes relevant as a strategic project, one that complements the existing policies and programmes around MHM in the following ways:

- The project has enabled adolescent girls to voice their demands to be provided with the necessary amenities that enable them to manage their periods safely and hygienically. This provides a major fillip to several policy initiatives that mandate the provision of infrastructure to support safe disposal and hygiene management.

- Besides generation of demand, the project has worked towards behavioural and attitudinal change, which is crucial in addressing norms that constrain the use of such facilities, as well as the adoption of practices that enable MHM.

- Furthermore, FLWs under the project have been promoted as agents of change at the grassroots level through capacity-building and enhancement of their knowledge with regard to menstruation.

5.1.6. GARIMA Project and UNICEF India Programme and Strategies

The overall goal of the 2013-2017 country programme included the advancement of the rights of children, adolescents and women to survival, growth, development, participation and protection by reducing inequities based on caste, ethnicity, gender, poverty, region or religion. Situated within a life-cycle approach built on an equity lens and inter-sectoral convergence, the goals set out for the GARIMA project align with the following UNICEF country programme results:

a) To ensure that boys and girls live in a protective and learning environment with equal access to and utilisation of quality education and other protection services.

b) To empower adolescents to fully participate and make informed decisions affecting their lives.

c) To integrate policies, practices, programmes and social norms to advance the rights of adolescents and women.\(^{30}\)

Nearly a quarter of India’s 1.2 billion people are adolescents. To make the most of this demographic fact, UNICEF had accorded priority to the empowerment and participation of adolescents, especially girls, in all spheres of life.\(^{31}\) The objective was to empower the adolescents, and especially girls, with correct knowledge and practices. This has also, in the context of MHM, been the focus of the GARIMA project. The project contributed to this objective by bringing on board adolescent girls and key influencers and decision makers in the community through various activities.

Besides designing its own intervention, UNICEF also played a catalytic role in supporting government initiatives on MHM through a rights-based approach and a combination of strategies outlined in its country program. These include:

a) Capacity development at the individual, institutional and policy levels to improve the skills of stakeholders involved and to empower the community and target groups to both use and demand services to which they are entitled.


\(^{31}\) Ibid
End line Evaluation of GARIMA Project in Uttar Pradesh (UP): Evaluation Report

b) Inclusion of civil society and NGO functionaries in augmenting the national and state level efforts towards achieving adequate MHM for all.

c) Promotion of social inclusion and equity by involving vulnerable and marginalised communities in the project to ensure better understanding and an equitable distribution of benefits

5.2. Assessing the Effectiveness of the GARIMA Project

This section explores whether the project has been effective by addressing the following key questions:

a) How does the initiative directly influence adequate MHM behaviours among AGs?

b) How does the initiative indirectly influence adequate MHM behaviours among AGs, mediated by knowledge, attitudes, interpersonal communication, social norms, and restrictions?

c) How does the intervention directly and indirectly influence mothers’, fathers’, frontline workers’ and teachers’ knowledge, attitudes, interpersonal communication, social support, social norms and restrictions related to adequate MHM among AGs?

d) How did the intervention influence cross-cutting issues such as WASH, nutrition and gender?
The following section presents the findings on effectiveness. The results are summarised below.

- Knowledge about puberty, reproductive parts and absorbent use was significantly higher in intervention sites versus comparison sites. In terms of attitudes, AGs in intervention villages had significantly higher proportions of positive attitudes towards menstruation, absorbent use, restrictions and gender versus AGs in comparison villages.

- Interpersonal communication results demonstrated that most AGs (64.4 per cent) had some discussion or dialogue about menstruation, absorbent use, restrictions and gender, yet AGs in comparison villages were significantly more likely to report no discussion when compared with AGs from intervention villages.

- A higher proportion of AGs had positive social norms around menstruation and issues related to menstruation when compared to comparison AGs. Positive in this case indicating that these participants approved of and practiced desired behaviours i.e. using sanitary pads, using cloths, using dry cloth after washing with soap, disposing by burning or burying, going to school during menstruation, demanding iron-rich foods during menstruation, demanding a private place to bathe/change during menstruation and interacting with boys after menarche.

- Personal, social and structural restrictions were reported by 80 per cent, 48 per cent and 6 per cent of the AGs. While personal restrictions were significantly higher among AGs in comparison villages than in intervention villages, social restrictions were higher among AGs in intervention villages.

- With regard to the effect of the GARIMA project on cross-cutting issues, it could be seen that the consumption of green leafy vegetables during the daily routine and during the menstrual cycle was significantly higher in intervention villages where the AGs made their own decisions pertaining to nutritional-intake.

- In terms of WASH facilities, the presence of ‘space for changing clothes’ was significantly higher in intervention areas. Furthermore, both household and school toilets in intervention villages appeared to have more facilities than those in comparison villages, which could be attributed to promotion of adequate WASH facilities under the project.

- With regard to learning and actions taken around issues of sexual harassment, education and child marriage, which gauge the effect of GARIMA on gender, AGs reported having learnt the importance of engaging with such issues in the community and discussing their implications with family members, FLWs, village heads etc.

5.2.1. Direct Effects on MHM Behaviours

The WHO’s definition of MHM outlines six constructs: i) preparation; ii) storage; iii) privacy; iv) frequency of changing the absorbent; v) hygiene; and vi) disposal. These also form the basis for our indicators on MHM behaviours.

Adequate MHM

Adequate MHM was elicited in the structured interviews with AGs, mothers, and PEs through a series of questions about practices related to menstruation. Additionally, FGDs conducted with AGs and using participatory methods yielded more in-depth information on MHM practices. Overall results from the structured interviews are summarised and presented in the figure below, where an asterisk denotes a statistically significant difference.
**Type of absorbent**: Overall the data indicates significant differences among intervention and comparison AGs. Sanitary pads/napkins were more likely to be used among comparison participants (51.4 per cent vs. 9.6 per cent). Additionally, 78.3 per cent of PEs reported using sanitary pads/napkins. Differences in adequate use of old cotton cloth among intervention and comparison stakeholders were substantial. Over three-quarters of intervention stakeholders versus half of comparison stakeholders who use old cotton cloth practice adequate washing; that is, the use of soap and water, or the use of disinfectant after using soap and water. Similarly, with regard to drying, two-thirds of intervention AGs versus one-third of comparison girls (61.3 per cent vs. 33.8 per cent) practiced correct drying behaviours. Since the use of old cotton cloth was reported by over three-fourths of AGs, these numbers translate into fairly high levels of practice.

**Storage of absorbent**: Participants were asked to report how and where AGs stored their absorbent. The responses were collapsed to measure storage in a safe and clean place, e.g. with other clothes or in a bag. AGs and mothers in intervention villages report significantly higher proportions of adequate storage when compared with the same participants in comparison villages.

**Disposal of absorbent**: Participants were asked to report how AGs ultimately disposed of their absorbent. Those who reported disposal through burning, storing and then taking it in to the school incinerator and burying in a pit were coded as practicing correct disposal. Overall, intervention villages had a significantly higher proportion of correct disposal practices versus comparison sites (45.7 per cent vs. 30.0 per cent). Even though intervention villages had significantly higher adequate disposal proportions, less than half the AGs practiced this behaviour.

**Frequency of changing**: Participants were asked how many times a day AGs changed their absorbent. Nearly three-quarters (74.9 per cent) of intervention participants reported changing the absorbent three or more times a day as compared to 47.1 per cent of participants in comparison villages. PEs standout with 93.4 per cent reportedly changing their absorbent at least three or more times a day.
**Private place to change the absorbent:** In order to practice adequate MHM, AGs need a private place to change their absorbent. Overall, 54.1 per cent of participants in intervention villages versus 45.4 per cent in comparison villages reported changing their absorbent in a private bath area or toilet.

**Personal hygiene during menstruation:** Participants were asked specific questions regarding personal hygiene during menstruation. Overall, AGs in intervention villages reported practicing all personal hygiene behaviours in significantly higher proportions than girls from comparison villages. For mothers, the trend was very similar, with higher proportions of intervention mothers using the bathing area during menstruation and taking a bath daily.

A participatory activity called ‘Day in the life of a cloth/napkin’ was conducted in the FGD setting in which the AGs were placed in two groups. One group represented ‘cloth’ and the second group represented the ‘sanitary napkin.’ Both groups were provided a set of discussion questions on the procurement of cloth and napkins, the frequency of changing them, their storage and the method of disposing them. The top three self-explanatory responses from the FGD indicate some differences between intervention and comparison AGs on procurement, use and disposal of absorbents, with intervention AGs reporting higher levels of all practices. For disposal, AGs in intervention villages reported lower proportions for disposal in the structured interview as compared to the FGDs. This could suggest a possibility of ‘group-think’ for those questions. Also, the FGDs were able to provide additional information beyond what was asked in the structured interviews. For instance, the FGDs revealed that another common source of disposal was using a water body (pond, river or lake).

5.2.2. Indirect Effects

Examination of indirect effects focused on how the initiative indirectly influenced adequate MHM behaviours among AGs mediated by knowledge, attitudes, interpersonal communication, social norms, and restrictions.

5.2.2.1. Knowledge

A first and vital step towards achieving the goal of adequate MHM is to empower girls with correct knowledge around menstruation and other related topics such as puberty, reproductive body parts, menstrual absorbents, and managing pain and discomfort experienced during the menstruation. Having correct knowledge enables girls to develop positive attitudes towards menstruation, practice adequate MHM and over time influence existing social norms and restrictions. In the following sub-sections we present the evaluation’s findings with respect to the level of knowledge among participants around these issues in both intervention and comparison areas.

**Knowledge about Puberty**

Puberty in girls is marked by external and internal physical changes. Participants (AGs, mothers, FLWs, FFs, and PEs) were shown cue cards with an image of a growth map that was used to prompt participants to first name the external changes girls undergo during puberty and then name the internal changes during puberty. Participants were expected to name a maximum of 13 changes (7 external and 6 internal). Composite scores were generated for all participants and then these were collapsed into three categories: low, medium and high knowledge. The following graphs (Figure 7 and Figure 8) represent the level of knowledge about puberty among project
participants (AGs and mothers) and project implementers (FLWs- ASHAs and AWWs, teachers, FFs and PEs) respectively.

The results show that the proportion of participants who have high knowledge in intervention areas is significantly higher than those in comparison areas across all types of participants (project participants and implementers). Although a greater proportion of intervention AGs and mothers displayed high levels of knowledge when compared to the comparison site participants, among participants overall the proportion displaying high knowledge was small (less than ten per cent across the board).

![Figure 7: Knowledge about changes during puberty (project participants)](image)

Among implementers in intervention areas, 61.5 per cent of FFs and 51.4 per cent of PEs revealed high knowledge. At 43.3 per cent and 39.4 per cent respectively FLWs and teachers lagged behind other implementers. In contrast to this the corresponding figures for comparison areas indicate lower levels of knowledge (table A.24 in Annex 6). Interestingly, participants in Jaunpur were found to have a higher degree of knowledge as compared to Mirzapur and Sonbhadra (table A.25 in Annex 6).

![Figure 8: Knowledge about changes during puberty (project implementers)](image)
Knowledge about Reproductive Body Parts

Cue cards with the image of a reproductive diagram were shown to participants to assess ability to name five reproductive organs: ovaries, uterus, fallopian tubes, endometrium and vagina. Scores were provided to the participants based on their ability to correctly name and describe each of these organs. The scores were combined and all participants were categorised as having low, medium and high knowledge. The results from project participants indicated similar trends as the puberty questions i.e. significant differences between intervention and comparison sites, very low levels of high knowledge overall and AGs displaying better knowledge than mothers. Although all project implementers in intervention areas showed higher knowledge of reproductive parts than about puberty as a whole, the overall trends were similar for both measures.

Knowledge about Managing Pain and Discomfort

In order to maintain good menstrual health, it is critical for girls to be aware of the various symptoms that may arise as a result of poor menstrual hygiene and to know who should be consulted to address these symptoms. This sub-section seeks to assess the level of knowledge among project participants and implementers around this issue.

Participants were asked to recall symptoms of poor hygiene during menstruation such as itching, excessive white discharge, yellowish discharge, burning sensation while urinating, ulcers in the urinal area and foul-smelling discharge. Thereafter, they were asked who they would consult in case such symptoms appear. Favourable options included the village health worker (ASHA/ANM/AWW) and/or a doctor.

Table A.35 in Annex 6 indicates that only a very small proportion of adolescent girls and mothers in comparison areas have high knowledge about managing pain and discomfort (6 per cent) when compared with intervention areas (18 per cent). Contrary to the overall findings on knowledge of puberty and reproductive organs, mothers across both intervention and comparison areas displayed higher levels of knowledge regarding the management of pain and discomfort than adolescent girls. A possible explanation is the fact that mothers are older than AGs and have been dealing with menstruation for a longer time.

Like other aspects of knowledge, FFs reported high knowledge on managing pain and discomfort (85 per cent) (see table A.36 in Annex 6). While there were no FFs and PEs in comparison sites, the FLWs and teachers in the comparison sites displayed significantly lower levels of knowledge regarding pain and discomfort (intervention FLW: 53 per cent, comparison FLW: 41 per cent; intervention teachers:60 per cent, comparison teachers: 47 per cent).

When asked about the most preferred choice for contacting in cases of experiencing adverse symptoms, ‘seeing a doctor’ was found to be the most common response across respondent categories, groups and districts (Figure 9). This was followed by discussion with village health workers such as ASHA/ANM/AWW, and then discussions with mothers.
5.2.2.2. Attitudes

**Attitude towards Menstruation – Word Association**

One method of measuring attitudes was by asking participants to say out loud the first five words that come to mind when they hear the term ‘menstruation.’ Overall, menstruation continues to be associated with pain, negative emotions and physical symptoms across intervention and comparison villages. Overall, menstruation was associated first and foremost with pain. Physical symptoms such as weakness, feeling unwell, and lethargy and negative emotions including irritation, anger and fear were also commonly associated with menstruation. To a lesser extent, menstruation was described in the context of social restrictions such as not going to school, not going to temple and not touching a pickle. Apart from these negative associations, participants also included more positively framed answers relating to adequate MHM practices including preparedness (e.g. arranging for clean cloth and being prepared in advance) and hygiene (e.g. staying clean, washing hands). Among project stakeholders, it is disheartening to see that significantly more AGs from intervention villages associated menstruation with negative emotions (32.9 per cent) and physical symptoms (40.3 per cent) as compared to AGs from comparison villages (18.7 and 35.1 per cent respectively) (see table A.39 in Annex 6). Even project implementers who should be able to think of menstruation in broader terms and as a normal part of womanhood are, on the whole, associating menstruation with pain, negative emotions and physical symptoms (see table A.40 in Annex 6).

![Figure 10: Feelings associated with menstruation: project stakeholders](image-url)
Attitudinal Scales

Attitudes were also measured by evaluating participants’ agreement with statements about menstruation. The participants were asked to show their agreement using a smile-o-meter, where 1 denoted ‘completely disagree’ and 5 denoted ‘completely agree’. Statements were grouped into four categories: attitudes toward menstruation; attitudes toward adequate procurement, use, and disposal of menstrual absorbents; attitudes toward restrictions associated with menstruation; and attitudes toward gender and menstruation. An index of all the statements was created to capture the respondent’s overall attitude toward the category, classifying it as positive, neutral or negative. It is important to remember that for restrictions, negative scale items were recoded, implying that positive attitudes towards menstrual-related restrictions actually signify that participants do not support menstrual-related restrictions.

Table 4 shows the proportion of individual types of participants reporting positive attitudes for each of the four categories. The decision to focus on positive attitudes was based on the assumption that the intervention was working to promote these attitudes. The expectation was, therefore, that intervention areas will report more positive attitudes than comparison areas. The results from project participants are reported first, followed by those for project implementers.

Table 4: Attitude and exposure project stakeholders

<table>
<thead>
<tr>
<th>Project Stakeholders</th>
<th>AGs</th>
<th>M</th>
<th>F</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>1248</td>
<td>1192</td>
<td>564</td>
<td>2289</td>
</tr>
<tr>
<td>Positive attitudes toward menstruation</td>
<td>44.6</td>
<td>22.6*</td>
<td>31.9</td>
<td>21.6*</td>
</tr>
<tr>
<td>Positive attitudes toward adequate procurement, use and disposal of menstrual absorbents</td>
<td>34.4</td>
<td>21.9*</td>
<td>28.9</td>
<td>19.7*</td>
</tr>
<tr>
<td>Positive attitudes toward restrictions associated with menstruation</td>
<td>39.4</td>
<td>24.3*</td>
<td>26.4</td>
<td>20.9*</td>
</tr>
</tbody>
</table>

*Statistically significant.
On the one hand, all intervention participants displayed significantly more positive attitudes towards menstruation, absorbents, restrictions and gender. On the other hand, the overall lower levels of positive attitudes among adolescent girls, mothers and fathers point to the need for additional SBCC addressing attitudes.

Table 5 below highlights positive attitudes among project implementers who, unsurprisingly, had the highest levels of positive attitudes, indicating that the GARIMA project has been somewhat successful in shifting the attitudes of those who play such a critical role in fostering community-level changes in order to break the silence surrounding menstruation.

<table>
<thead>
<tr>
<th>Project Implementers</th>
<th>PE</th>
<th>FF</th>
<th>FLW</th>
<th>T</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>I</td>
</tr>
<tr>
<td>N</td>
<td>107</td>
<td>13</td>
<td>157</td>
<td>180</td>
<td>38</td>
</tr>
<tr>
<td>Positive attitudes toward menstruation</td>
<td>77.6</td>
<td>92.3</td>
<td>75.9</td>
<td>33.9*</td>
<td>60.5</td>
</tr>
<tr>
<td>Positive attitudes toward adequate procurement, use and disposal of menstrual absorbents</td>
<td>64.5</td>
<td>92.3</td>
<td>68.8</td>
<td>40.0*</td>
<td>73.7</td>
</tr>
<tr>
<td>Positive attitudes toward restrictions associated with menstruation</td>
<td>74.8</td>
<td>84.6</td>
<td>73.3</td>
<td>42.2*</td>
<td>86.8</td>
</tr>
<tr>
<td>Positive attitudes toward gender and menstruation</td>
<td>62.6</td>
<td>92.3</td>
<td>70.1</td>
<td>51.7*</td>
<td>71.1</td>
</tr>
</tbody>
</table>

*denotes significant difference between I & C

5.2.2.3. Social Support
AGs were asked to list ways in which their mothers, PEs, and FLWs (ASHAs or AWWs) helped them before, during and after menstruation. Responses have been categorised into six broad categories: (a) providing information on MHM; (b) providing support in managing menstrual hygiene; (c) providing support for issues related to chores; (d) providing support for issues related to restrictions; (e) providing support for issues related to nutrition; and (f) no support at all.

Social Support Available to Adolescent Girls for Menstruation
Slightly more than three-quarters of AGs in intervention areas reported that they receive some support from their mothers before, during and after menstruation. About 45 per cent of AGs reported that they received some kind of support from PEs and 40 per cent girls reported that they receive support from FLWs. Interpreting this through a socio-ecological model lens, we see
that girls receive maximum support at the family level, followed by peers and then the community.

In terms of the types of support, the most common support provided to AGs relates to managing menstrual hygiene. It is not surprising that mothers were listed as the most common support providers for chores (24 per cent) and nutrition (15 per cent), both of which take place at home, whereas among non-family members FLWs and PEs primarily provide support for managing menstrual hygiene (31 and 34 per cent, respectively) (Figure 12).

![Figure 12: Support received by adolescent girls for menstruation from different stakeholders- intervention](image)

Tables A.41 and A.42 in Annex 6 reveal that overall a higher proportion of girls in intervention areas reported receiving some kind of support from their mothers and FLWs as compared to comparison areas. Figure 13 shows that 30 per cent of AGs in comparison areas reported not receiving any support from mothers while eight out of ten reported not receiving any support from FLWs.

![Figure 13: Support received by adolescent girls for menstruation from different stakeholders- comparison](image)

In comparison areas as well, it was reported that mothers primarily supported AGs in managing menstrual hygiene (51 per cent) followed by extending support for household chores (25 per cent) and then providing information on MHM (16 per cent).
5.2.2.4. Social Networks

Given that speaking up or talking about menstruation with one another was one of the central aspects of the GARIMA project, it is essential to understand the extent to which adolescent girls in the intervention and comparison areas across the three districts discussed issues related to menstruation with people around them. Social network mapping based on the social ecological model was also conducted as part of FGD activities with adolescent girls to understand the discussion and dialogue that is taking place around the issue of menstruation.

Social Network Map for Menstruation

Social network mapping allows us to understand how individuals are connected and how information flows through social networks. These maps are a way of diagramming who talks to whom and about what. Figure 14 and Figure 15 show the network map for overall findings related to MHM from the 18 intervention and 18 comparison areas across the three districts.

At the family level, (table A.43 in Annex 6) female family members including mother, sister, sister-in-law, aunt and grandmother (maternal and paternal) are the people who girls talk to about menstruation. One paradox that emerges is that while a higher proportion of girls feel comfortable talking to their mothers, some do not share the same feeling (39 per cent in intervention areas) and they mentioned that their mothers rank second among family members they are least comfortable talking to. This indicates that while there might have been improvements in communication among girls and their mothers on menstruation, there still remains some gaps that have not been filled.

At the level of peers (table A.46 in Annex 6), girls in both intervention and comparison areas reported that they talk about menstruation with their school/college friends, neighbourhood friends, AGG friends, PEs, cousins or other relatives who are of the same age, and FFs. 33 per cent of girls reported that they were most comfortable talking to PEs about menstruation. However, the same cannot be said for FFs: 22 per cent reported that they were least comfortable talking with the FF. Additionally, it is interesting to note that PEs were naturally recalled in only 11 per cent of discussions, while only on prompting did the respondents report FFs as individuals with whom they discussed menstruation and aspects related to it (tables A.49 and A.50 in Annex 6).

At the level of community (table A.51 in Annex 6), it emerged that girls mostly talk to AWW, ASHA, teachers, school helpers (dai) and Aanganwadi Sahayika. In 72 per cent of discussions in intervention areas, ASHAs were reported as the community member they were most comfortable talking to about menstruation, followed by AWWs (44 per cent) and teachers (33 per cent). In comparison areas, unlike intervention areas, teachers were reported to be the community member girls were most comfortable discussing menstruation with (72 per cent), followed by ASHAs (56 per cent) and AWWs (39 per cent). It is encouraging to note that ASHAs and AWWs were primarily recalled spontaneously by the girls during the discussions in both intervention and comparison areas, with the proportion of natural recall being slightly higher in comparison areas (tables A.55 and A.56 in Annex 6).

The girls were asked what issues surrounding menstruation were discussed with the above-mentioned people. They revealed that their discussions were primarily about reasons and remedies for pain/discomfort/weakness experienced during menstruation, as well as the use of absorbents - procuring, washing, drying, disposing, storage and the type of absorbent to be used.
Other topics of discussion in intervention areas were around nutrition and WASH, while in comparison areas they were around the nature of menstruation (physiology and process).

With regard to other sources of information for MHM (table A.58 in Annex 6), apart from their social networks, there emerges a similar pattern across both intervention and comparison areas - TV emerged as the top-most source (72 per cent in intervention areas and 100 per cent in comparison areas) followed by radio (56 per cent in intervention areas and 78 per cent in comparison areas). The third most common channel was mobile phones (44 per cent in intervention areas and 61 per cent in comparison areas). Additionally, for intervention areas around 44 per cent of girls also mentioned newspapers and magazines as an important source of MHM information.
End line Evaluation of GARIMA Project in Uttar Pradesh (UP): Evaluation Report

Figure 14: Menstruation: social network mapping (intervention areas)

Figure 15: Menstruation: social network mapping (comparison areas)
Interpersonal Communication

In order to assess the level of comfort in communication, a Likert scale was used and participants were shown the same smile-o-meter used for the attitudinal questions of the structured interview. Participants chose the emoticon that best expressed their level of comfort. During the analysis, 11 topics were categorised into two broad categories namely (a) absorbents - procurement, use, drying and disposal; and (b) other aspects related to menstruation such as household chores, restrictions, nutrition, WASH and education. Table A.69 in Annex 6 tell us that on an average adolescent girl in intervention areas have had discussions on about three out of five topics (mean=2.6) concerning procurement, use, drying and disposal of menstrual absorbents. The corresponding figure for comparison areas is two out of five topics (mean=2) thus indicating slightly wider dialogue in intervention areas. With respect to discussions around other aspects related to menstruation, adolescent girls in intervention areas have had discussions on two out of four topics on average (mean=1.6). The corresponding figure for comparison areas is only one out of four topics on an average (mean=1.2). Overall, girls in intervention areas report being marginally more comfortable discussing these two categories of topics when compared with girls in comparison areas.

5.2.2.5. Social Norms

Drawing a direct linkage between gender norms (defined by gendered roles in communities) and social norms, this evaluation situates adequate MHM within social norms that arise out of gendered expectations of behaviour around MHM in the community. Social restrictions, beliefs and myths that influence MHM affect the daily lives of women and girls. When menstruating, women and girls are subjected to various religious, food-related and domestic prohibitions, resulting in further isolation or stigmatisation.

The GARI MA project sought to influence social norms that are related to adequate MHM. To measure social norms, this evaluation used an innovative technique (2x2 tables) to examine eight MHM behaviours in both structured interview and FGD settings (Table 6).

Two categories of behaviours were examined. One set included norms directly associated with the preparation, use, and disposal of absorbents and the second set included norms around education, nutrition, WASH and gender, which impact menstruation and vice versa. For each behaviour, participants were first asked if they personally approve of the behaviour and if others in their community approve of the behaviour. Then, participants were asked if they (or their daughter, when participants were mothers) practiced the behaviour and if others in their community practiced the behaviour. Responses were mapped onto 2x2 tables in order to assess social norms as a function of injunctive norms (beliefs about others' approval) and descriptive norms (beliefs about the prevalence of the behaviour). Probes to elicit reasons, rewards and punishments for complying or not complying with a behaviour shed further light on whether or not behaviours are governed by normative factors.
Norms on Mensuration-related Behaviours

The specific behaviours included in the end line were:

- Use of sanitary pads.
- Use of menstrual cloth.
- Drying menstrual cloth in the sun after washing with soap.
- Disposing of sanitary napkins by burning or burying them.

Results on approval of all four behaviours indicated that most AGs and mothers approved of and believed others approved of these behaviours. Approval levels from intervention villages were significantly higher among AGs from comparison villages. At the other end of the spectrum, significantly fewer AGs from intervention villages did not personally approve of or think that others approved of these key behaviours. Approval among PEs were as expected higher than those exhibited by AGs.

Overall, across all the behaviours approval levels were higher than reported practices. However, the results on actual practice of these behaviours varied by behaviour. For example, about two-thirds of AGs and mothers reported that they/their daughters and others used sanitary pads with no significant difference between intervention and comparison villages. Other behaviours, including the use of menstrual cloth, drying cloth in the sun after washing with soap and disposing absorbent, while eliciting high levels of approval, showed that practice rates are lower, particularly among participants from comparison villages. AGs in intervention villages were significantly more likely than AGs in comparison villages to report practice of these behaviours. At the other end of the spectrum higher proportions of AGs from comparison villages reported that they did not practice these behaviours and expressed their beliefs that others in their communities also did not practice these behaviours. PEs in intervention villages reported the highest levels of practice of all four menstruation-related behaviours.

Reasons for Approval and Practice of Normative Mensuration-related Behaviours

When assessing norms around menstruation-related behaviours the participants were asked to provide reasons for their answers. Many participants could not provide reasons. More participants who reported that they themselves did not practice a behaviour and in their opinion neither did other girls in their communities did not know or could not cite reasons for their answers, compared to participants who reported that they practiced these menstruation behaviours and believed that other girls in their communities also practiced these behaviours. The most common reasons given by participants who did not practice a given behaviour concerned prohibitive costs, a lack of availability, personal preferences and beliefs of taboo/sin.

<table>
<thead>
<tr>
<th>Self-Approval</th>
<th>Yes</th>
<th>No</th>
<th>(No, No)</th>
<th>(Yes, No)</th>
<th>(No, Yes)</th>
<th>(Yes, Yes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approval</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>No</td>
<td>(No, No)</td>
<td>(Yes, No)</td>
<td>(No, Yes)</td>
<td>(Yes, Yes)</td>
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</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Table 6: Self vs. community approval
In contrast, more participants providing positive responses gave reasons related to ease of use, availability, affordability, cleanliness/hygiene, prevention of infection and litter prevention. Participants in the FGDs also had difficulty articulating reasons for conducting or not conducting a MHM behaviour. In both intervention and comparison villages, participants cited pollution and infection as reasons for their choices.

**Rewards and Punishments Associated with Menstruation-related Behaviours**

Participants were also asked to report on rewards and punishments associated with compliance with the menstruation-related behaviours (Figure 16).

<table>
<thead>
<tr>
<th>REWARDS (intervention)</th>
<th>REWARDS (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Don’t know/ can’t say</td>
<td>- Don’t know/ can’t say</td>
</tr>
<tr>
<td>- Ease of use/ comfort</td>
<td>- Ease of use/ comfort</td>
</tr>
<tr>
<td>- Saves money</td>
<td>- No rewards</td>
</tr>
<tr>
<td>- Good hygiene/ prevents infection</td>
<td>- Saves money</td>
</tr>
<tr>
<td>- Reduces litter/ cleaner environment</td>
<td>- Reduces litter/ cleaner environment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PUNISHMENTS (intervention)</th>
<th>PUNISHMENTS (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Don’t know/ can’t say</td>
<td>- No punishments</td>
</tr>
<tr>
<td>- No punishments</td>
<td>- Don’t know/can’t say</td>
</tr>
<tr>
<td>- Costs time and money</td>
<td>- Costs time and money</td>
</tr>
<tr>
<td>- Causes pain or infertility/ stops menstruation/ harms husband</td>
<td>- Litter &amp; community disapproval</td>
</tr>
<tr>
<td>- Causes infection</td>
<td>- Causes pain or infertility/ stops menstruation/ harms husband</td>
</tr>
</tbody>
</table>

*Figure 16: Rewards and punishments for norms around menstruation-related behaviours*

In both the intervention and comparison groups most participants did not know or could not cite any rewards or punishments associated with these normative behaviours. Of the rewards listed, ease of use/comfort, saving money and reducing litter to maintain a clean environment were the most cited in the intervention and comparison groups. Many participants in the intervention group also mentioned good hygiene and prevention of infection as a reward, whereas the control group mentioned avoiding other people knowing about menstruation in order to avoid restrictions. Of those who did mention punishments, costs of time and money, and the beliefs that burning and burying will cause infertility, stop menstruation, and can harm their husband were common in both the intervention and comparison groups. Many participants in the intervention group mentioned infection as a punishment, while the comparison group named litter and community disapproval as a punishment. These findings were supported by responses in the FGDs where hygiene and reducing litter were seen as rewards for proper drying of menstrual cloth or disposal of menstrual absorbents in both intervention and control villages. However, the focus group responses did place a greater emphasis on the perception of others, with the top punishment in both groups being that others will not like the behaviour or the girl will be scolded.

**Norms Around Issues That Impact Menstruation-related Behaviours**

Information on issues that are impacted by and in turn impact menstruation-related behaviours includes:

- Attending school during menstruation.
- Demanding iron-rich foods during menstruation.
- Demanding a toilet or a private place to bathe and change during menstruation.
Interacting with boys after menarche.

Overall, project stakeholders approved of and thought others in their community approved of AGs attending school during menstruation with a statistically significant difference emerging between intervention (83.9 per cent) and comparison groups (73.7 per cent). At the same time, about one out of ten intervention stakeholders (11.6 per cent) did not approve or think others approved of AGs attending school during menstruation. In terms of demanding iron-rich foods during menstruation, levels of approval were consistently high across intervention and comparison stakeholders, with significantly more AGs from intervention villages (90.3 per cent) approving of and thinking others approved of this behaviour as compared to AGs from comparison villages (84.7 per cent). Similar patterns emerged when considering demanding for a private place to bathe or change during menstruation: while approval levels were high for both intervention and comparison groups, significantly more AGs from intervention villages (96.4 per cent) reported self and other approval for this behaviour as compared to those from comparison villages (93.7 per cent).

Among all behaviours assessed, interacting with boys after menarche was the most divided. Overall, significantly more intervention stakeholders (53.9 per cent) approved of and thought others approved of AGs interacting with boys after menarche (comparison 45.2 per cent). Significantly more comparison stakeholders (51.4 per cent) disapproved of and thought others disapproved of this behaviour as compared to intervention stakeholders (40.5 per cent). The same trends emerge when looking at the data for AGs and mothers individually. PEs displayed the highest level of self-approval and other approval.

As we have seen with the other behaviours, levels of practice of menstruation-related behaviours such as attending school, demanding iron-rich foods and negotiating a private place to bathe and change during menstruation are lower than levels of approval. This same pattern holds true for mothers and stakeholders at the overall level. Overall, there were significantly more AGs in intervention villages who personally practiced and believed others in their communities also practiced these key menstruation-related behaviours when compared to comparison AGs. On the other hand, more comparison group AGs reported that they themselves did not practice these behaviours and that they did not think other AGs in their communities practised these behaviours.

Levels of practice for the fourth behaviour - “interacting with boys after menarche” - was, as with other behaviours, lower than levels of approval. Significantly more AGs from comparison villages (49.3 per cent) do not interact and do not think others interact with boys after menstruation as compared to AGs from intervention villages (44.5 per cent). However, even among PEs, only three-quarters (75.5 per cent) interact with and think others interact with boys after menstruation.

**Reasons for Approval and Practice of Normative Issues that Impact Menstruation-related Behaviours**

When asked about the reasons for following common restrictions during menstruation, most participants did not know or could not cite reasons for their answers. Of those participants in both the intervention and comparison groups who did provide reasons, pain, menstrual symptoms, and a fear of staining were common reasons for not attending school during menstruation. In contrast, participants who approved of attending and did attend school during menstruation reported getting behind in their studies and not having problematic symptoms as
reasons for their responses. Cost and availability were reasons for not demanding iron-rich foods or negotiating a private place to bathe and change during menstruation. Lastly, getting in trouble, earning a bad reputation and the belief that it is taboo were provided by many participants in the intervention and comparison groups as reasons for not interacting with boys after menarche. In the FGDs participants showed great concern that they would be scolded by elders or have the community think of them as “shameless” if they didn't comply with a restriction. This was true both in intervention and comparison villages.

**Rewards and Punishments Associated with Issues that Impact Menstruation-related Behaviours**

Participants were asked to relate the punishments and rewards for restrictions as a whole and, as noted in other examples, they struggled with these questions, with most saying they didn't know, couldn't say or that there weren't any (Figure 17).

![Figure 17: Rewards and punishments](image)

### 5.2.2.6. Restrictions

Specific questions inquiring about social restrictions related to clothes, food, mobility and activities were asked to AGs and PEs in the structured interview setting. In the FGD, only AGs were asked these questions. The most prevalent restrictions overall were going to the temple, puja or namaz, wearing white or light clothes, eating sour foods and eating pickle. When compared with AGs, PEs reported facing fewer social restrictions.

The most prevalent social restrictions among AGs in intervention villages were going to the kitchen (63.1 per cent), eating non-vegetarian food (57.1 per cent) and attending religious discourse (55.0 per cent). In comparison villages, the most prevalent social restrictions among AGs were going to the river (81.8 per cent), attending religious discourse (61.5 per cent) and going to the kitchen (59.7 per cent).

When comparing differences in social restrictions among AGs, comparison villages reported significantly fewer social restrictions. At the same time, there were two restrictions where AGs in intervention villages had a significantly higher proportion of "do it anyway" versus comparison villages: wearing puja clothes (8.1 vs. 0 per cent) and doing puja/namaz (3.6 vs. 0.8 per cent).

In the evaluation, the FGDs also explored with the AGs a variety of restrictions associated with menstruation. After having participants provide a list of potential restrictions, they were
questioned on how to classify the restrictions as things they could not do (structural constraints), will not do (self-imposed restrictions) or should not do (social restrictions). The results from the FGDs are comparable with the findings of the structured interviews, with the top three overall restrictions including touching pickles, eating sour foods and doing worship/puja.

The most common reasons for restrictions in intervention and comparison villages was excessive bleeding (38.9 per cent), food getting spoiled (25 per cent), and menstrual blood being considered impure (19.4 per cent). Actions for overcoming restrictions in intervention villages were: doing nothing (55.6 per cent); trying to make mother/family/others understand (27.8 per cent); and speaking to ANM/AWW/ASHA or asking mother to make people understand (11.1 per cent). In comparison villages, actions included doing nothing (77.8 per cent) and trying to make family and others understand (22.2 per cent).
The intervention has been successful in addressing restrictions by coordinated and grassroots-based efforts, as illustrated in the example below:

**Not dirty but natural: Fighting menstrual taboos**

An AGs belonging to an ST community in Mahalpura village, Sonbhadra, was forced to sleep on the floor during menstruation. This is a common custom among this community. She found it to be very uncomfortable and raised this problem in one of the AGG meetings. AGs group members and the FF went to the AGs mother to convince her that menstruation is a completely natural process and not dirty or unholy, and therefore the AGs should not be forced to sleep on the floor. They had to visit the mother regularly every month for the next 4-5 months. They were finally able to convince the mother and the AGs was allowed to carry on with her normal routine during menstruation.

Based on the data, we can see that comparison villages reported significantly lower proportions of social restrictions. These findings outline that social restrictions, in particular clothes, foods and religious restrictions, are prevalent in both intervention and comparison villages and that more targeted interventions involving families and communities are required in order to address them.

5.2.3. Effect of the GARIMA Project on Other Cross-Cutting Issues

5.2.3.1. Nutrition

The onset of menarche marks the entry of underprivileged girls to anaemia. As the need for healthy food increases due to changes in the body during adolescence, insufficient nutrition and poor food quality results in an undeveloped body structure. Women and girls are typically the last to eat in a family. Therefore, if there is not enough food available they are the ones who suffer most.

In the context of menstruation, this section explores the current situation with respect to nutritional intake for adolescent girls on both a routine basis and during menstruation. The section also explores who the key decision makers are in the household with respect to quantity and variety of food intake for adolescent girls.

The table below showcases the percentage of AGs in intervention as well as comparison areas who reported consuming different food groups on a routine basis and during menstruation.

<table>
<thead>
<tr>
<th>Resp. Category</th>
<th>AGs</th>
<th>Intake on a daily basis</th>
<th>Intervention</th>
<th>Comparison</th>
<th>During Menstrual Cycle</th>
<th>Intervention</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td></td>
<td></td>
<td>1248</td>
<td>1192</td>
<td>1248</td>
<td>78.0</td>
<td>74.9</td>
</tr>
<tr>
<td>Pulses &amp; Grams</td>
<td></td>
<td></td>
<td>96.7</td>
<td>97.5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

32 Kashyap & Gopaldas, 1988
33 Horowitz & Kishwar, 1985
34 Multiple food items were later on recoded into four broad categories – Pulses & Grams, Dairy Products, Green leafy vegetables & Jaggary, and Non-vegetarian food.
Individual food items were categorised into four groups. The results indicate there are significant differences between intervention and comparison girls vis-a-vis specific foods. Intervention girls report significantly higher levels of green leafy vegetables both routinely and during menstruation. Comparison girls on the other hand reported higher levels of consumption of dairy and meat products at both times. There are few changes in routine food consumption and foods consumed during menstruation. The only discrepancy is in the extremely high intake of pulses & grams on a routine basis, which reduces by almost a quarter during menstruation. The drastic reduction in consumption of pulses & grams during menstruation seems uncharacteristic. It is possible that since the question regarding 'intake during menstrual cycle' was asked after 'intake on a daily basis', adolescents chose to name those foods that are consumed specifically during menstruation.

Food intake, apart from being a function of supply, knowledge and beliefs, also depends heavily upon the economic status of the concerned households. A comparison of demographic indicators across households of sampled participants indicated significantly higher proportions of Kuccha houses in the intervention sample. It may be pertinent to control for social and economic variables while interpreting these results.

**Key Decision Makers with Respect to Nutritional Intake of Adolescent Girls**

In addition to actual behaviour, it is important to understand the power dynamics around nutritional intake at household level. It is known that women in general are relatively disadvantaged in terms of division of food. Within the context of menstruation and adolescent girls it is important to identify family members who play a critical role in deciding ‘what’ and ‘how much’ an adolescent girl eats.

<table>
<thead>
<tr>
<th>Resp. Category</th>
<th>AGs</th>
<th>Who decides what to eat</th>
<th>Who decides how much to eat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>Comparison</td>
</tr>
<tr>
<td>N</td>
<td>1248</td>
<td>1192</td>
<td>1248</td>
</tr>
<tr>
<td>Self (AGs)</td>
<td>73.0</td>
<td>75.3</td>
<td>89.8</td>
</tr>
<tr>
<td>Mother</td>
<td>44.1</td>
<td>42.7</td>
<td>20.2*</td>
</tr>
<tr>
<td>Father</td>
<td>12.6</td>
<td>9.2</td>
<td>5.8*</td>
</tr>
</tbody>
</table>

* Significant difference at 95% confidence interval
The data, as reported by adolescent girls, shows that in most of the cases they themselves take decisions pertaining to ‘what and how much they eat’. Given this high proportion of self-report, it is not surprising that there is no significant difference between intervention and comparison sites. Interestingly, while mothers tend to decide the food variety (what to eat), they do not play much of a role in how much food an adolescent girl consumes.

5.2.3.2. Water Sanitation and Hygiene (WASH)

The open defecation rate has been exceptionally high in India, despite rapid economic growth, rising literacy levels and improved water sources.\(^{35}\) Poor sanitation has been widely seen as a major cause of poor health, especially in places with high population density. Toilet facilities, as well as ensuring privacy, provide a safe and easy option for menstruating girls and women to change their menstrual absorbents and clean their body.

Despite tremendous progress made under Swachh Bharat Mission, when it comes to individual households containing toilet facilities, Uttar Pradesh (58.3 per cent) continues to be among the bottom five states.\(^{36}\) This section explores the current situation with respect to the presence of WASH facilities at home and school, especially during menstruation. In order to assess the presence or absence of toilet facilities, the participants were shown a picture of a basic toilet structure, with some common components (such as pot, bucket, mug, soap, door, roof and dustbin) clearly visible for reference. The participants who reported possessing their own toilet structure were asked if their respective structures lacked any of the visible components. Similarly, participants were also asked if their individual toilet structures consisted of any additional components not depicted in the picture.

**Presence of Toilet Facility at Household Level**

This sub-section discusses the extent to which participants possess WASH facilities at home and the major components present or absent from these facilities.

*Table 9: Percentage of participants reported having own toilet structure at home*

<table>
<thead>
<tr>
<th>Resp. Cat</th>
<th>AGs</th>
<th>Mothers</th>
<th>Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention</td>
<td>Comparison</td>
<td>Intervention</td>
</tr>
<tr>
<td>N</td>
<td>1248</td>
<td>1192</td>
<td>564</td>
</tr>
<tr>
<td>HHs with toilet</td>
<td>41.2</td>
<td>41.9</td>
<td>37.9</td>
</tr>
<tr>
<td>HHs without toilet</td>
<td>58.8</td>
<td>58.1</td>
<td>62.1</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

At an overall level, around four out of ten (40 per cent) reported having a toilet structure at home. The figure is largely similar across intervention and comparison areas and respondent types. The figure for the indicator is significantly higher among PEs (53 per cent).

---

\(^{35}\) cofley-et-al-2016-understanding-OD-rural-India  
\(^{36}\) http://sbm.gov.in/sbmdashboard/Default.aspx
Presence of Toilet Facility in Schools

According to the literature, one of the major reasons for absenteeism from school during menstrual cycles among adolescent girls is the absence of a toilet facility or a space where girls can change their menstrual absorbents (Birdthistle, Dickson, Freeman, & Javidi, 2011). Adolescent girls and school teachers were therefore asked about the presence of toilet facility in schools.

Table 10: Percentage of AGs reported having toilet structures in school

<table>
<thead>
<tr>
<th>Resp. Category</th>
<th>AGs</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention</td>
<td>Comparison</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>869</td>
<td>784</td>
<td></td>
</tr>
<tr>
<td>Presence of toilet</td>
<td>92.9</td>
<td>95.5*</td>
<td></td>
</tr>
<tr>
<td>Absence of toilet</td>
<td>7.1</td>
<td>4.5</td>
<td></td>
</tr>
</tbody>
</table>

The * Significant difference at 95% confidence interval

Table 10 shows that more than nine out of ten girls across both intervention and comparison areas reported the presence of toilets at school. It may be noted that despite the percentages for the indicator being so high, comparison sites reported significantly higher proportions of school-based toilets than intervention AGs.

5.2.3.3. Gender

Evaluating the effect of the project on critical gender outcomes involved assessing understanding and actions around issues pertaining to sexual harassment, child marriage and education for the adolescent girls and the PEs. This was done in order to gauge the effect of the project on the AGs in augmenting their self-efficacy in being able to articulate their needs and to negotiate with their external environment in order to gain recognition of those needs.

The following schematic presents the process of learning around the issue of sexual harassment and subsequent actions taken by the AGs and the PEs in addressing such harassment in their respective communities.

In the case of sexual harassment, calling a helpline line number was the top response reported by the adolescent girls and PEs. When compared to the PEs, about 50 per cent of adolescent girls reported having taken no action at all in the case of any instances of sexual harassment. Telling family members about the incident was reported as the most common action taken by both the AGs and the PEs; with the former reporting this action to a lesser extent than the latter.

Similarly, with regard to understanding and actions taken around child marriage, understanding the illegality of marrying a girl before having attained 18 years of age emerged as the topmost response for both the adolescent girls and the PEs. Telling family members about the ill effects of early marriage was cited as the main action taken. This action was reported by a higher proportion of PEs, by virtue of their being one of the project implementers. Figure 20 summarises key learning and actions taken around the issue of child marriage.

A high proportion of adolescent girls and PEs, ranging between 70 to 75 per cent, reported as their most critical understanding the importance of taking actions in the case of school dropouts. Following the trend observed with regard to actions taken in the cases of sexual harassment and child marriage, a greater proportion of PEs reported telling the girls and family members about the importance of education as their most commonly taken action.
Even when almost 50 per cent of adolescent girls reported having taken no action at all when it came to addressing sexual harassment, child marriage and school drop outs, there have been occasional incidents or cases (Annex 7) where they have successfully intervened to prevent such incidents, something which highlights their potential to confront such issues when the needs arises.

5.2.4. Putting it All Together

5.2.4.1. Relation between Exposure and MHM Behaviour among Post-Menarche AGs (Bivariate)

This section of the report summarises the key findings noted earlier. Only post-menarche AGs are included in this analysis because these were the key audiences who answered all the core questions on exposure and behaviour. The intervention and comparison samples contained very similar socio-demographic and socio-economic characteristics with some differences by caste, education and type of house. There was an equal distribution of the participants across districts (36.7 per cent in Jaunpur, 29.8 per cent Sonbhadra and 33.5 per cent in Mirzapur). 97.1 per cent of the population was Hindu, and 90.6 per cent were scheduled caste/scheduled tribe or other backward caste. The average age of the AGs was 16.2 years. In terms of education, on average AGs in intervention villages were in 9th grade, whereas AGs in comparison villages were in 8th grade (p<0.01). For housing, more than half the AGs in intervention villages lived in temporary housing versus 42.9 per cent in comparison villages (p<0.01). Lastly, about 99 per cent of the AGs were unmarried in both intervention and comparison villages.

![Figure 22: Encoded exposure to GARIMA project](image)

The independent variable used for the analysis was labelled “encoded exposure”, as it was a combination of 10 questions measuring dimensions of exposure, dose and recall. The additive index of these 10 questions ranged from 0 to 47. Given the number and complexity of questions, the desire to create a robust measure of exposure and the fact that the intervention had been completed a year prior to the end of the intervention, the actual scores encoded ranged from 0 to 77. These were collapsed into an ordinal variable. AGs in comparison villages who had not heard of the GARIMA project were included in the measure (n=1074) as the ‘no exposure’ group. In the intervention village (n=1132), based on the distribution of the data, 16.0 per cent, 21.6 per cent and 13.7 per cent of the AGs were classified as having low (1 – 18), medium (19 - 24) and high exposure (25 and above) respectively.
The key dependent variable was adequate MHM behaviours. An additive index was created for MHM behaviours by combining six components of MHM including adequate preparation, adequate storage, adequate frequency of changing, adequate disposal, adequate privacy to change absorbent and adequate personal hygiene. This yielded a scale ranging from 0 to 12. The maximum score assigned for adequate behaviour was 12 after which three categories were created based on total scores for key behaviours (0-4 for inadequate behaviour, 5-8 for somewhat adequate behaviour and 9-12 for adequate behaviour). The distribution of the MHM behaviours was not normal, therefore, based on the distribution, the variable was collapsed into three categories corresponding to inadequate, somewhat adequate and adequate MHM with low, medium and high exposure. Figure 23 demonstrates that intervention villages had a significantly higher proportion of AGs (40.3 per cent) reporting adequate MHM behaviours versus comparison AGs (14.3 per cent). Overall, a quarter of the AGs fell into the inadequate group (24.5) and just a slightly higher number (27.6 per cent) were practicing adequate MHM. Almost half of the AGs were categorised as practicing somewhat adequate MHM behaviours (48 per cent).

**Mediator Operationalisation**

Key mediators including knowledge, attitudes, interpersonal communication, social norms and restrictions were operationalised after creating composite measures. The mediators were all made into categories since the distribution of the data was not normal.

The results on the key mediators indicate that intervention AGs scored better than comparison AGs across all mediators. Knowledge about puberty, reproductive parts and absorbent use was significantly higher in intervention sites versus comparison sites. Overall, levels of knowledge on
the four sub-scales was low with less than 10 per cent of AGs scoring high on any of the individual knowledge sub-scales.

In terms of attitudes, AGs in intervention villages had significantly higher proportions of positive attitudes towards menstruation, absorbent use, restrictions and gender versus AGs in comparison villages; overall, 34.9 per cent, 29.3 per cent, 33.2 per cent and 30.7 per cent respectively of the AGs had positive attitudes towards these issues.

Interpersonal communication results demonstrated that most AGs (64.4 per cent) had some discussion or dialogue about menstruation, absorbent use, restrictions and gender. However, AGs in comparison villages were significantly more likely to report no discussion when compared with AGs from intervention villages.

In terms of social norms, 34.8 per cent of the AGs had positive social norms around menstruation and 31.6 per cent of the AGs had positive norms around issues related to menstruation. Positive in this case indicating these participants approved and practiced desired behaviours i.e. using sanitary pads, using cloth, using dry cloth after washing with soap, disposing by burning or burying, going to school during menstruation, demanding iron-rich foods during menstruation, demanding a private place to bathe/change during menstruation and interacting with boys after menarche. The proportion of AGs who had more progressive social norms around menstruation was significantly higher in intervention versus comparison villages (45.1 per cent vs. 23.9 per cent). The trends vis-a-vis norms around issues related to menstruation were similar, with 34.7 per cent of intervention AGs compared with 28.3 per cent of comparison AGs displaying progressive social norms around the issues related to menstruation.

At the overall level, personal, social and structural restrictions were stated by 80 per cent, 48 per cent and 6 per cent of the AGs. Personal restrictions were significantly higher among AGs in comparison villages versus AGs in intervention villages (83.1 per cent vs 77.6 per cent). AGs in intervention villages were significantly more likely to report social restrictions in comparison to AGs in comparison villages (54.7 per cent vs. 40.8 per cent).

<table>
<thead>
<tr>
<th>Mediators</th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/χ²-test value (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge about puberty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>57.7</td>
<td>40.9</td>
<td>75.3</td>
<td>&lt;0.001***</td>
</tr>
<tr>
<td>Medium</td>
<td>34.3</td>
<td>45.9</td>
<td>22.2</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>8.0</td>
<td>13.3</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>Knowledge about reproductive parts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>45.0</td>
<td>27.0</td>
<td>63.8</td>
<td>&lt;0.001***</td>
</tr>
<tr>
<td>Medium</td>
<td>43.6</td>
<td>55.5</td>
<td>31.0</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>11.5</td>
<td>17.5</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>Knowledge about absorbent use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>17.7</td>
<td>11.4</td>
<td>24.4</td>
<td>&lt;0.001***</td>
</tr>
</tbody>
</table>
## Mediators

<table>
<thead>
<tr>
<th>Mediators</th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/t-test (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medium</strong></td>
<td>65.2</td>
<td>61.0</td>
<td>69.6</td>
<td></td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>17.1</td>
<td>27.7</td>
<td>6.0</td>
<td></td>
</tr>
</tbody>
</table>

### Attitudes towards menstruation

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/t-test (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative</strong></td>
<td>34.1</td>
<td>27.2</td>
<td>41.4</td>
<td>&lt;0.001***</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>31.0</td>
<td>27.1</td>
<td>35.0</td>
<td></td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>34.9</td>
<td>45.7</td>
<td>23.6</td>
<td></td>
</tr>
</tbody>
</table>

### Attitudes towards absorbent use

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/t-test (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative</strong></td>
<td>32.4</td>
<td>28.9</td>
<td>36.1</td>
<td>&lt;0.001***</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>38.3</td>
<td>35.5</td>
<td>41.2</td>
<td></td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>29.3</td>
<td>35.6</td>
<td>22.7</td>
<td></td>
</tr>
</tbody>
</table>

### Attitudes towards restrictions

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/t-test (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative</strong></td>
<td>33.2</td>
<td>27.5</td>
<td>39.3</td>
<td>&lt;0.001***</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>33.6</td>
<td>31.7</td>
<td>35.6</td>
<td></td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>33.2</td>
<td>40.8</td>
<td>25.2</td>
<td></td>
</tr>
</tbody>
</table>

### Attitudes towards gender

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/t-test (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative</strong></td>
<td>32.1</td>
<td>28.8</td>
<td>35.6</td>
<td>&lt;0.01**</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>37.2</td>
<td>40.4</td>
<td>33.8</td>
<td></td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>30.7</td>
<td>30.8</td>
<td>30.7</td>
<td></td>
</tr>
</tbody>
</table>

### Interpersonal communication

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/t-test (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No discussion</strong></td>
<td>26.5</td>
<td>20.9</td>
<td>32.4</td>
<td>&lt;0.001***</td>
</tr>
<tr>
<td><strong>Some discussion and dialogue</strong></td>
<td>64.4</td>
<td>69.7</td>
<td>58.9</td>
<td></td>
</tr>
<tr>
<td><strong>All dialogue</strong></td>
<td>9.0</td>
<td>9.4</td>
<td>8.7</td>
<td></td>
</tr>
</tbody>
</table>

### Social norms around menstruation

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/t-test (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative</strong></td>
<td>44.4</td>
<td>28.6</td>
<td>60.8</td>
<td>&lt;0.001***</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>20.9</td>
<td>26.2</td>
<td>15.3</td>
<td></td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>34.8</td>
<td>45.1</td>
<td>23.9</td>
<td></td>
</tr>
</tbody>
</table>

### Social norms around other issues during menstruation

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=2212)</th>
<th>Intervention village (n=1132)</th>
<th>Comparison village (n=1080)</th>
<th>X²/t-test (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative</strong></td>
<td>32.8</td>
<td>27.5</td>
<td>38.4</td>
<td>&lt;0.001***</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>35.6</td>
<td>37.8</td>
<td>33.2</td>
<td></td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>31.6</td>
<td>34.7</td>
<td>28.3</td>
<td></td>
</tr>
</tbody>
</table>

### Restrictions
were norms. reproductive adequate knowledge high The in other puberty, In in MHM solid/concrete MHM measuring With high demographic among exposure, Table AG Multivariat ***: **: *: Significant difference between independent variable and intervention and comparison villages at p≤0.05 level. Significant difference between independent variable and intervention and comparison villages at p≤0.01 level. Significant difference between independent variable and intervention and comparison villages at p≤0.001 level.

Multivariate Analysis of the Relationship between Exposure and MHM Behaviour Among AGs

Table 12 is the multi-level multivariate model looking at the relationship between encoded exposure, mediators and MHM behaviour among 2,167 post-menarche AGs. Education was among the most significant predictors of high encoded exposure. After controlling for the socio-demographic variables, the results show that being in the intervention sites directly predicted high MHM behaviours (AOR: 3.1 (95 per cent CI: 2.2 – 4.3) (not shown in table).

With regard to socio-demographics, education and type of house were significant factors when measuring adequate MHM. A unit increase in education increased the probability of adequate MHM behaviour by 10 per cent (95 per cent CI: 6 per cent - 15 per cent). AGs living in a solid/concrete house had 2.3 (95 per cent CI: 1.8 – 2.9) times greater odds of being in the high MHM group in comparison to AGs who lived in a raw/temporary house. Interestingly, more girls in the comparison (i.e. no exposure) sites lived in pucca houses.

In the indirect effects model, high encoded exposure was associated with knowledge about puberty, knowledge about reproductive parts and interpersonal communication. When looking at the relationship between the encoded exposure and MHM behaviour, after controlling for all other predictors, AGs in the low, medium and high exposure groups had 3.1 (95 per cent CI: 2.1 – 4.5), 3.6 (95 per cent CI: 2.5 – 5.2) and 2.5 (95 per cent CI: 1.7 – 3.7) times greater odds of being in the high MHM behaviour group in comparison to the AGs with no exposure.

The relationship between the encoded exposure and mediators was also examined. AGs in the high encoded exposure group had greater odds of having higher knowledge about puberty, higher knowledge about reproductive parts and some discussion and dialogue. An examination of the relationship between mediators and adequate MHM showed that the mediators which were significantly different between those practicing adequate MHM and those in the somewhat adequate and inadequate groups included knowledge about puberty, knowledge about reproductive parts, and knowledge about absorbent use, interpersonal communication and social norms. Village level variance was significant for MHM behaviour and, therefore, these results were applicable to each village.
### Table 12: Multivariate analysis of exposure and MHM behaviour among AGs

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Adjusted Odds Ratio for High Exposed Exposure (95% Confidence Interval) (n=2167)</th>
<th>Adjusted Odds Ratio for High MHM behaviour (95% Confidence Interval) (n=2167)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Encoded Exposure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>3.1 (2.1 – 4.5)**</td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>3.6 (2.5 – 5.2)**</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>2.5 (1.7 – 3.7)**</td>
<td></td>
</tr>
<tr>
<td><strong>Caste</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Caste</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Scheduled Caste/Tribe</td>
<td>1.0 (0.6 – 1.5)</td>
<td>0.8 (0.6 – 1.1)</td>
</tr>
<tr>
<td>Other Backward Caste</td>
<td>1.0 (0.6 – 1.6)</td>
<td>0.7 (0.5 – 1.0)</td>
</tr>
<tr>
<td>Age (years (SD))</td>
<td>1.0 (0.9 – 1.1)</td>
<td>1.0 (0.9 – 1.0)</td>
</tr>
<tr>
<td><strong>Education (grade (SD))</strong></td>
<td>0.9 (0.9 – 0.99)*</td>
<td>1.1 (1.06 – 1.1)**</td>
</tr>
<tr>
<td><strong>Type of House</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kutcha (temporary)</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Semi-Pucca (frame is concrete, but walls are raw/temporary)</td>
<td>1.2 (0.9 – 1.7)</td>
<td>1.2 (0.9 – 1.5)</td>
</tr>
<tr>
<td>Pucca (solid/concrete)</td>
<td>0.9 (0.7 – 1.3)</td>
<td>2.3 (1.8 -2.9)**</td>
</tr>
<tr>
<td><strong>Duration since menarche</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Menarche (&lt; 1 year)</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Late Menarche (≥ 1 year)</td>
<td>0.9 (0.6 – 1.3)</td>
<td>1.0 (0.8 – 1.4)</td>
</tr>
<tr>
<td><strong>Knowledge about puberty</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Medium</td>
<td>1.5 (1.1 – 2.0)**</td>
<td>1.0 (0.8 – 1.3)</td>
</tr>
<tr>
<td>High</td>
<td>3.0 (1.9 – 4.7)**</td>
<td>1.6 (1.1 – 2.3)*</td>
</tr>
<tr>
<td><strong>Knowledge about reproductive parts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Medium</td>
<td>1.9 (1.3 – 2.5)**</td>
<td>1.2 (0.9 – 1.5)</td>
</tr>
<tr>
<td>High</td>
<td>1.9 (1.2 – 3.0)**</td>
<td>1.7 (1.2 – 2.4)**</td>
</tr>
<tr>
<td><strong>Knowledge about absorbent use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Medium</td>
<td>1.2 (0.8 – 1.8)</td>
<td>1.6 (1.2 – 2.0)**</td>
</tr>
<tr>
<td>Characteristics</td>
<td>Adjusted Odds Ratio for Encoded Exposure (95% Confidence Interval) (n=2167)</td>
<td>Adjusted Odds Ratio for High MHM behaviour (95% Confidence Interval) (n=2167)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>1.3 (0.8 – 2.1)</td>
<td>2.8 (1.9 – 3.9)***</td>
</tr>
<tr>
<td>Attitudes towards menstruation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>1.0 (0.8 – 1.5)</td>
<td>1.0 (0.8 – 1.2)</td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>1.2 (0.9 – 1.7)</td>
<td>0.8 (0.6 – 1.0)</td>
</tr>
<tr>
<td>Attitudes towards absorbent use</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>1.1 (0.8 – 1.5)</td>
<td>1.2 (0.9 – 1.5)</td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>1.2 (0.8 – 1.7)</td>
<td>1.3 (1.0 – 1.6)</td>
</tr>
<tr>
<td>Attitudes towards restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>1.1 (0.8 – 1.5)</td>
<td>1.0 (0.8 – 1.2)</td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>1.0 (0.7 – 1.5)</td>
<td>0.9 (0.7 – 1.2)</td>
</tr>
<tr>
<td>Attitudes towards gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>1.1 (0.7 – 1.5)</td>
<td>1.0 (0.8 – 1.3)</td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>1.4 (1.0 – 2.1)</td>
<td>1.2 (0.9 – 1.6)</td>
</tr>
<tr>
<td>Interpersonal communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No discussion</strong></td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Some discussion and dialogue</strong></td>
<td>1.4 (1.03 – 1.9)*</td>
<td>1.5 (1.2 – 1.8)***</td>
</tr>
<tr>
<td><strong>All dialogue</strong></td>
<td>0.9 (0.5 – 1.5)</td>
<td>1.5 (1.03 – 2.2)*</td>
</tr>
<tr>
<td>Social norms around menstruation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>1.0 (0.7 – 1.3)</td>
<td>1.0 (0.8 – 1.3)</td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>1.2 (0.9 – 1.6)</td>
<td>1.3 (1.02 – 1.6)*</td>
</tr>
<tr>
<td>Social norms around other issues during menstruation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>1.0 (0.8 – 1.4)</td>
<td>1.2 (1.0 – 1.5)</td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>1.2 (0.8 – 1.7)</td>
<td>1.2 (1.0 – 1.6)</td>
</tr>
<tr>
<td>Personal restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>
End line Evaluation of GARIMA Project in Uttar Pradesh (UP): Evaluation Report

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Adjusted Odds Ratio for High Encoded Exposure (95% Confidence Interval) (n=2167)</th>
<th>Adjusted Odds Ratio for High MHM behaviour (95% Confidence Interval) (n=2167)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>0.9 (0.6 – 1.2)</td>
<td>1.1 (0.9 – 1.4)</td>
</tr>
<tr>
<td>Social restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>No</td>
<td>0.9 (0.7 – 1.2)</td>
<td>0.9 (0.8 – 1.1)</td>
</tr>
<tr>
<td>Structural restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>No</td>
<td>1.0 (0.6 – 1.8)</td>
<td>1.2 (0.8 – 1.7)</td>
</tr>
<tr>
<td>Random effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District&gt;Block&gt;Village variance</td>
<td>0.9 (0.5 – 1.4)</td>
<td>0.3 (0.2 – 0.5)*</td>
</tr>
</tbody>
</table>

*: Significant difference between independent variable and MHM behaviour at p≤0.05 level.
**: Significant difference between independent variable and MHM behaviour at p≤0.01 level.
***: Significant difference between independent variable and MHM behaviour at p≤0.001 level.

The GARIMA project was primarily an interpersonal communication intervention which involved girl groups watching films, reading a storybook, getting a personal diary, and seeing a poster and apron. The results demonstrate that girls with high encoded exposure were significantly more likely to practice adequate MHM behaviours. High exposure and adequate MHM behaviour was also related to better knowledge about puberty and reproductive parts, increased interpersonal communication about menstruation and positive social norms around menstruation. Based on these results we can conclude that after controlling for key demographics and economic variables, the GARIMA project was successful in achieving a majority of its objectives.

These results also demonstrate that SBCC interventions can and do have both direct and indirect effects. On the one hand SBCC interventions such as GARIMA change desired behaviours directly. On the other hand, new thinking/behaviour diffuses into homogeneous communities and increase the probability of accepting new behaviours based on knowledge, interpersonal communication and positive social norms. Our results suggest that the GARIMA project was effective in changing behaviours and also specific key mediators of behaviour change. As such these results lend validity to the conceptual model that guided the project’s evaluation.
5.3. Assessing Impact of GARIMA Project

This section of the report provides information on the potential impact of the GARIMA intervention by specifically focusing on the following questions:

a) What are the positive or negative, intended or unintended consequences of the project?
b) How many people have been affected?
c) What was the impact of the intervention on education, WASH, nutrition and gender?

Impact assessment of GARIMA includes information on the changes in knowledge, attitudes and beliefs between baseline and midline as well as a comparison of differences between intervention and control sites. Additionally, this section examines the impact of menstruation on education and restrictions among adolescent girls, and the generation of social capital. The section does not include the impact on nutrition, gender and WASH; these have been covered in the section on effectiveness. The data points pertaining to each of the three topics mentioned above indicated immediate and intermediate results and hence were not powerful enough to be labelled as impact.

An impact evaluation provides information about the "positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended." 38 Based on this definition of impact, it is valid to claim that the effectiveness section of this report shows some trends that, if interpreted with caution, could indicate potential impact. Causal attribution — ascription of a causal link between observed changes and a specific intervention — is critical to establish when measuring impact. There are three broad strategies for causal attribution in impact evaluations: 1) estimating the counterfactual; 2) identifying alternative explanations for the achievement of impacts; and 3) checking the consistency of evidence for the causal relationships. While the nature and duration of the GARIMA initiative makes it difficult to make a strong case for causal attribution, this study incorporated key elements from within each of these three strategies (Annex 8) to arrive at findings pertaining to the impact of the GARIMA project. These are summarised below:

- Intervention girls at end line displayed the highest levels of knowledge, most positive attitudes, and reported greater levels of interpersonal communication about absorbent use and going to school during menstruation when compared with the baseline and end line comparison girls, demonstrating the positive impact that the GARIMA project has had on these mediators.

- However with regard to restrictions, at end line, intervention AGs in reported higher levels of social restrictions when compared with their comparison and baseline counterparts. This possibly indicates that while the project may not have had an impact on addressing restrictions imposed during menstruation, by virtue of participating in GARIMA the intervention girls are better able to articulate the imposition of restrictions pertaining to diet and mobility during menstruation.

- Adequate menstrual hygiene was the key behavioural outcome promoted by the GARIMA project. At the overall level, when compared to baseline, CM and end line intervention AGs showed improvement in practices with regard to washing reusable menstrual cloth with soap and water, indicating that exposure to GARIMA project is associated with specific MHM practices.

38 For more information see: http://www.oecd.org/dac/evaluation/dcdndep/37671602.pdf
Before examining impact it is important to compare research participants to ensure that they are demographically similar. Regarding socio-demographic variables there were some minor yet significant differences. For example, the CM and end line intervention groups included a larger proportion of respondents living in kutcha households and the CM had a slightly higher proportion of general caste respondents. Since these comparisons are between AGs who were part of the intervention, these findings indicate that the intervention achieved its objectives of reaching a diverse group of girls. Also, the girls in the CM were significantly more likely to be in school (82 per cent when compared with baseline and both end line comparison and intervention groups).

Table 13: Socio-demographic and socio-economic characteristics of AGs and mothers

| AG | Baseline M | Baseline C | Comp | End | Int | Sig | Baseline M | Baseline C | Comp | End | Int | Sig |
|----|------------|------------|------|-----|-----|-----|------------|------------|------|-----|-----|-----|-----|
| N Socio-demographics/ Socio- economics | 1653 | 900 | 1192 | 1248 | 1962 | 180 | 598 | 564 |
| District | | | | | | | | |
| Jaunpur | 35.6 | 33.3 | 35.7 | 37.5 | B | 34.5 | 34.4 | 36.3 | 37.6 |
| Mirzapur | 33.4 | 33.3 | 32.5 | 34.1 | | 34.2 | 33.3 | 32.8 | 34.6 |
| Sonbhadra | 31.0 | 33.3 | 31.9 | 28.5 | | 31.4 | 32.2 | 30.9 | 27.8 |
| House type | | | | | | | | |
| Kutch | 56.9 | 42.9 | 51.6 | b, c | 33.7 | 58.9 | 41.6 | 47.3 | a, b, c, d |
| Pucca | 17.9 | 31.7 | 25.2 | | | 24.7 | 20.0 | 32.1 | 24.8 |
| Semi-pucca | 25.3 | 25.4 | 23.2 | | | 41.6 | 21.1 | 26.3 | 27.8 |
| Religion | | | | | | | | |
| Hindu | 96.7 | 97.6 | 96.8 | | | 93.2 | 96.1 | 96.8 | 96.5 | a, d |
| Non-Hindu | 3.3 | 2.4 | 3.2 | | | 6.8 | 3.9 | 3.2 | 3.5 |
| Caste | | | | | | | | |
| General Caste | 13.2 | 9.4 | 9.9 | b, c | 11.2 | 12.2 | 9.5 | 9.9 | a, c, d |
| Scheduled Tribe | 35.9 | 33.7 | 40.4 | | | 28.5 | 32.8 | 30.8 | 38.5 |
| OBC | 11.1 | 13.2 | 12.7 | | | 8.7 | 15.6 | 13.7 | 13.1 |
| Age (years) | 39.8 | 43.7 | 37.0 | | | 51.6 | 39.4 | 46.0 | 38.5 |
| Marital Status | | | | | | | | |
| Unmarried | 15.4 | 15.4 | 16.0 | 15.9 | a, b, d | 40.3 | 39.4 | 41.3 | 40.7 | b, d |
| Married | | | | | | | | |
| Other | | | | | | | | |
| Education | | | | | | | | |
| Till which standard have you/ your daughter completed their education? | 7.9 | 9.1 | 8.7 | 9.0 | a, c, d | 9.2 | 8.5 | 7.7 | b, c |
| Currently Attending School | 68.8 | 82.1 | 65.7 | 69.6 | a, c, d | 77.0 | 76.1 | | |

A significant difference between baseline and end line intervention
B significant difference between CM and end line intervention
c significant difference between end line comparison and end line intervention
D significant difference between baseline and end line comparison

Some interesting results are evident when examining the extent to which girls report missing school during menstruation. This question was not asked during the CM, however, data from
baseline, end line comparison, and end line intervention girls shows significant improvement in school attendance. At baseline, one third of the AGs reported that they never miss school during menstruation compared to 49.8 per cent of end line comparison girls and close to 60 per cent of girls from end line intervention sites.

In order to estimate impact, the baseline, CM and end line data was also compared where possible on a variety of mediating indicators (Table 14).

### Table 14: Knowledge, Attitudes, Restrictions, IPC and Media Exposure of AGs and Mothers

<table>
<thead>
<tr>
<th></th>
<th>AG Baseline</th>
<th>CM</th>
<th>End Comp</th>
<th>End Int</th>
<th>Sig</th>
<th>M Baseline</th>
<th>CM</th>
<th>End Comp</th>
<th>End Int</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge about Reproductive Organs</strong>&lt;sup&gt;39&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low (0 - 1)</td>
<td>20.8</td>
<td>6.4</td>
<td>71.0</td>
<td>32.8</td>
<td></td>
<td>16.0</td>
<td>22.8</td>
<td>73.6</td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td>Medium (2 - 3)</td>
<td>59.8</td>
<td>6.2</td>
<td>13.7</td>
<td>12.9</td>
<td></td>
<td>63.6</td>
<td>13.9</td>
<td>14.2</td>
<td>12.8</td>
<td></td>
</tr>
<tr>
<td>High (4 - 10)</td>
<td>19.4</td>
<td>87.3</td>
<td>15.4</td>
<td>54.3</td>
<td></td>
<td>20.3</td>
<td>63.3</td>
<td>12.2</td>
<td>37.2</td>
<td></td>
</tr>
<tr>
<td><strong>Attitudes towards Absorbent Use</strong>&lt;sup&gt;40&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative (0 - 8)</td>
<td>42.3</td>
<td></td>
<td>16.5</td>
<td>12.7</td>
<td></td>
<td>53.6</td>
<td></td>
<td>19.9</td>
<td>18.8</td>
<td></td>
</tr>
<tr>
<td>Neutral (9 - 11)</td>
<td>32.5</td>
<td></td>
<td>33.1</td>
<td>29.8</td>
<td></td>
<td>27.6</td>
<td></td>
<td>37.8</td>
<td>31.4</td>
<td></td>
</tr>
<tr>
<td>Positive (12 - 20)</td>
<td>25.2</td>
<td></td>
<td>50.3</td>
<td>57.5</td>
<td></td>
<td>18.8</td>
<td></td>
<td>42.3</td>
<td>49.8</td>
<td></td>
</tr>
<tr>
<td><strong>Restrictions</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sour Food</td>
<td>35.7</td>
<td>16.7</td>
<td>47.2</td>
<td>49.8</td>
<td></td>
<td>32.6</td>
<td>14.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spicy Food</td>
<td>5.3</td>
<td>8.4</td>
<td>3.9</td>
<td>7.2</td>
<td></td>
<td>7.7</td>
<td>10.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk products</td>
<td>3.2</td>
<td>2.1</td>
<td>0.7</td>
<td>0.8</td>
<td></td>
<td>4.0</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>11.3</td>
<td>2.4</td>
<td>6.9</td>
<td>7.7</td>
<td></td>
<td>6.9</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Touch holy book</td>
<td>96.5</td>
<td>2.9</td>
<td>33.3</td>
<td>34.4</td>
<td></td>
<td>97.2</td>
<td>1.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temple</td>
<td>97.5</td>
<td>76.9</td>
<td>77.6</td>
<td>78.9</td>
<td></td>
<td>98.1</td>
<td>81.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wedding</td>
<td>35.7</td>
<td>7.1</td>
<td>1.9</td>
<td>3.1</td>
<td></td>
<td>32.6</td>
<td>4.4</td>
<td></td>
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<tr>
<td><strong>IPC</strong></td>
<td></td>
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</tr>
<tr>
<td>How to use an absorbent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No discussion</td>
<td>59.7</td>
<td>54</td>
<td>50.3</td>
<td>63.8</td>
<td></td>
<td>67</td>
<td>70.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion (other initiated)</td>
<td>14.6</td>
<td>14.5</td>
<td>17.9</td>
<td>18.5</td>
<td></td>
<td>4.5</td>
<td>8.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialogue (self-initiated)</td>
<td>25.8</td>
<td>31.5</td>
<td>31.8</td>
<td>17.7</td>
<td></td>
<td>28.5</td>
<td>20.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Go to school during menstruation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<sup>39</sup> Knowledge about reproductive organs was a composite of 5 questions. Scores for each question were: 0 (do not know), 1 (described) and 2 (named). Categories were made based on the distribution of the data.

<sup>40</sup> Attitudes towards absorbent use was a composite of 5 questions. Scores for each question ranged from 0 (strongly disagree) to 4 (strongly agree) for a desired behavior.
The results reported above show significant positive trends with regard to knowledge, attitudes and interpersonal communication about absorbent use and going to school during menstruation. As expected intervention girls at end line have the highest levels of knowledge, most positive attitudes, and report greater levels of interpersonal communication when compared with the baseline and end line comparison girls. The similarities between baseline and end line comparison show that knowledge, attitudes, and interpersonal communication do not change substantially in the absence of the GARIMA project. The high levels of correct knowledge, positive attitudes and interpersonal communication among the end line intervention AGs and mothers show that the GARIMA project had positive impacts these mediators. Interestingly, the results on restrictions are somewhat different. At end line, AGs in intervention groups report higher levels of social restrictions when compared with their comparison and baseline counterparts. It is possible to hypothesise that while the project may not have had an impact on changing prevailing normative restrictions around food and mobility, by virtue of participating in GARIMA the intervention girls are better able to articulate the social nature of menstruation related restrictions i.e. having been asked not to eat specific kinds of foods and/or go to specific places during menstruation.

Impact of SBCC interventions is contingent upon not just changes in mediators such as knowledge, attitudes and interpersonal communication but also adoption and maintenance of positive behaviours. The key behavioural outcome of the GARIMA project was promoting adequate menstrual hygiene. Given the differences in the types of questions asked and in sample sizes, it is not possible to calculate a composite score for adequate MHM. However, individual elements that comprise adequacy can be examined (Table 15).

### Table 15: MHM Behaviours of AGs and Mothers

<table>
<thead>
<tr>
<th>Type of Absorbent</th>
<th>AG Baseline</th>
<th>C</th>
<th>M</th>
<th>End Comp</th>
<th>End Int</th>
<th>Sig</th>
<th>M Baseline</th>
<th>C</th>
<th>M</th>
<th>End Comp</th>
<th>End Int</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Changing</td>
<td>450</td>
<td>1080</td>
<td>1132</td>
<td></td>
<td></td>
<td></td>
<td>530</td>
<td>511</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of changing absorbent 3 or more times</td>
<td>78.2</td>
<td>47.6</td>
<td>79.2</td>
<td>c</td>
<td></td>
<td></td>
<td>46</td>
<td>65.2</td>
<td>c</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing Cloth</td>
<td>1330</td>
<td>267</td>
<td>833</td>
<td>833</td>
<td></td>
<td></td>
<td>1033</td>
<td>60</td>
<td>415</td>
<td>385</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
End line Evaluation of GARIMA Project in Uttar Pradesh (UP): Evaluation Report

<table>
<thead>
<tr>
<th></th>
<th>AG Baseline</th>
<th>C</th>
<th>M</th>
<th>Sig</th>
<th>End Comp</th>
<th>M Baseline</th>
<th>C</th>
<th>End Int</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you/adolescent girls/does your</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>daughter always wash the cloth</td>
<td>28.3</td>
<td>49.7</td>
<td>62.3</td>
<td>a,</td>
<td></td>
<td>39.2</td>
<td>59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>before using it to absorb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>menstrual blood?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N washing cloth with soap and</td>
<td>1330</td>
<td>267</td>
<td>527</td>
<td>721</td>
<td></td>
<td>1033</td>
<td>60</td>
<td>275</td>
<td>318</td>
</tr>
<tr>
<td>water</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you/adolescent girls/does your</td>
<td>32</td>
<td>99.6</td>
<td>95.6</td>
<td></td>
<td></td>
<td>41.7</td>
<td>98.3</td>
<td>92.4</td>
<td></td>
</tr>
<tr>
<td>daughter wash menstrual cloth with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>soap and water/disinfec tant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N soap available for washing</td>
<td>462</td>
<td>527</td>
<td>721</td>
<td></td>
<td></td>
<td>458</td>
<td>275</td>
<td>318</td>
<td></td>
</tr>
<tr>
<td>cloth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is soap available for washing</td>
<td>62.3</td>
<td>82.2</td>
<td>76.8</td>
<td></td>
<td></td>
<td>56.8</td>
<td>85.1</td>
<td>70.1</td>
<td></td>
</tr>
<tr>
<td>of menstrual cloth always?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Drying Cloth in Sunlight

<table>
<thead>
<tr>
<th></th>
<th>AG Baseline</th>
<th>C</th>
<th>M</th>
<th>Sig</th>
<th>End Comp</th>
<th>M Baseline</th>
<th>C</th>
<th>End Int</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>N drying cloth in sunlight outside</td>
<td>267</td>
<td>833</td>
<td>833</td>
<td></td>
<td></td>
<td>60</td>
<td>415</td>
<td>385</td>
<td></td>
</tr>
<tr>
<td>Do you/adolescent girls/does your</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>daughter dry menstrual cloth in the</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>sunlight outside?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hygiene Behaviors</td>
<td>1653</td>
<td>450</td>
<td>1080</td>
<td></td>
<td></td>
<td>1132</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you/does your daughter use the</td>
<td>58.3</td>
<td>54.6</td>
<td>66.9</td>
<td></td>
<td></td>
<td>52.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bathing area at home for bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>during menstruation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>During menstruation do you/adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>girls/does your daughter take a</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bath daily with soap and water?</td>
<td>99.6</td>
<td>95.7</td>
<td>98.6</td>
<td></td>
<td></td>
<td>95.6</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

A  significant difference between baseline and end line intervention
B  significant difference between CM and end line intervention
C  significant difference between end line comparison and end line intervention
D  significant difference between baseline and end line comparison

The results presented in the table above show that baseline levels of adequate MHM practices are lowest. The end line comparison AGs show some improvements, especially when it comes to the availability of soap for washing menstrual cloth and washing reusable menstrual cloth with soap and water/disinfec tant. At the overall level, CM and end line intervention AGs reveal the most promising practices, again indicating that exposure to GARIMA project is associated with specific MHM practices.

**Generation of Social Capital**

The GARIMA project has been successful in creating strong institutions at village level, comprising adolescent girls (members of the AGGs), peer educators, and frontline health workers, which goes a long way in terms of bringing sustainable social change. The combined effect of generating strong social capital at village level, and creating a ‘social movement’ around MHM, can be observed and validated by the baseline-end line comparison, showcasing marked improvement in AGs’ knowledge, attitude, behaviour and inter personal communication regarding MHM.
5.4. Assessing the Efficiency of the GARIMA Project

This section assesses the project's efficiency and addresses the following evaluation questions:

a) Extent to which the project optimally used resources to achieve its objectives.
b) Adequacy and appropriateness of resource allocation.
c) Best practices established in implementation.
d) Bottlenecks faced and their resolution.

Further, based on interviews with partner organisations on specific efficiencies, a descriptive analysis is presented in this section which includes:

- Good practices.
- Low cost alternative activities with similar or better results.
- Challenges and ways to overcome these in the context of activity costs.

5.4.1. Approach for Assessing the Efficiency of the Project

The following section presents findings pertaining to the efficiency of the project. These are summarised below:

- Almost three quarters of the project expenditure was spent at the partner level, which seems appropriate for efficient implementation.
- While there is no reference cost available to compare it with, the low cost of USD 0.8 per month per adolescent girl or USD 28 for engagement with them during the whole project period of 35 months seems quite reasonable in order to achieve the intended outcome.
- Given the nature of the project (i.e. the focus on behavioural change) at the partner level most of the financial resources (67 per cent) were allocated to technical support (which included salary and direct costs related to the core members).
- The overall resources available for the project were more or less sufficient. The partner organisations also contributed 6 to 9 per cent of their total cost in the project, which evidences their ownership in the project.
- The project was implemented in a standardised and structured way ensuring quality delivery of capacity-building and communication outputs.
- Some of the good practices enabling better efficiency have a synergy with the child rights project, selection of FFs from the neighbouring villages and successfully managing attrition at the last mile connect.

Evaluating the efficiency of development programmes/projects is concerned with the processes by which a plan is delivered to produce outputs. Usually, efficiency evaluations compare the inputs with the outputs and determine how optimally the outputs for the resource were allocated. While there are various methods and approaches for the efficiency analysis of a development programme/project, the data requirement for conducting such assessment varies. Moreover, efficiency is a relative construct and is used primarily to assess cost per benefit (goods/services) in relation to some other programme or standard. While increasing efficiency would help in achieving the outputs at a lower cost, effective results would also lead to improved outcomes.
Multiple external factors may influence both the output and the outcome: stakeholder interest in the project; the prevailing legal framework; government policy and directives in giving the project its required impetus; and the prevailing political scenario. This section attempts to assess the model’s efficiency in achieving the desired outputs and to delineate inputs that may have triggered unplanned outcomes.

A Benefit-Cost Analysis (BCA) for the GARIMA project was proposed in the ToR, however, BCA requires availability or assessment of both costs and benefits in financial terms and is a complex procedure. It is also hard to find financial benefits of better awareness, improved attitudes and changed habits/practices. It is both data and time intensive to conduct BCA.

The GARIMA project has been implemented by different partner NGOs at the ground level. These partner NGOs had targets (yearly or periodic) and an allocated budget (for hiring human resources and conducting activities). While the overall approach and activities were designed by UNICEF and were standard across partners, some partners innovated or converged with the district and block administration to achieve greater efficiency.

The proposed analysis is therefore primarily descriptive, however, an overall expenditure tracking has been conducted as well, which provides an understanding of where the financial and non-financial resources were spent and what the output was given the resources deployed (Allocative Efficiency).

In expenditure tracking, a comparison of major and minor head-wise budget and expenditures at different levels, especially among partner NGOs has been carried out. The processes adopted by different partners for the deployment of financial and human resources have also been looked into and a descriptive comparison of these inputs, and the outputs they generated, has also been analysed. The material resources and technical services were either generated or procured primarily at the UNICEF state or national level, and the expenditure at national and state level has also been analysed.

5.4.2. Overview of Efficiency in the GARIMA project

The overall expenditure in the project was around USD 5.08 million and was spread across three levels; national, state and partner. Accordingly, the expenditure statements at national, state and partner levels were analysed. The statement had different output components or major heads and the share of these components is given in Figure 24.

At the national level, the expenditure was USD 0.45 million, which represents around 9 per cent of the total expenditure. This expenditure was on two aspects: a) development of the SBCC package, including development of the Paheli ki Saheli package and Ammaji videos on MHM, and b) concurrent monitoring study costs. At the state level, the expenditure was primarily on adolescent participation and empowerment (61 per cent), which was the expenditure made at the NGO partners level, on adolescent empowerment (27 per cent) and on staff costs (3 per cent).

The adolescent empowerment component at the state level included costs related to partner selection, proposal development, MHM material cost, trainings, implementation of the project in the district, and knowledge management.
End line Evaluation of GARIMA Project in Uttar Pradesh (UP): Evaluation Report

While the output component expenditure analysis suggests that partner level expenditure was 61 per cent of the total expenditure, a deeper assessment suggests that within other output components, grants were disbursed to partner organisations. If all the grants and the amounts reimbursed to partner organisation from all budget heads is added, the proportion of the total amount spent at the partner level is 74 per cent. Thus, almost three quarters of the project expenditure was spent at the partner level, which seems appropriate for efficient implementation.

The budget and expenditure statements from the partner organisations were also sought and these were received from eight organisations out of ten. A detailed analysis of these expenditure statements has been made and is detailed below.

5.4.3. Efficiency at the Partner Level

Cost of Intervention

One of the key indicators of the efficiency of a project is the cost per stakeholder, which can be referenced against an established cost in order to determine the efficiency of the project. However, in the case of GARIMA, no such reference point or cost is available. Nonetheless, the cost per unit or per stakeholder has been calculated and a preliminary assessment undertaken.

By December 2016, the GARIMA project had reached 204,652 AGs, 74,163 women and 5,020 FLWs through a combination of group meetings and home contacts. The overall budget of the project was USD 5.08 million and accordingly the cost per stakeholder (including adolescent girls, women and front-line workers) was around USD 18.

Table 16: Cost per village

<table>
<thead>
<tr>
<th>District</th>
<th>Name of the NGO</th>
<th>Per village/ per month cost (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirzapur</td>
<td>CREDA</td>
<td>27</td>
</tr>
<tr>
<td>Mirzapur</td>
<td>AAK</td>
<td>27</td>
</tr>
<tr>
<td>Mirzapur</td>
<td>Sarthak</td>
<td>29</td>
</tr>
<tr>
<td>Mirzapur</td>
<td>MDSS</td>
<td>29</td>
</tr>
<tr>
<td>Sonbhadra</td>
<td>GSS</td>
<td>29</td>
</tr>
<tr>
<td>Mirzapur</td>
<td>MPF</td>
<td>31</td>
</tr>
</tbody>
</table>
At the partner level, the average cost of implementation was around USD 30 per village per month. As there were around 20 adolescent girls in each group and each village had on an average 1.8 AGGs, the average cost per adolescent girl at the partner level for implementing the project activities to achieve behaviour change was around USD 0.8 per adolescent girl per month. While there is no reference cost available to compare this with, the low cost of USD 0.8 per month per adolescent girl or USD 28 for engagement with them during the whole project period of 35 months to achieve the intended outcome seems quite reasonable.

The variation in the cost of implementation across the partner organisations was also minimal: between USD 27 and USD 32, except for Banwasi Sewa Ashram. The higher cost for Banwasi Sewa Ashram was mainly due to additional activities, especially in trainings conducted. Moreover, the project area of the Ashram was also very remote, adding to the cost of implementation.

**Allocation of Financial Resources**

Main budget heads, at the partner level, are explained in Figure 25:

- **Technical Support**
  - Salary of Project Personnel
  - Travel cost of project personnel

- **Training/Orientation**
  - Trainings and orientation of varied duration at different levels

- **Meetings**
  - Variety of meetings of project staff, field level stakeholders (mother and daughter conferences) and interface meetings with block and district officials

- **Direct Programme Support**
  - Salary of programme support staff, office establishment cost and communication support to project staff. This head also included stationary expenses to AGGs

- **Additional Activities**
  - A few additional activities were undertaken by each partner depending on the need of the geographies and communities with which they were working

*Figure 25: Budget Heads*
The project pivoted on the involvement of personnel (including project manager, project support coordinators, field facilitators, *kishori* mobiliser and chief functionary) and, considering the nature of the project (focus on behaviour change communication), 66 per cent of the financial resources were allocated to the major budget head of technical support (which included salary and direct costs related to these core team members). The variation among the partners in cost allocation to this major budget head was, except in two cases, within ±5 per cent. The overall cost and its allocation to different heads seem to be relevant and sufficient.

**Adequacy of Financial Resources**

Within the major budget heads, the unit costs of activities were almost standard across different partners. The standard unit costs helped to minimise any discontent among the partner organisations. The unit costs for activities were also highly reasonable and encouraged efficiency measures on the part of partner organisations. For example, the venue hire charges for a three day training were USD 7, making it challenging to conduct the training programme. Moreover, the cost of food per person per day during training was less than USD 1. The partner organisation in Mirzapur, utilising its relationship with the block administration, organised the training programme at the block office level where they used the hall and facilities available in the block complex. While such efficiencies in conducting different activities were narrated by the partner organisations, an increase in budget of some of these activities would have made partner organisations relatively more comfortable.

While the overall cost allocation as per major budget heads was sufficient, the remuneration for each personnel category could have been increased considering the scale and intensity of the programme. For instance, field facilitators who were responsible for training and follow-up of around 10 AGGs were paid USD 70-77 per month, which was quite low. Moreover, partners related that there was a time gap of around two years between the planning of the project (including budget preparation) and its initiation, and therefore inflation adjustments could have been made in the project heads prior to the finalisation of the partner’s contracts.
**Contribution of Partner Organisations**

![Figure 27: Proportion of major head-wise budget (8 partner NGOs)](image)

Partner organisations involved in the GARIMA project contributed various project activities. This contribution was planned in their contract. The contribution was in cash or kind depending on the activities. The major contribution in absolute terms was in technical support, where a portion of the salary of the project personnel was paid/booked by the partner organisation. During training/orientation, the partners contributed by providing logistic support. This ensured, and is an indicator of, their ownership in the project and its outcomes.

From the beginning of the implementation phase of the project, the contribution from NGOs also helped to enhance efficiency. The overall extent of their contribution was 7 per cent of the total budget. The variation in contribution of different partners in their overall budget was not much (6 per cent to 9 per cent of the total partner level budget), except for SWARG, a partner organisation working in Sonbhadra district. SWARG’s contribution to the project was 3 per cent, because towards the end of the project the organisation worked in an additional 100 villages in the project area.

**Standardised and Structured Project**

The project was highly structured to ensure that standard communication, with the intended intensity and accuracy, reached the adolescent girls and other stakeholders. To achieve this, each activity and meeting took place almost within the same time period and for the same duration at different locations. This ensured that the quality of the activities was more or less the same and that they could be monitored appropriately. While, most of the activities were similar (Annex 9), there were some additional activities conducted by each partner depending on their requirements and the needs of the area. The overall budget of these activities (from the budget at partner level) was minimal at around 2 per cent, but it provided a degree of flexibility in programming for the partners. Most of the partners were happy with a standardised mode of implementation and found the project to be sufficiently flexible.

**5.4.4. Good Practices Enabling Efficiency**

There were a number of strategies and practices that were adopted at different levels that enabled efficient planning and utilisation of resources. Some key good practices are described below.

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41 Based on analysis of data received from 8 project partners.
42 Finding credible and competent NGO partners and training agencies that can work on the adolescent health and empowerment issues had been challenging. Stringent financial and programme monitoring resulted in termination of partnership with one of the partner NGOs in 2015.
Synergy with Child Rights Project

The GARIMA project has synergistically worked on the foundations provided by an earlier IKEA Foundation funded Child Rights Project (CRP) in the project area. The CRP, which worked in 5,160 villages, started in 2010 and continued until 2014. All 1,974 villages of the GARIMA project were part of the CRP as well. GARIMA was therefore built on the social capital created by the CRP at the community and implementation level. For GARIMA this provided a ready programming environment requiring minimal establishment and community mobilisation time.

All 11 GARIMA implementing partners had also been CRP implementing partners, sensitised on children’s issues and trained in community mobilisation and advocacy at the block and district level. GARIMA adopted NGO monitoring systems that had been established under CRP, such as quarterly review meetings at the state and district level. Building on these, GARIMA added components of peer review and learning within NGOs by organising joint field visits.

During the initial period of the project, environment-building activities for initiating work on MHM in the villages was undertaken with SHGs and Child Protection Committees which were formed under CRP. This ensured less initial resistance from the community. The GARIMA project continued the CRP strategy of group meetings and home contact with women and AGs and it built on the meeting format through structured content and communication tools.

Selection of FFs from the Neighbouring Villages

Given that MHM was a taboo subject in the project area and there was a silence around it, the project faced initial resistance from mothers and other family members in the project villages. To overcome this, FFs were strategically selected from the nearby villages so that people could relate to them easily. This helped in grounding the project quickly, and over time mothers and other family members started cooperating and sending their girls to the GARIMA meetings. An environment of trust was thus built in a short period of time.

Managing Attrition of Peer Educators

Attrition of ground level personnel, which affects the quality of outputs and the time efficiencies, has been a key challenge in large scale projects. A new member of field staff takes time to get trained and establish herself in the village before producing the outputs required by the project. In GARIMA, the key position connecting the project with the AGs and community in the village were the FFs and PEs. While FFs were responsible for organising theme-based monthly meetings with all the adolescent groups and mother groups, PEs were to support the FFs and conduct follow-ups on the trainings/information provided. It is to be noted that PEs were volunteers and not paid personnel in the project. However, intensive trainings on MHM, IPC and life skills were provided to PEs.

While FF positions saw minimal attrition (as reported by partner organisations), the attrition in PEs ranged from 20 to 40 per cent during the project period. The attrition at PE level was primarily due to increased age (PEs were not supposed to be volunteering after the age of 21) and their marriage. The trainings of new PEs were conducted by FFs in the field given that there

43 The contract with one of the partners was terminated in 2015
was no budget for the training of new PEs. To overcome this challenge, partner NGOs identified two PEs in each group (one younger and another relatively older) and trained them on various aspects. This strategy ensured that even if one PE left the group, the other could start taking the responsibility without affecting project implementation processes.

### 5.4.4. Challenges Affecting Efficiency

#### Phased Roll-Out

A total of 11 partner organisations were involved in implementing the project at ground level in the three districts. In the field, activities commenced in September 2013 with a phased roll-out, beginning in Mirzapur district. Field implementation expanded to Jaunpur and Sonbhadra in April of the following year. While in Mirzapur the intervention duration was the same across partners, in Sonbhadra, due to various reasons, it ranged from 31 months for Banwasi Sewa Ashram to only 8 months for SWARG in Ghorawal block. The intended training and activities were compressed into the short duration and while most of the activities (training and meeting heads) were conducted in Sonbhadra, a continuous and longer engagement with AGs and other stakeholders was missing, which may have affected the outputs and resultant outcomes for the project.

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<td>Swarg (Ghorawal)</td>
<td>Sonbhadra</td>
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<td>Implemented by a different organisation. No data available.</td>
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#### Lack of Robust MIS

The project had instituted processes wherein paper-based information on project activities (registers for attendance etc.) were aggregated from the village level upwards in excel sheets and utilised by the project managers at different levels. While this system was useful to some extent, in the absence of a robust online MIS, real-time tracking of an individual’s participation in the project was not possible as the information collected was at an aggregate level (group/village) and not at the individual level. This requires time to be aggregated, entered into the system and analysed for decision-making. Lack of strong MIS along with timely provision of PE registers, may have further reduced the efficacy of the project.
It is recommended that in future projects of this nature, an online MIS be designed and implemented. A holistic MIS would generate real time reports, facilitate tracking of the AGG meetings, assessment of the PEs’ and FFs’ performance at village level, in terms of regularity of meetings and attendance, and the measurement of the stakeholders’ intensity of exposure.
5.5. Assessing Sustainability of the GARIMA Project

This section outlines the findings from the evaluation of the sustainability of the project based on the following questions:

a) What components are sustainable and what actions would be necessary for the outcomes to be sustained?

b) What are the key factors that have and can have an influence on further integration with GoI programming for AGs, specifically the RSKS programme?

c) What good examples, practices or models emerged that can be documented for possible scaling up and replication? What did not work well?

d) What factors need to be in place before the intervention can be scaled up across the state and possibly replicated in other states?

5.5.1. Efforts towards Sustainability

In 2016, UNICEF developed a ‘Roadmap for Strengthening of Menstrual Hygiene Management in Uttar Pradesh’ in partnership with National Health Mission.\[^{44}\] The document lays a blueprint for:

- Integrating MHM across programmes and flagships working with girls and women.
- Strengthening and sustaining social and programmatic capital created by GARIMA in three intervention districts.

‘GARIMA Phase-out and Sustainability Plans’ were part of the document developed under the leadership of the District Magistrate and key officials from education, ICDS and Panchayati Raj departments within each of the three implementation districts. A snapshot of the status of this agenda, based on discussions with the partner NGOs, is presented below:

### Table 18: Phase out plan and actions taken

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<th>S. No.</th>
<th>Phase-out plan</th>
<th>Status</th>
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<td>1.</td>
<td>Nurturing GARIMA social capital:</td>
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  - Empowered girls to be linked with departments and flagship schemes like RKSK, Adolescent Friendly Health (AFHS) Clinics, Rashtriya Bal Swashthya Karyakram, Kishori Shakti Yojna (KSY), Village Health & Nutrition Day (VHND, DoHFW/NHM), SABLA (ICDS), KGBV and upper primary school (Education).  
  - GARIMA girls to be made mandatory members to influence governance within institutions like PRI and its committees such as VHNCS, block and district-level forums.  
  - AGG members to be linked with higher education and skill development education, as continued education for girls has shown to positively affect their health, hygiene, sanitation, nutrition and child protection indicators.  
  - Ensure effectiveness of Women's helpline service and Power Angel selection.  
  - Partners in Mirzapur and Sonbhadra reported that PEs and members of AGGs were appointed as members of 'Nigraani Samiti' in their respective villages.  
  - They were also appointed as 'Jal Doot' (Water Ambassadors) in a NABARD45 supported project. Also, a number of PEs and members of AGGs were appointed as 'Power Angels'.  
  - RKSK is operational only in Mirzapur and Sonbhadra. It also seems to be a low priority programme for the state government as the resources allocated for the programme have been drastically reduced.  
|  |    | Some of the GARIMA resource centres are still operational, as reported by some of the partner organizations. |
| 2.     | Systems to support adolescent girls: |  
  - Develop systems to ensure that district acknowledges, plans and monitors issues related to Adolescent Empowerment and MHM.  
  - Use information and communications technology to strengthen adolescent platforms like GARIMA Resource Centres.  
  - Supportive supervision and monitoring across departments' basic indicators related to adolescent empowerment.  
  - Identify champions, honour and celebrate their successes in public events in the presence of Commissioners, DMs and CDOs.  
  - Integrate adolescent girls' health and nutritional aspects in M-Sehat software.  
|  |    |    |
| 3.     | Capacity-building on adolescent issues: |  
  - Adolescent participation/emPOWERment in the context of developmental approaches needs better |

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45 National Bank for Agriculture and Rural Development (NABARD) is a central bank that lends for infrastructural and development projects in rural areas of India.
The following section presents findings on the suitability of the project in terms of the creation of sustainable project outcomes and outputs, good practices and pre-requisites important for sustaining the results achieved under the project. These are as summarised below:

Towards answering the evaluation questions on sustainability of the project in building a viable environment for MHM, the following observations were made:

- Through the recruitment and training of PEs and capacity-building of the FLWs, the project has created a repository of knowledge in the community around MHM. Creation of awareness has consequently resulted in greater demand in the community for facilities that support hygiene management. In many instances, this demand goes beyond MHM to also include wider aspects WASH facilities in schools and homes, adequate nutrition and education for the adolescent girls.

- The project’s prioritisation of issues around MHM and integration of the same with government initiatives (such as ICDS, RKSK, SABLA etc.) highlights its merits in holistically addressing the subject of menstrual hygiene, and provides an opportunity to expand the project across the state and possibly to other states as well.

- Innovative practices were conceived and adopted during the course of the project. These included the establishment of career counselling services and GARIMA resource centres, as well as the fostering of peer learning amongst the FFs and the inclusion of vocational training activities in the AGG meetings.

- While the project has broadly built in sustainability measures in its conception and implementation phase, challenges associated with engaging FLWs as facilitators need to be addressed before scaling up or replicating the project elsewhere. Similarly, advocacy with government departments for efficient utilisation of financial resources reserved for adolescent-oriented schemes is central in driving forward the shared goals of the project as well as the government programmes pertaining to MHM.

5.5.2. Sustainability of the Project beyond External Support

The sustainability of the GARIMA project has been assessed in terms of the continuation of the project outcomes beyond the project duration. This includes an assessment of the extent to which the outputs generated and processes adopted by the project to achieve these outcomes have been sustained after the project’s closure. Since the evaluation was conducted one year after the closure of the project, questions of sustainability have been interpreted in the light of the current environment, while also assessing the conditions necessary for scale up and the challenges in continuing the momentum generated by the project.
Sustainability of the Project Strategy, Outcomes, Outputs, and Processes

Qualitative discussions and findings from the structured interviews confirm that the outcomes generated by the project, in terms of knowledge enhancement around MHM and affecting positive changes with regards to attitudes and behaviour associated with menstruation, have been sustained one year after the closure of the project.

On the basis of the findings presented in Figure 28, it can be said that the discussion around MHM induced by the project, especially among AGs and project implementers (PEs and FLWs), was sustained over the following year. Nevertheless, it is likely that the AGG meetings might phase-out completely given that FFs were the driving force behind these meetings. Discussions around MHM and the knowledge imparted through the project, however, are likely to be sustained in the coming years. It is encouraging to note that 63 per cent of FLWs, positioned as potential implementers by the project following its closure, reported being approached by PEs and AGs for support on issues around MHM. Project participants have gradually come to understand the importance of the issue, the need for correct knowledge and the need to break the silence around menstruation.

Creating Demand beyond MHM

Qualitative interactions with community members and project functionaries showed that the intervention has been effective in enhancing confidence levels and self-efficacy amongst adolescent girls who were part of the groups formed under GARIMA. This in turn has encouraged them to demand facilities and negotiate a supportive environment that caters to adolescent needs beyond MHM, including WASH, nutrition, education etc.

The chief functionary of SARTHAK, one of the implementing NGOs operating in Mirzapur, stated that the girls have successfully raised demands related to village development in front of Block Development Officers (BDOs) of City and Manjhwaa block of the district. Similarly, girls raised their demands with candidates during Panchayat elections, and linked their votes to the realisation of their demands, which eventually led to the construction of toilets in various Panchayats.

Demand for amenities also went beyond MHM, and PEs have supported AGs and their families in procuring health cards in Manjhwa block in Mirzapur. Increase in awareness levels have also sensitised the AGs to the requirements of other girls and women. AGs have taken the initiative in taking family members and others in the community to use services that include pre-natal and post-natal check-ups.
**Generation of Social Capital**

The project design from the outset combined several elements to ensure sustainability. The replication of the Peer Educator Model, similar to the one existing under government initiatives such as RKKSK for adolescent girls, was a vital element. Institutionalising the project through capacity enhancement of key government functionaries, such as the AWWs and ASHA workers in the community, coupled with the creation of a ‘social movement’ around MHM through forming/strengthening groups of adolescent girls, mothers and fathers, was seen as necessary for sustainable social change. From the discussions conducted with the PEs and FFs, particularly in Mirzapur and Jaunpur, it transpired that in villages where the FLWs extended their support and facilitated the meetings, the community members’ response to the intervention was positive and welcoming. This illustrates that FLWs as resource persons in the community are trusted and respected figures whose involvement in community level initiatives renders it more effective and more acceptable to the community.

The Peer Educator Model adopted by the project, in which front-runners within the AGG groups were chosen, trained and equipped with relevant IEC materials, aided the establishment of dynamic networks and, within the community, ensured continued access to information, guidance and advice pertaining to menstruation and hygiene management. According to the FFs, the *Paheli ki Saheli* flip-book, available from the PEs, were widely read and circulated amongst the group as well as non-group members in many villages.

Following the recognition of the utility and efficacy of the social capital generated by the project, the PEs and AGG formed under GARIMA have been utilised towards the fulfilment of developmental aspirations of the community. Discussions with NGO representatives from SARTHAK and *Manaviya Dristikone Seva Samiti* (MDSS) in Mirzapur highlighted the assimilation of AGs groups in various government programmes in which they played a major role in the implementation of different government schemes. Many partners cited the example of Swachh Bharat Mission (SBM), in which the PEs and AGs supported the mission as change agents. The PEs and AGs have also supported partner organisations in their stream of work outside GARIMA. In 120 *Gram Panchayats*, AGGs were appointed as members of ‘Nigrani Samiti’ (Surveillance Committee) to ensure open defecation-free villages, with about 160 peer educators trained in a community-led total sanitation approach through SBM. PEs have been engaged by the NGO partners in the National Bank for Agriculture and Rural Development (NABARD) water campaign, wherein 40 PEs worked as ‘Jal Doot’ for a period of around five months.

Likewise, nearly 250 GARIMA AGG members were appointed as ‘Power Angels’, special police officers entrusted with the task of acting as links between the police and the society under the Government of Uttar Pradesh’s 1090 Women Powerline Programme.

**5.5.3. Convergence with GoI Programmes for Adolescent Girls**

Outcomes of the project have also been sustained through its integration with several government programmes. The MHM component forms a critical part of the SBCC strategy envisaged by NHM. Several aspects of GARIMA project’s communication strategy have been scaled up under NHM. The *Paheli Ki Saheli* communication package that was developed under GARIMA is part of the collection of materials contained within the “communication branding of health facilities” across all 75 districts of the state with an approved budget of USD 4.6 million within the NHM 2015-16 and 2016-17 Project Implementation Plan (PIP).
Besides integration with NHM, a crucial point of convergence for the project would also entail incorporation of project elements concerning MHM in the training and education materials developed under the Adolescence Education Programme (AEP).46 AEP primarily focuses upon life skills-based classroom education for adolescents around themes such as understanding changes during adolescence and being comfortable with them, understanding and challenging stereotypes and discrimination related to gender and sexuality, etc.

In October 2016, experiences and learnings from the project were further assimilated into the national Menstrual Health Guidelines for schools through the ‘National Consultation on Reaching Adolescent Girls in Schools: Way forward for MHM Programming,’ organised by the MoHRD. Besides dissemination of knowledge related to MHM and the provision of toilets and sanitary napkins in schools, recommendations following the consultation also recognised menstrual health as a pivotal entry point to empowering adolescent girls.

**Rashtriya Kishor Swasthya Karyakram (RKS)**

The MHM strategy developed by the project links well with RKS programme and the Menstrual Hygiene Scheme (MHS) aimed at the following:

a) To increase awareness among adolescent girls in the age group of 10-19 years on menstrual hygiene and build self-esteem and confidence for greater socialisation.
b) To increase access to and use of good quality sanitary napkins by adolescent girls in rural areas.
c) To ensure safe disposal of sanitary napkins in an environmentally friendly manner.

Given the linkage, communication packages and capacity-building measures developed by the project can be effectively integrated with these government programmes to support the promotion of MHM.

Likewise, platforms within the community such as Village Health, Sanitation and Nutrition Day (VHSND) could be used to bring together adolescent girls and women to help them prioritise MHM issues at the village level. At the block level, community health centres could be leveraged to run videos on MHM developed under the GARIMA project. These could also be integrated with other forums such as M-Sehat.47 The AGG members and PEs can also contribute towards the strengthening of community-based programmes through information and knowledge dissemination regarding initiatives such as the Adolescent Friendly Health Clinics, established at the village level under RKS.48

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46 The Adolescence Education Programme (AEP) is coordinated by the National Council of Educational Research and Training (NCERT) in partnership with the Ministry of Human Resource Development (MHRD) and United Nations Population Fund (UNFPA). This programme is a major initiative within the larger Quality Improvement in Schools Scheme of MHRD. The interventions include support for integration of life skills and adolescent concerns in the learning materials of National Institute of Open Schooling (NIOS) at the secondary level. The other important programme component is implemented through schools in the Navodaya Vidyalaya Samiti (NVS) and Kendriya Vidyalaya Sangathan (KVS).

47 M-Sehat is a mobile-based app for health workers to record maternal and infant data in real-time. It was launched in 2015 in select districts of Sitapur, Kannauj, Faizabad, Mirzapur and Bareilly in Uttar Pradesh for a period of three years, after which it was envisaged to cover all the districts in the state.

**Integrated Child Development Scheme (ICDS) and SABLA**

Under ICDS, nutrition, health and education for women between 15 and 45 years of age are the key elements that define the scope of work for the AWWs in the villages. In order to build their capacity, MHM could be integrated in the refresher trainings for the AWWs through ICDS supervisors and training institutions. This could aid the sustainability of the project. Furthermore, the AWWs, along with ANMs and ASHAs, could enlist support from the PEs and AGG members in utilising village level platforms such as VHSND to disseminate MHM-related information to out-of-school adolescents.⁴⁹

The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) or SABLA is yet another central government scheme initiated under the aegis of the MoWCD aimed at promoting awareness about health, hygiene, nutrition and adolescent reproductive and sexual health. Menstrual hygiene is an important component of ARSH, within which MHS derives the majority of its resources from SABLA. In UP, SABLA was implemented in 22 districts including the project districts of Mirzapur and Sonbhadra. Under SABLA, Kishori Samuhs (KS) and Sakhi Saheli networks were established to reach out to the girls on various adolescent-related issues.⁵⁰ It is possible that in the 22 districts where SABLA has been rolled out, *Paheli ki Saheli* communication packages prepared under the GARIMA project could be made available for internal use within Kishori Samuhs and Sakhi Saheli networks.

**Swachh Bharat Mission /Swachh Vidyalaya (Wash-In-Schools) and National Service Scheme (NSS)**

The Swachh Bharat Mission launched in 2014 promulgates universal sanitation coverage and it has issued national guidelines with special emphasis on addressing the issue of MHM facilities in schools (Swachh Vidyalaya). Provision of sanitation infrastructure, especially the installation of incinerators in schools, has been the key focus of these guidelines in order to maintain girls' attendance beyond primary schooling. The generation of demand for sanitation facilities through AGG members and PEs under the project gives a sufficient push to SBM’s mandate. SBM funds, available under the construction of solid-liquid waste management component, could be used to setup incinerators in schools and to create private spaces for girls to change their menstrual absorbent as frequently as required. Access to separate toilets with a regular water supply and the availability of soap is equally important to promote hygiene management in schools. Campaign days such as Global Handwashing Day, World Toilet Day, and MHM Day etc. could be leveraged to build a consensus around this issue with the help of village heads and school principals.⁵¹

Besides SBM, the NSS, under the Ministry of Youth Affairs and Sports, has about 3.2 million student volunteers spread throughout 300 universities across the country. The potential of NSS student volunteers could be used to bring together student peers and community members to raise awareness around the importance of hygiene management during menstruation by integrating training sessions on MHM into NSS events and camps.⁵²

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⁴⁹ *Ibid*
⁵² *Ibid*
5.5.4. Good Practices that Boost Community Participation

**Career Counselling**

During the implementation phase various novel practices and initiatives were interweaved into the project design that went beyond the original approach, with the aim of achieving the desired outcomes in consonance with the needs of the adolescent girls.

One need acknowledged by the project was the need for information with regard to career choices and, in turn, career counselling for the adolescent girls, especially those at the threshold of adulthood. Towards the conclusion of the project, one of the partner organisations, having experience with skills and career training, was contracted with support from a career counselling institute to provide services to girls in Mirzapur and also to create a local resource pool of career counsellors from within the government departments. The partners also felt that a next phase focusing on such activities (GARIMA +) could be initiated that would take these outcomes to a different level.

**GARIMA Resource Centres**

Additionally, around 195 GARIMA Resource Centres were formed with the purpose of providing a hub for the convergence of all adolescent-related services at in common place for clusters of five to six villages. The centres were located mostly at the Anganwadi centre, and in a few cases at the panchayat bhawan or an individual’s house. In two blocks of Mirzapur, out of 24 such centres that were established, eight are currently in operation.

**Peer Learning**

One of the innovative practices noted during the course of interactions with project stakeholders in Jaunpur was the facilitation of peer learning amongst the FFs in the district. Cluster meetings for the FFs were conducted on a monthly basis. An interesting feature of these meetings was that every quarter about three FFs from different areas would go to one village outside their area of supervision and would participate in organising AGG and mothers’ group meetings, *Jan sampark* sessions and home visits along with the FF for that particular village. This was beneficial in boosting peer learning on aspects pertaining to community mobilisation and outreach, which further promoted a healthy competitive spirit among the FFs.

**Vocational Training, Life Skills and Recreational Activities**

To sustain the interest of the girls in the monthly AGG meetings, the FF from Chopan block in Sonbhadra incorporated stitching and embroidery lessons as part of these meetings to break the monotony of discussion around menstruation. This, in her view, aided the retention of girls in the group, who otherwise did not feel motivated to partake in these monthly discussions, which were usually perceived as tedious and repetitive. It also served as a platform for them to acquire the skills that would assist them to become gainfully employed with some degree of financial autonomy. This practice was introduced almost 1.5 years after the intervention which led to an exponential increase in the attendance for AGG meetings in the FF’s villages.
5.5.5. Conditions to Ensure Continuity

**Greater Focus on the Interpersonal and Societal**

Given the intricacy of MHM as an issue and the culture of silence and misinformation surrounding it, the predominant objective of the project was to have individuals and communities discuss the topic in order to encourage acceptance and the practice of adequate MHM amongst the adolescent girls and women in the community. Involving the local community as well as family members by making them actors in their own social development becomes essential in sustaining the project outcomes. One way to ensure movement in this direction is through the creation and consolidation of channels/avenues for discussion around MHM for both the family and community members who form part of the social networks (socio-ecological model) of the adolescent girls.

**FF as the Key Mobiliser**

Through the course of interaction with the PEs and FLWs, along with the NGO partners, it was observed that the continuity of the meetings was largely incumbent upon the FFs and their sustained engagement with the AGs and mothers’ groups and the community at large. The selection of FFs from nearby villages was one of the key factors that facilitated community participation and interface with parents and family members to create an appreciative setting for discussions around MHM.

**Pitching with Multiple GoI Programmes**

The low priority accorded to RKSK by the government has resulted in delayed and partial implementation of the programme and this affected the sustainability and mainstreaming of the GARIMA project. Pitching the project with multiple government programmes such as SBM, which continues to be a high priority flagship for the government in terms of implementation and fund allocation, can prove helpful in ensuring the sustainability of the outputs and strategies envisaged by the project. The integration of AGGs as members of the surveillance committees under SBM adequately demonstrates the scope and potential of such convergence.

5.5.6. Challenges in Sustaining the Momentum

**Government Priorities and Lack of Resources in Flagship Schemes for Adolescents**

RKSK was the primary platform for scaling up GARIMA processes and learnings and for maintaining a focus on MHM. The RKSK programme was operational in Mirzapur and Sonbhadra, and the linkage with the programme through capacity-building of FLWs, improving their skills in and attitude towards MHM, was the key to the sustainability of the GARIMA project.

RKSK, however, continues to be a low priority scheme for the government. Discussions held with NGO partners in Mirzapur disclosed that the budget allocated under RKSK for Uttar Pradesh had been reduced. A review of budgetary data suggests that while the budget for RKSK was around INR 173 million in the year 2016-17, the expenditure until December 2016 (with only one quarter left) was less than 30 per cent of the amount allocated. Consequently, the proposed budget for
the year 2017-18 for RSKK in Uttar Pradesh was reduced to INR 21 million – a reduction of almost 88 per cent over the 2016-17 budget.53

Engaging FLWs as Change Agents

In the last quarter of the project FFs and PEs engaged the FLWs in the facilitation of the AGs and mothers’ group meetings to pass the baton in carrying forward the activities initiated under the project. This also signified the handover of responsibilities and duties previously discharged by the FFs to the FLWs to ensure the continuity of the project’s momentum. However, almost a year after the conclusion of the project, it was found that the FLWs, as a resource within the community, could not be capitalised upon as was envisioned by the intervention. Even during the course of the project, support rendered largely centered on offering space for the meetings (AWC) and being part of the meetings

The FLWs, during the course of discussions, cited increased workload, abysmal working conditions and nominal pay as impeding factors that limited their capacity to engage with the project in the villages. The AWWs and the ASHAs, who work on the frontlines providing basic healthcare and nutrition to the country’s vast rural population, remain overworked owing to their roles under government schemes such as ICDS, National Health Mission (NHM) and Mid-Day Meal Scheme.

Despite their role in providing critical services, the government only considers them as honorary workers volunteering their time for the community, resulting in meagre and delayed salaries. With rapidly deteriorating social sector budgets, especially following the recommendations of the 14th Finance Commission in 2015, the FLWs have been severely impacted due to the recommended cap on the centre’s contribution to the salary/remuneration of ASHAs and AWWs resulting in strikes and demonstrations across the country - in Delhi, Uttar Pradesh and Nagaland in the latter half of 2017.54

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53 Retrieved from http://www.nhm.gov.in/nrhm-in-state/state-program-implementation-plans-pips/uttar-pradesh.html. Only the main budget head for RSKK (A.4) was assessed for this analysis. The budget sheet also had other budgeted items under RSKK such as IEC material, equipment etc, but these amounts were together with other schemes and therefore difficult to segregate.

6. Key Findings and Conclusions

The project endeavoured to improve the knowledge base and build confidence amongst adolescent girls to improve their menstrual hygiene practices. By breaking the intergenerational silence that surrounded the issue, the project has been greatly successful in enhancing awareness around menstruation among girls and their immediate influencers. This was achieved through capacity-building and promotion of interpersonal communication.

6.1. Achievements of the GARIMA Project

**Breaking the Silence and Initiation of Dialogue and Communication around Menstruation**

Reflecting a departure from the previous scenario, the project has created a voice around menstruation, breaking the cycle of intergenerational silence. Large parts of these conversations took place within peer groups and families. Besides discussing menstruation with their friends and other AGG members, the girls to a certain extent also discussed these topics with their mothers and other female members of the family such as sisters and sisters-in-law. A greater proportion of mothers now rendered support to their daughters by facilitating hygiene management during menstruation and paid more attention to their diet and education. While mothers openly engaged in conversations around menstruation with their daughters, they also encouraged their daughters to do the same.

Similarly, minor changes could also be seen in fathers, although to a much smaller extent when compared to adolescent girls and mothers. These changes largely revolved around the extension of support in creating a conducive environment for their daughters to practice adequate MHM; this included provision of nutritious food, medicines and construction of toilets. Furthermore, the fathers were also progressively more aware of the importance of educating their daughters and ensuring their general well-being. Dialogue around MHM at the community level, however, was found to be negligible.

**Encouraging Adequate MHHM Behaviour**

The project has significantly contributed to an increase in knowledge among adolescent girls and mothers on various aspects of menstruation, such as puberty, reproductive body parts, use of absorbents, and managing pain and discomfort experienced during menstruation. Overall, the awareness levels of adolescent girls with regard to the importance of maintaining hygiene and cleanliness during menstruation had increased along with practices associated with proper disposal of their menstrual absorbents.

Findings on MHHM behaviour reveal that a significantly higher proportion of participants in intervention areas use new cotton cloth for their menstrual cloth, store absorbents in a safe and clean place, dispose of absorbents by burning or burying them in a pit, change absorbents three or more times a day and change absorbents in private changing places. A higher proportion were also found to wash their used menstrual cloth with soap and water and dry it in the sun afterwards, to take baths with soap and water and use the bathing area during menstruation, and to use medical and non-medical treatments for managing pain and discomfort experienced during menstruation. Thus, it has been demonstrated that the project has significantly influenced better knowledge among women and girls and a higher proportion of participants in intervention areas
now practice adequate MHM behaviour as compared to participants in areas where the project was not implemented.

**Challenging Menstrual Norms and Restrictions**
While dialogue and discussion around menstruation and the adoption of appropriate disposal and storage methods was widely reflected in the attitudes and behaviour of people, changing the norms and restrictions associated with menstruation remained in the embryonic stage. For most women and girls in the community, restrictions associated with menstruation formed an ineffaceable part of their day-to-day praxis and remained self-imposed and unopposed by a majority of the girls, barring a few who had been part of the intervention. Even then, while it was easier for them to flout restrictions pertaining to mobility, diet and disposal of absorbents (such as burning the menstrual absorbent), religious restrictions were still followed, owing to internalization of certain behaviours, pressure from their families and a fear of social exclusion. However, initiating a conversation around these restrictions could mean that forthcoming generations will not follow, or ask other female members to follow, these restrictions placed on them during menstruation. This would nevertheless remain an onerous process since most of these restrictions associated with menstruation have, over the course generations of social conditioning, become internalised by the adolescent girls and women.

**An Effective Platform for Voicing Demands beyond MHM**
Through its engagement with adolescent girls, the GARIMA project has not just empowered them with the required know-how and support around MHM, but has also enabled them to make demands that go beyond MHM such as addressing issues around WASH, nutrition, education, sexual harassment and child marriage.

The GARIMA project emphasised the importance of private changing and bathing spaces for girls, especially during menstruation. Girls have demanded such spaces, and the significantly higher presence of ‘space for changing clothes’ in intervention areas as compared to comparison areas is perhaps explained by such initiatives from girls. Similarly, adolescent girls, supported by FFs, have also played a key role in fighting incidences of child marriage and in a few cases they have been successful in preventing them. An increased consciousness around gender-based discrimination in education was also evident, with girls now being aware that they needed to be as educated as boys. Confidence in speaking up against sexual harassment, and realising the importance to do so, could also be noticed amongst the adolescent girls.
### 6.2. Challenges

**Mobilising the Community**

Interactions with the project implementers across the three districts revealed several challenges, especially with regard to the mobilisation of community members to build support for the project. Considered an ‘intimate’ subject, the mothers were either unwilling to discuss menstruation or would cite preoccupation with household chores as reasons not to attend the mothers’ group meetings or to allow their daughters to attend the AGG meetings. The prevalent culture of silence, and obliviousness, further compounded this reluctance to talk about such issues or to be part of platforms that encouraged such discussions. It was only through persistent engagement and interactions that the community gradually began to appreciate the importance of MHM and saw merit in such discussions.

**Limited Involvement of Fathers**

Although the GARIMA project has tried to engage with fathers, PEs and FFs related that it did not take place as planned. Opportunities to engage with fathers were few given that they were not willing to spare time for GARIMA meetings. Moreover, the project could not ensure regularity in attendance of fathers. Evidence suggests that most fathers attended only one meeting.

**Limited Scope for Wider Dissemination of Audio-Visual Material**

The audio-visual material developed under the project in the form of films and videos was widely appreciated by the audience. Even after a year since the closure of the project, most participants could recall these films and videos and appeared to be inspired by them. However, these materials could only be shown to them by the FF on her device. More than 50 per cent of the adolescent girls and PE reported lack of access to mobile phones where they could watch these videos. Due to this, dissemination of audio-visual material has been limited and could not be implemented as envisaged. In fact, some of these videos, as reported by the FFs, could only be shown to the intended audience in the latter phase of the project’s implementation due to a lack of adequate equipment (i.e. devices and the necessary electric connections where meetings were held).

**Lack of Effective Monitoring Mechanisms**

While concurrent morning played an important role in resolving issues during the course of implementation of the project, absence of a robust MIS database that captures individual level participation or the timely provision of PE registers, may have limited the usefulness of such data in aiding quick decision-making at the programmatic level with regard to both the actual implementation of the project as well as requisite improvisations and stratification of sample for the assessment of the project.
Lack of Support from FLWs

While the FLWs, towards the last quarter of the project, were trained and handed over the responsibility for carrying forward the activities under the project, there was a visible lack of initiative on the part of FLWs as revealed by the FFs. Of those who exhibited some interest, support was rendered in terms of offering space for the meetings (AWC) and being part of the meetings. Facilitation of meetings was always seen as the responsibility of the FFs.

Attrition of PEs and FFs

PEs and FFs played a central role throughout the project in holding meetings and conducting activities with the adolescent girls and other stakeholders. However, there have been a few instances of attrition among PEs and FFs during the course of the project. This could have impacted the cohesiveness of the groups and the confidence that was built in the community which was closely linked to and reliant upon the personality and charisma of these leaders and facilitators. Interactions with NGO partners such as SARTHAK and MDSS in Mirzapur ascribed the PE attrition rate of between 20 and 40 per cent to marriage and higher studies, which affected the functioning of the AGGs.

Changing Priorities of the GoI Programmes and Deficient Resources

The chief platform for scaling up the project learnings and outcomes was the RKSK programme that was operational in Mirzapur and Sonbhadra. However, interactions with implementing NGO partners and a review of the documents revealed a lack of priority and a deficiency of budget under RKSK for UP, which consequently impedes the continuity of the project elements concerning MHM that align with RKSK.

6.3. Unexpected Findings

The GARIMA project, through its endeavour to enhance knowledge and dialogue around menstruation towards fulfilling the overarching goal of adequate MHM, has also led to some achievements that expand the scope of the project beyond MHM.

Seizing the Future: Creating Responsible Citizens

Participation of adolescent girls in AGG meetings contributed to increased self-confidence and self-efficacy among them. Their exposure to films, videos and other IEC material distributed under the project, combined with their discussions with PEs, FFs and FLWs have contributed to enhanced social consciousness among AGs. In several instances, girls who had been a part of the GARIMA project have approached village heads and other authorities for resolution of issues. It is evident that the project has encouraged young girls to identify issues that affect their well-being and empowered them to think about plausible solutions to resolve these issues. Such exposure and advancements in personality carry strong potential for a ripple effect in terms of the growth and development of adolescent girls, much beyond the scope of MHM. Girls who have been part of the project and thus more aware and confident are more likely to exercise their knowledge and efficacy to achieve more in all walks of life. They will emerge as responsible citizens for the future who can take charge of their own lives.

Empowering Women through the GARIMA Project

FFs involvement in the project has contributed to their empowerment and strengthening of their overall position in society.
During IDIs in Jaunpur, one of the FF’s mothers shared how she felt proud that her daughter did not succumb to societal conventions imposed upon women (something which she could never think of as a young woman) and was doing such incredible work for young girls. Undoubtedly, it has not been easy for the mother to defend her daughter’s choice. However, both mother and daughter feel extremely proud about their choices and intend to carry on this way.

Other FFs have also shared that they are now much more confident speaking in public forums and organising events and meetings. The project also led to increased mobility for these women. One of the FFs in Sonbhadra shared the following story as her personal achievements from the project. Previously, she said, she relied on her husband to take her around for her work, losing out on precious time. This compelled her to learn how to ride a scooter and today she feels extremely proud to own her own vehicle that she can drive wherever she wants. She says if it was not for this job she would have never thought of riding a scooter and going around on her own.

Such experiences reflect that the project has gone a long way in infusing a greater sense of self-confidence among women and has significantly contributed to their personal growth and well-being.

**Extending Benefits beyond the Targeted Communities**

The project has also contributed towards influencing changes in attitudes towards menstruation, MHM behaviour and associated social norms and restrictions amongst a wider audience than what was envisaged under the project. It was reported by several FFs that the project contributed to an increase in their own knowledge around menstruation, leading to changes in MHM practices among them. It also appears on several occasions that FFs have shared what they learned with their families. Some of them even described instances of inviting their mothers-in-law and sisters-in-law to attend the GARIMA meetings, and how these meetings sensitised their family members to various aspects of menstruation including the frivolousness of certain social norms and restrictions associated with menstruation leading to non-adherence to such obsolete practices.

**Benefits to Implementers**

The PEs and FFs listed several ways in which being part of the project had contributed to their personal growth and enhancement of their knowledge. Besides being accorded greater respect within the community, increased awareness and mobility remained the most significant ways in which the project positively impacted the PEs and FFs. Being part of GARIMA had further boosted their confidence to speak up on issues concerning menstruation, a confidence that stemmed from their own improved knowledge on MHM practices.
7. Lessons Learned and Recommendations

7.1. Lessons Learned
The evaluation highlighted several learnings which may have a bearing on the replication of the project or the design of similar interventions focusing on adolescent health, particularly MHM. Some of these are summarised below:

a) The creation of safe spaces for adolescent girls, such as AGGs, by enlisting support from key community functionaries and family members enables them to come together to discuss their issues and to negotiate with families and the community so that they can be addressed.

b) Investing in the PE model ensures that AGs have a trusted peer with whom they can discuss issues pertaining to menstruation.

c) Interventions that focus on MHM are likely to be most effective in meeting their espoused goals and objectives when combined with behavioural and attitudinal change components as well as infrastructure provision. Increased awareness among adolescent girls leads to an increase in demand for various services, including the construction of toilets and the provision of MHM products so that they can safely manage their periods.

d) Prevalence of social norms results in a high level of internalisation of behaviours and adherence to certain restrictions related to MHM, as was observed amongst adolescent girls. Although it is easier to transgress certain restrictions, such as those pertaining to diet and clothing, religious restrictions remain sacrosanct in the community. While SBCC interventions enhance self-efficacy amongst adolescent girls in breaking away from certain restrictions, addressing restrictions that are more rigid in nature requires the conceptualisation of MHM within gender transformative approaches with a focus on specific gender norms in the community.

e) The creation of a conducive environment for MHM requires the initiation of conversations and dialogue not only at the individual level but also at the community level, especially due to the interlinkages between MHM and restrictive social norms. SBCC interventions, found to be an effective mechanism in breaking the silence around MHM, need to also include consistent intervention with the larger community and extended family members in order to foster a favourable environment for MHM.

f) FLWs in the rural context are valuable service providers in catering to the health-related needs of adolescents. Consistent upgrading of their knowledge pertaining to the sanitation and hygiene needs of adolescents through periodic refresher trainings strengthens their role as key catalysts in influencing adequate MHM.

g) An SBCC strategy to promote adequate MHM formed the core of the project. Communication packages and materials developed under the project were found to be effective in influencing behavioural changes. However, while the project commenced in the year 2014 in certain districts, communication materials were received only in the year 2015. This was compounded by a further delay in the availability of devices for showcasing the materials, leading to limited exposure to these communication packages.
SBCC interventions premised upon audio-visual packages require timely disbursement of these materials with adequate logistical support in order to achieve effective messaging and their recall over a longer period of time by the target groups.

7.2. Recommendations
Based on discussions held with project stakeholders, NGO partners and extensive review of project documents, the following recommendations which also echo stakeholder perspectives could be considered for future programming decisions concerning issues affecting adolescents.

**Recommendations for the Government**

- Findings from the evaluation demonstrate that the PE model coupled with necessary investments in training and handholding of PEs, capacity building of PE mentors along with communication and training package developed under the project, creates avenues for adolescent girls in the community to discuss MHM. Given that programmes such as RKSK promote menstrual hygiene through facility based services such as clinics and counselling, it is recommended that government considers replicating and scaling up the PE model. It is further recommended that the communication and training packages be used in similar contexts with adequate investment in handholding of PEs as well as periodic refresher trainings for on ground implementers comprising FLWs.
- Systematic budget analysis to determine allocation and utilization of funds to adolescent programmes is recommended, with funds specifically earmarked for the delivery of such programmes.
- Inter-departmental convergence remains of utmost importance in the formulation and implementation of MHM policies and programmes since the subject of MHM itself is marked by several cross-cutting involving nutrition, WASH, education and gender. Establishment of synergies between concerned departments and ministries for prioritization of policies, resource allocation and programming is therefore suggested for fine-tuning MHM interventions.
- Social capital created under the project, such as AGGs and PEs, the field facilitators, can be linked to programmes such as RKSK, ICDS, and NSS etc. Few ways in which this could be accomplished are as listed below:
  - Under RKSK, Ministry of Health and Family Welfare and concerned state departments can utilise AGG members and PEs towards mobilization of adolescent girls and awareness generation around menstrual hygiene and safe disposal practices during Adolescent Health Days (AHD) organised at the village level and through Adolescent Friendly Health Clinics (AFHC) and counselling services established at the block level under RKSK.
  - Under ICDS, Ministry of Women and Child Development and Health Department, along with AWWs, ASHAs and ANMs can seek support from the PEs and AGG members in utilising village level platforms such as VHSND to give out MHM related information to adolescent girls with a focus on out of school adolescents.
  - Similarly, NSS student volunteers can be utilised by the central government (Ministry of Youth Affairs and Sports) to bring together student peers and community members in raising awareness around MHM by integrating training sessions on MHM into NSS events and camps.
Recommendations for UNICEF/ NGO Partners

- In future projects with similar focus on MHM and adolescent girls, it is recommended that the national and state programme teams of UNICEF and concerned partner organizations brand MHM in broader terms as normal part of womanhood through the following ways:
  - Positively influencing the attitudes of family members, especially mothers and fathers to address regressive gender norms and taboos.
  - Addressing social norms pertaining to MHM at the community level through conceptualisation MHM within gender transformative norms through promotion replacement behaviours and attitudes with regard to MHM and gender that are both desirable as well as rewarding.
  - Towards addressing prevalent social norms and restrictions around menstruation, future projects should also utilise community dialogue forums through mobilization activities such as theatre performances, nukkad-natak, video-vans etc; and leveraging community level platforms such as Self-Help Groups (SHGs) for creation of a supportive environment for MHM in the community.
  - Community level activities such as these should also be utilised for focused interventions with fathers on aspects around their role in ensuring adequate nutrition, provision of safe spaces and other resources for adequate MHM since reaching out to fathers at the family level remains challenging especially in Uttar Pradesh that reports high levels of migration amongst menfolk.
- One of the needs recognized by the project was the requirement of career counselling as expressed by adolescent girls. In future projects, especially those with adolescent girls, career counselling and age appropriate skill/ vocational training should be used both as a topic for gaining entry into the community as well as meeting the needs of adolescent girls. Resource centres like those in GARIMA project should be used as spaces for career counselling and vocational training for adolescent girls through provisioning of necessary resources.
- Considering the usefulness of the SBCC model developed by the GARIMA project, it is recommended that the project/ similar projects links itself with various government programmes besides RKSK such as SBM, ICDS etc. to utilise potential avenues built within these programmes that endorses MHM. While drawing such linkages, UNICEF should also pitch with those government programmes which have some degree of outcome-based similarity, adequate resources and remain top priorities for the government. One such programme could be SBM wherein integration of AGGs as members of surveillance committees under SBM provides evidence for the scope and potential of such convergence.
- Addressing restrictions around MHM solicits a two-pronged approach that differentiates between personal (clothing) and social (mobility, diet) restrictions. While the former would require a behaviour change focus, the latter requires a norm-based approach. Before restrictions can be addressed programmatically, it is recommended that SBCC interventions under projects such as GARIMA focus on building confidence and efficacy of adolescent girls to enable them to articulate such restrictions.
- It is recommended that in future projects of this nature (communication/ SBCC) and scale, an online MIS system that can generate real time reports for managers at different levels should be designed and implemented. The MIS must collect and use data at the
basic unit level i.e. at the project participant level so that the data validity as well as its usefulness can be improved.
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End line Evaluation of GARIMA Project in Uttar Pradesh (UP): Evaluation Report


