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YouthPower Action

Integrating Workforce and Reproductive Health
Interventions for Improved Youth Outcomes

Final Study Report

February 2020

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This publication was produced for review by the United States Agency for International Development. It was prepared by Carina Omoeva, Geeta Nanda, Sarah Gates, Nina Cunha, Rachel Hatch, and Reana Thomas of FHI 360.

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Acronyms

BPO	Business Process Outsourcing
CM	Community Mobilizer
CPD	Community Participation and Development
CPR	Contraceptive Prevalence Rate
CRBP	Childs Rights Business Principles
DiD	Difference in Differences (analytical approach)
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HOTS	Higher Order Thinking Skills
HTSP	Healthy Timing and Spacing of Pregnancy
ICT	Information Communication Technology
IDI	In-Depth Interview
IP	Implementing Partner
IRB	Institutional Review Board
KASI	Knowledge, Attitudes, Skills, Intentions
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation, Learning
MHM	Menstrual Hygiene Management
PHSC	Protection of Human Subjects Committee
PMTCT	Prevention of Mother-to-Child Transmission
PYD	Positive Youth Development
SEEP	Social and Economic Enhancement Programme
S2S	Skills to Succeed
SOP	Standard Operating Procedure
FP/RH	Family Planning and Reproductive Health
STI	Sexually Transmitted Infection
SUF	Society for Underprivileged Families
USAID	United States Agency for International Development
WfD	Workforce Development
WPIP	Work Place Improvement Plans
YFHS	Youth Friendly Health Service(s)
YP	YouthPower
YP Action	YouthPower Action

Executive Summary

Introduction, Background, and Study Summary Building on a review of integrated youth workforce development (WfD) and family planning and reproductive health (FP/RH) interventions (Rutherford et al., 2017), this study, commissioned by USAID through YouthPower Action, investigates two major research questions:

- 1) Does integrating WfD and FP/RH components facilitate stronger workforce and FP/RH outcomes than a WfD intervention alone?
- 2) How does integration take place? What are the associated challenges, best practices and solutions?

YouthPower Action carried out this study in the context of the Skills to Succeed (S2S) program, implemented by Save the Children and three local partners in the slums of Dhaka, Bangladesh, with youth (16–24 years old) program participants who have at least an eighth-grade education. Over about a year, each cohort of youth goes through the following training modules: (Quarter 1) intensive employability and soft skills training; (Quarter 2) training in technical field; and (Quarters 3–4) opportunity to work with a mentor. For a randomly selected subsample of the youth clubs, additional Family Planning and Reproductive Health (FP/RH) content was integrated into the employability skills curriculum, as part of the randomized controlled trial design.

The study design included two major components: 1) a panel cluster-randomized **impact evaluation** with two cohorts of youth and 2) a qualitative **process evaluation**. The impact evaluation investigates research question 1, with the objective of determining if improved workforce and FP/RH outcomes are observed among youth participants in the integrated WfD and FP/RH study arm compared with youth participants in the workforce-only study arm. The process evaluation investigates research question 2, with the goal of understanding how the FP/RH and WfD components were integrated, what challenges integration brought up, and how these challenges were addressed.

Impact Evaluation The impact evaluation was designed to address research question #1 above, through an experimental design with randomization at the youth club level (15 clubs each in treatment and control), for two cohorts of youth. The treatment group received 40 hours of additional FP/RH content as part of their employability skills training; while the control group participants received the default S2S employability skills program intervention. For each cohort, sampled youth were surveyed at baseline (the month prior to intervention), mid-line (4 months after baseline, immediately following the completion of the FP/RH curriculum), and endline (13 months after baseline) to capture changes in workforce and FP/RH outcomes. Individuals were tracked throughout the study, forming a panel of 1,861 linked observations (out of the original sample of 2,100).

In short, the evidence on RQ #1 is inconclusive. We do not find support for the hypothesis that the integration of WfD and FP/RH facilitates stronger workforce and health outcomes than the WfD intervention alone. Without accounting for differences by gender, implementing partner, or cohort, impact evaluation findings reveal statistically significant effects for only two outcomes: positive identity and having ever tested for HIV. “Positive identity,” as part of the soft skills measurement, was negative at midline and endline, with the effects almost entirely coming from female participants. This is largely due to the control group “catching up on” the treatment group youth, however, rather than any actual decline of measured soft skills levels among youth in the treatment arm. The probability of having ever

tested for HIV was greater for the treatment group only at endline. The analysis also found substantial increases in contraceptive knowledge and reporting they have discussed contraception with their partner, at midline; however, those effects did not persist through endline. No statistically significant treatment effects were registered for workforce-related outcomes, including employment, income, strategies employed for finding employment, and job satisfaction. Some of the lack of treatment effects may be due in part to the similarity across the dynamics in outcomes in the two treatment arms, with control youth clubs in some cases showing similar or higher increases in outcomes. Missing data substantially affected analysis of employment status and income, as many youth still in the program reported “not applicable” to those outcomes while enrolled in youth clubs.

Generally, point estimates and variability ranged substantially across local implementing partners, indicating that implementation played a substantial role, even with a consistent set of materials and training.¹ Finally, while attendance appeared to have improved over time, based on data from one of the implementing partners, effects on contraceptive methods knowledge were more pronounced in the first cohort of the study, and much less so in the second cohort.

Limitations around the impact evaluation include the lack of ability to examine effects on workforce outcomes, particularly employment and income, due to the structural limitations and time span of the program. Additionally, the soft skills metrics applied in the evaluation did not go through full validation in Bangladesh prior to application as part of the evaluation survey, so may not be fully reflective of the true changes, or lack thereof, in soft skills in the study youth sample.

Process Evaluation. The process evaluation applied a range of methods—in-depth interviews (IDIs), key informant interviews (KIs), and focus group discussions (FGD)—to gather data from program implementing staff, youth club facilitators, and youth beneficiaries. YouthPower Action conducted 12 FGDs with male and female youth, 12 IDIs with youth (male and female, married and unmarried), and a follow-on round of 12 IDIs with married only male and female youth. YouthPower Action also conducted two focus groups (one from the treatment arm and one from the control arm) with “community mobilizers,” or the session facilitators, and two focus groups (one from the treatment arm and one from the control arm) with peer leaders (youth program participants that play an assistant role to the community mobilizer).

The analysis approach for the process evaluation included multiple iterative stages, beginning with content analysis of FGD and IDI data captured in verbatim transcripts uploaded to NVivo. YouthPower Action drafted a codebook in advance of the qualitative analysis (deductive approach) and revised as coding progressed (inductive approach). Inter-coder reliability among two qualitative analysts was checked with the first few coded transcripts, and the codebook was revised as necessary. Themes were identified, and second level coding was conducted as appropriate to better understand sub-themes and

¹ It is important to remember that the differences between the IPs are not to be interpreted as evidence of poor implementation. Like overall treatment effects, the treatment effects by partner are intended to capture differences between the workforce arm (control group) and the workforce + FP/RH arm that received the additional 40 hours of FP/RH content. Because the IPs are located in different areas around Dhaka, some of the differences between treatment arms within an IP may be explained by the ways that youth from the different communities responded to the FP/RH arm, compared to the ways they responded to the general WfD intervention offered to everyone. The research team was informed that IP2 is located in a more remote area, serves highly vulnerable youth, and that the community where it operates suffered two major fires during the time of the study.

investigate emergent themes. Throughout analysis, the team prepared thematic memos and discussed results among the study team. Emerging findings were shared with Save the Children and the local IPs.

Findings from the process evaluation fall into several key categories:

- 1) Youth-reported learning in terms of family planning, contraception, puberty, menstruation, and HIV/AIDS;
- 2) Youth-reported additional program benefits, including overcoming discomfort with FP/RH topics; feeling better able to seek help for FP/RH issues in the future; becoming more effective advocates—and sometimes self-advocates—on the issues that women and girls face;
- 3) Youth recognizing the importance of FP/RH component for negotiating safe working environments and making decisions that support their health and productive engagement in the workplace;
- 4) Youth recommendations for the FP/RH component, which center largely on the length and to a lesser extent on the sequencing of content.
- 5) Implementation challenges and highlights, including
 - Challenges in recruitment of staff for the FP/RH component; and
 - Challenges to recruitment and retention, largely stemming from community receptivity (or lack thereof);
- 6) Successes and challenges in FP/RH content delivery, with a focus on gender dynamics and rapport among staff and participants; and
- 7) Other challenges, including with the club environment, community mobilizers' attendance, divisions related to marital status and age, and inconsistency among clubs in following the planned schedule.

The findings from the process evaluation imply several key takeaways. Specifically:

Sessions on puberty and menstruation were reported to be more immediately useful than other topics, like family planning, contraception, and HIV/AIDS, though youth do plan to use those topics in the future, especially when married.

- 1) Youth reported overcoming their discomfort discussing FP/RH topics and feeling better prepared to discuss and seek help for FP/RH challenges in the future.
- 2) The integrated program faced real challenges recruiting and retaining youth, some of which seems to be directly related to discomfort with FP/RH topics.
- 3) Materials need review and potentially revision, given the challenges discussants report in understanding the language used in the materials.
- 4) Participants recommend that the FP/RH component be shortened to allow more time for vocational training; yet FP/RH outcomes—especially as seen in the impact evaluation—are already limited. This suggests that genuine integration of the FP/RH component of the program into the workforce component might both make the program more useful and help youth see it as useful.

Linking the Impact and Process Evaluations. Taken together, the findings from both evaluations provide a more complete picture of the integrated FP/RH/WfD program, and generate additional questions and lessons learned. The findings from the impact evaluation are inconclusive: despite initial growth in the integrated program (treatment group), on some outcomes, none of the outcomes hold over time. The process evaluation complicates this story by revealing areas where the integrated

program added value for youth. For example, there are indications that youth benefited from knowledge about puberty, menstruation, and related nutritional practices. In focus groups, youth also reported overcoming discomfort with FP/RH topics and building their ability and confidence for seeking solutions to FP/RH challenges that arise later in their life (confidence discussing problems/seeking solutions at clinics, discussing problems with friends and family). In other words, **youth may not leave the program with substantially improved knowledge on FP/RH topics, but they leave better equipped to identify when they need more knowledge and able to seek it out.** In addition to these findings, the combination of implementing partner effects and qualitative input from the process evaluation point to the importance of implementation and the variability that can affect outcomes even with uniform content and delivery model.

Introduction

Background

In 2016, to facilitate a more robust evidence-base of cross-sectoral youth approaches, YouthPower Action (Contract No. AID-OAA-I-15-00009/AID-OAA-TO-15-00003) consulted with experts and conducted an extensive review of integrated youth workforce development (WfD) and family planning and reproductive health (FP/RH) interventions. The findings from this review are presented in the *Assessment of Integrated Workforce Development and Sexual and Reproductive Health Interventions with Recommendations for the Future* (<http://www.youthpower.org/resources/assessment-integrated-workforce-development-and-sexual-and-reproductive-health>).

The review (Rutherford et al., 2017) demonstrated that integrated WfD and FP/RH programs can promote positive long-term outcomes for youth. However, the review found no impact evaluations that compared the outcomes of integrated programs to those of single-sector WfD or FP/RH interventions alone. To address this gap, YouthPower Action conducted an impact evaluation to examine outcomes of youth participating in a WfD only intervention with youth participating in an integrated WfD and FP/RH intervention. By testing “with” and “without” integration, we help fill a gap in the literature that largely examines the effects of different features of integrated WfD and FP/RH interventions. Impact evaluation findings will potentially assist policymakers and program designers to make better choices vis-à-vis youth wellbeing.

The literature review paper uncovered little information about *how* programs integrate WfD and FP/RH interventions for youth. To address this gap, YP Action included a process evaluation to the study of WfD/RH integration, to explore and document learning such as what worked well and what did not, and what changes were made to mitigate problems. The process evaluation helps answer several “how” questions that can guide implementers and program designers to make more efficient, effective and, hopefully, cost-effective design choices.

To carry out this study, YP Action collaborated with Save the Children on their Skills to Succeed (S2S) program² in Bangladesh, which initially included only a WfD intervention. YP Action worked with Save the Children and supported their S2S program to integrate FP/RH into the WfD intervention so that YP

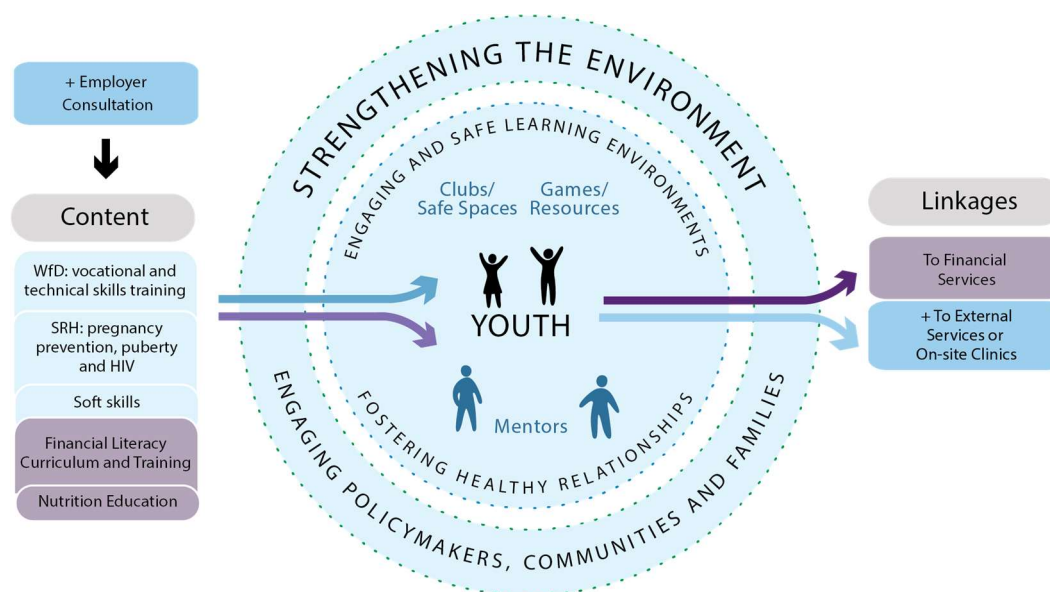
² Section 1.1 below provides more details on the S2S program.

Action could conduct the *Integrated for Youth* study (i.e., comparing outcomes in the WfD only intervention to the integrated WfD and FP/RH intervention).

Theory of Change

Stemming from the literature review, the theory of change for this study is shown below in Figure 1 and presents a holistic model for integrated WfD and FP/RH programming that builds on the evidence, incorporates external evidence on best practices, and aligns with the domains of positive youth development (PYD): (1) building skills, assets, and competencies; (2) fostering healthy relationships; (3) strengthening the environment; and (4) transforming systems.

Figure 1. Theory of Change



At the center of this theory of change are skills- and knowledge-building activities, as well as opportunities to build positive relationships with the support of mentors in the context of an engaging and safe learning environment. The delivery of activities in a group setting—such as a safe space, youth club, or savings group—provides a space for young people to interact with each other and build relationships. The incorporation of play/learning resources can create a social environment where youth support each other to learn and to change, thereby reinforcing new knowledge and behaviors.

Strengthening the enabling environment (in the second circle of the theory of change) includes engaging families, community members, and key stakeholders through engagement to shift norms and create a supportive environment for youth wellbeing. Approaches include interpersonal communication, radio messaging, and group-based discussion and reflection. Linkages to financial and FP/RH services appear to the right of the theory of change. Some of the most successful interventions sought to increase access to financial services such as banks or savings groups.

The Theory of Change posits that stronger knowledge and skills, including better ability to make decisions on their wellbeing, stronger interactions with communities and ability to engage more productively in the labor market, would then lead to improved youth outcomes such as employment,

ability to negotiate and make healthy family planning decisions, and reduced risk of HIV infection through increased testing.

As mentioned above, this study sought to test the hypothesis that an integrated WfD and FP/RH intervention facilitates stronger workforce and FP/RH outcomes for youth than does a WfD intervention alone. Per the recommendations from the literature review, integrated WfD and FP/RH programs are most successful when they take a holistic PYD approach by reinforcing the following PYD features (which were the same in both study arms):

- Implementing vocational/technical skills training and curricula-based FP/RH education,
- Integrating soft skills development,
- Providing opportunities for youth to interact with each other and mentors to build positive relationships in an engaging and safe learning environment,
- Engaging family, community members, and policymakers, and
- Offering additional features, in some contexts, such as financial literacy, links to financial services, nutrition education, and FP/RH behavior change communication.

Skills to Succeed (S2S) Program Description

The Skills to Succeed (S2S) program is implemented by Save the Children in the slums of Dhaka, Bangladesh (see map below), and 300-partnered workplaces. Youth program participants are between 16–24 years old, with an average age of 19, and have at least an eighth-grade education. Save the Children implements the S2S program in collaboration with three local partners: Community Participation and Development (CPD), the Society for Underprivileged Families (SUF), and the Social and Economic Enhancement Programme (SEEP). The program offers training for youth through a network of youth clubs, established as training center hubs. Training content includes general employability, occupational health and safety, and gender sensitivity training, in addition to career counselling (and FP/RH training in study arm 2; see below for topics' list).

Every quarter, S2S begins working with a new cohort of youth for up to one year as follows:

- Quarter 1: intensive employability and soft skills training,
- Quarter 2: training in technical field (Information communication technology/business process outsourcing; ICT/BPO),
- Quarters 3-4: opportunity to work with a mentor.

Workforce sessions are facilitated by community mobilizers, who are staff hired by the Implementing Partners. For a randomly selected subsample of the youth clubs, additional Family Planning and Reproductive Health (FP/RH) content was integrated in the employability skills curriculum, as part of the randomized controlled trial design (see Table 1 below). The FP/RH sessions were facilitated by separately recruited community mobilizers, ideally with training and/or experience with youth FP/RH. In addition to the community mobilizers, peer leaders—youth program participants who are nominated by their peers—play an assistant facilitating role.

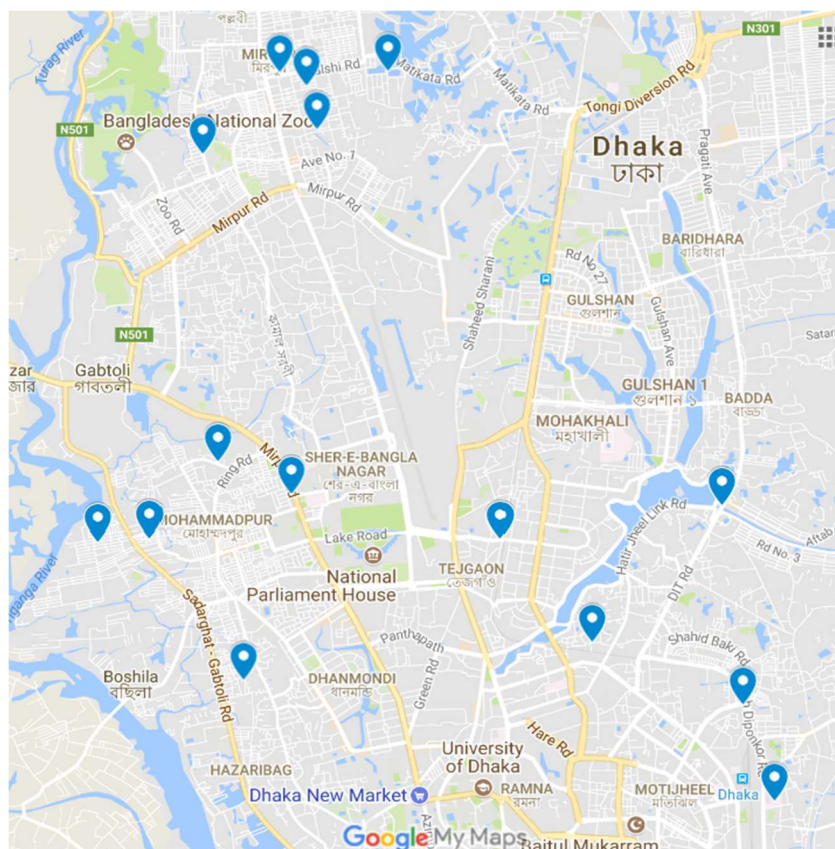
Workforce Topics	FP/RH Topics
<ul style="list-style-type: none"> • Who I am (e.g., sessions on positive qualities, identity, interests and preferences, and skills and qualifications) • Where I want to go (e.g., sessions on dreams and aims in life, goals and actions, leadership) • How I get there (e.g., sessions on social skills, positive relationships, conflict resolution, effective communication) • Job search skills • English language skills • Mathematics skills • Occupational health and safety 	<ul style="list-style-type: none"> • Menstrual hygiene management (females only) • Nutrition awareness • Adolescent FP/RH • Human body • Puberty • Pregnancy prevention • STIs/HIV • Relationships • Sexuality and sexual behavior • Gender

Table 1. Stand-alone and integrated program features mapped to the Positive Youth Development (PYD) domains

PYD Domain	Program Feature	Key Activities for Study Arm 1: Workforce only intervention	Key Activities Study Arm 2: integrated WfD + FP/RH intervention
Assets	Training: Interpersonal Skills Higher Order Thinking Skills Self Control	60 hours of employability skills training, 3 months of vocational training	60 hours of employability skills training, 3 months of vocational training, 5 hours of MHM training (only females), 30 hours of YFP/RH training, 5 hours of nutrition awareness (40 FP/RH/nutrition hours)
Agency	Positive Identity Self Efficacy Goal Setting Positive Beliefs about the future	60 hours of employability skills training (personal and professional) mentoring, Participation in youth clubs	60 hours of employability skills training (personal and professional) and 30 hours of YFP/RH training, Participation in youth clubs
Contribution	Youth leadership	Peer trainers	Peer trainers
Enabling Environment	Supports	Mentoring, job linkage services, MHM activities in the workplace	Mentoring, job linkage services, FP/RH linkage services, MHM activities in the workplace
	Healthy relationships	Mentors; peer mentoring	Mentors; peer mentoring
	Opportunities for pro-social involvement, belonging and membership	Participation in youth clubs	Participation in youth clubs
	Value and Recognition	Selection and training of youth peer leaders to run youth clubs	Selection and training of youth peer leaders to run youth clubs
	Positive norms, expectations and perceptions	Employability skills training (personal and professional)	Employability skills training (personal and professional) and YFP/RH training
	Safe spaces (physical and psychological)	Occupational Health & Safety training, improved workplaces by employers, participation in youth clubs, mentorship	Occupational Health & Safety training, improved workplaces by employers, participation in youth clubs, mentorship

PYD Domain	Program Feature	Key Activities for Study Arm 1: Workforce only intervention	Key Activities Study Arm 2: integrated WfD + FP/RH intervention
	Access to youth and gender responsive, appropriate services	Engagement with employers to improve workplace conditions	Engagement with employers to improve workplace conditions, Referrals to youth friendly FP/RH services

Figure 2. Map of Youth Clubs



Impact Evaluation

Study Summary

This study sought to test the hypothesis that an integrated WfD and FP/RH intervention facilitates stronger workforce and FP/RH outcomes than a WfD intervention alone. This study will help fill a gap in the literature that largely examines the effects of different features of integrated WfD and FP/RH interventions. Impact evaluation findings will help policymakers and program designers to make better choices vis-à-vis youth development programming.

This study design involved two major components: 1) a panel cluster-randomized impact evaluation with two cohorts of youth and 2) a qualitative process evaluation. The **sample** for both components consisted of 30 youth clubs across two cohorts of youth, with a total sample frame of 2,700 participants. For the impact evaluation, **2,100** youth were paneled from the total sample frame of 2,700. The sampling strategy involved randomizing participants by youth club. The baseline survey was implemented in the two weeks prior to treatment. Midline was implemented four months after the baseline (the month after the first 3-month intensive training, including the FP/RH module). Endline was implemented 13 months after baseline (about 12 months after treatment began, and approximately three months after the completion of the FP/RH module). Youth were enrolled in S2S up until the start of the endline survey, participating in the vocational training modules. For the process evaluation, YP Action randomly selected youth clubs per implementing partner for focus groups and purposefully sampled youth within youth clubs to meet stratification criteria (see Table 8 – Table 10). To be included in either component of the study, youth had to be between 16–24 years old, participants in the Skills to Succeed (S2S) program,³ and have provided consent to participate in the study.

The primary objectives of the impact evaluation were to determine if improved workforce and FP/RH outcomes are observed among youth participants in the integrated WfD and FP/RH study arm compared with youth participants in the workforce-only study arm. The primary objectives of the process evaluation were to understand how the FP/RH and WfD components were integrated, what challenges integration brought up, and how these challenges were addressed.

Study Design

YP Action employed an experimental design with randomization of youth clubs (cluster randomization). Each of the clubs hosted several youth groups; however, youth cannot be randomized individually or by youth groups, because the youth clubs are geographically located within their neighborhoods, and intervention activities involve all youth enrolled in a club. Each youth participant enrolled in the study was surveyed at baseline (the month prior to intervention), mid-line (4 months after baseline), and endline (13 months after baseline) to capture the following:

- Knowledge, Attitudes, Skills, and Intentions (KASI) and behavior changes in workforce and FP/RH outcomes;
- Demographic information; and
- Information on program participation

Youth clubs were randomly assigned into the WfD only study arm 1 or the integrated WfD and FP/RH study arm 2 as follows, according to study arm and implementing partner (IP):

³ S2S eligibility includes those who have completed at least Junior Secondary Education (grade 8) living in the slums in Dhaka, Bangladesh.

Table 2. General Stratification: Youth Clubs by Treatment and Control Status and Implementing Partner, Cohorts 1 and 2

Cohort 1				
	IP1	IP2	IP3	# youth clubs
Treatment	3	2	3	8
Control	2	3	2	7
Total # Youth Clubs	5	5	5	15
Cohort 2				
	IP1	IP2	IP3	# youth clubs
Treatment	2	3	2	7
Control	3	2	3	8
Total # Youth Clubs	5	5	5	15

While all 30 youth clubs (from both cohorts) are included in the impact evaluation, only 60 out of 90 youth participants from each youth club are randomly selected for the impact (panel) evaluation.

Attrition

Of our original sample of 2,100 youth, only 14 participants were not present at midline, and 225 were not present at endline.⁴ Because there is no correlation between attrition and treatment status, the study does not control for attrition in our main impact evaluation results. Table A. 2 in the appendix contains summary baseline statistics of the attrited and non-attrited segments of our sample. Findings show that women, older youth, and youth who reported ever having sex are more likely to drop the sample at endline (see Table A. 2 in the Appendix), which could imply that the estimated results are only valid for the type of youth that are less likely to drop from the sample.

Survey Outcomes

Outcomes are listed below and presented in more detail in Table 3.

- Primary FP/RH outcome: intention to use contraception
- Secondary FP/RH outcomes: contraceptive knowledge; contraceptive use; use of a modern method
- Primary WfD outcome: income, job satisfaction

Secondary WfD outcomes: employment seeking knowledge and behavior; social-emotional learning (positive identity, self-control, higher-order thinking skills, social and communication skills). New employment was not selected as a primary or secondary outcome, due to the short-term nature of the program and the focus on skill development. However, likelihood of employment was included in analyses as an outcome of interest.

⁴ Of the 14 participants not present at midline, 6 did also not respond to the endline survey, and 8 did respond.

Table 3. Survey Outcomes

Survey Outcome	Survey #	Variable construction
WfD Outcomes		
Monthly income	C03 &04b;	Variable adjusted to reflect payments in months (using C04a) and only current monetary payments are considered. Income = income employment + income business
Job Satisfaction	C15	Job satisfaction (dummy variable using C15, equals ==1 for very satisfied and satisfied and ==0 otherwise)
Job seeking knowledge/skills	C07	# Strategies job hunt =number of strategies used to look for jobs (count # of strategies selected in C07)
Positive identity	L01-L22	Positive identity (continuous variable containing the average all variables).
Self-control	L23-L35	Self-control (continuous variable containing the average all variables).
Higher-order thinking skills	L36-L46	HOTS (continuous variable containing the average all variables).
Interpersonal & communication skills	L47-L60	Interpersonal & communication skills (continuous variable containing the average all variables).
FP/RH		
Intention to use contraception in the future	F32	Intention to use contraception (dummy variable, ==0 if F32=NO, ==1 if F32=YES)
Modern contraceptive knowledge	F01-F07 and F10	Contraceptive knowledge (continuous variable created from variables F01-F07 and F10, counting the proportion of contraceptive methods known “spontaneously” AND “recognized”)
HIV/STI knowledge	G01-G09.d	HIV knowledge (dummy variable, ==1 If G02=G05=G08==Yes & G04=G06==no; ==0 otherwise) HIV knowledge (dummy variable, ==1 if G09.a=G09.b=G09.c== G09.d==1, ==0 otherwise)
Attitudes toward gender equity	I01-I10	Gender equity (continuous variable created from averaging items I01-I10 after recoding them to have the same direction so that gender equitable response is given a score of 1 and if not, score of 0.)
Comfort communicating about contraception with partners	F29.a	Comfort communicating partners (dummy variable using F29.a, equals ==1 for very comfortable and ==0 otherwise)
FP communication with partner/family (with partner, friends, MIL)	F30	Discussed contraception (dummy variable using F30, ==1 for yes, ==0 for zero)
Ever been tested for HIV	G10	Ever tested for HVI (dummy variable using G10, ==1 for yes, ==0 for zero)
Current use of modern contraception	D13	Use modern contraception (dummy variable using D13, ==1 if D13 = 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 OR 14, ==0 otherwise)

Descriptive Statistics and Pre-Treatment Balance

Table 4 presents the average youth characteristics by treatment status at baseline. Overall, 60% of the youth are male, with an average age of 18.8 years old, living in a house with an average of 4.7 people. Five percent report being head of household. In the control group, 9% are currently working and 55% are looking for employment. In terms of the FP/RH behaviors, 7% reported they already had sex, 2% reported they were already tested for HIV, and 31% reported they already visited a health facility. In the treatment group, 12% are working and 51% are looking for job. In terms of their FP/RH behaviors, 6% already had sex, 3% were tested for HIV, and 33% visited a health facility.

Table 5 presents the average outcomes for youth at baseline, by treatment status. Table A. 1 in the Appendix shows descriptive statistics on youth's characteristics and outcomes by time period.

Next, using t-tests, YP Action tested for sample balance between the treatment and the control group along observable youth characteristics and youth baseline outcomes. **The results of this analysis show that the samples are balanced along most demographic characteristics** (see Table 4), with the exception of age (youth in the treatment group are 0.2 years older than youth in the control group), asset index (0.05 higher for the treatment group), and if youth are currently working (3% higher for the treatment group). However, **findings show statistically significant differences in several of the outcomes:** youth in the treatment group present higher income, as well as slightly higher scores for positive identity, social and communication skills, intention to use contraception, PMTCT knowledge, and discussed contraception (see

Table 5).

Table 4. Mean differences in baseline youth characteristics by treatment status

	Control (WfD)	Treatment (WfD +FP/RH)	Diff (T-C)
Sex (male)	0.61	0.60	-0.01
Age	18.78	18.97	0.20*
Asset Index ⁵	0.74	0.79	0.05*
# people house	4.77	4.70	-0.06
Head of household	0.05	0.06	0.02
Currently working	0.09	0.12	0.03*
Looking for employment	0.55	0.51	-0.04
Ever had sex	0.07	0.06	-0.00
Ever tested for HIV	0.02	0.03	0.00
Visited Health Facility	0.31	0.33	0.02
Observations	1050	1050	

⁵ The wealth index is calculated using the variables collected in Section K of the survey. Each of the questions is transformed into dummy variables, and the index reflects the average of all the dummies.

Notes: Significance is denoted as: * $p < 0.05$

Table 5. Mean differences in youth outcomes by treatment status at baseline

	Means		Diff (T-C)
	Control (WfD)	Treatment (WfD +FP/RH)	
Income	3951.84	5209.19	1257.35*
Job satisfaction	0.92	0.87	-0.05
# Strategies job hunt	1.06	1.03	-0.02
Positive identity	2.85	2.91	0.05*
Self-control	2.70	2.68	-0.02
HOTS (higher order thinking skills)	3.02	3.04	0.02
Social & communication skills	2.93	2.96	0.03*
Intention to use contraception	0.83	0.91	0.07*
Contraceptive knowledge	0.27	0.29	0.02*
HIV knowledge	0.23	0.19	-0.04
PMTCT knowledge	0.26	0.30	0.04*
Gender equity	0.71	0.70	-0.01
Comfort communicating partners	0.44	0.44	-0.01
Discussed contraception	0.11	0.15	0.03*
Ever tested for HIV	0.02	0.03	0.00
Use modern contraception	0.92	0.93	0.00
Observations	1500	1500	

Notes: Significance is denoted as: * $p < 0.05$

We note that the groups were not fully balanced on key outcomes of interest at baseline, and therefore, adjustment through propensity score matching will be needed to mitigate the effect of that imbalance on impact estimation. The next section discusses our empirical impact analysis strategy.

Evaluation Approach and Methodology

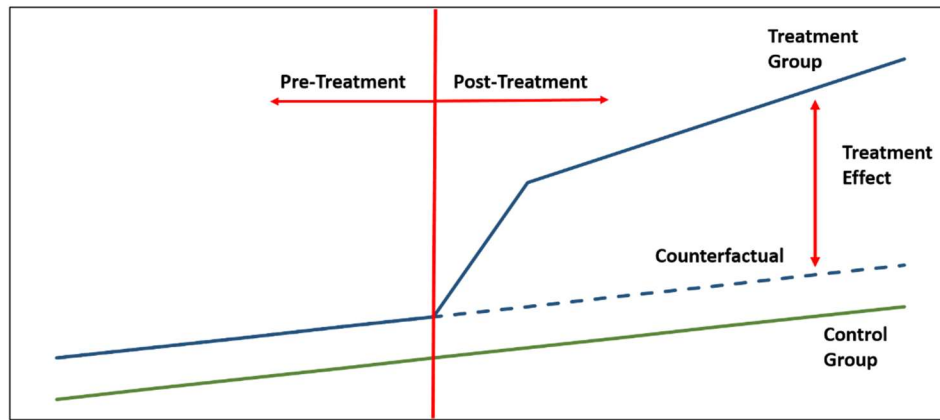
Differences in Differences

The difference-in-differences (DID) is a quasi-experimental approach that seeks to identify a treatment effect by tracing the differences in outcomes for treatment and control groups over time. This approach is particularly appropriate when outcomes are measured at two or more different time periods—specifically at least one time period before "treatment" and at least one time period after "treatment." In the example (see Figure 3), the outcome in the treatment group is represented by the blue line and the

outcome in the control group is represented by the green line. The outcome variables in both groups are measured at time period 1, before either group has received the treatment (“pre-treatment”). The treatment group then receives or experiences the treatment, and both groups are again measured at time period 2 (“post-treatment”).

This approach recognizes that groups may not be in identical conditions, and therefore not all of the differences between the treatment and control groups at time period 2 can be explained as being an effect of the treatment. DID therefore calculates the “normal” difference in the outcome variable between the two groups (the difference that would still exist if neither group experienced the treatment). The treatment effect is the difference between the observed outcome and the “normal” outcome.

Figure 3. Illustration of the difference-in-differences procedure



In this study, the DID analysis includes time contrasts and a treatment indicator (defined as 0 for those clubs assigned to the WfD-only arm and as 1 for those clubs assigned to the WfD + FP/RH arm). The model also includes an individual youth-specific invariant control (fixed effect). The individual fixed effects consider all characteristics of each youth in the sample that are time invariant, both observable and unobservable. This includes their background demographic, socioeconomic, and educational characteristics, allowing for the analysis to identify differences solely attributable to the intervention.

Our DID regression model is estimated as follows:

$$Y_{ict} = \text{midline}_t + \delta \text{Treat}_c * \text{midline}_t + \text{endline}_t + \alpha \text{Treat}_c * \text{endline}_t + \theta_i + \varepsilon_{ict} \quad [1]$$

- Where Y_{ict} denotes the outcome of interest for youth i attending a club c , in period (baseline, midline, and endline) t .
- midline_t takes on a value of 1 if t is in the midline post-treatment period, zero if in the pre-treatment period (baseline).
- endline_t takes on a value of 1 if t is in the endline post-treatment period, zero if in the pre-treatment period (baseline).
- Treat_c is an indicator variable that takes on a value of 1 if c belongs to the treatment group (WfD + FP/RH), otherwise zero.
- ε_{ict} represents the standard errors, clustered at the club-cohort-time level.
- θ_i is the youth-specific time invariant effect.

- δ and α are the parameters of interest to this evaluation which comes as a result of the interaction of the treatment assignment and the post-treatment indicators.

Impact Evaluation, Midline and Endline

The impact evaluation results present a mixed picture. Recall that the research hypothesis was that the integration of an additional FP/RH component into a workforce training program for youth would have a beneficial effect on cross-sectoral outcomes over and above the workforce-only training. In this framework, there is no evaluation of the WfD arm of the S2S program implemented in Bangladesh; only the additional FP/RH component, added through the combination of content modules amounting to 40 additional training hours.

The set of outcomes against which the treatment (FP/RH + WfD) and control (WfD only) groups are compared include knowledge of the FP practices, employment, income, and soft skills – as noted above. The results show that while some outcomes appeared to improve immediately following the intervention, the effect subsided over time. For other outcomes, such as soft skills, control group participants appeared to improve upon the treatment group. For the vast majority of outcomes, however, the differences between treatment and control arms were too small to detect a plausible effect of the intervention.

Table 6 shows group means by treatment status, at baseline, midline and endline, without any adjustment for demographic characteristics or confidence intervals around the estimates. The simple group averages indicate that in many cases, there appeared to be change in outcome levels for both of the groups without the treatment group showing substantial difference over the control arm.

Table 6. Means on key outcomes by treatment status, baseline, midline and endline.

	Baseline		Midline		Endline	
	WfD	WfD + FP/RH	WfD	WfD + FP/RH	WfD	WfD + FP/RH
Income	4196	5457	3350	6719	6886	6792
Job Satisfaction	0.92	0.87	0.93	0.96	0.92	0.94
# Strategies job hunt	1.06	1.03	1.25	1.16	1.93	1.85
Positive identity	2.85	2.91	2.91	2.90	2.92	2.92
Self-control	2.70	2.68	2.69	2.70	2.78	2.76
HOTS (higher order thinking skills)	3.02	3.04	3.04	3.03	3.04	3.04
Social & communication skills	2.93	2.96	2.97	2.95	2.96	2.96
Intention to use contraception	0.83	0.91	0.88	0.94	0.94	0.94
Contraceptive knowledge	0.27	0.29	0.45	0.54	0.47	0.52
HIV knowledge	0.23	0.19	0.28	0.21	0.37	0.40
PMTCT knowledge	0.26	0.30	0.32	0.32	0.28	0.30
Gender Equity	0.71	0.70	0.72	0.72	0.77	0.77

	Baseline		Midline		Endline	
	WfD	WfD + FP/RH	WfD	WfD + FP/RH	WfD	WfD + FP/RH
Comfort communicating partners	0.44	0.44	0.50	0.54	0.36	0.40
Discussed contraception	0.11	0.15	0.24	0.39	0.28	0.34
Ever tested for HIV	0.02	0.03	0.05	0.05	0.06	0.03
Use modern contraception	0.92	0.93	0.96	0.93	0.89	0.95

Note: Cell entries are group averages by treatment status: control (WfD) and treatment (WfD+FP/RH)

In this section, we present the results visually and narrate through each of the figures. Figure 4 through Figure 9. Pre- and (predicted) post-treatment means for gender equity

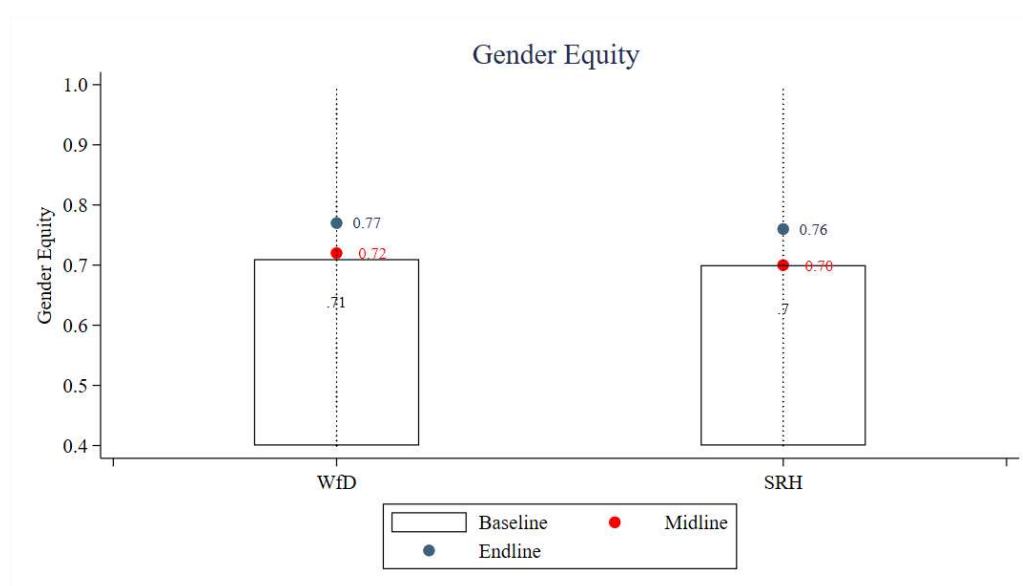


Figure 10 show visual representations of the effects at midline and endline. Figure 4 through

Figure 8 show the average of each outcome at baseline for the treatment (WfD) and control (FP/RH) groups (the white bar represents the baseline level for each group), as well as the predicted means for both groups at midline (red dot) and endline (blue dot). All of the differences in outcomes demonstrated in Figures 5–10 are summarized as standardized effects in Figure 11 at the end of this section.

Figure 4 shows results for employment outcomes. When looking at income,⁶ the treatment group presents a higher income mean at baseline and presents higher predicted means, or the estimated outcomes when the baseline level is adjusted for the average treatment effect, at midline and endline, when compared to baseline. The control group (WfD only) presents a lower predicted mean at midline and a higher predicted mean at endline when compared to baseline.

For job satisfaction, the control group presents a higher level of job satisfaction at baseline and this level remains stable at midline and endline. The treatment group shows higher predicted means at midline and endline when compared to baseline. Table A. 3 in the appendix presents the differences-in-differences regression results (from equation 3).

⁶ Only individuals with non-missing observations for income at baseline were included in the regression analysis.

Figure 4. Pre- and (predicted) post-treatment means for employment outcomes

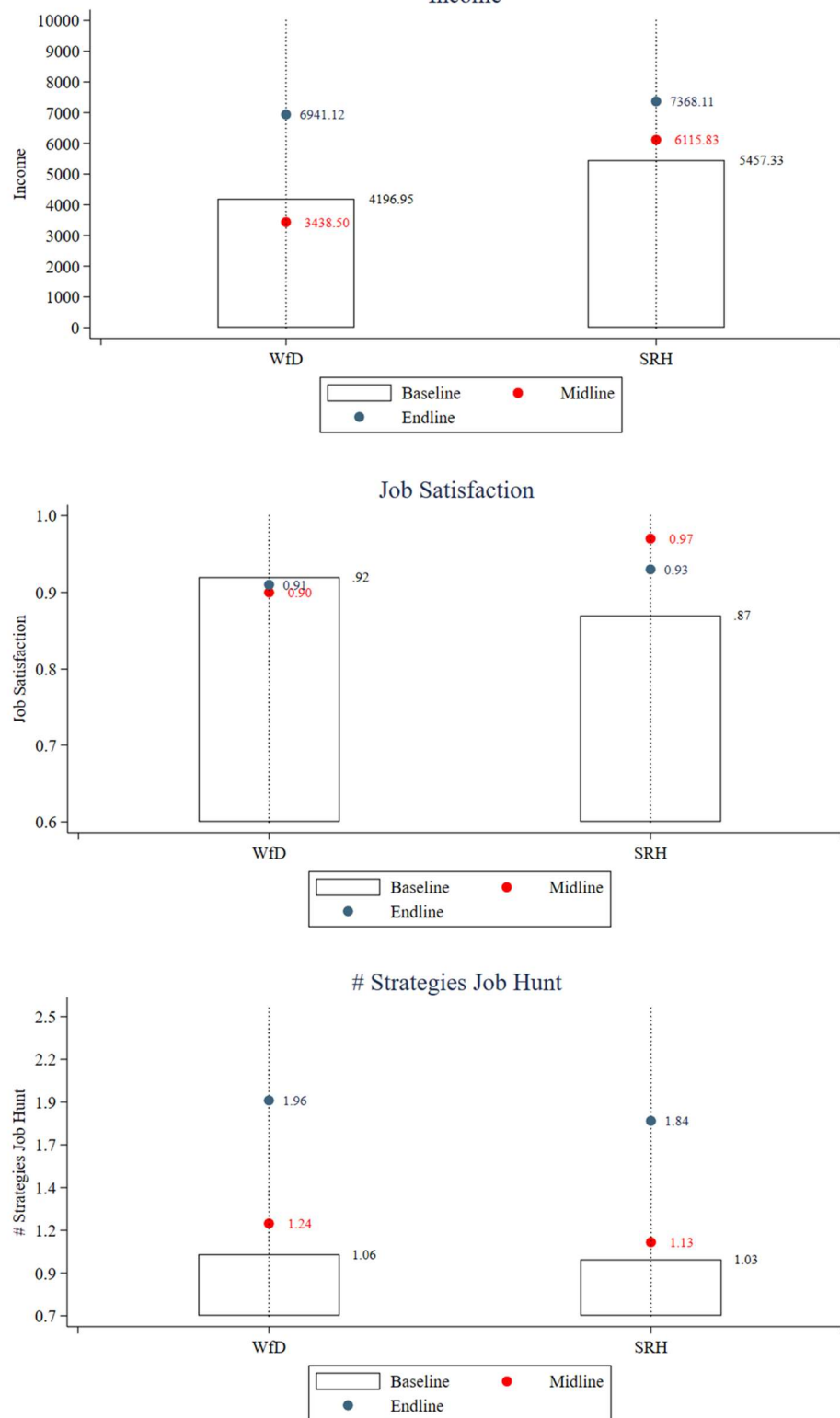


Figure 5 shows results for the soft skills outcomes. For positive identity, the treatment group starts better off at baseline and only shows a slight increase at endline. The control group, on the other hand, shows an increase at midline and a slight increase at endline, catching up with the treatment group. Overall, this results in a negative and significant impact (at a 10% level) of -0.26 std and -0.23 std at midline and endline, respectively (

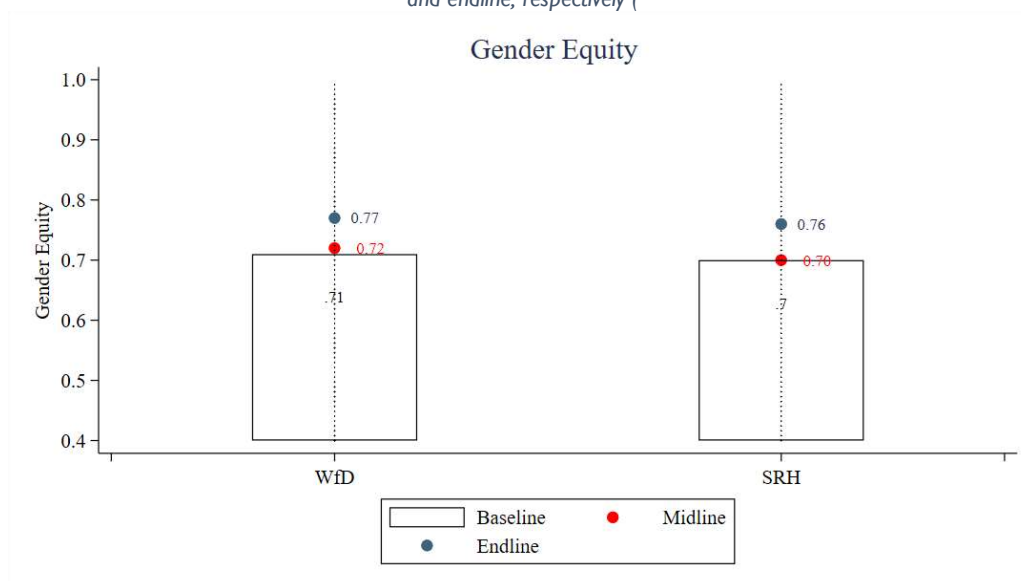


Figure 10). For self-control, both groups present similar averages at baseline, no increase at midline, and an increase at endline—more accentuated for the control group, which results in an overall positive and non-significant effect of 0.06 at midline and negative and non-significant effect of -0.06 at endline. For HOTS, both groups present high and similar averages at baseline, although it is slightly larger for the treatment group. The treatment group sees no changes at midline and endline, while the control group sees a slight increase at midline and slight decrease at endline, which results in overall negative but non-significant effects of -0.11 sd and -0.05 sd at midline and endline respectively. For social and communication skills, the treatment group started better off and only saw a slight increase at midline,

while the control group shows an increase for midline that remained practically stable at endline.

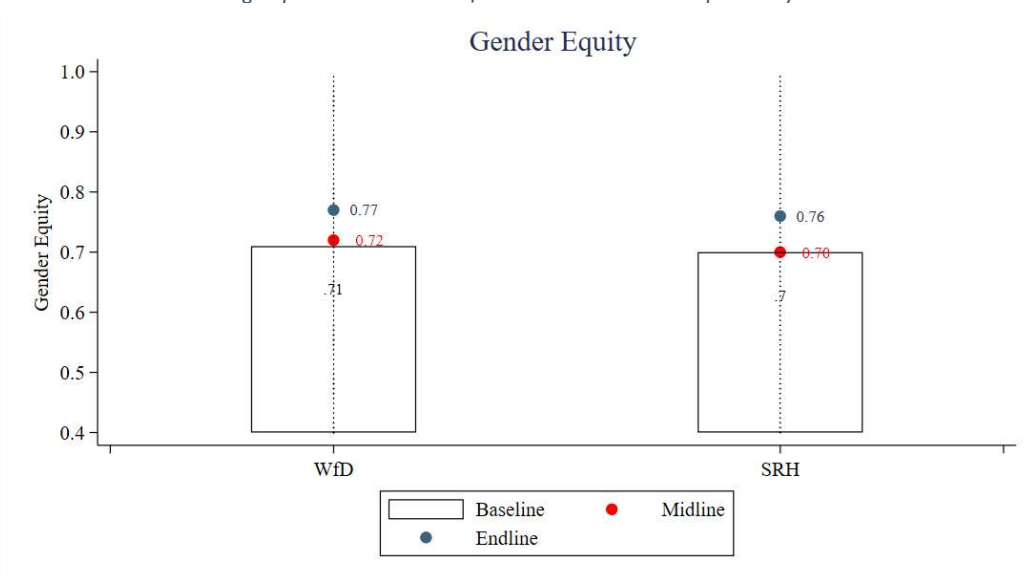


Figure 10 shows overall negative and non-significant effects of -0.16 std and -0.08 std at midline and endline, respectively. Conversely, in interviews and focus group discussions, youth, especially female youth, continuously cited greater comfort communicating FP/RH topics in general, even referring to it as liberating.

Figure 5. Pre- and (predicted) post-treatment means for soft skills

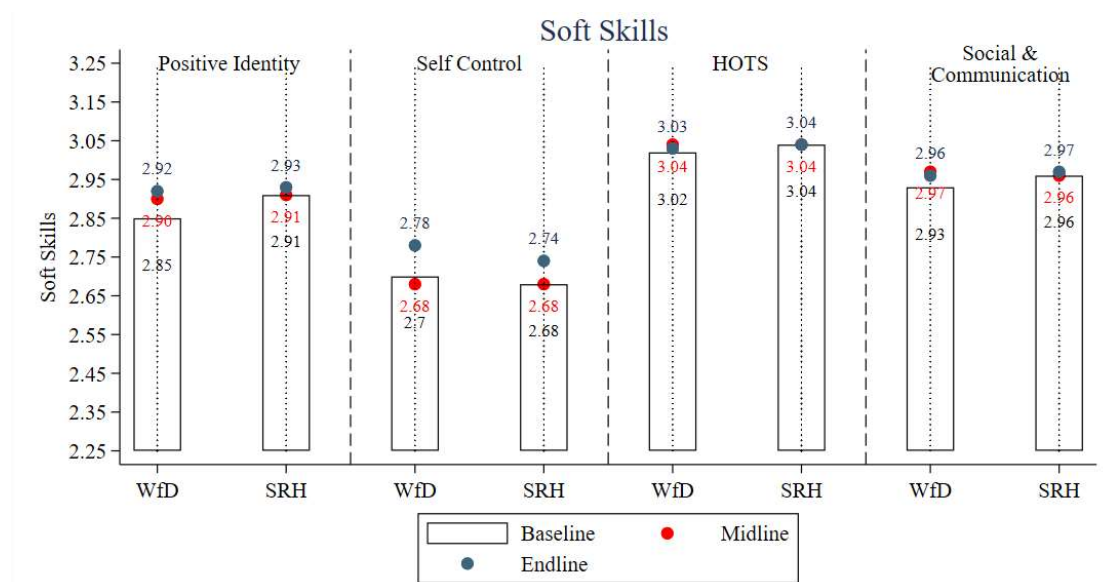


Figure 6 shows pre- and predicted post-treatment means for FP/RH outcomes. For intention to use contraception, the treatment group presents a higher average at baseline, no changes at midline and an increase at endline. The control group presents an increase at midline and a slight increase at endline.

On “comfort communicating with partners on family planning,” both groups present the same average at baseline, an increase at midline (more accentuated for the treatment group), and a decrease at endline, which generates a final positive and non-significant effect of 0.02 std at midline and a null effect at endline. This may be due to the fact that the sample largely consists of unmarried youth; the process evaluation revealed that typically, only married youth openly communicate with partners (or anyone) about contraception, while unmarried youth only *anticipated* doing this. Some reported shame around the idea of asking about contraception while unmarried. Therefore, we might not expect to see a change in comfort communicating with partners.

For use of modern contraception, both groups present similar average at baseline, the treatment group remains stable at midline and increases at endline, while the control group remains stable at midline and decreases slightly at endline. This translates into positive and non-significant effects of 0.03 std and 0.09 std at midline and endline, respectively (Figure 11).⁷ On discussing contraception with partner, the treatment group presents a higher average at baseline, an increase at midline, and a slight decrease at endline, while the control group presents an increase at midline and a slight increase at endline.

Figure 6. Pre- and (predicted) post-treatment means for FP/RH outcomes

⁷ Note that a smaller sample size was used to estimate the impact on use of modern contraception, since only those who reported having sex were asked about their use of modern contraception.

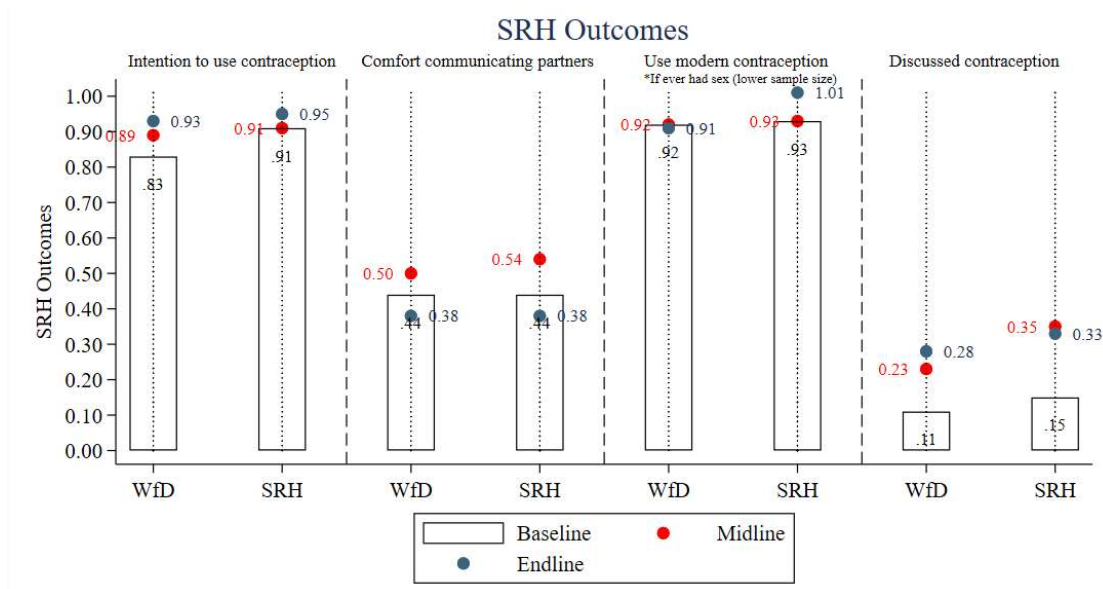


Figure 7 shows results for knowledge outcomes. The treatment group shows higher average for contraceptive knowledge at baseline and presents a considerable increase at midline, followed by a slight decrease at endline; while the control group shows a considerable increase at midline and a slight increase at endline. Overall,

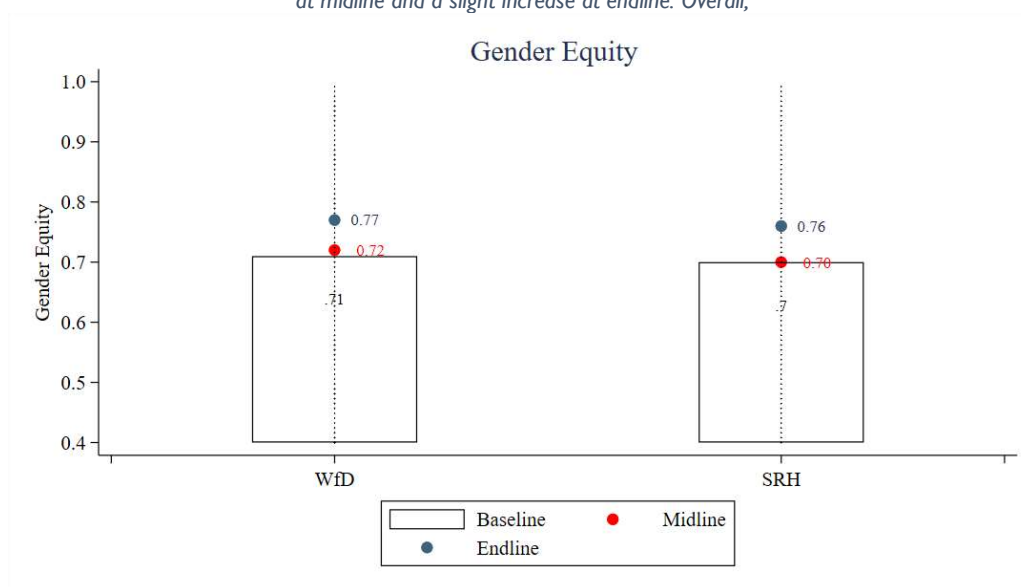


Figure 10 shows a large and positive effect at midline of 0.22 std and a positive effect at endline of 0.09 std, although none of the effects are statistically significant. For HIV knowledge, the control group starts

better off and shows increases at midline and endline, while the treatment group shows increases at midline and a more accentuated increase at endline, resulting in an overall non-significant effect of -0.03 std at midline and 0.07 std at endline. For PMTCT knowledge, the treatment group shows a higher average at baseline that remains practically stable over time, while the control group sees an increase at midline, followed by a decreased at endline, resulting in negative and non-significant effects of -0.05 std and -0.02 std at midline and endline, respectively.

This is consistent with findings from the process evaluation that showed that, while some youth claim to have learned more about FP/RH topics, these topics were also very new to them, and they do not cite detailed knowledge gained. Rather than having retained detailed knowledge on these topics, the gain to highlight (but that was not measured) may be their increased comfort and willingness to engage with FP/RH topics and seek out related knowledge and help.

Figure 7. Pre- and (predicted) post-treatment means for knowledge outcomes

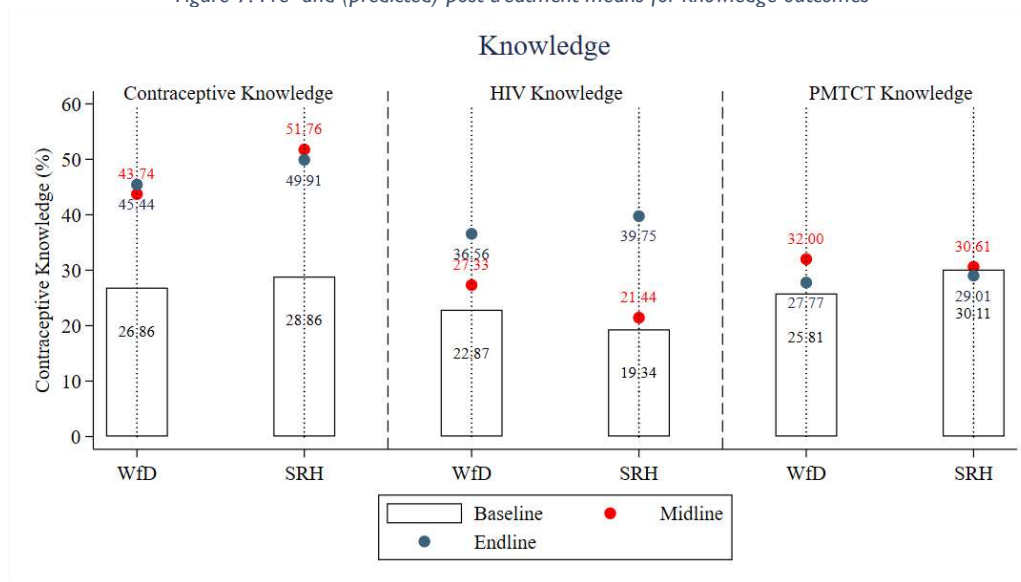


Figure 8 shows results for ever tested for HIV; Figure 10 shows results for gender equity. The treatment group presents a slight higher average at baseline for ever tested for HIV and this number remains stable over time, while it increases for the control group, both at midline and endline, resulting in an overall negative and non-significant effect of -0.01 std at midline and a negative and significant effect of -0.03 std at endline (Figure 11). For gender equity, both groups present similar averages at baseline and while the treatment group remains stable at midline and show an increase at endline, the control group shows

increases both at midline and endline, resulting in an overall effect of 0.04 std at midline and -0.01 std at endline (not significant).

The process evaluation, on the other hand, showed that while few youth report being tested, they did report greater knowledge gains on the topic of HIV/AIDS and reduced stigma around getting tested. They also report anticipating getting tested once married. This shows another area where the measure used may have been too narrow and targeted to a married population.

Figure 8. Pre- and (predicted) post-treatment means for HIV

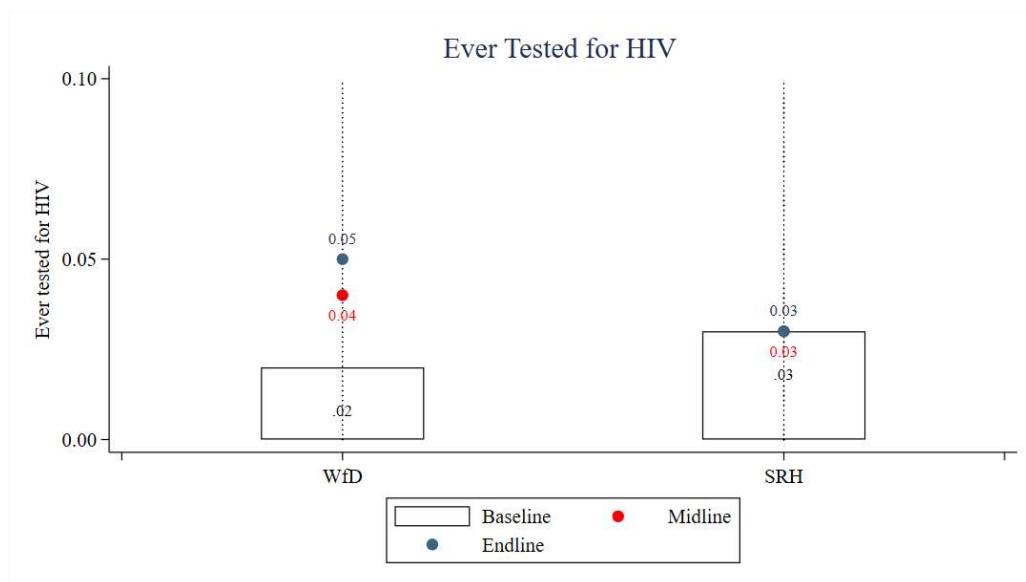


Figure 9. Pre- and (predicted) post-treatment means for gender equity

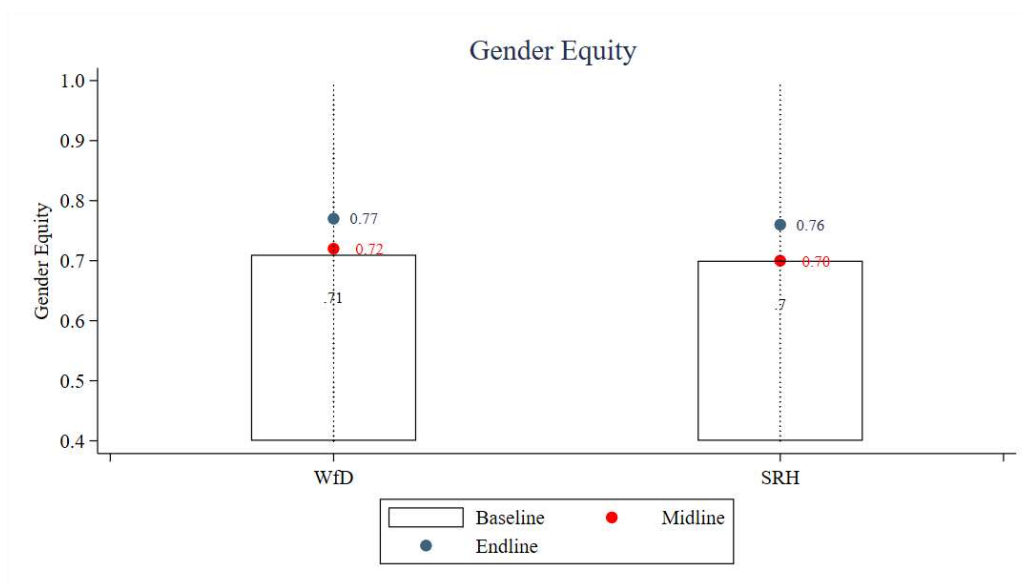
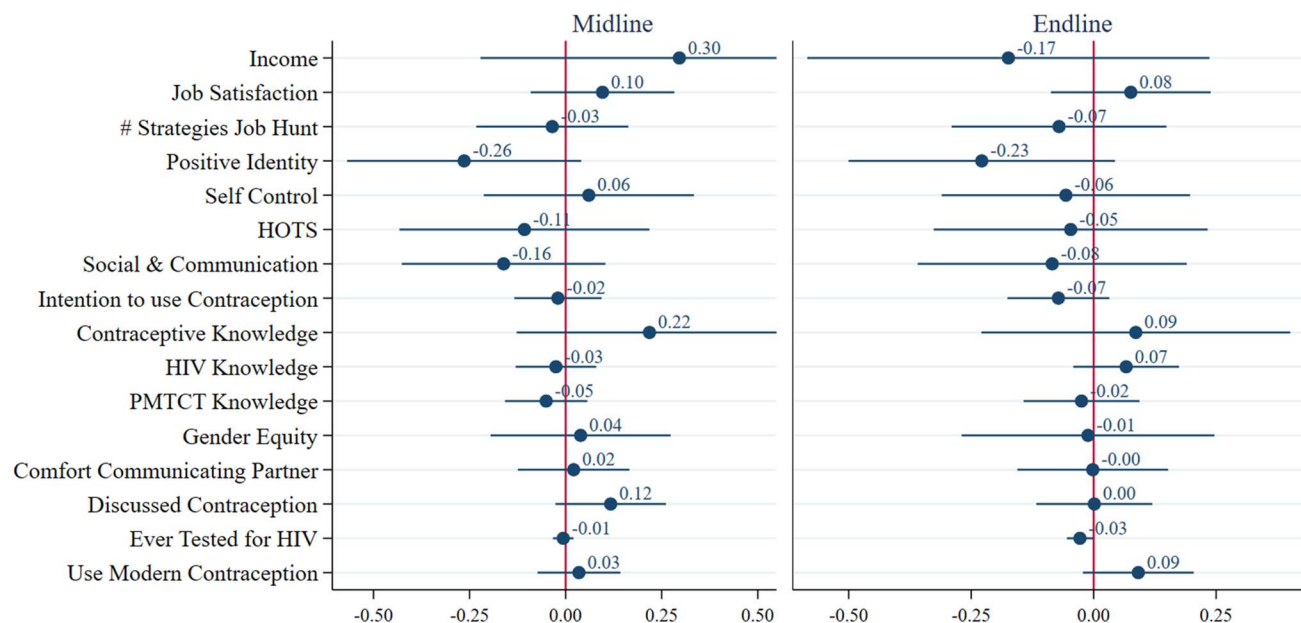


Figure 10. Impact of integrated arm at midline and endline⁸

⁸ The blue dots represent the magnitude of the effect for each outcome, in standard deviations (parameters δ_t and δ_t from equation 3), the horizontal blue lines that follows the dots represent the standard errors. The effect is only statistically significant if the blue line does not cross the red line (5% level of significance). Number of observations of each regression is displayed close to the outcome label on the left).



As explained above, Figure 11 shows the summary results as differences-in-differences effects (parameters δ and α from equation 3) at midline and endline. Note that in Figure 11 outcome variables were normalized across all the sample to have an average of zero and a standard deviation of one, to allow for better comparison of the relative magnitude of effects across the different outcomes. As the figure shows, the final overall effect on employment was positive at midline (0.30 of a standard deviation) and negative at endline (-0.17 std), although none of the effects are statistically significant. There was also a positive effect on job satisfaction of 0.10 std and 0.08 std at midline and endline, respectively, although none of the effects are statistically significant. For a number of job-hunting strategies, both groups present similar averages at baseline, a moderate increase at midline and a larger increase at endline, which resulted in small and non-significant effects of -0.03 std and 0.07 std at midline and endline, respectively. The fact that the control group advances in soft skills while the treatment group remains stagnant translates into a negative and significant impact on soft skills (at a 10% level) of -0.26 std and -0.23 std at midline and endline, respectively. On intention to use contraception,

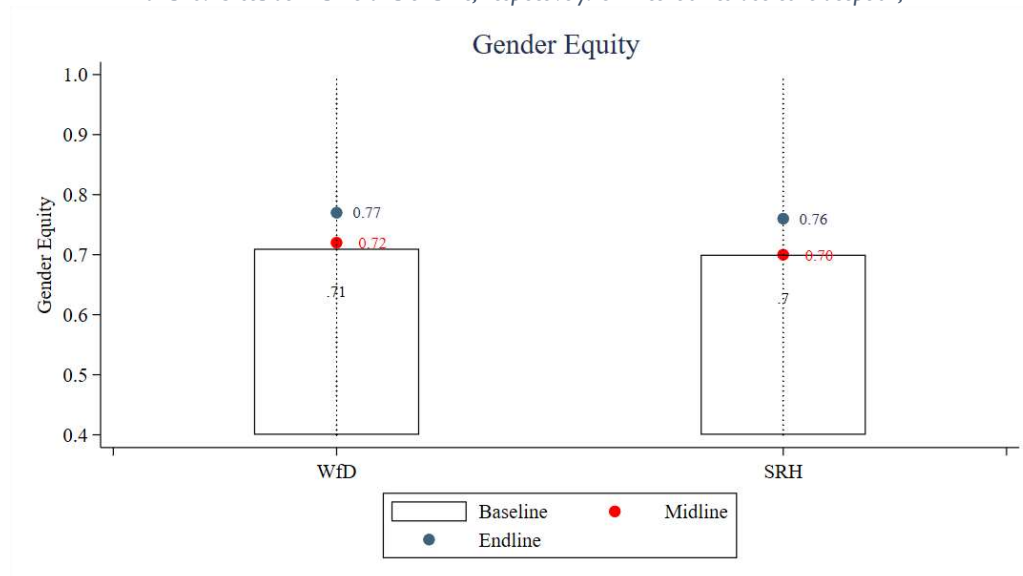


Figure 10 shows negative and non-significant effects of -0.02 std and -0.07 std at midline and endline, respectively. On discussing contraception with partner, we see a positive yet non-significant effect at midline of 0.12 std and a null effect at endline.

Key Takeaways: Overall, these analyses revealed several key findings. They show statistically significant effects for the treatment (FP/RH + WfD) group, compared to the control (WfD only) for only two outcomes: positive identity (negative, significant at midline and endline) and ever tested for HIV (positive, significant only at endline). They also reveal large and non-significant effects for income (positive at midline and negative at endline), contraceptive knowledge (midline) and discussed contraception (midline).

Next Step: To better understand these (somewhat confounding) results, YP Action decided to analyze heterogeneous effects by gender, implementing partner and cohort.

Heterogeneous Effects by Gender

The first step in our examination of heterogeneous effect by gender, implementing partner, and cohort, was to interact gender with the treatment and time dummies, as shown in regression 4 below. $Y_{ict} = \text{midline}_t + \beta \text{Treat}_c * \text{midline}_t + \gamma \text{midline}_t * \text{SEX}_{ict} + \delta \text{Treat}_c * \text{midline}_t * \text{SEX}_{ict} + \text{endline}_t + \alpha \text{Treat}_c * \text{endline}_t + \varphi \text{endline}_t * \text{SEX}_{ict} + \mu \text{Treat}_c * \text{endline}_t * \text{SEX}_{ict} + \theta_i + \varepsilon_{ict}$ [2]

Regression results are shown in Table A. 4 in the Appendix. Figure 11 and

Figure 12 show visual representations of the treatment effect for boys and girls.⁹ The analysis of income shows a much larger positive effect for boys at midline, and a much larger negative effect for boys at endline, when compared to girls, showing that the effect for the overall sample is mostly explained by changes to boys' income. However, the different effects for boys and girls on income are not statistically significant.¹⁰ The magnitude of the effects for job satisfaction are larger for girls at both periods, although this difference is also not statistically significant. Analysis of positive identity shows a much larger and negative effect for girls at both periods. These differences are statistically significant, showing that the

⁹ The effects from Error! Reference source not found.12 and Error! Reference source not found.13 were obtained from running equation 3 separately for boys only and girls only.

¹⁰ The coefficients "FP/RH diff – girls diff – midline" and "FP/RH diff – girls diff – endline" shows heterogeneous effects between girls and boys at midline and endline, respectively (parameters δ and μ from equation 4, respectively).

negative effect for the overall sample is mainly explained by variation on girls' positive identity. The same is true for HOTS and social and communication skills at midline, where girls present a much larger negative effect when compared to boys. These differences are statistically significant at midline. Analysis of contraceptive knowledge shows a much larger (and significant) effect for girls at midline when compared to boys, this difference is not statistically significant. Finally, for discussed contraception, girls show a larger and significant effect at midline, when compared to boys, and this difference is statistically significant.

Figure 11. Impact of the integrated arm on boys and girls at midline

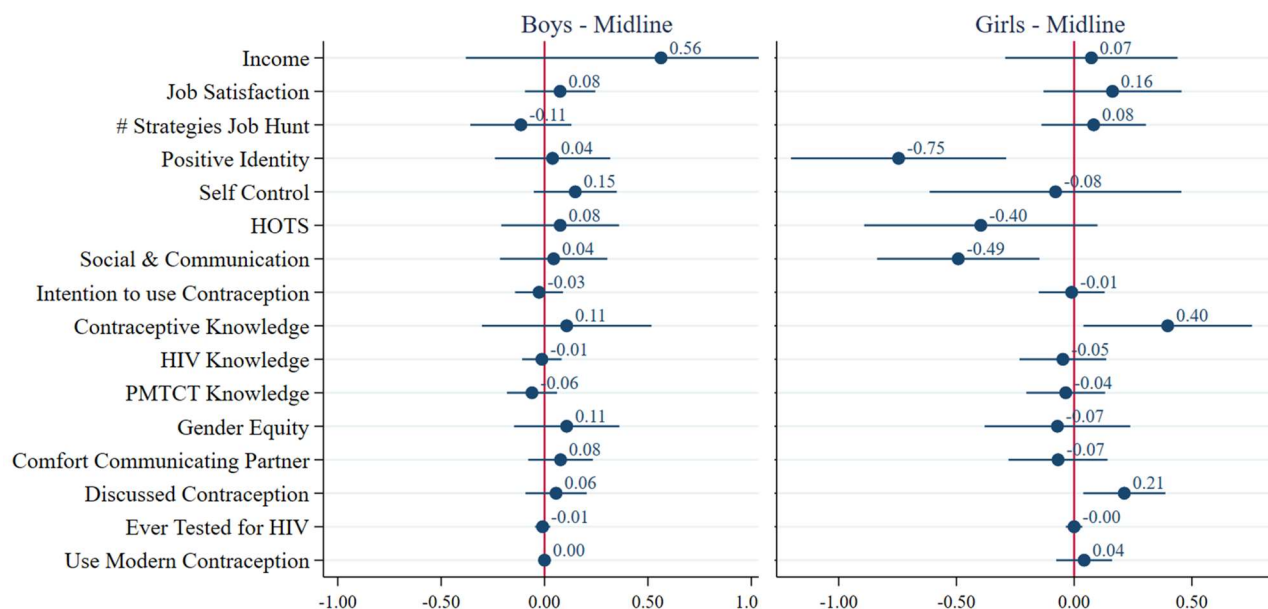
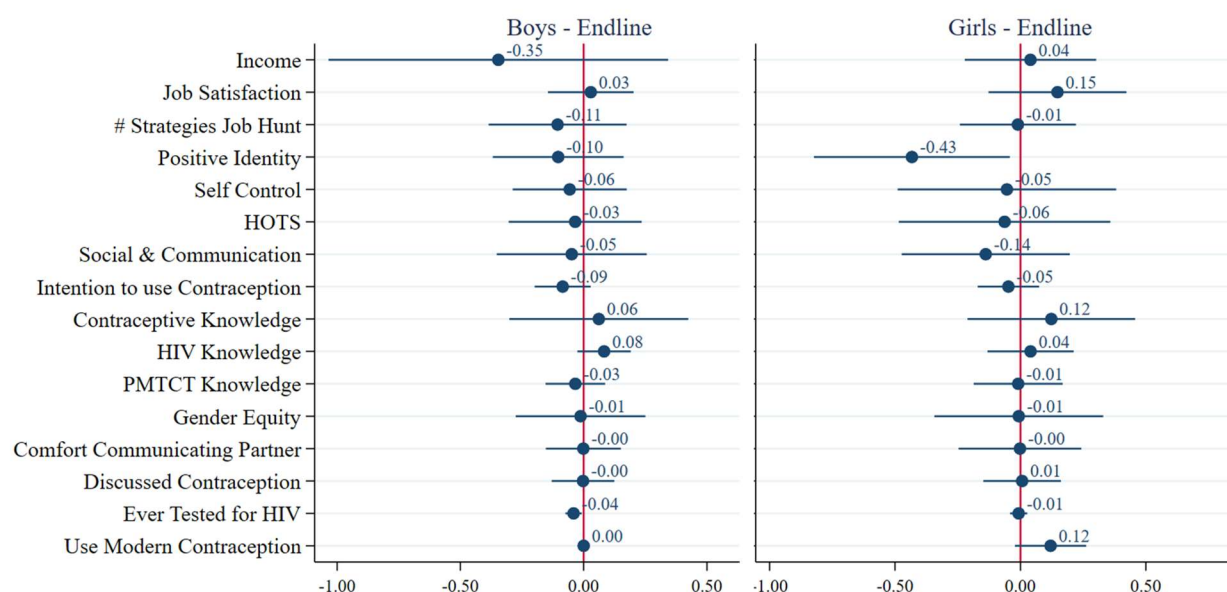


Figure 12. Impact of the integrated arm on boys and girls at endline



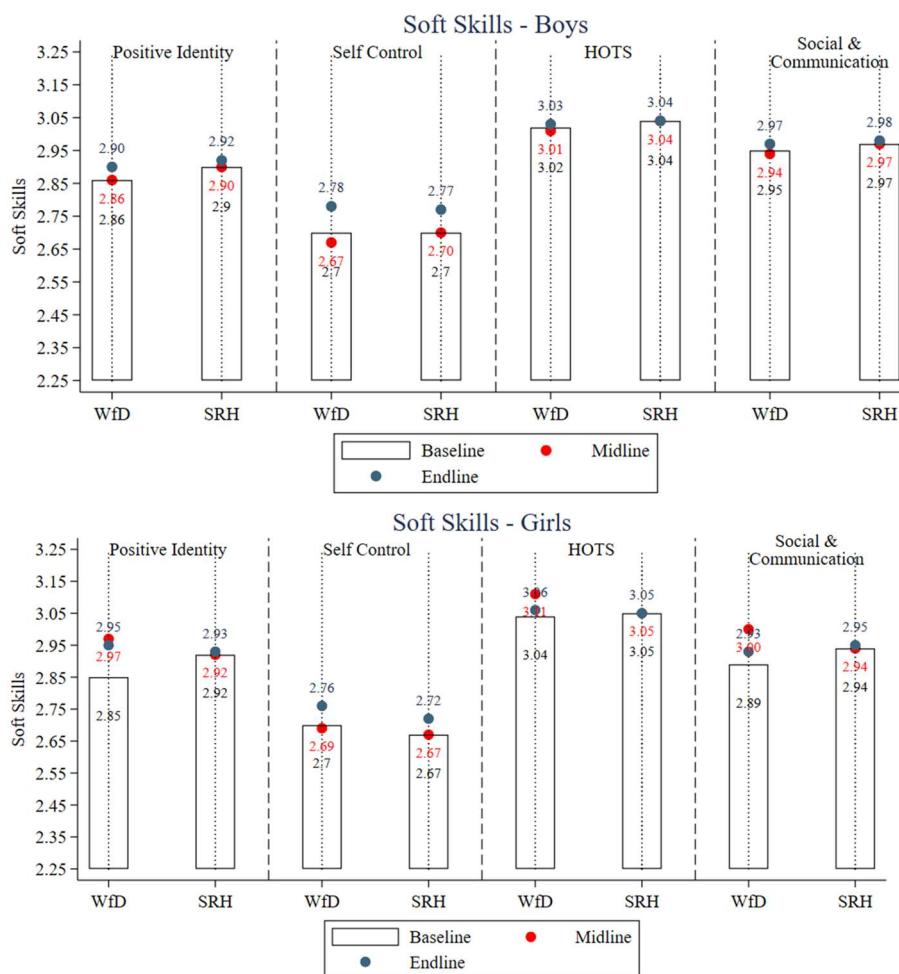
Key Takeaways: The analysis reveals some key differences in the outcomes by gender. Girls' positive identity, HOTS, and social and communication skills show a large, negative, and statistically significant effect at midline (and at both times for positive identity), explaining most of the variation on positive identity in the overall sample. Girls' discussed contraception shows a large statistically significant effect at midline, explaining much of the variation in this variable.

Next Step: To better understand the statistically significant differences between boys and girls for soft skills, YP Action looked at the pre- and predicted post-treatment means for soft skills by gender.

The pre- and predicted post-treatment means for soft skills by gender are shown by Figure 13. (Pre- and predicted post-treatment means for the other outcomes by gender can be found in the Appendix (Figure A.2 through

Figure A- 4). For positive identity, the treatment group shows a higher average at baseline for boys and girls, although this difference is more accentuated for girls. In other words, **the gap between treatment and control was larger for girls at baseline when compared to boys**. The treatment group for both girls and boys remains stable at midline and shows a slight increase at endline. The control group remains stable for boys and shows increase for girls at midline, while at endline there is a slight decrease for girls and an increase for boys.

Figure 13. Pre- and (predicted) post-treatment means for soft skills by gender



For self-control, both boys and girls of the treatment and control groups show a similar average at baseline, modest effects at midline, and positive effects at endline (the positive effects are more accentuated for the control group).

For HOTS, both girls and boys of the treatment group started off better and remained stable over time, while girls in the control group showed an increase at midline and a slight decrease at endline, and boys in the control group showed a slight decrease at midline and an increase at endline.

For social and communication skills, the treatment group showed higher averages at baseline for both boys and girls. This average remained stable at midline and increased slightly at endline. For the control group, boys decreased slightly at midline and increased slightly at endline, and girls increased at midline and decreased slightly at endline.

Overall, the treatment group shows higher averages for soft skills at baseline when compared to the control group and this gap is usually more accentuated for girls. Moreover, while the treatment group sees no or small increases over time, the control group catches up and both groups end up with similar averages at endline.

Key Takeaways: Looking at the pre- and predicted post-treatment means for soft skills by gender reveals that, because the treatment group's skills were higher than the control group's (for all skills except self-control), the improvement in the control group's skills shows up

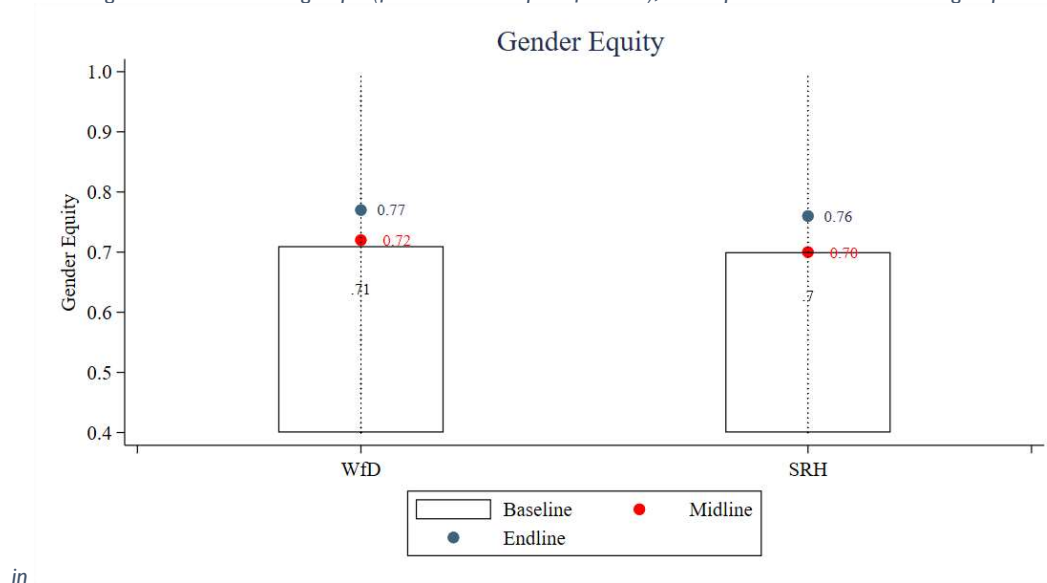


Figure 10 –

Figure 12 as a negative effect for the treatment group. In other words, it looks like the treatment is getting worse, but this is because the control group improves, while the treatment group remains stable over time, and the treatment group had started off “better” to begin with. Findings also show that this effect is more accentuated for girls.

Heterogenous Effects by Implementing Partner

Because the treatment was implemented by three local implementing partners, applying the same content and training modalities to designated youth clubs within the treatment and control arm, YP

Action also analyzed heterogeneous treatment effects by implementing partner, as shown in regression 5 below.¹¹ Note that each IP followed the same protocols in the designation of treatment and control groups, assigning equal numbers of youth clubs to each.

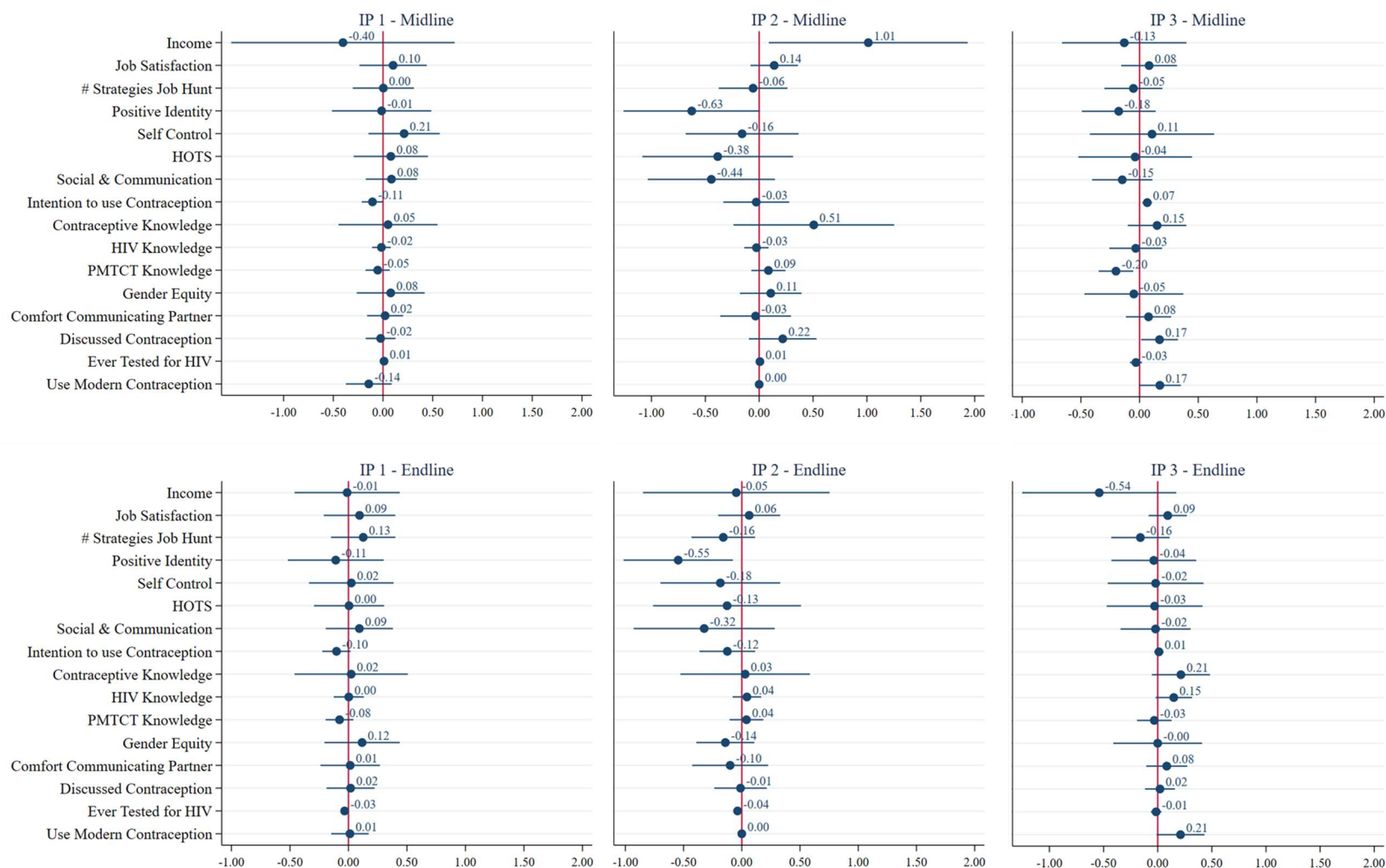
$$Y_{ict} = \text{midline}_t + \beta \text{Treat}_c * \text{midline}_t + \gamma \text{midline}_t * \text{IP2}_{ict} + \pi \text{midline}_t * \text{IP3}_{ict} + \delta \text{Treat}_c * \text{midline}_t * \text{IP2}_{ict} + \tau \text{Treat}_c * \text{midline}_t * \text{IP3}_{ict} + \text{endline}_t + \alpha \text{Treat}_c * \text{endline}_t + \varphi \text{endline}_t * \text{IP2}_{ict} + \rho \text{endline}_t * \text{IP3}_{ict} + \mu \text{Treat}_c * \text{endline}_t * \text{IP2}_{ict} + \sigma \text{Treat}_c * \text{endline}_t * \text{IP3}_{ict} + \theta_i + \varepsilon_{ict} \quad [3]$$

in the Appendix shows the regression results on FP/RH and knowledge outcomes by gender. Figure 15.¹² The DID effects are very different for each implementing partner, especially for IP 2. For IP 1, the statistically significant effects are a decrease on intention to use contraception of -0.11 std at midline and -0.10 std at endline, and a decrease of -0.03 std on ever tested for HIV at endline (all at a 10% level of significance). For IP 2, the statistically significant effects are negative effects on positive identity, of -0.63 std (10% level) and -0.55 std (5% level) at midline and endline respectively, and a negative effect of -0.04 std on ever tested for HIV at endline (5% level). Even though the other effects are not statistically significant, they are large in magnitude for income, HOTS, social and communication skills, and discussed contraception. Analysis of IP 3 shows positive and statistically significant effects at midline for intention to use contraception (0.07 std, 1% level), discussed contraception (0.17 std, 5% level), use of modern contraception (0.17 std, 10% level), and at endline for HIV knowledge (0.15 std, 10% level) and use of modern contraception (0.21 std, 10% level). IP 3 also presents a statistically significant negative effect of -0.20 std (1% level) for PMTCT knowledge at midline.

¹¹ IP 1 is the reference group in the regression.

¹² The effects from **Error! Reference source not found.**15 were obtained from running equation 3 separately for each implementing partner.

Figure 14. Impact of the integrated arm at midline and endline by implementing partner



Error! Reference source not found. shows the heterogeneous effects by implementing partner that are statistically significant.¹³ When comparing the effects between IP 1 and IP 2, the only statistically significant heterogeneous effect is for social and communication skills at midline (-0.53 std, 10% level). Comparing IP 1 and IP 3, at midline shows statistically significant heterogeneous effects for intention to use contraception (0.17 std, 1% level), discussed contraception (0.19 std, 10% level), and use of modern contraception (0.32 std, 5% level); and at endline for intention to use contraception (0.11 std, 10% level). Comparing IP 2 and IP 3 (p-values ≤ 0.10), at midline shows statistically significant effects for PMTCT knowledge and use of modern contraception; and at endline for positive identity and use of modern contraception.

Key Takeaways: The effects are very different for each implementing partner, especially for IP 2, indicating that the effects for the overall sample for these outcomes are mainly being driven by IP 2's performance.

Next Step: To better understand the different effects between implementing partners, YP Action looked at the pre- and predicted post-treatment means for soft skills and knowledge outcomes by implementing partner.

Figure 15 and Figure 16 show these different means for soft skills and knowledge outcomes by IP. Figure 15 shows that the treatment group shows higher averages for soft skills at baseline and a larger gap between treatment and control, which could possibly explain the negative effects on soft skills for IP 2. Figure 16 shows that IP 2 shows lower averages at baseline for contraceptive knowledge when compared to the other IPs, and IP 2 shows a large gain for the treatment group at midline. IP 2 also shows lower averages for HIV knowledge at baseline, but both the treatment and the control groups show increases over time. For PMTCT knowledge, while IP 2 shows large gains for both groups at midline, followed by a decrease at endline, IP 3 starts with higher averages and remains stable over time, while IP 1 sees increases for both groups over time. Pre and predicted post-treatment means for the other outcomes by implementing partner can be found in the appendix (Figure A- 5 through Figure A- 7)

Key Takeaway: The higher baseline scores for soft skills among IP 2's treatment group, as well as the larger gap between IP 2's treatment and control groups' soft skills, may explain the negative effects on soft skills for IP 2.

It is important to remember that the differences between the IPs are not to be interpreted as evidence of poor implementation. Like overall treatment effects, the treatment effects by partner are intended to capture differences between the workforce arm (control group) and the workforce + FP/RH arm that received the additional 40 hours of FP/RH content. Because the IPs are located in different areas around Dhaka, some of the differences between treatment arms within an IP may be explained by the ways that youth from the different communities responded to the FP/RH arm, compared to the ways they responded to the general WfD intervention offered to everyone. The research team was informed that

¹³ Note that the reference group is IP 1. The coefficients "FP/RH diff – IP 2 diff – midline" and "FP/RH diff – IP 2 diff – endline" show heterogeneous effect between IP 1 and IP 2 at midline and endline, respectively (parameters δ and μ in equation 5); and "FP/RH diff – IP 3 diff – midline" and "FP/RH diff – IP 3 diff – endline" show heterogeneous effects between IP 1 and IP 3 at midline and endline, respectively (parameters τ and σ from equation 5). The t-tests at the bottom of the table (p-values) show if the different effects between IP 2 and IP 3 are statistically significant (test if "FP/RH diff – IP 2 diff – midline" = "FP/RH diff – IP 3 diff – midline" and "FP/RH diff – IP 2 diff – endline" = "FP/RH diff – IP 3 diff – endline").

IP2 is located in a more remote area, serves highly vulnerable youth, and that the community where it operates suffered two major fires during the time of the study.

Figure 15. Pre- and (predicted) post-treatment means for soft skills by implementing partner

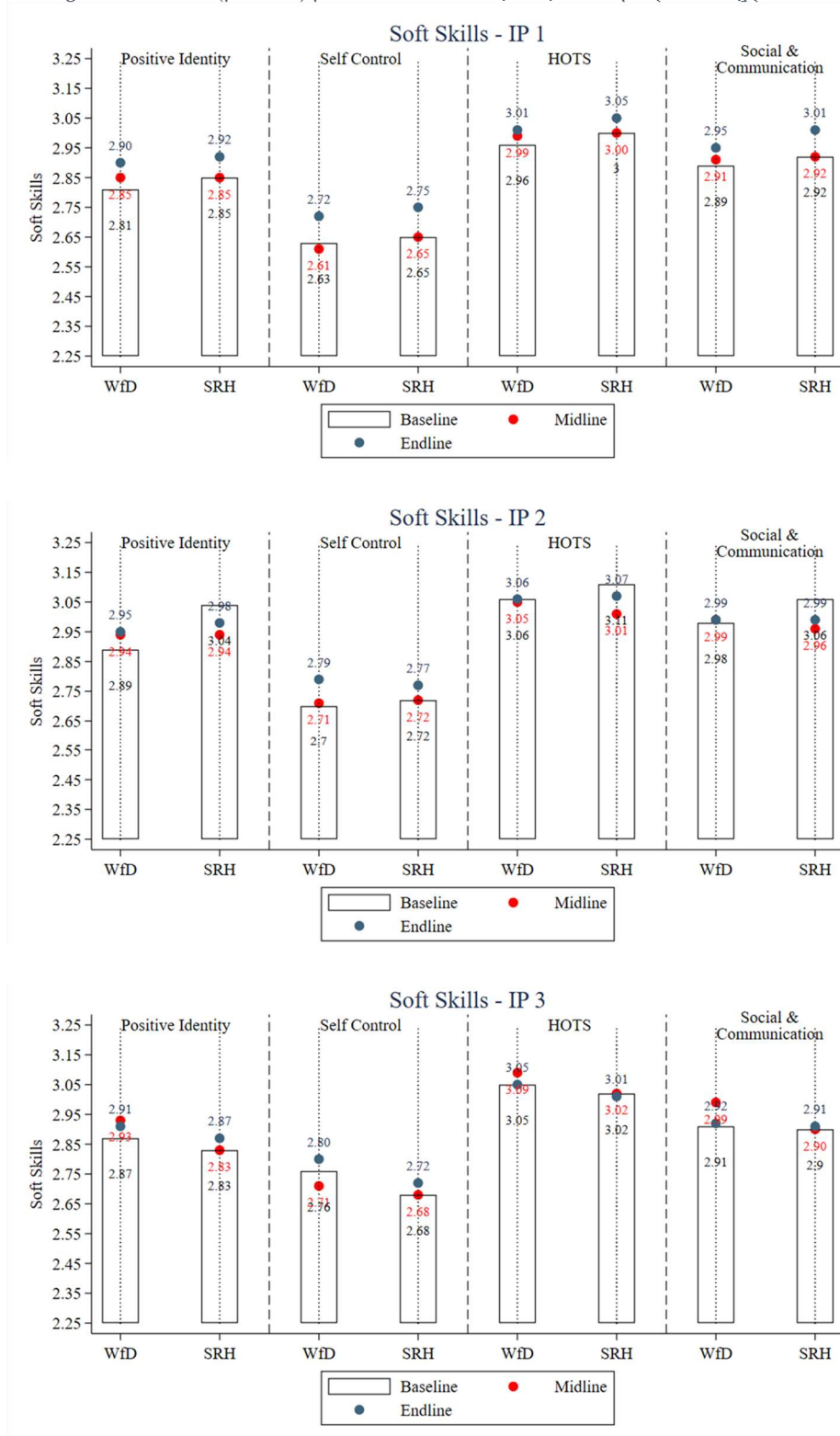
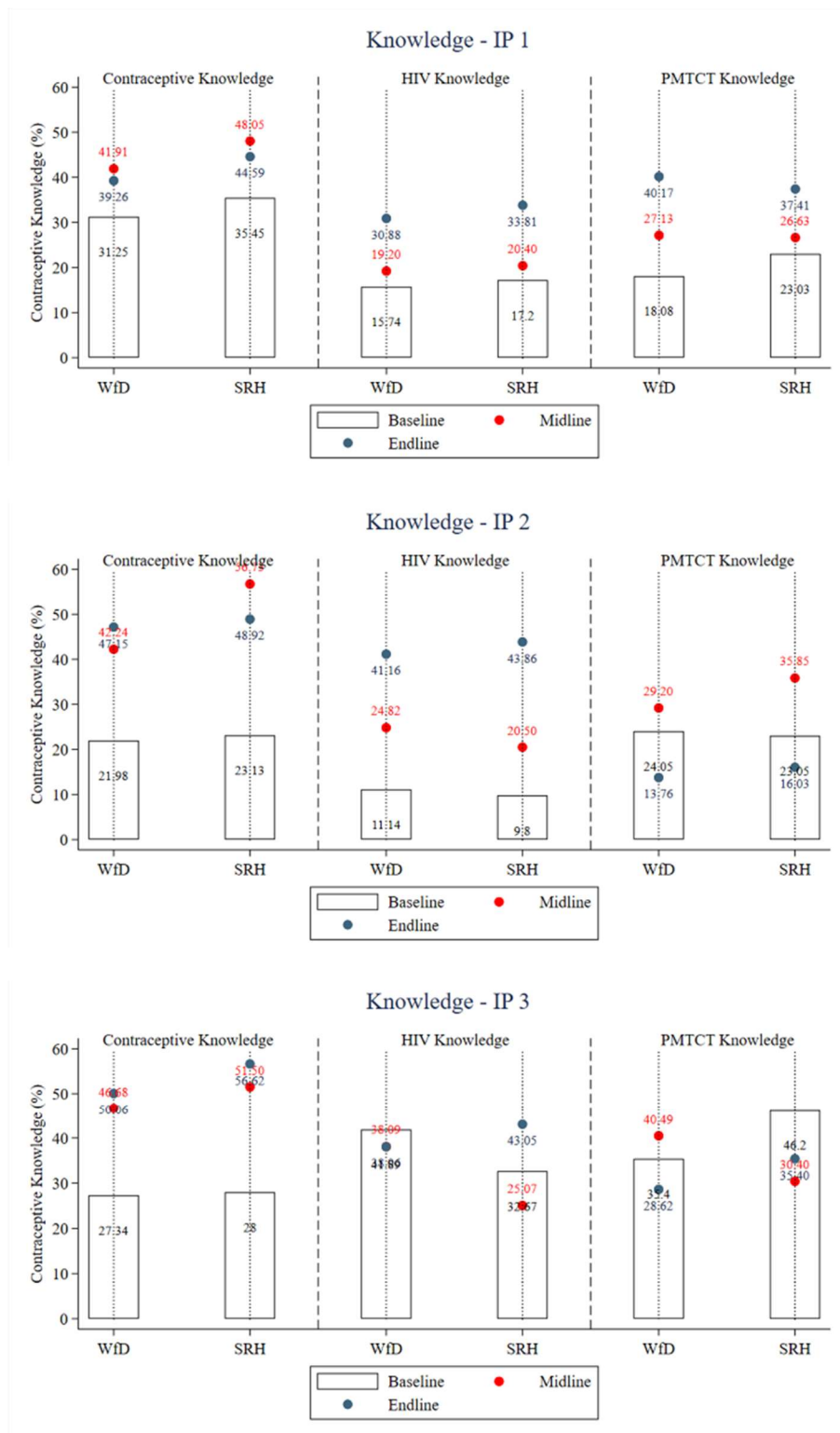


Figure 16. Pre- and (predicted) post-treatment means for knowledge outcomes by implementing partner



Heterogenous Effects by Cohort

Finally, YP Action analyzed heterogeneous effect by cohort, as shown in regression 6 below:

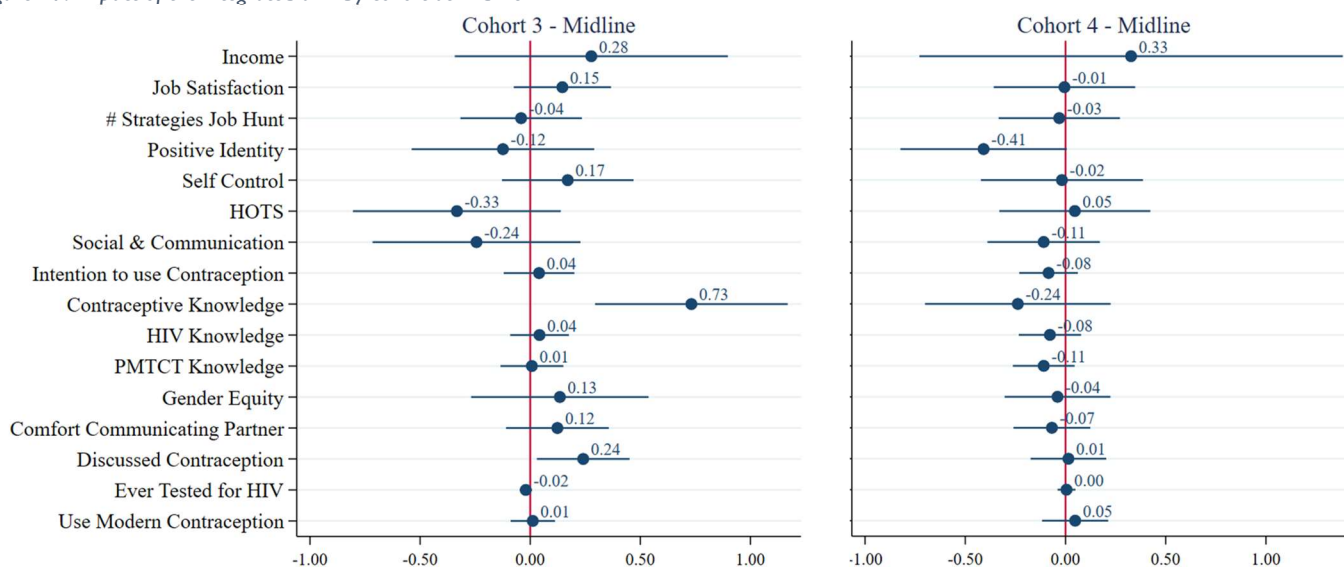
$$Y_{ict} = \text{midline}_t + \beta \text{Treat}_c * \text{midline}_t + \gamma \text{midline}_t * \text{Cohort}_{ict} + \delta \text{Treat}_c * \text{midline}_t * \text{Cohort}_{ict} + \text{endline}_t + \alpha \text{Treat}_c * \text{endline}_t + \varphi \text{endline}_t * \text{Cohort}_{ict} + \mu \text{Treat}_c * \text{endline}_t * \text{Cohort}_{ict} + \theta_i + \varepsilon_{ic} \quad [4]$$

Regression results are shown in Table A. 6. Figure 17 and Figure 18 show visual representations of the effect for each cohort at midline and endline, respectively.¹⁴ Analysis of cohort 3 at midline shows large magnitudes for income, self-control, HOTS, social and communication, contraceptive knowledge, and discussed contraception, although only the effects for contraceptive knowledge (0.73 std) and discussed contraception (0.24 std) are statistically significant. Analysis of cohort 4 at midline shows large magnitudes for income, positive identity, and contraceptive knowledge. The effects are only significant for positive identity (-0.41 std). At endline, the only significant effects are HIV knowledge (0.17 std) and ever tested for HIV (-0.03 std) for cohort 3, and positive identity (-0.39 std) for cohort 4. Overall, the magnitude of the effects is larger for Cohort 3, especially at midline.

Table A. 6 shows the heterogeneous effects by cohort and implementing partner that are statistically significant.¹⁵ At midline, the only statistically significant heterogeneous effect is for contraceptive knowledge (-0.97 std). At endline, the statistically significant heterogeneous effects are for self-control (-0.41 std), HIV knowledge (0.19 std), and gender equity (0.48 std).

Key Takeaways: There are several differences in the findings by cohort (and by cohort and implementing partner) in terms of what is significantly impacted, in what direction, and to what degree or magnitude. Most of the effects appear to come from Cohort 3 at midline.

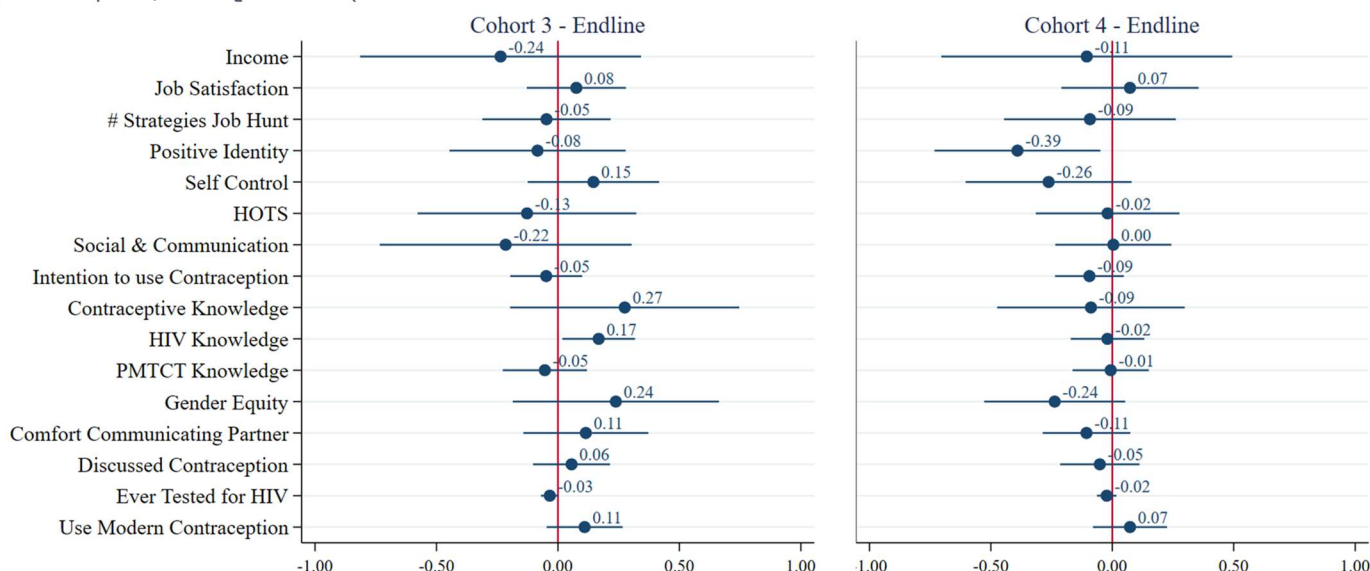
Figure 17. Impact of the integrated arm by cohort at midline



¹⁴ The effects from Figure 17 and Figure 18 were obtained from running equation 3 separately for each cohort.

¹⁵ The coefficients “FP/RH diff – cohort 4 diff – midline” and “FP/RH diff – cohort 4 diff – endline” shows heterogeneous effects between girls and boys at midline and endline, respectively (parameters δ and μ from equation 6, respectively).

Figure 18. Impact of the integrated arm by cohort at endline



Attendance

Attendance data on the sessions youth participants attended and their recovery (make-up) sessions was available from one implementing partner¹⁶ (1) for Cohorts 3 and 4. YP Action used this data to look at differences in attendance between treatment and control groups, as well as attendance patterns over time, first looking at trends by treatment status and then by cohort.

Table 77 shows mean differences in attendance for control and treatment groups. It examines two measures of attendance: on-time attendance, which is the rate of attendance on scheduled session dates, and flexible attendance, which is the attendance rate adjusted for recovery session participation. Attendance is high on both measures for control and treatment groups. On-time attendance was 89.04% for the control group and 91.80% for the treatment group, with the difference between these means statistically significant at the 95% level. Attendance rates rose a few percentage points when adjusted for recovery session participation to 92.70% for the control group and to 95.35% for the treatment group, though the gap between groups was not statistically significant.

Table 7. Mean differences in attendance by treatment status

	Control (WfD)	Treatment (WfD + FP/RH)	Diff (T-C)
On-time attendance (%)	89.04	91.80	-2.75*
Flexible attendance (%)	92.70	95.35	-2.65
Observations	450	450	

Notes: Significance is denoted as: * $p < 0.05$

Next, Figure 19 looks at attendance for treatment and control groups over the course of the program.

¹⁶ While records for other partners were made available, missed sessions were only marked for one of the partners. Other partner records did not provide sufficient accuracy of day-to-day attendance reporting to allow for an identification of absence patterns. Although we do not analyze attendance data from those partners because of this limitation, it is important to note that the records often show relatively high levels (often above 85%) of attendance corrected for make up sessions, pointing to strong youth engagement with the program content.

The first pair of charts documents on-time attendance day-by-day. It shows variable attendance patterns initially in the program for both groups, with attendance picking up roughly two-thirds through the program and tending to rise as the program continued. The second pair of charts makes this pattern clearer, with consecutive increases in flexible attendance beginning approximately two-thirds through the program for the control group and roughly halfway through the program for the treatment group. As also seen in Table 7, attendance is typically higher for the treatment group, though it appears the control group had more problems with attendance early in the program, effectively catching up with the treatment group by the end of the program.

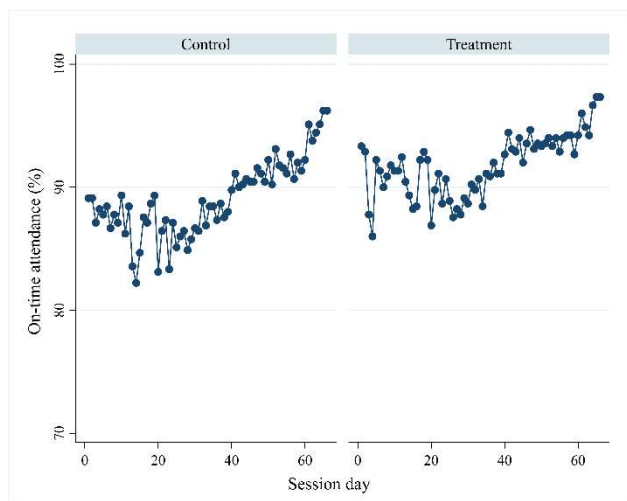
Key Takeaways: Together, Table 7 and Figure 19 suggest that **inclusion of FP/RH content with the treatment group did not, at least for these CPD cohorts, discourage attendance relative to the control group.** Rising attendance may point to increased commitment to the program over time, so that the program won over participants who were not originally interested. An alternative explanation is that the club components of the program, both the FP/RH and soft skills training, rather than FP/RH alone, which were typically a focus during the first half of the program, were less engaging for participants and that attendance rose more during the vocational skills training held in the second half of the program.

In contrast to this attendance analysis, youth and staff reported serious attendance challenges during the process evaluation. Despite differences in reported attendance levels between these two sections—which could reflect exaggerated perceptions of attendance challenges by staff and youth or a lack of representativeness of the attendance records from this one partner for the program as a whole, both analyses point to similar *patterns* of attendance, with attendance improving over the course of the program. As the process evaluation discusses, staff and youth often attribute this positive shift in attendance to increased comfort engaging with FP/RH topics.

Figure 19. Attendance over the course of the program by treatment status

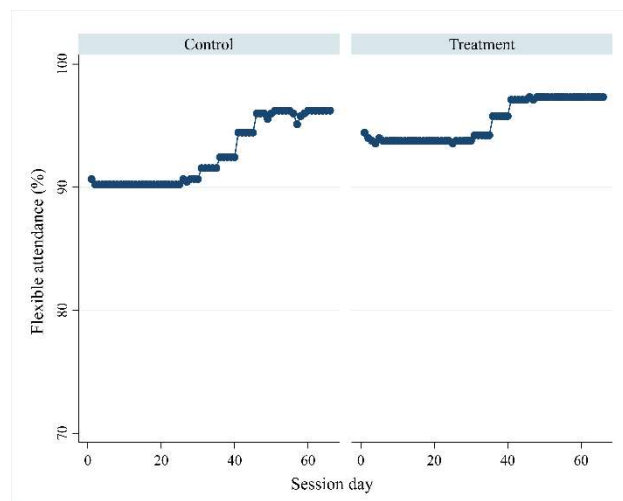
On-time attendance (%) by treatment status

On-time attendance = attendance on scheduled session date



Flexible attendance (%) by treatment status

Flexible = adjusted for participation in recovery sessions



Finally, Figure 20 shows the same two attendance measures over time by cohort, investigating reports

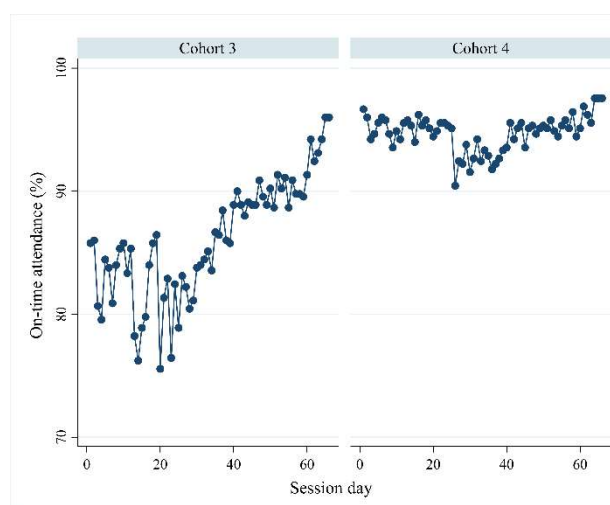
that Cohort 3 had particular challenges with attendance. The charts support these reports, showing relatively even attendance for Cohort 4, with dips in the middle of the program for on-time attendance that appear to have been made-up given the stable flexible attendance trend. For Cohort 3, both attendance measures show lower attendance at the beginning of the program with more pronounced increases as the program proceeded.

Key Takeaways: This indicates that **the attendance patterns discussed with Figure 19 hold primarily for Cohort 3, not Cohort 4**, and that cohorts faced unique attendance challenges.

Figure 20. Attendance over the course of the program by cohort

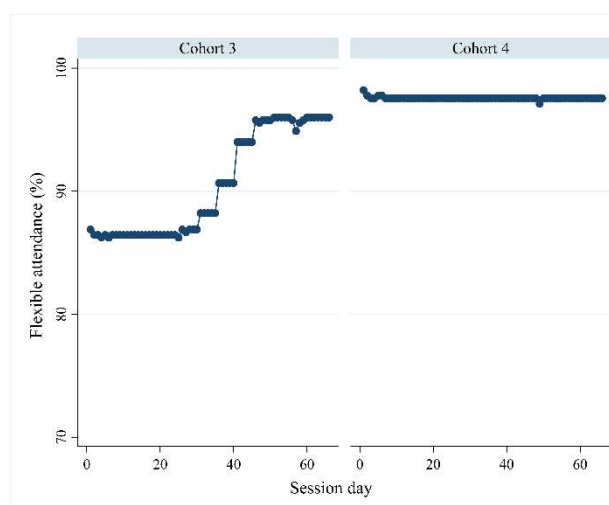
On-time attendance (%) by cohort

On-time attendance = attendance on scheduled session date



Flexible attendance (%) by cohort

Flexible = adjusted for participation in recovery sessions



Impact Evaluation Study Conclusion

Overall, the integration of FP/RH into workforce programming initially resulted in improved contraceptive knowledge among the participants of the integrated (treatment) arm, and the treatment group participants also were more likely to have discussed contraception with their partner. With time, these effects became more subdued, with lower effect estimates and the loss of statistical significance. No effects of the integrated intervention were noted for other major health outcomes or employment outcomes. For soft skills, control group participants, particularly girls, show more growth in their positive self-concept skills than the treatment group participants. However, the levels of positive self-concept were higher at baseline for the treatment group.

Generally, both point estimates and variability ranged substantially across local implementing partners, indicating that implementation played a substantial role, even with a consistent set of materials and training. Finally, while attendance appeared to have improved over time, effects on contraceptive methods

knowledge were more pronounced in the first cohort of the study, and much less so in the second cohort, again pointing to implementation differences.

These results indicate the complexity of measuring the direct impact of a multifaceted intervention on behavioral outcomes. Perhaps most surprising is the lack of stronger effects across the entire range of health knowledge and attitudinal outcomes, given the exclusive focus of the treatment intervention on providing that content to treatment group participants. Employment effects were difficult to estimate due to the fact that youth were still enrolled in the S2S program at the time of the midline and endline and had not yet reached a stage of active job search. This also explains the large portion of missing data from participants not yet in the labor market and not actively searching for employment. Consequently, most participants were also not able to consistently report income data, resulting in limitations to the analysis. Finally, the variability of treatment effects across implementing partners provides an indication of the need to more closely examine the role of implementation and the different facets that can affect the youth experience with ostensibly the same content and modality of content delivery. Because the partners worked in the different geographic areas in and around Dhaka, some of the variability may be due to the slight differences in context and community structures around the youth clubs.

Process Evaluation

Study Summary

Through the process evaluation, the study sought to learn from Save the Children's experience integrating FP/RH into their Skills to Succeed (S2S) workforce program. As part of the process evaluation, YP Action prioritized the following questions to be explored in this study:

- What did program beneficiaries think about participating in the integrated component? Did they perceive there to be interrelated benefits from receiving soft skills (e.g., self-control, positive self-concept), FP/RH, and workforce training together?
- What did and did not work about integrating FP/RH into the S2S program? How were challenges met?
- What did program beneficiaries think of the role of Peer Leaders and Community Mobilizers in facilitating improved FP/RH?
- What are the staffing and operational issues relating to an integrated program and how do implementers (Save the Children and their local implementing partners) address them?

Methodology

The process evaluation explored how the two sectors, WfD and FP/RH, were integrated, as well as challenges faced and how they were dealt with. As part of the process evaluation, we worked closely with Save the Children and their local implementing partners. The process evaluation applied a range of methods appropriate to each question and included Save the Children's M&E data, reports to FHI 360's investigators from Save the Children, and interviews and focus groups with stakeholders. More specifically, YP Action gathered data from the following various stakeholders:

- Peer Leaders
- Community mobilizers
- Implementing partners (IP) and Save the Children staff

- Youth beneficiaries of S2S

To complete the FGDs and IDIs, trained facilitators met with youth at youth clubs to gain their consent (or assent for minors, and afterward gained parental consent as needed for minors). At the time of consent, facilitators provided youth with details such as date, time, and location of the FGD or IDI. The location was often the youth club for the safety and familiarity of participants (or another convenient location for the participants) but would have been at a time when privacy could be maintained for the group discussions or individual interviews. FGDs and IDIs were audio-recorded with participant permission and transcribed and translated verbatim (but with identifiable participant information removed) by a hired transcriptionist/translator and reviewed by the facilitator(s). To maintain confidentiality, transcripts refer to the speaker by a participant number, e.g., P1, P2, etc. Transcripts were emailed to the investigator and local study coordinator within one week after each FGD or IDI for quality review and clarifications.

Focus group discussions (FGDs) included randomly selected youth from the S2S program. Based on Guest et al. (2016), YP Action used three FGDs per demographic sub-group (male/female) and age group as a likely number needed to generate thematic saturation. YP Action conducted 6 focus group discussions per cohort for a total of 12 focus group discussions. Individual in-depth interviews (IDIs) were also carried out with youth over two rounds. The first round included 12 youth (6 male, 6 female) recruited from one cohort of the Integrated FP/RH&WF of the S2S program, and comprised youth from a range of ages, as well as married and unmarried youth. YP Action prioritized interviews with married youth to be able to best understand the utility of the FP/RH component of the program. The second round of interviews (also n=12) targets only married youth to add more depth to our understanding of the FP/RH component.

Table 8. Distribution of Youth FGDs

FGD participants	IP1	IP2	IP3
FGD1: Youth over age 20	Male group (8-10 participants)	Female group (8-10 participants)	Female group (8-10 participants)
FGD2: Youth under age 20	Female group (8-10 participants)	Male group (8-10 participants)	Male group (8-10 participants)
Total: 6 FGDs per cohort for a total of 12 FGDs			

Table 9. Distribution of Youth IDIs, Round 1

IDI participants	IP 1	IP 2	IP 3
Youth over age 20, married	1 female	1 female	1 female, 2 males
Youth over age 20, unmarried	1 male	2 females	
Youth under age 20, married	1 female		
Youth under age 20, unmarried	1 male	1 female	1 female

IDI participants	IP 1	IP 2	IP 3
Married youth			
Total: 12 participants	4	4	4

Table 10. Distribution of Youth IDIs, Round 2 (Married Youth Only)

IDI participants	IP 1	IP 2	IP 3
Married youth	2 Female 2 Male	2 Female 2 Male	2 Female 2 Male
Total: 12 participants	4	4	4

In addition to the focus groups and IDIs with youth, YP Action conducted two focus groups (one from the treatment arm and one from the control arm) with “community mobilizers,” or the session facilitators, and two focus groups (one from the treatment arm and one from the control arm) with peer leaders, who were youth program participants that played an assistant role to the community mobilizer.

The analysis approach for the process evaluation included multiple stages beginning with content analysis of FGD and IDI data captured in verbatim transcripts uploaded to NVivo. A codebook was drafted in advance of the qualitative analysis (deductive approach) and revised as coding progressed (inductive approach). Inter-coder reliability among two qualitative analysts was checked with the first few coded transcripts and the codebook revised as necessary. Themes were identified and second level coding was conducted as appropriate to better understand sub-themes and investigate emergent themes. During analysis, analysts prepared thematic memos and discussed results among the study team as well as with Save the Children and IPs.

Findings

This section begins by reviewing the main FP/RH content areas where youth reported learning, focusing on contraception and family planning, puberty and menstruation, and HIV/AIDS, and discuss how they applied or anticipate applying that knowledge in their lives. Then it examines additional benefits youth report from their participation in the integrated program: overcoming discomfort with FP/RH topics, feeling better able to seek help for FP/RH issues in the future, becoming more effective advocates—and sometimes self-advocates—on the issues that women and girls face, and employment benefits. These areas of growth often reflect not only on knowledge gains from FP/RH sessions but also on soft and vocational skills from other parts of the program. Finally, this section considers recommendations for the FP/RH component of the program, which center largely on the length and to a lesser extent on the sequencing of content. Wherever relevant, differences in response patterns by gender and marital status are documented.

Experiences with FP/RH Topics Covered in the Program

Discussants often pointed to knowledge gains in sexual and reproductive health topics as a program outcome, with some referencing FP/RH broadly and others citing gains in specific areas. As one male youth commented in a focus group, “day by day, we got a clear concept after receiving training from here.” Examining applications and intended applications of that knowledge, several common themes arose:

- a) Participants have shared or plan to share learning with family, friends, and community members (e.g., “It is noticed that, for getting the training from here, I know better than my other friends regarding these topics. So, these topics emerge in the discussion, then I suggest them. I tell them about many things.” (female youth in IDI)
- b) Participants anticipate applying knowledge in the future, for example when married (e.g., “We need to know about family planning for our married life.” (male youth in FGD)
- c) Participants have applied knowledge during or since completing the program to improve personal health, nutrition, relationships, and other areas (e.g., “I also apply the knowledge from here on me. Specially, the fact of drinking water more and other than that I/we drink more water in time of our period, then we can stay well. To eat a fruit on a daily basis, these things.” (female youth in FGD).

Discussants also mentioned that FP/RH information shared during the program was valuable because it was difficult—or impossible—for youth to obtain through other means (e.g., “I didn’t have any discussion about these topics with anyone before, and I didn’t have the chance to know about it from outside. ... I thought, no, this is an important topic, and actually there any many things to know.” (female youth in IDI) or that the program helped to correct misconceptions about FP/RH topics. Below we discuss the specific content areas that participants commonly associated with learning gains and explore comments about why participants found knowledge in those areas useful.

New knowledge of family planning and contraception has been shared and will be useful in the future

Community Mobilizers and one Peer Leader praised learning gains related to family planning and contraception, especially on different contraceptive methods, their pros and cons, and how to use them safely. Most comments concentrated on raising youth knowledge from a low starting point, e.g., “most of them didn’t know about these methods at all.” One Community Mobilizer also explained that her own knowledge increased as a result of the program, stating, “We knew a couple of plans, but after coming here, there were three, four, five that I had never learned, never heard of before.”

Youth, both male and female, frequently mentioned new learning in this area, focusing their comments on new knowledge of contraceptive methods and, to a lesser extent, on considerations for timing and spacing of births. Specifics in this area were new for many youth; most came in with, at best, only basic knowledge of contraception and family planning. Some participants emphasized that there was no opportunity to learn this information at home or elsewhere, as one female youth participant explained in an IDI: “[I]ike you have said about birth control that maybe not told by elders to us. I learn this thing was totally new to me.” She offered several examples of new learning about birth control when prompted, i.e., “[w]hat we need to use, which medicine [we] should take, then how to control, a mother breastfeeding, how the boy will use birth control through the contraceptive methods, how well the boy will use those contraception methods.” One Community Mobilizer shared that some parents felt similarly—they wanted their children to have knowledge but felt uncomfortable or otherwise unable to share it themselves: “The guardians used to tell that, they took their child here and told that teach them, it [family planning] will be beneficial for their future. I will not be able to discuss these issues with her as I’m her mother.”

The FP/RH program also served to correct misconceptions, especially about contraceptive methods, as some youth entered the program with basic knowledge of one or a few methods for birth control but inaccurate information about how to use them. One Community Mobilizer explained her role in

addressing flawed information: “They had confusion about condom. They used to say that one condom can use several times... ‘sister, who told you can’t?’ We had to face these sorts of questions. So [we] used to give answer. ... Such as one youth was saying that can use two or three condoms at one time, so he said that sister who told you that we can’t use. So, they said these types of things too. Then I said that no, you can’t use two condoms together.”

Another Community Mobilizer shared an example where she addressed exaggerated claims about the side effects of birth control pills, putting the pros and cons of methods into perspective for youth: “Besides that, there were birth control pills. Most of them were unaware of the pills. And most of them said that if we take [the] pill, we will get fat; that’s why they don’t want to take pill. So, they were saying pill can cause a problem. And I was saying that every contraception method has some side effects.”

Ultimately few youth mentioned applying this knowledge themselves, with far more explaining how they had provided information or advice to others on these topics, potentially indicating an extension of program impact from primary beneficiaries to communities more broadly. For example, in a focus group discussion, one female youth reported sharing information with her sister: “My sister, my elder sister has given birth to a daughter. Now, she uses the Implant method. So, she was informed about the method from me.” In another focus group discussion, a male youth described offering information to a friend: “As like few days ago, one of my girlfriends asked me she got married, but she cannot want to get pregnant as quick. In this case, I can give her advice/suggestion how to recover this problem which is learned from here.”

These and other examples of sharing tend to emphasize relevance to married individuals, and unmarried youth regularly envisioned using it themselves in the future, especially once they were married. One Peer Leader illustrated explained this anticipated benefit to female youth: “Like, I’m a girl now. In the future I will go to someone’s house or my family. So, we can’t do that like that. So, that means in regard to birth control, we mean we can’t ask anyone who’s married. We feel ashamed. So, now that I know it, now we can plan like that.” In a focus group discussion, a female participant echoed this reasoning: “When I will get married, then if I’m not informed about it, I may need to take different methods after my marriage. So, if we don’t get informed about it, then we cannot take a method. and then we may take a wrong decision. I might have to suffer for taking the wrong decision. So, we are getting informed about it now for which we don’t have to suffer in the future, because I know which one would be good for me and which method will be proper for me. I will be safe, and my future will develop.” Recall that the impact evaluation showed substantial increases in contraceptive knowledge and reporting they have discussed contraception with their partner at midline; however, those effects did not persist through endline. This may due to fact that these topics were less immediately relevant to program participants, most of whom are unmarried.

In a rare statement, one male youth mentioned the possibility of using contraceptive knowledge before marriage in an IDI, saying, “that was beneficial for me. ... these things will be helpful to me in the future. [Facilitator asks if he had ever used any methods] Not yet, but I am thinking ... [Facilitator: “You mean before getting married?”] If I need it before or after the marriage, I will use it.”

Although unmarried youth tended not to report having used their new knowledge of family planning and contraception, the future significance they attribute to it suggests it will have delayed, longer-term benefits to them.

Perspectives from married participants

In contrast, married youth found information shared on family planning and contraception more immediately useful. Specifically, all married youth participants from the second round of IDIs reported that they or their partner had used information about contraception. A few mentioned entering the program with familiarity about condoms and birth control pills but felt the program's coverage of a variety of methods expanded their knowledge of contraception. In the words of one female youth, "I knew about some of those topics. I didn't know about the whole thing. I mean, suppose, previously I only knew about condom and pills as birth control methods. Afterwards, I have learned that sticks, injection and apart from something named ack, the name of which I have forgotten now; many things are available like these methods. I learned about these after coming here but previously I didn't know that the girls can use condom."

In terms of other family planning topics, married youth, including male participants, also mentioned new knowledge of the risks women face when they have children too early. Additionally, while the curriculum does not address abortion, it may be a family planning option that some youth think about. One male youth commented on discussing it with a friend: "As the baby has come to the womb, now, what you will do? You can keep it if you want. If don't want to keep it, then go and talk to the nearby Surjo clinic." In line with this example, married participants, like unmarried ones, also found sharing information from the program with family, including spouses, and friends to be an important benefit.

Notably, because contraception and family planning were relevant to married youth in the short term, many had already tested their skills navigating these topics with spouses and families. Promisingly, most reported negotiating family planning decisions as a couple. One added that she seeks help from her mother-in-law or her own parents if she and her husband are not able to make a decision. However, several reported that women take (and are obliged to take) more responsibility for contraception than boys. While this means that some female participants are empowered to make their own choices—one explained that she makes decisions on behalf of her and her husband, it also means that family planning and contraception decisions fall under the wife's purview, without equal engagement from her husband. For others, male preferences constrained contraception choices, with bias against condoms meaning that young women must use contraception.

In a related challenge, a couple of married participants struggled to transfer program knowledge to their spouses. For example, one male youth reported using condoms because his wife does not want to become "obese" using the pill, though it was not clear whether he identified her belief as a misconception. A female participant stressed that her new knowledge alone was not enough in her relationship—her husband needed training also for them to effectively make informed decisions: "It will not work if I only know about the method. My husband should also be informed about it. If my husband is informed about it, then we won't have any dispute or suspicion among us. Then he can understand it will be a good facility for controlling childbirth. So, about the method, the method should be known by two of us, and it should be taken by both of us. The method should be applied after having knowledge about it." Her discussion implies that her husband's education must come externally, not from her. While this power dynamic may be the greater concern, having Community Mobilizers do additional sensitization work with husbands may help others in her situation overcome this challenge.

In short, information about family planning and contraception found immediate application among married youth. While some reported effective communication with spouses and families on these topics,

others felt discussion and decision-making around their new knowledge was fraught, potentially undermining how well and deeply new learning could be applied.

Knowledge gains related to puberty and menstruation reassure youth about the normalcy of changes and yield immediate shifts in sanitary and nutritional practices

Unlike family planning and contraception, both unmarried and married discussants found information on puberty and menstruation useful in the short-term, perhaps because the information applied to immediate life changes they faced rather than ones they associated with events like marriage. This area represents one of the most significant benefits cited by youth, but it was not measured in the impact evaluation, pointing to the need for including measures on knowledge gains related to puberty and menstruation in future evaluations of integrated or FP/RH programs. One female focus group participant, speaking generally about the sessions on puberty, commended the practical details conveyed during the program: “I was unaware about the things that were required in daily life. I knew about the issues of related to puberty—I mean this chapter was added in the physical health education book, but we never talked about it directly. We knew all about it but didn't know in detail. There is a difference when we read one thing in book and when someone give us clear idea about that matter.”

Another female focus group participant highlighted the difficulty of getting this information from family, implicitly observing the importance of getting this information from the club. In her words, “I cannot share it with my parents, I feel shy when talking with my mother and sister about these topics.”

Both male and female participants expressed relief at better understanding that the changes experienced during puberty were normal. As one male focus group participant explained, “[w]e often used to be afraid to see the changes in our health during adolescence. Oh, my God! What happens, what happened, what is happening? Now we can understand that it's normal.” Another female youth echoed this sentiment in a focus group discussion, explaining she had reassured a friend's sister about the normalcy of changes during puberty:

For example, I have a friend. Her sister—I mean, her younger sister at the time during her puberty, she was getting silent. She weirdly thought about lots of things all the time. Then I told her that during this time these things may occur. Enlargement of the breast, I talk about the physical changes with her. Then she could understand that what are these changes. She was thinking that why these things are happening to me? Why these changes are happening to me? I mean, she always behaved strangely for these reasons. Then I told her that it is natural.

While knowledge of changes during puberty often reflected the curriculum—for example, reported understanding that wet dreams were common, not concerning, two married youth described masturbation as very harmful. While they provided limited context for their comments, the program may want to consider addressing these negative attitudes explicitly in the future, especially if they are shared by others.

Among some male youth—as well as Community Mobilizers—discussion of benefits centered on better understanding of reproductive anatomy and how sex works. As one Community Mobilizer summarized, “our reproductive health that is different from boys and girls—they knew about it, but they didn't know about the difference of reproductive organ in boys and girls, and the function of reproductive organ, ovary and uterus and here during pregnancy baby stay there.”

For female participants, who cited learning about puberty far more often than male youth did, managing menstruation was overwhelmingly the most common theme. A few mentioned learning not only about what was normal during menstruation but when to seek help for abnormalities. For example, during a focus group discussion one female youth described counseling her sister: “my elder sister had such kind of problem [long gap between periods]. She would have menstruation after two to three months. When I learned from here that it is actually a problem, I told it to my sister. Later she went to the doctor and got treatment; now she menstruates in every month.”

Many female youth found sessions on safe sanitary practices during menstruation illuminating and noted learning in this area, with several explicitly stating that they had changed their behaviors, especially related to cleaning and maintenance of reusable cloth pads. In a focus group discussion, one female youth gave an example, saying “need to change the pad in every 6 hours, otherwise there can be a chance of spreading infection. After knowing about these things, now I practice these things. This was beneficial for me.” Several female participants also volunteered examples of how their practices had changed in another focus group discussion:

[Female Youth A]: Previously, we didn't know that I have to dry the fabric in sunlight.

[Female Youth B]: I mean, previously, I used to dry the cloth in narrow places because of feeling shy.

[Facilitator]: Anyone else like this?

[Female Youth C]: How long we can keep the pad; we didn't know about it. Previously, we used to keep the pad for a long time.

[Female Youth D]: Previously, we didn't use to keep a pad with us. We used to try to cover the whole day in just one pad or something like this. Now, things like this don't happen.

Another important area of change, one typically though not always tied to menstruation in discussions, concerned nutrition, with a few males and several females flagging learning in this area and some explicitly mentioning shifts in general nutritional practices and menstruation-related nutritional practices as a result of the program. For several, the program dispelled misconceptions about nutrition. In a focus group discussion, one female youth described local beliefs about nutrition during menstruation and her shift in understanding:

When we read in school, I had a friend named Nishi (name of a person). So, when she had her period or when she was in her adolescence period, then her maternal grandmother used to suggest her not to eat meat or fish in that time. I mean, she used to deter her. No, you should not eat these.... You may have to suffer from some problems if you eat these. ... She deterred her to eat anything sour, don't eat anything like this and you should maintain yourself in this time. I mean, she suggested to eat only the green foods and she deterred to eat anything else. I got to know about nutrition after coming here. Our body becomes weak for menstruation, for which [reason] during our period or adolescence, we must need to eat fish or meat. We need the nutrition in that time—so we can get the nutrition if we eat fish and meat. I got to understand it from this theme though the maternal grandmother of my friend suggested not to eat these, but after coming here my confusion has vanished.

Others mentioned similar misconceptions, especially around the practice of avoiding fish during menstruation. As one female focus group participant explained, “Lots of food was forbidden. Can't eat

eggplant and fish. Now I know that I can eat all types of foods, in fact I need to eat more nutritious foods ... As lots of things were forbidden earlier now don't maintain those things."

A Community Mobilizer, speaking generally about nutrition, added that many youth believed that expensive foods were more nutritious, a misconception she addressed when teaching, telling youth that "... you can get nutrition from milk, egg, fish or vegetables. ... You don't need to eat expensive food every day." In a focus group discussion, a male youth also mentioned learning about the value of sleep as well as nutrition. Having often stayed up late at night on the computer, he said, "[p]eople could recognize me as a drug addict, and they called me heroin addict. Through this I can understand the value of eating on time and sleeping on time."

Finally, although male youth rarely brought up menstruation, those who did spoke of the knowledge as transformative. In an IDI, one said he "[f]elt uneasy at the very first time and thought that, 'What the heck is this! Is it really happens like this?' Then I felt good after knowing this vital thing that I didn't know before." Others reported having ended their practice of mocking girls during menstruation after learning more in the club. In a focus group discussion, another male youth noted he felt better able to care for women in his life as a result: "Also, we could learn how to take care of our mother and sister's health at home. We became aware of this matter ... When my sister or friend is in period, which things she needs instantly, we have come to know and get a clear idea from FP/RH session." One married youth even reported being better able to care for his wife as a result: "I told her during her menstruation, if your sanitary napkin is finished, you will ask me then I will bring it but do not use cloth. And always keep yourself neat and clean."

Taken together, discussions on puberty and menstruation suggest that the program led to shifts in perspectives and behaviors in the short-term, more so than other areas that were less urgently relevant to youth participants, most of whom were unmarried.

Learning about HIV/AIDS helps dispel misconceptions and destigmatize the disease, with information anticipated to be useful in the future

Discussants, both married and unmarried, frequently brought up HIV/AIDS, and sexually transmitted infections as an area of learning during the program. Community Mobilizers believed the topic to be more relevant for boys as one explained:

You will see that most of the girls stay at home. They come out from their houses very less and forward less in the path of becoming bad because most of the time, they live in domestically and on the other hand, the boys gossip with their friends and go to different places. In that case, a boy might have the possibility to forward in the path of doing any wrong. From this perspective, the boys are more (interested) [in] the medium how HIV spreads, for example, if he involves in physical relationships with many people and doesn't use the condom. In that case, he has the possibility of getting affected with HIV.

Despite this perception, youth brought up new knowledge of these topics in roughly equal numbers. In a focus group discussion, one male youth reported what he had learned: "I've come to know many things about HIV/AIDS. How does it occur, junkies use the same syringe, they would at least, now I don't see them. If a person uses another one's syringe, that would result in HIV/AIDS. And it occurs from unsafe sexual relation[s], if they didn't use any condom. I've come to learn so many things from here." Another

explained that “now I know that girl’s blood should be tested to check HIV and over viruses” (married male, IDI).

Some linked the applicability of HIV/AIDS knowledge to marriage. In a focus group discussion, one female youth explained that “her [married friend’s] husband might be a reliable person but how she can identify if her husband has HIV or not. ... We can apply the things which we have learned from the club.” A male focus group participant shared a similar lesson, noting its relevance in marriage: “When anyone gets the knowledge about AIDS, HIV and how the HIV virus transmitted then s/he will refrain from that. He told about marital life, and we will obey that instruction. HIV is the most epidemic disease. We can save ourselves by implementing the knowledge got from the club.” Indeed, the only participant who reported having been tested was married: “... HIV, everyone needs to check it. I was unaware of it and after coming here I got to know about it, and I took the test” (female focus group participant).

An important point of growth was in learning how transmission typically occurred and correcting related misconceptions. One female focus group participant noted, “... we didn’t know about HIV; rather I knew that HIV occurs for a mosquito bite. I had such a conception from my childhood. Afterward, I got to know that this happens through these.” Another female focus group participant detailed what she learned about transmission, explaining that “[f]or example, through an injection when transmitting blood if I take it, HIV I can spread through it. Afterwards, HIV can spread through having physical relation (was feeling shy) and by breastfeeding. HIV can spread in many other ways which we got to know.” Generally, youth demonstrated improved understanding of HIV/AIDS transmission, though one married participant mistakenly reported that the virus could be share via saliva: “Yes, they have informed us about how the HIV/AIDS spreads. HIV/AIDS doesn’t spread by drinking water in the same glass. Those germs are created by spit and semen, so I got to know all of those things from here. I didn’t know about these things before.”

According to Community Mobilizers, the sessions also helped to destigmatize HIV/AIDS, teaching youth that there is no reason to shun those with the disease. One observed that “[a]fter getting this proper knowledge, their perception was changed. A positive perception came in them that we can mix with our friends if they have HIV, and we can sympathize them.” A female focus group participant appears to have taken this lesson to heart, noting that she used to believe she should not associate with those with HIV/AIDS: “I used to think, if I maintenance acquaintance with them, then I can also suffer HIV, we knew these things.”

While many reported understanding strategies for prevention and the importance of getting tested and, if needed, treatment, few reported applying this information. Recall that the impact evaluation showed no significant effects on HIV/AIDS knowledge and a slight and significant increase on having been tested for HIV at endline only. As with knowledge about contraception and family planning, it could be that learning in this area will have stronger effects in the long-term than the short-term or that it is difficult or embarrassing to discuss examples of applying this knowledge, such as practicing safe sex, before marriage.

Additional Benefits from the Integrated Program

While knowledge gains were widely reported and discussants did, in some cases, outline behavior changes resulting from learning, not all youth could remember FP/RH topics they had been exposed to, and youth often did not volunteer specifics about their learnings. This may (or may not) indicate shallow

knowledge gains, ones potentially in line with those documented in the impact evaluation, or it may reflect on the nature of the interview process. Nevertheless, beyond knowledge gains and their applications, discussants reported additional general benefits from the FP/RH program as well cross-cutting benefits leveraging skills from both FP/RH sessions and other parts of the program.

Youth overcame discomfort discussing FP/RH topics

Youth, especially female participants, often explained that they were initially uncomfortable discussing—and sometimes even unable to discuss—FP/RH topics, but that they shed that discomfort during the program. Youth unease was an important hurdle that Community Mobilizers and Peer Leaders had to overcome to retain youth in the program and engage them during sessions. One Community Mobilizer described typical youth reactions, saying, “[if][w]e [the youth] feel shy while discussing these topics, we will not learn about these topics. In that case, it was tough for me to hold the youths. Then I had to convince them.” Another Community Mobilizer explained how overcoming discomfort enabled learning: “Now they know it’s not a matter of shy, then they learn about ovary, fallopian tube, uterus, etc.”

Youth not only linked greater comfort to their receptivity to FP/RH content, some spoke of it as liberating: “Without that, we used to feel hesitant to talk with the family members or it can be said that we didn’t want to talk with them but after going there sister (CM) helped us in vanishing our discomfort and we could discuss in a free mind. ... Now, I can freely talk with them and this was possible for the club (female youth participant in FGD during conversation on FP/RH issues).” Married youth in particular observed stronger communication skills with married peers and sometimes—though as discussed earlier, not always—with spouses.

In an IDI, one female participant emphasized her greater confidence in discussing FP/RH topics, stating, “I could get my courage from here. I never had courage like this before. ... Like, I am talking to you right now about these things; at first, I couldn’t talk to you like this if you had taken my interview.” Another female youth participant from a focus group discussion explained how this confidence extended outside the club, enabling her to independently manage activities she previously found uncomfortable: “I never went to the shop for buying the pad. I felt hesitated and thought about if I should go to the pharmacy or not. I used to feel a hesitation. I used to bring it with the help of my relatives or my father. So, after doing this course from here, now everyone knows about it intact—the boys who are unmarried, they also know about it. So, from this perspective gradually I got comfortable with it. Now I can go to pharmacy to bring pad.”

Prepared to seek help on FP/RH matters in the future when needed

A related benefit is that some youth, again largely female participants, feel better equipped to seek help with FP/RH matters that arise, with several emphasizing that now they would reach out to family or medical professionals with issues or recommend that others with issues do so. As a male youth participant explained in an IDI, “[w]hat I am learning from here is that if anyone is telling me that there is such a problem [related to sexual and reproductive health] then it means that he has to go to this place ... In health care center, to consult with the doctors.”

For some, this new ability stems from their greater comfort and confidence communicating about FP/RH topics. One female youth participant noted in an IDI that she can now ask for help with menstruation issues:

I couldn't express if I suffered from any problem regarding my period. Even, I also used to feel hesitated to tell my mother, so the matter of sharing it to a doctor is not a question. So, I mean, after coming here, whenever I got to understand that, yes, this is a part of human being. Afterwards, I became conscious about it. Now, if I face any kind of problem then I can express it to my mother, or I can openly describe it to the doctor. Moreover, I have faced many other problems which I can handle normally now, I don't have any problem regarding this.

In an IDI, another female youth participant explained how she had recently successfully visited the doctor: "I had period problem, so I went to hospital for a checkup. My problem then solved. ... I talked to the doctor ... before coming here I had no courage to talk with the doctor. I got this courage from here."

Along similar lines, two others suggested that they will learn the details of FP/RH topics later when they need the information. Specifically, the female youth participant credited FP/RH sessions with giving her the foundation to learn more in the future ("As we got to know about these things, and these things will help us to learn new things"), and stated that she would seek information on the internet when needed ("If we can know about the topics, then we can get all the information from the internet"). Although youth may not have retained in-depth knowledge about FP/RH topics—as the impact evaluation suggests and as qualitative interviews only occasionally refute, evidence points to their increased awareness of FP/RH resources via local clinics, the internet, and their support networks and to their growing confidence in accessing those resources. It is even possible that because they believe they can secure FP/RH knowledge when they need it, youth felt less pressure to retain the information from club sessions.

Youth apply program learning to advocate for better treatment of girls and women and for delayed marriage

While many discussants pointed to a new awareness and concern for the discrimination girls and women face, a few reported also taking action on this issue in the home. For example, one Community Mobilizer reported improvements in nutrition as a result of advocacy on behalf of girls, explaining, "[S]ome have sisters in their house and some have brothers in their house, but the brother is prioritized but the sisters don't get the priority. In that case, when they have got our session, then they have reconciled [with] their parents that boys and girls both need nutrition."

Youth participants shared personal experiences combatting general discrimination in their homes. As one male youth participant stated in a focus group, "[t]hen I learned from the club about gender discrimination. In every family, boys are seen [as] greater than girls [girls are seen as neglected]. I convinced my family [that] boys and girls have equal rights." Similarly, one female youth participant from a focus group outlined the case she had made for herself to her mother: "... in my family they don't give me that much importance because everyone thinks that boys are the head of the family but after learning from here, I shared these things with my mother that you shouldn't do this sort of discrimination. Whatever a boy can do, I also have the skills inside me to do the same thing like a boy. So, after saying that, it brought changes in my family."

Along the same lines, discussants—all but one of whom were female—reported that the program helped youth advocate to delay their own or others' marriages. Two Community Mobilizers mentioned that the program provided an important opportunity to correct the common misperception that the onset of menstruation signals readiness for marriage. In the words of one Community Mobilizer:

They thought that if they had the first period, then it means they are eligible for the marriage, also [they] can conceive a baby, but that's not like that. We thought that period starts, parents also thought that period starts that means it is the right time to getting married. Actually, when the right time to conceive and marriage, we gave them this knowledge. They don't have basic idea about these things ... Parents are bringing proposal for marriage, and they say yes for the marriage. So, she couldn't give her opinion to her parents ... Get matured from the physical side is not enough; we had to mature from the inner side, need proper time for the growth of uterus. They didn't know about it.

Some participants mentioned advocating against marriage on behalf of others in their community. One male youth participant gave an example in a focus group, saying, “[O]ne of our familiar girl’s marriage was happening next to our house. We were told from our club that if you were going to face a situation where a child marriage is taking place, then you would keep some matters in your mind, and we moved forward accordingly and were able to stop that child marriage.” In another example, a female focus group participant shared her knowledge from FP/RH sessions: “I had a friend. She was much poor. Her parents wanted to marry her off fast. Then I tried to reconcile them by saying many things that, to give marriage at an early age mean the breakage of health which she cannot bear.”

Other participants, all female, provided examples of standing up against marriages proposed for them. Their successes relied not only on knowledge and skills from FP/RH sessions, but sometimes also soft skills and vocational skills gained from other parts of the S2S program. For example, for one female focus group participant—as well as the examples discussed above about protesting discrimination against girls within families, stronger communication skills—one of the soft skills youth regularly reported developing during the program, coupled with new knowledge—make them more effective advocates. She explained that “now I can tell her [my mother] everything. So, if anyone tells about any marriage proposal, then my mother tells [them] that my daughter has become matured, and she knows about everything. She can share her opinion, and it is her right.” For another female focus group participant, greater self-confidence and goal-setting skills helped her decide to put off marriage: “[S]ister, let me tell you, earlier I used to think that as I am a girl, so I am one kind of burden. Now I am doing study, but my parents are thinking about my marriage and when they see any eligible bachelor, they want that I should get married.... I had to be self-dependent and I will do a job. I will be self-dependent, and I will earn money and it will help my family. Then when I will feel I need to get married, I will.”

Finally, for one girl—the friend from the economically strained family in the example earlier—the opportunity for training from S2S diminished the financial urgency for marriage. The friend’s family could not afford to pay for her continued education, but she eventually enrolled in S2S, importantly for free, at her friend’s recommendation:

I have informed them [her parents] about here and then admitted her here. Her parents came here to have a talk and after admitting her here, she is more or less good. She has not yet been married. She has involved herself with doing some tuitions. She is applying for jobs. I mean, she is bearing her own expenses.

Others also saw new skills as central to fighting discrimination, e.g., “They think their daughter as a burden. If we had any skills then we could do anything, we could make our parents understand.” (female youth in FGD) or marriage (e.g., “parents always want to marry their daughter as soon as possible. But if I could do something by learning those then we could protest them.” (female youth in FGD). One

married female youth offered an explanation why: when families understand that girls have the capacity and skill set to work, like boys, families begin to value them more.

Notably, one focus group brought up FP/RH session participation as a negative factor for resisting marriage. Recognizing female participants' new, mature awareness of FP/RH, some community members reportedly suggested that they were ready for marriage: "If we continue advising such [FP/RH] things, then many people teach our parents to give our marriage by telling that she knows about all of the things. They complicate by saying such things." For the girls who raised this issue, it was a challenge but a surmountable one and sharing about it triggered smiles from fellow focus group participants.

Perspectives from male youth

Continuing a theme that arose in relation to menstruation, some male youth explained that the program taught them to empathize with the experiences with women and girls, ultimately preparing them to advocate on their behalf. For example, in an IDI one spoke of learning to curb his own harassment towards girls in school and demanding that others do the same: "The girl who did not obey us, we used to slander about her such as she made a relationship with me or [if] I saw her with another boy. That means this type of saying was one kind of violence. We enjoyed those acts; it did not seem bad. But after knowing about it, now neither we go for these acts nor do this. And when we see these acts done by others, we forbid them that these are not good; it is a crime."

In an IDI, another championed maternal and child health care, noting the need for change especially in rural areas: "We, we don't properly care for pregnant mothers in rural areas. In that case, both the baby and the mother are at risk. The baby may become ill or the mother may become ill, in some cases, the baby may die, or if the baby doesn't die, s/he may suffer from malnutrition. That is why I liked the things about taking care of the mother and the baby during pregnancy."

Perspectives from married youth

Among married youth, several commended the program for preparing them to discuss or take action around better treatment for girls and women. Some articulated concerns unique to marriage, including resisting the pressure to have children early in marriage. As one female participant explained in an IDI, elders harass wives if newlyweds do not start a family immediately. She felt better able to resist this intimidation after the program. For another female participant, the vocational skills she learned allowed her to be less financially reliant on her husband and helped her overcome her husband's objections to her leaving the house, affording her more freedom outside the home.

FP/RH knowledge is perceived to have benefits for employment

Some youth—more girls than boys—spoke about the benefits they perceived from attending a program that integrated FP/RH topics with soft skills and vocational training. Of these, many youth, as well as three Community Mobilizers, saw FP/RH and skills development as two distinct benefits influential in different parts of their lives, FP/RH in personal or home lives and skills development in their professional lives (e.g., "computer is essential for professional life, FP/RH is the same as it is essential for our personal life," (female youth in FGD). A couple saw the topics as separate but linked, with good health a precondition for employability, e.g., "If we can't be healthy then we can't study and we also can't go to the workforce," (female youth in FGD). A male youth participant saw new skills in family planning as essential to growing professionally and supporting a family. He reasoned that, once married, he could

plan to delay starting a family, allowing him to “... excel at my job, then I’ll be able to fulfill my family’s demand.”

Others, including one Community Mobilizer, felt the program would help them ensure safe work environments, with male youth participants from focus group discussions committing to avoid harassment when asked about the possibility of having female co-workers: “We have to less the sight attraction. There are some people who make girls anger, do bad comment. They hit their eyes on them. We just left these [behaviors].” Female youth participants in IDIs emphasized new awareness of harassment or other workplace safety issues they may face in the future. In the words of one, “when anyone provides a job then they only talk about the positive aspects of the job but the problems which we might face were described in the FP/RH sessions. So, I learned about these things to be conscious and how to be safe in the workforce.”

Finally, a few female youth from two different focus groups saw their FP/RH knowledge as an important qualification for health positions. For example, one stated, “I can apply in health centers if I get the opportunity.” Another had been asked about her knowledge of HIV/AIDS during a job interview that led to a job offer: “So, she asked me separately that do I know about AIDS. Then I thought that in the program I learned about it. Then I said, yes, I know about it and I told her about it. Then she told me that yes you are right, and I got the job but as it was far from my home, that’s why I couldn’t join there. I learned it from here and I got the benefit from it.”

As such, it is possible that participation in the integrated S2S program not only led some youth to feel better prepared to enter the workforce or lead balanced professional and personal lives but inspired some to think about career paths in health.

Youth Recommendations for the FP/RH Component

Few discussants volunteered ideas for improving the content of the FP/RH component. In an exception to this norm, a married female youth proposed involving youth in field-based learning experiences from time to time, for example, to support polio vaccination efforts:

“Yes, I used to think about a topic, and I used to have this thought when I used to attend the classes. We have a polio vaccination week; it would be good if the sisters [CMs] could assure the participation of us, the students. Then it would have been good. I mean, if the sisters could be sent as volunteers to an organization where vaccination would be provided on that day, so the sisters can stay in that place. So, the fact is you have been learning about these topics related to the brought up of children, topics related to sexual matter, birth control so you can apply this knowledge in the field level. The leaders [Peer Leaders] actually. I think they can keep brothers and sisters who are students—they can keep us as volunteers in the polio vaccination week.”

More commonly youth participants in both FGDs and IDIs provided on recommendations on the length and sequencing of the program, usually in response to prompts. Some responded that the overall program length—typically six months with first three dedicated to soft skills and FP/RH topics and then next three dedicated to computer-related vocational skills training—was adequate.

However, the majority of youth from all three implementing partners and some Community Mobilizers requested that the length of the vocational skills training be extended so youth learn about and practice

the trades in greater depth. Some suggested shortening the FP/RH component to one or two months to allow for more vocational training while others wanted to lengthen vocational training without sacrificing FP/RH content. During a focus group discussion, one female youth participant emphasized the importance of extending the vocational skills component because, unlike FP/RH sessions, it directly improved employability: “[o]ur training is being done through the S2S, and due to the training, we are getting job. We are not getting job for these things [FP/RH]. We had to learn these things along with employability skills. But this is not possible for us to learn it in three months. Our course will end from here. When I will go back home, I have no scope to learn these things. In three months, nothing happens.”

On the other hand, one youth participant argued against extending the program, explaining that the urgency of finding employment would preclude or at least discourage participation in a longer program. In a focus group discussion, a female youth participant explained that even six months is a commitment, saying that “[H]ere, we need to wait long for stepping in the job world.” As discussed later, the pressure or preference to work arose as a challenge for program retention. Taken together, these objections suggest that future iterations of the program should consider whether it is possible to provide more vocational content and practice without lengthening the program.

Addressing FP/RH content, some youth participants requested longer classes, especially on topics covered in gender-divided classes, which presumably would have been those on sensitive, gender-specific topics. Some female youth participants explained that longer FP/RH sessions would enable more participation and more detailed learning: “We are just two and an hour to learn. When we learn, then they ask us again, [but] we cannot give answer all the time. The time is limited. And we learn 10 participants, but they ask only 2/3 participants for the short time. So, if time will extend it would be better, all the participant will give respond.” In an individual interview, one female participant observed that the class time naturally lengthened as the youth became more comfortable with their Community Mobilizer, because youth would ask more questions and have more open discussion.

Complicating the picture, some observed that length of sessions already posed a challenge both for travel home, especially if participants lived far from their club, and for community perceptions of their participation in the program, as community members raised concerns about where girls were going for many hours during the day. In the words of one female focus group participant, “[t]o come to an institution, I need one hour, and it takes an hour to go from there. In that case, many people ask our parents where your daughter is going, have you seen where she is going. You should see it. They talked about these things.”

When reviewing recommendations on the length of sessions, it is important to note that the time allotted for FP/RH sessions seemed to vary. One married male said that his class was only one hour per class, and he would have liked to have class for more than an hour. Sessions were more typically reported to be between two and two and a half hours.

Some youth participants and Community Mobilizers also suggested a revised sequencing of program content. Instead of completing club content, which encompassed FP/RH and soft skills, before vocational training, they suggested simultaneously holding the club and vocational training. One female Community Mobilizer said that student interest would increase if “any coordination could be established between teaching computer and these three months, it would have been like, you will learn the computer for two days and you have to attend the classes here for three days.”

Taken together, discussants' recommendations overwhelmingly centered on allocating more time to the vocational skills training component of the program. Youth regularly proposed shortening FP/RH content to achieve this, with the exception of a few participants who advocated for more FP/RH content. Most participants were satisfied with the overall length of the program, though a few problematized the length, arguing that the longer time commitment disincentivizes participation for those urgently in need of jobs. While some felt that the same FP/RH content could be covered in a more condensed way to allow more intensive focus on vocational skills training, whether this could be done effectively—especially in light of weak FP/RH knowledge gains seen in the impact evaluation—will be an important question for future iterations of the integrated program to consider.

Implementation Challenges and Highlights

This section turns to challenges and highlights reported from implementation of the FP/RH sessions. First, it presents challenges in recruitment of staff for the FP/RH component. Then it considers challenges related to recruitment and retention, considering community receptivity to an integrated program as well as other issues. After that, we look at successes and challenges with content delivery, focusing on how gender dynamics and rapport among staff and participants helped and hindered teaching and learning and on feedback on teaching methods and materials. Finally, this section discusses additional challenges that were reported.

Challenges in Recruitment of Staff for FP/RH Component

Discussions with IP staff revealed that recruitment of Community Mobilizers to lead the standalone FP/RH sessions was a challenge, particularly due to the requirements of prior public health experience and experience working with youth. While this was always the preference in hiring, not all of the FP/RH Community Mobilizers came from a public health background or had prior substantial knowledge on the topic. The training and coaching that Save the Children provided was intended to address any differences in background knowledge, and the staff spoke approvingly of the capacity building they had received.

Community Mobilizers spoke of the initial mistrust towards the program from the communities, with one citing that a community felt misled about the program's intentions, having believed the program would have only or primarily a vocational training focus: "They used to think that, they (community mobilizers) admitted the students by telling that they will teach computer but what they are teaching now?" Another Community Mobilizer mentioned that the challenge of community attitudes persisted through implementation. Even after overcoming participants' own discomfort with FP/RH topics, negotiating negative community reactions remained a challenge:

Because the scenario was like people were using the road. I had to talk loudly with the 20 people because the 20 learners have to hear me. If the words which I am discussing loudly goes out, then how will the outsiders will take it? I have motivated my learners, but I couldn't motivate the outsiders. They will say that, what they are teaching? They are totally spoiling them. I mean I had to close the doors before starting the discussion because the society has not developed in that way. ... If the society was developed in that way then I wouldn't have to close the doors. That was a challenging matter for me.

While reports of community perceptions of the FP/RH component of the program were overwhelmingly negative, some family members and friends, mainly older sisters and same-age peers, praised the inclusion of FP/RH content, especially coverage of family planning and contraceptive methods. In a focus group, one female participant provided an example: "[w]hen they gave us the sheet,

if we tell to an elder sister or others that read it, after reading they told us that; these things are right, in that age these things are important to know.” Speaking generally about the program, another female focus group participant mentioned feeling that her community sees her as a role model now: “I was able to come out from those issues and preparing myself for something better. For this reason, my family is also developing. My neighbor they are also looking at me (That means as her life is changing so others are getting motivation from her).”

Perspectives from married youth

Commentary from married youth, who were prompted to discuss community perceptions about FP/RH topics in IDIs, add nuance to reports on this area. In particular, they tend have a more optimistic perception of community receptivity than unmarried peers, with the majority of married youth believing that their communities feel positively about family planning and that contraception is widely used, though not always openly discussed. One male youth reported feeling comfortable talking about FP/RH matters with brothers, friends, and even grandmothers, though not his own parents.

Married youth also pointed to shifting attitudes about family planning. Although some reported that their communities still view a strong connection between religion and family planning, seeing children as gifts from Allah, one male youth said that there is less pressure to have large families than their used to be as people become more sensitive to the challenges of supporting a large family. One male participant explained these changes, saying “There are many reasons for this. The reason behind this change is- because it has been broadcasted huge on the television, it has been included in studies, lots of health workers have been explained this thing going to people’s door to door, then there is a role of activities of community clinics. Including all matters, now I think it is a normal thing; people do not take it negatively anymore.”

Another male youth described a similar cultural shift, “Our present society has become positive through different types of education, advertising; in fact, it has become positive through lots of discussion among friends. The people of previous ages had a problem with their caste system, there was a problem with their education system. Some of these things can be seen in some movies that they are promoting the use of sanitary napkins in this era, where people [Women] of earlier ages used a normal piece of cloth. In the movie, it shows that they are trying to make them understand to use it, but they do not understand, they are not using sanitary napkins. It is a matter of time, of awareness. That time has passed. In our time, we are having open discussions with our friends at certain times. What is happening through this discussion? We have been able to keep ourselves out of harm's way. I am trying to say that there was such a problem in the previous era.”

While married participants are discussing community attitudes towards FP/RH topics generally, not their attitudes towards the program, the increasing openness they report is likely to lead, eventually, to greater receptivity of programs, like S2S, including FP/RH components. An important caveat, however, is that the greater openness married participants report may partly be due to their marital status—being married may open doors to conversations that community members still feel are inappropriate for unmarried youth.

Inclusion of FP/RH complicates recruitment efforts

The sensitivity of FP/RH topics within community contexts strained recruitment efforts. After learning that the program teaches FP/RH classes, families did not want their children to participate, with

objections from mothers about their daughters' participation particularly common. One Community Mobilizer described this experience, saying, “[s]o, the mothers came to me. After coming to me they asked me, sister, what are you teaching them? I have sent my child to learn about computers. The motive of sending my child was, you will offer them a job. What are these things which you are teaching them?”

While guardians often disagreed with the need for teaching the course content initially, Community Mobilizers took time to meet with them regularly and use reflective, participatory techniques with parents to gain approval for their youth to learn the FP/RH content. When persuading mothers of the value of FP/RH content, some Community Mobilizers appealed to their memories of entering marriages without adequate knowledge of FP/RH, especially contraception and family planning. The objections from the mothers cited in the previous paragraph were often resolved in this way, as the Community Mobilizer explained:

Afterward, I had to motivate and counsel the mother. After providing the motivation and counseling I was successful, In Sha Allah. I told them, sister, look the thing which you are telling shameful and unsocial, each of the girls or women has to face it constantly. The matter of Uterus and the process of child delivery, it will be better for them if they have the knowledge about it. Tell me from your life perspective, did you know about it? If you knew about that then maybe you didn't have made the mistake. Many people come to us, the mothers tell us, yes, I didn't know about it. I had difficulties when taking a child. Then I was capable of making them understand that, if your daughter knows about the process and the possible problems which she might have to face then she can take preventions. Then I was successful in making them understand.

Another Community Mobilizer offered a similar example, suggesting to a mother that if she had known this material in her own youth, would she have been able to avoid certain mistakes: “After telling her, she told alright, if I knew about these things then I must have used any method. If I used any method, then I could have taken time for taking a child, but I gave birth to a child soon after my marriage.”

In an IDI, a married female participant reported facing objections from her husband and children, though these objections encompassed the program as a whole and not specifically the FP/RH component. She explained that, “[y]es, my husband didn't want that I should come here. He didn't like the fact that I learn Computer, Web designing, Customer Care, Graphic design. He also didn't like that I used to go to the youth club ... I had to face this difficulty because my husband didn't want me to join this program. I had to face many obstacles from my family. I used to come here by crossing those obstacles. Even, my children didn't want me to come here because they didn't want to miss their mother. Actually, Sister, a married student has many duties than an unmarried student.”

Youths' own objections to FP/RH content also constituted a challenge to recruitment. Their unease stemmed not only from a reluctance to discuss sensitive FP/RH topics with others—as discussed earlier in the report—but also from concerns about how they would be perceived if they participated. Some feared that their reputation in the community would be tarnished if they attended. Even once recruited into the program, some youth refused to join for the FP/RH component for this same reason. A Community Mobilizer explained that youth would even hide in the bathroom for the duration of FP/RH sessions: “The members of our while will say that we have become matured while learning computers or they might say that, what they have learned. We feel shy while discussing these topics, we will not learn about these topics. In that case, it was tough for me to hold the youths. Then, I had to convince

them. The case was like, some of them told that sister can I go to the washroom? They used to pass the whole time by staying in the washroom.”

The evaluation process itself, because it introduced ideas of sex and having children before marriage in the baselined evaluation, appears to have discouraged some from participating. This concern, felt intensely, came from Community Mobilizers in the control group but could potentially have impacted the treatment group (the integrated program) as well. These Community Mobilizers explained that many youth were offended about being asked about sex before marriage and did not join the program as a result. Future iterations of the program should strategize about how best to address this issue in monitoring, evaluation, and research efforts.

Other recruitment considerations

Some Community Mobilizers reported that similar programs in the area that offer youth money for the completion of the program. They believed that some youth joined those programs instead of joining Skills to Succeed because of the money. Some youth also suggested compensating participants as a means of incentivizing participation in the future.

Community Mobilizers also felt that recruitment targets were difficult to achieve, noting that it became hard to recruit once they approached most or all youth who met eligibility criteria. Some felt funds for pamphlets, community mic-ing or broadcasting from a microphone around town, acting in dramas, and going door-to-door supported recruitment efforts, but others did not have these resources available for recruitment.

Finally, while inclusion of FP/RH sessions in the integrated program typically posed a challenge to recruitment efforts, the reverse was sometimes true too. Some youth joining the standard S2S program expected the FP/RH content as part of their coursework and were upset if they did not receive it.

Inclusion of FP/RH constrains attendance, especially early in the program

Like recruitment, negative attitudes towards FP/RH content made it more difficult to retain participants throughout the program, with Community Mobilizers reporting that some youth did not want to attend to avoid FP/RH. One explained this as a substantial challenge, though one that was mitigated over time: “But each of our batches contained 20 people. 20 people didn’t want to hear when they got to know that they are not teaching computers rather they are taking the sessions of the FP/RH project. Then, 20 people among the 5, I mean they were present, and the rest 15 people were not present. ... Afterwards, when we started motivating gradually in the sessions that keeping a sound health is obviously important. If you don’t have a proper health, then how will you do a job? How you will execute your other works? Then gradually they started coming.”

Another Community Mobilizer stated, “I take the session for FP/RH for three days after that they remained absent for 5 days.” A third Community Mobilizer summarized the objections of youth in her club—reflecting a theme discussed under the *Recruitment* section about fearing that program participation would damage reputations:

That youth later told me, sister, I didn’t want to attend your classes. I (the youth) speculated what you will teach us about sex or what you will say about it. It is a shameful matter. Later on, my friends will say you have become mature after going there (youth club). What sexual matters you have learned while going to learning computers. ... So, I felt it as a problem in the beginning because they used to come out during the class time.

Youth tended not to state explicitly that their discomfort with FP/RH discouraged attendance but did speak of an aversion to attending the club program, which may have reflected the inclusion of FP/RH topics there, especially since at least one youth reported feeling surprised and distressed at the start of the program, having been unaware that the program would cover FP/RH topics.

More promisingly, one female focus group participant, like many others, reported eventually overcoming her objections to the FP/RH content and renewing her commitment to attend: “When I started to come to the club, I used to stare at everyone and I thought that what I will do here. I was also thinking that what are they teaching? At first, I did not come here for the first few days, thinking that what will happen by knowing these because I already know these. Then I saw that there are a lot of things to learn.”

In contrast, another female focus group participant never recovered from her initial disinterest in the club content and reported attending only vocational training: “I studied 2/3 days then I didn’t study. ... No, I was not interested to know. I didn’t care it. Then I directly came to the computer course.” A few married individuals also reported not attending the FP/RH component though they did not explain this decision. Whether because of increased comfort with FP/RH content or because youth rejoined following sessions on these topics, these reports from staff and youth reflect the same attendance trend—improved attendance over time—as presented earlier in the report in the analysis of attendance data from one implementing partner.

Ultimately, many attendance challenges were unrelated to the integrated nature of those program. These obstacles included that participants, typically female youth, couldn’t attend because of domestic work in the home or that participants, usually male youth, had work obligations outside of the home. Others noted that *sicknesses* or family emergencies kept them away. Still others flagged transportation challenges or safety concerns, especially with harassment, that participants experienced or that their parents thought they might face.

In one focus group exchange, two male participants also discussed dropout by their peers, perceiving drop out to be motivated by the belief that the program is not useful to youth. One explained that “[n]o one sees any of the visible benefits of training here. Because of which the interest here is very low. They are not seeing visible advantage anything. We are seeing they don’t get any facilities, don’t take any benefits. For these some youths are dropped out here. They lose interest in training from here.” The other focused on the lack of perceived financial benefits from the program, so that youth prefer to seek immediate opportunities in the local market: “Will I go there? Let’s work going to market. There will be some financial benefits in the market and if I work there. Many people drop out because of the financial benefits problems. Many people see that we are taking training, but we don’t get the job after training, we are living like the unemployed.”

Although these comments on drop out reflect the program as a whole and not specifically FP/RH sessions, such negative perceptions of workforce outcomes do nothing to incentivize participation in the FP/RH component.

Solutions addressing attendance challenges

To help resolve attendance problems, Community Mobilizers followed up with participants who were absent by phone to try to encourage them to come. As one female focus group participant explained, this strategy was effective, at least sometimes, “Even if we were not kids, we always were mischievous,

like we came late or even didn't come. They used to bring us by calling." Others suggested that calls from the Community Mobilizers made them feel cared for and supported by the program. Problematically, however, the air time required to follow up with missing participants became expensive. Community Mobilizers repeatedly expressed their hope that the program would allocate funds for this purpose.

Finally, the decision to allow recovery sessions was widely appreciated and taken advantage of. Although it is not clear whether the quality of content delivery equaled that of the original sessions, youth felt that it was an important offering and that they would have missed out on content had they not been offered. In particular, in IDIs, married female participants with children expressed how important it was that Community Mobilizers and Peer Leaders understood that they sometimes needed to stay home to take care of their sick children or attend to other duties at home. Knowing that the program welcomed participants when they could attend and would help them catch up on content when they could not helped participants feel accepted and supported.

Successes and Challenges in FP/RH Content Delivery and Youth Engagement

Beyond issues of recruitment and retention, discussants reported on their experiences, some positive and negative, with the program content and the means of delivery. The section below reviews themes that arose related to gender dynamics during sessions, the rapport between youth participants and Community Mobilizers and Peer Leaders, teaching methods during FP/RH sessions, and program materials.

Gender dynamics in FP/RH sessions

Mixed classes

Youth typically had mixed-gender classes for their S2S sessions but were separated for FP/RH sessions, although a few reported joint sessions for some of the FP/RH content sometimes after a group decision to remain together. Youth in the mixed-gender classes for Skills to Succeed were initially uncomfortable being in classes together, but that discomfort dissolved over time as youth got to know one another and became friends, "Everyone used to feel a little ashamed at first. Gradually everyone becomes familiar since everyone was together. Later, when we were able to take it properly in us, we became like brothers and sisters. Then naturally, everyone would ask many questions that mean everyone became curious to know it" (Peer Leader, FGD).

Some felt uncomfortable in mixed classes, with one female youth participant stating that she and the other females in her class were not comfortable sitting side-by-side with male youth in the class. One male youth participant said that they were also uncomfortable sitting next to females at first, but that discomfort went away over time. Two female participants in individual interviews said that even though joint classes became comfortable over time, it would have been better to have the classes separated initially. Youth and Peer Leaders justified the acceptability of being in mixed gender classes because the workforce has mixed gender environments. A couple youth participants complained in IDIs and FGDs that having both genders in class sometimes led to negative personal consequences, such that youth were starting to form intimate relationships with one another.

Others, both male and female youth, enjoyed the opportunity to learn about one another's perspectives in mixed classes. Two female focus group participants expressed their interest learning about boys' perspectives and the importance of boys hearing from girls in mixed classes:

[Female Youth A]: It means; he is a boy so in that case I was able to know about this opinion. Like I am a girl so they (boys) were able to know my opinion.

[Female Youth B]: I was talking about the things that are equally important for both boys and girls such as family planning. It is also important for the boys and also for the girls. In a family both the husband and the wife need to know about this matter, in that case, we both can know about this matter. then it will be beneficial for us. There may be lots of things I know but he/she doesn't know about it. If I tell it in front of everyone then they will also be able to know about those things too.

One married participant even linked his participation in mixed classes to better communication with his own wife in an IDI:

[Facilitator]: “Have you found it useful for learning with girls?

[Male participant]: Yes.

[Facilitator] Why do you think this, brother?

[Male participant]: Then I get used to talking with my wife.

Given the varying degrees of comfort that different groups felt with FP/RH topics and the range of group dynamics established, it may be useful, as at least some groups did, to allow youth to elect to remain together or separated for FP/RH sessions, keeping in mind that group preferences may shift depending on the session topic.

Gender matched teaching

Initially, some Community Mobilizers and Peer Leaders were nervous about teaching youth of a different gender. Most youth, some Peer Leaders, and some Community Mobilizers believe that the Community Mobilizers teaching FP/RH should be the same gender as the youth in that class. Peer leaders said that the same gender Community Mobilizers would then have their own experiences to draw on when explaining FP/RH content. Some male youth echoed this sentiment, requesting via the club’s information box that a male Community Mobilizer teach FP/RH (all FP/RH Community Mobilizers were female).

Female Community Mobilizers agreed that same gender Community Mobilizers should be assigned but they also defended the decision to use female Community Mobilizers for all classes, arguing that females can teach male youth comfortably—and that male youth did become comfortable with them over time—whereas female youth may never grow comfortable with a male Community Mobilizer. In a focus group exchange, male youth felt similarly, reporting that the initial discomfort they felt with a female Community Mobilizer eventually dissipated:

[Male Youth A]: There was one thing, when we were taught on sexual and reproductive health, which was taken separately, that time we felt a bit different from other times. Everybody will be agreed on this.

[Male Youth B]: Many of us felt uneasy at the beginning.

[Male Youth B]: If there were one brother [male teacher/CM] then that would have been more interesting.

[Male Youth A]: But when we saw madam discussing on this topic, we felt a bit uncomfortable.

[Male Youth B]: Gradually this inertia has gone away.

Rapport with CMs and Peer Leaders strengthened throughout the program

Many Community Mobilizers had trouble engaging youth at first, but they built trust with the youth throughout the program, which led to improved attendance, trust from families, and more open discussion during sessions. Community Mobilizers approached their relationship with the youth more as friends than teachers—and numerous youth participants referred to them as friends. In the words of one Community Mobilizer, “At the beginning of the training, the students are not interested to talk with us freely but gradually they keep pace with us. It is seen that the inertia that they have, we can reduce their inertia after few classes. They couldn’t express their feelings and expectation to others they keep their feelings in their mind. We can reduce their inertia gradually when we provide them such kind of training or when we talk to them at a meeting.”

Community Mobilizers sometimes served as advocates on the youth participants’ behalf. When families did not approve of the youth participating in the program, the Community Mobilizers visited homes to discuss the purpose of the program and any family concerns, such as fears about girls getting to and from the club safely. Youth grew to trust them and continued to seek friendship, mentorship, and council on FP/RH and other matters from the Community Mobilizers beyond the duration of the course.

Youth also grew to trust the Peer Leaders with information. They expressed that the Peer Leaders were their friends and respected their leadership of sessions when Community Mobilizers were away for meetings or conducting community visits with resistant families. Peer Leaders also played an important role in helping to explain concepts to their peers that were difficult to understand, as one male participant observed, saying, “[i]f we could not understand well, then the peer leader would explain that to us.” A female youth participant praised their work in problem solving, stating that “[y]es, they solved our problems. Might be in family or other problems they were step forward. They asked us what happened, if we felt sad. They tried to solve that problem.”

In IDIs, married participants noted similarly strong relationships with the Community Mobilizers and Peer Leaders. Although one married female felt wary about believing everything the Peer Leaders said given that they were the same age as her, more typically married participants spoke of turning to their Community Mobilizers for relationship advice. One married female appreciated how the Community Mobilizers were able to ease her fears on side effects of different contraceptive options, particularly when community members kept feeding those fears.

The abundant praise that youth participants gave to Community Mobilizers and Peer Leaders and the positive terms with which they described their relationships with them suggest that strong dynamics were established and that future interactions of the program may want to try to foster similar rapport.

Teaching methods were admired

Focus groups discussions and IDIs identified several teaching strategies as effective and enjoyable. For example, many referenced the value of drama and role playing in the curriculum in focus group discussions, though not in IDIs. A male youth participant from one focus group noted that drama enhanced comprehension: “Suppose there is a discussion going on, perhaps I don’t understand it, after telling this to the teacher, they used to explain the issue through acting.” One Community Mobilizer pointed to the power of this instructional method to shift youth perceptions of those living with HIV and AIDS, explaining that: “[W]e used to think that if someone affected from HIV then maybe he or she do bad things that’s why he or she face this problem. Usually we don’t want to accept them in society...In role play at first, they don’t support the HIV affected person then when they understand that actually this is not his/her fault then, it happens accidentally then they give support to the HIV affected person.”

Stories, analogies, and examples also helped Community Mobilizers make complex FP/RH topics more accessible, and youth in focus group discussions and IDIs appreciated them. The two male participants who mentioned storytelling in IDIs also cited examples they recalled, both illustrating instances of discrimination against women, suggesting those stories—and also the themes they address—were memorable. As one of these male participants explains, “They [CMs] would have been explained to us through the story.... As like the Mina cartoon, Mina was given an apple and Raju was given two apples. Here means women are being neglected. Women are not seen with equal eyes; they would tell us like these stories.” Much like the role-playing example above, storytelling techniques may benefit youth by allowing participants to empathize with those different than themselves and making FP/RH concepts more relatable.

Games came up repeatedly in focus group discussions with Peer Leaders and youth as another teaching method that made lessons productive and/or pleasant. One female youth participant explained, “[w]e played different games there, so was able to learn lots of things as the games were related to educational topics.” Two Peer Leaders emphasized specifically that this method kept youth engaged during lessons. In the words of one, “[l]essons were taught from the games. That’s why where there is entertainment, everyone is attentive.... They didn’t even realize that we were learning a thing through play. For that reason, everyone was interested.”

Another learning approach that focus group discussants cited as effective is the practice of building FP/RH knowledge together with youth, for example drawing on youths’ prior knowledge or co-constructing meaning through discussion. One male youth participant explained that “Then we started loud speaker and read the topic everyone heard the topic. After reading we discussed about the matter and we found the main theme that matters.” For one Community Mobilizer, these techniques helped generate interest in FP/RH topics, such as thinking through qualities in a life partner, and shifting youth attitudes towards the program for the better: “I told them, alright, have a discussion for 5 minutes. I use this method. You all discuss for 5 minutes and think about the matter. Later on, they told between themselves that, no, sister teaches us well, it’s not bad.” In IDIs, one female youth participant brought up the role of peer-to-peer discussion in learning.

In both focus groups and IDIs, youth expressed how important it was to have the opportunity to ask questions. They valued the openness with which Community Mobilizers received questions as well as Community Mobilizers’ patience in repeating content until it was understood. In one focus group, a male participant described the support they received from Community Mobilizers: “They used to behave

friendly, so that we could talk and asked to them easily. So that we don't feel any problem to ask or feel shy to ask that I don't understand, I can't do this work, this shouldn't not happen like that. If you don't understand you will tell us on that time or ask that in the end. If you still can't understand then I will teach you again, no problem with that."

Youth comments make clear that they were aware of not understanding at times and that Community Mobilizers' kindness and persistence in addressing confusion, although not something that Community Mobilizers themselves noted explicitly during interviews, was crucial to the perception of the club as a safe space. As male youth from a focus group observed, "[w]hen we get there, we do feel safe.... They would explain to us repeatedly if we didn't understand the topic. They would describe it more appropriately."

Instructional challenges and solutions

Discussants referenced two strategies that helped youth overcome their discomfort with FP/RH topics that the program could consider retaining. First, Community Mobilizers would have youth write notes or comments that would be shared among the class anonymously to curb shyness: "When we work in group we used to pass the note that they wrote about the changes about them, we do this so that both of (girls and boys) them know about each other. We don't use to express these things in front of all as this is an organ." Building on that comment, another Community Mobilizer reiterated the importance of this secrecy, saying, "Our work is sensitive, so we have to do this by maintaining secret."

A related strategy that was raised several times was having an information box where youth could submit private or anonymous questions, providing them a safe space to ask sensitive, confidential questions. The Community Mobilizers would answer questions from the box openly and honestly. For example, one explained that "[y]es, they used to share. Maybe they are going, or they will have their other training on employability, in that case, they used to ask or used to put a question in the box. I used to reply to those questions later personally. They may feel shy if I reply in front of everyone because replying the topic in front of everyone." These strategies helped to build trust with youth participants and ensure that information relevant to specific questions in their lives received answers.

Materials are helpful but need some revision

Focus group discussions point to the importance of materials in supporting FP/RH instruction. Specifically, Community Mobilizers noted that visual aids—figures, pictures, and drawings by the CMs—helped youth participants understand content, as did handouts. As one CM observed, "It was the pictures. If we pointed at the pictures when explaining the topic, then they could understand. In that sense, the materials were good to them." One married male youth enjoyed having the book to look back on once the course was finished, and two Community Mobilizers and one Peer Leader emphasized that the handouts allow youth to review materials at home, with the Peer Leader adding that handouts allow youth who missed sessions to catch up at home. In the words of one Community Mobilizer, "[l]ater they [the youth] used to take the handouts and read them at home." In one focus group, three male participants echoed this same theme—the potential of materials to create opportunities for youth to learn at home—but hypothetically, not something they experienced. They explained, in what might indicate an implementation issue, that handouts were not provided until the end of their program.

Challenges. Several challenges were noted with materials. First, in focus group discussions, some Community Mobilizers mentioned difficulties with the language used in teaching and learning materials. Two Community Mobilizers suggested that the language of modules should be simplified, with one

explaining that: “The module which we had was not like I can easily understand after reading it. It had difficult pronunciations and difficult sentences...It would have been better if the module was written in proper Bangla. We had 40 modules. If the module could be updated, organized in a proper way or if simple language could be used in conducting the sessions then it would have been good.”

Other Community Mobilizers brought up similar challenges, noting that the reading level of materials was sometimes too difficult or that the use of English in figures impeded understanding. One Peer Leader and one female participant also cited difficulties related to their own or others’ comprehension of program materials. Faced with this challenge, Community Mobilizers and Peer Leaders offered additional explanation to improve understanding. In IDIs, one male participant echoed reflections from the focus group discussions, observing that the Community Mobilizers asked them to read the program materials and he had trouble understanding them.

In another recommendation widely voiced during focus group discussions, Community Mobilizers and youth participants—especially female ones—believe use of projectors, videos, and other multimedia or real objects during FP/RH lessons would improve understanding and retention of information. Although discussants volunteered only a couple examples of content that would better understood through multimedia, those examples centered on contraception, with one Community Mobilizer reporting that youth participants said, “it would be better if you could show these in front of us so we could see it” while learning about implants, IUDs, and condoms. Findings from IDIs align with those of focus groups, with two female participants suggesting multimedia would improve FP/RH sessions. In the words of one, “[i]t would be better if they could practically show us. I mean, for example, animation video and after that, different multimedia. If they could show us a little bit, then I think it would be better.” One male participant proposed using posters to better illustrate content after stating that a projector would likely be too costly for the program.

In another suggestion for program materials, two Community Mobilizers noted that the black and white photocopies of pictures used in materials were insufficiently compelling for youth. One explained that, “black-white pictures have been printed in the module which we have provided them. They would have been impressed if colorful pictures were printed in the module.... It was totally plain.... They have told that, if colorful pictures were printed then it would have been like their expectation.”

A final suggestion for program materials came from a female participant in one focus group who requested more detailed material about female-specific issues. As she explained, “I want health-related details should be included more...Basic knowledge was provided but about the diseases the girls suffer individually...so I want this program to reflect about the problems which the girls have to suffer in their real-life.”

Other Challenges

Discussants reported additional challenges that came up during the program related to the club space and environment, hunger among youth, and the difficulty that Peer Leaders face managing sessions in the absence of Community Mobilizers.

Challenges with club environment

Several discussants cited issues with some club environments (e.g., “It might be seen that one club has a good environment but the other is not so good something like this,” male focus group participant).

Some criticized the club interior, noting problems with cold or heat; uncomfortable seating arrangements, including having to sit on the floor, and a cramped space.

Others raised issues related to the safety and location of some clubs. Some objected to the location of clubs in what they felt were downtrodden, dirty neighborhoods, with one male focus group participant positing that a better location would improve attendance: “Internal environment of youth club was good but outside was not that good. There was a camp of Bihari people. They kept their garbage outside or in front of club. We faced lots of problems while arrived at and left from our club. If that club shifted to another place, then many students might be interested to do that class.”

In an IDI, another youth linked location, specifically difficulty with transportation to the club especially during rainy season, to poor attendance:

According to me, the environment is a problem. I mean, if the environment could be improved then, many people face transportation difficulties and without that, many people stay there or what should I say about it? There were many localities [slums], or a kind of situation which can be created by many people living there [The nearby slums in the area of the club made it a difficult environment to learn in]. It was very uncomfortable. It was seen that, we felt uncomfortable when walking through that road. It would be better if the environment could be improved and most of the time the road used to be under-construction. It was difficult to come here, and it used to become more difficult at the time of rain.

One youth reported being intentionally hit by something thrown from nearby the club, potentially suggesting a safety concern:

The environment beside this seemed like a slum, all threw rubbish, we couldn't go, odor popped out... One interesting thing is, one day we were coming out from club and one of my friends is coming aiming to club, but someone from the room next door threw something which hit his body [this matter happens sometimes, not by accident; intentionally being thrown]. Our club was in a situation like this ... [Facilitator asks whether this was from outside] ... Yes, there were many people in 2nd floor. When they came down using stairs, they threw dirt from that floor.

Youth hunger impacts engagement and attendance

A few discussants raised hunger as an obstacle to attendance and engagement within sessions. One Community Mobilizer explained that this is because of the potential length of sessions or because youth come from other obligations: “might have to be present for that long period of time or it might be seen that they had to come quickly for having any work so they couldn't take any food.” A male focus group participant suggested that providing snacks would improve retention and focus, recommending, “during classes some opportunities like keeping a short time for break and provided snacks to children would feel them more interested to learn for long time. Many children left their class without completing due to feeling hungry.”

Challenges with Community Mobilizers' attendance

Two Peer Leaders mentioned having difficulties managing lessons, at least initially, when a Community Mobilizer was late or absent. In the words of one:

We would take the class if any CM brother hadn't come. But the problem was we all would attend the classes together. If brother Najmul (CM) or peer leaders had not visited the club for some reason, the youths would become undisciplined and scattered then. Many youths would be absent in the club, or we would show a lack of concentration. Most of the time it's either me or him (indicating another peer

leader) would take the class if a brother (CM) hadn't come on that day. We would encounter some problem while running a class at the beginning, but eventually, it became a bit easier, there was no difficulty taking the class.

The other shared a similar story, ultimately stating that, despite challenges, they were able to learn to manage the class: "The class doesn't always go on well, it's not like that, the sir hasn't come yet, or he is being late. ... And, at first, it was very tough for me to teach them, because what should I need to say, no one else was paying attention to me." Their stories raise questions about whether the Community Mobilizers at their club were tardy or absent usually often. Even if this was not the case, future trainings for Peer Leaders may want to consider stronger preparation for teaching and classroom management for Peer Leaders.

Overcoming divisions related to marital status and age

In an IDI, one married female youth participant spoke of feeling uncomfortable learning with unmarried peers. Although she explained that these divisions were ultimately overcome, she reported that unmarried female participants would not help her initially and that she felt discriminated against early in the program because of her marital status. In her words:

I'm a married girl or a woman so, it could be seen that learning with the unmarried sisters and brothers resulted in some kind of hesitation. For example, they don't accept the fact that a married woman is learning beside them and they are also learning at the same time. Maybe they don't like it. Most of the time it could be seen that they were not willing to help me. I mean, they wanted to avoid me. In that case, I feel very bad that though I'm married but I'm also a student... There were many unmarried sisters who didn't want to help me, and they didn't like the fact that I used to come here. So, sometimes I used to feel bad that I'm different from them and they are not prioritizing me for me being married or it can be said, they were not supporting me. I used to feel bad about this thing. I think whenever any married sister or any married woman will join this Youth Club or this organization then everyone should help her. Everyone should mix with her because she has nothing to do about the fact that she is married. That is a thing of the past... After explaining them in this way, many of them had offered their helping hand to me because it was not right. In the beginning, they didn't want to have acquaintance with me, I mean, they tried to insult me but later all of them had become my friends.

The same participant reiterated her concern, adding that she felt unmarried youth did not take FP/RH matters seriously, not believing them to be priorities: "I didn't feel comfortable because I was married, and they were unmarried. So, it could be seen that, when these topics were delivered to them, they used to laugh and feel shy. They used to say that what is the necessity of learning these topics but as I was married so my case was not the same as them."

Along the same lines, in an IDI one married male participant pointed to issues stemming from having youth from different age groups in the same class, believing that separating age groups would lead to more comfortable conversation. He explained that "suppose if my age is 30 or 35, it will be a problem to discuss these things with 25 years old boy; or a 16 years old girl sits in front of me, my age is 30, she is 16 years younger than me. Maybe she is calling me a brother, but she is not comfortable talking about this thing, she is feeling shy. In this case, there should be made a difference in age. Moreover, if problems like these are being notified, then they should have taken in a separate class. Then they will not feel ashamed, even they will not have trouble asking a question." Although the inclusion of 30 and 35-year-

olds suggests his example is hypothetical, his point about including youth from a more moderate age span and different life phases, especially married and unmarried, applies.

Not all clubs may have followed the planned schedule

In an IDI, a married female youth participant remarked that her FP/RH class was only taught for three or four days per month rather than the intended two or three days per week. She did not provide detail on how the length or content of those sessions, but she indicated that she would have liked more exposure to FP/RH material. If it is the case, as this participant noted, that some clubs did not fully cover the planned FP/RH curriculum, this may explain weaker than expected knowledge gains in this area.

Key Recommendations and Programmatic Implications

Key Takeaways from FGDs and IDIs

- A. **Sessions on puberty and menstruation were reported to be more immediately useful** than other topics, like family planning, contraception, and HIV/AIDS, though youth do plan to use those topics in the future, especially when married.
- B. **Youth reported overcoming their discomfort discussing FP/RH topics and feeling better prepared to discuss and seek help for FP/RH challenges in the future.** While these may be more modest gains than the program initially sought, the program should not overlook the importance of these new skills to youth.
- C. The integrated program faced real **challenges recruiting and retaining youth, some of which seems to be directly related to discomfort with FP/RH topics.** Community mobilizers need to provide more sensitization around FP/RH upfront so that youth don't leave the classroom or attendance drops. Youth eventually thought of FP/RH as key knowledge for life; CMs could potentially use this framing up front.
 - a. One youth (female, IDI) stressed the importance of informing participants that FP/RH would be covered: "We felt afraid and after going back home I shared it with my mother then she asked why they will teach such things? You have gone there to learn the computer. **I think if it could be informed to us that they will provide us a health-related training and they will prepare us for a job, or they will have discussion with us related to these topics then it would have been better [emphasis added].** Firstly, they will provide a training related to those topics (FP/RH). If this thing could be informed to the student then they will be mentally prepared about, yes, classes related to these topics will be conducted."
- D. **Materials need review and potentially revision** to incorporate more multimedia and demonstrative methods, given the challenges discussants report in understanding the language used in the materials. Otherwise, teaching methods for FP/RH sessions were widely viewed as successful.
- E. Participants recommend that the FP/RH component be shortened to allow more time for vocational training; yet FP/RH outcomes—especially as seen in the impact evaluation—are already limited. Given that many unmarried participants don't envision (or don't feel comfortable with) applying detailed information until they are married or employed. This is useful feedback and suggests that **a truer integration of the FP/RH component of the program** (rather than merely adding it on) into the workforce component might both make the program more useful and help youth see it as useful.

Linking the Impact and Process Evaluations: What Do We Learn?

The two evaluations ask different questions; however, looking at the findings together strengthens the understanding of the overall impact of the integrated FP/RH/WfD program. The impact evaluation sought to examine whether the integrated program facilitated greater workforce and FP/RH outcomes than a WfD intervention alone, while the process evaluation sought to unpack how the process of integration. The impact evaluation revealed that integration initially improved some knowledge outcomes (such as contraceptive knowledge), but that these effects diminished over time. Generally, treatment effects were not statistically significant in many of the cases. It also revealed substantial variability across the three local implementing partners, and some variability by the two cohorts, suggesting differences in the program's implementation.

It is important to remind the reader that the impact evaluation did not assess the effect of the S2S program on youth outcomes, but rather just the effect of the added FP/RH component of 40 additional hours with focused content.

The process evaluation showed that **youth benefited from knowledge about puberty, menstruation, and related nutritional practices**. Youth also reported overcoming discomfort with FP/RH topics and building their ability and confidence for seeking solutions to FP/RH challenges that arise later in their life (confidence discussing problems/seeking solutions at clinics, discussing problems with friends and family). In other words, **youth may not leave the program with substantially improved knowledge on FP/RH topics, but they leave better equipped to identify when they need more knowledge and able to seek it out**.

Some lessons learned emerge from the process evaluation that can help guide future studies and program designs.

First, participant health knowledge is less directly predicted by exposure to FP/RH sessions than could be expected. This suggests either spillover across the groups, or potentially other sources of information that youth could draw on for knowledge on FP/RH topics. Future programming may be informed by baseline surveys of youth knowledge **prior to** design, to address specific remaining issues and misconceptions, and tailoring the session content to the needs of the youth participants. The impact evaluation design, in this study, in some ways limited the opportunities for the formative exploration of the appropriate content and mode of delivery to youth, imposing a stricter calendar on implementation that may have been ideal from an implementation standpoint. That said, the process evaluation, and particularly sessions and interviews with youth, undeniably showed the value of learning the FP/RH content, despite initial doubt and awkwardness. It also showed immediate benefits to youth from sessions on menstruation and puberty. These topics were the ones youth reported as most immediately relevant, while they reported that areas such as family planning and HIV/AIDS would be useful in the future but were less relevant to them in their current lives. On the other hand, the small number of married youth interviewed reported that the topics were useful to them. The lesson learned may be that further formative research on what content, duration, and modality of FP/RH content delivery is most in demand by youth is necessary, prior to large-scale implementation and impact analysis. It also might be worthwhile to consider separating program participants by marital status.

Second, the initial resistance of the community to the inclusion of FP/RH sessions points to the need to include an inception phase that is used to build understanding and buy-in from the communities. The success of the program in securing regular attendance of youth after the sensitization with communities is a sign of the crucial importance of this step.

Third, a measurement of effects of FP/RH integration on employment outcomes is difficult to quantify and is perhaps more conceptual than empirically evident. What may benefit from additional inquiry, over a much longer-term period, is whether inclusion of the FP/RH component helps young female participants *who are employed* to better negotiate and manage their needs vis-à-vis the workplace. This would call for further research in the context of job training programs with subsequent follow up over the course of several months, at a minimum; and in the context of on-the-job training, to observe health outcomes and behavior change among youth and young adults as they obtain better health knowledge and competencies.

Fourth, the measurement of soft skills continues to be an area in need of continued exploration and validation. While we noted the negative effect of the intervention on positive identity for girls, this effect was localized to one partner, and was largely due to the static level of the treatment group with the control group improving upon it. Content-driven FP/RH sessions, where the focus is placed on retaining knowledge of specific health topics, may or may not be traceable directly to the cultivation of soft skills such as self-efficacy or higher-order thinking skills as general domains. Instead, more specific aspects of self-knowledge and self-efficacy, related to health or family planning decision making, for example, may be useful to help parse out how integrating FP/RH in Workforce programming affects soft skills outcomes.

This last point also relates to the challenges in managing the add-on modality of integration that was chosen for the S2S program. The FP/RH content was added on top of the regular number of hours within employability skills training, and separate staff were hired to deliver this content. Perhaps a more sustainable option may be the blending of content, such that the employability program would draw on knowledge elements on FP/RH, and participants would receive it as part of their skills training, and within the same number of curricular hours.

Finally, there are substantial differences across implementing partners, both in the average levels as well as variability of outcomes – pointing to the need for a deeper understanding of implementation fidelity, as well as the contextual factors that may affect content delivery – such as the capacity of the provider staff, as well as any differences in community support or youth engagement.

In sum, this study reveals the full complexity of integration of FP/RH content in a workforce training program, while demonstrating the undeniable value of the health knowledge in youth reflections. More research on the various modalities of implementation and measurement that directly reflects the goals of the program in the short term will help further expand the knowledge base to which this study contributes.

Appendices

Appendix A. Propensity Score Matching Approach

To account for the sample imbalance, **we re-weight our sample to ensure comparability between the treatment and control groups.** We implement a propensity score matching approach, where we first calculate the probability of being in the treatment group for all individuals (propensity scores), and we then re-weight the observations using the inverse probability of treatment weights to balance the two samples. Using baseline data, we run a probit regression of treatment status as a function of individual observable characteristics¹⁷, as follows:

$$Pr(T_i = 1|X) = \Phi(X_i\theta + \mu_j + \mu_k) \quad [5]$$

- Where $Pr(T_i = 1|X)$ denotes the probability of youth i being assigned to the treatment group, conditional on their observable characteristics X .
- $\Phi(.)$ represents the cumulative density function of the standard normal distribution.
- θ is a vector of parameters associated with each element within X (estimated via Maximum Likelihood).
- The propensity score for each youth i is represented by $Pr(T_i = 1|X) = P(T_i)$ and is produced by the estimator procedure described above.

Treatment and control observations are re-weighted as follows:

$$\omega_i = \begin{cases} 1/P(T_i), & T_i = 1 \\ 1/(1 - P(T_i)), & T_i = 0 \end{cases} \quad [6]$$

s

A.I shows the un-weighted and weighted predicted probabilities of being in the treatment group. We see that **once the inverse probability weights are applied, the distributions of the two groups align more closely, indicating a better balance.**

¹⁷ The following individual characteristics at baseline were used to calculate the propensity score: gender, age, asset index, number of people living in the household, if the youth is the head of household, if the youth is working, if the youth is looking for jobs. And the following youth's outcomes at baseline were used to calculate the propensity score: number of strategies the youth knows to search jobs, positive identity, self-control, hots, social and communication skills, intention to use contraception, contraceptive knowledge, HIV knowledge, PMTCT knowledge, gender equity, comfort communicating with partners, discussed contraception.

Appendix B. Additional Figures and Tables

Figure A. I. Propensity Score Distribution Pre- and Post- Matching

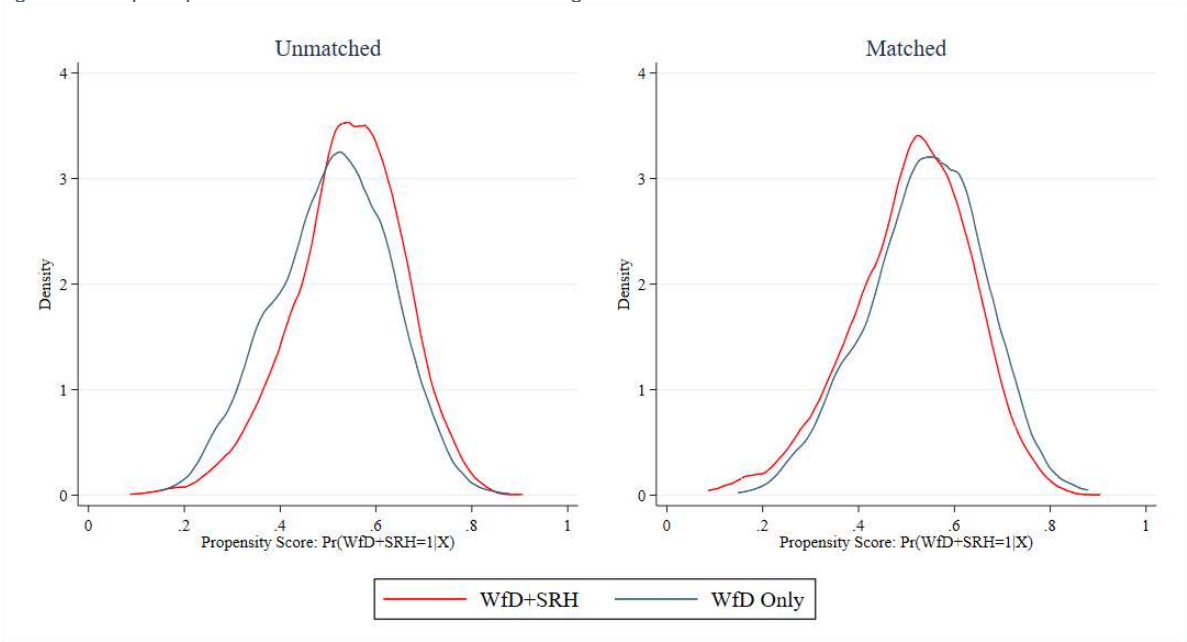


Table A. 1. Descriptive statistics of outcomes by time period

	Baseline						Midline						Endline					
	WfD			WfD + FP/RH			WfD			WfD + FP/RH			WfD			WfD + FP/RH		
	Obs.	Mean	SD	Obs.	Mean	SD	Obs.	Mean	SD	Obs.	Mean	SD	Obs.	Mean	SD	Obs.	Mean	SD
Income	131	4196	3530	150	5457	4292.80	51	3350	2824	63	6719	5996	111	6886	5095	120	6792	5439
Job Satisfaction	210	0.92	0.27	236	0.87	0.33	137	0.93	0.26	161	0.96	0.19	466	0.92	0.27	511	0.94	0.24
# Strategies job hunt	1050	1.06	1.18	1050	1.03	1.24	1049	1.25	1.37	1051	1.16	1.35	940	1.93	1.56	935	1.85	1.57
Positive identity	1050	2.85	0.19	1050	2.91	0.23	1045	2.91	0.21	1041	2.90	0.21	940	2.92	0.21	935	2.92	0.20
Self-control	1050	2.70	0.24	1050	2.68	0.24	1045	2.69	0.25	1041	2.70	0.23	940	2.78	0.26	935	2.76	0.27
HOTS (higher order thinking skills)	1050	3.02	0.25	1050	3.04	0.32	1045	3.04	0.25	1041	3.03	0.29	940	3.04	0.18	935	3.04	0.18
Social & communication skills	1050	2.93	0.25	1050	2.96	0.27	1045	2.97	0.23	1041	2.95	0.23	940	2.96	0.24	935	2.96	0.24
Intention to use contraception	1016	0.83	0.37	1003	0.91	0.29	1037	0.88	0.32	1033	0.94	0.24	929	0.94	0.24	921	0.94	0.24
Contraceptive knowledge	1050	0.27	0.22	1050	0.29	0.24	1049	0.45	0.26	1051	0.54	0.25	940	0.47	0.25	935	0.52	0.24
HIV knowledge	1023	0.23	0.42	993	0.19	0.40	1028	0.28	0.45	1022	0.21	0.41	934	0.37	0.48	932	0.40	0.49
PMTCT knowledge	1023	0.26	0.44	993	0.30	0.46	1028	0.32	0.47	1022	0.32	0.47	934	0.28	0.45	932	0.30	0.46
Gender Equity	1050	0.71	0.16	1050	0.70	0.15	1045	0.72	0.15	1041	0.72	0.15	940	0.77	0.13	935	0.77	0.13
Comfort communicating partners	1017	0.44	0.50	1017	0.44	0.50	1045	0.50	0.50	1041	0.54	0.50	940	0.36	0.48	935	0.40	0.49
Discussed contraception	1050	0.11	0.32	1050	0.15	0.35	1045	0.24	0.43	1041	0.39	0.49	940	0.28	0.45	935	0.34	0.47
Ever tested for HIV	1023	0.02	0.15	992	0.03	0.17	1028	0.05	0.21	1022	0.05	0.21	934	0.06	0.23	932	0.03	0.17
Use modern contraception	53	0.92	0.27	54	0.93	0.26	49	0.96	0.20	46	0.93	0.25	56	0.89	0.31	75	0.95	0.23

Table A. 2. Sample attrition at midline and endline

	Midline			Endline		
	Means		Diff	Means		Diff
	Non-Attrited Sample	Attrited Sample		Non-Attrited Sample	Attrited Sample	
Youth characteristics						
FP/RH	0.50	0.71	0.22	0.50	0.51	0.01
Sex (male)	0.61	0.57	-0.04	0.62	0.47	-0.16*
Age	18.88	18.79	-0.09	18.83	19.29	0.46*
Asset Index	0.76	0.79	0.02	0.76	0.79	0.03
# people house	4.74	4.50	-0.24	4.74	4.67	-0.07
Head of household	0.06	0.00	-0.06	0.06	0.06	0.00
Currently working	0.10	0.07	-0.03	0.11	0.09	-0.01
Looking for employment	0.53	0.64	0.11	0.52	0.58	0.06
Ever had sex	0.07	0.07	0.01	0.06	0.15	0.10*
Ever tested for HIV	0.03	0.00	-0.03	0.03	0.02	-0.00
Visited Health Facility	0.32	0.36	0.03	0.33	0.31	-0.01
Outcomes						
Income	4633.14	460.00	-4173.14	4721.36	3803.04	-918.33
Job satisfaction	0.89	1.00	0.11	0.90	0.87	-0.03
# Strategies job hunt	1.05	1.00	-0.05	1.03	1.15	0.11
Positive identity	2.88	2.85	-0.03	2.88	2.88	0.00
Self-control	2.69	2.62	-0.07	2.69	2.68	-0.01
HOTS (higher order thinking skills)	3.03	2.97	-0.07	3.03	3.05	0.02
Social & communication skills	2.94	2.96	0.01	2.94	2.94	-0.01
Intention to use contraception	0.87	0.85	-0.02	0.87	0.86	-0.01
Contraceptive knowledge	3.93	3.14	-0.79	3.91	4.06	0.15
HIV knowledge	0.21	0.17	-0.04	0.21	0.21	0.00
PMTCT knowledge	0.28	0.08	-0.20	0.29	0.23	-0.05
Gender equity	0.71	0.73	0.03	0.70	0.71	0.01
Comfort communicating partners	0.44	0.64	0.20	0.44	0.45	0.01
Discussed contraception	0.13	0.07	-0.06	0.13	0.12	-0.02
Ever tested for HIV	0.03	0.00	-0.03	0.03	0.02	-0.00
Use modern contraception	0.92	1.00	0.08	0.91	0.96	0.05
Observations	2086	14		1875	225	

Notes: Significance is denoted as: * $p < 0.05$

Table A. 3. Differences-in-differences regression results

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
	Income	Job Satis.	# Strat. Job Hunt	Positive Identity	Self-Control	HOTS	Soc. & Commu. Skills	Intent. use Contracep.	Contracep. Know.	HIV Know.	PMTCT Know.	Gender Equity	Comfort Commu. Partners	Discussed Contracep.	Ever Tested for HIV	Use Modern Contracep.
WfD Only - Midline	-0.16 (0.16)	-0.02 (0.07)	0.13* (0.07)	0.22** (0.10)	-0.07 (0.09)	0.07 (0.12)	0.16* (0.09)	0.06 (0.05)	0.64*** (0.12)	0.05 (0.04)	0.06 (0.04)	0.05 (0.09)	0.06 (0.06)	0.12*** (0.04)	0.02** (0.01)	-0.00 (0.04)
FP/RH diff. - Midline	0.30 (0.26)	0.10 (0.09)	-0.03 (0.10)	-0.26* (0.15)	0.06 (0.14)	-0.11 (0.16)	-0.16 (0.13)	-0.02 (0.06)	0.22 (0.17)	-0.03 (0.05)	-0.05 (0.05)	0.04 (0.12)	0.02 (0.07)	0.12 (0.07)	-0.01 (0.01)	0.03 (0.05)
WfD Only - Endline	0.57*** (0.16)	-0.01 (0.06)	0.63*** (0.07)	0.31*** (0.09)	0.31*** (0.09)	0.06 (0.10)	0.11 (0.09)	0.11** (0.05)	0.70*** (0.11)	0.14*** (0.04)	0.02 (0.04)	0.43*** (0.10)	-0.06 (0.06)	0.18*** (0.04)	0.03*** (0.01)	-0.01 (0.03)
FP/RH diff. - Endline	-0.17 (0.21)	0.08 (0.08)	-0.07 (0.11)	-0.23* (0.14)	-0.06 (0.13)	-0.05 (0.14)	-0.08 (0.14)	-0.07 (0.05)	0.09 (0.16)	0.07 (0.05)	-0.02 (0.06)	-0.01 (0.13)	-0.00 (0.08)	0.00 (0.06)	-0.03** (0.01)	0.09 (0.06)
Observations	596	1673	5839	5827	5827	5827	5827	5791	5839	5787	5787	5827	5827	5827	5787	326
T-test: Effect Midline = Effect Endline	0.10	0.79	0.74	0.79	0.38	0.64	0.54	0.22	0.40	0.05	0.66	0.69	0.73	0.11	0.14	0.2

Note: * p<0.1 ** p<0.05 *** p<0.01. P-values reported for t-tests.

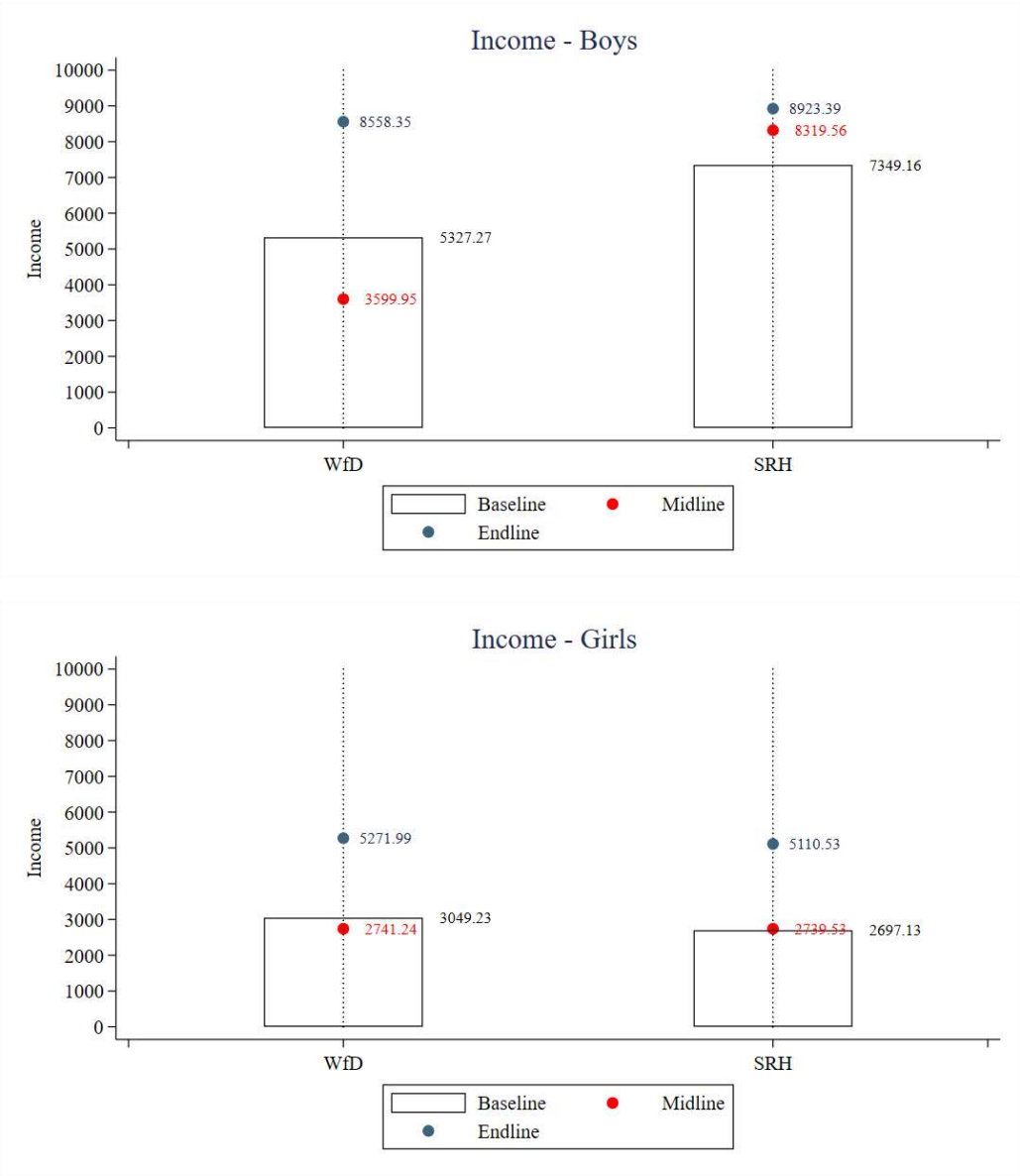
Table A. 4. Heterogeneous effect by gender

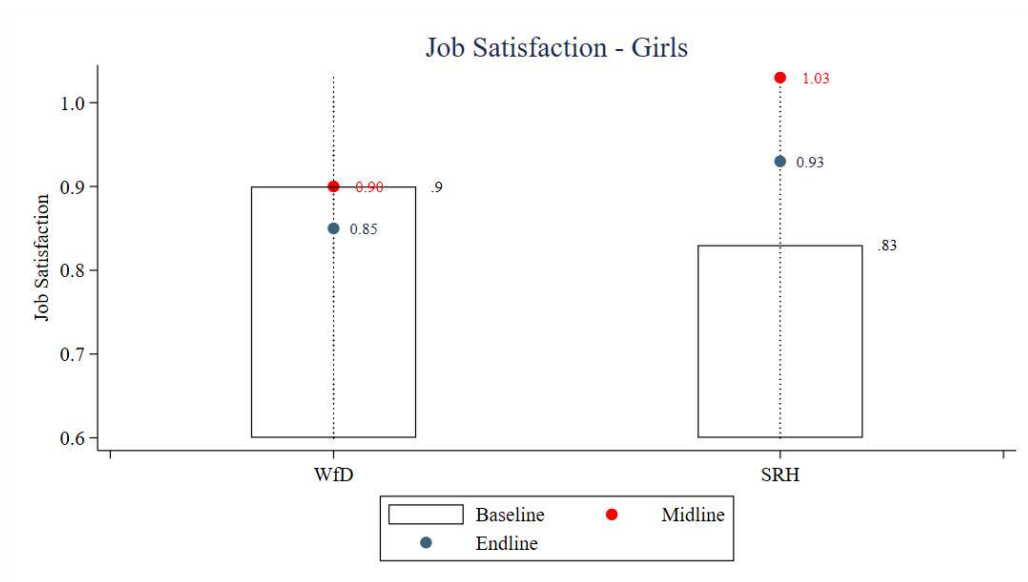
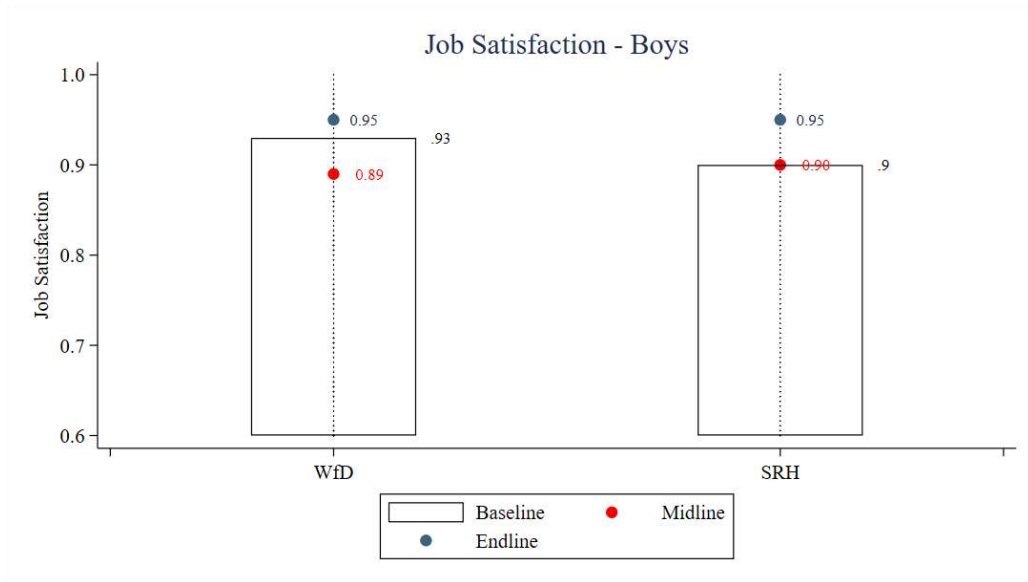
(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16)

	Income	Job Satis.	# Strat. Job Hunt	Positive Identity	Self-Control	HOTS	Soc. & Commu. Skills	Intent. use Contracep.	Contracep. Know.	HIV Know.	PMTCT Know.	Gender Equity	Comfort Commu. Partners	Discussed Contracep.	Ever Tested for HIV	Use Modern Contracep.
WfD Only - Boys - Midline	-0.36 (0.38)	-0.04 (0.06)	0.11 (0.09)	0.02 (0.09)	-0.11 (0.08)	-0.04 (0.10)	-0.02 (0.09)	0.08 (0.05)	0.73*** (0.13)	0.04 (0.04)	0.07* (0.04)	0.01 (0.10)	-0.00 (0.06)	0.15*** (0.04)	0.03** (0.01)	-0.00 (0.00)
FP/RH Diff. - Boys - Midline	0.56 (0.47)	0.08 (0.08)	-0.11 (0.12)	0.04 (0.14)	0.15 (0.10)	0.08 (0.14)	0.04 (0.13)	-0.03 (0.06)	0.11 (0.21)	-0.01 (0.05)	-0.06 (0.06)	0.11 (0.13)	0.08 (0.08)	0.06 (0.07)	-0.01 (0.02)	0.00 (0.00)
WfD Only - Girls diff. - Midline	0.30 (0.38)	0.04 (0.11)	0.05 (0.10)	0.54*** (0.13)	0.09 (0.19)	0.30* (0.17)	0.47*** (0.10)	-0.06 (0.04)	-0.23** (0.10)	0.02 (0.07)	-0.03 (0.07)	0.10 (0.10)	0.16* (0.08)	-0.07* (0.04)	-0.02 (0.02)	-0.00 (0.05)
FP/RH diff. - Girls diff. - Midline	-0.49 (0.47)	0.09 (0.15)	0.20 (0.14)	-0.78*** (0.20)	-0.23 (0.25)	-0.47** (0.21)	-0.54*** (0.14)	0.02 (0.06)	0.29 (0.19)	-0.04 (0.09)	0.02 (0.09)	-0.18 (0.15)	-0.15 (0.11)	0.16** (0.07)	0.01 (0.02)	0.04 (0.06)
WfD Only - Boys - Endline	0.67** (0.29)	0.02 (0.06)	0.66*** (0.09)	0.20** (0.09)	0.33*** (0.10)	0.04 (0.09)	0.07 (0.10)	0.15*** (0.05)	0.70*** (0.12)	0.15*** (0.04)	0.04 (0.04)	0.46*** (0.11)	-0.10* (0.05)	0.17*** (0.04)	0.04*** (0.01)	-0.00 (.)
FP/RH Diff. - Boys - Endline	-0.35 (0.35)	0.03 (0.09)	-0.11 (0.14)	-0.10 (0.13)	-0.06 (0.12)	-0.03 (0.14)	-0.05 (0.15)	-0.09 (0.06)	0.06 (0.18)	0.08 (0.05)	-0.03 (0.06)	-0.01 (0.13)	-0.00 (0.08)	-0.00 (0.06)	-0.04** (0.02)	0.00 (.)
WfD Only - Girls diff. - Endline	-0.21 (0.30)	-0.08 (0.12)	-0.08 (0.10)	0.29** (0.12)	-0.07 (0.15)	0.03 (0.15)	0.09 (0.10)	-0.11*** (0.04)	0.01 (0.10)	-0.04 (0.06)	-0.07 (0.07)	-0.09 (0.10)	0.11 (0.08)	0.01 (0.05)	-0.02 (0.02)	-0.01 (0.04)
FP/RH diff. - Girls diff. - Endline	0.39 (0.36)	0.12 (0.16)	0.10 (0.15)	-0.33* (0.18)	0.00 (0.21)	-0.03 (0.19)	-0.09 (0.16)	0.04 (0.06)	0.06 (0.17)	-0.04 (0.08)	0.02 (0.09)	0.01 (0.14)	-0.00 (0.12)	0.01 (0.07)	0.03 (0.02)	0.12 (0.08)
Observations	596	1673	5839	5827	5827	5827	5827	5791	5839	5787	5787	5827	5827	5827	5787	326

Note: * p<0.1 ** p<0.05 *** p<0.01

Figure A.2. Pre- and (predicted) post-treatment means for employment outcomes by gender





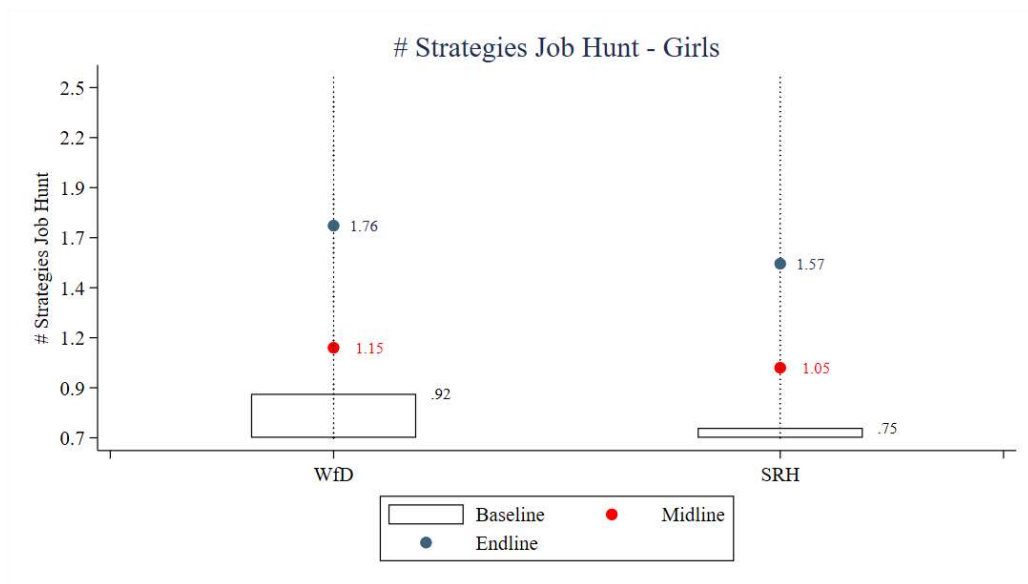
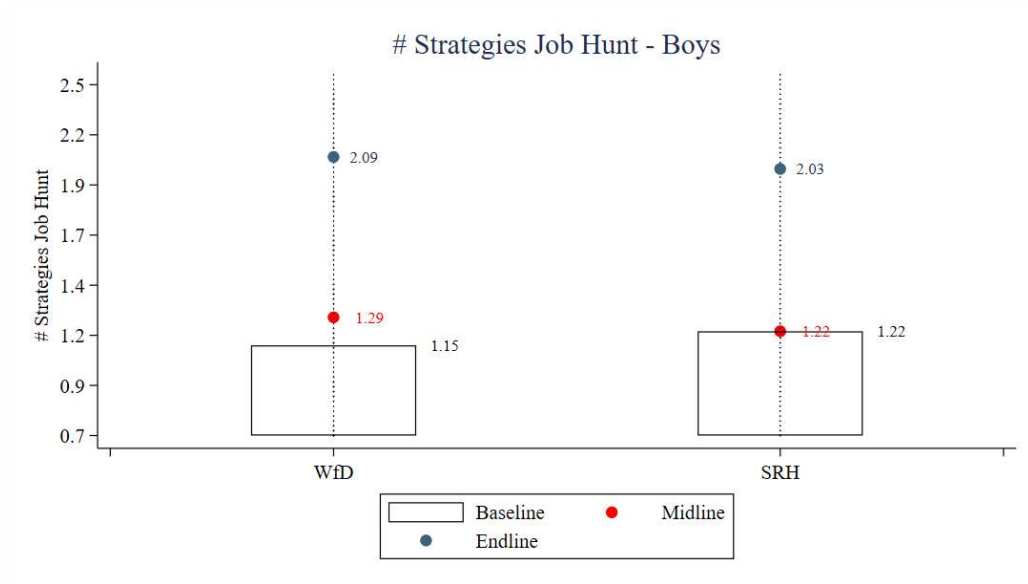


Figure A- 3. Pre- and (predicted) post-treatment means for FPIRH and knowledge outcomes by gender

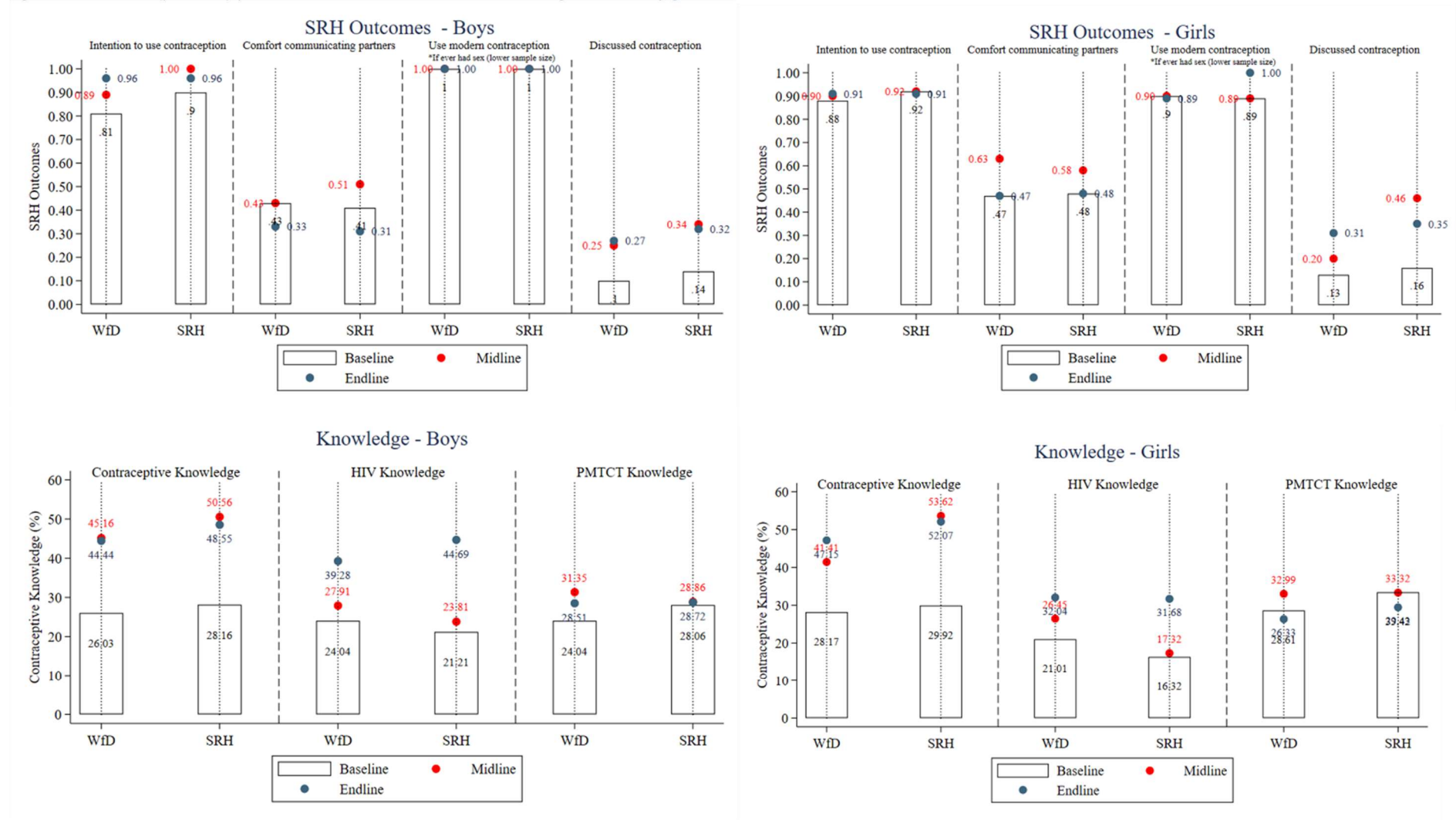


Figure A- 4. Pre- and (predicted) post-treatment means for gender equity and ever tested for HIV by gender

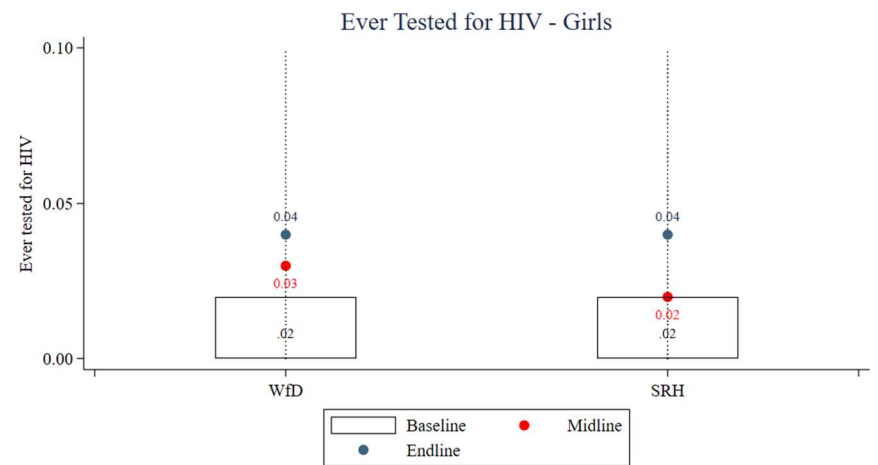
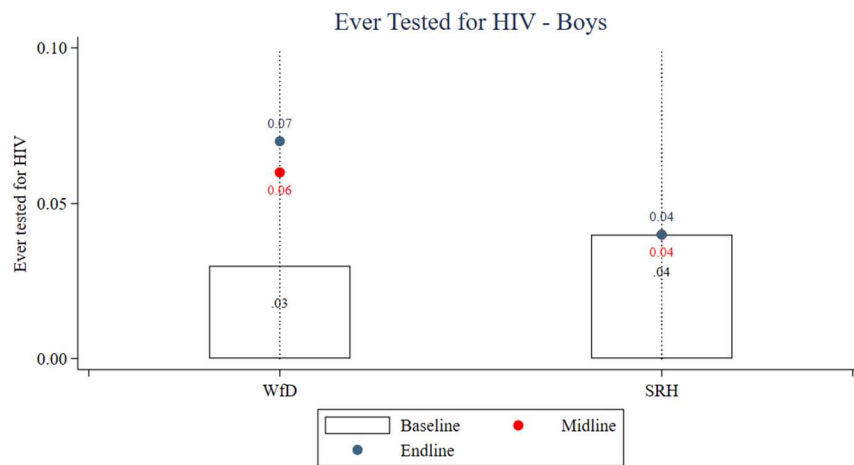
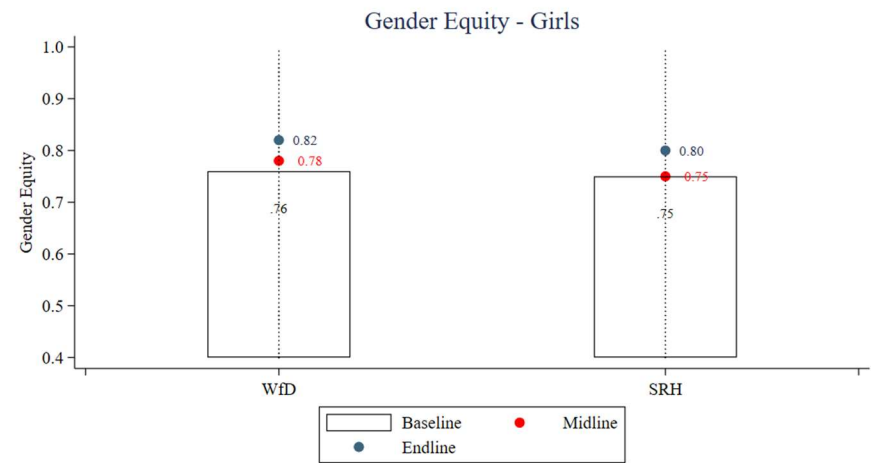
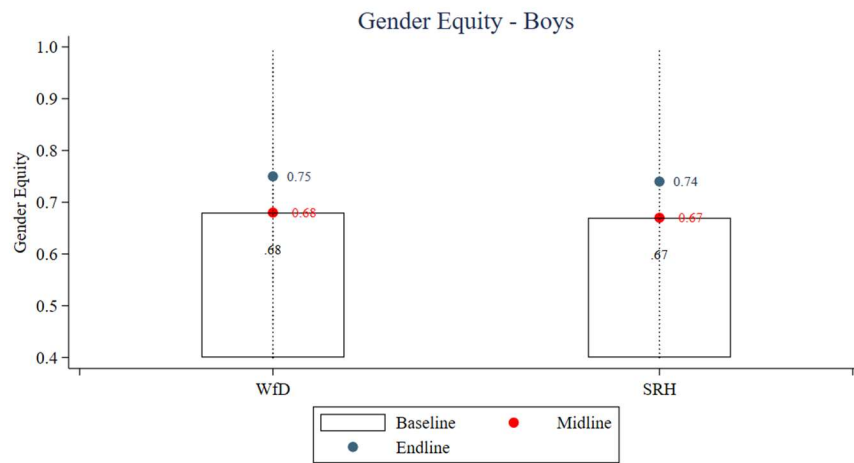


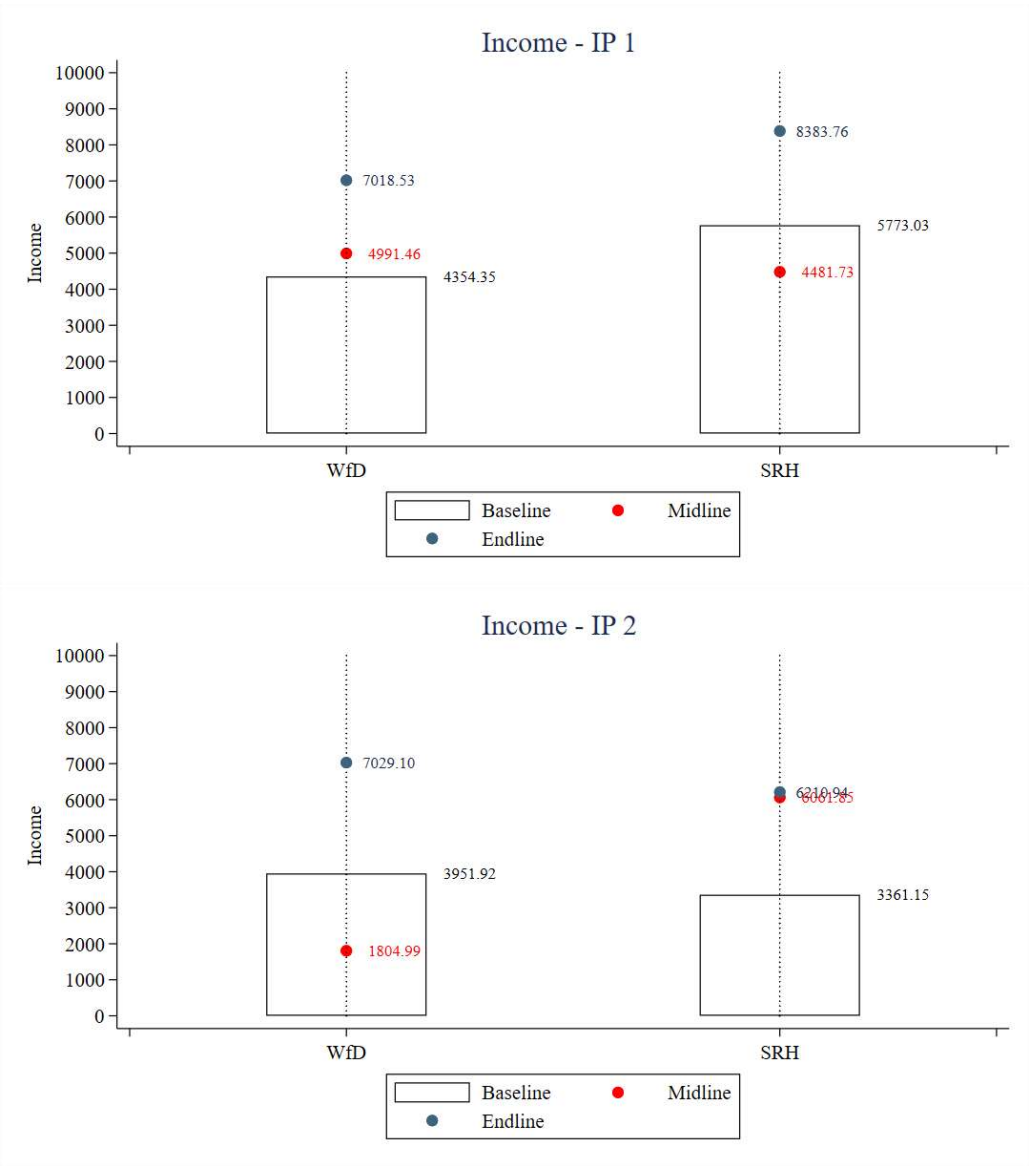
Table A. 5. Heterogenous effects by implementing partner

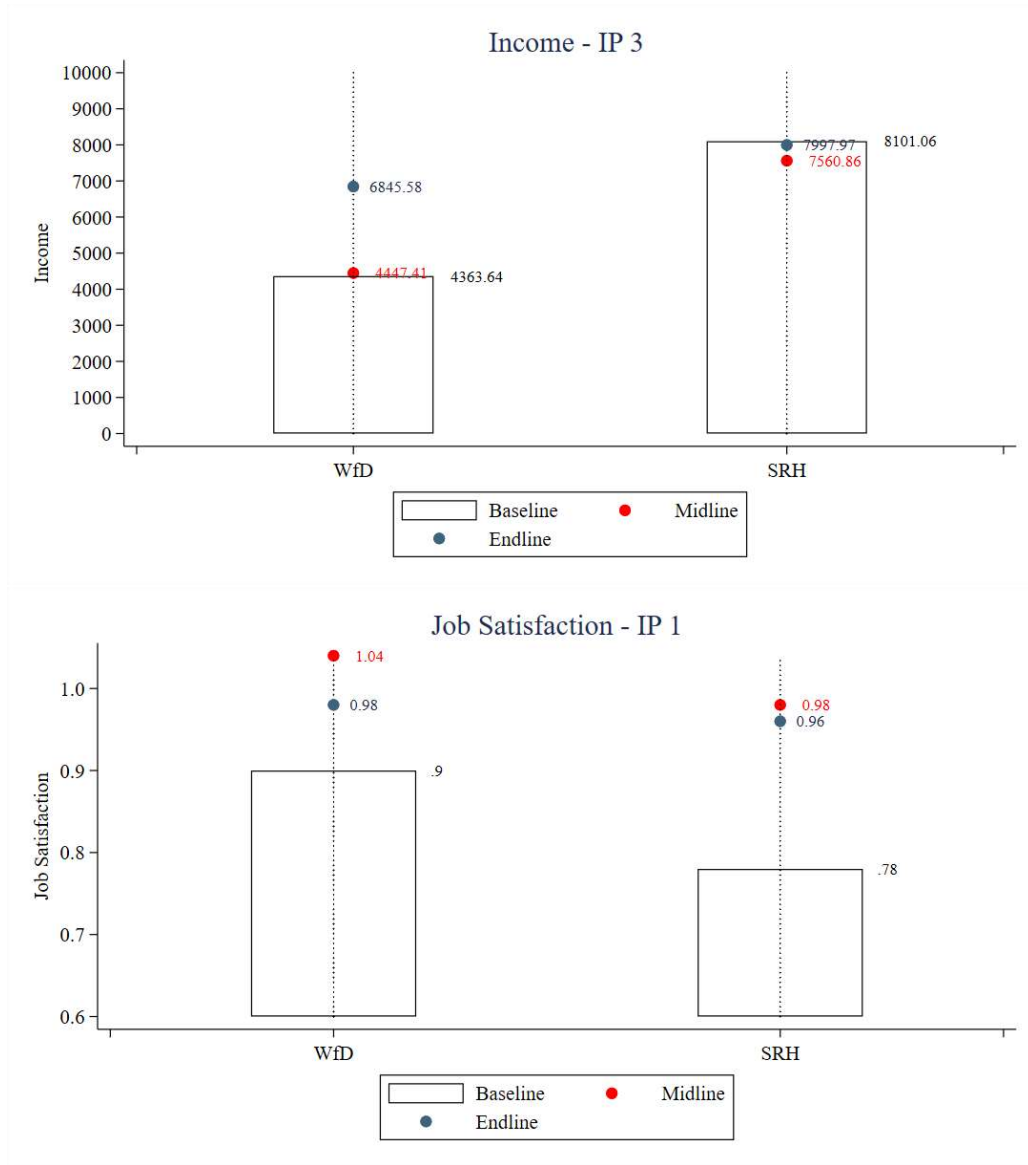
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
	Income	Job Satis.	# Strat. Job Hunt	Positive Identity	Self-Control	HOTS	Soc. & Commu. Skills	Intent. use Contracep.	Contracep. Know.	HIV Know.	PMTCT Know.	Gender Equity	Comfort Commu. Partners	Discussed Contracep.	Ever Tested for HIV	Use Modern Contracep.
WfD Only – IP1 Midline	1057.47 (2101.91)	0.14 (0.10)	-0.00 (0.10)	0.19 (0.18)	-0.07 (0.13)	0.12 (0.12)	0.10 (0.09)	0.17*** (0.04)	0.71*** (0.20)	0.04 (0.04)	0.09** (0.04)	-0.11 (0.11)	0.01 (0.06)	0.05 (0.06)	-0.00 (0.01)	0.09 (0.09)
FP/RH diff. – IP1 Midline	-1773.43 (2913.56)	0.10 (0.15)	0.00 (0.15)	-0.01 (0.24)	0.21 (0.17)	0.08 (0.18)	0.08 (0.12)	-0.11** (0.05)	0.08 (0.37)	-0.02 (0.05)	-0.05 (0.06)	0.08 (0.17)	0.02 (0.09)	-0.02 (0.07)	0.01 (0.01)	-0.14 (0.11)
WfD Only – IP2 diff. - Midline	-2209.86 (2848.74)	-0.28** (0.14)	0.29* (0.15)	0.03 (0.27)	0.11 (0.18)	-0.18 (0.30)	-0.06 (0.24)	-0.17 (0.15)	0.52 (0.58)	0.09 (0.06)	-0.04 (0.07)	0.25* (0.15)	0.21 (0.13)	0.13 (0.09)	0.02 (0.02)	-0.09 (0.09)
WfD Only – IP 3 diff. - Midline	181.93 (2367.72)	-0.18 (0.13)	0.10 (0.13)	0.08 (0.22)	-0.12 (0.22)	0.02 (0.24)	0.24** (0.12)	-0.18*** (0.04)	0.41* (0.23)	-0.09 (0.09)	-0.04 (0.06)	0.21 (0.21)	-0.06 (0.09)	0.09 (0.07)	0.06*** (0.02)	-0.19* (0.11)
FP/RH diff. – IP 2 diff. - Midline	4510.19 (3954.41)	0.04 (0.19)	-0.06 (0.21)	-0.61 (0.39)	-0.37 (0.31)	-0.46 (0.38)	-0.53* (0.31)	0.08 (0.16)	0.75 (0.72)	-0.01 (0.07)	0.14 (0.10)	0.03 (0.22)	-0.05 (0.18)	0.24 (0.17)	-0.00 (0.02)	0.14 (0.11)
FP/RH diff. – IP 3 diff. - Midline	-205.35 (3544.38)	-0.02 (0.19)	-0.06 (0.19)	-0.16 (0.29)	-0.11 (0.31)	-0.12 (0.30)	-0.23 (0.18)	0.17*** (0.06)	0.15 (0.42)	-0.02 (0.12)	-0.15 (0.09)	-0.13 (0.26)	0.06 (0.13)	0.19* (0.11)	-0.04 (0.03)	0.32** (0.14)
WfD Only – IP 1 Endline	2578.13** (1020.78)	0.08 (0.07)	0.60*** (0.08)	0.44*** (0.15)	0.37*** (0.13)	0.19* (0.10)	0.25*** (0.10)	0.24*** (0.05)	0.55** (0.25)	0.16*** (0.05)	0.22*** (0.03)	0.31*** (0.10)	-0.09 (0.09)	0.14* (0.07)	0.01 (0.01)	0.04 (0.05)
FP/RH diff. – IP 1 Endline	-101.52 (1548.60)	0.09 (0.14)	0.13 (0.13)	-0.11 (0.20)	0.02 (0.17)	0.00 (0.15)	0.09 (0.14)	-0.10* (0.06)	0.07 (0.35)	0.00 (0.06)	-0.08 (0.06)	0.12 (0.16)	0.01 (0.12)	0.02 (0.10)	-0.03* (0.02)	0.01 (0.07)
WfD Only – IP 2 diff. - Endline	62.50 (2695.15)	-0.11 (0.14)	0.32*** (0.11)	-0.18 (0.21)	0.01 (0.23)	-0.21 (0.22)	-0.22 (0.22)	-0.14 (0.12)	1.14** (0.48)	0.14** (0.06)	-0.33*** (0.06)	0.56*** (0.12)	0.17 (0.15)	0.03 (0.10)	0.04** (0.02)	-0.04 (0.05)
WfD Only – IP 3 diff. - Endline	-640.34 (1418.03)	-0.19* (0.10)	-0.20* (0.12)	-0.24 (0.22)	-0.20 (0.20)	-0.19 (0.21)	-0.21 (0.15)	-0.25*** (0.05)	0.75*** (0.26)	-0.20*** (0.08)	-0.29*** (0.06)	-0.19 (0.21)	-0.08 (0.12)	0.05 (0.09)	0.01 (0.02)	-0.13 (0.08)
FP/RH diff. – IP 2 diff. - Endline	631.38 (3103.69)	-0.03 (0.19)	-0.29 (0.19)	-0.44 (0.30)	-0.21 (0.30)	-0.13 (0.34)	-0.42 (0.32)	-0.02 (0.13)	-0.05 (0.59)	0.04 (0.09)	0.12 (0.09)	-0.26 (0.20)	-0.11 (0.20)	-0.03 (0.15)	-0.00 (0.02)	-0.01 (0.07)

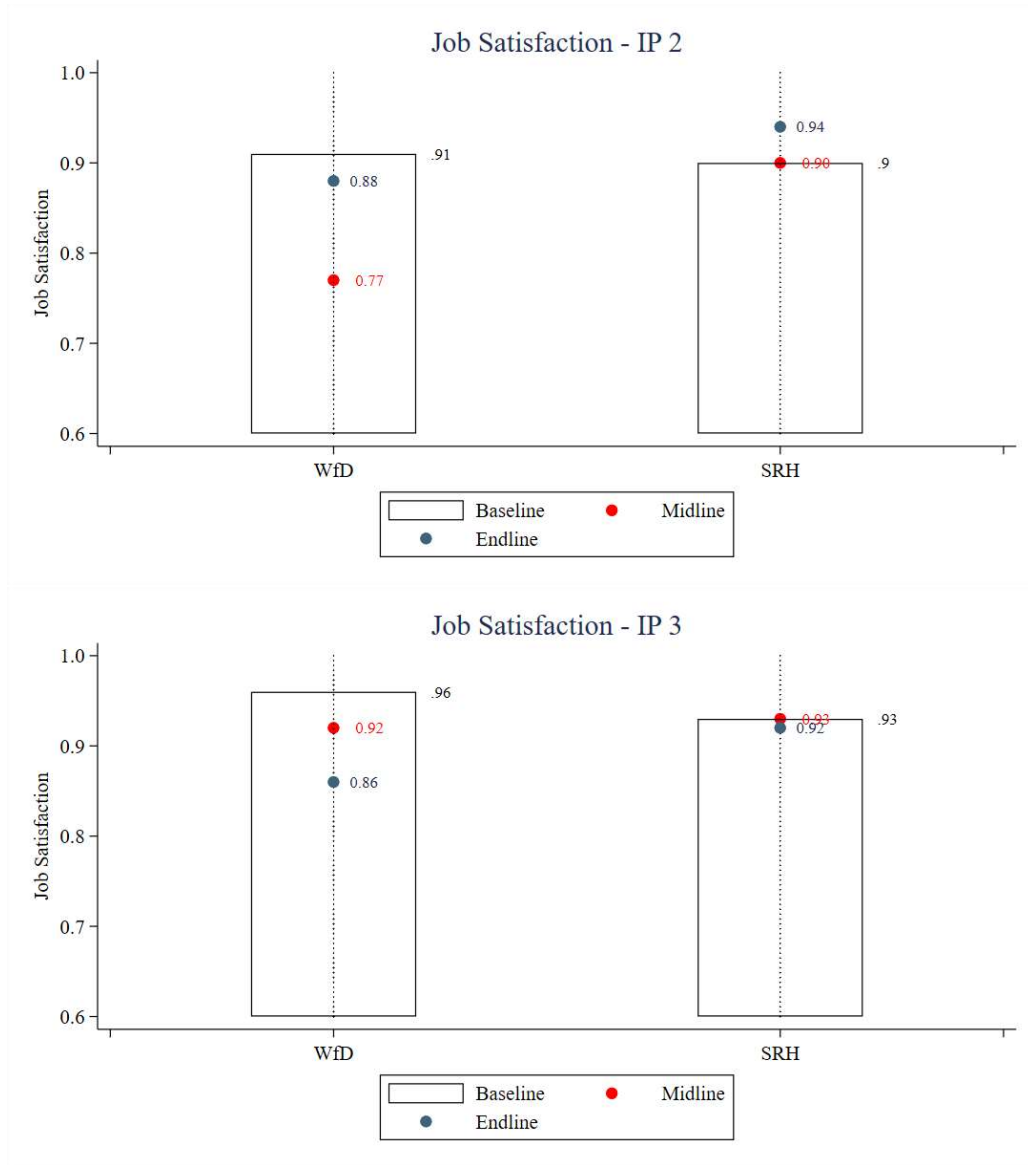
FP/RH diff. – IP 3 diff. - Endline	-1774.39 (2794.10)	-0.00 (0.16)	-0.29 (0.19)	0.07 (0.27)	-0.04 (0.28)	-0.03 (0.26)	-0.11 (0.21)	0.11* (0.06)	0.25 (0.40)	0.15 (0.10)	0.04 (0.10)	-0.12 (0.25)	0.07 (0.15)	0.00 (0.12)	0.02 (0.03)	0.20 (0.13)
Observations	1663	1673	5839	5827	5827	5827	5827	5791	5839	5787	5787	5827	5827	5827	5787	326
T-test: effect IP 2 midline = effect IP 3 midline	0.16	0.72	0.98	0.19	0.46	0.40	0.34	0.54	0.36	0.95	0.01	0.53	0.55	0.78	0.22	0.05
T-test: effect IP 2 endline = effect IP 3 endline	0.50	0.85	1.00	0.09	0.62	0.79	0.36	0.25	0.56	0.30	0.49	0.54	0.32	0.80	0.45	0.05

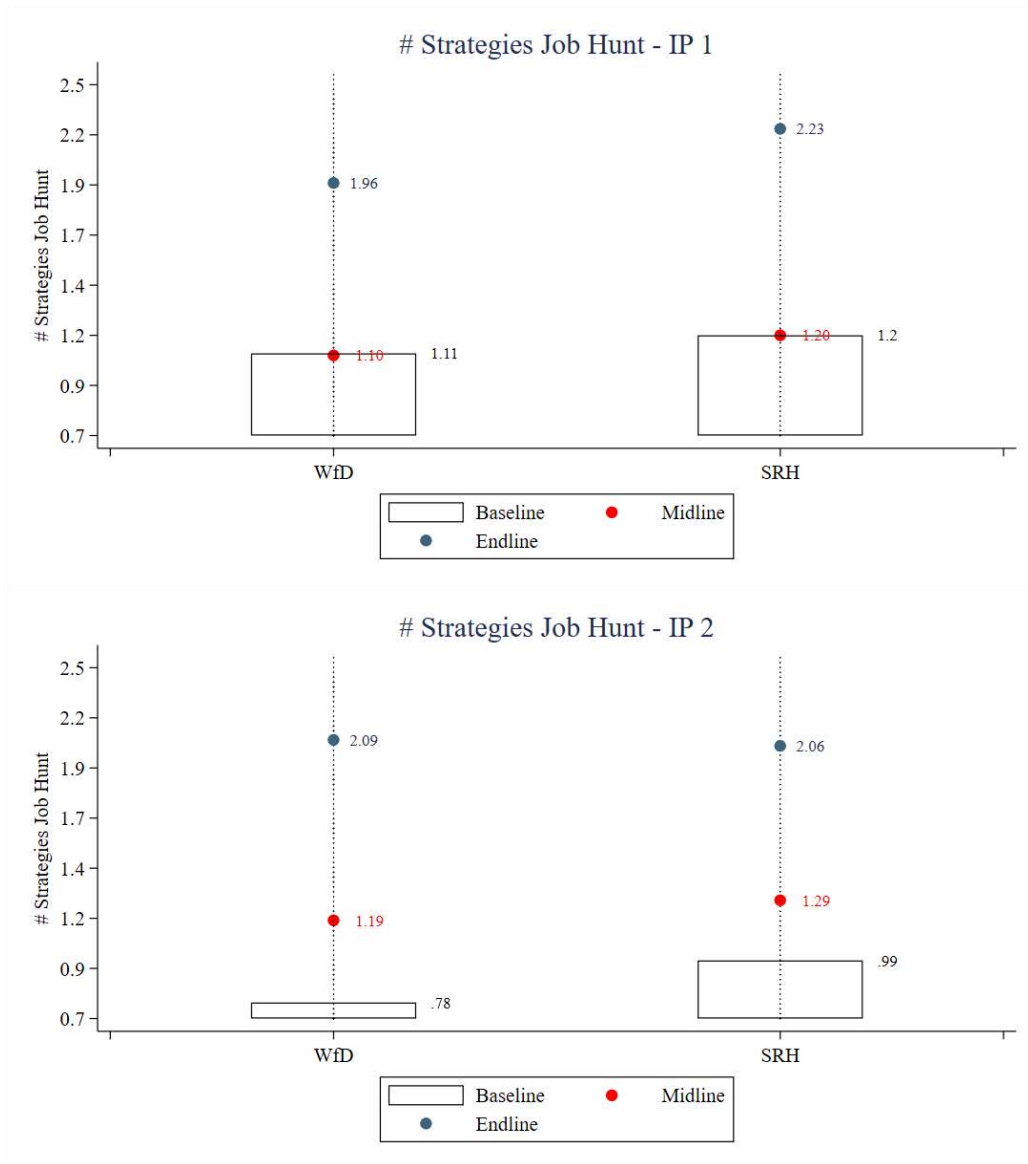
Note: * p<0.1 ** p<0.05 *** p<0.01.

Figure A- 5. Pre- and (predicted) post-treatment means for employment outcomes by implementing partner









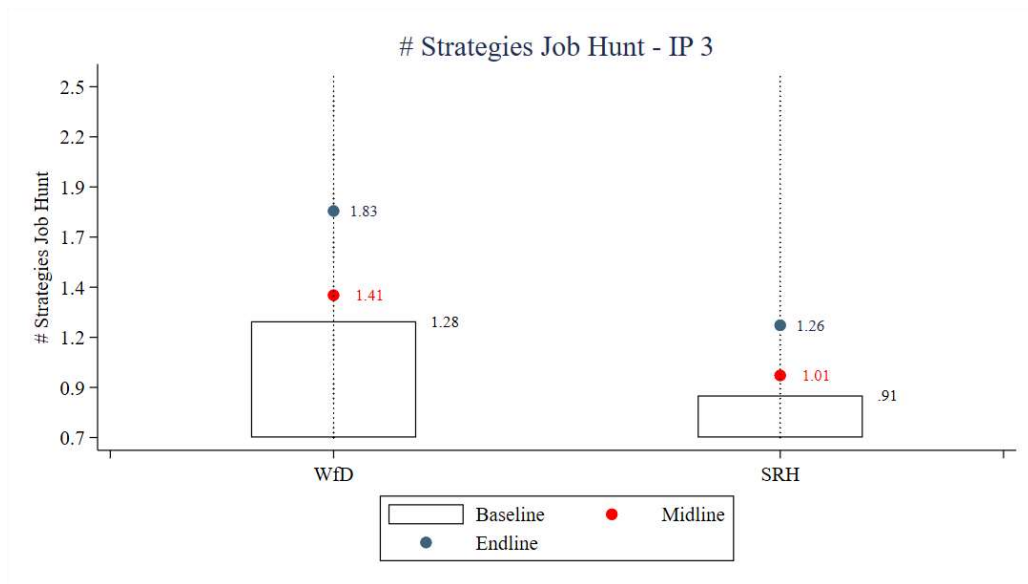
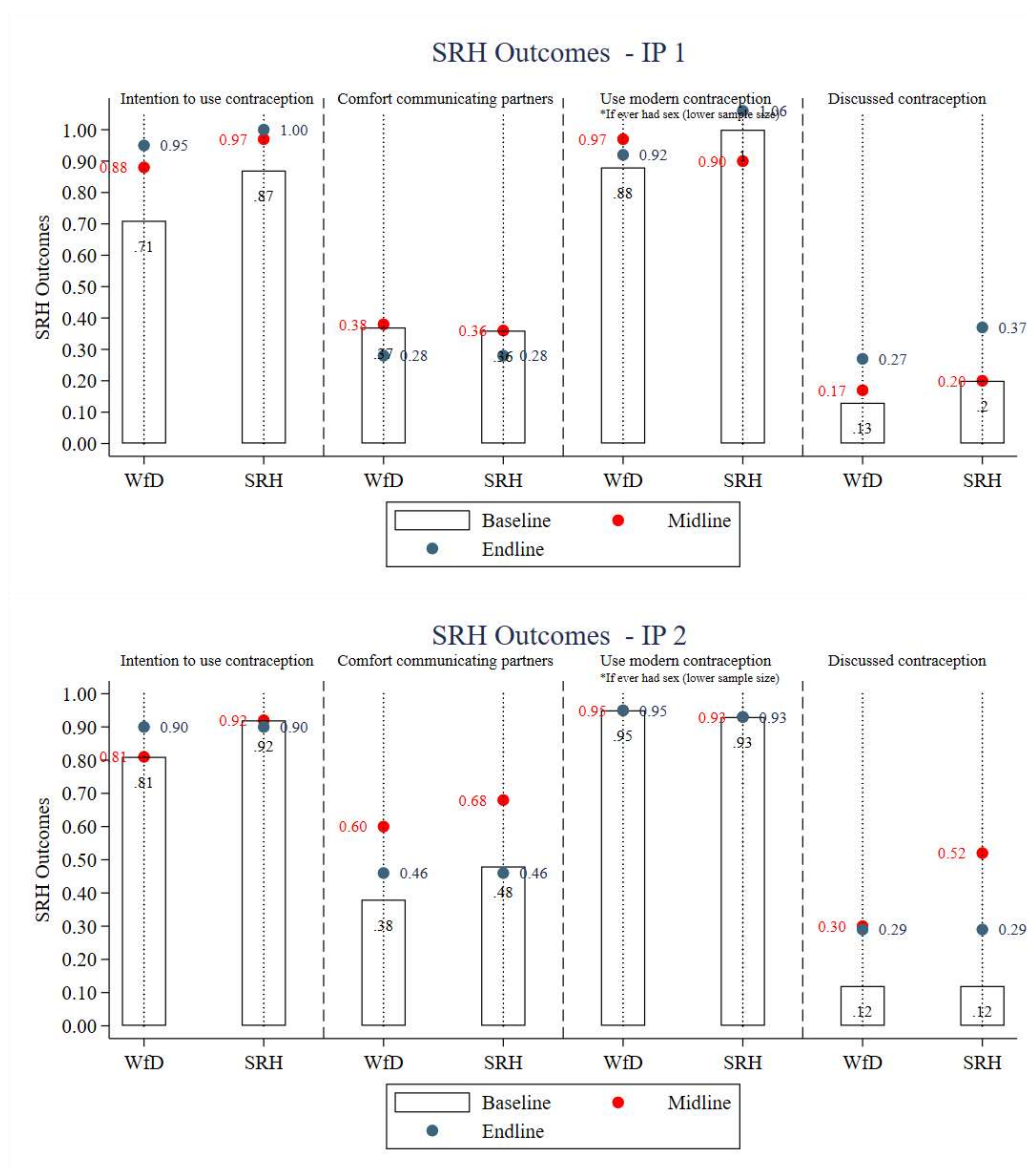


Figure A- 6. Pre- and (predicted) post-treatment means for FP/RH outcomes by implementing partner



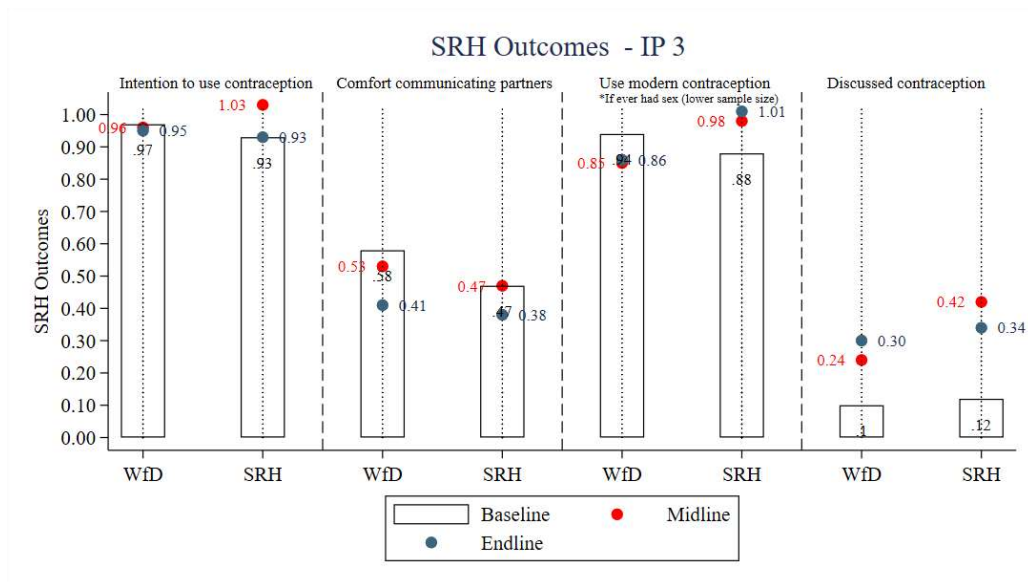


Figure A- 7.Pre- and (predicted) post-treatment means for gender equity and ever tested for HIV by implementing partner

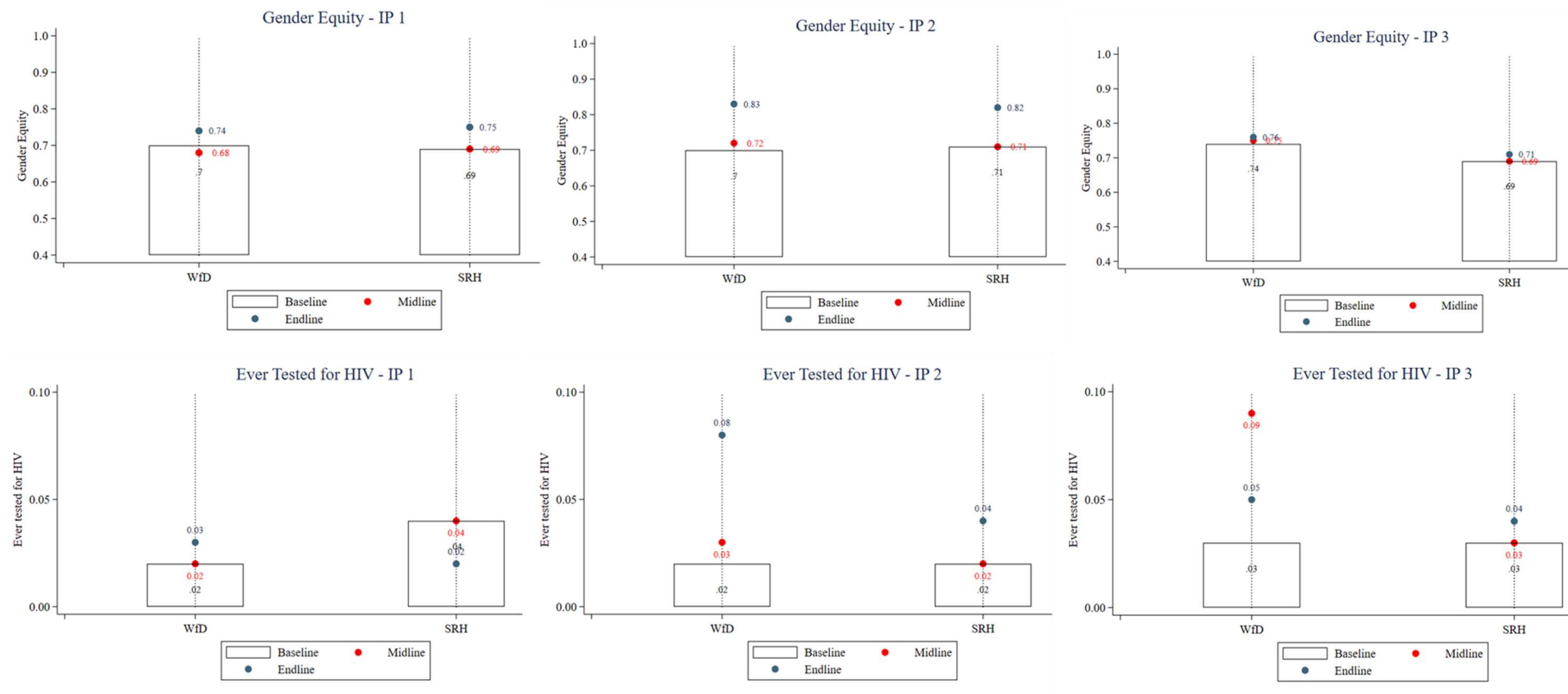


Table A. 6. Heterogeneous effect by cohort

	(1)	(2)	(3) # Strat. Job Hunt	(4) Positive Identity	(5) Self- Control	(6) HOTS	(7) Soc. & Commu. Skills	(8) Intent. use Contracep.	(9) Contracep. Know.	(10) HIV Know.	(11) PMTCT Know.	(12) Gender Equity	(13) Comfort Commu. Partners	(14) Discussed Contracep.	(15) Ever Tested for HIV	(16) Use Modern Contracep.
WfD Only - Cohort 3 - Midline	-0.14 (0.21)	-0.04 (0.08)	0.12 (0.07)	0.09 (0.15)	-0.02 (0.10)	-0.03 (0.18)	0.13 (0.15)	-0.02 (0.08)	0.43*** (0.14)	0.05 (0.05)	0.02 (0.05)	0.02 (0.15)	0.02 (0.07)	0.11*** (0.02)	0.02** (0.01)	-0.00 (0.00)
FP/RH Diff. - Cohort 3 - Midline	0.28 (0.31)	0.15 (0.12)	-0.04 (0.14)	-0.12 (0.20)	0.17 (0.15)	-0.33 (0.23)	-0.24 (0.23)	0.04 (0.08)	0.73*** (0.21)	0.04 (0.07)	0.01 (0.07)	0.13 (0.20)	0.12 (0.11)	0.24** (0.10)	-0.02 (0.01)	0.01 (0.05)
WfD Only - Cohort 4 diff. - Midline	-0.03 (0.28)	0.08 (0.15)	0.02 (0.14)	0.27 (0.18)	-0.10 (0.16)	0.21 (0.24)	0.07 (0.18)	0.16 (0.10)	0.43* (0.23)	-0.00 (0.08)	0.08 (0.07)	0.06 (0.18)	0.07 (0.11)	0.02 (0.07)	-0.00 (0.02)	-0.01 (0.07)
FP/RH diff. - Cohort 4 diff. - Midline	0.05 (0.60)	-0.15 (0.20)	0.01 (0.20)	-0.28 (0.29)	-0.19 (0.25)	0.38 (0.30)	0.14 (0.27)	-0.12 (0.11)	-0.97*** (0.31)	-0.12 (0.10)	-0.12 (0.10)	-0.17 (0.24)	-0.19 (0.15)	-0.23 (0.14)	0.03 (0.03)	0.04 (0.10)
WfD Only - Cohort 3 - Endline	0.65** (0.25)	0.00 (0.06)	0.63*** (0.08)	0.09 (0.13)	0.07 (0.09)	-0.05 (0.15)	0.05 (0.15)	0.10 (0.07)	0.54*** (0.16)	0.10* (0.05)	-0.01 (0.06)	0.30* (0.16)	-0.12 (0.09)	0.11*** (0.03)	0.04*** (0.01)	-0.00 (.)
FP/RH Diff. - Cohort 3 - Endline	-0.24 (0.29)	0.08 (0.11)	-0.05 (0.13)	-0.08 (0.18)	0.15 (0.13)	-0.13 (0.22)	-0.22 (0.25)	-0.05 (0.07)	0.27 (0.23)	0.17** (0.07)	-0.05 (0.09)	0.24 (0.21)	0.11 (0.13)	0.06 (0.08)	-0.03* (0.02)	0.11 (0.07)
WfD Only - Cohort 4 diff. - Endline	-0.17 (0.31)	-0.02 (0.13)	0.02 (0.14)	0.44*** (0.15)	0.48*** (0.15)	0.23 (0.19)	0.12 (0.17)	0.01 (0.09)	0.33 (0.21)	0.07 (0.08)	0.05 (0.09)	0.25 (0.20)	0.12 (0.11)	0.13* (0.07)	-0.01 (0.02)	-0.02 (0.05)
FP/RH diff. - Cohort 4 diff. - Endline	0.13 (0.41)	-0.00 (0.17)	-0.04 (0.22)	-0.31 (0.25)	-0.41* (0.22)	0.11 (0.27)	0.22 (0.28)	-0.05 (0.10)	-0.36 (0.30)	-0.19* (0.11)	0.05 (0.12)	-0.48* (0.25)	-0.22 (0.15)	-0.11 (0.11)	0.01 (0.03)	-0.04 (0.11)
Observations	596	1673	5839	5827	5827	5827	5827	5791	5839	5787	5787	5827	5827	5827	5787	326

Note: * $p < 0.1$ ** $p < 0.05$ *** $p < 0.01$.

