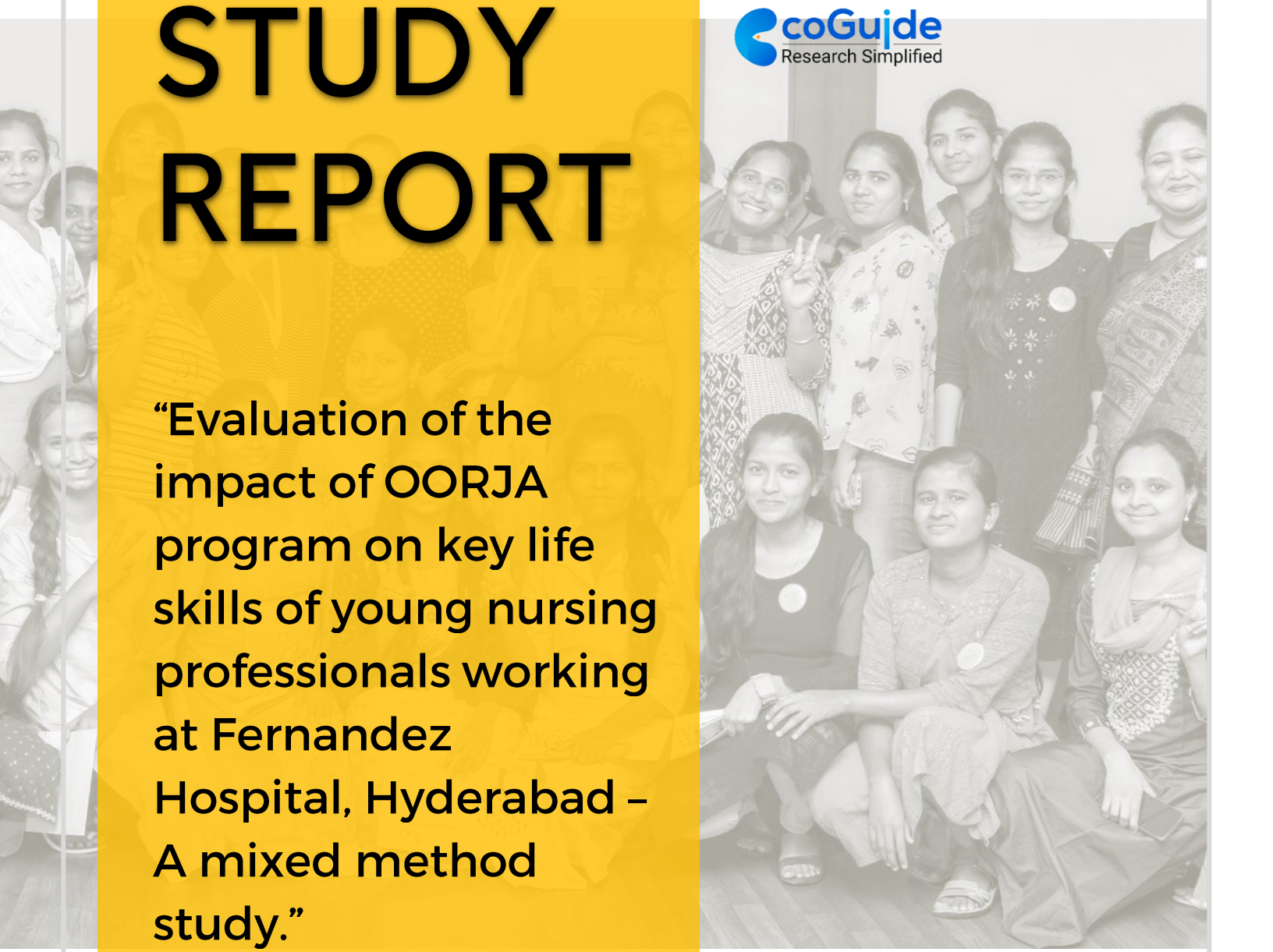
OORJA - A Study Report.docx

STUDY REPORT



"Evaluation of the impact of OORJA program on key life skills of young nursing professionals working at Fernandez Hospital, Hyderabad – A mixed method study."

Study conducted by
Voice 4 Girls and
Fernandez Foundation

March 2024

Evaluation Team

Dr Amarjeet Singh

Former professor & HOD (Department of Community Medicine)

PGIMER School of Public Health (Chandigarh)

Strategic advisor, coGuide Academy, Bangalore

Dr G. Murali Mohan Reddy

Global Lead Evidence & Impact

coGuide Academy, Bangalore

Dr Andrea Vincent

Senior Research and Laison Lead,

coGuide Academy, Bangalore

Ms Jayashree

Research Associate

coGuide Academy, Bangalore

Ms Rashmi Dungna

Research Associate

coGuide Academy, Bangalore

Ms G Divya Jyothi

Research Associate,

coGuide Academy, Bangalore

Mr Vignesh

Biostatistician

coGuide academy, Bangalore

Acknowledgement

The success of this project would not have been possible without the guidance and support of many individuals and organisations, and we are grateful to have got all these along during the entire duration of the project. The project has benefited immeasurably from the input of many.

First and foremost, we would like to express our gratitude to the Fernandez Foundation for supporting the intervention ***"OORJA"*** with a grant as part of their ***institutional social responsibility*** to empower the nursing cadre of the organisation. We are highly indebted to Dr Evita Fernandez, Chairperson and Managing Director of Fernandez Foundation, and management and staff for their inputs and suggestions at various project stages. We sincerely thank Mrs Sumani Ajay for the valuable insights and thoughts that helped us enrich the report.

We are grateful to the Voice4Girls for designing the intervention, identifying the trainers, and ensuring a smooth delivery of the programme. We are thankful and fortunate enough to have the unwavering support from Ms Anusha Bharadwaj, the executive director, and Ms Vanitha Prabhu, deputy director of Voice4Girls, during the study. We appreciate Ms Mallika, and Ms Pallavi, program managers of Voice4Girls, for effectively delivering the intervention program.

We would also like to thank our team of young investigators who painstakingly collected the survey and qualitative data. Ms Jayashree G and Ms Rashmi Dungna, research associates, coGuide Academy, translated our in-depth interview transcripts and coded data from these transcripts; we are grateful to them for their careful work.

We are grateful to Ms Satyaveni, data entry operator, and Ms Lalasa, monitoring and evaluation officer, voice4girls, for their help in preparing and monitoring data entry and editing. We want to thank Mr. Vignesh, a biostatistician at the coGuide academy,

for contributing to the statistical analysis and interpretation of data. We thank Ms Divya Jyothi G, research associate, coGuide, for her support at different project stages.

Earlier drafts of this report underwent peer review by a formidable group consisting of Dr Amarjeet Singh and Dr Murali Mohan Reddy. Moreover, their insightful suggestions and collegiality are gratefully acknowledged, and we thank them for their input in making this report a more robust product.

Most of all, we would like to record our appreciation of all the girls who participated in the project and answered our questions. They gave us their time and shared their insights, experiences, and aspirations. Our findings will help more girls attain life and livelihood skills by building girls' agencies and ensuring that they determine the course of their own lives.

Contents Pg.no

Chapter 1

Introduction

India is the second most populous country in the world, with 1.3 billion people. The average age of an Indian is 29 years, so it has one of the youngest populations in the world (Government of India,2022). Around 66 % of the total population in India is below the age of 35 (Decent Work for Youth in India, 2012). With an average yearly growth rate of 1.79%, India's female population expanded from 287 million in 1973 to 685 million in 2022 (India Female Population, 1960-2022 - knoema.com, 2023). Young women play a vital role in society's economic, environmental, and social evolution. This is particularly true for women hailing from rural and socio-economically poor backgrounds. In addition to shouldering the bulk of the household responsibilities, they also support the family by engaging in economically productive activities or professions. Young women in India grow up in a complex socio-cultural ecosystem, influencing their growth, development, persona, decision-making process and overall well-being at all critical stages of their lives. Socio-cultural factors are deeply rooted elements encompassing the values, attitudes, norms, practices, institutions, stratifications, and related ways of society. These factors can have a strong gender dimension, differentially affecting women (Kabeer,2005). The domineering male factor and resulting gender stereotypes, societally assigned gender roles, boy child preference, and lesser attention to female children in matters of nutrition, health, education and overall development are some of the significant aspects affecting girl child adversely (Kabeer,2005).

The health of women, both physical and mental, is a neglected aspect in the male-dominated Indian society. Due to biological differences and the uniqueness of some of the biological processes like menstruation and childbearing, women are prone to different sets of physical health issues. This unique biological process, coupled with relative neglect of a girl child, often leads to poor nutritional status and physical health among young women. Women’s tendency to place their family members' well-being ahead of their own in Indian society further compromises their physical health. Gender norms that emphasize the 'purity' of young unmarried women lead to a tabooization of sexual and reproduction-related aspects (Miriam,2019), which leads to poor access

to appropriate information and lower awareness levels. The improper management of sexual and reproductive health by young women (Guilamo-Ramos et al., 2012) results in high-risk behaviour and poor health outcomes. Women are more likely than men to struggle with mental illnesses, especially anxiety and depressive disorders; gender disparities in the patterns of mental illness are significant (Malhotra & Shah, 2015). Violence against women – particularly intimate partner violence and sexual violence affects the health of women (World Health Organization: WHO, 2021). Sexual exploitation and harassment in the workplace are major problems that affect their self-esteem and job satisfaction levels and their overall well-being (Meenakshi et al., n.d.).

This complex and often restrictive socio-cultural ecosystem can have a strong and long-lasting impression on young women during their formative years. Many of the norms and restrictions imposed by society are internalized and considered as "perfectly acceptable" by women. Girl children who experience discrimination in early childhood have more probability of accumulating socioeconomic disadvantages in later life, including reduced employability, poor labour market outcomes and poverty (International Labour Organization, n.d.). The lower female labour force participation rate compared to their male counterparts has prompted discussions among policymakers and academicians in India in the context of the 'demographic dividend' and a larger share of the working-age population. The factors influencing the labour force participation rate of women include human capital determinants like education, skills and health, household income, cultural and socioeconomic determinants, and access to critical resources like land, credit and financial capital, which inhibits a woman's possibility to be in paid work (Sorsa, et al., 2015).

Social norms attribute the primary household income generation responsibility to men and assign women to domestic chores (Bairagya et al., 2021). The other constraining factors are maternity and child care (Sudarshan & Bhattacharya, 2009) and framing caregiving responsibility primarily for women (Fletcher,2012), which restricts women's labour force participation in India. Empirical studies in India found that women's

labour force participation rate follows a U-curve pattern (Chatterjee et al., 2018). Women with less education participate more in the labour force than women with primary or secondary education. Women from poorer households participate in the labour market to complement the family income to meet their subsistence needs. After attaining tertiary education, women are more likely to get into white-collar jobs with high wages and more social status attached (Jensen, 2012). Between these two groups, women with primary and above levels of schooling face barriers to participation in the labour force due to the absence of an urgent need for work, along with facing the cultural norms that restrict women's mobility and the presence of social stigmas associated with women's employment (Klasen & Pieters, 2015). Thus, household ties and status often restrict an individual's decision-making process to participate in the labour market (Kapsos et al., 2014).

Evidence shows that women are more likely to participate in home-based work while caring for their domestic responsibilities (Singh & Pattanaik, 2020). As households become financially stable, women drop out of the labour market as domestic and home-based work is perceived to have a higher status than market work. In addition, women are more likely to be engaged in work, which is an extension of their responsibilities at home (like domestic help, cooks, nurses and teachers) (Banerjee, 2019). Attaining formal education and workforce participation is an effective solution to address the issue. Educated women are likely to earn money, participate more in economic decisions at home, and make their own choices about critical aspects of their personal life and family (Kabeer,2005). Women with education tend to be more labour market-oriented and have a stronger preference for specific jobs in the service sector (like the education and health sectors). Despite being a preferred job of women, nursing has a high attrition rate, in the range of 28-35%, whereas the overall attrition rate in the healthcare sector is around 10% (Dasgupta, 2015). The primary reasons for attrition cited are low pay, poor working conditions and limited opportunities for self-development and career progression (Sharma et al., 2020). The other issues that nurses face include poor self-concept and self-esteem, sexual harassment in the workplace,

lack of motivation and assertiveness, and poor decision-making skills. The young nurses reported having fewer social networks and restricted ability and options to exercise choice, whether selecting a life partner or choosing a career. Young women also have limited control of income, savings and assets, which inhibits their empowerment (Sharma et al., 2020). The formal education system and professional training courses are primarily curriculum and job-focused and often fails to impart essential life skills to young women. Taking care of physical health, maintaining psychological well-being, having higher goals, sustaining the professional career, leadership, financial management, exercising rights, ability to say no, etc., are some of the critical life skills they fail to acquire.

Social factors like the low status attached to the profession, as it is considered as the "feminine and menial" profession, and difficulty in getting marriage proposals due to the preconceived notions of "moral and sexual purity" of patrifocal societies also act as deterring factors for nurses to continue in their profession (Nair & Healey, 2006). Thus, nursing "symbolizes a tension" between the modern notion of independence and empowerment, and patrifocal notions of women playing a domestic, subordinate role dependent on males/community to fulfil their economic/personal needs as a member of rural and agrarian communities (Nair & Healey, 2006). The gender identity of nurses, along with the constrained social-cultural environment, restricts them from progressing in their careers and also taking up leadership roles in policy and decision-making at institutional, state and national levels. World Health Organization (2003) emphasizes the importance of building nurse leadership, which is about creating empowered nurses who can act as "change agents". However, the opportunities to update their knowledge and skills for nurses are very limited in the Indian context. Nurses, who constitute a significant portion of human resources in the Indian healthcare system, have limited opportunities and resources to undergo Continuous Professional Development (CPD) programmes (Smith et al., 2018). Even after the Indian Nursing Council's mandate of CPD for nurses towards their renewal of registration, their lack of engagement in such programmes is attributed to personal factors,

including cost, family commitments, distance to venue and organizational barriers like staff shortages, lack of relevant programmes and employer support (Macaden et al., 2017). Women in the nursing profession have fewer opportunities for personal and professional development, adversely affecting their labour market integration, job readiness and professional development.

Since the formal education system is failing to impart essential life skills and aid in the overall development of young women, there is a strong need for initiatives to address this gap. Among all the institutions of society, after the family and school, the workplace has a significant role in shaping any individual, particularly a young woman's life. On the one hand, organisations are interested in ensuring the productivity of their workforce, and on the other hand, they are also responsible for the welfare of their employees. Thus, institutions should be responsible for offering training and development programmes for personal growth, competency development, and continuous professional enhancement to improve job satisfaction and, thus, employee productivity.

Youth training programmes on life skills improve socio-emotional skills and also help them acquire employability skills, which in turn helps them in successful labour market insertion. Life skills help the youth develop self-esteem, improve workplace readiness skills, and realize the importance of making adequate day-to-day decisions, which helps them engage in positive behaviours that are "profitable" and avoid risky behaviours that are "costlier"(Ibarrarán et al., 2014). Life skills programmes are sought for the empowerment of girls, to create awareness about themselves and their bodies; enhance their mobility; empower them to voice their opinion and to participate in decisions affecting their lives, like marriage and career; promote egalitarian gender role attitudes; enhance their control over resources through the development of a savings orientation; or build career-oriented skills among girls (Acharya et al., 2009). To help young nurses in the early stages of their careers overcome the barriers in their personal and professional lives, a life skills training programme was implemented by a collaborative effort of the Voice 4 girls' organization and Fernandez Hospital,

Hyderabad. This project report aims to document the impact of life skills training programmes empowering women across various domains in their personal and professional lives. Some studies report the impact evaluation of life skills training programmes on adolescents and young adults and have documented the effectiveness of these programmes (Acharya et al., 2009). However, our study is unique in the following ways.

1. The project reports the efficiency and effectiveness of an intervention programme organized for the nurses as part of Fernandez Hospital's institutional social responsibility. Studies have highlighted the importance of the involvement of top management with various stakeholders to ensure the effectiveness of social responsibility programmes offered by hospitals (Rohini & Mahadevappa, 2010). In this project, the management felt the need to invest in and empower young female nurses from poor socioeconomic strata who completed nursing training courses and are in the early stages of their careers. The programme's vision was to develop their leadership and decision-making skills and improve their motivation to continue and grow in their careers. To our knowledge, this is one of the first life skill interventions to improve the labour market integration of young nurses fully funded and supported by the employer.

2. Considering nurses' personal and organizational barriers to attending professional development programmes, this life skill intervention was arranged as an 8-day residential programme. In addition, a fully residential 8-day programme gave the participants ample time to participate actively, reflect on various topics discussed, and practice necessary life skills through mock sessions arranged.

3. The programme's immediate impact was evaluated using rigorous qualitative and quantitative research methods. A triangulation mixed method study design was adopted where qualitative and quantitative data are collected simultaneously and analyzed separately.

The structure of the report is as follows:

The second chapter deals with the methodology adopted for the impact evaluation, followed by a chapter explaining the intervention in detail. The fourth chapter presents the quantitative and qualitative data results. The fifth chapter discusses the study's findings, followed by a chapter discussing the major findings of the study. The final chapter concludes the report and recommends suggestions for scaling up the study.

Chapter 2

Methodology

The study used quantitative and qualitative research techniques to document the OORJA program's impact on young early-career nurses' lives. The first part of this chapter describes the methodology adopted for conducting quantitative research.

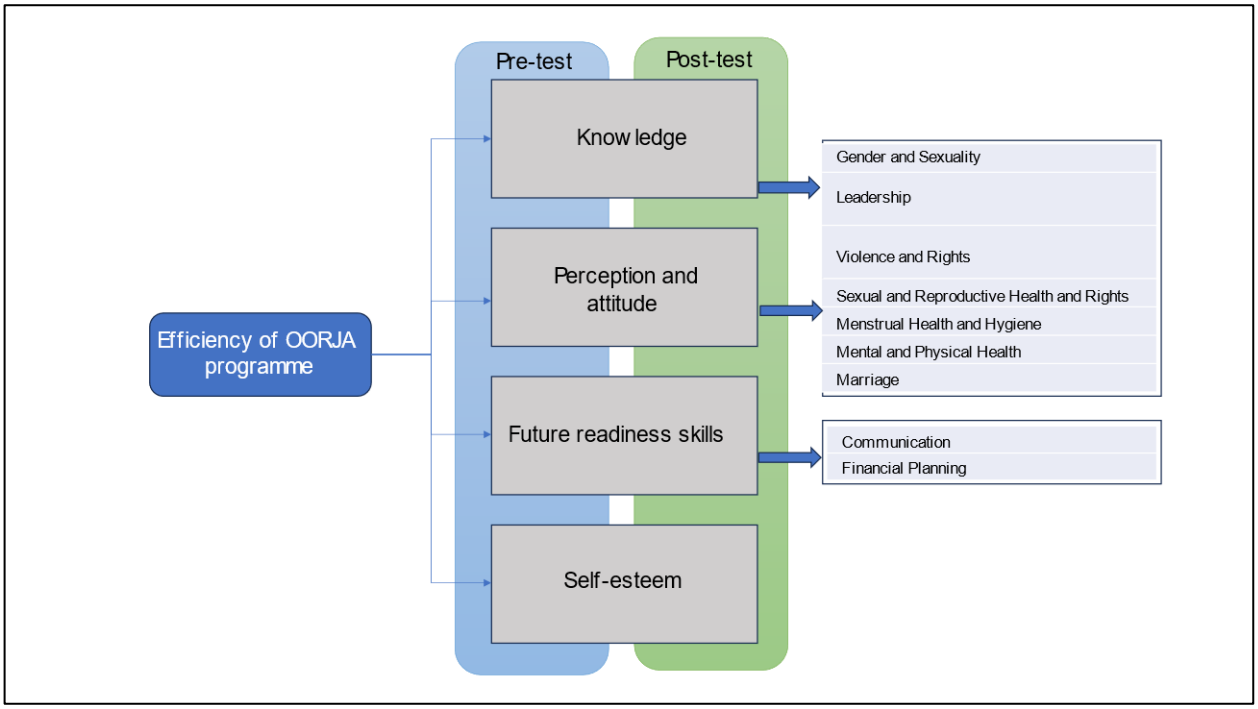
2.1. Objectives

- To describe the socio-demographic profile of young women who attended the OORJA programme.
- To evaluate the effectiveness of the programme in terms of improving the knowledge of the participants.
- To examine the programme's impact on changing the participants' attitudes and perceptions.
- To understand the current practices followed by young women in various assessment domains, i.e., menstrual health, sexual and reproductive health, mental health, gender roles, safety and rights and financial planning.
- To analyze the change in participants' perception of the possession of skills for future readiness pre and post-intervention.
- To assess the intervention programme's impact on the participants' self-esteem level.

2.2. Study design: Quantitative methods

The study uses a quasi-experiment design with pre-test and post-test evaluation to document the impact of a life skill intervention programme on participants' knowledge, attitudes and perceptions, practices, future readiness skills and self-esteem.

Figure 1: The Conceptual framework adopted for the quantitative study



2.2.1. Ethical considerations

Ethical clearance was obtained from the Fernandez Foundation Institutional Ethics Committee before conducting the study. The young women who participated in the study were fully informed about the study objectives, and their consent was taken with the assurance that their confidentiality would be maintained throughout the study. The data collected for this study will be used solely for academic and further research purposes and will not be disclosed for other reasons. A detailed Patient Information Sheet (PIS) was prepared and handed to the participants in readable language.

2.2.2. Sampling method

The participants for the Oorja training programme were selected from the nursing department of Fernandez Hospitals, located in Hyderabad. The total population of young women in the nursing department is 250. Using a simple random sampling technique, 25 young women were selected as per the inclusion criteria and who were willing to participate until saturation was reached.

2.2.3. Duration of study

The baseline survey of the study was conducted on the first day of the training programme on 18th March 2024. End line assessment was performed on the last day of the programme on 25th March 2024. Data were collected at two time points. A pre-test was administered on the first day of the camp, and the post-test was administered on the eighth day. After obtaining the data from both visits, the results of the pre and post-study tests were compared to assess the impact of the intervention. After explaining the purpose of the study to the participants, written informed consent was obtained.

2.2.4. Tools for data collection

A self-administered and semi-structured questionnaire was used to collect the data (Appendix 1). The questionnaire is divided into six sections: socio-demographic information (Section A), subject knowledge (Section B), attitude and perceptions (Section C), healthy practices (Section D), future readiness (Section E), and self-esteem (Section F). A brief description of the tools is provided below.

Section A: Socio-demographic information

Section A includes questions on understanding the socio-demographic characteristics such as age, annual income, religion and caste, fathers' and mothers' education and occupation, and access to the participants' information and communication tools (ICT).

Section B: Subject knowledge

Section B of the pre and post-test was designed to evaluate the participants' levels of knowledge regarding different topics, including menstrual, physical, mental, sexual, and reproductive health, gender and sexuality, safety, and violence, both before and after the workshop.

Section C: Attitude and Perceptions

Section C of the pre and post-test served as an evaluation tool to assess the training effectiveness in bringing about a positive shift in participants' attitudes and perceptions regarding different themes, including menstrual, physical, mental, sexual, and reproductive health, gender and sexuality, safety, and violence after training.

Section D: Practices

Section D of the tool assessed the current practices that are followed by the participants at the time of intervention.

Section E: Skills and Future Readiness

Section E of the pre and post-training aims to gauge the participants' skill enhancement following the training and to determine whether any improvement in skills could contribute to enhancing the future readiness of the participants. The section assesses the development of critical competencies, such as communication, problem-solving and financial planning.

A 7-item, 5-point Likert scale questionnaire was administered to participants before and after the training to evaluate the training program's impact on communication skills. The questionnaire measured improvement in communication skills, with scores ranging from strongly agree to disagree strongly.

The study assessed participants' problem-solving proficiency, a cognitive and behavioural process involving advanced questioning to analyze a situation, identify an appropriate solution, and apply it to resolve a problem.

Section F: Self-esteem

Section F in the pre and post-tests is focused on assessing the participants' levels of self-esteem before the training and assessing the participants' improvements in self-esteem after the training. It was assessed using a 15-item Likert scale like Rosenberg's

Self-Esteem Scale. The scores were determined on a 5-point scale ranging from strongly agree to disagree.

2.2.5: Outcome variables

The dependent variables are reported in Table 1. Based on the broad objectives of the life skills intervention programme, the dependent variables include measures to assess knowledge, attitudes and perceptions on gender and sexuality, safety and rights, leadership, menstrual health and hygiene, sexual and reproductive health, mental and physical health, and marriage. The other dependent variables of the study are skills for future readiness, such as communication and self-esteem.

The table lists the variable type, the possible range, and baseline and end-line ranges. The dependent variables are primarily numerical. The appendix provides descriptions of the components or questions of all variables. The respondents were asked several questions for the two domains of knowledge, attitude and perception. For the knowledge domain, which had seven components, the respondents were asked 25 questions, and for the second domain, 33 questions were asked to measure the seven components. A score is generated based on correct and wrong answers for each component, and the total score for each domain is computed by totalling the individual component-wise score. Respondents were asked 7 and 15 questions for communication domains and self-esteem, respectively, and measured by a 5-point Likert scale (strongly agree, agree, neutral, disagree, and strongly disagree).

Table: 1: Description of the dependent variables

Variable	Number of components	Type of variable	Possible range	Baseline range	Endline range
Knowledge					
Menstrual health	5	Count	0 to 5	1 to 4.50	2 to 4.75
Sexual and reproductive health	6	Count	0 to 6	0 to 6	1.58 to 6

Mental and physical health	2	Count	0 to 2	0 to 2	0.33 to 2
Gender and sexuality	1	Count	0 to 1	0 to 1	0 to 1
Marriage	5	Count	0 to 5	0.25 to 5	1.25 to 5
Safety and rights	3	Count	0 to 3	0 to 2.67	0 to 3
Leadership	2	Count	0 to 2	0 to 1.33	0.33 to 2
Attitudes and perception					
Menstrual health	4	Count	0 to 4	0 to 4	0 to 4
Sexual and reproductive health	7	Count	0 to 7	1 to 6	3 to 6
Mental and physical health	2	Count	0 to 2	0 to 1	1 to 2
Gender and sexuality	7	Count	0 to 7	1 to 7	3 to 7
Marriage	3	Count	0 to 3	0 to 3	0 to 3
Safety and rights	6	Count	0 to 6	1 to 6	2 to 6
Leadership	3	Count	0 to 3	0 to 3	1 to 3
Skills for future readiness					
Communication	8	Count	8 to 40	8 to 39	8 to 40
Financial planning	7	Categorical	1 to 7	1 to 7	1 to 7
Self-esteem	15	Count	15-75	35-73	48-75

2.2.6. Data management

The data collected was stored in a password-protected Google Sheet. Access was granted to limited personnel to ensure confidentiality and anonymity. Any information or personal details gathered during the study will remain confidential. No individual will be identified by name in any publication of the results. The filled questionnaires and the in-depth interview, which was video-recorded and transcribed, will be held confidently.

2.2.7. Limitations of the study

1. Since it is a pilot study, it was conducted with a limited sample size, which makes generalizations difficult.

2. The questionnaire used to collect the data needed to be standardized as the reliability and validity of the tools should be ascertained, affecting the study's overall quality.

3. There were mismatches in how the questionnaire was drafted, especially in the practices theme. While the intent of that theme was to measure practices, the way few questions were framed was to measure respondent's perceptions.

4. Few participants reported limitations, like the lengthy nature of the questionnaire, which needed more time to be completed.

5. The questionnaire was in English, which some participants needed help understanding and were hesitant to ask the trainers for translation assistance.

6. The analysis plan for specific questions in the questionnaire was unclear, creating confusion in analyzing those items while the researcher reported the findings.

7. The questions in the questionnaire did not factor in 'recall bias' that might affect the quality of responses of the respondents.

8. Proper statistical analysis tests for grouping items should have helped construct the tools and thus report the results better.

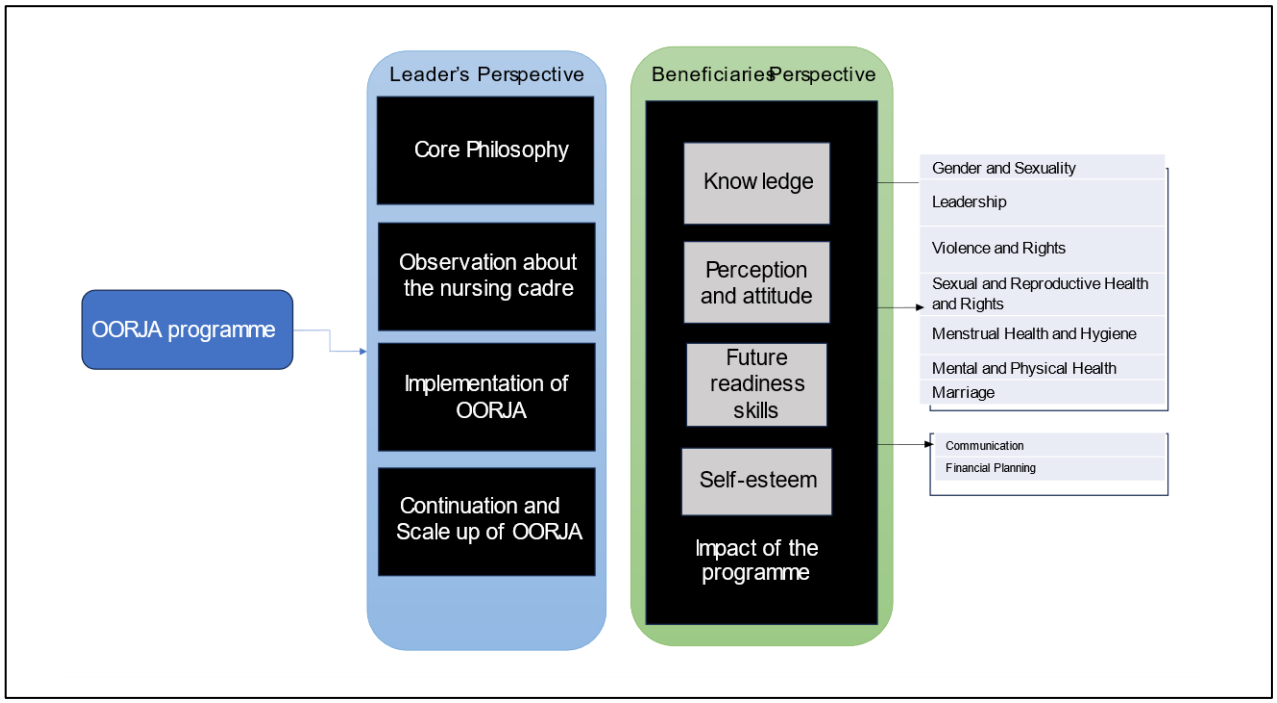
9. The choices given to mark the responses could have been clearer in some places, which resulted in the tool needing to be more precise. The response categories formed for some questions were not mutually exclusive, which might have confused the respondents while answering.

10. The intervention programmes were not standardised with validation from experts, which limits its scope for replicability.

2.3. Qualitative study

The qualitative part includes the perception and expression of the learning of participants of the training. Data was collected using in-depth interviews. Among the participants who completed the quantitative questionnaire, nearly eleven of the participants responded to the open-ended questionnaire regarding the benefits of this intervention. Key informative interviews were conducted among two representatives of the Voice 4 Girls' team and two representatives of Fernandez Hospital. Both participants and KII were collected virtually and recorded using Zoom software. Data obtained from the qualitative interviews were transcribed and translated into English language. Open coding methods were used by researchers to analyse the interview transcripts of participants and representatives. During this phase, transcripts were read line-by-line and general codes, themes and categories were created. Common themes and links between emerging concepts were noted, and similarities and differences were analysed, leading to main themes and sub-themes with clear names and definitions (thematic analysis). Figure 2 describes the qualitative framework adopted for the study.

Figure 2: The Conceptual framework adopted for qualitative study



Chapter 3
Intervention

Project setting:

The Fernandez Foundation is committed to taking forward its legacy of leadership in healthcare through excellence, compassionate service, and Institutional Social Responsibility. The Foundation strives with the spirit of inclusion and justice, respecting every human being and upholding their dignity at every stage of life, adhering to values enshrined in Christian beliefs. They conduct specific programs to empower midwives from their Institutions.

There are two such programs: one is the two-year in-house Professional Midwifery Education and Training (PMET) program, and another is in collaboration with the government of Telangana and UNICEF, an 18-month certification program in midwifery for nurses.

The PMET Program is a two-year training programme that began in August 2011 to help build a select group of skilled nurses trained to promote and deliver effective maternity care. Tutors/midwives come regularly from the UK to help train batches of nurses. The programme was started to reduce maternal and neonatal mortality and morbidity.

The Government of Telangana requested that the Fernandez Foundation train 30 nurses as **"Professional Midwives".** The training programme was for 18 months. It was initiated in 2017 with the support of UNICEF.

The government of India initiated the Nurse Practitioner Midwifery (NPM) Educator programme on November 6th, 2019. Fernandez Foundation was recognised as one of the National Midwifery Training Institutes. A cohort of 30 postgraduate nurses from 5 states, i.e., Andhra Pradesh, Karnataka, Maharashtra, Orissa and Uttar Pradesh, are undergoing 6 months of intensive residential training at the Fernandez Institute.

The project OORJA was launched by the FERNANDEZ FOUNDATION for young women to empower them and meet their career needs. In the OORJA Program, the participants are selected from Fernandez Institute who completed their nursing training and are in the early stages of their careers. Oorja camp is an eight-day program that Voice 4 Girls NGO conducts. A sample of young women was selected per the inclusion criteria (Participants>18 years of age) using simple random sampling until study saturation is reached. Data from each participant was collected and interviewed using a standard questionnaire, and to analyse the qualitative data, the recorded and video interviews from each participant were transcribed and coded. In addition, in-depth interviews were conducted with trainers and stakeholders.

This training program was conducted in an independent building belonging to **Bala Vikasa** on a rental base with a classroom, board room, one spacious room for activities/ discussions and rooms to accommodate participants for the entire program, eight days.

The participants stayed there for the entire program with 100% attendance. Daily 4-5 meals were provided, including breakfast, mid-morning snacks, lunch, evening snacks and dinner. The snacks were provided in the classrooms, and the big meals were given in the dining area.

A fixed schedule was followed, and classes were conducted in respective classrooms. Additionally, many group activities, like skits, role plays, poster making, and enacting scenarios related to the concepts, were performed. The delivery of the sessions was performed based on the participant's needs, which was not following the schedule list blindly but giving them real-life scenarios as examples to make them relate to the concepts in a better way.

Two facilitators were involved majorly in this training session, and one participated in the Voice 4 Girls office team as a visiting guest for one day to deliver the training.

Objectives of the programme:

To empower women from nursing backgrounds through a life skill education program, equipping them with essential knowledge and abilities to enhance their personal development, mental and physical health, financial independence, self-confidence, and community engagement, thereby fostering holistic empowerment and sustainable progress.

This project was undertaken in collaboration with the V4G team. Voice 4 Girls, a non-governmental organisation, was started in 2011. Voice's mission is to empower marginalised adolescent girls. After hearing stories of bravery and resilience, the Voice realised it was not enough to work with girls in isolation. Following this revelation, they conceptualised a program that works intensively with adolescent boys. It conducts programs/camps for girls to take charge of their futures by imparting critical knowledge, spoken English, and life skills through activity-based camps at government and low-cost private schools. VOICE's curriculum imparts knowledge on critical topics such as health, safety, rights, future planning, life skills, and self-awareness. Thus, campers acquire problem-solving, decision-making, negotiation, and communication skills. Camps are led by motivated college students recruited and intensively trained to impart our curriculum.

VOICE aims to reach thousands of girls and boys across the developing world and inspire the next generation to take their futures into their own hands. VOICE currently operates in seven states of India – Telangana, Andhra Pradesh, Tamil Nadu, Uttarakhand, Uttar Pradesh, Haryana, and Jharkhand and has reached over 2,44,500 adolescent girls and boys.

Evolution of OORJA:

The V4G team conducts camps for adolescent girls, particularly in rural areas, imparting knowledge on menstrual health, getting them to understand their bodies, recognising good and bad touch, safety and rights, etc.

After visiting their camp and noticing the positive impact of the intervention provided to this particular group, they have energised the Fernandez team to conduct the OORJA camp among their working professionals from nursing backgrounds, who are in their early 20s, as part of their Institutional Social Responsibility. This program is considered an excellent opportunity to empower them with life skills. Hence, a plan to conduct training programs focusing on these aspects was a valuable option. After considering their low socio-economic status and rural background, participants were selected based on their requirements.

Curating content in OORJA:

Topics, content, and activities are created based on the requirements of the nurses of the Fernandez Institution. V4G has designed this program for almost a year with many discussions and revisions to execute the training program with the Fernandez Foundation. The main motto is to develop, encourage, and empower women to focus on their career plans and take up more productive careers rather than staying at home. Social factors that restrict women from making decisions for their lives were addressed. Activities and interactive games were included to make it enjoyable.

Main components of the intervention program:

It was an 8-day training program conducted to empower young women. The program was conducted in two sessions (morning and afternoon sessions). The program comprised 12 core sessions that branch out into two sub-themes: understanding the self, health – mental, physical, menstrual, and reproductive health, marriage, family and future planning, protection from violence and recognition of rights, and future-readiness – communication and employability skill development programmes like public speaking, problem-solving, communication, and leadership.

Morning session:

Training started with a **self-introduction** session to help participants express themselves better and learn about facilitators and other participants.

Let us talk about periods: This session aims to raise awareness of menstrual hygiene practices, including the availability of menstrual products, restrictions, and taboos followed during menstruation.

Mind matters: This session focused on mental health issues, identifying them, and overcoming them to maintain good mental health.

My body, my choices: It covers a wide range of issues relating to sex, pregnancy, contraception, and sexually transmitted infections (STIs), including HIV/ AIDS, as well as the laws governing age at marriage. It also covered a short revision on parts and functions of the male and female reproductive system.

My identity: Information on gender roles and gender identity was discussed in this session. The importance of their family, community and media in shaping their identities were discussed. It helped them understand and recognise their strengths, shaping them to be how they want and what they want to be in the future. Also, it made them understand what a healthy relationship is and how to negotiate with one. The job readiness skills like resume writing were conducted to prepare them for the near future.

My future family: Beginning with the importance of marriage and the role played by women in her family, make them understand the issues faced by women in marriage, family, and relationships and how important it is to maintain good and healthy relationships, letting them know the equality in the marriage and household responsibilities.

Say no to violence: knowledge on ways to tackle violent situations, overcome negative relationships, gender inequality. It also includes the fundamental rights of women, laws against violence, and necessary life skills to be trained to overcome the potential dangers of violence.

Goodbye: The final session was used to comprehend and consolidate the learnings of all the sessions.

Afternoon session:

Seeing your life with a perspective: Changing your perspective can profoundly impact your life. It can alter how you perceive yourself, others, and the world around you, leading to more positive experiences and outcomes. This session focused on ways to improve their resilience and appreciate the journey of their life.

Girl power: During this session, the focus was teaching them the importance of skills and working towards their goal. They discussed the girls' power and the understanding of the collective power of women. The sessions also dealt with topics like recognising the sources of power in society, how media propagates girls' power in society and so on. This session is to educate them about women's powers, organise the inequality in society, and come up with various ways to bring change to it.

Solve it: This session is planned to educate them to identify and recognise the root causes of the problem. Learn how to deal with the problem effectively with smart solutions. This session is scheduled to make them understand the context of diversity in society, and how they reflect on a person, community, nation or global. It sought to enhance the population to develop suitable and smart solutions.

Communicating effectively: Learning about verbal and non-verbal communication, the core elements of a good speech, and the basic and major steps to create a good

presentation. The outcome of this session is expected to be able to make relevant speeches and presentations confidently.

The ultimate game: This session reflects the OORJA sessions' learnings. Learning about decision-making and making conscious decisions when there are limited resources to choose from. The outcome is expected to be that they should be able to make active decisions based on the resources they have on hand.

Investing in you: This session will teach them to set financial goals, budget, manage household expenditures, learn different ways to save or invest their money and avoid unhealthy ways of handling money. After this session, they should be able to save or invest their money wisely and know the importance of savings.

I will lead: The major topics discussed in this session are identifying the qualities of a leader, various types of leadership, the need for a leader, and learning how to lead a team. They should be able to lead a team effectively, collaborating with different people to reach their goals.

Graduation: This is the final or "GOODBYE" session, where all the concepts learned through the activities are revised and a Post-Impact Assessment is conducted. The participants will graduate from the program.

Feedback process:

Feedback was collected daily after the sessions to understand if they could follow the concepts. Also, a feedback survey was conducted after the entire program to evaluate their understanding of the concepts they learned in the training sessions.

Chapter 4
Study Findings

Quantitative analysis

The findings from the analysis of quantitative data collected pre and post-intervention of OORJA are reported in this chapter. Data from 25 samples were collected to compare the pre and post-intervention results and document the programme's effectiveness.

Statistical analysis:

Descriptive analysis was carried out by frequency and proportion for categorical variables. Continuous variables were presented as mean ± SD. A paired sample t-test was used to compare the mean ± SD of continuous variables within the groups. A P value of 0.05 was considered statistically significant. RStudio Desktop Version 2023.03.0+386 was used for statistical analysis. (Reference: RStudio Team (2023). RStudio: Integrated Development for R. RStudio, PBC, Boston, MA URL **http://www.rstudio.com/**) The qualitative data from the sections on practice is also discussed under various sub-headings with the help of frequency tables and thematic analysis. Forest plots and other graphical representations are used for the visual representation of data

Session - 4.1: Socio-demographic profile

The socio-economic background of the participants is analyzed using descriptive statistics. A basic description of the sample is provided in Table 2. Characteristics like age, income, religion, caste, parents' education, parents' occupation and access to Information and Communication Technology (ICT) tools were considered to understand their socio–demographic profile. The mean age of the participants is 25 years, ranging from 19 to 30. In the overall sample group, nearly 68% are from households with fathers' occupation status as farmers and wage earners. More than 52% of the respondents reported their mother's occupation as housewife, followed by 20% as farmers. Most of the respondents were from low socio-economic status families, SC/ST and OBC backgrounds. Nearly 68% of the respondents were from the Christian religion, followed by Hindus (32%). The socio-demographic profile of the

respondents reaffirms the existence of social status issues associated with the nursing profession. Historically, nursing as a profession was associated with destitute women; it was very unlikely that either 'non-Christian' or 'respectable' Christian families would allow girls to train as nurses (Nair & Healey, 2006). Missionaries usually offered nursing training, and the nurses were drawn from low-status families, formerly low-caste communities of Christian converts and orphans/ destitute. Disassociating nursing from these false perceptions has always remained a challenge, and the profession remains a second-class option with poor attractiveness.

Table 2: Summary statistics of socio-demographic profile of population (N =25)

Parameters	Summary
Age In Years, Mean ± SD	25.23 ± 2.14
Father's occupation	**N (%)**
Farmer	14 (56%)
Daily wage earner	3 (12%)
Private job (salaried employee)	1 (4%)
Self-employed	1 (4%)
Other	3 (12%)
No response	3 (12%)
Mother's occupation	**N (%)**
Housewife	13 (52%)
Farmer	5 (20%)

Daily wage earner	2 (8%)
Government job	1 (4%)
Private job (salaried employee)	1 (4%)
Self-employed	1 (4%)
Other	1 (4%)
No Response	1 (4%)
Father's education	**N (%)**
Illiterate	6 (24%)
Up to Class 5	5 (20%)
Class 6-10	7 (28%)
Class 11-12	3 (12%)
Graduate and above	1 (4%)
No response	3 (12%)
Mother's education	**N (%)**
Illiterate	13 (52%)
Up to Class 5	4 (16%)
Class 6 -10	6 (24%)
Class 11-12	1 (4%)

Graduate and above	1 (4%)
Religion	**N (%)**
Christian	17 (68%)
Hindu	4 (32%)
Caste	**N (%)**
Scheduled Caste	16 (64%)
Scheduled Tribe	1 (4%)
Other Backward Caste	1 (4%)
No Response	7 (28%)
Access to ICT	**N (%)**
Yes	13 (53%)
No	12 (47%)

Session - 4.2 - Subject knowledge

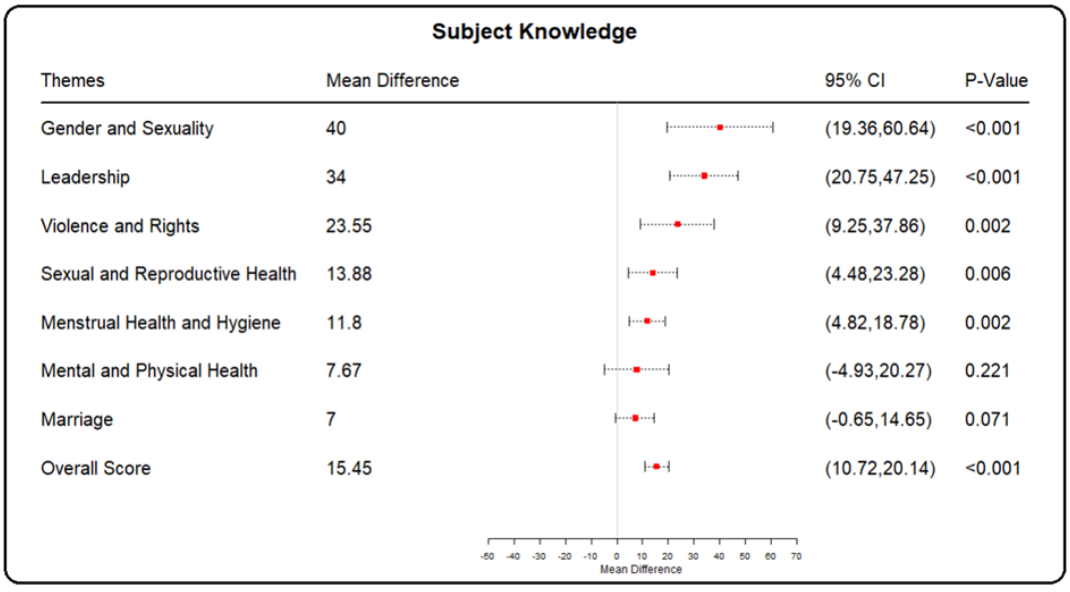
Pre and Post-test were designed to evaluate the participant's level of knowledge in a few topics, including gender and sexuality, leadership, violence and rights, sexual and reproductive health and rights, menstrual health and hygiene, mental and physical health, and marriage both before and after attending the OORJA programme. The training has brought maximum improvement from the baseline scores in terms of gender and sexuality (MD=40), leadership (MD=34), violence and rights (MD=23.55). Though there is not much significant difference in terms of menstrual health and hygiene, SRH and rights, and marriage, the baseline scores indicate a good subject

knowledge prior to intervention. Also, the overall mean score of the participants increased to 15.45, with a statistically significant difference of p<0.001 at 95% CI (10.92,20.80) between pre and post-scores (Table 3).

Table 3: Pre and post-score for subject knowledge (N=25)

Theme	Pre (Mean ± SD)	Post (Mean ± SD)	P value
Gender and Sexuality	28 ± 45.83	68 ± 47.6	<0.001
Leadership	22.65 ± 18.56	56.65 ± 30.05	<0.001
Violence and Rights	26.66 ± 23.89	50.21 ± 28.88	0.002
Sexual and Reproductive Health and Rights	50.20 ± 25.98	64.08 ± 53.25	0.006
Menstrual Health and Hygiene	55.06 ± 19.74	66.86 ± 16.66	0.002
Mental and Physical Health	52.99 ± 31.36	60.66 ± 25.63	0.221
Marriage	67 ± 28.87	74 ± 22.36	0.071
Overall	48.71± 19.94	64.16 ± 15.63	<0.001

Figure 3: Forest plot summarizing mean difference of knowledge scores



4.2.1 Gender and sexuality:

One of the reasons for planning the intervention programme was the management's concern about the nurse's ability to manage relationships and the emotional turmoil they get into due to poorly managed relationships. The sessions on "My Identity" addressed these issues and had activities to discuss the difference between gender and sex, the role society plays in shaping identities and training them on the ingredients of a healthy relationship, how to maintain a healthy relationship, and how media impacts it. Table 3 indicates that the training has brought improvement from the baseline scores in terms of Gender and Sexuality (Mean Difference MD =40), with a statistically significant difference of $p<0.001$ at 95% between pre and post-scores.

The respondents were more open about their relationship status post-intervention. One respondent changed the relationship status from marriage to cohabitating post-intervention (Table 4).

Table 4: Descriptive analysis of current relationship status in pre and post-intervention (N=25)

What is your current relationship status?	Pre	Post
No current relationship	11 (44%)	8 (32%)
In a relationship	8 (32%)	11 (44%)
Cohabiting	0 (0%)	1 (4%)
Married	3 (12%)	2 (8%)
Didn't Respond	3 (12%)	3 (12%)

The respondents who reported being in a relationship reported reduced physical violence after attending the intervention programme. There was a slight decrease (10%) in the incidence of physical violence by the intimate partner after the intervention (Table 5). Post intervention, the participants reported a slight decline in problem-solving capacity and joint decision-making as partners. The sessions on recognizing a healthy relationship have helped the respondents identify their relationship's true essence.

Table 5: Pre and post-intervention scores of the subject who are in a relationship status pre-post-intervention relationship metrics

If you are in a relationship	Pre (N=11)	Post (N=14)
Is your relationship healthy, loving and stable?		
Yes	9 (81.82%)	11 (78.57%)
No	1 (9.09%)	2 (14.29%)
Didn't Respond	1 (9.09%)	1 (7.14%)
Are you treating each other as friends?		
Yes	10 (90.91%)	10 (71.43%)
No	1 (9.09%)	3 (21.43%)
Didn't Respond	0 (0%)	1 (7.14%)
Are you able to solve problems together?		
Yes	9 (81.82%)	11 (78.57%)
No	1 (9.09%)	2 (14.29%)
Didn't Respond	1 (9.09%)	1 (7.14%)
Does your partner respect your decisions?		
Yes	9 (81.82%)	11 (78.57%)
No	1 (9.09%)	3 (21.43%)
Didn't Respond	1 (9.09%)	0 (0%)
Are there any restrictions imposed by your partner? Ex: Do not talk to other boys, don't go alone anywhere, etc.		
Yes	5 (45.45%)	5 (35.71%)
No	5 (45.45%)	8 (57.14%)
Didn't Respond	1 (9.09%)	1 (7.14%)
Does he hit you if you don't listen to him?		
Yes	5 (45.45%)	4 (28.57%)
No	6 (54.55%)	9 (64.29%)
Didn't Respond	0 (0%)	1 (7.14%)

4.2.2 Leadership:

Leadership is the foremost important skill for any individual to progress in their career. A good leader has good problem-solving, decision-making, and public speaking skills. The management of the Fernandez Hospital had the vision of making the nurses

"Change Agents" by building young women's ambitions and leadership skills. Before the interventions, most participants seemed content with what they had in life, with little or no aspirations. Through the sessions on leadership skills required for a good leader, the respondents have learned about leadership by discussing the characteristics of a good leader. Table 3 indicates that the training has brought improvement from the baseline scores in terms of leadership (Mean Difference MD =34), with a statistically significant difference of $p<0.001$ at 95% CI between pre-and post-scores.

Table 6: Crosstabs for I have good problem-solving skills (N=25)

Pre \ Post	Agree	Disagree	Total
Agree	20	0	20
Disagree	5	0	5
Total	25	0	25

Activities to enhance their problem-solving and decision-making skills were planned as part of the intervention. Pre and post-tests were conducted to evaluate the respondents' problem-solving skills by asking questions, putting them in a scenario, and asking them to respond to how they would react in such situations. Before the training, 80% of the participants reported to have good problem-solving skills and the ability to solve problems Following the training, this figure increased to 100%, indicating a positive change in problem-solving proficiency and level of confidence in their problem-solving abilities.

Table 7: Crosstabs for I have confidence about the ability to solve problems (N=25)

Pre \ Post	Agree	Disagree	Total
Agree	20	0	20
Disagree	5	0	5
Total	25	0	25

All 25 participants unanimously agreed that the program was beneficial for their career." (Table 8).

Table 8: Crosstabs for problem-solving skills will be useful in my Career (N=25)

Post / Pre	Agree	Disagree	Total
Agree	21	0	21
Disagree	4	0	4
Total	25	0	25

4.2.3 Violence and rights:

Violence against women – particularly intimate partner violence and sexual violence is a significant public health problem and a violation of women's human rights. Spousal or Intimate Partner Violence (IPV) is one of the most common forms of violence women experience. It refers to any physically, psychologically, sexually, or economically harmful behaviour in an intimate relationship (Garg et al., 2021). The studies on determinants of IPV in India have found IPV more prevalent among poor and uneducated women. Contrary to our beliefs, urban areas depicted more probability of IPV. Furthermore, the economic empowerment of women, which is usually considered a shield which protects women from IPV, was actually of little help but increased the probability of violent episodes. In such a scenario, life skill interventions like OORJA have a considerable role to play in offering training to women on identifying different types of violence, and the importance of reporting it, knowledge of legal provisions, among other measures to reduce its incidence. Sexual harassment at the workplace is another major problem that affects their self-esteem levels, the decline in job satisfaction levels, as well as physical and psychological health problems. Enabling women to deal with violence can help women fulfil their potential as individuals and as contributors to work, communities and economies. The intervention program had a "Say no to violence" session, which improved the baseline scores regarding violence and rights (MD=23.55).

The pre and post-values, which were 44% and 56%, respectively, for the question if they have faced violence, indicate an increased awareness of violence or reduced hesitancy to report the violence, which is a positive sign (Table 9).

Table 9: Crosstabs for- Did you ever face violence at Home/School/College/Work Place? (N=25)

Post / Pre	Yes	No	Didn't respond	Total
Yes	11	2	1	14
No	5	2	1	8
Didn't respond	0	1	2	3
Total	16	5	4	25

Nearly 50% of the respondents acted against the person who perpetrated violence after the intervention, whereas the corresponding figure was 14% before the intervention (Table: 10).

Table 10: Descriptive analysis of- Did you take action against the person who had perpetrated violence for pre and post-intervention?

Did you take action against the person who had perpetrated violence	Pre (N=14)	Post (N=16)
Yes	2 (14.29%)	8 (50%)
No	9 (64.29%)	8 (50%)
Didn't respond	3 (21.43%)	0 (0%)

4.2.4 Sexual and Reproductive Health and Rights (SRHR)

Indian patriarchal mindset and socio-cultural practices have been argued to inhibit sexual and reproductive-related communication among women in India; youth-focused interventions are an essential way to address their SRH needs. The sessions on "Sexual and Reproductive Health" focused on providing information on reproductive systems, contraceptives and how they can protect themselves from sexually transmitted infections.

The pre-post analysis of the data did not show any significant change in the knowledge levels in the domain of Sexual and Reproductive Health and Rights (SRHR). The reasons could be the professional background and age of the participants.

Table 11: Crosstabs for- I think that I can encourage my partner to use condoms while having sex. (N=25)

Pre \ Post	Agree	Disagree	Total
Agree	13	0	13
Disagree	8	4	12
Total	21	4	25

Before the training, 52% of the participants were only confident in encouraging their partners to use condoms as a contraceptive measure. Following the training, this figure increased to 84%, indicating a positive change in the awareness level of different contraceptive measures and confidence in convincing their partners to use contraceptives after the training (Table 11).

Table 12: Crosstabs for- I believe that It Is okay for a person to have sex with different partners (N=25)

Pre \ Post	Agree	Disagree	Didn't respond	Total
Agree	2	1	0	3
Disagree	5	16	1	22
Total	7	17	1	25

There is also a change in perception in terms of having sex with different partners and also considering sex as a cool thing to do in their age group (Table 12, Table 13).

Table 13: Crosstabs for- Having sexual intercourse at my age is a "Cool" thing for a girl. (N=25)

Pre \ Post	Agree	Disagree	Didn't Respond	Total
Agree	3	3	0	6

Disagree	6	12	0	18
Didn't Respond	0	0	1	1
Total	9	15	1	25

4.2.5 Menstrual health and hygiene:

Menstrual health and hygiene-related complications remain one of the top health issues faced by women in India. Women's lack of awareness and lack of access to related products and hygiene facilities are the main reasons for increased complications. The session "Let Us Talk Periods" dealt with this problem and contained the information on process of menstruation, different absorbent methods available and the disposal of absorbent materials. The pre-post analysis of the data did not show any significant change in knowledge of menstrual health and hygiene. Most participants reported incinerating their absorbent material (52%) for disposal, compared to other methods before the intervention. Although there was no significant change in disposal methods except an 8% reduction in toilet flushing post-intervention, the number of participants disposing of waste in dustbins has increased to 40%.

4.2.6. Mental and physical health

The nursing professionals who play a crucial role in delivering care to patients are more prone to develop negative mental states like depression, anxiety and stress due to the nature of work (Nagel & Nilsson, 2022) The management of Fernandez Hospital found that their nursing professionals are not concerned about their physical and mental health and professional development. The sessions "Girl Power" and "Mind Matters" addressed these issues. However, the pre-post analysis of the data did not show any significant change in the knowledge of nurses on mental and physical health.

4.2.7. Marriage

Marriage and childbirth are the most important determinants of women's workforce participation rate. The management of the Fernandez Hospital observed that nurses in the hospital leave the profession because of the compulsion of their families to get

married. They lacked the necessary negotiation skills to convince their family otherwise. They left the decision of choosing a life partner to their parents. The session on "My Future Family" dwelt on issues young women face after marriage. It dealt with issues like power imbalances in the family and the importance of equitable division of roles and responsibilities in a family. Nearly 80% of the sample population responded positively and stated that marriage should not be forced by parents to be consummated by a certain age. They also thought that the best age to get married is when they are physically and mentally ready. However, the pre-post analysis of the data did not show any significant change in nurses' knowledge on the issues of marriage.

Section - 4.3: Attitude and perception

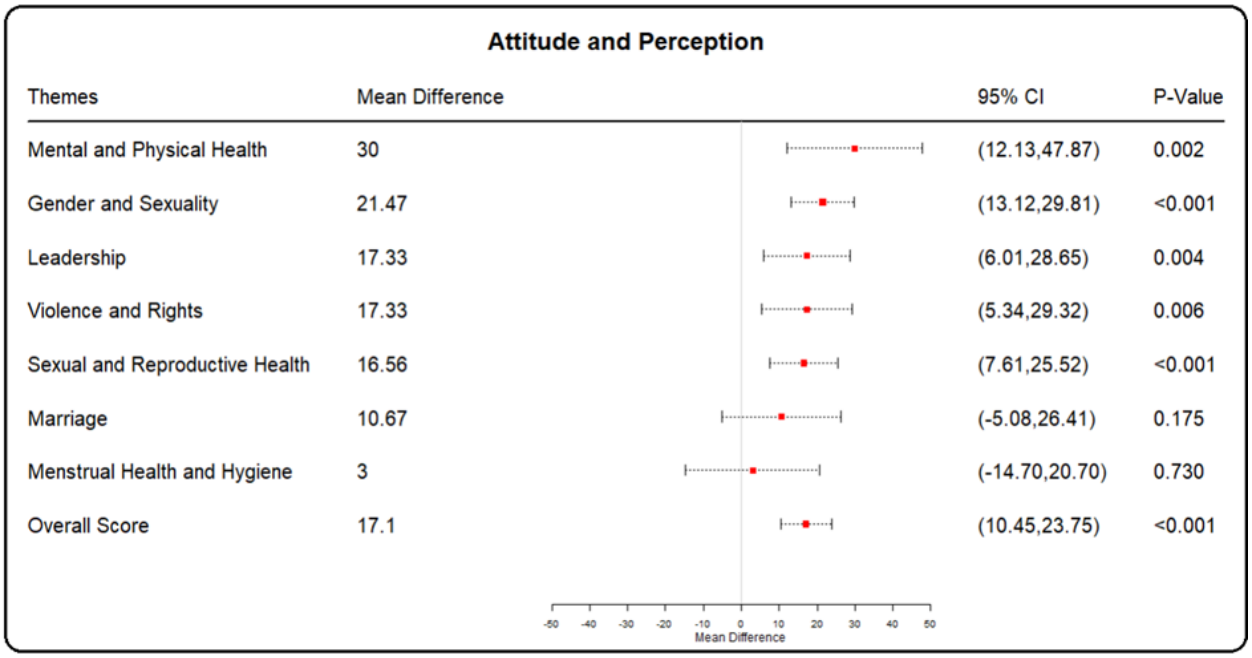
Fig 4 shows that mental and physical health (MD=30) and gender and sexuality (MD=21.5) showed a greater improvement in the attitude and perception section followed by violence, rights, and leadership (MD=17.3). According to Table 14, there is no significant difference in the attitudes and perceptions related to menstrual health pre and post-intervention (P=0.730). However, the pre-intervention mean score of 73 ± 26.93 indicates that the young women were already aware of certain taboos surrounding menstruating.

Table 14: Attitudes and perception; pre- and post-intervention score (N=25)

Theme	Pre (Mean ± SD)	Post (Mean ± SD)	P value
Mental and physical health	56 ± 41.63	86 ± 22.91	0.002
Gender and sexuality	50.42 ± 20.85	71.88 ± 17.1	<0.001
Violence and rights	65.31 ± 24.49	82.63 ± 18.92	0.006
Leadership	61.33 ± 34.26	78.66 ± 21.25	0.004
Sexual and reproductive health and rights	51.98 ± 17.91	68.54 ± 13.04	<0.001

Marriage	61.33 ± 22.93	71.99 ± 28.35	0.175
Menstrual health	73 ± 26.93	76 ± 34.97	0.730
Overall	60.28 ± 16.13	77.38 ± 15.47	<0.001

Figure 4: Forest plot summarizing mean difference of attitude and perception scores.



Section 4.4: Skills and Future Readiness:

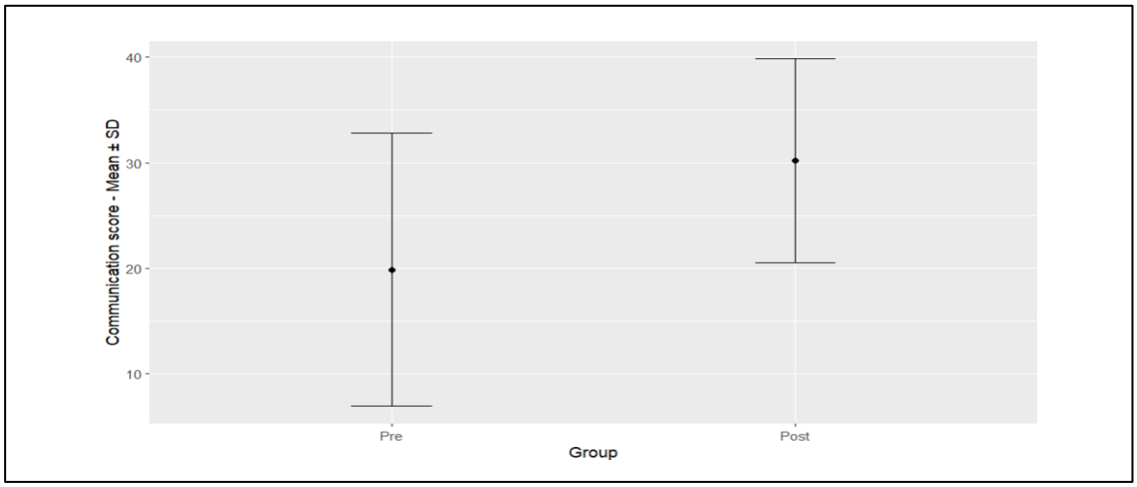
4.4.1 Communication skills:

The nurses from Fernandez Foundation were perceived to have less confidence in communicating with their family members and colleagues. The session on “Public Speaking and Effective Communication” focused on building and developing effective communication skills through public speaking and presentation. A comparison of pre and post-test scores revealed that the nurses have rated an improvement in their communication skills and abilities.

Table 15: Pre and post-score for communication skill (N=25)

Communication skill	(Mean± SD)	Mean Difference	95% CI of mean difference		P-value
			Lower	Upper	
Pre	19.88 ± 12.94	10.32	4.05	16.59	0.002
Post	30.2 ± 9.66				

Figure 5: Box plot of communication skills pre and post- intervention scores



Before the training, 64% of the participants feared public speaking. Following the training, this figure was reduced to half, indicating a positive change by reducing the fear towards public speaking (Table 16).

Table 16: Crosstabs for- Do you have fear while making public speeches? (N=25)

Post / Pre	Yes	No	Total
Yes	5	11	16
No	3	6	9
Total	8	17	25

The training also helped increase the participants' confidence level in public speaking (Table 17). Before the training, 8% of the participants were afraid of public speaking, and 48% reported being nervous while speaking in front of the public. After the training, none of the respondents reported being afraid, and only 16% reported being nervous while speaking.

Table 17: Crosstabs for-How do you rate your confidence during public speaking? (N=25)

Pre \ Post	A bit nervous	Quite confident	Extremely confident	Total
Terrified	0	2	0	2
A bit nervous	3	6	3	12
Quite confident	0	6	0	6
Extremely confident	1	2	2	5
Total	4	16	5	25

Nearly 88% of the respondents rated they have either good or excellent communication skills after the training. In contrast, only 56% reported good or excellent communication skills before the training (Table 18).

Table 18: Crosstabs for- How do you rate your public speaking skills? (N=25)

Pre \ Post	Average - I could improve	Good	Excellent	Total
Average - I could improve	2	9	2	13
Good	1	7	3	11
Excellent	0	1	0	1
Total	3	17	5	25

4.4.2. Financial planning

Financial literacy can empower women to make informed decisions about budgeting, saving, investing, and managing debt effectively. Savings and investing the income for future needs helps women build confidence to lead their lives confidently and motivates them to continue their careers. Intervention related to financial planning

has increased their awareness of different saving options available, such as savings in banks (72%), savings in post offices (68%), Fixed Deposits (68%) (Table 19 and shown in Fig. 6)

Table 19: Descriptive analysis for financial planning (N=25)

Financial accounts	Pre (n%)	Post(n%)
What are the different savings options available?		
Savings in bank	15(60%)	18(72%)
Savings in post office	7(28%)	17(68%)
Fixed deposit	6(24%)	17(68%)
Mutual funds	6(24%)	14(56%)
Life insurance	10(40%)	14(56%)
Shares	3(12%)	12(48%)
Recurring deposit	1(4%)	11(44%)
Bonds	1(4%)	9(36%)
Loans	3(12%)	6(24%)
Scholarship	2(8%)	1(4%)
Don't know	3(12%)	0 (0%)

Figure 6: **Graph showing different options available for savings and their choice in pre and post-intervention study in the population (N=25)**

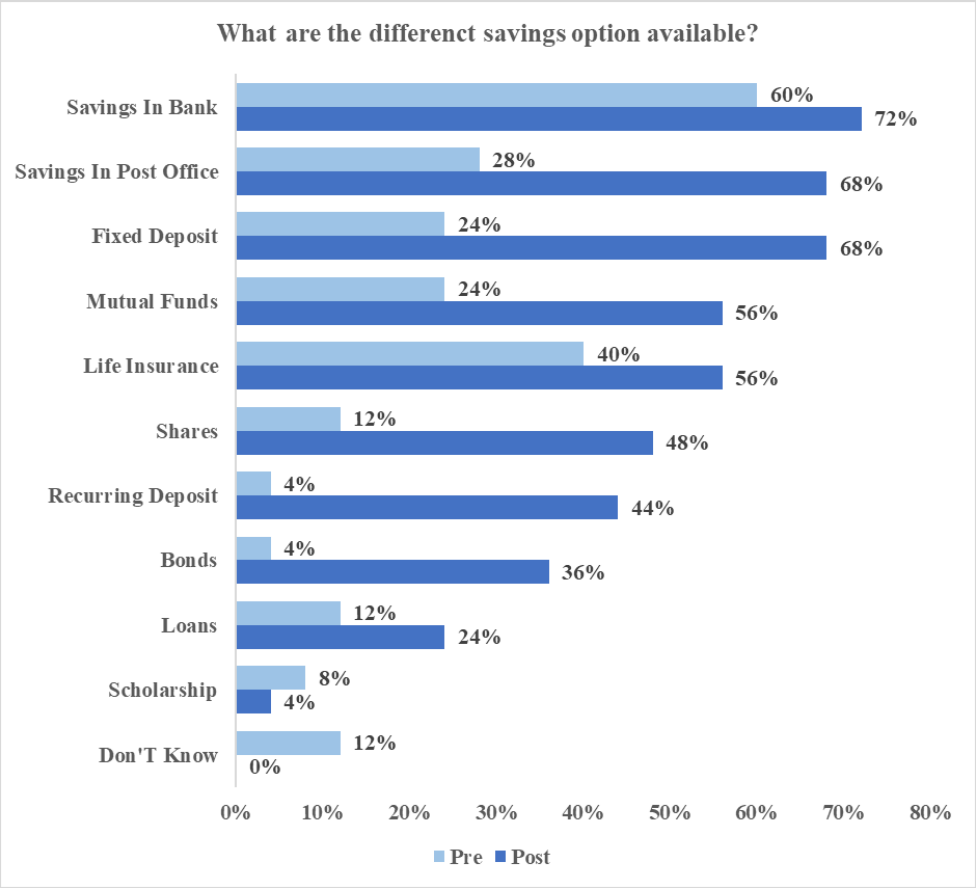


Table 20: **Crosstabs for maintaining financial records in the study population (N=25)**

Post / Pre	Maintain no records	Maintain minimal records	Maintain very detailed records	Total
Maintain no records	1	5	5	11
Maintain minimal records	0	2	4	6
Maintain very detailed records	0	2	2	4
Didn't Respond	0	0	3	3
Total	1	9	14	24

The participants were evaluated pre and post-study about the maintenance of financial records. Table 20 shows that before intervention 44% of them maintained no records, 24% responded that they maintained minimal records, 12% responded that they maintained detailed records, and the rest 12% did not respond. Post-training results have increased in the case of maintaining detailed records (56%) (Table 20).

Table 21: Crosstabs for budget and tracking the spending in the study population (N=25)

Post / Pre	Not at all true	Sometimes	Very true of me	Total
Not at all true	1	1	1	3
Sometimes	0	9	2	11
Very true of me	0	3	2	5
Didn't Respond	1	2	3	6
Total	2	15	8	**25**

Post-intervention results of the participants' interest in tracking and budgeting their spending can be understood from the Table 21.

Table 22: Crosstabs for the contribution to savings account in the study population (N=25)

Post / Pre	Sometimes	Very true of me	Didn't respond	Total
Not at all true	1	2	0	3
Sometimes	10	4	0	14
Very true of me	2	1	0	3
Didn't respond	1	2	2	5
Total	14	9	2	**25**

It can be observed that the contribution to savings in the participants has shown a tremendous change from 12% in Pre-Training to 36% (Table 22).

Table 23: Crosstabs for the readiness to read to increase the financial knowledge in the study population(N=25)

Post / Pre	Sometimes	Very true of me	Total
Not at all true	1	0	1
Sometimes	6	5	11
Very true of me	1	6	7
Didn't respond	2	4	6
Total	10	15	**25**

In Table 23, readiness to acquire information about financial matters pre and post-intervention are recorded. Nearly 24% of the participants were interested in reading information about financial matters before the intervention, which increased to 60% post-intervention.

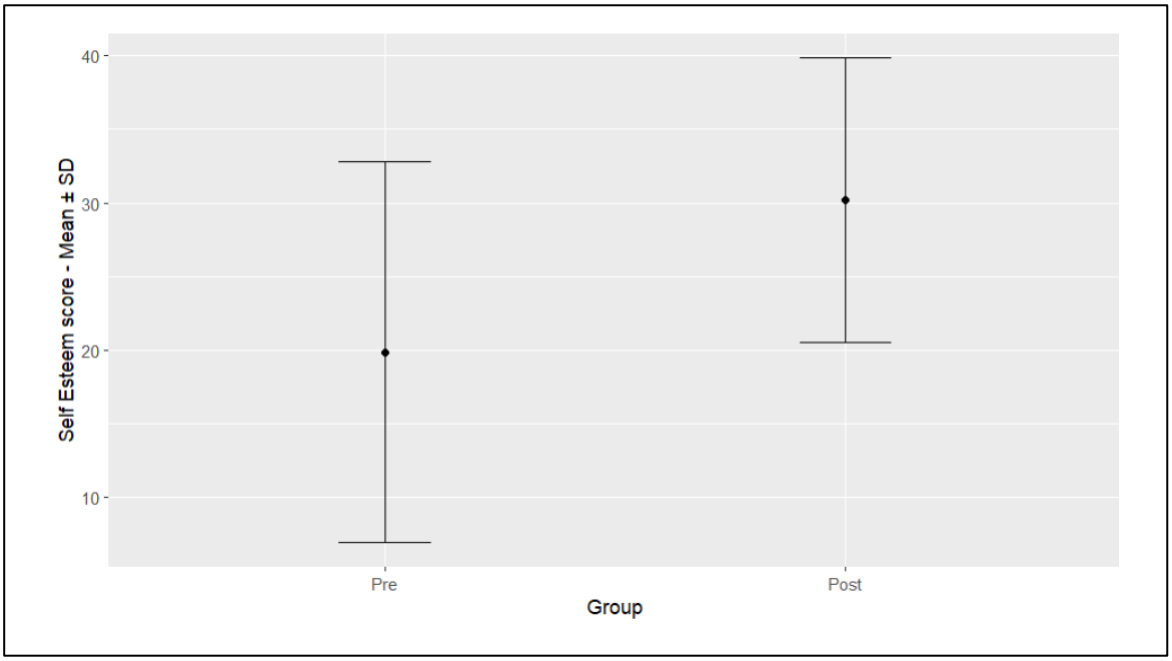
4.4.5 Self-esteem:

Table 24 indicates that there was a rise in the average score in self-esteem of the participants after the intervention (MD=6.88).

Table 24: Pre and post-intervention score for Self-esteem (N=25)

Self-Esteem	(Mean± SD)	Mean Difference	95% CI of mean difference		P-value
			Lower	Upper	
Pre	56.76 ± 10.09	6.88	3.97	9.79	<0.001
Post	63.64 ± 7.6				

Figure 7: Box plot of self-esteem levels in pre vs post-intervention scores

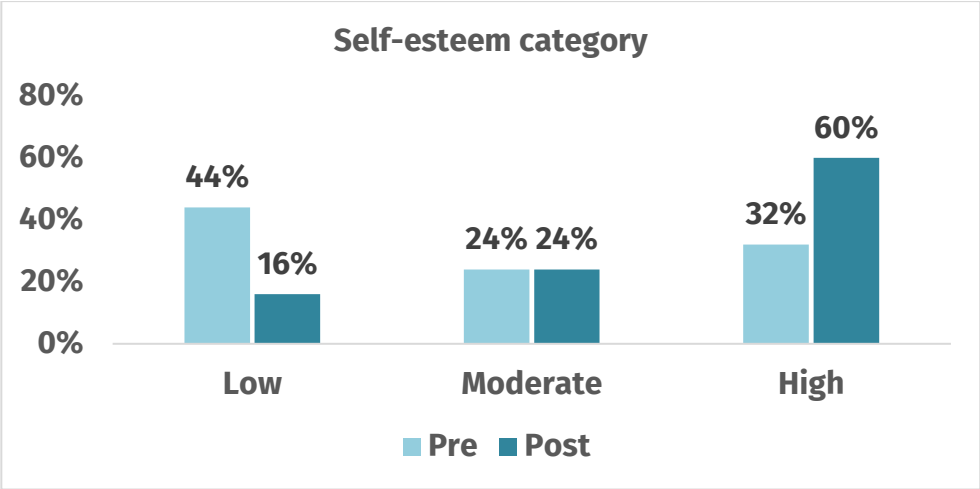


Out of eleven participants with low scores before intervention, four remained in the low category, two improved to moderate, and five improved to the high category. Of the six with moderate levels pre-intervention, two remained moderate and four improved to high. None deteriorated to low. Two of eight individuals with high pre-intervention levels declined to moderate, while six remained high. The results suggest that the intervention had a beneficial effect on the participants' self-esteem (Table: 25).

Table 25: Crosstabs for self-esteem (N=25)

Pre \ Post	Low	Moderate	High	Total
Low	4	2	5	**11**
Moderate	0	2	4	**6**
High	0	2	6	**8**
Total	**4**	**6**	**15**	**25**

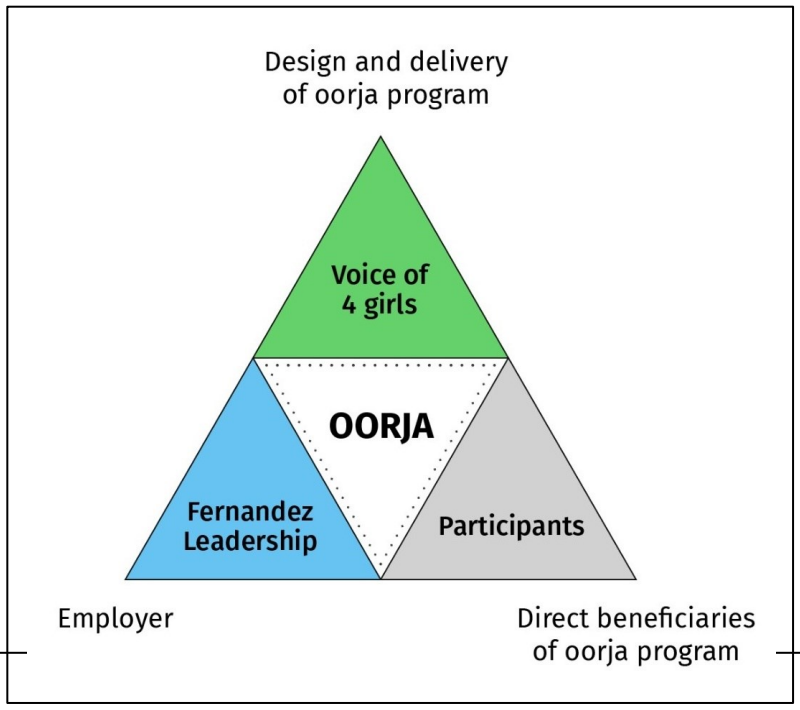
Figure 8: **Self-esteem levels: pre and post-intervention comparison**



Qualitative findings:

The project has three important stakeholders: Voice 4 Girls, who assist in-programme design and delivery; employers of Fernandez Leadership; and the participants- direct beneficiaries of the OORJA program (Fig 9). This study includes 11 out of 25 participants who completed the intervention program. Out of four key informant interviews, two are representatives from the Voice 4 girls' organization and two from Fernandez institution.

Figure 9: **Schematic diagram of stakeholders**



The main themes that emerged from assessing and interpreting the qualitative data are summarized in Table 26.

Table 26: Emergent themes and subthemes on different stakeholders:

Stakeholder	Themes	Sub-themes
Leaders' perspective	Core Philosophy	• Respectful maternity care • Role of nursing cadre • Institutional social responsibility
	Observations about the nursing cadre	• High professional attrition • Ambition and leadership • Interpersonal relations • Communication • Managing self • Financial management
	Implementation of OORJA	• Intent to empower the nursing cadre • Felt utility of OORJA • Perceived benefits • Perceived risks • Evidence on impact and scale-up.

Stakeholder	Themes	Sub-themes
The beneficiary's perspective	Status about the OORJA	• Validation of management assumptions • No self-awareness • Felt need • Perceived utility of OORJA programme
	Impact of the program	• Self-awareness • Physical health • Perceptions and beliefs • Learning and change in self-behaviour • Existing inequality and related policies, laws, and rights • Future planning and readiness • Financial planning and management • Career options and future plans

The leader's perspective

Theme 1: Core philosophy

Sub-theme 1: Respectful maternity care

- Every mother needs personalized, quality care to make childbirth a pleasant experience, conducted as per her choices in a respectful environment.

"We work in simple theory: no mother in labour without a birth companion should be left alone, without the health care worker." – Management Representative -1

Sub-theme 2: Role of nursing cadre

- Nurses are the key pillar of providing respectful maternity care.
- It is good for the organization and the society if they continue their professional careers withstanding compulsions from family and society.
- It would be really good for the organization if some of them could take up management and leadership roles in the organization.

"I and some of the others believe that the nursing cadre, the midwifery cadre also get into management roles, involve in policy decision further for the organization." –Management Representative - 1

Sub-theme 3: Institutional social responsibility

- The institution is willing to invest in any initiative aiming at the welfare of the employees, particularly the nursing cadre; but would like to have objective evidence on the impact of such initiatives.
- An empowered employee, even if leaving the organization in search of a better career can be a great asset to society.

"You are developing leadership, you are developing a cadre and your organization is also hopefully benefitting. If they are not staying with us, hopefully, we are sending a better citizen to the world. So either way, we are not losing them."- Management Representative 1

Theme 2: Observations about the nursing cadre

Sub-theme 1: High professional attrition

- Many girls leave the nursing profession with compulsions of marriage and childbirth.

"The first reason why they leave the profession is because their parents want them to get married. When I ask them if they want to get married, they say no but they have to listen to their parents."- Management Representative 1

- Poor motivation to continue and grow in a career and achieve something professionally is one of the reasons.

"On day one, we asked them about the next five years, and what is that they wanted to do. In fact, with our OORJA also, few of the participants wrote that they wanted to get married, only few of them said that they wanted to go to some other country." -Trainer 1

Another participant said, "I want to build my house, or I want to get married to a nice person." - Trainer 2

"There was a married participant and she said that in her marital family, it is not respected if women go out and work."- Trainer 1

- Poor skills in negotiating with family members (perception that it is going against the family if they insist on continuing the career)

"When we ask why they don't speak to their parents and if they want us to speak on their behalf, they say no. They tell us that their parents are farmers and not educated. Hence, they don't understand."- Management Representative 1

- Leaving the decision of choosing the life partner to family members (Not even attempting to choose a life partner who can support them)

Sub-theme 2: Ambition and leadership

- Very contented with what they have achieved so far and their ability to support the family with finances till they get married.

"When we ask them what they will do with this money, they say that they will keep thousand rupees for themselves and send the rest of the money to their family."- Trainer 2

- Just confining them to the execution of given tasks with no enthusiasm for bringing change or being the drivers of change at the workplace.

"Their state of mind is that they have to earn money, help their parents, get married and then leave."- Management Representative 2

Sub-theme 3: Interpersonal relations

- Many of them are poor in managing personal relationships
- They even get exploited, get into physical relationships, and undergo a lot of emotional turmoil because of poorly managed relationships.

"We have some girls who get into relationships, get trapped, and become pregnant. So, during the time they are with us, we could provide them with skills to manage these aspects better. This way, we will actually help them to get on with their life."- Management Representative

Sub-theme 4: Communication

- Generally, not very confident in communicating with the mothers, their families and colleagues at the workplace.
- They can provide ~~much~~ better quality care if they communicate confidently at work.

"I believe "What I believe and I could evidently see was that an empowered girl can do better in terms of communication and confidence."- Trainer 1

"With this training, if they can increase their efficiency or if they can show that in their performance and output, I can surely correlate with it by saying that, the quality of their interaction with the patients, the quality of

answering a question, and the confidence in carrying themselves will definitely improve."- Trainer 1

Sub-theme 5: Managing self

- Generally, not aware of how they are spending time and happy to spend time on unproductive tasks after work.

  "They come to work, go back to their room and watch TV. Nothing else. We should give them the skills and empower them."- Management Representative 1

- Don't focus on improving their skills and preparing for bigger things in life.
- Not concerned explicitly about their physical and psychological health.

Sub-theme 6: Financial management

- Spend the money very casually, with little skills to plan and manage personal finances.
- Usually send all the additional money beyond their immediate needs to the family and feel very satisfied with it.

  "Most of the nurses don't know how to save money. Whatever salary they get, whether 8000 or 10000 rupees, they will just keep 500 for their basic needs and give all the remaining amount to the family."- Management Representative 2

- Don't keep any money at their disposal for unforeseen needs.

  "They live in the same hostel, eating the same hostel food. They will earn money for some time, then their parents call them, and they go back and get married. There is no future plan for them."- Management Representative 2

- Very few people save the money for future needs and attempt to have financial control.

Theme 3: Implementation of OORJA

Sub-theme 1: Intent to empower the nursing cadre

- They have a strong intent to do something to empower these nursing cadres with a suitable programme.

  "They should be able to say what they want to with their life on a professional and personal level. It is huge if we can motivate them to think that they have their own vision and dreams."- Management Representative 1

  "I think we were very sure as an organization that we are going to give them this information ~~for sure~~, even if most of their ecosystem is not supporting it." –Trainer 1

  "I think when we started OORJA, we were very sure as an organization that we are going to take this up with women who require this the most." - Trainer 1

Sub-theme 2: Felt utility of OORJA

- Liked the components of the Oorja program and the work being done by them with marginalized school children.

  "We visited a government college in the month of January where the Oorja project was going on for the students from class 6th to 8th. We were surprised by the way the students interacted. They know menstrual hygiene, they know how to say no to violence, and they are negotiating with their family members for their further studies. They are from rural areas and few of them are prepared to stop their education and get married. The girls expressed how they have started negotiating with their family every year. This was a very strong impression for me. I thought that if I had been given training at such a young age, I would also have negotiated with my family. I was inspired a lot by these girls."- Management Representative 2

- Especially liked the core philosophy of sensitizing boys about women's well-being, the role of women, and respecting women.

  "I was quite fascinated with what she was doing in terms of reproductive health. She was getting these girls to understand their bodies, and menstrual hygiene, while also giving them skills on how to say 'NO' and recognize good and bad touch. At the same time, she was dealing with boys and bringing in the aspect of how important it is to respect women."- Management Representative 1

- Felt that if school children at a much younger age can be educated about key life skills, why can't it be done for the working professionals from the nursing cadre.

  "Voice 4 Girls–works for children under 8th and 9th standard. We were so impressed that they were-able to teach these girls how to negotiate with their parents and say, 'No, we don't want to do this'. If they are doing this with schoolchildren, we should be able to try this with the nurses who are much older than the kids."- Management Representative 1

Sub-theme 3: Perceived benefits

- The participants will be able to address all the key concerns mentioned under Theme 2 including opening up their minds to self-reflect; dreaming big about professional life; being able to negotiate with family for a professional career; proactively involving in key decisions of their life like marriage; managing personal and professional relationships; communicating with confidence and being the drivers of change in the workplace. Some of them emerge as future leaders.

  "They have a different energy and I was surprised to see the nurses talking very boldly in the sessions they have taken. I was in disbelief and gazed at

them in awe. There was a great impact in their lives and a few girls shared their personal stories."- Management Representative 2

"This programme has made them feel and believe in themselves. Whatever abuse they have gone through, they were ready to deal with it differently now. They learned how to say no, how to negotiate, and how they can help their family. Now, they had a clarity on what their future should look like. We were going on a path to empower them and from my interaction, I understood that they are very strong and empowered as nurses."- Management Representative 2

"I was meeting them for the first time. They came up and spoke with courage and confidence. This is the only glimpse I had of them."- Management Representative 1

"On the tenth day, they just blew our minds. When asked, they said that they wanted to become the head nurse in a hospital, wanted to get promotions and excel in their career. Their confidence level and the way they had started dreaming were amazing."- Trainer 1

"Few of the girls opened up about the violence, abuse, or trauma that they went through a couple of years back. A few of them also shared about their mental health issues with us."- Trainer 1

- This can minimize professional attrition and if they continue to stay with the organization, it can improve the quality of care.

  "In the workplace, they became very flexible and were ready to accept challenges." – Management Representative-2

- Even if they leave the organization, they can be a great asset to the society.

- Some of them can be groomed to become future leaders and play leadership roles in the organization, bringing balance and nursing perspectives to the decision-making.

  "OORJA helps you in a way to broadly reflect on your own life and it inspires you to do something for yourself."- Trainer 1

Sub-theme 4: Perceived risks

- Empowerment may lead to organizational-level attrition due to career advancement.
- This may lead to a more demanding cadre in terms of salary, employment benefits, etc.

  "Points which majorly came up was the pay that they are getting is very minimal." –Trainer 1

- This may lead to conflict at the workplace, family, and society due to sudden changes in perception towards social norms and confirmatory behaviour; but it is a minor concern.

Sub-theme 5: Evidence on impact and scale-up

- Not sure whether the program is beneficial.
- Need objective evidence to make sure the program is impactful.
- Even if the girls start self-reflecting strongly about their career, life, and well-being; able to discuss things openly with family members and be involved in decision-making about their life, it is worth all the hard work and investment.
- The institute is willing to invest further and scale up the program to all the 400-plus nursing cadre of the organization.
- This can also be a model program for other health care organisations also to consider for the benefit of their employers.

The Beneficiaries' perspective

Theme 1: Status before OORJA

Sub-theme 1: Validation of management's assumptions

- During the qualitative interview, almost all the participants confirmed the observations and assumptions of the leadership and management. They can be summarized as a lack of big ambition in life, considering the current job as a temporary arrangement to support the family till getting married, poor communication, lower confidence levels in dealing with colleagues and mothers, not planning about the finances, getting into troubled relationships etc.

Sub-theme 2: No self-awareness

- Almost all the participants have mentioned that they never thought of these aspects very seriously, never reflected on them deeply, and had serious conversations about many aspects which they feel are very important post-training. Lack of self-awareness makes them less confident and they would not know their capabilities which are necessary to succeed in their career.

Sub-theme 3: Felt need

- Since the awareness about many critical life skills was poor, that was reflected as not feeling the need for any programme to impart life skills.

Sub-theme 4: Perceived utility of the OORJA program

- Almost all of them felt that the OORJA program was like "Any other routine training program" and never thought that it would be a "life-changing" or "totally transforming" experience. Many of them thought of not attending ~~it~~ if it was not compulsory to attend. Many of them really did not look forward to it and were very reluctant.

Theme 2: Impact of the program

Sub-theme 1: Self-awareness (learning about self)

- The interaction was carried out with a few of the participants of the training session (nurses), where they shared about their learning and how they understand themselves. The second theme that arises is “self-awareness”, where almost all the respondents talked about how the learning they acquired helped them in self-reflection.

Sub-theme 2: Physical health

- Most respondents spoke about their clarity on understanding menstrual hygiene and the related material available in the market. One of them felt so glad to know about the availability of menstrual cups and ~~has~~ planned to use them for herself.

  “I have told my sister and friends about menstrual cups after the programme”- Participant M

- Likewise, others shared that using menstrual cups fascinated them as it could save time and money, and is hygienic.
- Besides they also shared their learning on self-care routines and the observed health outcomes.

  “Before, I was not eating properly, keeping unnecessary things in mind and getting upset. Now everything has changed and keeping my thoughts positively ~~which~~ also shows an impact on my physical health” - Participant M

- One of the respondents shared that she has improved her haemoglobin level after learning to make healthcare routines.
- Another participant shared that she has been suffering from PCOD for four years. After attending the intervention, she was able to manage the

symptoms of PCOD, and her menstrual cycle became more regular after making the necessary lifestyle changes.

Sub-theme 3: Perception and beliefs

- The respondents also shared their perception that they had prior sessions in which most of the attendants talked about their reluctance to choose career paths, decide on life, and deal with problems.

  "I have become strong and overcame the feeling that I am the only child and girl child for my mom. I now feel that if I am a girl, I can look after my mother and make her proud. I also got a feeling to go abroad after attending the program"- Participant M

- One of the respondents shared that she had heard about women's empowerment before the session and thought she was self-empowered as a nurse. She changed her perception and understood the actual meaning of empowerment after the session.
- The respondents also shared that they lacked communication skills earlier. Amongst them, one of them said that not being fluent in the English language is one of the significant barriers she has encountered while caring for the patients.

  "Before OORJA, I avoided talking with others. Even if they asked anything, I never replied to them. Nevertheless, after attending Oorja, I have improved my communication. If anyone comes to talk and asks me something, I could now reply to them properly." – Participant D

- Besides, a few shared that they had stage fear, less self-confidence and faced problems in initiating conversations with people.
  "Before, I used to have stage fear and I never took initiative to speak first, but after this program, I got that confidence" - Participant -V

Sub-theme 4: Learning and change in self behaviour

- Almost all the respondents spoke about learning the required negotiation skills with the parents /family for future plans and with the patients to make them understand the procedure.
- Few of them acquired communication skills and learned to communicate without hurting others' feelings, especially learning to talk positively. Some respondents spoke about learning about dividing the earnings and saving for the future.

  "I only interact with people whom I know. I am not comfortable talking to everyone. So after this programme, I am slowly trying to talk and interact with all and participate in conversations." - Participant D

Sub-theme 5: Existing inequality and related policies, laws and rights

- During the session, a few spoke about their learnings about gender equality. They could relate to the current family dynamics and how the brothers are given preference in decision-making and how they are asked to accompany when the girls go out, for security reasons.
  "In my friends and family circle, I have heard them say that only boys should get educated and go out and do whatever they wanted, while girls are not supposed to get an education and go out and work. Before Training, I also had same thoughts, but after attending training sessions, I understood that girls too could go further for their education and fulfil their wish." - Participant V.

- Two of them also shared about the existing social rules a girl has to face, and they also added that after the session, they could understand the social and cultural violence they had been facing so far.
- Some participants said they know specific laws and acts that support women.

“Initially, it was like only boys should go to work, not girls. Now I feel like both should work together, which helps each other financially and in other aspects. Now I have been telling my friends in our hometown the same thing.” – Participant S

Sub-theme 6: Future planning and readiness

- The session highlighted the girls' empowerment, where financial management is crucial. The third theme that arises for the study is "Future Planning and Readiness".

  "Even after getting married, I would like to learn things as learning is a continuous process rather than stopping and wish to utilize every opportunity to go further in my career in future.” – V

- Many participants are now willing to go further in the future in their careers and handle their personal lives wisely.

Sub-theme 7: Financial planning and management

- The respondents shared what they learned about saving options and the importance of savings. One of them shared that she did not know about various saving options, and after the session, she went up for a fixed deposit. Besides, they also shared that they were spending less and saving more.
- One of them shared that she will provide the need-based money to parents and the rest she will keep for further education.

- One participant shared that she was somewhat irresponsible in savings before the training session as she spent all her money on clothes or other things. Now, she understood the importance of savings.

- Many understood that financial planning and budgeting are the most important, which they must adopt after training sessions.

"I started saving my earnings, and after my father's demise, I am paying EMIs and I am also able to help others with what I have without hesitating."- Participant R

Sub-theme 8: Career option and future plan

- The respondents also shared their realization of the need to plan for the future.

"I had planned to go abroad, which I dropped after my father's demise to look after my mother. Now I am trying to fulfil that dream after OORJA"- Participant R

- One of them shared that after the session, she realized that she should continue her education and has planned to join IELTS to go abroad for further education.
- Likewise, a few of them also added that the OORJA made them plan for work-life balance and motivated them to step around and achieve the goal.

"I have learnt from the sessions how to set and implement a goal. We should set our goal. If not, we do go in any way. If we set a goal, only we can work on achieving it."- Participant S

"Before, I used to feel that my day-to-day aim was only to do my duty, but now I have started thinking about my future savings and stability, improving my knowledge **and receiving more education." Participant** *R2*

A few also said that after the session, they had planned to support the family and help with siblings' education. A few of them also spoke, *"Concerning family, if we get into any problems like finances or anything, I am confident enough to solve the problem- Participant SL"*

- Most of them express that after the session, they are now open to new roles and responsibilities. If they arise and think they could lead and communicate appropriately.

Figure 10: Factors influencing ~~the~~ young women's life skills during formative years

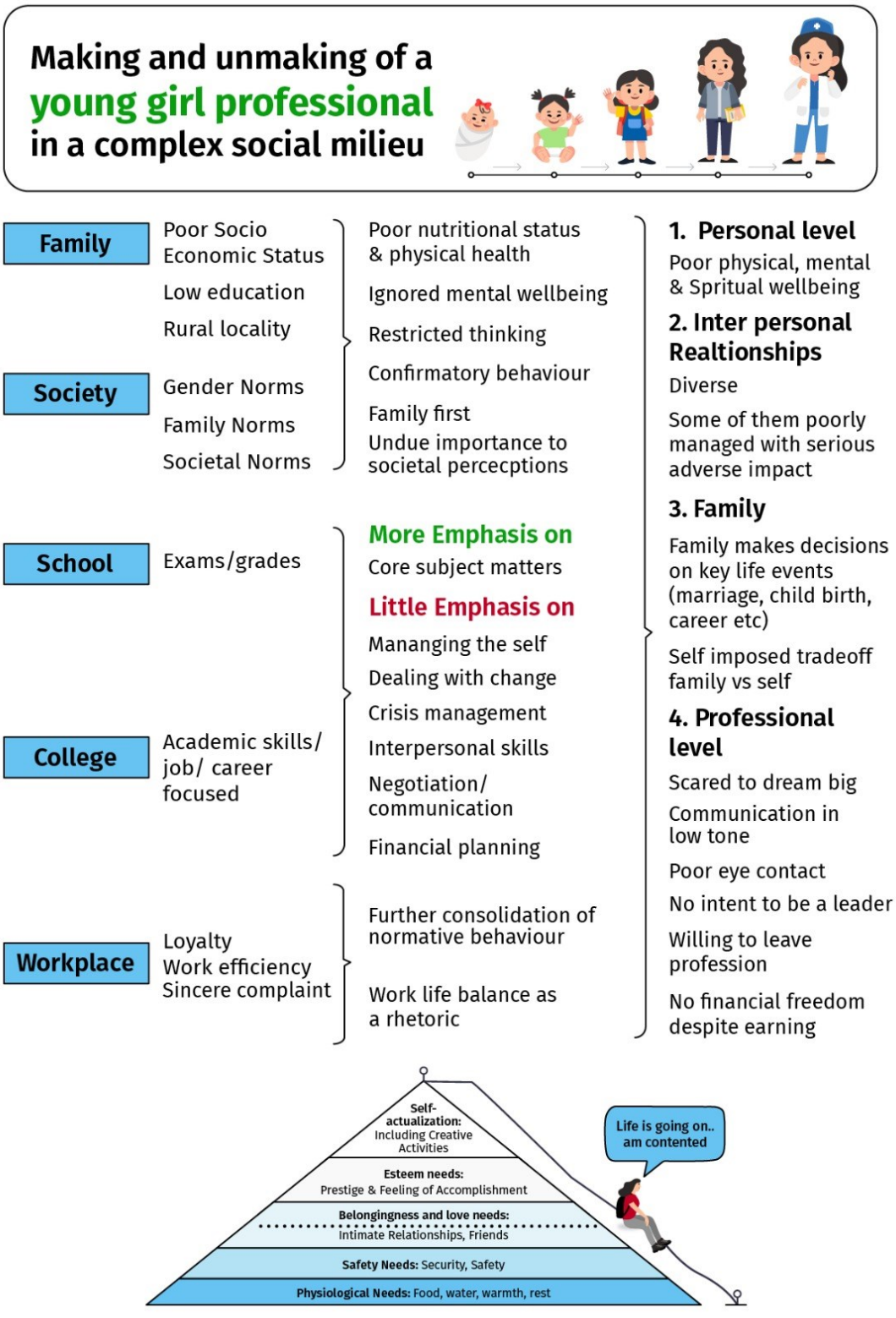


Figure 11: Interplay of factors that led to the implementation of OORJA programme

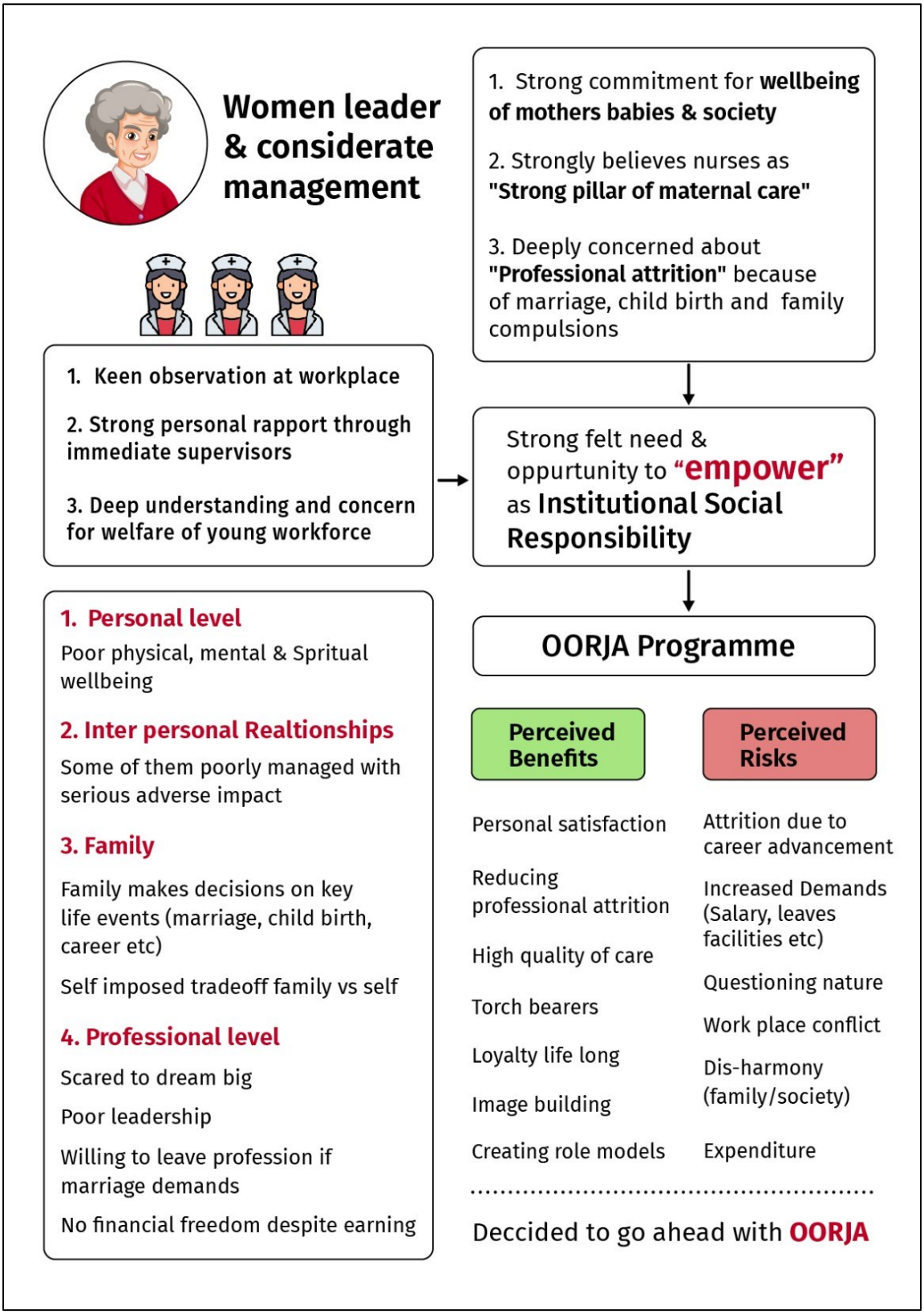
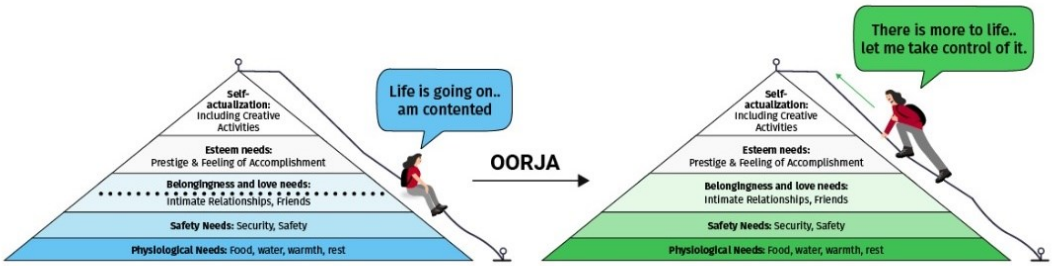


Figure 12: Beneficiaries perception of change as a result of participation in OORJA



Attribute	Before OORJA	After OORJA
Communication	Timid, poor eye contact	Bold, good eye contact
Leadership	Not my concern	I can be a leader
Career Ambition	Ok to discontinue	Will try to continue & grow
Decision making	Let family & others decide	I will involve in all key decisions
Self esteem	Low	Iam as important as anyone
Inter personal relationships	Driven by others often troubled	More aware, gained controlled
Financial planning	Very casual, send it family	Careful, save for future, keep some control
Physical health	Never really cared	More consious
Mental health	Never really aware	Aware & pro active
Rights	Poor awareness	Good awareness

Chapter 5

Discussion

Abraham Maslow's pyramidal "Hierarchy of Needs" model is a highly influential way of organising human needs from the most "basic" to the most advanced. Maslow's (1943) argument is that the most basic needs must be met before people can move "up" to the more advanced needs. Every person is capable and has the desire to move up the hierarchy towards the level of self-actualization. Unfortunately, progress is often disrupted by a failure to meet lower-level needs. Low-socioeconomic status, life experiences, and lack of empowerment may cause the individual to fluctuate ~~in~~ between the levels of hierarchy. Here comes the need for intervention programs to empower them and to push the individuals to higher levels.

Historically, women and girls have faced significant barriers to education, health care, and opportunities for personal and professional growth. This has led to a lack of empowerment and limited access to resources, which can contribute to negative health outcomes, poverty, and discrimination. Providing education about menstruation from childhood may promote safe practices and alleviate the suffering of millions of women.

Women empowerment and economic development are closely related: in one direction, development alone can play a major role in driving down inequality between men and women; in the other direction, empowering women may benefit development (Duflo, 2012).

In the present study, many of the participants' fathers worked as a farmer (56%) and mothers were housewives (52%). Only 4% of the parents were self-employed and worked in a private firm. They don't even have access to computers with internet connection at their homes and some don't have mobile phones or landline connections at their home reflecting their low-socioeconomic status and lack of basic needs towards self-empowerment.

The program OORJA has been designed specifically for these marginalized young women with special needs, including the areas of mental and physical health, SRH, Menstrual health, violence and rights, and basic life skills. This programme, generically focused on “women empowerment,” covers a wide range of activities. To make young women aware of the world around them; create awareness of growing up issues; enhance their mobility; empower them to express their opinion and to participate in decisions affecting their lives, including when and who they will marry; promote egalitarian gender role attitudes; enhance their control over material resources through the development of a savings orientation; or build vocational skills among them.

In accordance with the data analyzed, the **knowledge** levels of the respondents showed a significant difference from baseline scores with overall mean difference (15.45), with a greater improvement in leadership quality, gender and sexuality, violence and rights and menstrual health. These findings indicate that the training program was effective in improving the knowledge levels of the participants. They developed a deeper understanding of leadership styles and qualities, gender identity and sexuality, identifying safe places during instances of violence, responding effectively to violence, and comprehending their legal and human rights for self-protection in society.

Positive change in **attitudes and perceptions** was witnessed with overall change with an MD=17.1 from pre to post-camp. A larger statistically significant difference ($p<0.001$) was observed in mental and physical health themes, followed by leadership. This shift is largely about believing mental illness as a real illness and understanding the warning signs that can signal a person's transition from a healthy mind to an unhealthy mind. It also involves promoting a culture where it is acceptable to ask for help when needed, supporting transgender individuals, setting clear goals for effective leadership, and motivating teams to work together towards a common goal. The observed shift in attitudes and perceptions could potentially result in a cascading effect, leading to more widespread and long-lasting positive changes in the personal

and professional lives of these nurses. This eventually may be beneficial to their patients.

Every girl should be aware of menstruation, which is a very important event at the threshold of adolescence, ideally, a mother should be the main informant at that tender age. In this study, mothers were the first informant for about 64% of participants compared to teachers, friends and relatives which corresponds with the study conducted by Patle and Kubde (2014). All the respondents reported using only sanitary napkins as menstrual absorbent rather than cloth pieces (16%), menstrual cups and tampons which is in line to a study by Mathiyalagen et al. (2017) where 78.1% use sanitary napkins. Only 8.3% of the participants felt that the menstrual cycle was usual. Though there is a good change in terms of less usage of cloth pieces, awareness of other available market products are too low. It may either be due to mothers' low literacy rates or discomfort on the usage of these products. Still in many parts of India, having a conversation about menstruation in schools and colleges, within friends in public is considered a shame. It can be attributed to a lack of menstrual hygiene-related education initiatives in schools or a lack of awareness programs in public places.

The programme also sought to increase participants' awareness, particularly of sexual and reproductive health matters. Findings indicate an appreciable change in the proportion of participants who were aware of various sexual and reproductive health matters, including the timing of marriage, sex and pregnancy-related issues, contraception, HIV and other STIs, and particularly their in-depth awareness of these matters.

Having strong communication skills aids in all aspects of life – from professional life to personal life and everything that falls in between. Being able to communicate effectively is one of the most important life skills to learn. It is defined as transferring information to produce greater understanding. In terms of the workplace especially in healthcare, good communication fosters trust between patients and providers. In this

study, participants being young professionals prefer assertive behaviours, and they are likely to quietly acquiesce to other stakeholders, thus ignoring their own need to communicate their convictions in conflict situations.

The communication skills of the participants improved with a mean difference of 10.32 from the baseline. These findings are consistent with the interventional study conducted by Brahmbhatt & Lodhiya, 2019, that assessed the change in attitude and basic communication skills before and after training using the SEGUE (set the stage, elicit information, give information, understand the patient's perspective, end the encounter) framework score among medical students, which showed a statistically significant difference between the pre and post- training communication skills assessment (p=0.001).

Additionally, participants reported feeling more confident in their ability to communicate effectively using both verbal and non-verbal communication and had become more active listeners and better equipped to receive feedback. Participants' self-ratings of proficiency demonstrated a significant shift, indicating good proficiency and ~~indicating~~ excellent proficiency. They were able to communicate effectively with improved eye contact and without any hesitation they could open up their concerns and queries when needed. These findings suggest that the training intervention had a positive impact on participants' self-perceived public speaking proficiency and confidence.

Autonomy is the ability to obtain information and make decisions about one's ~~own~~ concerns. Women's autonomy in decision-making is associated with their ethnicity, deprivation level, urban/rural classification and education. These young women have limited agency in terms of decision-making on matters affecting their own lives, sense of self-efficacy and access to resources. Also, with limited participation in low income generating activities, they prioritize their income to cover family expenses. In this study most of the participants, considering their family situation, hand over their salary to their parents and keep a very minimum amount for their expenses. This is in line with the report "Broadening Girls' Horizons: Effects of a Life Skills Education Programme in

Rural Uttar Pradesh" where only a smaller number of girls took independent decisions of spending their own money or buying clothes for themselves (57% and 28%).

This is because, since they have no control over their earnings to make personal and productive expenditures, they are not able to make choices about their time and their autonomy over decision-making, ranging from employment and personal expenses to marriage.

Findings suggest that exposure to the intervention programme succeeded in developing a savings orientation among girls, calling for efforts that enable girls to access formal savings mechanisms, such as bank and post office savings accounts. Findings show that at the time of the baseline survey, a considerably larger percentage of girls in the study were not aware of the different saving options available. At the end of the programme, all participants demonstrated the ability to identify available financial planning options.

At the same time, when asked "What's your plan for the next 5 years", they ended up saying either to "get married" or "move abroad". They are not definite in their goals. With key knowledge provided by this intervention now they are able to think ahead, focus on their career and open-up with their parents to delay marriage. Participants expressed a high level of confidence (100%) in their problem-solving abilities after completing the training. The results were in congruence with the study published by Lolaty et al. (2012) which revealed that life skills education helped the medical sciences students in enhancing their emotional intelligence skills.

The pattern of mental ill health across one's lifespan is the mirror image of that seen in physical illness. The peak for the onset of mental illness is adolescence and early adulthood. The majority of the participants faced mental illness either due to unavoidable relationships or due to abuse by their family members. They were not able to share those incidents with their parents or even fellow mates. This programme

gave them an opportunity to open up their minds and think about what is good and what is bad and the ways to come out of it.

Self-esteem can be defined as the perception of self-worth, or the extent to which a person values, prizes, or appreciates the self. A person who has low self-esteem, feels incompetent, unworthy, and incapable, which these participants felt before attending this camp. There was good progress in terms of self-esteem to an excellent level by the end of the training showing that the nurses benefitted from the acceptance of responsibility for their own actions, the ability to take reasonable risks, assuming total command and control over their own lives, including the adoption of healthy behaviours. Many participants shifted from the low category (16%) to the high category (60%) post-intervention.

Feeling good about themselves, ability to participate in activities, being confident in social situations and good sense of self-worth are the impacts gained after attending the camp.

Hence findings from this study specifies that, life skill education enhanced the young women's ability to understand, use, monitor and manage their own emotions in positive ways which helped them to relieve stress, communicate effectively, empathize with others, overcome challenges and defuse conflict and gain positive personality traits.

Chapter 6
Conclusions

6.1. The impact of the programme

The Oorja programme had a notable positive impact on some of the critical life skills of young nursing professionals, as revealed by quantitative as well as qualitative assessments.

Communication and public speaking skills

The most notable impact was on improved communication and confidence levels both at the workplace and outside. The respondents reported increased confidence in public speaking, initiating conversations and talking carefully without hurting other people's feelings. The majority of the participants reported higher levels of satisfaction with the quality of care they deliver, which was attributed to improved communication and motivation.

Decision-making skills and career progression

Another critical life skill where a consistent positive impact was observed was higher levels of ambition, intention to progress in career, and active involvement in decision-making regarding career. Participants also reported improved ability to negotiate with family members, friends, colleagues and superiors after the programme.

Financial planning

Participants have started proactively managing their finances after the programme. Some of the consistently reported changes include "spending responsibly", "retaining some money with them", “started saving", etc. The program also improved financial

awareness manifested by maintaining records, preparing budgets, and tracking spending.

Physical and mental health

Improved focus on self and better self-care concerning their nutrition, physical health and psychological well-being also were reported consistently.

Gender and sexuality

Participants had better baseline knowledge regarding menstrual health, gender, and sexuality. However, there were still some critical gaps in their knowledge regarding gender rights, which were enhanced by the OORJA programme. The participants reported less occurrence of intimate partner violence after the programme.

Participants were more open to discussing the relationship post-training, and they could also identify the characteristics of healthy relationships.

Feedback on training

Interestingly, almost all the participants thought, "This is like any other routine training programme" and had very few expectations. Some of them were even reluctant to participate when it was announced.

They were pleasantly surprised and realized its profound utility by the second or third day of the programme. At the time of evaluation, a majority have recommended attending the programme to their friends and colleagues, "We strongly wish others should also get an opportunity to be part of such a programme; they will miss a lot if they do not get an opportunity".

Majority of the participants felt the programme was very intense. It was physically and mentally exhausting by the end of each day. They suggested reducing the number of hours per day and increasing the number of days if need be.

None of them have reported any significant adverse consequences or major conflict with family, friends or at the workplace attributed to sudden changes in the thought process following the OORJA programme. The trend of improvement could be

attributed to various other factors, such as the participants' motivation, engagement, and diligence throughout the program.

6.2. The intervention

The OORJA programme was curated after multiple rounds of discussions and reviews by the organisation's leadership team. The evaluation study revealed that the programme was impactful in developing the life skills of young early-career nursing professionals. However, the contents of the programme should be standardized to make it more scientific and scalable. A systematic and well-documented approach is recommended in designing, evaluating and implementing the life skill intervention approach before scaling up the programme.

6.3. The research methods adopted

The impact evaluation of OORJA adopted a rigorous quasi-experimental pre-post design. The study used quantitative and qualitative research methods to ascertain the programme's positive impact. However, the following limitations were observed in the research process.

1. Small sample size, which makes generalizations difficult.
2. The reliability and validity of the study tools were not established at the time of their construction. The problems related to "recall bias" were not addressed while framing the questionnaire. The choices given for responses were not "mutually exclusive," which might have influenced the participants' responses.
3. Mismatches in the domains of the study tools. For example, the practice session had questions to measure beliefs and attitudes.
4. The analysis plan for the questions in the study tools were not appropriately framed at the beginning of the research, which resulted in confusion.
5. The grouping of the components under various domains in the tools should have been done after proper statistical analysis to make the tool more precise.

6. This evaluation study could assess the programme's short-term impact on a young nurse's life. The impacts of programmes may vary after a specific time or when the time to practice the learnt skills arrives. Earlier studies (Campbell-Heider et al., 2009) recommended conducting a long-term outcome assessment after a year or two to understand the actual impact of the programme on attitudes, perceptions and the application of the learnt topics to real-life scenarios they encounter.

In order to improve the effectiveness and efficiency of the programme the following recommendations are provided.

Chapter 7

Recommendations

Recommendations:

1. Considering the notable positive impact in key life skills, it is recommended to scale up the programme to other young nursing professionals of the organization.

2. To measure the long-term impact, it is necessary to follow up with the participants prospectively at periodic intervals. Each successive batch of Oorja participants can be considered as a cohort. Their status with respect to key dimensions of life like career, marriage, financial independence etc., shall be captured to assess long term impact of the programme.

3. Comparative studies of the OORJA cohort with other professionals who have not undergone the training will be able to establish the impact of the programme in an even more scientifically robust manner.

4. Standardizing the intervention programme through a multi-modality approach, using an extensive review of literature, expert reviews, and consensus building, is recommended before scaling up the programme. This is to ensure replicability of the intervention in other settings.
5. Considering many ambiguities in the quantitative assessment tools, it is strongly recommended to undertake the validation of tools to make the assessment valid and reliable.
6. It would be prudent to consider integrating a structured monitoring and evaluation process into the programme to document the evidence on outcomes and impact more efficiently.
7. It would be of great scientific value to document the long-term impact of the programme on quality of care. This might be used to advocate for the implementation of the OORJA programme at a larger scale in other similar organisations in both private and government sectors. All the stakeholders in this

programme have an opportunity to emerge as “change agents” to impact the lives of young female professionals.

8. The Voice for Girls’ team can consider having continuous engagement to a very optimum level to extend ongoing counselling or support services if the need arises (though the philosophy of showing the way and leaving them to fight on their own is appropriate; minimum support services or mechanisms to engage can help many people in dealing with complex situations).

9. The hours spent on conducting training programmes per day can be reduced and the number of days can be extended to avoid exhaustion among participants.

Chapter 8

References

Acharya, R., Kalyanwala, S., Jejeebhoy, S. J., & Nathani, V. (2009). Broadening girls' horizons: Effects of life skills education programme in rural Uttar Pradesh. https://doi.org/10.31899/pgy15.1002

Bairagya, I., Bhattacharya, T., & Tiwari, P. (2021). Does Vocational Training Promote Female Labour Force Participation? An Analysis for India. Margin: The Journal of Applied Economic Research, 15(1), 149-173. https://doi.org/10.1177/0973801020976601

Banerjee, M. (2019). Gender Equality and labour force participation: Mind the gap. ANTYAJAA: Indian Journal of Women and Social Change, 4(1), 113 123. https://doi.org/10.1177/2455632719831827

Brahmbhatt, K. R ; Lodhiya, K. K. (2019). Teaching and assessment of basic clinical communication skills among undergraduate third year medical students in Gujarat. International Journal of Community Medicine and Public Health, 6(4), 1461. https://doi.org/10.18203/2394-6040.ijcmph20191003

Chatterjee, E., Desai, S., & Vanneman, R. (2018). Indian paradox: Rising education, declining womens' employment. Demographic Research, 38, 855–878. https://doi.org/10.4054/demres.2018.38.31

Dasgupta, P. (2015). Turnover Intentions among Nurses in Private Hospitals: Antecedents and Mediators. Journal of Strategic Human Resource Management, 4(3). https://doi.org/10.21863/jshrm/2015.4.3.01v

Decent work for youth in India. (2012, April 17). https://www.ilo.org/newdelhi/info/WCMS_175936/lang--en/index.htm

Duflo, E. (2012). Women empowerment and economic development. Journal of Economic Literature, 50(4), 1051–1079. https://doi.org/10.1257/jel.50.4.1051

Fletcher E., Pande R., & Moore C. (2017). Women and work in India: Descriptive evidence and a review of potential policies, HKS Working Paper No. RWP1800. http://dx.doi.org/10.2139/ssrn.3116310

Garg, P., Das, M., Goyal, L. D., & Verma, M. (2021). Trends and correlates of intimate partner violence experienced by ever-married women of India: results from National Family Health Survey round III and IV. BMC Public Health, 21(1). https://doi.org/10.1186/s12889-021-12028-5

Guilamo-Ramos, Soletti, Burnette, Sharma, Leavitt, & McCarthy. (2012). Parent–Adolescent Communication About Sex in Rural India: U.S.–India Collaboration to Prevent Adolescent HIV. Qualitative Health Research, 22(6), 788–800. https://doi.org/10.1177/1049732311431943

Jensen, R. (2012). Do Labor Market Opportunities Affect Young Women's Work and Family Decisions? Experimental Evidence from India. ideas.repec.org. https://ideas.repec.org/a/oup/qjecon/v127y2012i2p753-792.html

Ibarrarán, P., Ripani, L., Taboada, B., Villa, J. M., & García, B. (2014). Life skills, employability and training for disadvantaged youth: Evidence from a randomized evaluation design. IZA Journal of Labor & Development, 3(1). https://doi.org/10.1186/2193-9020-3-10

International Labour Organization. (n.d.). Gender and Employment. ilo.org. Retrieved December 15, 2023, from https://www.ilo.org/employment/areas/gender-and-employment/lang--en/index.htm

India Female population, 1960-2022 - knoema.com. (2023, July 5). Knoema. https://knoema.com/atlas/India/topics/Demographics/Population/Female-population#:~:text=In%202022%2C%20female%20population%20for,average%20annual%20rate%20of%201.79%25.

Campbell-Heider, N., Tuttle, J., & Knapp, T. R. (2009). CE FEATURE: The Effect of Positive Adolescent Life Skills Training on Long Term Outcomes for High-Risk Teens. Journal of Addictions Nursing, 20(1), 6–15. https://doi.org/10.1080/10884600802693165

Kabeer. (2005). Gender equality and women's empowerment: A critical analysis of the third millennium development goal 1. Gender & Development, 13(1), 13–24.

Kapsos, S., Silberman, A., & Bourmpoula, E. (2014). Why is female labour force participation declining so sharply in India. RePEc: Research Papers in Economics. https://www.ilo.org/wcmsp5/groups/public/---dgreports/inst/documents/publication/wcms_250977.pdf

Macaden, L., Washington, M., Smith, A., Thooya, V., Selvam, S. P., George, N., & Mony, P. (2017). Continuing Professional Development: Needs, Facilitators and Barriers of Registered Nurses in India in Rural and Remote Settings: Findings from a Cross Sectional Survey. Open Journal of Nursing, 07(08), 930–948. https://doi.org/10.4236/ojn.2017.78069

Mathiyalagen, P., Peramasamy, B., Vasudevan, K., Basu, M., Cherian, J., & Sundar, B.(2017). A descriptive cross-sectional study on menstrual hygiene and perceived reproductive morbidity among adolescent girls in a union territory, India. Journal of Family Medicine and Primary Care, 6(2), 360. https://doi.org/10.4103/2249-4863.220031

Klasen, S., & Pieters, J. (2015). What explains the stagnation of female labor force participation in urban India? The World Bank Economic Review, 29(3), 449–478. https://doi.org/10.1093/wber/lhv003

Lolaty, H. Â., Ghahari, S., Tirgari, A., & Fard, J. H. (2012). The effect of life skills training on emotional intelligence of the medical sciences students in Iran. Indian Journal of Psychological Medicine, 34(4), 350–354. https://doi.org/10.4103/0253-7176.108217

Malhotra, S., & Shah, R. (2015). Women and mental health in India: An overview. Indian J Psychiatry, 57(2), S 205-S 2011. https://doi.org/10.4103/0019-5545.161479

Maslow, A. H. (1943). A theory of human motivation. Psychological Review, 50(4), 370–396. https://doi.org/10.1037/h0054346

Meenakshi, S., Subrahmanyam, C. V., & Ravichandran. (n.d.). The Importance of Work-Life Balance. IOSR Journal of Business and Management (IOSR-JBM), 14(3), 31–35.

Miriam. (2019). Decision-Making Process around Teenage Motherhood: A Qualitative Exploration of Early Childbearing in Nicaragua (1st ed.). Springer VS Wiesbaden. https://doi.org/10.1007/978-3-658-28775-7

Nagel, C., & Nilsson, K. (2022). Nurses' Work-Related Mental Health in 2017 and 2020 - A Comparative Follow-Up Study before and during the COVID-19 Pandemic. International Journal of Environmental Research and Public Health, 19(23), 15569. https://doi.org/10.3390/ijerph192315569

Nair, S., & Healey, M. (2006). A profession on the margins: status issues in Indian nursing. RePEc: Research Papers in Economics. http://www.cwds.ac.in/OCPaper/profession_on_the_margins.pdf?origin=publication_detail

Patle, R. A., & Kubde, S. S. (2014). Comparative study on menstrual hygiene in rural and urban adolescent girls. International Journal of Medical Science and Public Health, 3(2),129. https://doi.org/10.5455/ijmsph.2013.161020133

Rohini, R., & Mahadevappa, B. (2010). Social responsibility of hospitals: an Indian context. Social Responsibility Journal, 6(2), 268–285. https://doi.org/10.1108/17471111011051766

Sharma, S. K., Thakur, K., & Peter, P. P. R. (2020). Status of nurses in India: Current situation analysis and strategies to improve. DOAJ (DOAJ: Directory of Open Access Journals). https://doi.org/10.4103/jme.jme_164_20

Smith, A., Macaden, L., Washington, M., Mony, P., John, V., & Dias, S. (2018). Achieving Consensus on Continuing Professional Development Priorities for Registered Nurses in Rural and Remote India through Nominal Group Technique. Open Journal of Nursing, 08(11), 848–859. https://doi.org/10.4236/ojn.2018.811064

Social Statistics Division, Ministry of Statistics and Programme Implementation. (2022). Youth in India 2022. In https://mospi.gov.in/ (4th Issue). Government of India. Retrieved December 15, 2023, from https://mospi.gov.in/sites/default/files/publication_reports/Youth_in_India_2022.pdf

Sorsa, P., et al. (2015). Determinants of the Low Female Labour Force Participation in India, OECD Economics Department Working Papers, No. 1207, OECD Publishing, Paris, https://doi.org/10.1787/5js30tvj21hh-en.

Singh, P., & Pattanaik, F. (2020). Unfolding unpaid domestic work in India: women's constraints, choices, and career. Palgrave Communications, 6(1). https://doi.org/10.1057/s41599-020-0488-2

Sudarshan R. M., & Bhattacharya S. (2009). Through the magnifying glass: Women's work and labour force participation in urban Delhi. Economic and Political Weekly, 44(48), 59–66.

World Health Organization: WHO. (2021, March 9). Violence against women. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

Annexures

List of Tables

List of Figures

Appendices

Appendix 1
Questionnaire for project OORJA

Section A: Demographics

Sl#	Question	Codes
1	Write your full name	....
2	Write the name of the college you are studying	....
3	Which district/Mandal is your College in?	District .... Mandal.....
4	Write today's date	____/_____/_____ (DD/MM/YYYY)
5	Write your date of birth	____/_____/_____ (DD/MM/YYYY)

6	Circle the religion you belong to	1) Hindu 2) Muslim 3) Christian 4) Other (Specify)..... 5)I don't know
7	Circle the caste you belong to	1) Scheduled Caste 2) Scheduled Tribe 3) Other Backward Class 4) None of the above 5) ther (Specify)..... 6) I don't know
8	On an average, what is your total annual income?	1) Rs. _____ 2) Don't know
9	Father's education (completed)	1) No formal education 2) Up to class 5 3) Class 6 – Class 10 4) Class 11-12 5) Under-graduation (BA, BSc. etc.) 6) Post-graduation (MA, MSc. etc.) 7) Professional degree (medicine, law, engineering) 8) Other (Specify)..... 9) I don't know 10) Refuse to answer
10	Father's occupation	1) Government job 2) Private job (salaried employee) 3) Self employed 4) Business owner 5) Farmer

		6) Daily wage earner 7) Other (Specify)..... 8) I don't know 9) Refuse to answer
11	Mother's education	1) No formal education 2) Upto class 5 3) Class 6 – Class 10 4) Class 11-12 5) Under-graduation (BA, BSc. Etc) 6) Post-graduation (MA, MSc. Etc.) 7) Professional degree (medicine, law, engineering) 8) Other (Specify)..... 9) I don't know 10) Refuse to answer
12	Mother's occupation	1) Housewife 2) Government job 3) Private job (salaried employee) 4) Self employed 5) Business owner 6) Farmer 7) Daily wage earner 8) Other (Specify)..... 9) I don't know 10) Refuse to answer
13	Do you have access to a computer with internet in your house?	1) Yes 2) No
14	What is your email id?	_____

		2) I do not have an email
15	Do you have access to a landline / mobile phone in your house?	1) Yes 2) No
16	What is the phone number that you can be reached when you are home?	_____

Section B: Subject Knowledge

Sl#	Question	Codes
	Menstrual health	
B1.1	Which among the following are the female reproductive parts? (You can circle more than one option)	1. Penis 2. Scrotum 3. Uterus 4. Ovary 5. Testicles 6. Don't know
B1.2	What is the function of the Uterus?	1. It releases tiny eggs every month 2. It releases hormones during menstruation 3. It grows baby 4. It protects and nourishes the baby 5. The unfertilized egg and uterine lining are shed from uterus 6. Don't know
B1.3	What happens during menstruation? (You can circle more than one option)	1. Blood flows from vagina 2. Facial hair growth 3. Frequent headaches 4. Blood flows from abdomen 5. Stomach cramps

		6. Backache 7. Don't know 8. Other (Specify).....
B1.4	How often does menstrual cycle happen usually?	
B1.5	What are some of the restrictions during menstruation? (You can circle more than one option)	1. Do not enter Pooja room or read Quran 2. Do not play/physical work/exercise 3. Do not go to school/college 4. Do not talk to boys 5. Do not enter the kitchen 6. Do not visit other's homes 7. Do not attend family functions 8. Segregated in the house 9. No restrictions 10. Don't know
B1.6	What are the different menstrual products available in India? (You can circle more than one option)	1. Tampons 2. Menstrual cups 3. Sanitary napkin 4. Cloth pad 5. Don't know
	Sexual and reproductive health	
B1.7	Which among the following is the male reproductive part?	1. Uterus 2. Ovary 3. Fallopian tubes

		4. Penis 5. Don't know
B1.8	Which stage of the menstrual cycle are you most likely to get pregnant?	1. Menstrual period 2. A few days before and after menstruation 3. About 14 days before menstruation 4. Don't know
B1.9	What are the different kinds of contraceptives used to prevent pregnancy?	1. Copper IUD 2. Condoms 3. Pills 4. Injectable contraceptive 5. Don't know
B1.10	Who do you think should be responsible for contraception?	1. Man 2. Woman 3. Both of them should have responsibility 4. No one should have responsibility 5. Don't know
B1.11	Which is the emergency contraception that prevents pregnancy after sex?	1. Contraceptive pills 2. I-pill 3. Condom 4. IUD 5. Don't know

B1.12	Sexually Transmitted Infections are transmitted from infected person to non-infected person through:	1. Sharing needles 2. Blood transfusion 3. Touching the infected person 4. Sexual intercourse with an infected person 5. Sharing lunch with the infected person 6. Don't know 7. Other (Specify).....
	Mental and physical health	
B1.13	What contributes to good health?	1. Eating proper diet 2. Physical exercise 3. Mental well being 4. Smoking/Drinking alcohol 5. Not resting and not sleeping well 6. Others Specify _____ 7. Don't know
B1.14	What are your immediate thoughts on hearing mental illness?	1. _____ 2. Don't know
B1.15	What are the warning signs of mental health illness?	1. Extreme sadness 2. Drastic change in behaviour 3. Feeling low because scored less marks 4. Feeling sad because your mother is in hospital 5. Don't know
B1.16	Mention two commonly heard mental health illnesses"	1. _____ 2. _____

		3. Don't know
B1.17	Whom would you approach in case you identify someone with mental illness?	1. _____ 2. Don't know
	Gender and sexuality	
B1.18	What is the difference between gender and sex?	1. Sex is a social construct and gender is the biological or reproductive characteristics of a person 2. Sex is the biological or reproductive characteristics of a person and gender is a social construct 3. Sex represents choices of clothes or a person's name and gender represents expression of a person 4. Don't know
B1.19	What are the characteristics of a healthy relationship?	1. When there is excitement in a relationship 2. When the partner is over possessive 3. When there is dignity, respect and consent in a relationship 4. Don't know
B1.20	Do media (advertisements, movies, etc) negatively influence the relationships?	1. Yes 2. No (Skip to B1.23) 3. Don't know
B1.21	If yes, explain with an example	
	Marriage	

B1.22	According to you, what is the best age for marriage?	1. After 12th standard 2. After graduation 3. After post-graduation 4. When you are physically and mentally ready 5. Don't know
B1.23	What are the important elements of successful /healthy relationships?	1. Love 2. Commitment 3. Being loyal 4. Has enough money 5. Don't know
B1.24	If a married couple wants a son and not a daughter, they can abort the female foetus	1. Yes, legally under the law 2. Yes, not legally under the law 3. No, not legally under the law 4. Don't know
B1.25	In a situation, if a woman is not happy with her marriage, can she ask for a divorce from her husband?	1. Yes 2. No, it is not acceptable in the society 3. No, it will bring dishonour to the family 4. Don't know
B1.26	What is the difference between separation and divorce?	
	Safety and rights	
B1.27	Radha was alone at home and her neighbour Ramesh comes to meet her father. Knowing that Radha was alone, he started touching her private parts and made her feel uncomfortable. He	1. No, he was expressing his love for Radha 2. May be, I am not sure 3. Physical violence 4. Sexual violence

	threatens to harm her if she discloses it to anyone. Is it considered as violence?	5. Emotional violence 6. Don't know
B1.28	What do you think are the reasons that a woman face violence?	1. The woman would have provoked the man's anger 2. Lack of respect for the male member in the family (husband/brother/partner/father) 3. Man is very stressed 4. Family issues 5. To control woman 6. Woman cheats on her husband 7. When a woman makes a mistake that husband/partner doesn't like 8. Mental health issues 9. Don't know
B1.29	What are the possible consequences of violence on women?	1. Stress 2. Loss of confidence 3. Feeling scared and anxious 4. Will go out and make friends 5. Will focus more and get work done 6. Don't know
B1.30	Are you aware about the laws that prevent a woman from facing violence?	1. Yes, Child labour prohibition act 2. Yes, dowry prohibition act 3. Yes, POCSO act 4. Yes, PWDVA act 5. Don't know
	Leadership	

B1.31	What are the qualities of a good leader?	1. Inspires the group 2. Spends money for the group 3. Should be committed 4. Flexible 5. Don't know
B1.32	A leader that gives the task to the people in the team and tells them to come up with a solution themselves	1. Participative leader 2. Democratic leader 3. Delegative leader 4. Autocratic leader 5. Don't know

Section C: Attitudes and perceptions

	Menstrual health	
C1.1	A woman should not enter a temple/church during periods	1. Agree 2. Disagree
C1.2	A woman can enter the kitchen and cook food	1. Agree 2. Disagree
C1.3	A woman should not wash her hairs during menstruation	1. Agree 2. Disagree
C1.4	A woman can touch pickles during menstruation	1. Agree 2. Disagree
	Sexual health and reproductive system	
C1.5	A woman cannot get pregnant if she has intercourse for one time	1. Agree 2. Disagree
C1.6	Once you had sex with your partner, it is harder to say "no" the next time	1. Agree 2. Disagree
C1.7	It is ok for a boy to ask a girl to have sex with him to prove her love to him.	1. Agree 2. Disagree
C1.8	Girls cannot have sex before marriage	1. Agree

		2. Disagree
C1.9	It is okay to hug, kiss, and touch each other before marriage as long as it is consensual	1. Agree 2. Disagree
C1.10	A married man can force his wife to have sex with him even if she doesn't consent to it	1. Agree 2. Disagree
C1.11	If your partner doesn't want to use a condom it is normal to comply with his wish	1. Agree 2. Disagree
	Mental and physical health	
C1.12	It is best to avoid someone who has mental health issues	1. Agree 2. Disagree
C1.13	People with mental illness are unpredictable. Hence, they should not be given any responsibility	1. Agree 2. Disagree
	Gender roles	
C1.14	A woman's most important role is to take care of the family and cook	1. Agree 2. Disagree
C1.15	A good woman never questions the opinion of her husband/partner	1. Agree 2. Disagree
C1.16	A man should have the final say in the family decisions	1. Agree 2. Disagree
C1.17	A man should decide if contraceptives have to be used to prevent pregnancy	1. Agree 2. Disagree
C1.18	It is the responsibility of the man to earn for the family	1. Agree 2. Disagree
C1.19	Girls should have the same freedom as boys	1. Agree 2. Disagree
C1.20	I will not be friends with a transgender person	1. Agree 2. Disagree
	Marriage	
C1.21	How important is being married someday?	1. Very important

		2. Somewhat important 3. Not at all important
C1.22	If there is a good proposal, girls should agree with parents and get married even if that means they have not completed their graduation or post-graduation	4. Very important 5. Somewhat important 6. Not at all important
C1.23	If the girl doesn't give dowry or take gifts with her during marriage, she is not respected by her in-law's family	1. Agree 2. Disagree
C1.24	It is not important to register your marriage	1. Agree 2. Disagree
	Safety and rights	
C1.25	Woman should be tolerant to violence	1. Agree 2. Disagree
C1.26	A woman from good family does not report incidences of violence	1. Agree 2. Disagree
C1.27	A woman from a good family will not go to police station	1. Agree 2. Disagree
C1.28	Most often, sexual assault is committed by a stranger	1. Agree 2. Disagree
C1.29	A woman who wears short clothes gets raped	1. Agree 2. Disagree
C1.30	Physical violence between husband and wife is a private matter and has to be handled within the family	1. Agree 2. Disagree
	Leadership	
C1.31	It is alright for a leader to misuse the power	1. Agree 2. Disagree
C1.32	To be a good leader, you should never fail	1. Agree 2. Disagree
C1.33	If my best friend is my team leader, I need not follow the rules	1. Agree 2. Disagree

Section D: Practices

	Menstrual health	
D1.1	Were you aware about menstruation before the first menarche?	1. Yes 2. No
D1.2	What was your reaction to first menstrual cycle?	1. Scared 2. Usual 3. Discomfort 4. Worried 5. Irritated 6. Cried 7. Don't remember
D1.3	Who spoke to you regarding menstruation?	1. Mother 2. Sister 3. Friends 4. Relative 5. Teacher
D1.4	What absorbent material do you use during menstruation?	1. Sanitary pad 2. Cloth pad 3. Old cloth 4. Tampons 5. Menstrual cups
If cloth pad was mentioned in the earlier question, please answer the following questions (D1.4 and D1.5):		
D1.5	How do you wash the cloth?	1. With water only 2. With soap and water 3. Others specify _____
D1.6	How do you dry the cloth?	1. In sunlight 2. Outside the house 3. Inside the house

		4. Hide it under other clothes 5. Others Specify _____
D1.7	When do you bathe during periods?	1. Daily 2. First day 3. Last day 4. Do not bathe 5. thers Specify _____
D1.8	How do you dispose your absorbent material?	1. Burying 2. Disposal in public dustbins 3. Flush it in the toilet 4. Incinerating/burning 5. Use the cloth pad for further use 6. O thers specify _____
D1.9	How many cloth pads/sanitary pads do you change every day?	1. Less than 4 pads 2. 2-3 pads 3. Less than 2 pads
	Sexual and reproductive health	
D1.10	I think that I can encourage my partner to use condoms while having sex	1. Agree 2. Disagree
D1.11	I believe that it is okay for a person to have sex with different partners	1. Agree 2. Disagree
D1.12	Having sexual intercourse at my age is a “cool” thing for a girl	1. Agree 2. Disagree
	Mental health	
D1.13	I don’t know how to act around people with mental illness	1. Agree 2. Disagree

D1.14	Would you support your friend who is suffering from mental illness?	1. Yes 2. No
D1.15	How do you identify yourself?	1. Male 2. Female 3. Transgender
	Gender roles	
D1.16	Does your gender identity match your sex assigned at birth?	1. Yes 2. No 3. Prefer not to say
D1.17	Do you consider yourself to be:	1. Heterosexual 2. Homosexual 3. Bisexual 4. Prefer not to say
D1.18	Would you be comfortable with a transgender person in the following situations:	
	a. As part of your family	1. Yes 2. No
	b. As one of your friends	1. Yes 2. No
	c. As one of your work colleagues	1. Yes 2. No
	d. As your doctor	1. Yes 2. No
	e. As a chief minister of your state	1. Yes 2. No
	Safety and rights	
D1.19	What is your current relationship status?	1. No current relationship (Skip to D1.22) 2. In a relationship

		3. Cohabiting 4. Married
D1.20	Please answer the following questions if you are in a relationship (If not, skip to D1.21)	
	a. Is your relationship healthy, loving and stable?	1. Yes 2. No
	b. Are you treating each other as friends?	1. Yes 2. No
	c. Are you able to solve problems together?	1. Yes 2. No
	d. Does your partner respect your decisions?	1. Yes 2. No
	e. Are there any restrictions imposed by your partner? Ex: Do not talk to other boys, don't go alone anywhere, etc.	1. Yes 2. No
	f. Does he hit you if you don't listen to him?	1. Yes 2. No
D1.21	Did you ever face violence at home/school/college/ workplace?	1. Yes 2. No (Skip to D1.25)
D1.22	Can you briefly explain the incident? (Where, how and when)	

D1.23	Did you take action against the person who had perpetrated violence?	1. Yes (Skip to D1.25) 2. No
D1.24	If no, can you explain why you choose to remain silent?	
D1.25	If you face violence, what would you do?	1. I will talk to my parents 2. I will discuss it with my friends/relatives 3. I will discuss it with my teachers 4. I will approach police for help 5. I will keep it to myself without telling others 6. I will not do anything about it
	Financial planning	
D1.26	Some people tend to be very thrifty, saving money whenever they can while others are spending or even borrowing to consume. How would you classify yourselves?	1. Very thrifty, saving money whenever I can 2. Somewhat thrifty, often saving money 3. Neither thrifty nor spending oriented 4. Somewhat spending oriented, seldom saving money 5. Very spending oriented, hardly ever saving money
D1.27	What kind of financial accounts do you have?	1. Savings account in bank 2. Savings account in post office 3. Deposits 4. Stocks 5. Bonds 6. Mutual funds 7. Doesn't have anything

	What are the different savings option available?	1. Savings option 2. Savings in post office 3. Bonds 4. Mutual funds 5. Shares 6. Life insurance 7. Fixed deposits 8. Recurring deposits 9. Loans 10. Scholarships 11. Don't know.
D1.28	In what manner do you maintain financial records	1. Maintain no records 2. Maintain minimal records 3. Maintain very detailed records
D1.29	I budget and track my spending	1. Not at all true 2. Sometimes 3. Very true of me
D1.30	I get pocket money from my parents	1. Not at all true 2. Sometimes 3. Very true of me
D1.31	I contribute to my savings account frequently	1. Not at all true 2. Sometimes 3. Very true of me
D1.32	I read to increase my financial knowledge	1. Not at all true 2. Sometimes 3. Very true of me
D1.33	Three important things that I hope to happen in the future are	1. _____ 2. _____ 3. _____

D1.34	Three fears I have for the future are	1. _____ 2. _____ 3. _____

Section E: Skills on future readiness

E1.1	On a scale of 1 -5, how do you rate your **communication skills.** (5 = strongly agree; 4 = Agree; 3 = Neutral; 2 = Disagree; 1 = Strongly disagree	
	a. I can communicate effectively	
	b. I am an active listener	
	c. I can communicate clearly using verbal and nonverbal communication	
	d. I can communicate in a way that is easier for others to understand	
	e. I encourage two-way communication and take feedback	
	f. I keep communication safe and confidential when requested	
	g. My body language conveys clear message that reinforces verbal communication	
	h. I repeat important points to ensure understanding	
E1.2	I have good **problem-solving skills**	1. Agree 2. Disagree
E1.3	I have the confidence about the ability to solve problems	1. Agree 2. Disagree
E1.4	Problem solving skill will be useful in my career	1. Agree 2. Disagree
E1.5	Read the scenario given below and answer the following questions? Urban areas of India generate around 2,00,000 tonnes of solid waste. Of which, 80% of the waste reaches the open dumping yards resulting in environmental degradation, and health issues. Plastic forms a major chunk of this waste.	

	a. What is the problem?	
	b. What are the causes of this problem?	
	c. What is the effect of this problem on public?	
	d. What are the solutions?	
E1.6	Do you have fear while making public speeches?	1. Yes 2. No
E1.7	How do you perceive your voice?	1. Adequate 2. Hoarse voice 3. High pitched voice 4. Soft voice 5. Deep voice 6. Nasal voice
E1.8	How do you rate your confidence during public speaking?	1. Terrified 2. A bit nervous 3. Quite confident 4. Extremely confident
E1.9	How do you rate your public speaking skills?	1. Poor – I certainly need help 2. Average – I could improve 3. Good 4. Excellent
E1.10	What are the effective public speaking skills required?	

E1.11	You have been asked to give a presentation in your college on the Violence faced by women. Give us four steps to create a good presentation?	
E1.12	What are the different savings options available?	1. Savings in bank 2. Savings in post office 3. Bonds 4. Mutual funds 5. Shares 6. Life insurance 7. Fixed deposit 8. Recurring deposit 9. Loans 10. Scholarships 11. Don't know
E1.13	The most important factors that lenders use when deciding whether to approve a loan are	1. Marital status 2. Number of children 3. Education 4. Occupation 5. Age and gender 6. Bill paying record 7. Income 8. Don't know
E1.14	Menaka and Srujana are the same age. At the age of 25, Menaka began saving Rs.2000	1. Menaka because she saved more money overall

	per month for 10 years and then stopped at the age of 35 years. Srujana realizes that she did not save for retirement ~~and~~ and starts saving Rs. 2000 per month for 30 years and then stops at 65 years. Now both of them are at the same age. Who has the most money in their retirement? (Assume both of them had gained same interest rate).	2. Srujana because her money has grown for longer period 3. They would both have the same amount 4. Unable to determine with the given information. 5. Don't know

Section F: Self-esteem

Q.no	Statement	Strongly agree (5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly disagree (1)
F1.1	I love and accept myself just the way I am					
F1.2	I am a confident person					
F1.3	I should not express my feelings or needs with anyone					
F1.4	I feel frustrated about my performance					
F1.5	If I am sexually abused, it's my fault					
F1.6	I cannot set goals for my future					
F1.7	I can make good decisions about my life					
F1.8	I can solve my own problems					

F1.9	If I work hard, I can succeed					
F1.10	I have strengths that I can use to improve myself and community					
F1.11	I can motivate others					
F1.12	I make decisions for myself					
F1.13	I am willing to take up new challenges					
F1.14	I listen to feedback and ask questions					
F1.15	I am worried about what other people think of me					

Appendix 2

Detailed schedule of the training program

Date	Day	Topic	Objective	Outcome
Morning session				
18th Mar	Day 1	Introduction	1. Acts as an icebreaker for the participants 2. Will reflect on their current knowledge base 3. Reflect on their goals for future	1. Will be able to express about themselves better 2. Know the facilitator and people around them 3. Know the goal they want to work on
19th Mar	Day 2	Let's Talk Periods	1. To provide knowledge to the participants on the parts and functions of the female reproductive system 2. Understand menstruation and menstrual cycle 3. Get to know the various menstrual hygiene products available in the market 4. Understand the physical and mental conditions that are associated with menstruation 5. Reflect on the taboos surrounding menstruation	1. Able to manage their periods better in the future 2. Able to calculate their periods and be prepared 3. Recognise taboos surrounding menstruation 4. Provide information to others on various menstrual hygiene products

20th Mar	Day 3	Mind Matters	1. Learn the importance of feelings and emotions to maintain ~~a~~ good mental health 2. Build an understanding of triggers and unhealthy emotions 3. Learnt to maintain a positive mental health 4. Reflect on the myths surrounding mental health	1. Become support systems and caregivers to those around them facing mental health challenges 2. Able to bust mental health myths 3. Able to recognise triggers and emotions that may manifest into a mental health challenge
21st Mar	Day 4	My Body, My Choices	1. Learn about the parts and functions of the male reproductive system and revise the female reproductive system 2. Learn about sexually transmitted infections (STIs) and how they spread 3. Learn about the various contraceptives available in the market 4. Understand the meaning of consent and how it plays out in a sexual relationship	1. Will be able to make better sexual decisions for their bodies 2. Will be able to decide on contraceptives suitable for themselves 3. Exercise consent 4. Share knowledge on STIs and break myths around it
22ndMar	Day 5	My Identity	1. Learn about socialization and how it plays a major role in influencing our behaviour in the society	1. Reflect on the kind of relationship that they want in their life 2. Negotiate for a healthy relationship

			2. Identify gender roles, gender identity and gender expression 3. Understand difference between gender and sex 4. Learn about transgenders	
23rd Mar	Day 6	My Future Family	1. Understand the difference between love and commitment 2. Understand that marriage is a process and not the end of the journey 3. Understand the various ways in which consent manifests in our life	1. Set relationship goals for themselves 2. Manage problems that arise in the process of marriage 3. Able to recognise unhealthy relationships
24th Mar	Day 7	Say No To Violence	1. Learn to recognise violence 2. Understand the role of power in gender-based violence 3. Learn about the long term and short term effects of violence on the victim 4. Learn to respond to violence	1. Tackle violent situations better 2. Support victims of violence 3. Able to better recognise and respond to violent situations
25th Mar	Day 8	Good Bye	1. Reflect on the learnings from the Oorja sessions 2. Think about ways in which they can use	1. Comprehend and consolidate the learnings of all the sessions

			their knowledge in the future	
Afternoon session				
18th Mar	Day 1	Seeing your life with a perspective (Frames)	1. Reflect on their life 2. Discover the moments of joy 3. Reflect on how these moments have brought them to the future	1. Appreciate the journey of their life
19th Mar	Day 2	Girl Power	1. Learn to recognise the sources of power in the society 2. Understand how media propagates power in the society 3. Understand about collective power of women	1. Will be able to recognise inequality in the society 2. Come up with various ways in which they can come together to bring a change
20th Mar	Day 3	Solve It	1. Learn to recognise the problem 2. Understand the context divers in the society 3. Reflect on the effects of a problem on a person, community, nation, or global 3. Learn to come up with SMART solutions	1. Will be able to recognise problems and come up with relevant solutions
21st Mar	Day 4	Communicating Effectively	1. Learn about verbal and non-verbal communication 2. Learn the core elements used to make a good speech	1. Able to make relevant presentations and speak confidently

			3. Steps to create a good presentation	
22nd Mar	Day 5	The Ultimate Game	1. Reflect on the learnings from the Oorja session 2. Learn decision making 3. Make conscious choices when they have limited resources	1. Will be able to make active decision based on the resources that they have at hand
23rd Mar	Day 6	Investing In You	1. Will learn to set financial goals 2. Learn about budgeting 3. Learn different ways in which they can save or invest their money 4. Learn about unhealthy ways of handling money	1. Will be able to manage their money better 2. Know the importance of investing their money wisely
24th Mar	Day 7	I Will Lead	1. Identify the qualities of a leader 2. Learn about various types of leaders 3. Recognise the need of a leader 4. Learn to lead a team	1. Will be able to collaborate with different people to reach their goal 2. Identify people who match their vision
25th Mar	Day 8	Graduation	1. Participants will showcase their learnings from the session 2. Valedictory	1. Will graduate from the program
Project				

Appendix 3

Informed Consent Form

This Informed Consent Form is for the young women from the Fernandez Institution, who we are inviting to participate in research, **"Evaluation of OORJA training programme among young women in the nursing department of Fernandez Hospitals in Hyderabad- A mixed method study".**

[Name of Principle Investigator]
[Name of Organization]
[Name of Sponsor]
[Name of Project and Version]

I have been invited to participate in the research **"OORJA program"** which provides the right tools of empowerment, life skills, critical knowledge and career guidance conducted by Voice 4 Girls organization.

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.
A copy of this ICF has been provided to the participant.

Name of Participant_____
Signature of Participant _____
Date _____
Day/month/year

“All the top achievers I know are life-long learners... Looking for new skills, insights, and ideas. If they’re not learning, they’re not growing... not moving towards excellence.”

Denis Waitley