



IMPROVING SEXUAL AND REPRODUCTIVE HEALTH AMONG
MAHADALIT ADOLESCENTS IN BIHAR, INDIA

SASHAKT BASELINE EVALUATION FINDINGS

Swetha Sridharan, Kimberly Smith, and Dana Rotz

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1. INTRODUCTION

A. Background and Program Motivation

India has the largest population of adolescents in the world with over 250 million young people between the ages of 10 and 19, representing one-fifth of the country's population. Recognizing the importance of this population to India's broader social and economic goals, the Indian government has shown a strong interest in the health of adolescents, and their sexual and reproductive health (SRH) in particular. While the overall health and education levels of adolescents have been improving over time, young people continue to face a wide array of unmet SRH needs. Despite laws prohibiting early marriage, almost one-quarter of women aged 20 to 24 were married before the age of 18, with childbearing starting soon after marriage (International Institute for Population Sciences [IIPS] and ICF 2017). Early, closely-spaced, and multiple pregnancies continue to be a dominant feature of young women's lives, leading to increased health and mortality risks for these women and their children as well as school drop-out, both of which have long-term socioeconomic consequences (WHO 2014). Evidence also indicates that many young women face sexual violence within their marriages (IIPS and Population Council 2010). The SRH situation for young women in poorer states, rural areas, and scheduled castes (SCs) is even starker. For example, in the state of Bihar, over 40 percent of women are married before they turn 18 and 37 percent begin childbearing by age 19, with adolescents from SCs more than twice as likely to have a child by this age than those from upper castes (IIPS and ICF 2017).

India's political commitment to meeting the SRH needs of adolescents has been demonstrated through a series of policies and programs over the last decade and a half, starting with the National Population Policy in 2000. Health sector efforts have tended to be narrowly focused on specific reproductive health issues and oriented toward facility-based services, with limited attention to the broader health and development needs of youth. However, the 2014 launch of *Rashtriya Kishor Swasthya Karyakram* (RKSK), or National Adolescent Health Program, signaled a marked shift in the government's adolescent health programming. While RKSK still specifies SRH as a priority area, it expands the scope of the government's adolescent health efforts to life skills, gender-based violence (GBV), and broader health needs, including nutrition, mental health, and substance abuse.¹ It also represents a more participatory approach that focuses on community health promotion and relies on intersectoral collaboration. The program aims to reach youth in their environments (including communities, schools, and cyberspace) and link them to the public health system through referrals. To do so, the program incorporates multiple intervention strategies, including community-based interventions (such as peer education), facility-based interventions (such as adolescent-friendly health clinics), and broad-based behavior change communication efforts (Figure 1.1).

Concurrent with India's policy focus on adolescent health, there has also been increasing political attention paid to the health needs of other underserved and vulnerable populations in India, including those in poorer states and rural areas and belonging to SCs. In 2005, the Indian government launched the National Rural Health Mission (NRHM), an initiative to address the health needs of underserved rural populations, with a special focus on eight states with particularly weak public health indicators. Among those states, Bihar has been especially attentive to the needs of vulnerable groups. In 2007, the Government of Bihar designated particularly marginalized sub-groups of the SC (or "Dalit") population

¹ RKSK includes six priority areas of action: SRH, nutrition, mental health, injuries and violence (including GBV), substance abuse, and non-communicable diseases.



FIGURE 1.1. KEY COMPONENTS OF RKS

1. Community-based interventions

- Peer education
- Quarterly adolescent health day
- Weekly iron and folic acid supplementation program
- Menstrual hygiene scheme

2. Facility-based interventions

- Strengthening of adolescent-friendly health clinics at public health facilities

3. Convergence

- Leveraging synergies within the Ministry of Health and Family Welfare and between it and other departments (such as the Ministry of Women and Child Development, the Ministry of Human Resource Development, and the Ministry of Youth Affairs and Sports)

4. Behavior change communication

- Mass media, social media, events, mobile phone-based platforms, printed materials

as “Mahadalits” and established the Mahadalit Vikas Mission to improve this population’s access to social programs and entitlements.

While the above initiatives all involve efforts to improve access to health services among underserved groups, they have not been systematically integrated to address the SRH needs of Mahadalit adolescents, a particularly vulnerable youth population in Bihar. Responding to this gap, Pathfinder International developed the Sashakt program in 2015 with support from the David and Lucile Packard Foundation. Sashakt, which means “empowerment” in Hindi, aims to meet the specific SRH needs of Mahadalit adolescents in Bihar. To do so, it leverages efforts under RKS, the NRHM, and the Bihar Mahadalit Vikas Mission. In building the Sashakt program model, Pathfinder drew on achievements and learnings from its highly successful Promoting Change in Reproductive Behavior of Adolescents (PRACHAR) program, implemented in Bihar from 2001 to 2012 among youth aged 12 to 24 (Population Council 2016). Sashakt

incorporates key elements of PRACHAR, including SRH and life skills education trainings and home visits by frontline workers (FLWs) introduced under the NRHM. However, it also includes several new program components designed to meet the specific needs of Mahadalit adolescents. These include (1) a narrower focus on adolescents aged 15-19, (2) leveraging of Vikas Mitras, local employees of the Mahadalit Vikas Mission, to better reach Mahadalit youth, and (3) provision of technical assistance to the government of Bihar to support its statewide rollout of RKS.

Pathfinder conducted an initial, brief pilot of Sashakt in 2016, which was used to refine the original program model. Refinements included narrowing the program’s focus to 15-19 year olds, adding a 1-day training on key SRH issues for married adolescent couples, and supporting the roll-out of RKS. Following the pilot, Pathfinder also decided to focus Sashakt on the most vulnerable segments of the Mahadalit population. The revised Sashakt model is currently being implemented under a new two-year pilot (January 2017 to December 2018). This Phase 2 pilot offers a valuable opportunity to do a more in-depth assessment of the program’s effectiveness in reaching, engaging, and addressing the specific needs and preferences of Mahadalit adolescents.

To support implementation learning and program refinement during the Phase 2 pilot, the Packard Foundation asked Mathematica Policy Research to conduct an implementation learning evaluation of the Sashakt program model. This mixed-methods study focuses on one implementation block, drawing on quantitative and qualitative data collected before, during, and towards the end of the Phase 2 pilot to better understand the implementation and outcomes of Sashakt and offer ongoing insights for program improvement.

This report presents findings from the baseline data collected by Mathematica and its evaluation partner, Outline India, as part of the implementation learning study. The organization of the report is as follows. In the remainder of this chapter, we provide a detailed description of the Sashakt program model. In Chapter 2, we provide an overview of our approach to the implementation learning study and the

baseline data collection effort. Chapter 3 presents baseline findings based on survey data collected from Mahadalit adolescents and qualitative data collected from program stakeholders. Chapter 4 summarizes key findings and discusses their implications for program improvement.

B. The Sashakt Program

OVERVIEW

The Sashakt program seeks to address the SRH needs of adolescents from the most disadvantaged Mahadalit castes in Bihar. It aims to (1) improve SRH-related knowledge and attitudes, (2) increase access to family planning (FP) and maternal health services, and (3) strengthen the government's capacity to deliver SRH services and behavior change programming to Mahadalit adolescents under RKSK. The program leverages key elements of existing government programs and policies focused on underserved populations, drawing for instance on FLWs deployed under the NRHM. Key program components such as life skills education and awareness-building around adolescent-friendly health centers (AFHCs) are aligned with RKSK interventions.

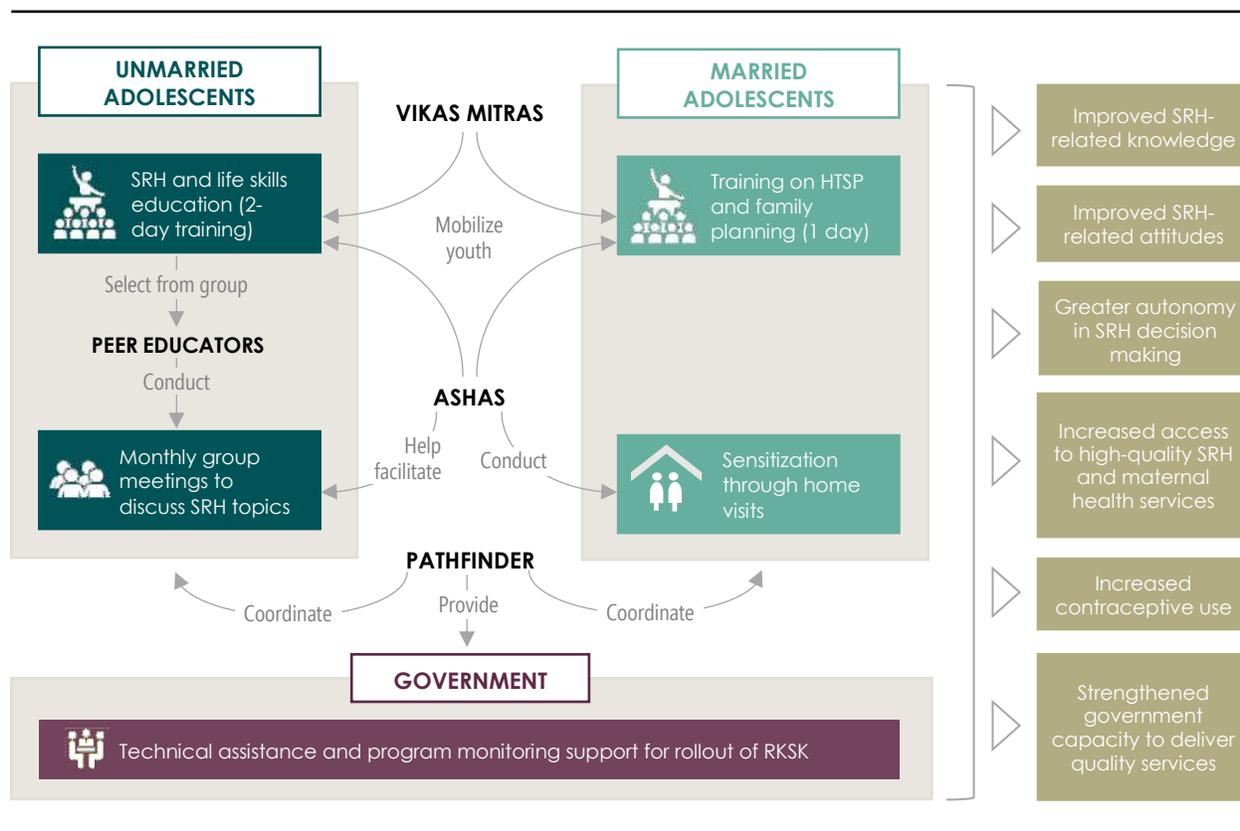
The Sashakt program targets both married and unmarried Mahadalit adolescents between 15 and 19 years of age. For married couples, only one spouse, typically the woman, is required to fall within this age range (recognizing that women tend to marry earlier than men in these communities). The program includes differentiated sensitization and service provision activities for each group. The program sensitizes unmarried adolescents to SRH issues related to marriage, childbearing, sexually transmitted infections (STIs), and gender norms and violence, and aims to build communication and negotiation skills that young people need to engage in healthy decision-making. For married couples, the focus is on empowering adolescents with information and skills to support healthy marriages, healthy timing and spacing of pregnancy (HTSP), and responsible parenting.

Under the Phase 1 pilot, the program was rolled out in three blocks in three different districts (Purnea, Katihar, and Saharsa). In Phase 2, Pathfinder replaced Saharsa with Araria, such that all project districts are priority districts selected by the government for RKSK roll-out. Sashakt is being implemented in six blocks across the three Phase 2 districts. The program focuses on villages within selected blocks that have Mahadalit populations comprised largely of the most disadvantaged Mahadalit sub-castes.

PROGRAM MODEL

Figure 1.2 presents an overview of the Sashakt program model. As mentioned, Pathfinder has developed tailored interventions to meet the different needs of married and unmarried adolescents. Interventions for unmarried adolescents include a two-day SRH and life skills training, followed by monthly group meetings conducted by peer educators (who are selected from the groups attending the trainings). Interventions for married adolescents include a one-day training on SRH/HTSP followed by home visits from ASHAs, who are village-based FLWs deployed under the NRHM. ASHAs also recruit and mobilize Mahadalit adolescents for the one- and two-day trainings. Also involved in recruitment and mobilization are Vikas Mitras, employees of the Mahadalit Vikas Mission who are responsible for connecting Mahadalit households with government social welfare programs. These activities are coordinated and overseen by local Pathfinder staff, who also support the state government's efforts to roll out RKSK.

FIGURE 1.2. SASHAKT PROGRAM MODEL



By implementing these components, the program hopes to achieve a range of intermediate and long-term outcomes, including improved SRH-related knowledge and attitudes, greater autonomy in making decisions related to marriage and childbearing, increased access to and use of maternal and reproductive health services, and increased contraceptive use.

Below we describe each of the program’s components in more detail.

Sensitization of unmarried adolescents

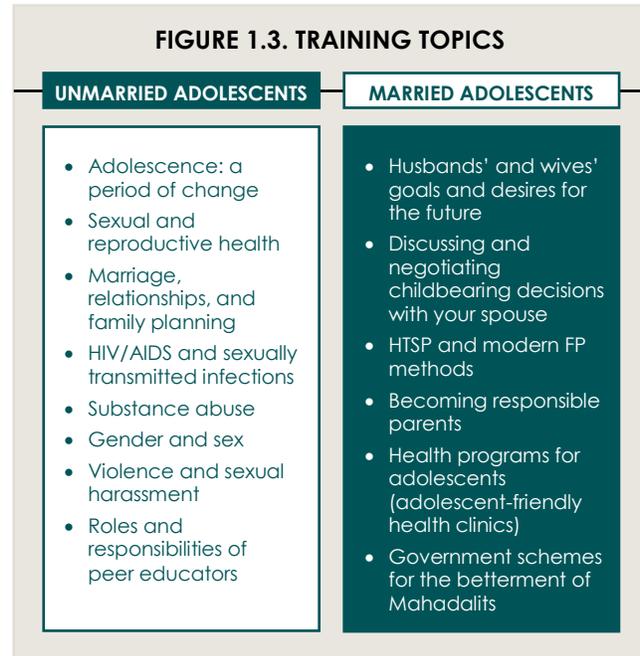
- SRH and life skills education training.** Professional trainers employed and trained by Pathfinder conduct a two-day SRH and life skills education session for unmarried Mahadalit adolescents. The training is provided to groups of 40 unmarried adolescents, and is conducted separately for unmarried men and women. As mentioned, Pathfinder relies on ASHAs and Vikas Mitras² to recruit and mobilize youth for the training. ASHAs receive Rs. 30 for each unmarried adolescent they bring to the session. The training curriculum, adapted from PRACHAR and RKSK materials, covers a wide variety of SRH themes, including marriage, childbearing, HIV/AIDS, STIs, and gender-based violence (Figure 1.3). The training also discusses issues related to gender in this community, and has an overarching focus on building adolescents’ decision-making and negotiation skills. Trainers use

² In Phase 1 Vikas Mitras were also responsible for disseminating health messages and providing referrals. However, this strategy had mixed success, given communities traditionally look to ASHAs and other FLWs for information and services related to family planning. Phase 2 narrowed the scope of Vikas Mitras’ involvement in Sashakt, relying on them mainly to mobilize Mahadalit youth for the SRH trainings

interactive methods and tools—such as job aids, role play, and games—to share information and facilitate discussion, and ensure that low literacy is not a barrier to understanding key messages for any of the participants.

- **Peer education.** Following the two-day training, unmarried adolescents receive continued sensitization on SRH issues through peer education. Pathfinder selects life skills training participants who demonstrate leadership and public speaking skills to act as peer educators in their communities. Supported by ASHAs and Pathfinder staff, peer educators lead monthly group meetings with unmarried adolescents in their community to emphasize and reiterate key messages from the training and promote informed SRH

decision-making. In conducting peer-to-peer sensitization, Pathfinder is leveraging and strengthening program linkages with RKSK, which includes peer education as a key element. By doing so, Pathfinder hopes to support and contribute to RKSK goals and also ideally effect greater prioritization of Mahadalits in RKSK interventions. (For instance, Pathfinder hopes to have the government eventually integrate the Mahadalit peer educators trained under Sashakt into RKSK’s broader peer educator cohorts.)



Outreach and service provision to married adolescent couples

- **Training on HTSP and family planning.** Professional trainers employed and trained by Pathfinder conduct a one-day session on HTSP for married adolescent couples. This element was added following the Phase 1 pilot, which only had ASHAs conduct sensitization for married women, and found that husbands, who played a key role in decisions around FP, were not being reached. The one-day training is provided to groups of 30 married adolescents (15 couples altogether). The training session offers information on the benefits of delaying and spacing births, modern contraceptive methods, and health and other benefits and services available to Mahadalit adolescents through the government. It also includes modules focused on strengthening negotiation skills and fostering discussion around healthy relationships and responsible parenting (Figure 1.3).
- **Sensitization by FLWs.** To ensure married adolescents receive continued sensitization following the one-day training, ASHAs are asked to include married Mahadalit adolescent women in their home visit schedules (during home visits, ASHAs are expected to deliver messages on key HTSP behaviors, p short-acting contraceptive methods if requested, and provide referrals for facility-based contraceptive, abortion, and maternal health services). Pathfinder provides training to ASHAs on key HTSP messages and the unique needs and conditions of married Mahadalit adolescents. It also trains ASHAs on how to identify and sensitize key gatekeepers and decision-makers in households and reinforces their overall interpersonal communication skills. Finally, Pathfinder also plans to engage with Auxiliary Nurse Midwives (ANMs), and encourage them to deliver targeted SRH messages to

Mahadalit adolescent women (ANMs staff health sub-centers, and travel monthly to the multiple villages in their coverage area to provide immunization, maternal, neonatal, and child health, and other basic health services).

Government capacity-building

- **Support for RKSK rollout.** Pathfinder is providing technical, managerial, and program monitoring support to block and district officials in project areas to facilitate the roll-out of RKSK. By doing so, Pathfinder hopes to build a strong enabling environment for the implementation of Sashakt and also contribute to Bihar's overarching adolescent health goals. A key element of its support focuses on peer education, a core component of Sashakt. Pathfinder recently conducted a training of trainers for ANMs (in the Sashakt blocks), who are responsible for training RKSK peer educators.

2. APPROACH TO THE IMPLEMENTATION LEARNING EVALUATION

A. Overview of Study Objectives and Approach

The overall objective of the implementation learning study is to generate actionable information on implementation processes and outcomes to inform program improvement and potential scale-up. Our approach to the study integrates program implementation and evaluation by focusing on (1) collection of timely data relevant for program decision-making and (2) establishing a feedback loop that will allow program managers to respond to evaluation learnings in an efficient way. To this end, it involves three main components:³

1. **Baseline and endline quantitative data collection to track program reach, uptake and perceptions and shifts in key program outcomes.** This component focuses on collection of household survey data from Mahadalit adolescents (married women, married men, unmarried women, and unmarried men) prior to implementation of the Phase 2 pilot (July 2017) and toward the end of the pilot period (September 2018). The small population within many Mahadalit *tolas* (communities bordering villages) shaped our survey approach. To achieve sample size targets that would enable us to track outcomes over time, we adopted a modified convenience sample approach for the survey, whereby we interviewed as many adolescents living in a selected *tola* at the time of data collection as possible. As discussed below, this technique enabled us to capture a large proportion of targeted adolescents in each *tola* for the baseline survey effort.⁴
2. **Three rounds of in-depth qualitative data collection on program perceptions and experiences to complement and aid in interpretation of the quantitative findings.** Qualitative data from a range of program stakeholders will provide nuanced insights into contextual factors that have facilitated or inhibited the program's reach and influence, as well as the program's potential for further replication and scale-up. Program stakeholders targeted under the qualitative data collection effort include program staff, beneficiaries, community members, teachers, FLWs, and government officials. Qualitative data collection will take place concurrently with quantitative data collection at baseline and endline; we will also conduct a qualitative "midline" at an intermediate phase of program implementation (February/March 2018) to assess progress and inform ongoing program improvement.
3. **Learning workshops after midline and endline data collection to draw out implications of study findings for program design and implementation.** Following completion of the midline and endline data collection, Mathematica and its India-based program strategy consultant will facilitate an implementation learning workshop with Pathfinder and the Packard Foundation, which will focus on the implications of findings for program decision-making and refinement. During the workshops,

³ The study design evolved over time, in response to emerging information about program implementation plans and the target population. The original design focused on (1) quarterly quantitative data collection and dashboard reporting based on a modified Lot Quality Assurance Sampling (LQAS) approach whereby villages were designated as "lots" and (2) annual in-depth qualitative data collection to complement quantitative findings and feed into annual mixed-methods dipstick reports. However, the phased roll-out of the Saskakt intervention, combined with the unexpectedly small size and homogeneity in sub-caste composition of targeted Mahadalit communities (*tolas* within villages) led to the adoption of the more traditional learning evaluation approach described in this section.

⁴ We originally planned to randomly sample households based on an initial mapping of *tolas* conducted by Outline India. However, early on in baseline field data collection effort, when we discovered that the target population in each *tola* was smaller than expected (see above footnote), we realized that to achieve sample size targets within and across the *tolas* included in the study, we would need to do an exhaustive sampling of each sub-population in most *tolas*.

the local program strategy consultant will lead an interactive session with Pathfinder to draw out additional learnings from the evaluation findings, and identify how to adjust and improve the model based on those learnings.

To enable in-depth and rapid data collection to support a learning evaluation approach, the study focuses on one intervention block in Araria district, the new intervention district added under the Phase 2 pilot. The timeline for the evaluation, and data collection in particular, was determined based on the planned roll-out and implementation of the various components of the Sashakt program. More information on the evaluation timeline and plan through the final reporting period can be found in a prior concept note (available upon request).

In the remainder of this section, we describe the baseline data collection effort upon which this report is based.

B. Baseline Quantitative Data Collection

As mentioned, to track progress toward targeted outcomes in intervention areas, the learning evaluation includes baseline and endline survey data collection with Mahadalit adolescents (married women, married men, unmarried women, and unmarried men). To ensure a survey sample large enough to allow for outcome tracking, we set a sample size target of 1,200 adolescents (300 adolescents in each of the four subgroups) for both waves of data collection. For the baseline data collection, we largely met these goals, achieving a total baseline sample size of 1,208, including 300 or more adolescents from each subgroup except married men (sample size of 188). High rates of migration among adolescent married men compromised our ability to meet the sample size target for this group.

Below, we provide a description of our approach to sampling, survey data collection, and the baseline analysis.

SAMPLING APPROACH

The study focuses on Raniganj block in Araria district. Araria was selected because it was part of the Sashakt Phase 2 pilot but had not been involved in the initial pilot. To inform selection of the intervention block, Pathfinder provided the evaluation team with population size estimates for each intervention *tola* across the two program blocks in Araria. The criteria used for block selection were (1) number of *tolas* with relatively large Mahadalit adolescent populations (for data collection cost efficiency) and (2) the extent of variation across larger villages in the dominant Mahadalit sub-caste. While we sought to ensure that the study included villages with different compositions of Mahadalits, we found that there was very little variation in sub-caste composition across larger villages (potentially the result of the Phase 2 pilot's focus on the most marginalized Mahadalit sub-castes). As a result, selection of the study block (and villages) was driven largely by village size.

Survey data was collected from 1,208 respondents across 32 *tolas* in one block

- 306 married adolescent women
 - 188 married adolescent men
 - 300 unmarried adolescent women
 - 414 unmarried adolescent men
-

Once Raniganj block was selected for the study, the evaluation team initially selected the 15 *tolas* with the largest Mahadalit populations for data collection, based on the initial population estimates provided by Pathfinder. However, early on in our data collection efforts, we learned that these population sizes were inaccurate and, in most cases, considerable overestimates. Upon receiving revised population estimates from Pathfinder, which incorporated updated input from Pathfinder field staff and ASHAs in

program villages, we selected a new set of *tolas* for data collection. Selection at this stage was still driven by population size estimates, as well as sample size targets. In the end, all program *tolas* in Raniganj with at least 13 unmarried boys ages 15 to 19 and 13 unmarried girls age 15 to 19 were selected for inclusion in the survey component of the study. This resulted in an ultimate sample of 32 *tolas* in Raniganj, including 27 *tolas* from the revised selection process and 5 *tolas* from the initial selection process.

Our approach to sampling Mahadalit adolescents for the survey was driven by the small size of most of the *tolas*. To achieve our sample size targets, we adopted a modified convenience sample approach, whereby we interviewed as many eligible adolescents living in the *tola* at the time of data collection as possible. To be eligible for the survey, all unmarried adolescents had to be between the ages of 15 and 19 and have provided verbal consent; unmarried adolescents under the age of 18 also had to have obtained written parental consent (in the form of digital signatures on a tablet or thumb-prints on a paper form). In cases where the parent was not available or was reluctant to sign but gave verbal consent, informed witness consent was sought from another enumerator. Married adolescent women and men were eligible for the study if they or their spouse was between the ages of 15 and 19. Married adolescents were subject to the same study consent requirements for program eligibility as unmarried adolescents, whereby all participants had to provide verbal consent and those under 18 were also required to obtain written parental consent.

In most *tolas*, we ended up interviewing a large proportion of (or all) adolescents living in the *tola* on the day(s) of data collection. Across all *tolas*, there tended to be more unmarried adolescents than married adolescents, and many married adolescent men had left the *tolas* to work elsewhere for an extended period (typically Punjab). However, as shown in the next chapter, a large proportion of the married men included in our final sample (85 percent) had also recently migrated for work and returned to the village. In addition, many married adolescent women were involved in agricultural activity outside of the *tola* during the day. To ensure that our sample captured a sufficient proportion of this population, the data collection team arrived in study *tolas* early in the morning and stayed into the evening.

SURVEY DATA COLLECTION

In July 2017, staff from Outline India administered surveys to eligible and consented adolescents in each of the program's four targeted subgroups. The surveys collected data on a range of outcomes targeted by the program, including (1) attitudes related to marriage, (2) attitudes related to timing and spacing of births and family planning, (3) gender roles and decision-making autonomy, (4) knowledge of key FP/reproductive health (RH) topics, (5) access to and perceived quality of FP/RH services, and (6) contraceptive use. Specific data elements differed by respondent type. To develop the surveys, we drew heavily from existing, validated instruments used for other youth SRH studies in India and elsewhere. These included instruments developed by the Population Council and Pathfinder for evaluations of the PRACHAR program in Bihar, Population Council instruments used in their ongoing Youth Study in

India, and instruments developed by Mathematica for evaluations of adolescent SRH programs in several countries. We also included in the survey validated measures of contraceptive self-efficacy and discrimination in health care settings (Peek et al. 2011).

The surveys underwent two rounds of review by an Institutional Review Board in New Delhi, India (Sigma) to ensure they were closely tailored to and appropriate for the target population. Particular attention was paid to sections that might be considered inappropriate for youth in rural settings. Questions that touched on exceptionally sensitive issues that might raise concerns in the community, such as premarital and extramarital sexual activity and abortion, were dropped or reworded. The surveys were piloted by Outline India, and further streamlined and refined on the basis of learnings from the pilot.

Despite these efforts, data collectors encountered some resistance from communities in the early days of the data collection effort, leading the field team to adopt additional precautions. Field data collectors reported that community members were sometimes initially hesitant to allow “outsiders” to speak confidentially with their youth regarding SRH issues, especially given the high incidence of child trafficking in Bihar in recent years. The data collection team mitigated this issue by liaising more closely with the *Mukhiya*, or village head, and the local ASHA, and obtaining their assistance with respondent recruitment.

APPROACH TO DESCRIPTIVE ANALYSIS

The descriptive statistics presented in this report are based on simple univariate analysis of the individual subgroup samples and a pooled sample that includes all adolescents. In the pooled sample analysis, the respondents from each subgroup are given equal weight, so that the pooled mean is the average of the four subgroup means. Although survey sample sizes varied by subgroup, evidence indicates that approximately half of all Mahadalit women ages 15 to 19 in Raniganj are married and that the sex ratio is close to 100, supporting this equal weighting (Census of India 2017a, 2017b).^{5,6}

C. Baseline Qualitative Data Collection

At baseline, we conducted focus group discussions (FGDs) with Mahadalit adolescents in two *tolas* and in-depth interviews (IDIs) with ASHAs, ANMS, and head teachers in six *tolas*. We also interviewed staff at the block’s primary health center (PHC) and Pathfinder program staff (see Figure 3.1 for the number of respondents). All conversations were recorded, transcribed, and translated. Transcripts were analyzed to draw out information related to (1) common beliefs regarding marriage, childbearing, pregnancy, and gender roles among Mahadalit adolescents, (2) barriers in accessing and using FP/RH services, (3)

⁵ In 2011, approximately 50 percent of Musahar women (the dominant Mahadalit sub-caste in the selected *tolas* of Raniganj) ages 15 to 19 were married (Census of India 2017a).

⁶ We also explored weighting data to account for variation across *tolas* in the probability of respondents being surveyed or giving each sampled *tola* equal weight. These weights produced results very similar to our preferred estimates.

perceptions of the quality of FP/RH services, and (4) key contextual factors, such as migration, which may influence program implementation and effectiveness.

TABLE 2.1. BASELINE QUALITATIVE DATA COLLECTION SAMPLE

Respondent	Data collection method	Number
Mahadalit adolescents (unmarried women, married women, unmarried men, married men)	FGD	8 (FGDs)
ASHAs	IDI	4
ANMs	IDI	4
Head teachers	IDI	4
Block government staff	IDI	1
Pathfinder staff	IDI	1

As with the quantitative data collection effort, we faced some initial resistance to the FGDs, with mothers concerned about their daughters discussing these controversial issues. The field team’s mitigation strategies were to (1) enlist the support of the ASHA and other FLWs in recruiting FGD participants, and (2) allow either the mothers or ASHAs to sit at a distance from the FGDs, such that they could see, but not hear their daughters. The latter strategy, despite the field team’s precautions to ensure that conversations were inaudible outside of the focus group, may have influenced participants’ responses.

3. FINDINGS

A. Sample Characteristics

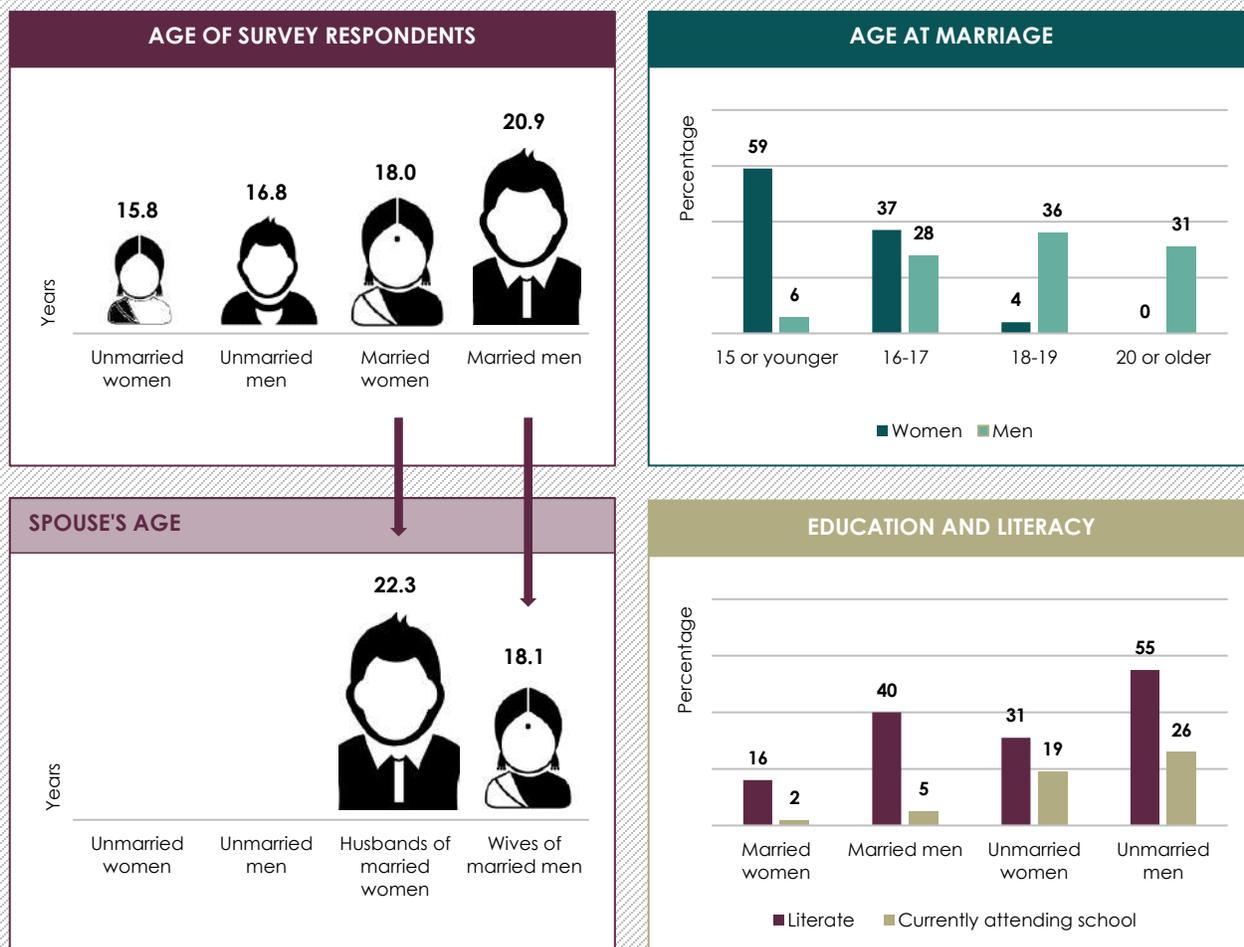
In this section, we describe the characteristics of our sample, which offers insight into the population being served by Pathfinder. As mentioned, although our findings are based on a convenience sample, in most *tolas*, our survey captured a large proportion of the target population residing in the *tola* on the days(s) of data collection. Notable exclusions to the sample include members of the target population (largely married men) who had migrated to another area and were not residing in the village at the time of data collection. However, as discussed below, our sample includes a large proportion of recent migrants (or wives of migrants).

Figure 3.1 presents a summary of the survey sample, detailed below.

- **Age.** As expected, unmarried adolescents tend to be younger than married adolescents in our sample. The average ages of unmarried women and men surveyed is 15.8 and 16.8, respectively. As noted above, married adolescents were eligible for our survey if they or their spouses were between the ages of 15 and 19. On average, married women in our sample are younger than married men (aged 18.0 versus 20.9), which is consistent with the tendency in the combined sample of married adolescents for wives to be roughly three to four years younger than their husbands.
- **Marriage and fertility.** The average age of marriage in our sample is 15.2 among married women and 18.4 among married men.⁷ Nearly 60 percent of married women in our sample were married by the age of 15. Levels of early childbearing are high among married adolescents in our sample. Three-fifths of married adolescents had at least one child and one-quarter were pregnant or had a wife who was pregnant at the time of the survey.
- **Education.** On average, women had completed roughly 3 years of schooling and men had completed roughly 4.5 years at the time of the survey. Only 16 percent of married women in our sample are literate; literacy is higher among other subgroups (ranging from roughly 31 percent among unmarried women to 55 percent among unmarried men). Married respondents are generally less educated than unmarried respondents, and levels of education are highest among unmarried men, about a quarter of whom were enrolled in school at the time of the survey.
- **Employment and migration.** Across all subgroups, most respondents had engaged in some form of labor outside the household in the past year, including about two-thirds of married women. The vast majority of married men (85 percent) and more than half of unmarried men (58 percent) had migrated in the past year for work or education. Almost 30 percent of married men were away from home for at least half of the past year. Our qualitative data indicate that men migrate mainly to the state of Punjab to do agricultural work. They return to Bihar in March and November for large festivals and the planting and harvesting seasons for specific crops.
- **Caste.** About 84 percent of respondents in our sample are members of the Musahar caste, the most disadvantaged group of Mahadalits. The Rajwar and Chamar castes each account for an additional 5 percent of the overall sample.

⁷ It is possible age at marriage is even lower. Our qualitative data indicate there is considerable apprehension around reporting the true age at marriage for younger brides.

FIGURE 3.1. SAMPLE CHARACTERISTICS



Source	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Average age at marriage	16.9	15.2	18.4	NA	NA
Pregnancy and childbearing (%)					
Any live births	62	64	60	NA	NA
Currently pregnant/wife currently pregnant	26	21	30	NA	NA
Have a child or pregnant/wife currently pregnant	75	75	75	NA	NA
Education					
Highest grade completed (mean)	3.9	2.6	4.1	3.5	5.1
Literate (%)	36	16	40	31	55
Employment (%)					
Engaged in paid work last year	80	65	98	81	78
Migration (%)					
Respondent/husband been away from home for work or education in past year	76	85	85	NA	58
Respondent/husband been away from home for work or education in past year for 6 or more months	29	37	28	NA	22
Caste (%)					
Musahar	84	85	86	85	81
Rajwar	6	4	5	8	7
Chamar	5	1	6	2	9
Other	5	10	2	5	3
Sample size	1,208	306	188	300	414

Source: Sashakt baseline survey, 2017.

Notes: Sample sizes accounting for item nonresponse range from 303 to 306 married women and 413 to 414 unmarried men depending on the measure (total sample size ranged from 491 to 1,208 adolescents). All married men and unmarried women responded to all relevant measures in this figure. Estimates for pooled sample are weighted to give each subgroup equal weight.

NA = Not applicable.

B. Exposure to Information on SRH Topics

Exposure to information on SRH varies by gender and marital status, but is generally low, with the exception of married adolescent women. The survey asked respondents if they had ever received information on topics related to how pregnancy happens and how it can be prevented (Table 3.1). Not surprisingly, levels of exposure to information on these topics are considerably higher among married compared to unmarried adolescents in our sample, and highest among married women, 75 percent of whom have had a child or are currently pregnant (Figure 3.1). However, there are marked differences in exposure rates by gender. Women were more than twice as likely to report receiving information on SRH topics than their male counterparts (74 versus 36 percent in the case of married adolescents and 54 versus 18 percent in the case of unmarried adolescents). With the exception of married women, exposure rates are generally low across all of the subgroups examined.

The most common sources of information on SRH are friends and family members. Among those who had received information on SRH topics, the most commonly reported sources of information were same-sex friends or neighbors (67 percent) and family members (61 percent), followed by health care providers (39 percent). While this pattern generally holds across subgroups, there were some notable differences in sources accessed. First, married women were considerably more likely than other groups to have received information from a health care provider (55 percent of those exposed to information), most commonly an ASHA (34 percent of those exposed). Second, unmarried men were much less likely than

TABLE 3.1. EXPOSURE TO AND SOURCES OF SRH INFORMATION

	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Any information received (%)	46	74	36	54	18
Sample size	1,208	306	188	300	414
Sources of information among adolescents who reported receiving information (%)					
 Same-sex friends or neighbors	67	68	58	78	72
 Family members	61	61	58	78	17
Spouse/partner	13	8	50	2	0
Parent	9	7	3	20	0
Sisters- or brothers-in-law	33	34	3	61	6
Other family member of same sex	11	16	6	9	11
 Health care providers	39	55	28	35	11
ASHA	22	34	17	13	6
ANM	4	8	0	2	0
Other health care provider	17	22	14	22	6
 Other sources	11	7	22	6	28
Radio/TV	7	5	14	2	17
Teacher/school	4	1	8	4	11
Sample size	556	226	68	162	75

Source: Sashakt baseline survey, 2017.

Notes: Sample sizes did not vary across measures. Estimates for pooled sample are weighted to give each subgroup equal weight.

Individuals could indicate up to three sources of information in response to this question – “Where or from whom do you mainly get this information [about how pregnancy happens and how it can be prevented]? Individuals who did not receive any information on these topics are included in the analysis. Estimates for pooled sample are weighted to give each demographic subgroup equal weight.

Other sources mentioned by one percent or less of the sample: books/magazines, Anganwadi worker, newspapers, siblings, other family members of the opposite sex, the internet, friend or neighbor of the opposite sex, poster/billboard, Vikas Mitra, youth/Mahila Mandal, NGO worker, peer educator, and any other source.

other groups to report receiving information from a family member, with only 17 percent of those exposed reporting that they received information from a family member. Finally, men (married and unmarried) were more likely than women to report receiving information from radio/television and teachers/school. Schools do not provide information on RH information until middle or, more typically, high school, by which point most Mahadalit adolescents have dropped out.⁸

Our qualitative data suggest that the SRH information that Mahadalit adolescents receive is often incomplete or inaccurate. During FGDs with female and male adolescents, moderators facilitated discussions aimed at understanding the type and accuracy of information adolescents are receiving about SRH topics. Our data suggest that the SRH information that adolescents receive is not always constructive, especially for girls. For example, one unmarried woman said that when she started menstruating, her mother simply told her “not to talk to boys.” Another said she told her mother she was bleeding and her mother said “just let it happen.” A program coordinator noted that men usually have a little more information than women on these issues, given that they travel outside of their villages, but stressed that the information they receive is often inaccurate.

C. Knowledge and Beliefs about SRH Topics

MARRIAGE

Reported levels of awareness about the legal age of marriage are low, but most adolescents reported an ideal age of marriage aligned with India’s Prohibition of Child Marriage Act. Across all subgroups, reported awareness of the legal age of marriage is low (Table 3.2). Less than one-third of respondents in any group correctly reported that the legal age of marriage is 18 for girls and 21 for boys, or said they knew there is a legal age of marriage. However, on average, survey respondents’ stated ideal age of marriage corresponds exactly with the minimum ages of marriage set by law. This suggests that respondents are aware of the legal age of marriage, but reluctant to admit to it, given they or their spouse likely married at a young age. (Roughly 96 percent of married women and 82 percent of married men in our sample got married before the legal age cut-off.) Our field notes also corroborate this, with data collectors reporting that many respondents were hesitant to reveal they were married at a young age.

If the reported “ideal age of marriage” reflects respondents’ own preferences, even if it also aligns with the legal age of marriage, our data suggest that married adolescents enter into marriage before they want to. On average, married women in our sample married at age 15 and men at age 18, which is three years younger than the stated ideal age of marriage for each gender. The anticipated story for unmarried adolescents is similar. On average, unmarried women reported that they would like to be married between the age of 18 and 19, but their parents want them to marry about one year earlier. Similarly, unmarried men reported a preference for marrying between the ages of 22 and 23 on average, but that their parents want them to marry about two years earlier.

⁸ One school captured in our qualitative sample reported holding *Meena Manch* sessions for middle school girls, which address questions of biological or hormonal changes, and *Kishori Manch* sessions for high school girls, which cover topics related to health and hygiene and provide information on self-defense and safety issues. (None of the female FGD respondents reported attending these sessions, but none of them are currently in school and most left school before they would have been exposed to these activities). RH issues are covered as part of the general curriculum from 10th grade onwards, but, again, most Mahadalit adolescents drop out well before then. One male FGD respondent did report learning about the menstrual cycle in 10th grade.

TABLE 3.2. KNOWLEDGE AND BELIEFS REGARDING MARRIAGE

Source	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Knowledge related to marriage (%)					
Know legal age of marriage for girls is 18	25	29	23	28	21
Know legal age of marriage for boys is 21	19	19	20	20	15
Know there is a legal age of marriage	31	33	31	30	28
Attitudes about age of marriage (years)					
Age by which a boy should be married	21.3	20.7	21.0	20.7	22.8
Age by which a girl should be married	18.2	17.9	18.1	18.6	18.1
Age by which parents think respondent should be married	19.2	NA	NA	17.8	20.7
Any perceived benefits of delaying marriage (%)					
Gives girls' bodies time to prepare for motherhood	52	55	52	53	49
Gives boys and girls time to prepare for motherhood	27	41	15	37	14
Gives boys and girls time to find employment	26	21	36	16	31
Gives boys and girls time to prepare for married life and parenthood	17	21	20	12	15
Gives boys and girls time to finish education	13	15	5	19	13
Sample Size	1,208	306	188	300	414

Source: Mathematica Sashakt baseline survey.

Notes: Sample sizes accounting for item nonresponse range from 268 to 306 married women, 179 to 188 married men, 263 to 299 unmarried women, and 167 to 413 unmarried men depending on the measure (total sample size ranged from 437 to 1,206 adolescents).

Estimates for pooled sample are weighted to give each subgroup equal weight.

Sample sizes did not vary due to item nonresponse.

NA = Not applicable.

Our qualitative data shed light on parents’ rationales for encouraging early marriage. A program coordinator noted that parents get their daughters married at an early age not only because that is the custom in their communities, but also because they want to “protect their girls” and “make sure they don’t fall into bad company.” Dowry customs also motivate parents to get their daughters married at a young age—parents who have many daughters start arranging marriages early on to avoid having to raise several dowries at once.

Only about half of all Mahadalit adolescents feel there are benefits associated with delaying marriage. Across subgroups, only about half of survey respondents said there were any advantages to delaying marriage (Table 3.2). Among those who believed there were advantages, the most commonly cited benefit by women was that it gives girls’ bodies time to become prepared for motherhood. The most commonly cited benefit by men was that it allows boys and girls time to find employment. Our qualitative data indicate that women also feel they retain their independence longer by marrying at a later age—some unmarried women in our FGDs said they would prefer to live with their parents for longer and “[living] with in-laws feels bad”.

Mahadalit adolescents, and women in particular, feel they have limited control over deciding when to get married, but are hesitant to suggest they should play a larger role in this decision than their parents. Only about a third of all respondents said they were or will be involved in the decision about when to get married (Table 3.3). Men were more likely than women to report having some control over the timing of their marriages, with 55 percent of married men reporting that they had been involved in this decision, compared to 25 percent of married women. Similarly, among unmarried adolescents, 48 percent of men, but only 21 percent of women, said that would tell their parents if they wanted to delay their marriage. Accentuating these gender discrepancies, the vast majority of married

TABLE 3.3. DECISION-MAKING REGARDING MARRIAGE

	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Marriage Timing					
Involved in decision about when to get married (%) ^a	37	25	55	23	44
Would tell parents if they were planning marriage but he/she wanted to wait (%)	35	NA	NA	21	48
Believe that girls should not be allowed to decide when they get married (%)	78	69	91	69	85
Spousal Selection					
Involved in selection of spouse (%)	14	3	24	NA	NA
Met spouse before got married (%)	7	6	8	NA	NA
Would tell parents if did not like chosen spouse (%)	38	NA	NA	22	54
Sample size	1,208	306	188	300	414

Source: Sashakt baseline survey, 2017.

Notes: Subgroup sample sizes did not vary due to item nonresponse. Total sample size ranged from 494 to 1,208 adolescents, based on the demographic groups contributing to each measure. Estimates for pooled sample are weighted to give each subgroup equal weight.

^a This measure combines responses from married men and women to the question "Who mainly took the decision about when you got married?" and from unmarried men and women to the question "Who will mainly take the decision about your marriage?"

NA = Not applicable.

and unmarried women (69 percent) and men (85 to 91 percent) believe that girls should not be allowed to decide when to get married.

Respondents also have limited autonomy in deciding whom to marry. Very few married women (3 percent) and a minority of married men (24 percent) said they were involved in the selection of their current spouse. Furthermore, 7 percent of married respondents had met their spouse before they got married. Among unmarried adolescents, perceived autonomy may be slightly higher, with roughly one-fifth of girls and half of boys saying they would tell their parents if they did not like their chosen spouse. Our FGDs indicate that while most women accept this status quo ("we will marry as they tell us"), men do not. Several male FGD participants expressed frustration about their lack of autonomy in deciding when and whom to marry.

"Whatever the guardian says, the boy has to abide by it. He has to follow the guardian. If the guardian thinks that the boy has come of age and so has the girl, then they need to get married. What can the boy say? He can say something but has to agree in the end."

– Married man

AGE AT FIRST BIRTH

Although a majority of Mahadalit adolescents would prefer to delay childbearing, most succumb to familial pressure to have children immediately after marriage. Across all subgroups, almost all respondents thought that women should be 18 or older before their first birth (Table 3.4). Additionally, around 40 percent of respondents thought a couple should wait two or more years after marriage to have their first child. While this reported preference to delay the first birth suggests married adolescents have a need and desire for FP, FGD respondents report there is overwhelming pressure to have children immediately after marriage in order to "prove one's fertility." One married woman said, "If we don't have a baby early on, our husbands will leave us." Reflecting this social pressure, 75 percent of married women had had at least one child or were pregnant at the time of the survey (Table 3.1).

TABLE 3.4. ATTITUDES RELATED TO AGE AT FIRST BIRTH

	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Believe optimal age at first birth for women is:					
18 or older	95	96	92	98	92
21 or older	22	15	21	22%	32
Believe optimal time after marriage to have a child is 2 or more years	42	44	38	50	35
Perceived benefits of delaying first birth					
Any	53	69	51	56	36
Any benefits to mother	46	63	41	52	26
Any benefits to child	37	52	35	38	25
Sample size	1,208	306	188	300	414

Source: Sashakt baseline survey, 2017.

Notes: Sample sizes accounting for item nonresponse range from 267 to 269 married women, 165 to 175 married men, 260 to 284 unmarried women, and 299 to 349 unmarried men depending on the measure (total sample size ranged from 991 to 1105 adolescents).

With the exception of unmarried men, a majority of adolescents stated at least one broad benefit to delaying childbearing. More than two-thirds of married women and roughly half of married men and unmarried women stated there were benefits to delaying the first birth (Table 3.4). In contrast, only 36 percent of unmarried men were aware of any benefits to delaying childbearing. Most reported that waiting to have a child would make the mother, child, or both healthier overall. Other common benefits mentioned were a mother being more mentally and physically prepared to raise the child and the child being better cared for.

BIRTH SPACING

Nearly all women and more than half of all men reported that the optimal timing between births is two to three years, but qualitative data suggest that many adolescents have not given this much thought. When asked how long they would want to wait after having a child to have the next one, 92 percent of married women and 66 percent of married men said two or more years (Figure 3.2). Rates of support for spacing births by at least two years were similar among unmarried women and men (91 percent and 53 percent; data not shown). In FGDs, moderators asked for adolescents' thoughts on birth spacing in a more open-ended way ("How much time do most women wait between children? Do you

FIGURE 3.2. ATTITUDES ON OPTIMAL AMOUNT OF TIME BETWEEN BIRTHS



Source: Sashakt baseline survey, 2017.

Notes N = 280 married women, 166 married men, 291 unmarried women, and 338 unmarried men (total of 1,075 adolescents). Sample sizes did not vary due to item nonresponse. Estimates are weighted to give each demographic subgroup equal weight. Less than one year category includes respondents indicating consecutive births should occur as soon as possible.



TABLE 3.5. AWARENESS OF BENEFITS OF BIRTH SPACING

	Pooled Sample	Married women	Married men	Unmarried women	Unmarried men
Any benefits (%)	63	76	62	65	50
Any benefits for mother (%)	55	69	54	62	35
Mother will be healthier	40	55	34	51	21
Mother will be more mentally and physically prepared to care for children	19	22	24	17	12
Mother will be able to work	17	17	16	17	15
Reduced risks of pregnancy and delivery complications	9	11	10	10	3
Any benefits for child (%)	55	66	56	58	39
Child will be better cared for	39	42	42	39	31
Child will be healthier/not underweight	32	39	36	35	19
Reduced risk of premature birth	5	12	2	7	1
Sample size	1,208	306	188	300	414

Source: Sashakt baseline survey, 2017.

Notes: Sample sizes did not vary due to item nonresponse. Estimates for pooled sample are weighted to give each demographic subgroup equal weight. Benefits mentioned by less than 5 percent of the pooled sample include reduced risk of abortion or unsafe abortion, reduced risk of infant death, reduced risk of maternal death, mother can complete education, and any other benefits.

think this is the right amount of time to wait? Why or why not?”). This revealed that most adolescent respondents had not given birth spacing much thought, with FGD participants responding to facilitators only after significant probing and often answering haphazardly.

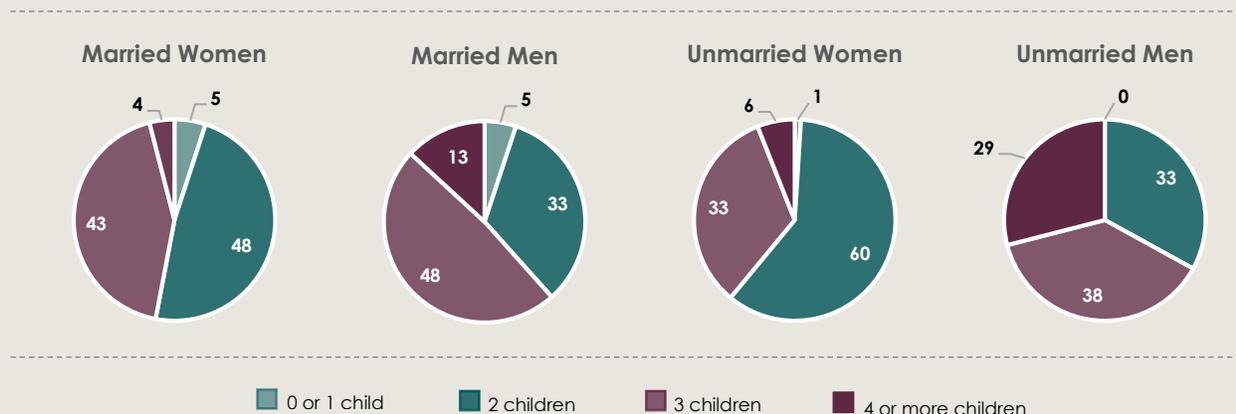
Awareness of the benefits of birth spacing is moderately high, particularly among married women. More than three-quarters (76 percent) of married women and 62 percent of married men said there were benefits to waiting after having one child to have the next child (Table 3.5). Unmarried men were the least aware of the benefits of birth spacing, with only half reporting that there were any benefits. The most highly cited benefit of birth spacing was that the mother will be healthier (reported by 55 percent of married women and 34 percent of married men), followed closely by the child will be better cared for (reported by 42 percent of married women and men) and the child will be healthier or less likely to be underweight (reported by 39 percent of married women and 36 percent of married men). Other benefits mentioned relatively frequently were that the mother will be more mentally and physically prepared to raise children (reported by roughly one-quarter of married adolescents) and that birth spacing allows the mother to work (reported by roughly 16 percent of married adolescents).

Women participating in our FGDs revealed a few other reasons for spacing births. For example, some women thought having a second child too soon could interfere with breastfeeding for the first child. In fact, the second child is often referred to as *Doodh Kattu* or “milk stealer,” because women stop breastfeeding their first child when they become pregnant with their second. A health provider even reported cases of women seeking to abort their second child to ensure there was enough milk for the first. One female FGD respondent also noted that a gap of two to three years was to be expected when men were out of town for a substantial portion of the year.

FERTILITY PREFERENCES

A majority of men, especially unmarried men, want large families of three or more children. Preferences around family size vary substantially by gender. Women in our sample tend to want fewer

FIGURE 3.3. DESIRED NUMBER OF CHILDREN



Source: Baseline survey data, 2017.

Notes: N = 306 married women, 187 married men, 298 unmarried women, and 404 unmarried men (total of 1,194 adolescents). Sample sizes did not vary due to item nonresponse. Estimates for pooled sample are weighted to give each demographic subgroup equal weight.

children than men, with 61 percent of unmarried women and 53 percent of married women reporting that they want two or fewer children (Figure 3.3). In contrast, 61 percent of married men and 67 percent of unmarried men said they want at least three children. Unmarried men expressed a desire for the most children, with around 40 percent saying they would like to have three children and 30 percent saying they would like four or more children. Qualitative data indicate that the number of children a couple chooses to have may be driven by a preference for sons. Female FGD respondents reported that women in their communities generally try to have at least two sons, which leads to additional childbearing if first-born children are girls.

FAMILY PLANNING

Awareness of modern contraceptive methods is relatively high for select methods, including sterilization, oral contraceptives, and condoms. When asked to mention contraceptive methods they knew of, only 16 percent of married women and no more than 6 percent of respondents in other subgroups could name three or more modern methods (Table 3.6). However, after being asked specifically about different methods (for example, “Have you ever heard of oral pills a woman can swallow to prevent pregnancy?”), respondents reported much greater awareness.⁹ When prompted, around 80 percent of married women and 72 percent of married men indicated awareness of three or more modern methods. Not surprisingly, a lower proportion of unmarried adolescents reported awareness of three or more methods, even after prompting (57 percent of unmarried women and 48 percent of unmarried men).

Across all subgroups, most respondents know of female sterilization, which the Indian government has promoted intensively for many decades, but awareness of other modern methods is mixed and varies substantially by gender. For example, 90 percent of married men, but only 50 percent of married women and under 20 percent of unmarried women, said they knew about condoms when prompted. Not surprisingly, levels of awareness of female-controlled contraceptive methods (the pill, injectables, and

⁹ Spontaneous response rates may be very low because respondents were reluctant to reveal they were familiar with contraceptive methods.

TABLE 3.6. AWARENESS OF MODERN METHODS AND METHOD SOURCES, BY SUBGROUP

	Married women	Married men	Unmarried women	Unmarried men
Spontaneously reported awareness of FP methods (%)				
Awareness of 3 or more modern methods	16	5	6	3
Awareness of specific methods:				
Female sterilization	71	22	63	10
Pill	46	21	23	9
Condom	8	37	0	23
Injectables	13	3	8	1
IUD	5	1	2	1
Male sterilization	1	1	1	1
Reported awareness of FP methods after prompt (%)				
Awareness of 3 or more modern methods	81	72	57	48
Awareness of specific methods:				
Female sterilization	98	94	95	86
Pill	83	63	65	39
Condom	50	90	18	73
Injectables	72	42	55	27
IUD	48	6	26	5
Male sterilization	68	36	39	21
Awareness of a place to obtain contraception	76	69	69	47
Sample size	306	188	300	414

Source: Sashakt baseline survey.

Notes: Sample sizes did not vary due to item nonresponse.

IUDs) were highest among married women and lowest among unmarried men. However, awareness rates for IUDs are low across all subgroups, including married women (48 percent) and unmarried women (26 percent).

Our qualitative data highlighted particularly sizeable gaps in awareness of contraceptive methods among unmarried women. For instance, some unmarried women seemed unfamiliar with short-term methods entirely; they appeared to think that sex after marriage automatically led to childbearing unless a sterilization procedure was conducted or an IUD was used.

A small but sizable proportion of Mahadalit adolescents do not know where to obtain contraception. Roughly 25 percent of married women, 30 percent of married men and unmarried women, and 50 percent of unmarried men said they do not know where to obtain contraceptive methods (Table 3.6).

Women’s perceived level of autonomy in contraceptive decision-making is relatively high, though actual levels of autonomy may be more limited. We asked survey respondents about how they make decisions regarding FP and contraceptive use, and administered a series of questions to understand “contraceptive self-efficacy.” More than 80 percent of married women believe that whether or not to use contraception should be a joint decision, and around 60 percent said they had discussed FP with their husbands in the past three months (Table 3.7). Interestingly, only 19 percent of married men in our sample said that they had discussed FP with their wives over the same time period. This discrepancy may reflect some differences in how men and women understand the concept of FP. For example, men may understand FP to mean contraception and women may understand it to mean decision-making around when to have children and how many children to have. Responses to the series of questions on

TABLE 3.7. AUTONOMY IN CONTRACEPTIVE DECISION-MAKING AND USE

	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Decision making regarding family planning (%)					
Believe contraceptive use should be a joint decision between husband and wife	79	82	77	NA	NA
Discussed FP with spouse in past three months	41	63	19	NA	NA
Self-efficacy with regard to contraceptive use (%)					
Believe could initiate discussion with husband about FP	84	89	NA	80	NA
Believe practicing contraception is their own decision	47	51	NA	43	NA
Believe they can use contraception if they want to, no matter what	53	60	NA	47	NA
Believe their husbands will support them in decisions about contraception	NA	67	NA	NA	NA
Believe they could buy contraception even if their husbands do not give them money	NA	43	NA	NA	NA
Allowed to go unescorted to friend's house or shops	83	81	NA	85	NA
Sample size	1,208	306	188	300	414

Source: Sashakt baseline survey.

Notes: Sample sizes did not vary due to item nonresponse. Total sample size ranged from 306 to 794 adolescents, based on the demographic groups contributing to each measure. Estimates for pooled sample are weighted to give each demographic subgroup equal weight.

NA = Not applicable.

contraceptive self-efficacy suggest that women’s perceived levels of autonomy in contraceptive decision-making and use are moderately high. For example, more than 80 percent of married women reported that they could initiate a discussion of the topic with their husbands, so a large fraction of those who did not recently discuss FP with their husbands may have chosen not to because they saw no reason to do so (for example, because their husbands are away for work or they are actively trying to conceive), not necessarily because they felt they could not raise the issue.

When asked specifically about their ability to directly control their contraceptive use, responses again indicated higher than expected levels of autonomy. About half of married and unmarried women responded that practicing contraception is their decision alone and that they could use contraception if they wanted to, “no matter what” (Table 3.7). Two-thirds of married women believe their husbands will support them in decisions about contraception.

Responses to some survey questions indicate that autonomy may be lower than it is perceived to be by Mahadalit adolescent women. For instance, only 43 percent of married women said they could buy contraception without money from their husbands, and about 20 percent of married women and 15 percent of unmarried women said they are not allowed to leave their homes unescorted to visit shops or friends’ homes (Table 3.7). In addition, as mentioned above, one quarter of married women do not know of a place to obtain contraception.

GENDER-BASED VIOLENCE AND GENDER NORMS

Most Mahadalit adolescents feel it is permissible for a man to beat his wife in at least some circumstances. Around three-quarters of respondents said a man is allowed to beat his wife if she is unfaithful, and around half said this is permissible if she does not listen to or obey her husband. Other situations in which respondents tended to feel beatings were acceptable are when the woman goes out without permission and if she disagrees with her husband (around 40 percent thought violence was

TABLE 3.8. GENDER-BASED VIOLENCE AND GENDER NORMS

	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Gender-based violence (%)					
Share believing that it is acceptable for a husband to beat his wife if she:					
Is unfaithful	73	64	77	71	79
Doesn't listen to or obey her husband	54	41	67	43	64
Goes out without permission	44	40	46	42	48
Disagrees with her husband's opinion	40	35	42	36	48
Refuses to have sex	34	21	45	23	47
Gender Norms (%)					
Share believing that:					
Girls do not require education because they get married	48	59	37	55	38
It is necessary to give a dowry	61	72	46	69	59
Giving the children a bath and feeding the children are women's responsibility only	50	68	27	68	37
A woman should obtain her husband's permission for most things	74	78	70	77	70
Sample size	1,208	306	188	300	414

Source: Sashakt baseline survey.

Notes: Sample sizes did not vary due to item nonresponse. Estimates for pooled sample are weighted to give each demographic subgroup equal weight.

permissible in these cases) (Table 3.8). Views tended to be similar for married and unmarried women and for married and unmarried men, but men were slightly more likely to consider this practice acceptable. Opinions differed more around whether a man is permitted to beat his wife if she refuses to have sex—almost half of all men felt this was acceptable, compared with less than a quarter of all women.

Mahadalit adolescents, and particularly women, seem to have a narrow view of the role women should play in their families and communities. The majority of married and unmarried women (between 55 and 72 percent) agreed with statements claiming that girls do not require higher education because they get married, providing a dowry is necessary, and bathing and feeding children are a woman's responsibility alone (Table 3.8). Interestingly, men were considerably less likely to agree with these statements than women. For example, only 37 percent of married men thought that girls do not require education, compared to 59 percent of married women. Across all subgroups, most respondents agreed that a woman should obtain her husband's permission for most things, with rates of agreement ranging from 70 to 78 percent across subgroups.

ABORTION

Very few Mahadalit adolescents are aware that abortion is legal. Only 8 percent of Mahadalit adolescents indicated they knew that abortion is legal (with little variation across subgroups, Table 3.9).

TABLE 3.9. AWARENESS RELATED TO ABORTION

	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Aware that abortion is legal (%)	8	9	11	6	8
Aware of risks of unsafe abortion (%)	55	78	54	49	39
Sample size	1,208	306	188	300	414

Source: Sashakt baseline survey.

Notes: Sample sizes did not vary due to item nonresponse. Estimates for pooled sample are weighted to give each demographic subgroup equal weight.

However, over half know about the risks of unsafe abortion. Levels of awareness are highest among married women, 78 percent of whom indicated awareness of the risks of unsafe abortion. Levels of awareness were lowest among unmarried men, only 39 percent of whom knew of these risks.

D. USE AND QUALITY OF FP/RH SERVICES

In this section, we explore Mahadalit adolescents’ experiences with and perceptions of health services, with a focus on married women’s access to maternal health (MH) and FP/RH services through ASHAs, a key change agent under the Sashakt program. We also explore the existence and use of adolescent health services available to Mahadalit adolescents in our sample, particularly those being rolled out under RKSK.

RECEIPT OF MATERNAL AND REPRODUCTIVE HEALTH SERVICES

We first explore receipt of MH services, a key conduit for provision of FP/RH information and services, among married Mahadalit women who have had at least one live birth.

TABLE 3.10. RECEIPT OF ANTENATAL & DELIVERY CARE AMONG MARRIED WOMEN WITH ANY CHILDREN BORN ALIVE

Most	Percent
Receipt of ANC during most recent pregnancy	
Received ANC	96
Received ANC 3 or more times	19
Received ANC in first trimester	74
Location of last birth	
Home	30
Public facility	64
Private facility	6
Any advice on FP received from ASHA	
Before last birth	3
After last birth	5
Sample size	197

Source: Sashakt baseline survey, 2017.

Notes: Sample size accounting for item nonresponse ranges from 192 to 197.

Nearly all married women who had begun childbearing had received antenatal care (ANC) during their most recent pregnancy, and many gave birth at a health facility, but provision of information on FP during these key “touch points” was very limited. Among married women who had at least one live birth, 96 percent received ANC during their most recent pregnancy and 70 percent delivered at a health facility (Table 3.10). However, very few reported receiving FP information in the course of the antenatal and delivery care they received. Only 3 percent reported receiving advice on FP before their last birth from the ASHA, who conducts ANC visits and accompanies women to the PHC for delivery, and only 5 percent received advice on FP after their last birth.

TABLE 3.11. FREQUENCY OF ASHA VISITS TO MARRIED WOMEN WHO ARE CURRENTLY PREGNANT OR GAVE BIRTH IN THE PAST 3 MONTHS

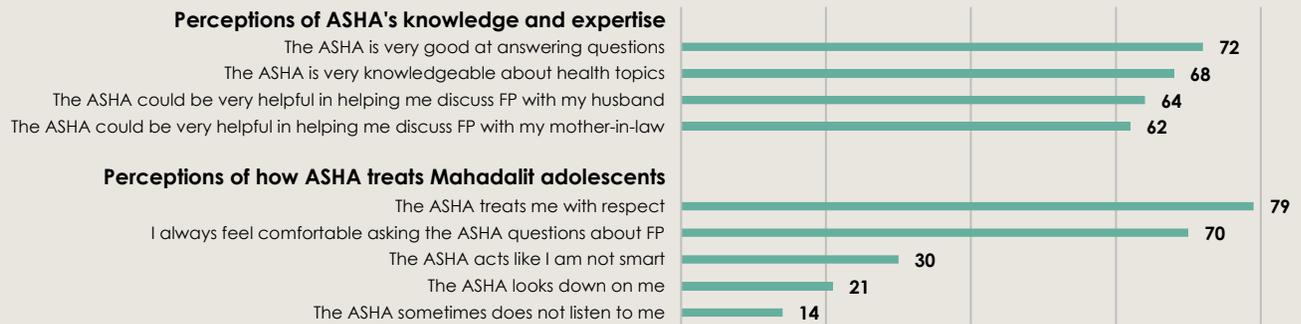
	Percent/ mean	N
Met with ASHA in past 3 months (%)	44	93
Average number of interactions with ASHA (among those who met with the ASHA in past 3 months)	2.1	41

Source: Sashakt baseline survey, 2017.

FREQUENCY AND QUALITY OF RECENT INTERACTIONS WITH FLWS

Next, we sought to gain a deeper understanding of the scope and quality of FLW service provision by examining recent interactions (over the past three months) between FLWs and married adolescent women. Because interactions with ASHAs largely occur from the antenatal to postnatal period, this section focuses on married women who are currently pregnant or gave birth in the past three months.

FIGURE 3.4. MARRIED WOMEN'S PERCEPTIONS OF THE ASHA



Source: Sashakt baseline survey, 2017.

Notes: N = 92 married Mahadalit female adolescents who had met with ASHA in the past three months. Sample sizes did not vary due to item nonresponse. Measures based on survey questions adapted from Peek, Monica E., Marcella Nunez-Smith, Melinda Drum, and Tené T. Lewis. "Adapting the everyday discrimination scale to medical settings: reliability and validity testing in a sample of African American patients." *Ethnicity & Disease* 21, no. 4, 2011: pp. 502-509.

Less than half of married Mahadalit adolescents who are pregnant or gave birth in the past three months met with an ASHA recently. Almost 45 percent of married women who are currently pregnant or gave birth in the past three months met with the ASHA in the past three months (Table 3.11). On average, these women met with the ASHA twice in this time period.

The ASHAs we interviewed reported conducting group meetings with young women and girls following the monthly village health, sanitation, and nutrition days. At these meetings, they reported sharing information on nutrition, hygiene, and disease prevention, promoting sterilization, and providing condoms and pills. However, none of the adolescent women participating in our FGDs reported participating in such meetings.

Many married women believe their local ASHA is helpful and knowledgeable, but a few also feel she looks down on them. Married women's views about the ASHA's knowledge and expertise are largely positive (Figure 3.4). Roughly 70 percent of married women who had met the ASHA in the three months prior to the survey think she is very good at answering questions and knowledgeable about health topics, and slightly more than 60 percent feel the ASHA could provide useful assistance in helping them discuss FP with their husbands or mothers-in-law (two key household influencers of birth timing and spacing decisions). Perceptions of how the ASHA treats Mahadalit adolescents are also mainly positive, with almost 80 percent noting that the ASHA is respectful. At the same time, three in ten married women feel that the ASHA does not think they are smart and about two in ten feel she looks down on them. This might be indicative of widely held community biases against Mahadalits (see below).

Our qualitative findings provide additional insight into the quality of services provided by FLWs:

Interviews with FLWs suggest they have an uneven grasp of key messages related to FP/RH. Our interviews indicate that ANMs and ASHAs know that the recommended spacing between births is three years. However, opinions about when to get married, when to start having children, and how many children to have were haphazard and often vague. For instance, one ASHA said, "Girls should get married only after reaching the physical maturity of having kids." In another example, an ANM reported that she tells women not to have more than three children. A program coordinator noted that ASHAs are

“These are Mahadalit, low caste people, they don’t understand and are poor...they live in an unclean environment, and don’t have enough food to eat. They don’t understand about diseases and health.”

– ANM

“They are illiterate and uncivilized. They don’t know when to get married...They don’t understand what a condom is. They are stupid.”

– ANM

“The thing is that in Mahadalit tolas, even when we explain things, they don’t want to understand. Why, I don’t know.”

– ANM

typically less focused on FP methods other than sterilization, which is financially incentivized. He further noted that most ASHAs equate family planning with sterilization.

ASHAs may have low motivation. Several ASHAs reported not receiving the financial incentives they are due for promoting sterilization and IUDs. This has negative implications for their commitment to their work and for the quality of their services. One ASHA asked rhetorically why she should visit the Mahadalit community or do her job at all.

ANMs have very negative perceptions of Mahadalits. During interviews, ANMs used words like “stupid” and “uncivilized” to describe Mahadalits, and linked their poor health behaviors to lack of education, poverty, and unsanitary environments. ASHAs did not generally voice these sentiments in their interviews. While ASHAs noted that Mahadalits are poorly educated, they seemed to be less openly biased against Mahadalits than ANMs. That said, and as mentioned above, between 20 and 30 percent of married Mahadalit women who had recently interacted with an ASHA felt the ASHA had a negative perception of them.

EXISTENCE AND USE OF ADOLESCENT HEALTH SERVICES

Finally, we examined the extent to which Mahadalit adolescents are drawing on adolescent health services available through the public sector.

TABLE 3.12. USE OF ADOLESCENT HEALTH SERVICES

	Percent
Attended a group training on sexual and reproductive health	1
Attended peer session in past three months or otherwise spoke to peer educator	0
Heard of Adolescent Friendly Health Center	3
Sample size	1,208

Source: Sashakt baseline survey, 2017.

Notes: Estimates are weighted to give each demographic subgroup equal weight. Sample sizes did not vary due to item nonresponse.

Very few Mahadalit adolescents are aware of or have used services at the block-level AFHC.

Receipt of key adolescent health services is limited, which is to be expected given services to be provided under RKSK and the Sashakt program have not been rolled out yet. Only 1 percent of all Mahadalit adolescents surveyed said they have attended a group training on SRH and none have interacted with a peer educator, both key elements of the Sashakt program (Table 3.12). Only 3 percent have heard of AFHCs, which are supposed to be established at the PHC as part of RKSK. The AFHC in the study block is currently not operational

because the PHC is partially under construction. Regardless, PHCs may have limited ability to address the health needs of Mahadalit adolescents in our sample given the remoteness of Mahadalit *tolas* (our field team reports that the *tolas* they visited were often 3 to 5 kilometers from a paved road, which significantly limits the access of these communities to key services).¹⁰

E. CONTRACEPTIVE USE

FIGURE 3.5. CONTRACEPTIVE USE BY MARRIED ADOLESCENTS

Any method	16 percent ever used 10 percent use currently
Any modern method	10 percent ever used 5 percent use currently
SPECIFIC METHODS USED	
Condoms 	7 percent ever used 3 percent use currently
Rhythm 	6 percent ever used 3 percent use currently
Withdrawal 	3 percent ever used 1 percent use currently
Pills 	3 percent ever used 1 percent use currently
LAM 	1 percent ever used 1 percent use currently

Source: Mathematica Sashakt baseline survey.
 Notes: N = 306 married women and 188 married men (total of 494 married adolescents). Sample sizes did not vary due to item nonresponse. Estimates are weighted to give demographic subgroups equal weight.

In this section, we discuss use of contraceptive methods by Mahadalit adolescents. These measures focus on married adolescents (we did not ask unmarried adolescents questions about contraceptive use). Because married women and men are each reporting on the couple's use of contraceptives, and we did not sample couples as a unit, some contraceptive use measures are based on a pooled sample of married women and men. While it is possible men may not be aware that their wives are using contraceptives, levels of reported contraceptive use are similar across men and women, which suggests that men are a fairly reliable source of reporting on contraceptive use within married couples in this context (data available upon request).

Reported use of contraception is low among married Mahadalit adolescents. Pooling the samples of married men and women, only 16 percent of married adolescents in our sample have ever used a contraceptive method and 10 percent have ever used a modern method (Figure 3.5). Rates of current contraceptive use are similarly low, with only 10 percent of married adolescents reporting current use of any method and 5 percent reporting current use of a modern method.

Condoms, pills, and traditional methods are the most commonly used contraceptive methods among married Mahadalit adolescents. Based on the pooled sample of married men and women, 7 percent of married adolescent couples have ever used a condom, 6 percent have ever used the rhythm method, 3 percent have ever used withdrawal, and 3 percent ever used the pill (Figure 3.6). Rates of current use were between 1 and 3 percent for each of these methods. Only one married survey respondent had undergone tubal ligation, but discussions about contraception with both male and female Mahadalit adolescents generally revolved around

¹⁰ The PHC in this block is also limited in its ability to serve Mahadalit adolescents because of other limitations in capacity. It faces severe staffing shortages given its remote location, and is led by a medical officer who does not have the MBBS qualification required of the position and runs his own private practice next door to the PHC.

TABLE 3.13. SOURCE OF CONTRACEPTIVE METHODS AMONG MARRIED WOMEN CURRENTLY USING A METHOD

	Percent
ASHA	6
ANM/government worker	6
Government dispensary, PHC, hospital	3
Private shop	45
Private doctor	23
Private hospital	3
Other	4
Sample size	31

Source: Sashakt baseline survey, 2017.

Notes: Sample sizes did not vary due to item nonresponse.

eventual sterilization for women as the main means of FP. Many female FGD respondents indicated that they would “keep having children” until they had two sons and then would undergo sterilization (tubal ligation is also financially incentivized for recipients, with women receiving Rs. 1,400 for undergoing the procedure).

Most married women currently using contraceptive methods obtain them from private doctors or private shops. The most common sources of contraception among married women currently using a method are private shops and doctors, which are often located within or close to villages and therefore relatively easy to access (Table 3.13). Forty-five percent obtained the contraceptive they are currently using from a private shop and about a quarter obtained it from a private doctor. Receipt of contraception from public sector sources such as ASHAs, ANMs, and government health facilities is very limited, likely due to the issues of access and perceived quality discussed above.¹¹

Most women reported an intention to use a contraceptive method in the future, with 50 percent of married women reporting an intention to use contraception in the next 12 months. Almost 90 percent of married and unmarried women reported that they intend to use a contraceptive method at some point in the future (Table 3.14). About half of married women report intentions to use a

TABLE 3.14. INTENTION TO USE AN FP METHOD IN THE FUTURE

Source	Pooled sample	Married women	Married men	Unmarried women	Unmarried men
Intend to use a FP method (%)					
Ever	71	87	65	88	47
In next 12 months	42	52	31	NA	NA
To delay the first pregnancy after marriage	44	NA	NA	63	26
Sample size	1,208	306	188	300	414

Source: Mathematica Sashakt baseline survey.

Notes: Sample sizes accounting for item nonresponse range from 275 to 306 married women and 267 to 300 unmarried women (total sample size ranged from 494 to 1,144 adolescents). All married and unmarried men responded to all relevant measures in this table. Estimates for pooled sample are weighted to give each subgroup equal weight.

We asked married women the following questions – “Do you think you will use a contraceptive method to delay or avoid pregnancy in the next 12 months?” And “Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?”

We asked married men the following questions – “Do you think you or your wife will use a contraceptive method to delay or avoid pregnancy in the next 12 months?” and “Do you think you or your wife will use a contraceptive method to delay or avoid pregnancy at any time in the future?”

We asked unmarried women the following questions – “Do you think you will practice contraception after you get married in order to delay your first pregnancy?” And “Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?”

We asked unmarried men the following questions – “Do you think you will practice contraception after you get married in order to delay your wife’s first pregnancy?” And “Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?”

NA = Not applicable.

¹¹ We do not provide data on this measure for married men, because only one man provided a response on where he obtained the contraceptive method he was currently using.

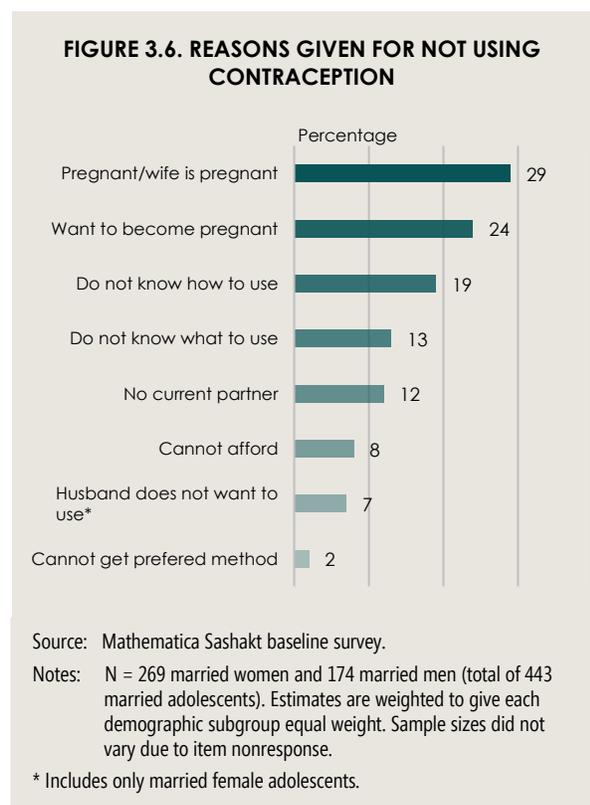
contraceptive method within the next year. Intentions to use contraception were lower among adolescent men, with 65 percent of married men reporting that they or their wives intend to use a contraceptive method at some point in the future, and 47 percent of unmarried men reporting an intention to ever use a contraceptive method. Only 31 percent of married men reported that they or their wives intend to use contraception in the next 12 months. High intentions to use contraception among married women may reflect a desire to eventually use female sterilization to limit family size, mentioned frequently in the FGDs. It may also reflect married women’s plans to use contraception when their husbands return home (the survey was conducted at a time most married men were out of town for work).

Pregnancy, migration, and desire to get pregnant are the main drivers of low contraceptive use.

In total, 29 percent of married respondents were either pregnant or had a pregnant partner at the time of the survey, and 12 percent reported that they do not need to use a contraceptive method because they do not have a sexual partner (presumably, this is due to a spouse being away from home) (Figure 3.6). In addition, 24 percent of both married men and women respondents not currently using contraception want to have children soon.

There are a variety of potential barriers to using contraception, including limited knowledge around contraceptive methods and limited access to services.

In particular, 19 percent of the pooled sample of married women and married men said they do not know how to use contraception and 13 percent reported not using contraception because they do not know which method to use (Figure 3.6). The qualitative data further reveal that misconceptions about birth control methods might impede use. Respondents said they believe IUDs and pills can cause cancer and other diseases. Pills were reported to cause infertility or make respondents hot and there was concern about IUDs traveling into the stomach. (These misconceptions were shared by both men and women.)



Additionally, a small proportion of married women (7 percent) reported not using contraception due to their husbands’ objections (Figure 3.6). The ANMs interviewed believe this is a serious barrier for many Mahadalit women. One ANM said that Mahadalit women claim that “their husbands would not understand” if they wanted them to use condoms. Another stated that Mahadalit women typically believe men will be against using condoms.

Other important barriers to contraceptive use not captured in the survey data emerged during the FGDs and IDIs. The most commonly discussed barrier during these conversations was that Mahadalit women do not have the time to seek and obtain contraception. Most adolescent female FGD respondents reported working long hours in the fields, especially during harvest season, allowing them little time to visit a facility and obtain contraception. Women’s lack of comfort with discussing FP also impedes use. Women reported being shy about asking male doctors questions about health problems and that male family

members often approach doctors on their behalf. ANMs and ASHAs also reported that, while they are sometimes asked for contraception by Mahadalits, women are often shy and hesitant to ask questions. This could promote inconsistent use and the aforementioned misconceptions around the dangers of contraceptive use.

4. DISCUSSION AND IMPLICATIONS

Below we summarize key findings and discuss the implications of baseline results for the Sashakt program.

A. Summary of Key Findings

- **Access to reliable information on SRH topics is low, particularly among adolescent men, with most adolescents relying primarily on friends and family.** Levels of exposure to information on pregnancy and childbearing are considerably higher among married adolescents, and highest among married women, three-quarters of whom have already begun childbearing. However, there are marked differences by gender. Women were more than twice as likely to report receiving information on SRH topics than their male counterparts, with only one-fifth of unmarried men reporting any exposure to information on these topics. Across all groups, adolescents rely primarily on friends and family for information, with qualitative data suggesting the information they receive is often incomplete or inaccurate.
- **Mahadalit adolescents tend to marry very young and before their preferred age of marriage, but have little say over when or whom they marry.** The average age of marriage in our sample is 15 for women and 18 for men, both three years below the minimum legal age of marriage. Our data suggest that adolescents may be aware of the legal age of marriage, but reluctant to admit to it because of the high prevalence of early marriage in their communities. Married adolescents indicated they would have preferred to marry later, and unmarried adolescents said they would prefer to wait beyond the legal age of marriage. However, adolescents, and particularly women, appear to have little say in when they marry. Moreover, qualitative data suggest that adolescents accept that marriage timing is a decision made primarily by parents or guardians, though about one-half of married men said they had some say in the timing of their own marriage. Strikingly, the vast majority of adolescents believe that girls should not be allowed to decide when to get married. This acceptance of the status quo may stem, in part, from low awareness of the benefits of delaying marriage, with only one-half of respondents reporting any benefits to delaying marriage.
- **Women have more supportive attitudes than men toward HTSP, with unmarried men being the least supportive, but knowledge about HTSP is low overall, and social pressure to begin childbearing immediately after marriage is high.** Across all subgroups, almost all respondents said that women should be at least 18 years of age before their first birth, with one-fifth saying that women should be at least 21. With the exception of unmarried men, a majority of adolescents stated at least one broad benefit to delaying childbearing; however, levels of awareness are considerably higher for married women than other groups. While there is some support for delaying first births, only one-half of women and fewer men thought a couple should wait a full two years before having a child.

A similar pattern of gender differences emerged for birth spacing, whereby nearly all women but only about one-half of men reported that the optimal timing between births is two years or more. Perhaps more notably, one-half of married women reported that optimal birth spacing is three years compared to one-tenth of married men. Similarly, most married women mentioned at least one benefit to birth spacing, versus 50 to 65 percent of adolescents in other groups. However, although reported awareness of the benefits of HTSP is high among married women, our FGDs reveal that

adolescents have not thought much about birth timing and spacing, as they feel compelled to succumb to strong social pressure to have children immediately after marriage.

- **Adolescent women tend to want fewer children than men, with unmarried men wanting the most children.** A majority of men (over 60 percent), and particularly unmarried men, expressed a desire for three or more children, compared to roughly 40 percent of adolescent women. Notably, one-third of unmarried men said they would like four or more children. Qualitative data indicate that the number of children a couple chooses to have may be driven by a preference for sons, with many respondents indicating that communities support couples having at least two sons.
- **Awareness of modern contraceptives is relatively high for select methods, but conceptualization of FP seems to center on eventual sterilization, and a sizable share of adolescents do not know where to obtain contraception.** When prompted, most married adolescents said they were aware of three or more modern contraceptive methods. Not surprisingly, awareness of modern methods is considerably lower among unmarried adolescents. Across all subgroups, most respondents know of female sterilization, but awareness of other modern methods is mixed and varies substantially by gender. For example, almost all married men, but only half of married women and one-fifth of unmarried women said they knew about condoms. Our qualitative data highlighted particularly large gaps in awareness of modern methods among unmarried women, with some seemingly unfamiliar with short-term methods entirely, and many thinking that sex after marriage automatically leads to childbearing unless a sterilization procedure is conducted. In addition, a sizable share of married adolescents (25 to 30 percent), and one-half of unmarried men, said they did not know where to obtain contraceptives. Furthermore, less than 10 percent of adolescents knew that abortion is legal.
- **Respondents' attitudes toward GBV and gender roles suggest highly inequitable gender norms in Mahadalit communities, which contrasts with women's perceived autonomy in contraceptive decision-making.** Three-quarters of respondents said a man is allowed to beat his wife if she is unfaithful, and half said this is permissible if she does not listen to or obey her husband. A large share also said beatings are acceptable when the woman goes out without permission and when she disagrees with her husband. Opinions were similar for women and men, with the exception of beatings when a wife refuses to have sex with her husband, with almost half of all men thinking this is acceptable, compared with less than one quarter of all women. Similarly reflecting women's status, a majority of women agreed with statements claiming that girls do not require higher education because they get married, providing a dowry is necessary, and bathing and feeding children are a woman's responsibility alone. Interestingly, men were considerably less likely to agree with these statements than women. However, across all subgroups, most respondents agreed that a woman should obtain her husband's permission for most things.

These findings stand in contrast to adolescent women's views on their current or potential role in contraceptive decision-making. Most married women believe that whether or not to use contraception should be a joint decision, with many (60 percent) saying they had discussed FP with their husbands in the past three months. Furthermore, about one-half of all women said that practicing contraception is their decision alone and that they could use contraception if they wanted to "no matter what". Most married women believe their husbands will support them in decisions about contraception. However, responses to some survey questions indicate that women's autonomy may be lower than they perceive it to be. For example, only 40 percent of married women said they could buy contraception without money from their husbands. Issues around women's autonomy and

contraceptive self-efficacy, and how they affect contraceptive decision-making and behaviors, will be explored further in the next round of data collection.

- **Mahadalit adolescents have limited interaction with the health care system, with the exception of married women, who generally have positive views of FLWs, with some notable exceptions.** In general, Mahadalit adolescents have limited interactions with the health care system, in part because they tend to live in remote and relatively isolated communities. One exception is married adolescent women who have children, nearly all of whom received at least one ANC visit from the ASHA during their most recent pregnancy and around 70 percent of whom delivered at a health facility. Married women have mixed views about the services that are provided by FLWs. While roughly 70 percent of married women who met with the ASHA in the past three months think she is knowledgeable about health topics, around 30 percent feel she does not think they are smart and 20 percent feel she looks down on them. These views may reflect widely prevalent discriminatory attitudes toward Mahadalits. ANMs have particularly negative views, using words like “stupid” and “uncivilized” to describe this population.

B. Program Implications

- **More intensive sensitization and tailored messaging may be needed for Mahadalit adolescent men.** Given that a substantial proportion of men (and particularly unmarried men) exhibited considerably lower levels of knowledge and more negative attitudes toward SRH issues than women, the Sashakt program may want to intensify its sensitization activities for men, and ensure that its trainings and other activities are responsive to male migration patterns. Regarding the latter, our data suggest that a large share of married and unmarried men migrate for work for long periods, typically returning in March and November. Given this, scheduling Sashakt trainings for married couples and unmarried adolescent men in these months may expand the program’s reach within this critical population. In addition, because migration may constrain the ability of men to engage in on-going sensitization activities under the program, such as peer education meetings, it may be beneficial to extend the length of the trainings targeting men (to ensure that the program is intensive enough to spur changes in this population). In the case of married men, this may mean holding a separate training for married men, in addition to the one-day training for married couples. Finally, the program may want to consider tailoring its curricula and messaging further to ensure that it adequately addresses men’s limited knowledge and less supportive attitudes related to HTSP and FP. Specifically, Sashakt could consider (1) broadening and deepening its focus on these topics during its trainings for men and couples, as well as during outreach activities and (2) addressing in its sensitization efforts the widespread social norm of “son preference,” which our qualitative data show is a key factor driving family size.
- **The SRH trainings may benefit from integrating a “preparation for migration” module, which discusses how migration can lead to ineffective FP use, frequent childbearing, and risky sexual practices.** Male migration has significant implications for HTSP and contraceptive use. First, seasonal migration appears to lead to low or irregular contraceptive use; for example, one woman reported taking oral contraceptives only when her husband was in town. Migration may also be a driver of frequent childbearing; several FGD respondents noted that men want to conceive a child each time they come home. Finally, extended migration, as is common among Mahadalit men, is associated with risky sexual practices among male migrants while they are away. This can increase the prevalence of HIV and other STIs among male migrants and their spouses. These issues may need to be explicitly addressed in Sashakt trainings, perhaps in a standalone module focused on migration.

- **The program may benefit from engaging key gatekeepers and community leaders, who play a critical role in decisions related to marriage and childbearing.** Working with Mahadalit adolescents alone may not be effective in tackling a key barrier these young people face in making healthy marriage and childbearing decisions: pressure from parents, in-laws, and the community writ large to marry and have children as early as possible. FGD participants reported that adolescents often succumb to this pressure, despite their own preferences to delay marriage and childbearing. To address this issue, Sashakt may benefit from expanding its sensitization efforts to parents, in-laws, and other community members and gatekeepers (such as village elders).
- **Limited acceptance of gender equality among Mahadalit adolescents—which can restrict women’s autonomy in making SRH decisions—needs continued and targeted attention from the program.** Mahadalit adolescents revealed several negative, but not unexpected beliefs, about women’s role in marriage decisions, the household, and the broader community, as well as women’s right to education and the acceptability of domestic violence. These views underscore the limited autonomy and mobility of Mahadalit women. Embedding a strong focus on gender norms and equality in the SRH/life skills trainings, and reinforcing these messages repeatedly through ongoing sensitization, may help change gender attitudes and norms over time.
- **Contraceptive awareness is limited to only select FP methods, and could be expanded.** There is a high level of awareness around sterilization, given the Indian government has been promoting sterilization for many decades and that the procedure is financially incentivized (for both FLWs and women). Other methods Mahadalit adolescents know about are oral contraceptives and injectables. Awareness of other modern methods, such as condoms, injectables, and IUDs, is very uneven. Sashakt has the opportunity to expand awareness and promote use of these modern methods.
- **Strengthening contraceptive self-efficacy among women, and dismantling misconceptions around the harmful effects of some methods, could increase contraceptive use.** Outside of pregnancy, married adolescents said they have not used contraception because (1) they did not know how to, (2) they did not know which contraceptives to use, or (3) they were concerned about the potentially harmful side effects of using contraceptives. The SRH trainings are providing important information to adolescents on contraceptive choices available to them, and how to use these methods. They could also address the misconceptions Mahadalit adolescents have about some methods and thereby foster increased contraceptive use among couples seeking to delay or prevent pregnancy. Contraceptive use is one realm of decision-making where married women feel like they have (or should have) more control. The program should leverage existing (positive) perceptions of contraceptive self-efficacy to encourage and empower women to seek contraceptive methods that meet their FP needs and preferences.
- **High workloads and low motivation among ASHAs may compromise their effectiveness as a vehicle to increase Mahadalit adolescents’ interaction with the public health system, and access to SRH services in particular.** Our data suggest that Mahadalit adolescents have very limited interaction with the public health care system. Increasing this even slightly could help create an enabling environment where, with successful demand generation efforts, utilization of FP/RH services may increase. Encouraging adolescents to visit PHCs is a potential strategy, but one that may not succeed given the remoteness of Mahadalit *tolas* and existing capacity constraints at PHCs. The answer may lie in increasing access to community-based services, though this too will present challenges. ASHAs already have a full workload between conducting home visits to pregnant women and new mothers, accompanying women to the facility for deliveries and sterilization, and

organizing VHSNDs or immunization days in their villages. Our interviews suggest that they may be disinclined to take on more work, regardless of whether it entails home visits to married adolescents in faraway Mahadalit *tolas* or helping peer educators with group meetings for unmarried adolescents. Sashakt may want to consider integrating strategies to incentivize ASHAs to expand their portfolio.

- **FLW discrimination against Mahadalits is prevalent, and could be addressed in trainings for ASHAs and ANMs and through ongoing capacity-building.** A key reason Mahadalit adolescents may not be taking advantage of community-level services is that service providers exhibit high levels of discrimination against Mahadalits. Views shared by ANMs, as mentioned, are particularly pernicious, and may be difficult to dismantle in the short term. Still, the program could benefit from adopting strategies to at least start to shift these attitudes among health workers, and thereby gradually increase Mahadalits' level of comfort with approaching these service providers.

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