



**Behavioural and  
social determinants  
of maternal, child  
and adolescent  
health and nutrition  
in select areas of  
Kolkata, Howrah and  
Hooghly**

**Rapid Assessment Study Report**

**December 2018**

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# 1. Introduction





## About the Community Partnerships Project

ITC, a diversified business conglomerate believes that the performance of business enterprises must be measured in terms of the value they create for the society. ITC's Social Investment Programme christened "Mission Sunehra Kal" (ITC MSK) aims to transform the lives of its community to live a life of dignity and envisages achieving "Adarsh Habitation" through a holistic approach with the goal of empowering stakeholder communities to promote sustainable livelihoods. Towards this end its "stakeholder representation cuts across rural and urban milieus and targets rural communities residing in the business vicinity with whom ITC is involved in agri-businesses & communities residing in close proximity to production units, situated in urban and rural locations". The "current basket of interventions" is based on addressing "the twin challenges of securing sustainable livelihoods today and tomorrow" and calls for an integrated response comprising several layers of interventions. ITC's Social Investment Programmes accesses knowledge/ technical knowhow, leverages' government partnership and focuses on core operational geographies to promote all-inclusive development aligned to national priorities and goals.

In West Bengal, ITC MSK is being implemented in rural and urban areas of Kolkata, Howrah and Hooghly through expert NGO partners to overcome the social problems related to health & nutrition; education; water, sanitation and hygiene (WASH); waste Management; livelihoods etc.

YouthInvest Foundation, the maternal, child health and nutrition programme partner of ITC MSK, is implementing the "Community Partnerships" project that aims to improve the maternal, newborn, child and adolescent health and nutrition (MNCHN) through a community-led targeted approach for young couples and adolescents focusing on behaviour change. The project operates in select vulnerable pockets of Kolkata, Howrah and Hooghly with poor socio-economic indicators and high child malnutrition.

YouthInvest Foundation's (YouthInvest) mission is to empower young people (10-29 years) in reaching productive lives by creating and facilitating opportunities that enable them to participate in activities that ensure their rights to health, education and livelihoods. YouthInvest believes life skills to be foundational and essential for young people in understanding, negotiating and mediating everyday challenges and risks, and preparing them for adulthood as responsible, healthy, emotionally and socially adept, enterprising and productive citizens.

Considering the high levels of early marriage (47%) and childbearing (52%) among married adolescent girls and young women below 24 years in West Bengal<sup>1</sup>, the "Community Partnerships" project has undertaken a targeted intervention approach focusing on this age-group instead of the entire reproductive age-group for accelerated improvement in MNCHN. YouthInvest is using a community-led rights-based approach focusing on behaviour change of young married couples (15-24 years) and adolescents (10-19 years) to bring about positive changes in maternal and child health, nutrition, family planning, and gender-related issues such as early marriage.

The "Community Partnerships" project builds capacity of community groups (young women and adolescent groups) using participatory processes to plan, monitor and sustain behaviour change practices on critical MNCHN issues; and work in convergence with the Departments of Social Welfare (ICDS), Health & Family Welfare, and Panchayat & Rural Development, to access commodities, services and technical support in ensuring provision of integrated services to improve MNCHN outcomes including reduction of child marriage, early pregnancy and childhood malnutrition.

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<sup>1</sup> National Family Health Survey 4, 2015-16



## 2. Executive Summary





## 2.1. Objectives and process of the Rapid Assessment Study

As part of the ITC Mission Sunhera Kal “Community Partnerships” project, YouthInvest Foundation (YouthInvest) conducted a rapid assessment study to understand behavioural determinants of maternal, newborn, child, adolescent health and nutrition (MNCHN) among populations of 49 Anganwadi Centres in 7 Gram Panchayats of Hooghly and Howrah and 1 Municipal Ward of Kolkata. The selection of these areas was based on vulnerability-index using indicators such as the presence of large SC/ST population, low literacy, high unemployment and low nutritional status of children.

### Study objectives

- Understand behavioural determinants of key MNCHN behaviours amongst young couples, children and adolescents in these communities
- Create a programme intervention framework to address these factors leading to behaviour change

**Phase 1:** The Rapid Assessment Study was conducted in phases. In Phase 1, YouthInvest conducted a vulnerability mapping exercise through household level enumeration to identify the most vulnerable population with low levels of MNCHN indicators. The vulnerability mapping showed clustering of several key behaviours, such as child marriage, early childbearing, low contraceptive use and poor infant & young child feeding practices throughout the project area leading to poor maternal and child health outcomes including high child malnutrition levels.

**Phase 2:** Based on these findings, YouthInvest designed a qualitative study to understand the determinants of these poor health behaviours. Data was collected from following primary target groups – (i) 15-24 married women (non-pregnant, pregnant, and lactating) and (ii) 10-19 adolescents. In addition, data was collected from husbands and mothers-in-law of young women, community leaders, and frontline health & nutrition service providers, namely Anganwadi Workers (AWW) and Accredited Social Health Activists (ASHAs) for a comprehensive understanding of factors working at multiple individual, interpersonal and societal level<sup>2</sup>.

**Phase 3:** YouthInvest team analysed the data in order to confirm the problems and understand the factors driving these in the project area. Potential interventions to address the barriers and challenges of the problems were brainstormed and prioritised based on evidence and feasibility. This exercise concluded in the design of the programme intervention strategy and framework.

Figure 1. Rapid Assessment Phases



<sup>2</sup> Sallis, J. F. and Owen, N. G. (2002). *Ecological models of health behaviour*. Health Behaviour and Health Education: Theory, Research and Practice, edited by K. Glanz, B.K. Rimer and F.M. Lewis. San Francisco: Jossey-Bass. 462-484.

## 2.2. Major findings

**Cycle of malnutrition perpetuating due to prevalent social norm of child marriage and early childbearing**

**Child marriage is not only sanctioned socially but also provides legitimacy to child motherhood**

**Lack of positive role models, low autonomy, limited awareness and life skills make young girls vulnerable and unprepared for marriage and childbearing**

**First child is without any planning and almost always “accidental”, signifying high unmet need for family planning**

### 2.2.1. The complex reality of high levels of child marriage and early pregnancy

The findings from the rapid assessment suggest a cycle of malnutrition getting perpetuated in the project area due to the prevalent social norm of early marriage (52% of married women between 15-24 years were married off before they attained 18 years, another 23% at the age 18) leading to early pregnancy and childbearing. Boys also tend to marry relatively young and are far from being prepared to assume marital responsibilities. Interviews with young married couples show that there is no dialogue between couples on family planning after marriage and the first child is almost always unplanned and “accidental”, with majority of them having unmet need for family planning. This is acceptable by all as marriage provides the social sanctity to child motherhood. As a result, it is common to find adolescent mothers with poor health and nutritional status who are more likely to have children suffering from poor nutritional status and stunting.

The findings highlight that the decision to marry girls off early is influenced by an interplay of multiple social, cultural and economic drivers that are rooted in patriarchy placing less societal value on girls than boys. How deep-rooted these values are, become clear, when respondents from the parents, mothers-in-law, community leaders’ group while accepting “*child marriage is high*” and “*(parents) should wait till the girl is 18*”, also mentioned “*marriage is inevitable in the life of a girl from the moment she is born*”, “*why wait if you get a good groom?*”, “*boys like younger girls who are prettier and demand less dowry*” and “*younger girls are more malleable and adjust better (in marital home)*”.

At multiple levels, why the tradition of child marriage continues to be perceived as a “win-win” situation is understandable when one looks at the social and economic vulnerabilities prevalent in the pockets where the project works, where families – with limited access to education and economic opportunities for girls, faced with dowry demands and fearful of girls’ security as they attain puberty – would opt for their early marriage.

In the absence of positive role models, unfortunately, this social legitimisation of child marriage as an acceptable way of life has been internalised by the young girls as well, many of whom viewed marriage as a means to achieve independence and social identity which is essential for transition to adulthood. They felt that marriage would bring them more respect, legitimacy to fulfil emotional needs that puberty brings in and independence in decision-making in their future life. However, low autonomy, lack of agency, limited awareness and insufficient life skills add to their vulnerability and leave them unprepared for marriage, childbearing and the responsibilities and restrictions that come with marriage.

### 2.2.2. Poor infant & child feeding practices, irregular growth monitoring & lack of nutrition counselling

It is well-known that infants born to adolescent mothers are more likely to be malnourished<sup>3,4</sup>. Despite high proportion of antenatal check-ups and institutional delivery in the project area, gaps in understanding of exclusive breastfeeding, inadequate weaning and influx of formula-food and readymade items such as biscuits and *kurkure*, hamper traditional complementary feeding practices that exist in the communities and further perpetuate malnutrition among infants and under two children. Although there is universal awareness of exclusive breastfeeding, it is not practiced in a sustained manner for six months. Also, the concept of exclusive breastfeeding is not fully understood by all stakeholders, many of whom think that giving honey and water could be “allowed” in exclusive breastfeeding. Majority of the respondents felt mothers should not breastfeed if they are sick as mother’s illness could be passed to the baby. As a result, growth faltering is common among infants under 1 year.

In addition, the study found that although supplementary feeding among 3-6-year old children is practiced in majority of the Anganwadi Centres (AWC), growth monitoring, nutrition counselling and community-based malnutrition management (Sneh Shivar) is irregular. Further, it was observed universally that there was no communication of the weight and plotting on the growth chart with the mothers/care givers defeating the purpose of weighing and growth monitoring, wherever it is happening. Hence, AWWs lack of motivation and skills for regular weighing and growth monitoring leads to gaps in service delivery. Thus, understanding of their children’s nutrition status and healthy cooking & feeding practices among young mother and other caregivers is low, leading to further perpetuation of child malnutrition.

### 2.2.3. Low contraceptive use for spacing among young couples

The study findings show universal preference for two children among young couples as well as traditional gatekeepers in the families, such as mothers-in-law. While majority felt “*one son, one daughter is ideal*”, there is no indication of sons being preferred. However, gaps in knowledge and myths regarding contraceptive methods among young couples lead to low use of modern methods for spacing and a culture where young women even less than 25 years opt for tubectomy once the two-child norm is achieved. As responsibility for family planning is largely seen as a woman’s responsibility with very limited male involvement in these communities, it is obvious why young women in their early twenties – with limited resources, negotiating skills, incomplete knowledge about available methods, and little or no support from husbands – would choose a terminal method over other temporary methods once their desired family size is met.

**1000-day window is being missed due to incomplete understanding of what constitutes “exclusive breast feeding” and inadequate weaning and complementary feeding**

**Regular growth monitoring and community-based malnutrition management are irregular**

**Gaps in knowledge of contraceptive methods lead to low use of modern methods for spacing, preference for permanent methods at young age**

<sup>3</sup> Branca, F et al. (2015) Nutrition and health in women, children, and adolescent girls. BMJ 2015; 351:h4173.

<sup>4</sup> Black, R et al. (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet 2013; 382: 427–51

**Adolescent girls and boys are ill-prepared to face challenges of adolescence and adult life with limited information on puberty, health and nutrition issues**

**Adolescents are aspirational but lack skillsets and agency essential for negotiating challenges of life including major life decisions**

**Gender-discriminatory social practices add to the disempowerment of adolescent girls and reinforce the patriarchal values and masculinity among adolescent boys**

**ASHAs are not fully equipped to meet needs of young married women and some AWWs lack basic skills for weighing, growth monitoring and nutrition counselling**

## **2.2.4. Low awareness of health & nutrition, gender-discriminatory social norms and limited life skills among adolescent boys and girls**

As a critical population group at the cusp of adulthood, the study attempted to understand adolescents' preparedness for adulthood and family life. The study found although both boys and girls are conscious of the physical and emotional changes of adolescence, lack of complete and correct information about pubertal changes, reproductive health and nutrition render them ill-prepared to face challenges of adolescence and adult life. Although anaemia among adolescent girls is generally high in West Bengal, majority of respondents reported that they did not take IFA due to incomplete knowledge of side effects.

Both adolescent girls and boys are aspirational and full of energy but lack the skillsets and agency that is required to make choices and take an active role in one's life path, rather than being the product of one's circumstances. School dropout rate among both girls and boys was found to be high, with boys migrating for job prospects and girls waiting for marriage. When asked how they see themselves five years from now, majority of girls said, "*married in a good family*" with only a few saying "*studying further or having a job*". While majority of boys see themselves with a "good job", few could answer what kind of job or how they could equip themselves with the requisite skillsets to get their dream job.

Study findings indicate that prevalence of gender-discriminatory social practices further add to the disempowerment of adolescent girls and reinforce the patriarchal values and masculinity among adolescent boys as they transition into adulthood. Almost all the respondents agreed that discrimination increases as girls reach puberty, including restrictions on girls' mobility, lower access to resources such as mobile phones, household chore-distribution disproportionately skewed towards adolescent girls, higher school dropout rates and early marriage for adolescent girls.

## **2.2.5. Readiness of frontline health and nutrition service providers to meet needs of married adolescents and young mothers**

Interviews with AWWs and observations at AWCs confirmed that regular weighing, nutrition counselling and community-based malnutrition management are lacking. Some AWWs need skills refresher on weighing and growth monitoring. ASHAs do talk about exclusive breast feeding as they make home visits frequently after childbirth, however, focus on timely weaning and introduction of complementary food is lacking. They are also not able to provide the support that adolescent first-time mothers require to sustain breastfeeding. ASHAs are welcome in most of the households and can talk about contraceptives, however, they are not sensitive towards special needs of young married adolescents and their families.

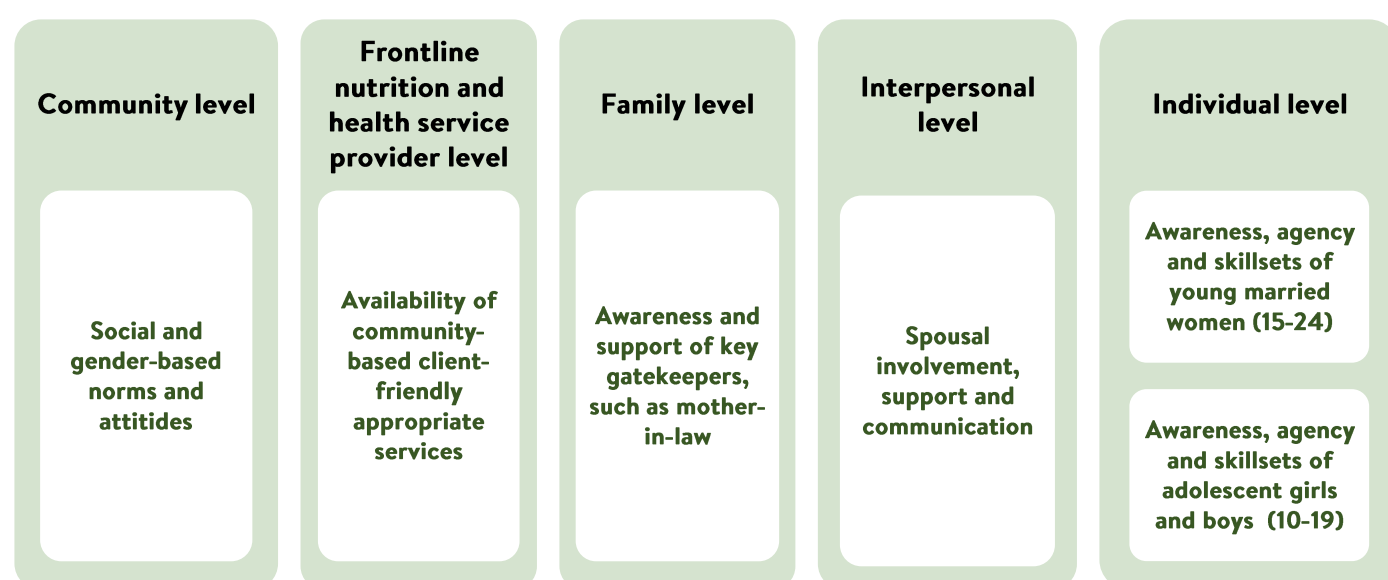
## 2.3. Conclusion: a comprehensive intervention approach using a socioecological model is essential as drivers operate at multiple levels

The study findings demonstrated that to improve MNCHN, focus should be on addressing key challenges and barriers related to three key strategic outcome areas as these are the key contributors towards poor MNCHN in the project area. Working towards these three strategic outcome areas will enable us to break the cycle of malnutrition perpetuated through generations in these communities.

- Prevent child marriage
- Delay first childbearing and spacing between children among young married couples
- Improve nutrition among 0-6 children, specifically, exclusive breastfeeding & complementary feeding and community-based malnutrition management

The findings showed that the factors driving these behaviours are multifarious; operate at multiple levels and mutually reinforcing. Specifically, the study identified five sets of factors that need to be addressed (Fig. 2).

Figure 2. Key factors to be addressed at multiple levels



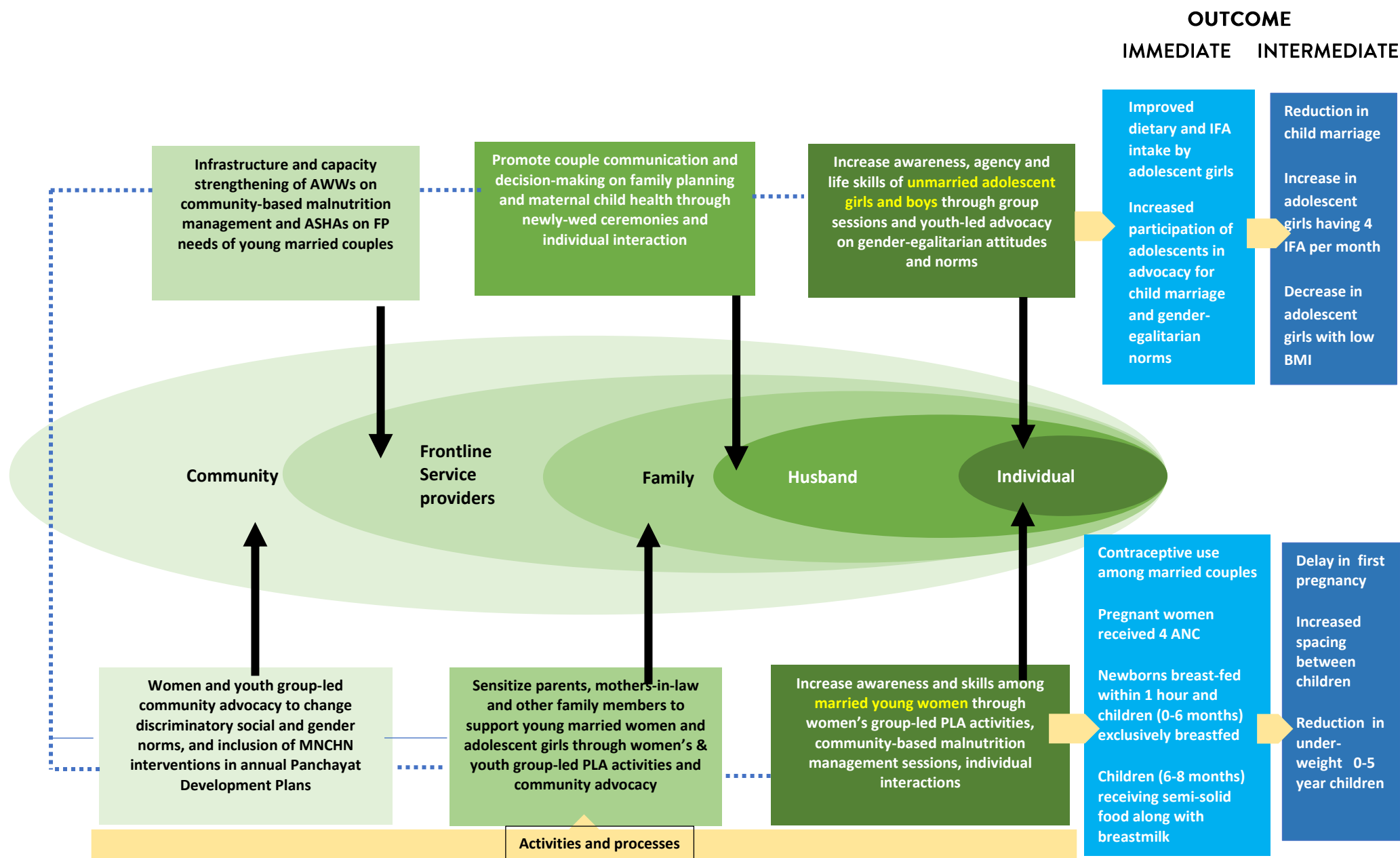
Based on a synthesis of existing evidence<sup>5,6</sup> and feasibility in the project area, YouthInvest team developed the following social behaviour change intervention framework tailored to specific life stages and aimed at drivers working at different levels of the socioecological model<sup>7</sup> (Fig. 3) to reach the desired outcomes.

<sup>5</sup> Subramaniam, L et al. (2018). *Increasing Contraceptive Use Among Young Married Couples in Bihar, India: Evidence from a Decade of Implementation of the PRACHAR Project*. Global Health: Science and Practice 2018 | Volume 6 | Number 2.

<sup>6</sup> Prasad, V. Sinha D. (2015). Potentials, Experiences and Outcomes of a Comprehensive Community Based Programme to Address Malnutrition in Tribal India. *International Journal of Child Health and Nutrition*, 2015, 4, 151-162.

<sup>7</sup> Sallis, J. F. and Owen, N. G. (2002). *Ecological models of health behaviour*. Health Behaviour and Health Education: Theory, Research and Practice. edited by K. Glanz, B.K. Rimer and F.M. Lewis. San Francisco: Jossey-Bass. 462-484.

Figure 3. Project social behaviour change intervention framework



# 3. Objectives and Methodology





### 3.1. Background, objectives and process of the Rapid Assessment Study

The ITC Mission Sunhera Kal “Community Partnerships” project implemented by YouthInvest Foundation aims at improving maternal, child, adolescent health and nutrition (MNCHN) in selected Gram Panchayats of Hooghly and Howrah districts and one Municipal Ward of Kolkata, West Bengal with poor nutrition indicators.

Figure 3. Project districts

Between October and November 2018, YouthInvest conducted a rapid assessment study among populations of these areas covering 49 Anganwadi Centres in 7 Gram Panchayats of Hooghly and Howrah and 6 community pockets in Ward 80 with the following objectives.

- Understand behavioural determinants of key MNCHN behaviours amongst young couples, children and adolescents in these communities
- Create a programme intervention framework to address these factors leading to behaviour change

In order to understand the MNCHN issues and their determinants, YouthInvest undertook a phase-wise process. In Phase 1, YouthInvest mapped the vulnerable target population with low levels of MNCHN indicators through household level enumeration. The vulnerability mapping showed clustering of several key behaviours leading to poor maternal and child health outcomes: child marriage, early childbearing, low contraceptive use, poor infant & young child feeding practices; and high malnutrition levels throughout the project area across districts. Institutional delivery was found to be high in the project area<sup>8</sup>. Table 1 below summarizes the key findings from the household level enumeration.

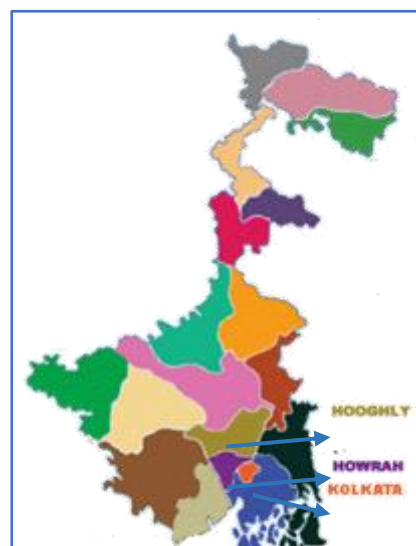


Table 1. MNCHN status in the project area

Indicators	Howrah	Hooghly	Kolkata	Total
Mean age at marriage	17	17	18	17
Percentage of girls among 15-24 married before 18 years	55	54	37	52
Percentage of girls among 15-24 married before 15 years	22	21	11	20
Percentage of 15-19 married women who have one or more children	60	58	40	57
Percentage of 15-24 married women using contraceptive methods	31	47	11	35
Percentage of institutional delivery	93	98	97	96
Percentage of children < 2 years who were breastfed	61	69	79	67
Percentage of children who were malnourished (moderate & severe underweight) **	33	25	17	28

Source: Household level vulnerability mapping, YouthInvest Foundation, September 2018

\*\* Data from Integrated Child Development Services

<sup>8</sup> This could perhaps be explained by the high uptake of Janani Suraksha Yojana, the National Health Mission Maternity Benefit Scheme in the project districts.

In Phase 2, based on these findings, YouthInvest designed a qualitative study to understand the determinants of the above poor health and social behaviours using a socioecological model that recognizes that behaviours are influenced by multiple individual, interpersonal and societal factors. YouthInvest engaged DataSpeak, a research agency to collect data from following primary target groups – (i) 15-24 married women (non-pregnant, pregnant, lactating) and (ii) 10-19 adolescents. In addition, data was collected from husbands and mothers-in-law of young women, community leaders, and frontline health & nutrition service providers, namely AWWs and ASHAs for a comprehensive understanding of MNCHN behaviours and their drivers.

In Phase 3, YouthInvest team analysed the data in order to confirm the problems and understand the factors driving these in the project area. Potential interventions to address the barriers and challenges of the problems were brainstormed and prioritised based on evidence and feasibility. This exercise concluded in the design of the programme intervention framework and strategy.

## 2.4.3.2. Data collection methods

Data was collected in October and November 2018 through the following qualitative methods.

1. Focus group discussions (FGD)
2. In-depth interviews (IDI)

For each category of participants for the FGDs and IDIs, open-ended semi-structured guides were used. IDIs and FGDs were conducted in Bangla or Hindi, based on the location. A total of 64 FGDs and IDIs were conducted with the target respondent groups. Separate FGDs were held with married adolescents (15-19) and young married women (20-24). Each type of target group was covered in each of the seven Panchayats (three in Howrah, four in Hooghly) and in one borough (ward-80) of Kolkata Municipal Corporation (Table 2).

**Table 2. Data collection details**

	No.			Total Participants
	Howrah	Hooghly	Kolkata	
A. Focus group discussions				
(i) Young married women (15-24 years) **	6	8	2	100
(ii) Adolescent girls (10-19 years) unmarried	3	4	1	63
(iii) Adolescent boys (10-19 years) unmarried	3	4	1	60
B. In-depth interviews				
(i) Husbands of young married women	3	4	2	9
(ii) Mothers-in-law of young married women	3	4	1	8
(iii) Community leaders (Panchayat member/ Teacher/ Youth club secretary, MNREGA Supervisor, Local politician)	3	4	1	8
(iv) Frontline service providers (ASHAs and AWWs)	3	3	1	7

\*\* included newly married, pregnant and non-pregnant, lactating

## 3.3. Quality Assurance

Data collection tools were developed and reviewed by experts from YouthInvest. Effectiveness of the tools was re-evaluated following a quick analysis of the findings after one round of data collection. The qualitative sessions were facilitated and documented by field researchers of DataSpeak. The team of field researchers were oriented by YouthInvest Foundation. A team of two field researchers were engaged for each session. One of them facilitated the interaction and other was responsible for documentation. The women's team facilitated the session with women and the men's team with the men. In order to prevent loss of data, every session was voice-recorded with permission of the participants. Participation in the FGDs and IDIs was voluntary.



### 3.4. Limitations

Given the large population covered by the project in the 7 Gram Panchayats in Hooghly and Howrah and Ward 80 of Kolkata, the sample size used in this study for the in-depth interviews were small. However, triangulation of data collected from several types of respondents on same issues largely mitigated this limitation.



## 4. Findings





## 4.1. Early marriage: child brides aplenty

*“Bindi was 10 or 11 years old when she was married off. She became pregnant within a year. By now, she has conceived five times. All five children were sons. But only two of them survived. 18-year old Bindi now is a sick woman.”*

*Narrated by adolescent girls, Howrah*

Bindi’s case is one of the most appalling stories of early marriage in the project area, which is high in both Howrah and Hooghly districts. Bindi’s story may be an extreme case, but FGDs and interviews with all categories of respondents, particularly in Hooghly and Howrah, point to a situation where child marriage is not only sanctioned socially but also provides legitimacy to child motherhood. Findings demonstrate that despite high awareness on the adverse effects of early marriage among all categories of respondents, child marriage continues as a social norm propelled by individual, familial as well as societal factors. Across all social categories, marriage is considered to be the most important part of the lives of young people. Both men and women are encouraged to aspire to it from a young age. This *centrality of marriage* is also accompanied by specific norms around marriage. These norms dictate what is and is not an “ideal” marriage. Because social norms require everyone to marry, and because marriage is governed by rigid rules, marrying early is a way parents secure the future of their children. Indeed, marriage is so central that adolescents are often eager for it as well. For adolescents, marriage is a means to satisfy sexual desires or access the mobility and freedom reserved for adults; in addition, there is often a deep desire for the romance associated with the act and ritual of marriage itself. Often, the dreams of young people, particularly of girls are limited to those that can be accessed through marriage.

### 4.1.1. Societal factors: Cultural and gender norms endorse child marriage

Respondents among all categories are aware of the consequences of early marriage and knew the legal age of age. However, they all agree that child marriage is still a very common occurrence. Community leaders and service providers stated that although the rate of early marriage had fallen in the recent years, it is still very much prevalent. Interviews with community leaders revealed that inequitable gender norm that places less value on girls is still very much prevalent and is a major deciding factor for child marriage instead of continuing girls’ education. The recent “Kanyashree Prakalpa” that financially incentivizes girl’s secondary education was mentioned to be having positive effects, but only sporadically. It was also mentioned that in some cases, the “one-time” money received is used for marriage as soon as the girls turn 18 years.

*“Previously it used to be 70%, now 50% of the marriages are early marriages.”*

*Panchavat member. Howrah*

*“Younger girls adjust much better in their marital home....it is difficult to manage an older daughter-in-law”.*

*Mother-in-law, Hooghly*

According to respondents from all categories, age-old traditions dictate that girls must be married off, and preference for younger girls who are considered to be “prettier” is widespread. According to community leaders as well as mothers-in-law and service providers, there is widespread perception in the community that chances of getting married for the girls decrease with age and hence the sooner is the better. Boys’

families too want a young girl as daughter-in-law as they feel that it is easier for a young girl to get adjusted in the in-law's house.

***"Only change in our attitudes towards girls will bring in sustained change in preventing child marriages".***

***Community leader, Hooghly***

places and get them married from there to avoid police action.

Some of the community leaders and service providers said that reporting child marriage and police intervention have stopped a few marriages in their locality. However, they all agreed that this was not a solution as desperate parents shift their daughters to their relatives' house located at distant

#### 4.1.2. Family-level factors: Economics reinforces social norm of child marriage

Marriage plays a central role in reproducing the family and since individuals are identified by their location within families and wider kin networks, after a certain age, a person's identity, legitimacy and ability to participate in society hinge on his or her marital status. Marriage is, in many ways, seen as a transition to adulthood. At the family level, this centrality of marriage, coupled with gender-inequitable social norms that prefer sons over daughters often relegate girls to be *"someone else's wealth"* that the family is safekeeping till marriage. Families are reluctant to invest in their daughters' education as it is not seen as a good economic investment. These patriarchal notions combined with the expense for daughter's marriage are major drivers of child marriage. In addition to meeting dowry demand, arranging a marriage requires considerable money as it is a social function. Parents keep on saving for their daughter's marriage over the years. As soon as there is enough savings for this purpose, they do not want to delay as it is difficult to hold on to saved money in a poor family. Families try to keep savings for daughter's marriage airtight, not to be touched upon even in emergencies. Consequently, families, particularly poorer ones, start looking for a groom as soon as young girls attain "marriageable age" as it is easier to find a suitable boy for younger girls. The girls do not have much choice but agree, with an expectation that post-marriage they will live a better life.

***"Our parents cannot bear our education cost, but surprisingly manage the expense for our marriage."***

***Young married girl, Hooghly***

***"You have to marry her off at some point, right? For a girl to be socially respectable, she has to be married. And it is easier (less expensive) if the girl is young"***

***Mother of child bride, Howrah***

***"Parents whose daughters elope are socially stigmatized and no one wants that for their daughter and family. It is better to marry off girls early than be sorry."***

***Mother of adolescent girl, Hooghly***

Fear for girls' security is another key factor in deciding age of marriage. In discussions with mothers-in-law, community leaders and service providers, incidences of "elopement" had been mentioned across all the districts. Even one case of elopement in the neighbourhood has a ripple effect in reinforcing "marriage" as the response to the problem.

However, the study also found changing trend among many families. Many young married women and adolescent girls shared that early marriage is discouraged by their families, especially by their mothers. All respondent categories agree that keeping girls in schools and allowing them to flourish is the best option. However, for a large majority, this is not the case and child marriages are still very common despite a lot of efforts by government and civil society.

***“My mother got married at 16. She became very weak since the birth of my elder brother. She is dead against my early marriage. She will never get me married until I am 18-20 years of age.”***

***Adolescent girl, Howrah***

### 4.1.3. Individual factors: Gender stereotypes, low autonomy and lack of agency among adolescent girls

Discussions with adolescent girls and boys in the project area brought out how deeply entrenched the idea of marriage as “inevitable” and “the only option for a girl to support herself and be socially respectable” is. For many adolescent girls reached out during the study, getting married seems like the only way to have a future. According to adolescent girl respondents, girls agree to a marriage because it seems like a way to escape the challenges of their current life – from feeling like a burden on their family to a promise of a better life. Although majority also know that this may result in a situation that is worse than what they had before marriage, lack of agency, positive role models and choice make them dream of marriage as the only pathway to freedom reserved for them.

***Marriage is the ticket to freedom and adulthood. In one step, you become an adult”.***

***Adolescent girl, Hooghly***

The study sought to understand “elopement” that has been mentioned by all categories of respondents as a reason for child marriage. Conversations with adolescent girls and boys revealed how the social sanction provided by marriage is perceived by them as a means to explore their sexuality or access the mobility

and freedom reserved for adults. Limited awareness, lack of agency and absence of positive role models make adolescent girls look at marriage “as the ticket to freedom and adulthood”. The natural tendency of adolescents exploring their sexuality as they are growing up also finds an easy channel when one is married. Majority of the girls thought “having a boy-friend is a must. Only the unattractive ones have to wait till marriage.” Some also believe that it is easy to manage a young husband or a boy-friend.

Peer pressure plays a big part in the decision to marry too. One child bride explained that “there were too many rumours, so I told him I would marry him.” Such is the lure of marriage that “if they are prevented from getting married, they will run away or cut their veins to attempt suicide”. For runaway couples, although the families initially shun them, once a child is born, majority are integrated within their families. However, some were doubtful about the durability of such marriage and one commented, “Disparities between young spouses are often ignored by each other in early years of marriage as they are busy enjoying its fun. But as time goes, responsibility takes over and the disagreements turn into disputes souring the relationship. Then they get separated.”

***“In good families, girls are married between 12-14 years”***

***“The most common age of marriage for girls is 15-16 years”***

***Adolescent girls, Howrah***

Discussions with child brides showed they do not receive differential treatment or discrimination in in-laws' house if the marriage is "arranged". Many said that they were treated like their own daughters. They received hands-on training on domestic duties from their mothers-in-law. However, the story might be different for "love marriages". One woman shared, *"Husbands are never good. They love you when you are young. Afterwards they turn abusive and get addicted to alcohol and other substances. When I complain to my mother-in-law, she shrugs off her responsibility by saying that I myself had chosen her son. She did not bring me here."*

Discussions with child brides also revealed that many of them regret that they were married off, and how that had curtailed their freedom instead of enhancing it. Many of them also shared how it had limited their education and job opportunities. *"Now I am saddled with a baby and have nowhere to go".*



## 4.2. Pregnancy and contraception: unplanned and early first pregnancy

*“One should be married at 17 and enjoy the married life for 3-4 years without any child. First child should come at 20 or 21”*

*Adolescent girl, Howrah*

### 4.2.1. First pregnancy: unplanned and accidental

In a culture where early marriage is the norm, majority of respondents across all categories said early marriage is ideal if pregnancy is delayed. However, in reality, early marriage is followed by early pregnancy. For almost all married young women and men participated in FGDs, the first pregnancy was “unplanned and accidental.” The household vulnerability mapping in the intervention areas show that 75% of girls married within 18 years and 45% married girls between 16-18 years have at least one child.

### 4.2.2. Ideal Age of first Pregnancy: Community Perception

Participants had different opinions about the right age for marriage, majority felt it is ideal to get married between 17 and 20, and right age for first pregnancy should be between 20 and 25. Majority recommended a gap that ranges from 3 to 4 years between marriage and first childbearing, when they would enjoy the married life without much responsibility (children). But in practice, none could delay their first pregnancy beyond a few months.

*“I got married at an early age and within one month of marriage, I became pregnant. Initially we, my husband and I, thought of abortion. But my mother-in-law advised not to abort the child, lest I do not get pregnant again.”*

*Young married woman, Kolkata*

### 4.2.3. Community Attitudes towards First Pregnancy

There are mixed reactions in the community towards the first pregnancy. Contrary to the discourse that pressure from mothers-in-law to prove fertility after marriage, the study found that in the project areas, mothers and mothers-in-law generally encourage their daughters and daughters-in-law to delay pregnancy after marriage, especially when she is very young. But the relatives and neighbours are often insisting and keep on teasing the young couples as long as they become parents. Abortion of the first pregnancy is not approved in the community and considered inauspicious. *“If I abort my first pregnancy, everybody will hate me, and I will never be allowed to participate in any auspicious ceremonies.”* Sometimes husbands too do not favour abortion of the first child.

### 4.2.4. Lack of pre-marital awareness on contraception

Despite the couple's reluctance to get a child soon after marriage (which is also favoured by the parents and in-laws), a first pregnancy comes early and almost immediately after marriage. Lack of awareness about the modern contraceptive methods before marriage is a major contributor towards first pregnancy. Although most young married women and their husbands said that they knew that there are methods to prevent pregnancy, there was hardly any dialogue between them regarding pregnancy and family planning. They also had no clear information about contraceptive methods or what would be suitable for them. One newly married girl who was yet to become pregnant, confirmed that she was not aware of any such methods. She wanted to have a child after two years, but always had unprotected sex with her husband. Only after the first child is born, they become aware of contraceptive methods.

*"I know there are methods to prevent pregnancy, but I have no specific knowledge of any method. I became pregnant soon after marriage although we did not want the child so soon. After the birth of my first child, my mother-in-law advised me to take pills. She herself buys pills from the shop for me. I do not know any other method."*

**Rekha, 18 years, married with**

#### 4.2.5. Contraceptive use among young married women who have had a child

Level of awareness about the modern contraceptives is high among those who already had a child. However, many of the respondents who have had one child did not report using contraceptive for spacing but would rather have tubal ligation after birth of second child. Oral pills seem to be most popular among those practicing family planning. A few of the women also reported using Copper-T. Some reported use of condoms. One woman reported taking injections every month to prevent pregnancy. Quite a few had their tubal ligation done after the second child although they were younger than 25 years. *"I wanted to have ligation done after the birth of my first child. But the doctors at the hospitals did not approve the idea. He asked me to get my ligation done after the birth of my second child."* Interviews with ASHAs also brought out that there was no client segmentation regarding messages regarding contraception and they promote tubal ligation after the second child irrespective of age of a woman. One woman below 19 years old had her ligation done after the birth of her second child.

*"My mother-in-law asked me to undergo ligation after my first child. My first child was a girl. She (mother-in-law) said that I should concentrate on bringing up one child properly and have no more issues. But I wanted to have another child with a gap a few years. So, I got Copper-T inserted. But it was lost within my body and I became pregnant twice. Both the times I got my pregnancy aborted. The doctor said that she cannot trace the Copper-T. She (the doctor) said that it would cost Rs. 10,000 to locate the Copper-T and take it out of the body. At present I do not use any family planning methods. I am very worried if the copper-T would do any harm to my body."*

**Young married woman, 22 years, Howrah**

Couples, who are not practicing any family planning method, do not necessarily want more children immediately. They maintain the gap between children by traditional withdrawal method or by indulgence only during safe period. Interviews with some of the non-users of any modern contraceptive methods revealed that prevalent myths and misconception and fear of side effects regarding contraceptives are key factors for their non-use. Condoms are not preferred as some fear it might burst inside the vagina. There are also reservations against using pills propelled by these myths. Large-scale misconception and side-effects on Copper-T is also prevalent. It was also mentioned that in

a few cases, Copper-T was inserted after delivery without asking for permission. ASHAs too confirm that women have fears about Copper-T. There were also complaints about their side-effects.

#### 4.2.6. Ideal number of children

Almost all married young women preferred to have two children and ideally would want a gap of few years between children. One woman shared, *“A gap of 5-6 years between two children is important, because by the time I get over the responsibility for the older one.”* Couples like to have one son and one daughter; however, no strong preference for any particular sex was noted. One commented, *“Some people look down upon the birth of a girl child, but girls are much better than boys.”* However, many of the respondents who have had one child did not report using contraceptive for spacing but would rather have tubal ligation after birth of second child.

#### Box 1. Myths on common contraceptives

- If I take pills continuously, I may not become pregnant when I want to be
- Pills make the umbilical cord thicker
- Copper-T causes ulcers that may lead to cancer. One of my family members died from ulcer from Copper-T.

#### 4.2.7. Couple communication and male involvement in family planning

Interviews with young married men reinforced lack of communication with wives regarding family planning after marriage. Although most of them said that they had knowledge about family planning methods such as condom, pills and tubal ligation, this was never discussed with their wives immediately after marriage. Only after the first child is born that some of them would discuss this with their wives. A lot of them felt “this was wife’s responsibility”. Majority of them said that they are aware of the contraceptive method used by their wives. One husband shared, *“Previously my wife used to take pills. Then at the instance of one of my friends I started using condom. Our children were planned by us. There was no influence from any quarters.”* None of the husbands had a vasectomy operation. Young men reported to get contraceptive information from TV, ASHAs and Health Centres.

***“There was no question of discussing family planning after marriage. We were too busy discovering each other, and these things (family planning) never came to our mind. Only after she (wife) became pregnant within one month of marriage, that I realized our mistake”***

***Young married man, 22 years, Hooghly***

Some husbands were found to be averse to using any family planning methods as they had myths about some of the methods. Popular myths include *“rubbing of condom against female genital may cause ulcers”* and *“pills cause infertility in women”*. Husbands also reported that they have “controlled” (i.e., withdrawal, safe period)

intercourse. Majority of young men preferred wives to undergo tubal ligation after the second child is born.

#### 4.2.8. Supply of contraceptives

Supply of contraceptives is not an issue as condoms and pills are delivered at home free by the ASHAs. Copper-T and tubal ligation are also free at government hospitals. Young married couples also buy commercially branded OCPs (*Subidha, Sukhi*) from retail shops.

### 4.2.9. Role of ASHAs

ASHAs reported that they visit the houses of newly married women and generally provide condoms to such couples. According to their observations, first pregnancy soon after marriage takes place due to pressure from the mothers-in-law. This observation, however, is not supported by the women participants in FGDs. ASHAs also reported that they do not face any taboo while communicating with young married couples. They can discuss family planning issues openly and it is encouraged by the in-laws as well. ASHAs also reported that they find most of the mothers-in-law very caring towards their daughters-in-law. Some mothers-in-law have initial difficulty in accepting the daughters-in-law if the marriages were not arranged by the families, but initial conflicts are resolved, particularly after a child is born. ASHAs recommend ligation after two children irrespective of age of the client.

## 4.3. Antenatal care and institutional delivery: high levels of awareness and practice

*“These days, everyone has antenatal check-ups and all our babies are born in hospital.”*

*Mother-in-law, Howrah*

### 4.3.1. Awareness and preparedness for first pregnancy

Majority of the young mothers said they had no knowledge or preparedness about first pregnancy. They talked about their experience of common symptoms of pregnancies: amenorrhea, vomiting, lack of appetite, weakness, vertigo, swelling of legs, increase in weight etc. A few mentioned about complications like anaemia (pallor), lack of sleep, hypothyroid, bleeding, water-breaking and inability to eat anything due to fishy smell. A few child mothers said that they found pregnancy overwhelming, but generally mothers and mothers-in-law took good care of them.

### 4.3.2. Use of antenatal care

Awareness about antenatal care is ubiquitous. Most of the young women said that they registered themselves with government hospitals and had Mother and Child Card (MCH) cards. They go for registration generally after three months of pregnancy as there is a superstition in the community against speaking about pregnancy in the first trimester. Young mothers reported that they are given tetanus toxoid injections; blood tests were done; weight was checked regularly, ultrasonography (USG) was done at the 9<sup>th</sup> month. According to the respondents, the well-to-do families prefer to go to private hospitals. Some women also reported that they prefer to visit private clinics for regular check-up as they had no one to accompany them during hospital hours.

Majority of the women also reported that they had four antenatal checkups. This is confirmed by the AWWs, ANMs and by the husbands who were interviewed. ANMs also reported that they visit the house of the pregnant women to ensure 4<sup>th</sup> ante-natal check-up. According to the service providers, incentives through different government schemes have improved ANC compliance.



### 4.3.3. Compliance to IFA

The study revealed side-effects to be a major problem related to compliance to iron folic acid (IFA) supplementation among pregnant women. Women reported that they received IFA tablets free from the health centres or hospitals. Although many of them said they took the full course of IFA, however, quite a few also reported that they discontinued

taking IFA tablets after experiencing side-effects. They mentioned nausea after taking IFA tablets to be the major reasons for stopping IFA. When asked if ANMs and ASHAs counsel about side-effects, they could not remember. ASHAs however said that IFA compliance has been improving over the years. According to them, when the women are told that IFA is good for their babies' health, they agree to take IFA regularly.

#### 4.3.4. Nutrition during Pregnancy

Most women reported eating all kinds of food, including vegetables, ghee, milk, lentil, fish, meat, eggs during pregnancy. They were advised to eat more vegetables and sprouted grams. Some women however could not eat certain items as they smelt fish in them that caused nausea. One woman shared that she used to follow dietary charts given in a book on pregnancy care. Women reported that they received cooked food from the ICDS centres.

Interviews with AWWs ASHAs and ANMs confirm that in Howrah and Hooghly, that are primarily agriculture-based rural areas, most of the women receive the minimum required nutrition. However, the level of nutrition varies according to the financial conditions of the families. In Kolkata, for example, many women continue to work throughout pregnancy and as a result do not receive adequate nutrition pregnancy.

#### 4.3.5. Restrictions during pregnancy

Although not widespread, food-related taboos during pregnancy do exist in the community. Women reported that in some families, elders discourage from consuming certain foods during pregnancy. Some of these are (varies between locality) pineapple, green papaya, grapefruit, green banana, banana flower (locally called "*mocha*") and stem of banana tree (locally called *thor*), green coconut, eggs, fish, meat, any sour item, snack mixture (locally called "*chanachur*"). Women also described that for some foods, reasons for avoiding them is well-known, for example, palm (it increases the size of the head of the newborn), plum (it makes the lips of the newborn black), salt (intake of salt makes the body swell).

*"Although we are always not clear why intake of these foods is prohibited in pregnancy, we generally comply".*

*Young married women, Kolkata*

Young women also talked about restrictions imposed upon them during pregnancy by their in-laws. They were not allowed to go outside with unlocked hair, sit at the doorway, cut wood or cross river. One of the young girls narrated that she was asked to carry a nail on her head while going outside.

#### 4.3.6. Male involvement in antenatal care

Discussions with husbands revealed that majority of husbands are not involved in antenatal care visits. They feel it is "*feminine matters*". However, they reported that they keep themselves updated about antenatal care visits. They knew that wives took the medicines prescribed by the doctors or health workers but have no clear knowledge or interest in the specifics. Husbands generalized all types of medicines prescribed during pregnancy as "*vitamins*".

#### 4.3.7. Institutional delivery

All the women reported to have given birth in hospital. They reported to have received free ambulance and incentives (Rs. 6,000-7,000) for hospital delivery under Janani Surakhsha Yojana (JSY). For those who have delivered in government hospital, majority said that they did not have to pay any amount to anybody except to the *ayahs* (nursing attendants) for the first two children. One woman chose to visit private nursing home because her elder sister died in a government hospital during childbirth.

The women were generally satisfied with the service received from the government hospitals and health centres for antenatal care and delivery. They confirmed that the ANMs had come home for follow-up when they missed due dates for ante-natal check-up. However, they seemed to have lesser faith on government hospitals in case of complications, and majority of them said they would prefer to go to taken to a private hospital in case of emergencies.

**Box 2. Rekha's story**

**Rekha had four miscarriages in a row. She was pregnant for the fifth time. In each of the last pregnancies, bleeding started at 4<sup>th</sup> or 5<sup>th</sup> months leading to miscarriage. Then the doctor advised her complete bed rest. During her current pregnancy she decided not to go to the government hospital. She is consulting a gynaecologist at a private clinic.**

## 2.5.4.4. Infant and young child feeding practice and child nutrition: critical gaps remain

*“Salima’s son stopped gaining weight around 9 months. In spite of her best efforts, the child is sick and in very poor condition. He is now eleven months and looks like a 3-4-month baby”.*

*Mother-in-law, Howrah*

Despite high proportion of antenatal check-ups and institutional delivery in the project area, study findings showed gaps in understanding of exclusive breastfeeding, inadequate weaning and influx of formula-food and readymade items such as biscuits, hamper traditional complementary feeding practices that exist in the communities and further perpetuate malnutrition among infants and under two children. Although there is universal awareness of exclusive breastfeeding, it is not practiced in a sustained manner for six months. The concept of exclusive breastfeeding is not clear to majority of stakeholders and even to some of the local medical practitioners, majority of whom thinks that giving honey and water could be “allowed” in exclusive breastfeeding. Majority of the respondents felt mothers should not breastfeed if they are sick as mother’s illness could be passed to the baby. As a result, growth faltering is common among 9-11 months children.

### 4.4.1. Immediate breastfeeding

Majority of young women reported that they fed colostrum to their babies right after birth. As majority of deliveries take place in hospitals, colostrum is generally introduced immediately after delivery. If it is a caesarean delivery, the newborn gets the first milk usually on the next day as the mother remains too sick to breastfeed the baby on the day the baby was born. All mothers seem to be aware of the colostrum (which they refer to as ‘yellow milk’) and its importance.

### 4.4.2. Breastfeeding for first 6 months: not exclusive always

Awareness of importance of breastfeeding for the first six months is very high among all respondent categories. Almost all mothers save a few reported that they breastfeed up to a period of six months. One of the young women estimates that 95% of the mothers breastfeed their babies, which is also endorsed by the Anganwadi workers and ASHAs. Mothers are aware of the importance of breastfeeding and said it enhances immunity and protects the child from many diseases. Mothers are advised (by the doctors) not to eat spicy and oily food during the breast-feeding stage as it may harm the child. Mothers also take good and healthy food (vegetables, fish, fruits and milk) during this time. There is a common perception that intake of water-spinach (*kalmi shaag*) and red-lentils (*masoor daal*) help



produce breast-milk. Mothers are also asked not to lift heavy weight during this period. Mothers report that they breastfeed a usually at a 2-hour interval.

However, further probing reveals that this breast-feeding is not exclusive in nature. Giving water and honey (at times with basil leaves) is quite common. Mothers reported that although they are advised by the health centres not to give water or honey or any other items except the breast-milk in the first six months of child, local quack doctors suggest giving water and medicine to the baby when he was sick. Mothers feel children's throat dries up during summer and it is necessary to give them water at that time. Some of the mothers reportedly give only boiled water to their babies. Anganwadi workers and ASHAs too confirmed that despite repeated counselling about exclusive breast-feeding; it is sometimes difficult to make mothers believe that additional water and honey are not needed for the babies in the first six months. The community leaders feel that 100% of the mothers' practice exclusive breast-feeding to their babies. However, according to them giving water and honey is permissible in exclusive breast-feeding.

***"We give honey (at times with basil leaves) after the child is born. It is our family custom."***

***"Their (babies') throat dries up in summer, and that time they need a little water."***

***Mothers groups, Hooghly***

***"My baby was not suckling properly and would cry all the time. So, my mother-in-law told me to give him cow's milk along with breastmilk"***

***Young mother, Howrah***

Some mothers introduced other forms of milk such as cow milk and formula feed like Lactogen and Nestum within six months for various reasons that included "non-production of breastmilk" and "inability of the newborn to suckle". However, in case of formula food, majority of the mothers did not know or could not afford to give the prescribed quantity. As a result, they give a diluted version of the formula feed to the child leading to malnutrition. Introduction of cow's milk and formula food also increases the risk of infection among children who were not breastfed.

#### 4.4.3. Breastfeeding during illness

Mothers were aware that babies should be given breast milk even when they (babies) were sick. But breastfeeding was stopped during the sickness of mothers. Women shared that this was advised by local doctors. Most of the women agree to this. One of the mothers explained, *"I had acidity once and my child also got it after breast-feeding."*

However, incidences were also shared where mothers took extraordinary steps to breastfeed their children even if they were unwell. One mother shared: *"I had complications during breast-feeding of my child. Breast-milk seeped into my veins and doctors advised not giving breast-milk to the child. Finally, there was an operation and I breast-fed my child from one breast only."*

#### Box 3. ASHAs encourage breast-feeding

**Mothers in Hooghly and Howrah reported that they received counselling and support in breast-feeding from ASHAs. They acknowledged contribution of ASHAs and elder family members in helping them continue breast-feeding their babies. ASHAs and AWWs have received training on breast-feeding and they have sufficient knowledge on the subject. One AWW observed that those mothers who delivered at private nursing homes are more prone to introduce formula feed within first six months.**

#### 4.4.4. Complementary feeding after six Months

Complementary feeding in the community usually starts after the “*annaprasan*” ceremony (literally means first rice eating ceremony) of the child. The ceremony takes place between 7-8 months of the child implying that there is 1-2 months’ delay in initiating grain food to the child. Women usually introduce all grains such as rice, lentils, suji (semolina), sattu (gram powder) and vegetables like carrots, beets etc. Children are also given non-vegetarian food like egg, fish and meat gradually. One woman shared that she had introduced non-vegetarian food to her child after 1 year only. Mothers perceive more food value in the yellow-part of the egg than in the white part. So, children are given the yellow part of the egg with smashed grain. Some women reportedly gave their children fruit-juice and fruits like banana. Children also eat ‘*khichuri*’ supplied from ICDS centres.

Biscuits, puffed-rice (muri) and formula feed are also introduced during this stage. One woman said, “A child after 7 months wants to eat the same items when it watches us eating something. We give a piece in their hands as well.” Women named Lactogen, Cerelac and Nestum among a few available in the open market.

Mothers did not have much idea when to introduce what types of food, however, they confirmed that they gradually introduced all kinds of food and a child learns to eat all kinds of food like an adult from 1- 1½ years of age. Till that time, they cook child’s food separately from food for other members of the family. Child’s food is mostly boiled and smashed.

#### 4.4.5. Frequency of complementary feeding

Children were given complementary food 3-4 times a day (mostly thrice). Some said children were fed when they felt hungry. Mothers continue breast-feeding their children during this stage. Although they breastfeed less frequently (6-7 times a day), majority says that they pacify the child with breast-milk majority of the time the child cries, just like they used to do before six months. Majority of the mothers and mothers-in-law were not aware of the importance of weaning and as a result, babies like Salma’s son are not uncommon in the project area.

#### 4.4.6. Growth monitoring, nutrition counselling and supplementary feeding of 3-6-year-old children

The study found that in majority of the Anganwadi Centres (AWC), supplementary feeding among 3-6-year old children is practiced regularly. However, discussions with mothers group revealed that although children are weighed, growth monitoring and nutrition counselling are not taking place. In majority cases, weights are not plotted or explained, and mothers have no understanding of their children’s growth status. The focus of the programme is on supplementary feeding and there is hardly any nutrition demonstration or feeding practice sessions



using locally available food in the AWCs. Further, in interviews with AWWs, they could not recall the importance or steps of Community-based malnutrition management (Sneh Shivar). In a few instances, it was observed that AWWs lack motivation and skills for regular weighing and growth monitoring leading to gaps in service delivery. Thus, understanding of their children's nutrition status and healthy cooking & feeding practices among young mother and other caregivers is low, leading to further perpetuation of child malnutrition.

According to AWWs, they are aware of the under-weight children (yellow) in their centres. They keep on counselling those mothers for proper nutrition of their children. Also, AWWs report that complementary feeding practices are regularly discussed at the ICDS centres. Those mothers who attend the discussion are aware of the practices. However, "as all mothers do not come, they might not have all information regarding complementary feeding practices."

A common practice that was observed in all the districts that

#### 4.4.7. Male involvement in child nutrition

Most of the husbands interviewed for the study were aware of the benefits of exclusive breastfeeding. Some said that they knew it from their childhood, "Those children who are exclusively breastfed are more intelligent." Other husbands acknowledged the ANMs and ASHAs as source of their knowledge. They also know that water and honey are given to their children in first six months of breastfeeding. One shared that it was told by the hospital nurse that honey is good for a babies' health, but he does not know what good it does to the babies. Husbands had general knowledge about the complementary feeding practices. They knew it from TV and ASHAs. Husbands too confirmed that formula-feeds (Lactogen, Cerelac) were prescribed by the doctors. However, most of them have no role in infant feeding excepting buying the occasional formula for or accompanying to the health centre for immunization.

## 4.5. Awareness, autonomy and agency of adolescent boys and girls: need for an empowerment approach

*"I want to understand how one gets pregnant, but I cannot ask anyone. None of my friends are very clear although some pretend, they know."*

*Adolescent girl, 13 years, Hooghly*

*"No one ever explains anything, only impose restrictions."*

*Adolescent girl, 15 years, Kolkata*

### 4.5.1. Preparedness for adulthood and family life: awareness of reproductive and sexual health issues

As a critical population group at the cusp of adulthood, the study attempted to understand adolescents' preparedness for adulthood and family life. The study found although both boys and girls are conscious of the physical and emotional changes of adolescence, lack of complete and correct information about pubertal changes, reproductive health and nutrition leave them ill-prepared to face challenges of adolescence and adult life.

Adolescent girls described a range of pubertal changes they had experienced. These include sudden change in height, change in voice, weight increase, breast development, growth of hair in different parts of the body, change in skin-texture and menstruation. They also spoke about becoming more mature – *"I understand a lot of things now, that I did not understand before"*; *"I am now confident that I can travel alone, I can go to school and other place on my own; I do have an opinion (bhalo-mondo bujhte pari)"*.

Majority of the girls reported that they were not fully aware of menstruation and were not prepared at all. Some of the girls said that they knew about it from their elder sisters, mothers, grand-mothers, school teachers and from friends. Some of the girls mentioned they had been told about menstruation in school. However, majority did not have any prior knowledge about menstruation.

#### Box. 4. What adolescents want

Girls want to know about the cause of changes they experience during adolescence: why they get abdominal pain during menstruation, why they feel tired, why they are asked not to mix with boys, why white discharge occurs, why there are pimples on their face, why they should burn pads after using. Girls have queries about pregnancy, family planning and diet.

Boys have queries about sex, nightfall, masturbation and nutrition. Both girls and boys complain that these issues have never been explained to them properly.

***"I started crying when I first bled. Then my mother assured me that it was natural for all girls, otherwise there would be many problems in future."***

***Adolescent girl, Kolkata***

There are misconceptions regarding menstruation among many girls as they are not clear why menstruation occurs. Adolescent girls commonly face restrictions during menstruation for certain daily activities, such as bathing during restriction, not including specific "hot" food in their diet during menstruation. A few also face movement restriction during menstruation.

Boys talked about the physiological changes they go through. They have a lot of questions on their emerging sexuality issues, particularly nightfall and masturbation. Myths regarding masturbation are very common. Some of them visited *Anweshha clinics*<sup>9</sup> where they received information about bodily changes including masturbation. *"I learnt (from Anweshha clinic) that one might fall sick due to masturbation."* The boys also talked about identity issues that they face. *"We are no longer children, but we are not fully adult also, we are in the intermediate zone"*. The boys acknowledged that these



changes happen to them due hormonal change that takes place in their body during this age. They said that they learnt from friends and elder brothers that these are quite natural at this age. Science teachers too taught them in school about biological changes that happens in their body during adolescence.

***"We should avoid masturbation as we need to preserve our energy until marriage."***

***Adolescent boy, Howrah***

Both boys and girls talked about romantic interest and of their awakening sexuality issues. Girls described how they get attracted and "fall in love". They also talked about popular movies and TV serials, where love among teenagers is a common theme that they identify with and aspire for. Boys

talked about their interest in meeting girls and how they groom themselves so that they can get the girls attracted. A few boys also revealed that they have watched pornographic videos and wished to have sex. Both boys and girls want "love" to end in marriage.

Self-image is a big issue with both girls and boys. Almost all the girls wanted to "change their hair-styles, get fancy dresses". Boys said that they are very sensitive to ridicule over physical features.

***"Every girl wants to have a boy-friend. If one has not got one, then she has been chosen by none."***

***Adolescent girl, Hooghly***

The study also explored whether adolescent girls and boys are aware of HIV and AIDS. Although both adolescent girls and boys are aware of HIV/AIDS, which they have heard from *Anweshha clinics*, and could correctly identify that HIV spreads through unprotected sex, injection and blades (if one shares blade used by an HIV+ individual), there are several misconceptions regarding routes of transmission. For example, both boys and girls cited saliva through sharing

<sup>9</sup> Adolescent clinic at Government Primary Health Centre

food and kisses as routes of transmission of HIV. Friends are major source of information, some also mentioned *Anwesha clinics*. One boy referred to a popular TV serial (Crime Patrol) as source information. One boy mentioned that his friend's brother had died of AIDS.

The girls mentioned that they prefer to visit to "Lady doctor" and accompanied by their mother and father for "feminine" symptoms, such as irregular menstruation. Major source of information on reproductive and sexual health matters were sisters, friends and mothers (for menstruation). Friends, books and TV were mentioned as major source of information for boys. Boys mentioned that they have visited the Anwesha clinic and met with "Didi" (counsellor) who provided information on "growing up matters".

#### 4.5.2. Nutrition and iron folic acid supplementation

Although by and large adolescents are a healthy population group, the study delved into dietary habits, particularly consumption of iron-rich food, and IFA supplementation among adolescents as anaemia and low Body Mass Index (BMI) is a major problem leading to stunting and inter-generational growth retardation.

Majority of adolescents reported that they consume both vegetarian and non-vegetarian food. In Kolkata, it was mentioned that iron-rich non-vegetarian items such as fish and meat are generally more expensive, and they have it a few times in a week. In Howrah and Hooghly, fish is more frequently consumed. Girls, who are in middle school (Grade 6 to 8), mentioned that egg is served in their mid-day meal in school.

There are many popular beliefs around food that the adolescent girls generally were found to be more aware of. Some of these are mentioned below.

- Bitter gourd, papaya, pumpkin, boiled egg, milk, sprouted grams are rich sources of protein and vitamin.
- Neem juice is a blood cleanser.
- Cucumber keeps the body cool.
- Banana, banana flower (*mocha*) and stems of banana tree (*thor*) are sources of Iron.
- Milk helps to develop intelligence.
- Green guava helps maintain cholesterol.
- Kulekhara (swamp weeds) keeps one's blood pressure normal.

Both girls and boys said they learnt from school and Anwesha clinics that for adequate iron, they should mix lemon with rice and consume red lentils, leafy vegetables, gourd and adequate water. They also knew about importance of calcium to strengthen their bones. They are also aware of food that are harmful, such as oily food, potatoes, sweets (it causes worms), vegetables grown by chemical fertilizers and mutton dishes in restaurants and fast-food centres (as they might be contaminated with inferior materials).

***"We all know that IFA increases blood in our body. A lot of blood drains out from our body during period. IFA tablets help regenerate the blood. If we take one IFA tablet daily, our period will be clear, and we will not suffer from anaemia."***

***Adolescent girls, Hooghly***

Majority of the girls are aware of IFA tablets and the benefits of consuming IFA. Those who attend government schools received IFA tablets from schools. However, they informed that private schools do not provide IFA tablets. They knew that those, who do not receive it from schools, may collect it from health centres, hospitals or ICDS centres. Majority of the school-going adolescents mentioned that IFA supply is not an issue in schools.

Despite the awareness and supply, when it comes to intake of IFA, most of the girls who participated in the study, did not consume the IFA tablets that they received. The first complaint was that the tablets smelt bad and they had

***“One teacher in our school was insisting that we take IFA tablets. He said that we should inform him in case any of us experienced any adverse effects. But our head teacher came and advised us not to take IFA tablets,”***

***Adolescent girl, Hooghly***

nausea after taking the tablets. There are contradictory views among the teachers as well. There are rumours that circulate regarding side-effects of IFA, such as many students of a school had fallen sick after taking IFA, that also stop students from consuming IFA. The AWW also confirmed that this incident was actually aired on TV, but it was related to deworming tablets and not IFA tablets. But somehow wrong message has spread in the

community. There is another myth prevalent in the community that *“consuming IFA tablets by adolescent girls may make them infertile in future.”* Interviews with community leaders showed that such negative views about the IFA tablets are also prevalent among community.

According to AWWs, non-consumption of IFA is not universal and there are girls who come to AWC to collect IFA tablets regularly. AWWs did not have clear idea about the prevalence of anaemia in their area. They reported to be conducting sessions on anaemia for girls from time to time. They also advice “weak” adolescent girls to take juice of *kulekhara* leaves (swamp weeds), livers of lamb and sprouted grams. Severe anaemic cases are referred to the health centres. In one of the locations in Hooghly, the AWWs reported that anaemia camps were organized around one or two year back that revealed 50% of the girls to be anaemic. However, in the last one year, no such camp has been held.

***““My school gives IFA every Tuesday. Whenever I take the tablet, I have nausea”.***

***Adolescent girl, Howrah***

Majority of boys had no exposure to any life skills or family life education programme. Some of the girls had been part of an NGO health and nutrition programme and has received information on health and hygiene issues.

### **4.5.3. Gendered identity: girls prepare for roles of wife and mother, while boys focus on taking the role of provider and protector**

Study findings indicate that gender attitudes regarding role of men and women and gender-discriminatory social practices direct girls and boys into different pathways as they transition into adulthood, and lead to disempowerment of adolescent girls and reinforce the patriarchal values and masculinity among adolescent boys.

***“Growing up as a girl is not easy. We are not allowed to even speak to a boy. Not only family members, even our teachers do not believe us. If we are absent from school for a genuine cause, they think we spend time with boyfriend instead of attending school. They whisper among themselves... brothers are mistaken as boy-friends.”***

***Adolescent girl, Howrah***

Gender roles and attitude shape adolescent girls’ and boys’ daily lives, socialisation process, their command over resource and aspirations in a big way. The girls described how, with puberty, their freedom of movement become more restricted, they are expected to take on more household chores, marry and/or stay away from boys due to adult concerns about their developing bodies and emerging sexuality. *“Friendship with boys is usually not liked by the family members and teachers. This creates tension in the family. Study of the girl is hampered. Parents stop her education (so that she has no excuse for leaving*

the house) and fix marriage in haste. When the boy and girl both are desperate, they run away or threaten to commit suicide.” Importantly, even one such incidence damages the reputation of other girls too. Majority of the girls also described that neighbours and relatives also start putting pressure on parents to get them married off as early as possible. There is restriction on how they dress and carry themselves.

Boys reported experiencing greater freedom to move outside of the household and engage in leisure activities. Boys generally have access to mobile phones while girls do not. This plays out on their preference for entertainment where girls “prefer to watch movies” while boys spend a lot of time on mobile phones, particularly watching YouTube videos and Facebook. This also gives them exposure to pornography that further adds to “skewed” idea about sex and marriage. Adolescent boys described how they want to indulge in risky behaviour as these are considered to be more “masculine”, such as hanging from train doorway and leaning outside for fun, travelling in train without ticket etc. Some of the boys disclosed that they were addicted to alcohol and smoking.

***“It is important that we become good wives and mother. For that, it is important that we remain within our boundaries,”***

The notion of male as providers and protectors of the family also mean increased expectations and pressure on boys to join workforce and help support the family financially as soon as they can. Boys shared that it is common practice for them to give up study and join work due to financial constraints in the family. According to the boys, migration to other state, such as Gujarat, is common.

#### 4.5.4. Aspirations for a better life

Both adolescent girls and boys are aspirational but lack the skillsets and agency that is required to make choices and take an active role in one’s life path. School dropout rate among both girls and boys was found to be high, with boys migrating for job prospects and girls waiting for marriage. When asked how they see themselves five years from now, majority of girls said, “Married in a good family” with only a few saying “Training for a job”. While majority of boys see themselves with a “good job”, few could answer how they could equip themselves with the requisite skillsets to get their dream job. Gender stereotypes are also reflected in the choice of training or jobs as girls mentioned training in handicraft, stitching and tailoring and boys mentioned technical education, computer skills and starting a business.





## 5. Conclusion and way forward





## 5.1. Conclusion

### 5.1.1. Key behaviours need to be targeted for sustainable change in malnutrition

The findings from the rapid assessment suggest a cycle of malnutrition getting perpetuated in the project area due to the prevalent social norm of early marriage (52% of married women between 15-24 years were married off before they attained 18 years, another 23% at the age 18) leading to early pregnancy and childbearing. Boys also tend to marry relatively young and are far from being prepared to assume marital responsibilities. There is no dialogue between newly married couples on family planning and the first child is almost always unplanned and “accidental”. This is acceptable by all as marriage provides the social sanctity to child motherhood. As a result, it is common to find adolescent mothers with poor health and nutritional status who are more likely to have children suffering from poor nutritional status and experiencing stunting.

Further, despite high proportion of antenatal check-ups and institutional delivery in the project area, gaps in understanding of exclusive breastfeeding, inadequate weaning and influx of formula-food and readymade items such as biscuits, hamper traditional complementary feeding practices that exist in the communities and further perpetuate malnutrition among infants and under two children. As a result, growth faltering is common among infants before they reach one year. Further gaps in growth monitoring, nutrition counselling and community-based malnutrition management (Sneh Shivar) in majority of the AWWs lead to further perpetuation of child malnutrition and the critical 1000-day window is missed.

At many levels, why the tradition of child marriage continues to be perceived as a “win-win” situation is understandable when one looks at the social and economic vulnerabilities prevalent in the pockets where the project works, where families – with limited access to education and economic opportunities for girls, faced with dowry demands and fearful of girls’ security as they attain puberty – would opt for their early marriage. In the prevalent social context, unfortunately, this social legitimisation of child marriage as an acceptable way of life has been internalised by the young girls as well, many of whom viewed marriage as a means to achieve independence and social identity which is essential for transition to adulthood. However, low autonomy, lack of agency, limited awareness and insufficient life skills add to their vulnerability and leave them unprepared for marriage and childbearing. For girls to refuse marriage, they have to understand and own their rights, and be able to support their own life plans. At the same time, adolescent boys, who internalise traditional attitudes and norms about masculinity as they grow up, also need to be exposed to gender-egalitarian values and life skills.

To break the cycle of malnutrition that is being perpetuated, through generations in these communities, the study points to three key strategic outcomes.

- **Prevention of early marriage**
- **Delay in first child birth** and spacing between children among young married couples
- **Improve nutrition among 0-6 children**, specifically, exclusive breastfeeding & complementary feeding and community-based malnutrition management

Clearly, as the factors driving these behaviours are multifarious; operate at multiple levels and mutually reinforcing, a multipronged strategy is required to address the three key issues.

## 5.2. Way forward

### 5.2.1. A comprehensive social behavior change intervention approach is essential as drivers operate at multiple levels

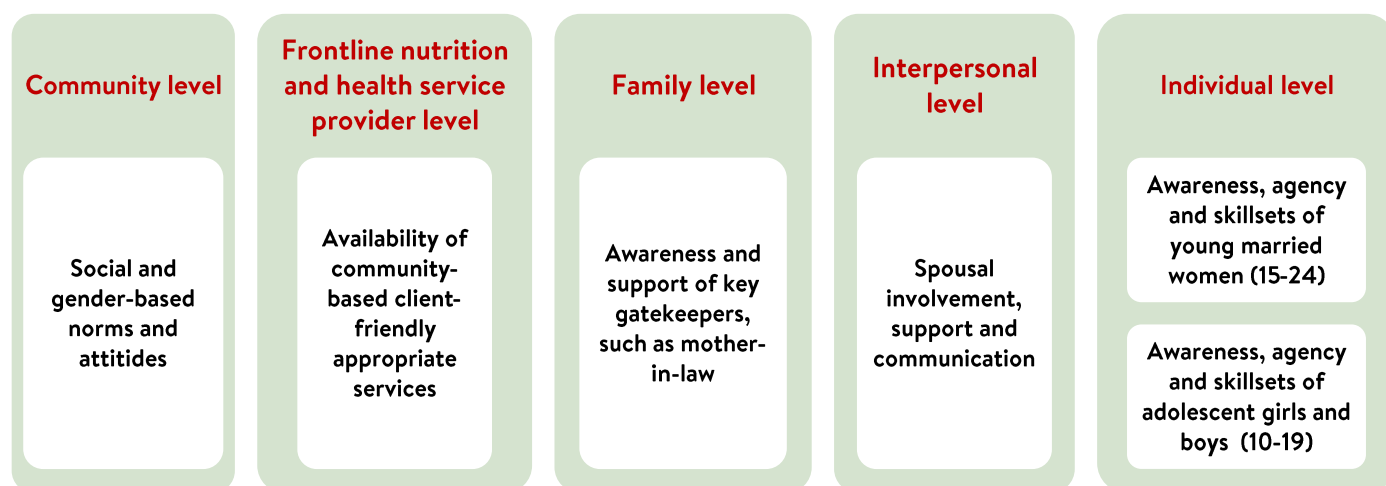
Building a safety-net for prevention of child marriage will require a multi-level strategy to reach out to parents and community leaders aimed at changing social norms and attitude towards girls and women, and at the same time, an adolescent-centric programme perspective that empower both adolescent girls and boys towards a more gender-egalitarian set of norms and attitudes is critical. Thus, working with adolescent groups to create a space for dialogue about gender roles and attitudes, their rights, the social structures that disempower them, and encourage them to voice their own opinions, beliefs and desires, and develop their information base and skillsets will pave the right way to prevent child marriage and exercise their choice.

Various cultural and structural level barriers impede young married couples to access the quality reproductive health care services. Given the high unmet need for family planning among newly married young couples, it will be critical to reach out to young married women (15-24 years) through a multi-pronged intervention which includes not only building her awareness and skills, but also improve her communication with husband on family planning issues, sensitizing family members and strengthening capacity of frontline health functionaries, particularly ASHAs to provide services tailored to their needs.

To develop sustained change in child malnutrition, there is need to build community capacity to improve infant and young child feeding practice so that exclusive breastfeeding and appropriate complementary feeding leaves no child out of the safety net and get into the “growth faltering” stage. Based on existing evidence, a multi-level strategy focusing on empowering women’s group through participatory learning and action to address the issue of child malnutrition as well as systems strengthening through supporting Integrated Child Development Services (ICDS) to ensure regular weighing and growth monitoring, nutrition counselling and community-based management of malnutrition is essential.

Based on study findings, we conclude that it is not individual behaviours, but also social norms and practices that should also be equally addressed, as behaviours and norms complement one and other for sustainable change. Specifically, from the study we identified five sets of factors that need to be addressed (Fig. 4).

Figure 4. Key factors to be addressed at multiple levels



### 5.2.2. Proposed Intervention Framework

YouthInvest team developed the following social behaviour change intervention framework based on a synthesis of existing evidence<sup>10</sup> and feasibility in the project area using a socio ecological model that addresses the complex multi-level factors<sup>11</sup> (Fig. 5). This model recognizes that health behaviours are influenced by multiple individual and societal factors, including age at marriage, partner involvement, family communication, and health system characteristics. To affect and sustain behaviour change, comprehensive interventions are needed that not only engage individuals at risk of poor health outcomes, but also target family and community members who influence individual behaviour, and health service providers responsible for the provision of health services, and the social norms, beliefs, and systems that impact health practices within communities.

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<sup>10</sup> Subramaniam, L et al. (2018). Increasing Contraceptive Use Among Young Married Couples in Bihar, India: Evidence from a Decade of Implementation of the PRACHAR Project. *Global Health: Science and Practice* 2018 | Volume 6 | Number 2.

<sup>11</sup> Sallis, J. F. and Owen, N. G. (2002). *Ecological models of health behaviour*. *Health Behaviour and Health Education: Theory, Research and Practice*, edited by K. Glanz, B.K. Rimer and F.M. Lewis. San Francisco: Jossey-Bass.462-484.

Figure 5. Project social behaviour change intervention framework

Sayan, **Please repeat the figure used in executive summary.**

