

**BASELINE STUDY OF KNOWLEDGE,
ATTITUDE & PRACTICE RELATED TO KEY
HEALTH & NUTRITION ISSUES AMONG YOUNG
PEOPLE IN CHANHO, JHARKHAND: A REPORT**



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I. EXECUTIVE SUMMARY

1.1. Introduction and purpose of the baseline study

This report presents findings and recommendations from the “*Baseline Study on Knowledge, Attitude and Practice related to Health and Nutrition among Adolescents and Youths*” (KAP) conducted in Chanho block, Ranchi district by YouthInvest Foundation, as part of the ATC CSR Foundation India (ATC CIF) supported project entitled “*Preventive and promotive health among adolescent and youths (10-24 years) through an integrated digital platform in rural areas of Jharkhand*”.

The purpose of the study was to understand the baseline status and information gaps regarding key health and nutrition practices among unmarried and married adolescents and youths (12-24 years). Study findings are expected to develop customized intervention strategies as well as serve as a benchmark for evaluation after project completion.

1.2. Key findings from the Baseline KAP Study

1. Households do not have uniform access to essential public health amenities, such as sanitation, drinking water and clean fuel: The study findings demonstrate that in Chanho block, in rural and tribal communities, many households do not have basic public health amenities. 14 % of household still practice open defecation, 24% do not have access to safe drinking water and only 15% have access to liquid petroleum gas (LPG) that make them vulnerable and susceptible to the risk of infection and disease. There is a clear need to improve coverage of essential amenities among these unreached vulnerable populations for preventive and promotive health programmes to be successful.

Unmarried young people and married male are particularly vulnerable have low levels of awareness and practice related to key health issues and are not part any health awareness and promotion programme: 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 a 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. Young people are vulnerable and lack skillsets required to mediate through adult life due to prevalence of high rates of school dropouts, early entry into workforce and migration, early marriage and pregnancy. Majority of the unmarried adolescents and male groups have not participated in any health awareness and promotion programmes. Unmarried girls especially do not have knowledge of contraception and have limited self-efficacy and agency. A clear understanding of conception and contraceptives would help to dispel misinformation about menstruation, conception, pregnancy, and help them prepare better for marriage

and pregnancy. Married young women also need support to practise exclusive breastfeeding and early initiation of complementary feeding. Although institutional delivery is high, 10% of deliveries among married adolescents have taken place at home. Promoting awareness of institutional delivery among these vulnerable communities is critical. Majority of the young people reported not having heard about HIV-AIDS and other STDs. Accurate information is important in prevention of spread of these infections.

3. Gender discriminatory values and attitudes among young people undermine their self-efficacy and agency: Study findings indicate that prevalence of gender-discriminatory social practices add to the disempowerment of adolescent girls and reinforce the patriarchal values and masculinity among adolescent boys as they transition into adulthood. Acceptance of domestic violence as a part of daily lives by young people is a cause for concern and show how deeply entrenched negative gender stereotypes are. The incidence of such violence is not the object of this study but young people though in small numbers, do support the husband's right to physically abuse his wife.

4. Mobile phone usage is very high and participation in traditional social programmes by young people is common, signifying the importance of such platforms for preventive and promotive health programmes: More than 85% of young people, both married and unmarried, use mobile phones, higher than any other media and could be harnessed to disseminate health information.

I.3. Recommendations

The following priority action areas are recommended to promote health and nutrition awareness and uptake of positive behaviour among adolescents and youths and their communities. As a critical population group at the cusp of adulthood, such a programme should have the following components to increase adolescents' preparedness for adulthood and family life.

- 1) **Accessible, easy-to-understand, context-specific information on health and nutrition for young people and their communities:** Evidence shows that programme combining a comprehensive health and life skills programme will be critical in raising awareness of sexual and reproductive matters and helping to adopt protective behaviours. Accordingly, a strong outreach programme involving youth leaders and peer educators will be essential in reaching out to adolescents. Such cadres must be equipped with adolescent-specific communication materials, including using mobile technology and must be trained in how to break down barriers to reach adolescents effectively.

- 2) **Use of digital platform and mobile technology as well as existing platforms for increase programme coverage:** Using a digital platform by creating a health information and resource centres as well as harnessing mobile technology will greatly enhance programme reach and make it attractive to young people. Further, using existing platforms such as traditional fairs, cultural events to promote health information to community will be critical to increase coverage of such a preventive and promotive health programme.
- 3) **Build youth leadership for critical community awareness and ensure essential public health amenities for all poor, vulnerable households:** Building youth leadership to improve community awareness on preventive health will be critical so that community can access existing government schemes and programmes for water and sanitation, clean cooking fuel, maternal and child health etc. This
- 4) **Working in close collaboration with the public health and nutrition system to increase coverage of health services and supplies:** Working closely with the public health and nutrition system to strengthen coverage of the National and State level programmes, such as Rashtriya Kishor Swasthya Karyakram (RKSK), Weekly Iron Supplementation Programme (WIF), Menstrual Hygiene Management Programme (MHM) is important for long-term sustainability. Strengthening the capacity of existing frontline functionaries, such as ASHA, ANM and AWW, along with other stakeholders like Panchayat and teachers is also essential to create an enabling environment.
- 5) **Gender transformative life skills education:** Gender transformative life skills education is essential to address and break-down gender-discriminatory social practices and patriarchal values and masculinity that are internalized by young people. This can go a long way in creating a more egalitarian society that has improved health and nutrition parameters.



2. INTRODUCTION TO THE BASELINE STUDY

2.1. Background

India is faced with the triple burden of diseases: reproductive child health problems and nutritional deficiencies, communicable diseases, and increasing non-communicable, lifestyle-related diseases^{1,2}, that takes a huge toll on health and wealth of the population. Given that every third person in India is an adolescent or youth (10-24 years) and current adverse health practices in this age-group, targeted intervention on health education and promoting healthy behaviours and lifestyle among this age-group is particularly critical for ensuring a healthy, productive nation.

Jharkhand is the 14th most populous state in India and home to 33 million people, 13 million of who are poor. Although improving, progress of health and nutrition indicators is slow in Jharkhand that has a higher maternal mortality ratio (MMR) and infant mortality rate (IMR) than the national average³. The mean monthly out-of-pocket (OOP) expenditure on hospitalization for the state is high at INR 9167, much of which could be prevented with preventive and promotive health interventions⁴. Adolescents and youths are particularly vulnerable, with high



levels of early marriage and childbearing among adolescent girls; poor contraceptive use, low uptake of antenatal and nutritional practices; the prevalence of smoking, tobacco consumption, and alcohol abuse among adolescent boys¹. Use of modern methods of family planning is low and malnutrition and open defecation are among the highest in the country⁵.

However, in Jharkhand, which is predominantly rural and tribal, authentic health information is not easily accessible to communities that are tribal, inaccessible and hard-to-reach. Existing public and private health services often do not reach these communities and are not focused on the provision of health information amongst young people. To bring about positive health behaviour and increased uptake of health services among these young people, digital platforms and the use of mobile technology can play

¹ WHO 2005. Burden of diseases in India.

² Lancet 2017. Nations within a nation: variations in epidemiological transition across the states of India, 1990–2016 in the Global Burden of Disease Study. 390: 2437–60

³ National Family Health Survey, 2015-16

⁴ Singh, P K. Sinha, A. IHD Policy Brief: Healthcare and Nutrition in Jharkhand. 2016

⁵ Health and Education. Jharkhand State Brief. World Bank Group. 2016.

a big role. It is in this context that ATC CSR Foundation India (ATC CIF) has engaged YouthInvest Foundation (YouthInvest), a not-for organisation with a mission to empower young people in reaching their full potential and lead productive lives, to initiate the project entitled “Preventive and promotive health among adolescent and youths (10-24 years) through an integrated digital platform in rural areas of Jharkhand”. The project aims at increasing awareness, skills and uptake of positive health, nutrition and lifestyle practices among adolescents and youths (10-24 years) through the provision of up-to-date, authentic, scientific information using an integrated digital health platform.

The “*Baseline Study on Knowledge, Attitude and Practice related to Health and Nutrition among Adolescents and Youths*” was conducted in selected villages in Chanhoo block, Ranchi district, where the project will be operational. The purpose of the study was to understand the baseline status and information gaps regarding key health and nutrition practices among unmarried and married adolescents and youths (12-24 years). Study findings are expected to develop customized intervention strategies as well as serve as a benchmark for evaluation after project completion.

2.2. Objectives of the Baseline Study

1. To assess prevailing knowledge, attitudes and practice related to reproductive and sexual health, anaemia and nutrition, lifestyle issues, maternal and child health, psychosocial health and gender issues among unmarried and married adolescents and youths (12-24 years).
2. To understand family level demographics and socio-economic status and access to key resources, such as sanitation and cooking gas facilities, that has bearing on health and nutrition behaviours.
3. Develop recommendations for customized intervention strategies.

2.3. Design and methodology

The baseline study was designed as a cross-sectional study, covering in five-gram panchayats in Chanhoo block of Ranchi district of Jharkhand state. The total area to be covered by the study has a population of 32,836 spread across 21 villages.

For the purpose of the study, the adolescent group is divided into four sub-populations

- Unmarried girls (12-19 years)
- Unmarried boys (12-19 years)
- Married young females (15-24 years)

- Married young males (15-24 years)

A combination of probability proportional to size (PPS) and cluster sampling was followed in a two-stage sampling procedure. The minimum recommended sample size was 150 for each adolescent sub-population with an estimation of population proportion with an accuracy of $\pm 10\%$ (absolute), confidence level 95% and design effect 1.5 under the assumption of maximum possible variation of the variable in the population. Provisions for no-response was not required, as the survey continued until the desired sample size was achieved. 10 villages were selected from universe of 21 villages in the first stages. In the second stage, three clusters of five each were selected from the selected villages. The total sample thus calculated was around 600, 150 from each sub-population.

Research tools were designed in the form of 4 structured questionnaires – one for each group. Socio-economic details of the households were collected in a separate questionnaire for all the respondents. YouthInvest engaged *Baseline*, an expert survey and research agency, for survey field implementation, data collection and analysis. Data were collected by trained male and female surveyors from *Baseline* during December 2019. The data were analysed using SPSS v24 and MS Excel 2007.



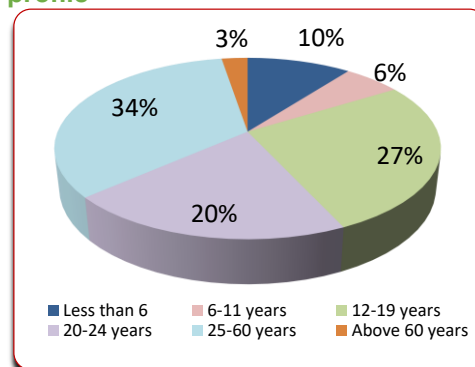
3. KEY FINDINGS

3.1. Family Profile

3.1.1. Demographic Information

To achieve the desired sample size, 537 families were surveyed with a total of 2,738 members. The average family size is 5.1, which is lower than the Jharkhand average of 5.4. 60 % of the families are nuclear families. 16 % of the families are headed by women. Caste distribution of the families shows 47 % of the families belong to ST (Scheduled Tribes), 5 % as SC (Scheduled Castes) and 45 % are OBC (Other Backward Classes). Age-wise distribution of the family members shows that 41 % of the members in the surveyed families are between 12 - 24 years age group.

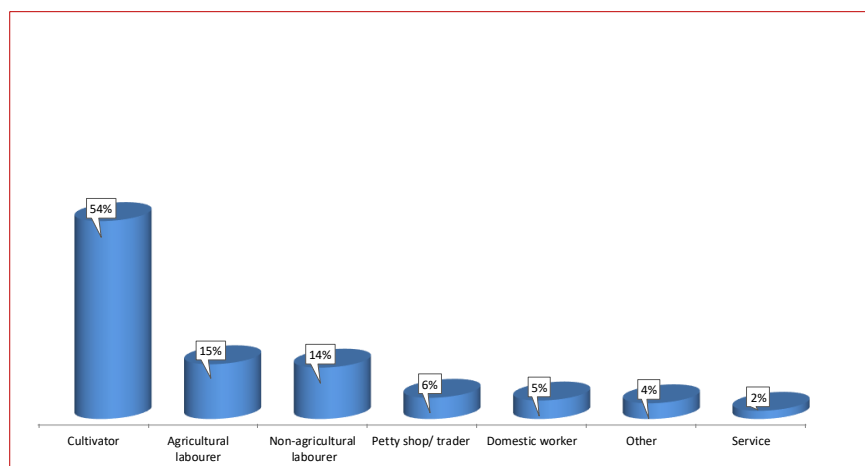
Figure 1. Household respondent age-profile



3.1.2. Socio-economic profile

Agriculture is the primary source of income for 54 % of the families. 15 % of the families have

Figure 2. Household occupation



agricultural labour and 14 % non-agricultural labour as their main source of income. 5% of the families work as domestic help, 6 % have a minor business, such as a petty shop, and 4 % work as driver, carpenters, tailor etc.

Only 2 % of families have salaried workers. Overall, 3% of the population migrate to other places for work. The highest migration rates are observed among the unmarried persons 25-35 years old: 17% among unmarried females and 15% among unmarried males.

3.1.3. Living Conditions and access to water, sanitation and cooking fuel

House structure: 65 % of families live in kuccha houses, 16 % in semi-pucca and 18 % in pucca houses. Only two of the surveyed families lived in huts.

Source of Drinking Water: Only 7% have tap water facility exclusive for them. 47 % use hand pump and 24 % still fetch water from well, river, canal or stream.

Electricity: 96 % of the families receive electricity and use it as the primary source of lighting. 4 % still use kerosene lamps.

Cooking Fuel: 60 % of the families use chullah for cooking whereas 25% cook in open fire. Only 15% have Liquid Petroleum Gas (LPG) connections.

Access to the toilet: 83% of the families use pit toilets, 14% practice is open defecation. Only 1% has flush toilets. Open space defecation is prevalent in the area.

Sleeping under mosquito nets: 67% of the families use mosquito nets regularly.

Table 1. Demographic and socio-economic profile of families surveyed

Indicators	Percentage	Indicators	Percentage
Family structure		Source of lighting	
Nuclear	60%	Electricity	96%
Joint	40%	Kerosene	4%
Religion		Type of toilet	
Hindu	29%	Flush Toilet	1%
Muslim	28%	Pit Toilet	83%
Christian	5%	No facility/Bush/ Open space	15%
Sarna	38%	Other	1%
Caste		Cooking fuel	
SC	5%	Stove	1%
ST	47%	Chullah	60%
OBC	45%	Open fire	25%
General	4%	Gas (LPG)	15%
House structure		Livelihood	
Pucca	18%	Cultivator	54%
Kuccha	65%	Agricultural labourer	15%
Semi-pucca	16%	Non-agricultural labourer	14%
Source of drinking water		Service	2%
Tap exclusive to HH	7%	Domestic worker	5%
Public Tap	21%	Petty shop/ trader	6%
Well	23%	Other	4%
Hand pump	47%		
River/Canal/Stream	1%		
Number of households	537		

KEY TAKEAWAYS

- Many households do not have access to proper sanitation facilities, and open defecation is practised by 14% of families. This clearly increases the risk of infection and diarrhoeal disease.
 - Although safe drinking water is largely available, 24% of families still fetch drinking water from well, stream or river, thus increasing the chance of infection and disease.
 - LPG connection is available to only a small percentage of households, and the majority use chullah and open fire, thus increasing their risk to respiratory illnesses.
- 14% of households practice open defecation, that increases the risk of infection.
 - 24% of households do not have access to safe drinking water and fetch water from well, river or stream.
 - LPG gas is available to only 15% of households.



3.2. The situation of young people

“Adolescents and youths comprise 41% of the total population”

- Unmarried boys (12-19): 14%
- Unmarried girls (12-19): 14%
- Married young men (less than 24 years): 5%
- Married young women (less than 24 years): 8%

3.2.1. Education status

Although most of the adolescents and youths surveyed have been to school, the level of education varies across the four groups. Only 68% unmarried boys and 54% unmarried girls (12 – 19 years) attend school full-time, with a considerable proportion outside school.

3.2.2. Employment status

The responsibility of providing for the family means 90% of married men are in full-time employment. Only 10% of married men reported being not working in the last month. Significantly, a considerable percentage of unmarried girls and boys (30 % and 26 % respectively) are working or have worked for pay in the last one month. The casualty here is pursuing educational ambitions. Agriculture labour is the predominant source of occupation for both male and female.

3.2.3. Marital status

51 per cent of adolescents and youths are married. Among 12 – 19 years adolescents, 9% of males and 20% of females have already been married. In the 20 – 24 years age group, 63 % males and 71% of females have been married.

Figure 3. Highest level of education completed

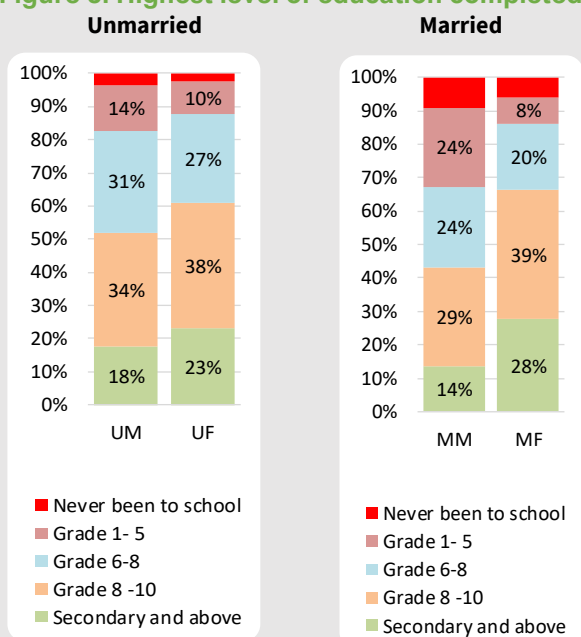
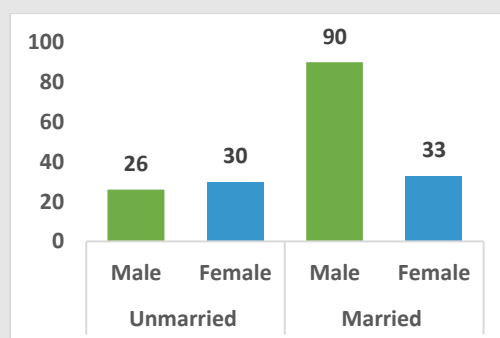


Figure 4. Employment status



3.2.4. Migration

Respondents majorly work within the village of residence. Seasonal employment is more amongst married young women whereas unmarried and married males find employment throughout the year. Married males in 20-24 years age group have the third-highest rate of migration (13%). Married females in both age-categories also migrate, but the rate of migration is comparatively lower among them.

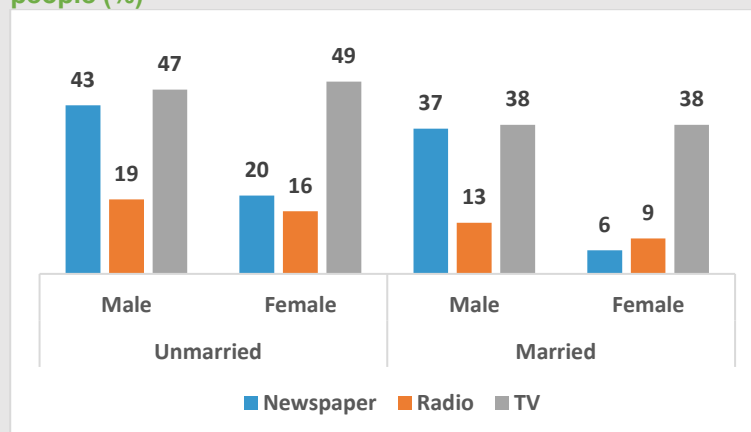
3.2.5. Social interactions

Participation in social activities is common amongst all groups. Participation in local tribal cultural events, such as Sarhul, Karma etc. is 70 % or more amongst all respondent groups.

3.2.6. Mass media exposure and exposure to mobile phone

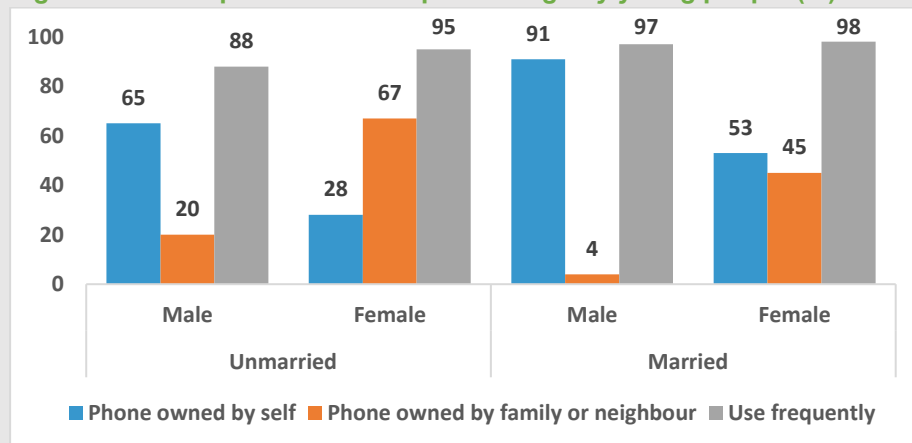
Television is the most popular among all media. Watching movies in cinema halls is not very popular, mostly because it involves travelling to the nearest market centre. Only 12% of unmarried boys reported watching a movie in a cinema hall in the last two months, for all other groups, it is less than 10%.

Figure 5. Mass media exposure at least once a week by young people (%)



Penetration of mobile phone is very high, with more than 85% of young people across all categories using mobile phone daily or frequently, irrespective of whether they own a mobile phone. 91% of married young men possess their own mobiles and 84% of them use mobile phone daily. Unmarried girls and boys though often do not possess phone, have access to a phone within the family and use it frequently.

Figure 6. Mobile phone ownership and usage by young people (%)



KEY TAKEAWAYS

- A large section of unmarried adolescents (12-19 years) (46% girls) and (32% boys) are outside school, and vulnerable to early marriage and trafficking.
 - 30 % of unmarried adolescent boys and 26 % of unmarried adolescent girls are working, many of whom are school dropouts.
 - 20% of girls between 12 and 19 years are already married, showing that child marriage is common in the project area, similar to the rest of Jharkhand.
 - Although exposure to mass media is moderate to low, mobile phone penetration is very high amongst all young people. These findings are significant for designing health information programmes whether the focus should clearly be on using digital platform.
- High levels of school dropout and early marriage make adolescent girls vulnerable and have the potential to compromise their health.
 - Participation in traditional social programmes is high, signifying the importance of such platforms for preventive and promotive health programmes.
 - Mobile phone usage is very high among all adolescents and youths, signifying the importance of using digital modes of communication for preventive and promotive health programmes.

3.3. Awareness and practice related to health and nutrition

The survey explored adolescents' awareness and practice of various health and nutrition issues, including sexual and reproductive health issues during puberty, pregnancy, contraception, HIV/ AIDS, pregnancy and infant feeding practice.

3.3.1. Awareness, myths and misconception on pubertal changes

3.3.3.1. Awareness and myths related to menstruation among adolescent girls and young women

Misconceptions about menstruation, a normal physiological function, is common among both unmarried and married adolescents and young women. There is a predominant view that a menstruating woman is 'unclean'. 62% and 70% of unmarried and married women believe that menstrual blood contains poisonous substances respectively. A high percentage of unmarried and married females believe that proteins (fish, meat etc.) should not be eaten during menstruation. An equal number of married and unmarried women believe that women should not leave the house during periods.

Table 2. Myths and misconception about menstruation among unmarried adolescent girls and young married women*

	Unmarried	Married
Menses make a woman unclean		
True	50	51
False	29	41
Don't know	20	8
Menstrual blood contains poisonous substances		
True	62	70
False	30	28
Don't know	8	3
Girls should not eat proteins, such as meat/ fish etc. during menstruation		
True	42	34
False	35	51
Don't know	23	16
Girls should not go out of the house during menstruation		
True	40	49
False	48	43
Don't know	12	8
The menstrual cloth should be dried in the dark as it will cause harm if men see it		
True	40	41
False	46	47
Don't know	14	13
Number of respondents	161	152

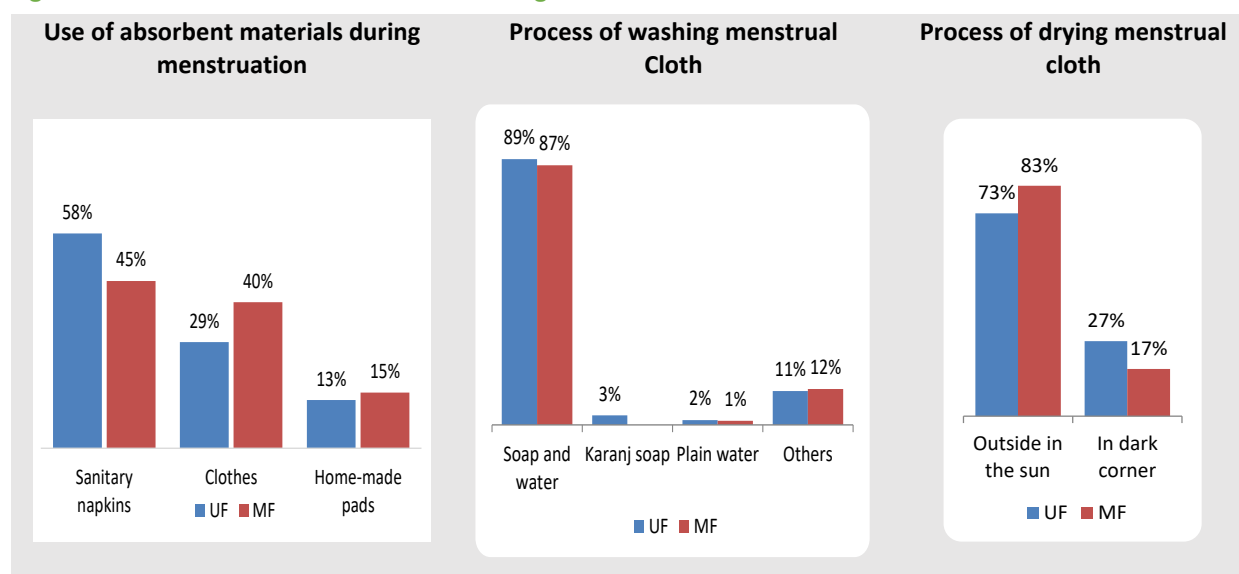
*All figures in percentage

3.3.3.2 Menstrual hygiene practices among adolescent girls and young women

The popularity of sanitary napkins is gradually increasing. A higher percentage of unmarried adolescent girls as compared to married young women use sanitary napkins. A large segment of married and unmarried females (40% and 29% respectively) still use old clothes that they wash for repeat use during menstruation. 45% of the married and 58% of the unmarried females use sanitary napkins.

Cloth napkins are washed using soap and water. 87% of the married females and 89% of the unmarried females confirmed this. However, a few do not use soap and wash the cloth in plain water. Some mention about using Karanja soap, a locally available herbal soap, for cleaning menstrual cloth. 17% of the married females and 27% of the unmarried females, who use old clothes during menstrual period, dry it in the dark corner. Disposal of sanitary napkins is by burial, discarding in open fields, and burning in the order of preference. 67 to 75% use burial. Disposal of sanitary napkins is by burial (more than 65%), discarding in open fields, burning in the order of preference.

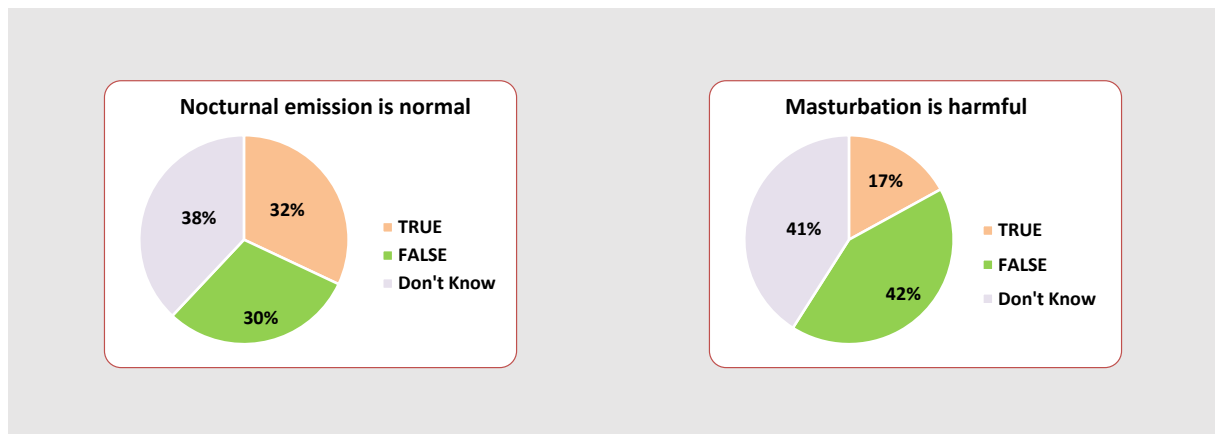
Figure 7. Use of absorbent materials during menstruation



3.3.2. Myths and misconceptions about male pubertal changes

Unmarried boys were asked whether they think nocturnal emissions are normal, and masturbation is harmful to health. The misconception that nightfall as a normal physiological process is widespread, with 30% thinking it is not and another 38% did not know.

Figure 6. Myths and misconceptions about male pubertal changes among unmarried male adolescents



3.3.3. Awareness about iron-deficiency anaemia and use of iron-folic acid supplementation

Iron deficiency anaemia is one of the major public health problems in India. NFHS 4 showed very high levels of anaemia among adolescent girls and married women in Jharkhand. The survey asked questions on both awareness and practice related to the prevention of anaemia.

3.3.3.1. Awareness about symptoms of iron-deficiency anaemia

All participants from all four sub-groups have heard of anaemia. However, many of them were not aware of its symptoms, causes, remedy and prevention. 60% of the unmarried girls, 55% of the married young males, and 49% of each - unmarried boys and married young women - know nothing about symptoms of anaemia. The most common symptoms of anaemia known to the respondents were weakness, dizziness, reeling of head and constant tiredness. A few mentioned about breathlessness, loss of appetite, and blackout.

3.3.3.2. Awareness about the causes of anaemia

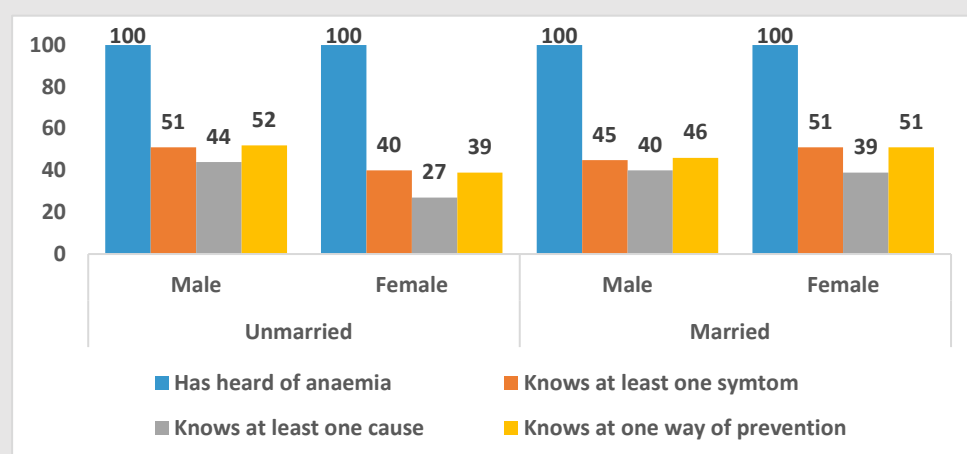
73% of the unmarried girls, 61% of the married young women, 60% of the married young men and 56% of the unmarried boys know nothing about the causes of anaemia. Poor diet is the most repeated response when asked about the causes of anaemia among unmarried boys and girls and married young women. Among the married young men, however, it was heavy work. A few also referred to worm infestation, lack of iron in the diet and bleeding as causes of anaemia.

3.3.3.3. Awareness about the prevention of anaemia

Most of the young people are not aware of how to prevent anaemia. Eating nutritious food is

the most common answer received from those who possess some knowledge about the prevention of anaemia. This is followed by eating green leafy vegetables, taking vitamin and iron tablets, and eating animal proteins like fish, meat, eggs, milk etc. Only 24% of unmarried women, 22% each of married men and women, and 20% of unmarried women had correct knowledge that drinking tea/coffee, in fact, reduces iron level in the body and increases the chance of anaemia.

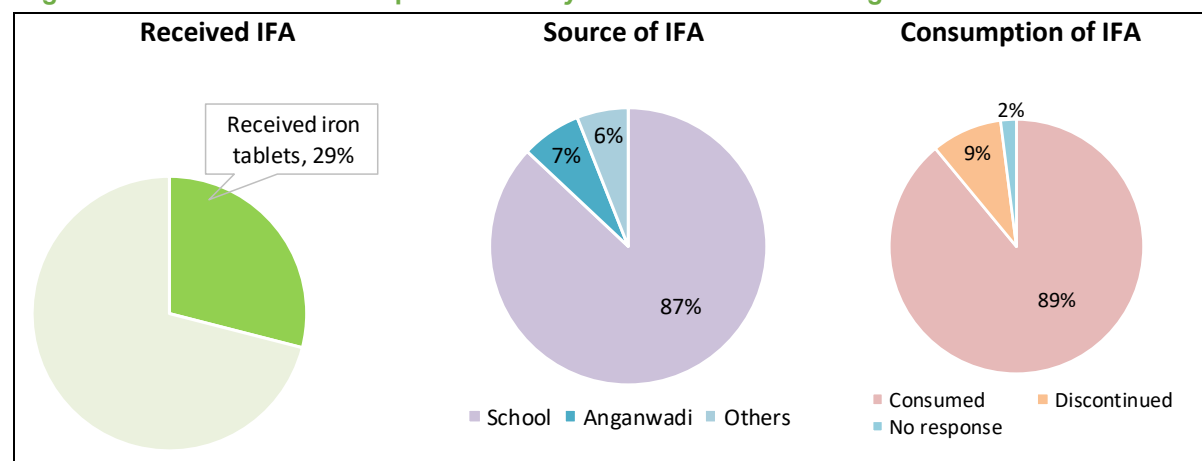
Figure 9. Awareness of symptoms, causes and prevention of anaemia (%)



3.3.3.2. Access and use of iron-folic acid (IFA) supplementation

Although the National Weekly Iron & Folic Acid Supplementation (WIF) programme among unmarried adolescent girls is being implemented in Jharkhand, the survey found that only 29% of the unmarried girls received iron tablets in the 3 months preceding the survey. Of them, 87% of them received IFA tablets from schools and 7% from Anganwadi Workers. Among those who have received IFA tablets, 89% of consumed them and 9% did not due to nausea.

Figure10. Access and consumption of IFA by unmarried adolescent girls

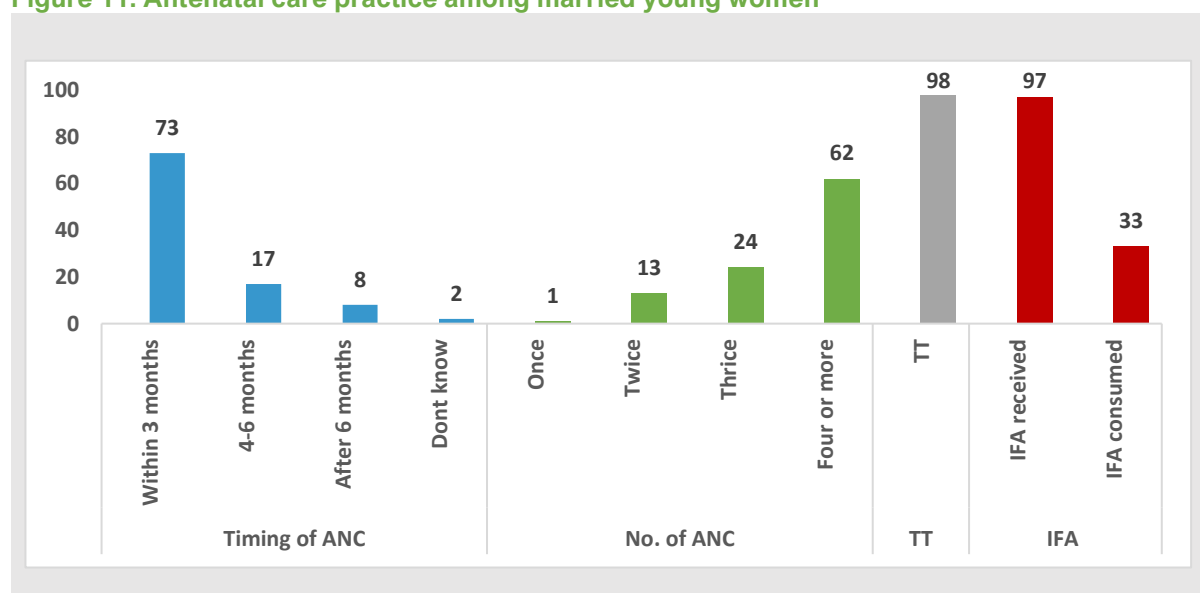


3.3.4. Antenatal care practice among married young women

3.3.3.1. Antenatal check-up (ANC)

Of the young married women (15-24 years) interviewed, 123 have had a child in the last two years. All of them reported having received ANC. 62% received four or more ANC. Majority of them received ANC from government hospital or health centre compared to private doctors. 73% of the mothers reported that they received their first antenatal check-up within three months, 17% within 4 to 6 months, and 8% received it after six months. 2% of the mothers did not answer. 98% of mothers reported that they received tetanus toxoid (TT) during ANC. 97% of the mothers received iron tablets or syrup during pregnancy. Of them, iron tablets or syrup, 33% have consumed all. 67% were non-compliant and discontinued.

Figure 11. Antenatal care practice among married young women

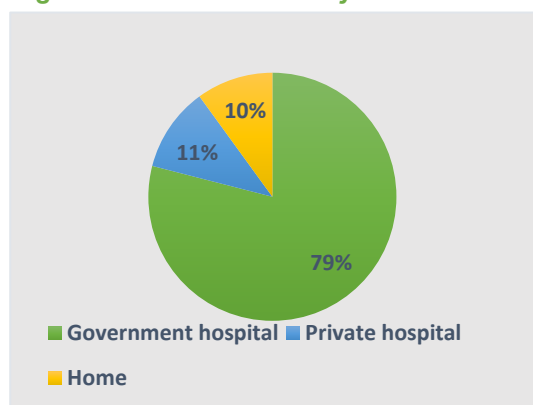


3.3.5. Awareness and practice related to delivery and infant feeding practice

3.3.5.1. Place of delivery

The survey found that government hospital is the preferred place for delivery with 79% using the facility for childbirth. 11% went to private facilities. Although declining, a significant 10% of women had home deliveries.

Figure 11. Place of delivery

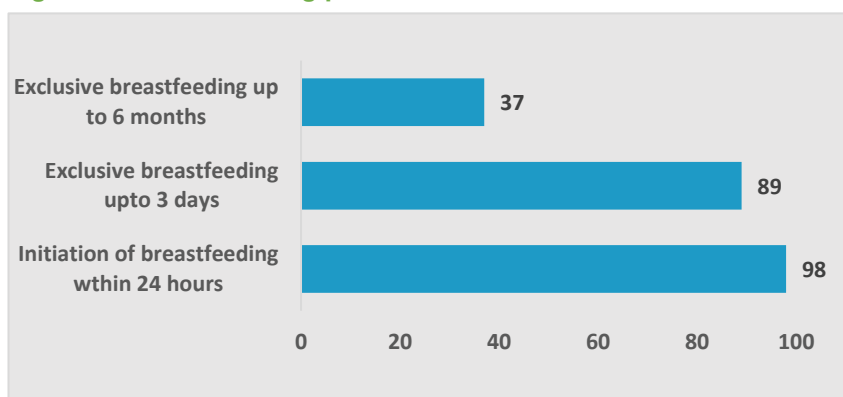


3.3.5.2. Awareness and practice regarding breastfeeding and complementary feeding

Breastfeeding was initiated within 24 hours of birth in 97% of cases. Awareness on colostrum feeding is high and 98% mothers reported that breastfeeding was initiated with 24 hours of delivery.

Exclusive breastfeeding was followed up to three days by 98% of the mothers. However, only 37% of young mothers could continue exclusive breastfeeding for 6 months. Others reported

Figure 12. Breastfeeding practices



feeding their babies a host of other items with or without breastmilk.

However, there is a delay in introduction of complementary food starts. None of the mothers reported introducing semi-solid food when the infant was 6-8 months. Common food given after 8 months included roti or rice (43%), followed by plain water (30%), biscuits (24%), other types of milk (19%), fruits or vegetables (14%), meat chicken/ fish/Eggs (14%), tinned/ powdered milk (8%), potatoes (8%) and a range of other items.

3.3.5.3. Infant Death

Of the 148 infants who were born to the young married female respondents, 5 (3 male, 2 female) died within one year.

3.3.6. Awareness and practice of family planning methods

3.3.6.1. Awareness of fertile period and conception

All categories of respondents were asked about their understanding of fertile period through the question “When is a woman most likely to get pregnant in relation to her menstrual period?” The survey found that awareness about fertility is low among all categories, with least amongst unmarried girls. When asked about “if a woman can get pregnant just after one intercourse”, majority of the respondents across all four sub-populations either did not know or gave an incorrect answer to the question. Awareness was lower among the unmarried

groups as compared to the married ones. Table 3 shows awareness about fertile period among four different sub-populations.

Table 3. Awareness of fertile period and conception

	Unmarried boys	Unmarried girls	Married young male	Married young female
A woman has the maximum likelihood of getting pregnant				
During her period	11 %	10 %	23 %	22 %
In the middle of her cycle	11 %	3 %	35 %	23 %
Right after her period has ended	2 %	3 %	7 %	32 %
Just before her period begins	2 %	-	1 %	5 %
Other	7 %	1 %	2 %	-
Don't Know	69 %	83 %	36 %	20 %
A woman can conceive during the first intercourse				
Tue	22	13	44	39
False	28	12	35	47
Don't know	50	75	21	14
Total Respondents	169	161	153	152

3.3.6.2. Awareness about family planning methods

A large section of respondents across all categories have reported having no awareness of any family planning method. Married women knew most about contraception among all the sub-groups. The incidence of teen pregnancy is reportedly low in India, but there is still hesitation in discussing contraception with young girls. Only 19% of unmarried girls know about any method of contraception. This could also have a bearing on use of contraception post-marriage. The condom is the most known of all methods and vasectomy the least known among both unmarried and married males. A large section of married and unmarried women are aware of injectable (DMPA) which has been recently added to the basket of choice for family planning offered by the government. Knowledge of natural birth control method and emergency contraception is also more among women than among men. Table 4 shows awareness of various contraceptive methods among four different sub-populations.

Table 4. Awareness of family planning methods among young people

	Unmarried boys	Unmarried girls	Married young male	Married young female
Pill	6%	4%	19%	23%
Condom	36%	6%	56%	30%
Copper T	6%	2%	20%	23%
Injectable	3%	4%	11%	26%
Vasectomy/ male sterilization	4%	0%	5%	4%
Tubectomy / female sterilization	2%	9%	3%	24%
Natural methods (Safe period, withdrawal)	1%	6%	3%	9%
Emergency contraception	4%	17%	1%	9%
Other (herb, <i>jaributi</i> etc.)	4%	6%	1%	9%
No knowledge	57%	81%	40%	38%
Total Respondents	169	161	153	152

Awareness about the sources of contraceptives widely varies across the sub-populations. While the most familiar place for the procurement of contraceptives among married women and unmarried girls are government hospitals and health centres, it is the pharmacy among the married men and unmarried boys. More females than males are aware of private clinics and doctors as providers of contraceptive. ANM is the least known source across all sub-populations.

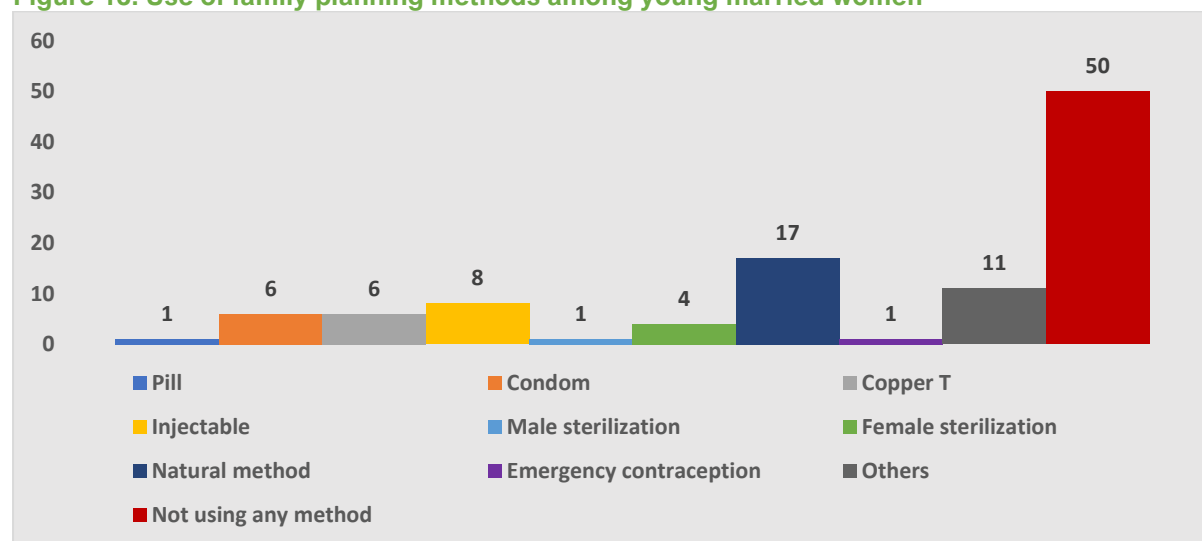
Table 5. Awareness about the source of family planning methods

	Unmarried boys	Unmarried girls	Married young male	Married young female
Government hospital/ PHC	24 %	73 %	30 %	85 %
Pharmacy	58 %	43 %	54 %	48 %
Sahiyaa (ASHA)	15 %	13 %	30 %	24 %
Private doctor	1 %	17 %	4 %	14 %
ANM	0 %	0 %	7 %	6 %
Private clinic/ hospital/ nursing home	3 %	17 %	2 %	6 %
Other	14 %	0 %	4 %	1 %
Total Respondents	72	30	92	95

3.3.6.2. Family planning practice among young married women

Young married females were asked about their family planning practice. Of the 145 women who responded, 50% were not using any contraceptive method at the time of the survey. Use of modern methods of contraception is found to be low among respondents (Table 5). Of the women not using any contraceptive method, 49 % of married young women reportedly wanting to conceive. 6% reported that their husbands did not approve the use of contraceptive, 3% did not know what methods they should use, 43% cited some other reasons, such as husband staying outside, not indulgence in sexual activity regularly or could any give any specific reasons for not using any contraceptive method.

Figure 13. Use of family planning methods among young married women

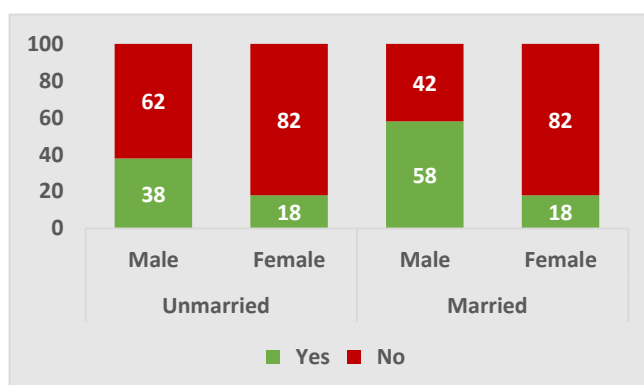


3.3.7. Awareness of HIV/AIDS and other Sexually Transmitted Disease (STD)

3.3.7.1. Awareness about routes of transmission of HIV/AIDS

This is a matter of grave concern that 82% of each, unmarried girls and married young women; 62 % of unmarried boys, and 42 % of married young men have not heard about HIV-AIDS.

Figure 14. Heard about HIV/AIDS (%)



46%-55% of those who have heard of AIDS across the four sub-populations believe that it is possible to cure AIDS. The most known source of infection of HIV/AIDS across all sub-groups was sexual contact followed by infected syringe or needle, and blood transfusion. The parent to child transmission of HIV was the least known route of transmission of HIV/AIDS in all four groups. There are also prevailing myths and misconceptions that HIV can spread through a mosquito bite, handshaking, kissing, hugging, and sharing dresses and utensils with an infected person. Table 6 below gives details of the awareness of HIV/AIDS prevention.

Table 6. Awareness about modes of transmission of HIV/AIDS among young people who heard about HIV/ AIDS

Mode of transmission	Unmarried boys	Unmarried girls	Married young men	Married young women
Sexual contact	47 %	28 %	64 %	64 %
Infected syringe/Needles	11 %	28 %	22 %	25 %
Blood transfusion	14 %	28 %	17 %	18 %
Infected mother to child	2 %	3 %	4 %	-
Mosquito bite	5 %	-	6 %	-
Shaking hands	-	-	20 %	-
Kissing/ Hugging/ Eating using same utensils	3 %	10 %	2 %	-
Wearing an infected person's dress	-	3 %	-	-
Other	2 %	0 %	7 %	-
Don't know	44 %	48 %	22 %	32 %
Total Respondents	64	29	89	28

3.3.7.2. Awareness about HIV/AIDS prevention

Abstaining from sex is the most common method of prevention of HIV/AIDS known to all except married young men. Most of the married young men know about condoms as a method to prevent AIDS. Condoms are well-known also among the unmarried boys and married young women. Myths and misconception regarding methods of prevention of HIV/AIDS include

avoidance of kissing, hugging, handshaking, and sharing clothe and utensils (Table 7).

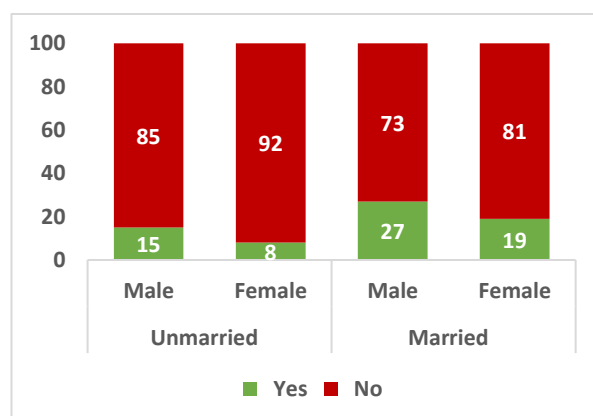
Table 7. Awareness about methods of prevention of HIV/AIDS

Question/ indicator	Unmarried boys	Unmarried girls	Married young men	Married young women
1 Abstain from sex	36 %	28 %	43 %	61 %
2 Use condoms	25 %	3 %	52 %	14 %
3 Have only one sex partner	8 %	10 %	22 %	14 %
4 Avoid injections/ use clean needles	3 %	17 %	7 %	18 %
5 Avoid Intra-venous drug use	3 %	3 %	2 %	7 %
6 Avoid kissing/ hugging/ hand shaking/ Sharing clothes	3 %	3 %	1 %	-
7 Avoid sharing utensils	-	-	1 %	-
8 Avoid sharing shaving kits/ razors	3 %	-	-	-
9 Avoid mosquito bites	2 %	-	2 %	-
10 Other	3 %	10 %	1 %	-
11 Don't know	45 %	52 %	30 %	39 %
Total Respondents	64	29	89	28

3.3.7.3. Awareness of other STDs

Across all four respondent groups, very few young people have knowledge of other STDs. Of the small proportion of young people who have heard of STDs, lack knowledge of its symptoms is even poorer (Table 8). Genital discharge and ulcers are the most familiar STDs to those who had awareness of STDs. For all respondent groups, government hospitals and

Figure 14. Know about STD (%)



health centres were the most preferred choice of providers. However, a large proportion of women and girls would also like to visit a private clinic for treatment of STDs. Very few will depend on the village doctors for STD treatment (Table 9).

Table 8. Awareness about the symptoms of STDs

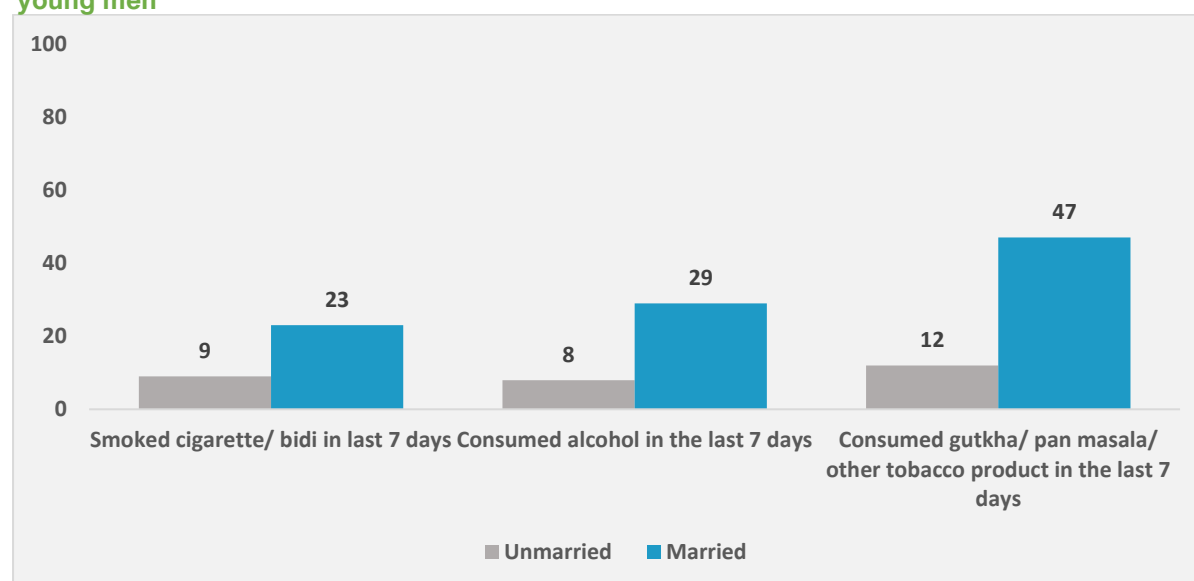
	Unmarried boys	Unmarried girls	Married young men	Married young women
Discharge from penis	32 %	23 %	52 %	21 %
Ulcers/sores in genital area	20 %	23 %	24 %	17 %
Pain during urination	8 %	8 %	19 %	34 %
Vaginal discharge	8 %	8 %	7 %	10 %
Other	8 %	23 %	5 %	7 %
Don't know	56 %	46 %	31 %	38 %
Total Respondents	25	13	42	29

Table 9. Choice of STD treatment provider

	Unmarried boys	Unmarried girls	Married young male	Married young female
Village doctor	8 %	23 %	19 %	3 %
Pharmacy	8 %	31 %	24 %	10 %
Govt. hospital/health centre/clinic	36 %	54 %	36 %	83 %
Private doctor/clinic	-	31 %	2 %	48 %
Other	4 %	0 %	2 %	-
Don't know	48 %	23 %	36 %	7 %
Total Respondents	25	13	42	29

3.3.8. Substance Abuse

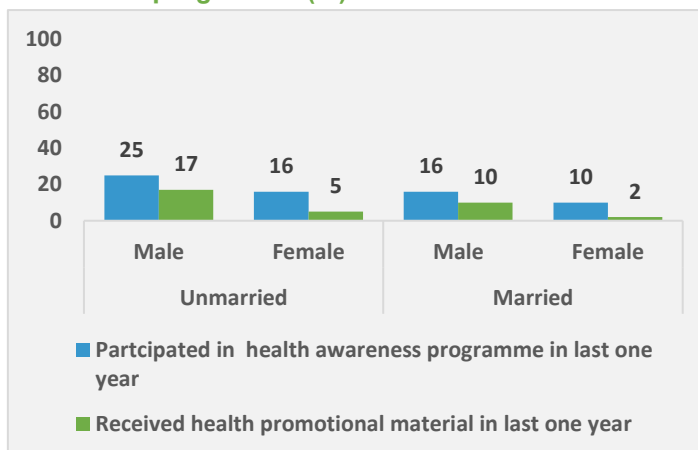
Adolescents are the time when habits such as smoking, alcoholism etc. are formed, that lead to onset of non-communicable diseases - such as cancer, heart disease etc. – which are rising in India. The survey collected information on substance abuse among young people so that preventive and promotive health campaigns and messages can be given to young people. Although substance abuse is reported to be almost absent female respondents, it is found to be common among male respondents. Smoking is reported by 23 % and 9 % of married and unmarried males. Consumption of tobacco in the form of *gutkha* or *pan masala* is reported by 47% of married men. Alcohol consumption is reported by 29% of married young men. Local liquor variants are more popular than foreign or Indian-made foreign liquors (Fig 15).

Figure 15. Substance abuse among unmarried and married adolescents and young men

3.3.9. Participation in health promotion and awareness programme

The survey collected information on access to health check-up or any health promotion programme for young people in the last year. This is excluding married females who have had a child and have availed maternal and child health services. Majority of respondents across all sub-groups had not participated in any health promotion or awareness programme. Even unmarried boys and girls who are attending school full-time have not reported having participated in any health camp, despite school health programmes in place.

Figure 16. Participation in health promotion and awareness programme (%)



KEY TAKEAWAYS

- Awareness of pubertal changes is low among both unmarried male and female adolescents.
- Use of sanitary napkins and home-made sanitary pads is increasing. 29% of married girls and 40% of young married women still use old clothes.
- Awareness of anaemia is poor and only 29% of unmarried girls had received IFA in the last 3 months. IFA consumption during pregnancy is also low only at 33%.
- 10% of the deliveries still took place at home.
- Infant and young child feeding practice are unsatisfactory.
- Family planning awareness and usage are low among married young women.
- Substance abuse is common among male respondents, particularly among the married.
- Myths and misconception regarding physiological processes during puberty and menstruation are common.
- Awareness on health and nutrition topics, such as family planning, anaemia, HIV/AIDS, infant feeding practice etc. are low.
- Use of modern contraceptive methods among married young women is low and there is unmet need for contraception.
- Substance abuse is common among male unmarried and married young people, leading to potential health hazards.

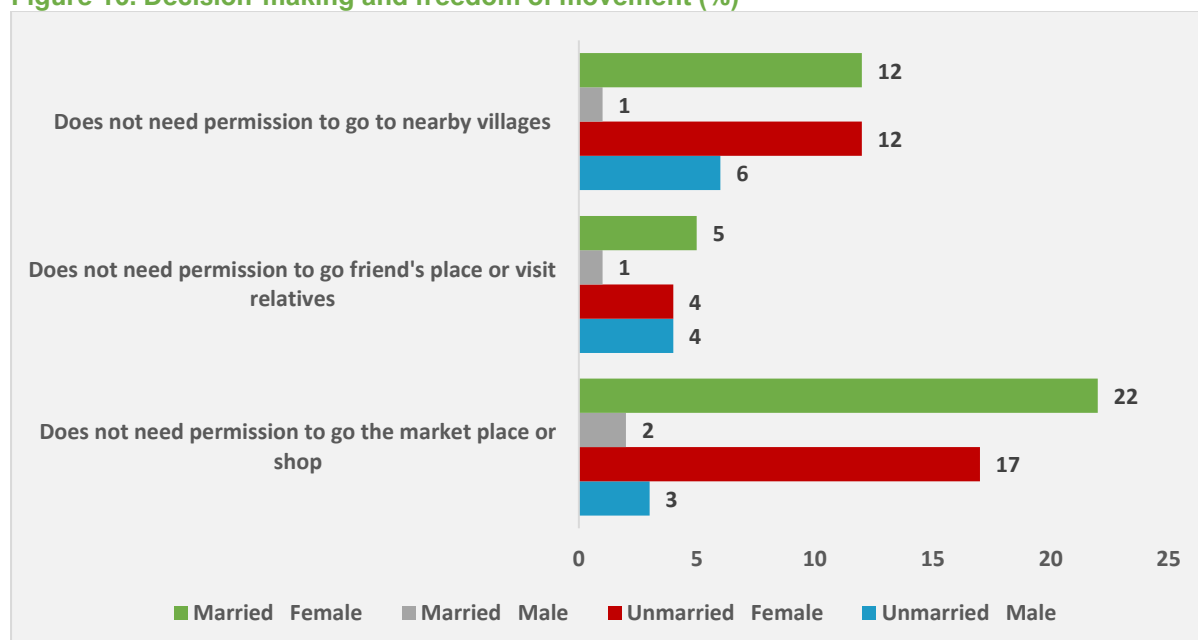
3.4. Attitudes and agency of young people

The baseline survey measured adolescents' attitudes and agency via a range of questions reflecting their attitude towards gender-related values, decision-making authority about matters affecting their life, their freedom of movement, and their self-efficacy. It also measured their attitude towards gender-based violence.

3.4.1. Adolescent agency: decision-making and freedom of movement

The survey asked questions whether the respondent is free to go unescorted to a shop or market inside and outside his/her own village, and to a friend's or relatives place. Findings suggest that agency is limited, and as expected, hugely gendered.

Figure 16. Decision-making and freedom of movement (%)



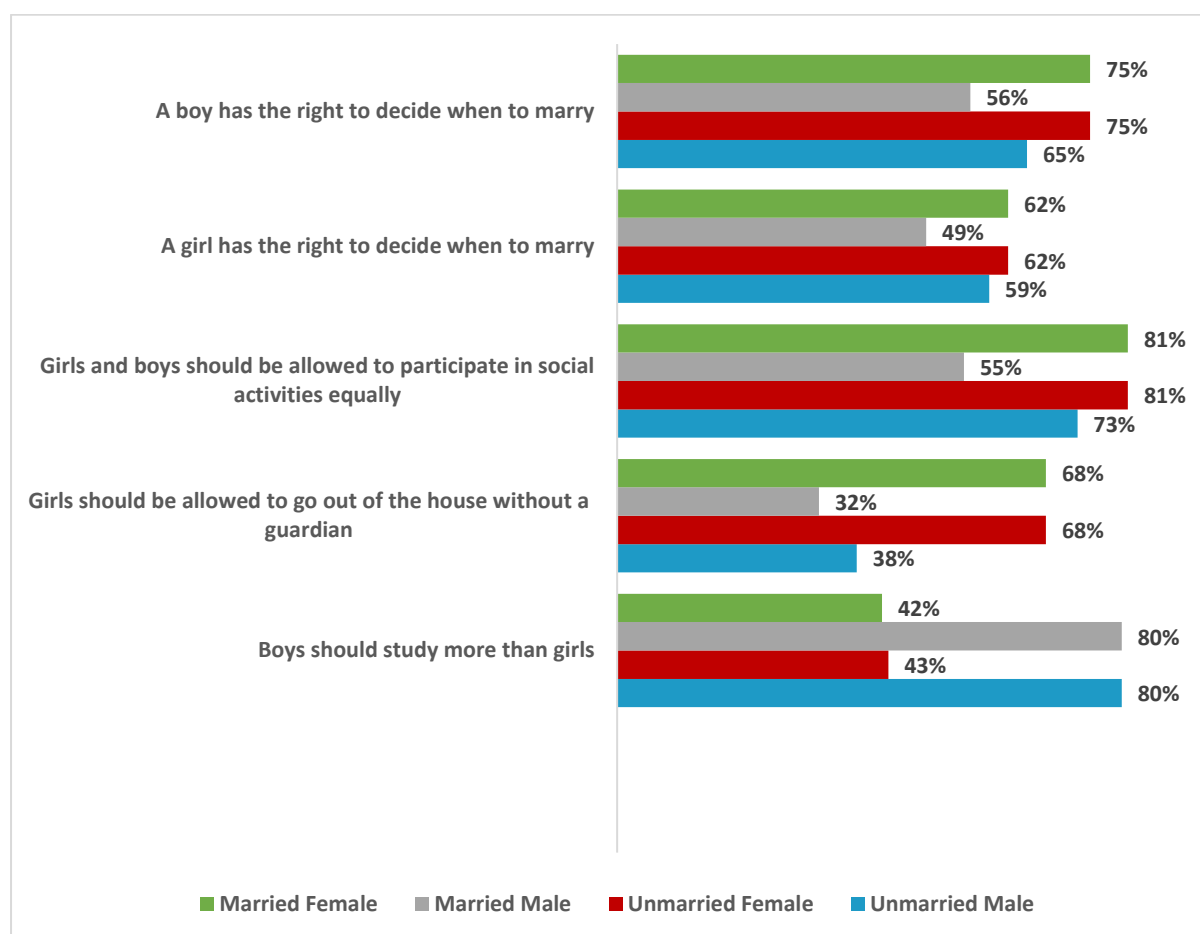
3.4.2. Attitude towards the age of marriage and first childbearing

According to all respondents, on an average 19 and 21 is the minimum age at which girls and boys respectively can get married. More than 95% of respondents from all sub-groups feel that the women should bear her first child between 18 and 25 years of age and that a man should father a child by 24 years of age. All respondents reported that the average age gap between two children should be a minimum of 3 years.

3.4.3. Gender-related values

To understand gender-related values and attitudes, respondents were asked about whether “boys should study more than girls, girls should be allowed to go out of the house without a guardian, girls and boys should participate equally in social events, girls and boys have a right to decide when to marry”. Responses show that in general, male responses are more skewed towards patriarchal values and traditional gender-roles (Table 10).

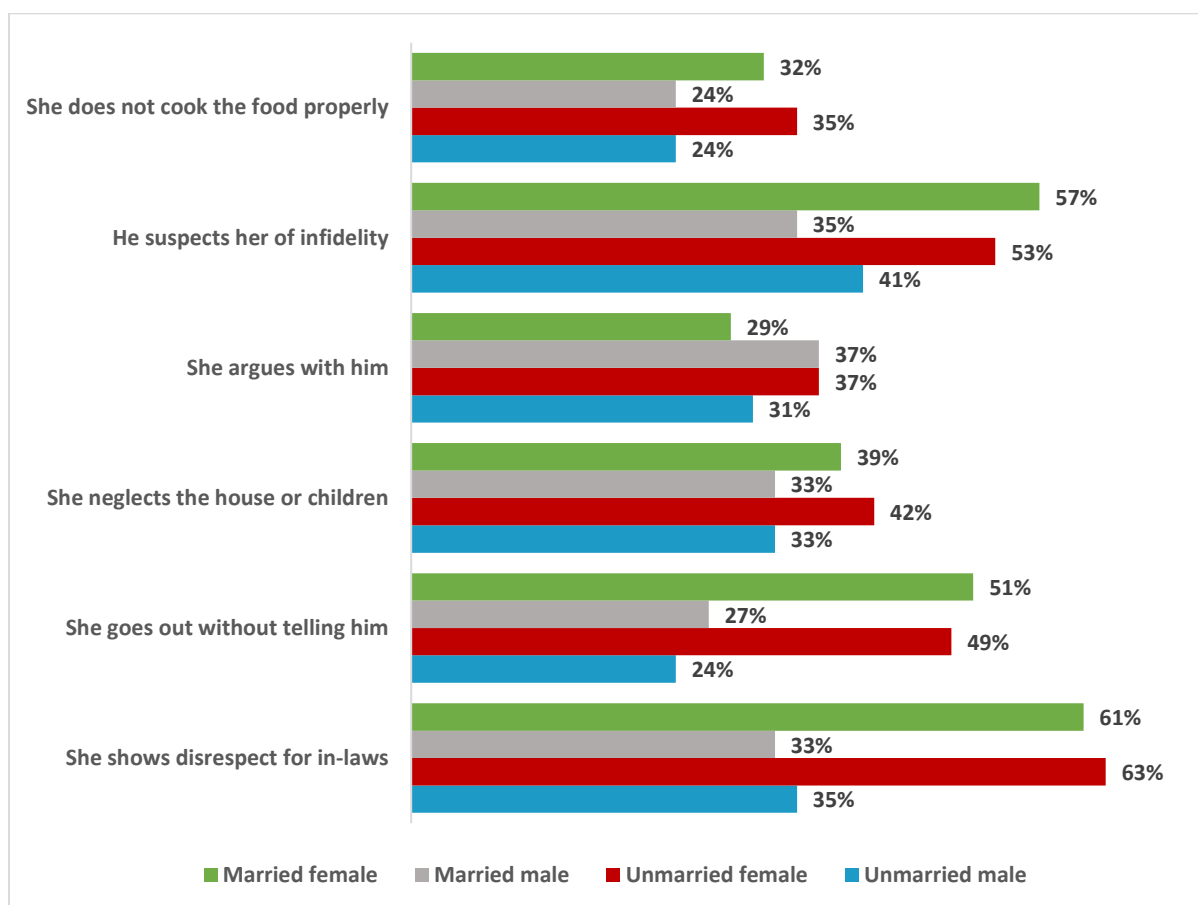
Figure 17. Gender related values and attitude



3.4.5. Attitudes towards violence gender-based violence

The survey also asked questions regarding attitudes towards gender-based violence, and surprisingly, the findings suggest that more females, both unmarried and married, think that wife-beating is justified than the male respondents. This clearly shows how deeply values of patriarchy and gender are entrenched (Figure 18).

Figure 17. Attitude of regarding physical abuse of wives by husbands



KEY TAKEAWAYS

- Patriarchal values are deeply entrenched and affect adolescent gender-related attitude, their decision-making and agency.
- Gender differences were more in terms of freedom of movement and attitude towards decision-making about marriage, participation in social activities and education.
- More female than male adolescents think that wife-beating is justified than male respondents.
- Gender transformative life skills education is critical to change these values and attitudes, and increase self-efficacy and agency, particularly for female adolescents.

- Patriarchal values are deeply entrenched and affect adolescent attitude, decision-making and agency, affecting all spheres of life including health and nutrition related awareness and practices.
- Gender transformative life skills education is critical to change these values and attitudes, and increase self-efficacy and agency, particularly for female adolescents.



4. WAY FORWARD

4.1. Conclusions

The study findings demonstrate that in Chanho block, in rural and tribal communities, many households do not have basic public health amenities. 14 % of household still practice open defecation, 24% do not have access to safe drinking water and only 15% have access to liquid petroleum gas (LPG) that make them vulnerable and susceptible to the risk of infection and disease. There is a clear need to improve coverage of essential amenities among these unreached vulnerable populations for preventive and promotive health programmes to be successful.

A large proportion of unmarried adolescents between 12 and 19 years have dropped out of school and already entered workforce. A high proportion of married young men work as migrant labourers. Child marriage is common making adolescent girls vulnerable and has the potential to compromise their health. Participation in traditional social programmes is high, signifying the importance of such platforms for preventive and promotive health programmes. More than 85% of young people use mobile phones, higher than any other media and could not be harnessed to disseminate health information.

In this backdrop, the study findings show that adolescents and youths have low awareness of key health and nutrition issues that have bearing on their current and future health. Study findings show that majority of adolescents and youths, particularly male and unmarried, are vulnerable as they are not part of any health awareness and promotion programme.

Majority of the young people interviewed have correct information about pubertal changes and other reproductive and sexual health issues. Although the age of marriage is relatively low, unmarried girls especially do not have knowledge of contraception and have limited self-efficacy and agency. A clear understanding of conception and contraceptives would help to dispel misinformation about menstruation, conception, pregnancy, and help them prepare better for marriage and pregnancy. Married young women also need support to practise exclusive breastfeeding and early initiation of complementary feeding. Although institutional delivery is high, 10% of deliveries among married adolescents have taken place at home. Promoting awareness of institutional delivery among these vulnerable communities is critical. A large proportion of the sample population reported not having heard about HIV-AIDS and other STDs. Accurate information is important in prevention of spread of these infections.

Study findings indicate that the prevalence of gender-discriminatory social practices add to the disempowerment of adolescent girls and reinforce the patriarchal values and masculinity among adolescent boys as they transition into adulthood. Acceptance of domestic violence as a part of daily lives by young people is a cause for concern and show how deeply entrenched negative gender stereotypes are. The incidence of such violence is not the object of this study but young people though in small numbers, do support the husband's right to physically abuse his wife.

4.2. Recommendations

The following priority action areas are recommended to promote health and nutrition awareness and uptake of positive behaviour among adolescents and youths and their communities. As a critical population group at the cusp of adulthood, such a programme should have the following components to increase adolescents' preparedness for adulthood and family life.

- 6) **Accessible, easy-to-understand, context-specific information on health and nutrition for young people and their communities:** Context appropriate health and nutrition programme focusing on preventive and promotive health and its determinants is critical. Evidence shows that programme combining a comprehensive health and life skills programme will be critical in raising awareness of sexual and reproductive matters and helping to adopt protective behaviours. Youth advocates peer educators must be equipped with adolescent-specific communication materials, including using mobile technology and must be trained in how to break down barriers to reach adolescents effectively.
- 7) **Use of digital platform and mobile technology as well as existing platforms for increase programme coverage:** Using a digital platform by creating a health information and resource centres as well as harnessing mobile technology will greatly enhance programme reach and make it attractive to young people. Further, using existing platforms such as traditional fairs, cultural events to promote health information to community will be critical to increase coverage of such a preventive and promotive health programme.
- 8) **Build youth leadership for critical community awareness and ensure essential public**

health amenities for all poor, vulnerable households: Building youth leadership to improve community awareness on preventive health will be critical so that community can access existing government schemes and programmes for water and sanitation, clean cooking fuel, maternal and child health etc. This

- 9) **Working in close collaboration with the public health and nutrition system to increase coverage of health services and supplies:** Working closely with the public health and nutrition system to strengthen coverage of the National and State level programmes, such as Rashtriya Kishor Swasthya Karyakram (RKSK), Weekly Iron Supplementation Programme (WIF), Menstrual Hygiene Management Programme (MHM) is important for long-term sustainability. Strengthening the capacity of existing frontline functionaries, such as ASHA, ANM and AWW, along with other stakeholders like Panchayat and teachers is also essential to create an enabling environment.
- 10) **Gender transformative life skills education:** Gender transformative life skills education is essential to address and break-down gender-discriminatory social practices and patriarchal values and masculinity that are internationalized by young people. This can go a long way in creating a more egalitarian society that has improved health and nutrition parameters.



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