

## **Draft Report of Evaluation**

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Submitted to

**Breakthrough**

Submitted by

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### **Abbreviations and Acronyms**

<b>BPL</b>	<b>Below Poverty Line</b>
<b>CBO</b>	<b>Community-based Organisation</b>
<b>DID</b>	<b>Difference in Difference</b>
<b>FGD</b>	<b>Focus Group Discussions</b>
<b>HH</b>	<b>Household</b>
<b>3ie</b>	<b>International Initiative for Impact Evaluation</b>
<b>EM</b>	<b>Early Marriage</b>
<b>KII</b>	<b>Key Informant Interviews</b>
<b>NGO</b>	<b>Non Governmental Organizations</b>
<b>NTFP</b>	<b>Non Timber Forest Produce</b>
<b>OBC</b>	<b>Other Backward Classes</b>
<b>OP</b>	<b>Other Population</b>

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<b>PHC</b>	<b>Primary Health Centres</b>
<b>PPI</b>	<b>Progress Out of Poverty</b>
<b>SC</b>	<b>Scheduled Caste</b>
<b>SHG</b>	<b>Self Help Groups</b>
<b>ST</b>	<b>Scheduled Tribe</b>
<b>UN</b>	<b>United Nations</b>
<b>UNICEF</b>	<b>United Nations International Children’s Emergency Fund</b>

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## Baseline Report on Impact Evaluation of Breakthrough's Early Marriage Campaign

### SUMMARY

1. Breakthrough, an international human rights NGO, is engaged in a media campaign with the goal of reducing early marriage. The programme is being implemented initially in three districts of Bihar and Jharkhand. According to a UNICEF report from 2010, about **a third of the women in the developing world between the ages of 20 and 24 were married before reaching the age of 18**, with prevalence being the highest in South Asia at 46%. The goal of the programme is to reduce the incidence of early marriage in the programme area. The object of the programme is to address the issue of early marriage by challenging gender norms through pop culture and mass media. The intervention areas emerged from the formative research conducted by PRAXIS and include sexuality, sexual harassment and sexual and reproductive health since work in other areas is already being implemented.
2. International Initiative for Impact Evaluation (3ie) commissioned Catalyst Management Services (CMS) to carry out the impact evaluation of this programme under their policy window. In collaboration with Breakthrough and 3ie a cluster randomized control trial using mixed methods was developed as the study design. Three control districts were taken in addition to the programme districts of Ranchi, Hazaribagh and Gaya as a part of the design. The baseline survey was conducted in 2012. The design developed for this evaluation consists of 4 treatment groups and 1 comparison group. The 4 treatments refer to various combinations of the type of interventions Breakthrough implements. The first is a combination of all interventions, i.e., training, community mobilization, and mass media. The second is training and mass-media; third is community mobilization and mass media, and the fourth is only mass media. The objective of using such a design is to assess which component and what combinations of components have the largest impact on age at marriage.
3. Deriving from the theory of change the following evaluation model has been developed for this programme, and the baseline impact and outcome indicators are drawn from this model and the theory of change.



4. The key indicators that are established at baseline are as follows:
- Impact indicators:** Age at marriage, incidence of early marriage, years of schooling
  - Outcome Indicators:** Gender norms, perceptions with respect to appropriate age at marriage, and awareness levels.
  - Contextual indicators:** Social, religious, economic profiles of the households, and access to media.

To assess these, the study adopted a '**mixed-method design**' combining quantitative and qualitative methods and tools (with quantitative as the primary method, and qualitative as the complementary method). The quantitative component of the study consists of the household questionnaire, key informant interviews and the Gram Panchayat (GP) profile.

### Key Findings

5. **At the impact level** the baseline report presents the current status with respect to age at marriage, incidence of early marriage and years of schooling.
- The average age at marriage for women in all the treatment groups for this study is between 15 to 16 years. For men it is 20 to 21 years. The incidence of early marriage is lesser for men compared to women. On both parameters the results are similar across the 5 treatment and control groups indicating that the randomized clusters are comparable.
  - The average years of schooling are also similar across the treatment groups. There isn't much of a gap between men and women on this indicator, though men tend to have marginally higher average years of schooling in the sample. The gap between men and women in terms of years of schooling increases in the older age groups relative to younger age groups.
  - The main factors that appear to affect early marriage, as emerges from the linear regression model, are gender norms, distance of household from district headquarter,

and the social and religious profile of the household. In schedule tribe households age at marriage tends to be higher than all other groups.

**6. At the outcome level,**

- a. In terms of inheritance, education and responsibilities within the household gender norms are more unequal. In 95% of the households daughters do not tend to inherit family property. More households reported that sons/male children should be able to study as much as they want relative to female children. Men are also seen as primarily responsible for the financial needs of the household. About 65 to 70% of the respondents said that this was primarily the responsibility of men. For household work, 96% to 99% of respondents report that it is the primarily the responsibility of women in the household. Thus, in terms of division of responsibilities clear gender roles are assigned.
- b. The awareness of the negative effects or consequences of early marriage, particularly with respect to health is very high. The most commonly cited health related consequences were maternal and infant mortality, followed by miscarriages and mental health issues. The other causes cited included domestic violence and disruption in education.

**7. Media Habits** were also included in the survey questionnaire.

- a. The most commonly availed sources of media are television, radio, newspaper followed by cinemas. In terms of the more interactive, as opposed to mass-based sources, Bhajan Mandalis are more popular and regularly attended. On television the most commonly watched channels are DD national and the general entertainment channels and the local cable channel.
- b. The access to these media sources is also very similar across all 4 treatment groups, though it seems to be more limited in the control districts.

# Baseline Report on Impact Evaluation of Breakthrough's Early Marriage Campaign

## MAIN REPORT

### 1 INTRODUCTION

The United Nations (UN) convention on the Rights of the Child defines child marriage (referred to in this document as early marriage henceforth) as marriage under the age of 18. Early marriage, in South Asia, affects both young boys and girls, though the latter disproportionately more so<sup>1</sup>. Early marriage has been defined in different terms across the globe. The Child Marriage Prohibition Act of India – 2006 defines a child as a female below the age of 18 and a male below the age of 21<sup>2</sup>. According to a UNICEF report from 2010, about **a third of the women in the developing world between the ages of 20 and 24 were married before reaching the age of 18**, with prevalence being the highest in South Asia at 46%<sup>3</sup>.

Early marriage has been recognised as an area in need of intervention due to negative impacts on **health, educational outcomes, well-being and growth of a child**. The recognition of these impacts has led to various legal reforms and programmatic efforts to address early marriage. The Indian government in 1929 defined a minimum age for marriage and raised the same in the 1980s to 18. There have been several government investment and saving programmes for the education and delaying marriage of a girl child up to 18 years of age. Apart from these, there have also been efforts from NGOs that have sought to address various factors that contribute to early marriage. Despite these interventions the practice of early marriage, rooted in patriarchal notions and customs that view girls as burdens for their families, has continued though the incidence has dropped slightly over time. Between NFHS-I (1992-1993) to NFHS-3 (2006-07) the **percent of women marrying before the age of 18 in India showed a small decline from 54% to 47%**.

The negative impacts of early marriage on children have been recorded by various studies. These include impacts on health such as **higher maternal mortality and morbidity, increased risk of infant mortality and morbidity as well as mental health problems**. The other most significant impact of early marriage is that it **restricts access to education for girls**, ultimately affecting their skills, **capacity to move out of poverty**, and **overall well-being of their families and children**<sup>4</sup>. "The lack of health, education, physical safety and autonomy, **deprives girls of their basic human rights, and it also acts as a brake to their social and economic development**."<sup>5</sup>

It is in this context that Breakthrough has developed its early marriage campaign. Breakthrough is a **global human rights organisation that utilises pop culture and unique education-based interventions to inspire leadership for social change**. Breakthrough's primary focus is on **addressing violence against women in various forms**, including domestic violence, early marriage and sex

<sup>1</sup> Solutions to End Child Marriage – What the Evidence Shows, ICRW

<sup>2</sup> PRAXIS formative research

<sup>3</sup> Progress for Children Report, UNICEF 2010

<sup>4</sup> Solutions to End Child Marriage – What the Evidence Shows, ICRW

<sup>5</sup> Ibid, 4

selective elimination. Breakthrough utilises pop culture and various forms of mass media to **reach mass audiences and challenge norms** and builds on this **through training and partnerships with communities for lasting impact**.

## 2 THE EARLY MARRIAGE CAMPAIGN

Breakthrough's Early Marriage media-campaign aims to reduce the incidence of early marriage and increase the average age at marriage in three districts of the Indian states of Bihar and Jharkhand. The goal of the intervention is to use media and community mobilization to bring about social change. They do this by **addressing knowledge, attitudes and practices** related to early marriage and gender norms. The campaign consists of three different types of components that operate at different geographical and administrative levels. The aim of the campaign is to reduce early marriage through targeted messages located within a framework of gender rights. Before developing the various messages and modules that were to be utilised as a part of the project, **a formative research conducted by PRAXIS** was commissioned in the project area to identify prevalent marriage practices as well as existing programmes on Early Marriage in the area. The formative research helped Breakthrough identify six possible areas for intervention: Teenage pregnancies, education, livelihoods, Sexuality, Sexual Harassment, and Sexual and Reproductive Health awareness. The PRAXIS study found that organisations in the area already work on the first three aspects extensively; however, the latter three have not been covered by previous efforts to reduce early marriage. The research showed that two of the most significant reasons due to which early marriage takes place is, (a) fear that unmarried girls will be sexually harassed, and (b) traditions and customs that encourage control over the sexuality of girls and seek to prevent interaction with the opposite sex outside of marriage. This is in addition to dowry demands that increase with age and the notion that women do not contribute to the natal home financially.

Thus messages and training modules developed by the programme team were focused on the above key areas, norms and beliefs. The findings of the study helped in shaping Breakthrough's intervention and in locating the intervention in a human rights framework. The document looks at how the practice of early marriage can be understood from the perspective of child rights, women's rights, as well as community rights. According to the child right's approach, all children are rights holders and are "claimants" to rights of "survival, protection, and development" due to the negative impacts listed earlier<sup>6</sup>. Early marriage also restricts a child's ability to exercise a right to decision making for their own marriage. Early marriage can also be seen as a consequence of a patriarchal society that denies women and girls certain rights. Early marriage is a form of discrimination against the girl child which perpetuates patriarchal notions of honour and morality, which restrict the girl child's access to education, better health and decision making power<sup>7</sup>. Once girls attain puberty restrictions are placed on their mobility and are unable to exercise their agency. In terms of community rights, early marriage is often a part of traditional customs. And therefore, any intervention in this area needs to examine how community level action can be incorporated into the programme.

The programme is implemented through three main components which are as follows:

- a. **The mass media campaign** will be aired on radio, TV, in newspapers and cinemas. It will consist of messages which urge young fathers and boys to act against early marriage. It

<sup>6</sup> PRAXIS formative research

<sup>7</sup> Ibid

- encourages young fathers to see their daughters as productive members of the household.
- b. **Block level training:** Breakthrough will train NGOs at the block level on certain modules on gender rights, sexuality and sexual harassment. These are NGOs that have interests that align with Breakthrough's mission. It is expected that these NGOs will then become change agents in their communities and work towards reducing early marriage.
- c. The **Community mobilization and interactive media** component takes place at the gram Panchayat level. Here the Breakthrough team will organise GP level events such as Kishori melas, street plays, puppet shows, and video vans and use ambient media such as posters and wall paintings which will cover the same messages.

## 2.1 Breakthrough Intervention Plan

Breakthrough's intervention is primarily a media campaign that is targeted at young men and boys and tries to replace prevailing notions and messages about the value of the girl child, the desire to restrict her mobility and decision-making power, with notions that see women and girls as equal contributors to the household. The intervention consists of interventions implemented at multiple levels and accordingly the sampling frame for the study has been drawn. For the purpose of the evaluation a cluster randomized control design utilising a mixed methods study is being implemented.

The 4 packages of interventions used by Breakthrough include various combinations of the three components of the media campaign: **mass media, block-level training, and community mobilization**. Three of the districts in the study, **Ranchi, Hazaribagh and Gaya**, will receive the mass-media intervention. In these districts there are **a total of 55 blocks**. After accounting for blocks that are inaccessible due to heavy Naxalite activity, 42 blocks are available in the sample. Out of these, **21 blocks receive the training component** of the intervention. This means that partner NGOs that Breakthrough identifies in these blocks will be given training on modules related to gender norms, sexuality and sexual and reproductive health – areas through which Breakthrough plans to address early marriage. Each block included in the study has, on average, 16 gram panchayats. Out of all the Gram Panchayats **in the training blocks, 40 were randomly selected to receive the community mobilization component**, while the other **40 did not receive any additional treatment**. Out of the **21 blocks with no training, 40 gram panchayats were randomly assigned to receive the community mobilization package** while another **80 were selected which receive no additional treatment**. The following table depicts the complete range of treatments and the relevant samples in each. In each Gram Panchayat 10 households will be selected for the sample. This gives an overall sample of 400 households in each intervention package except for the mass-media only and control areas where the sample size is 800 households.

Apart from these there are three additional districts that have been included in the study to serve as control for the mass-media component. These won't receive any intervention.

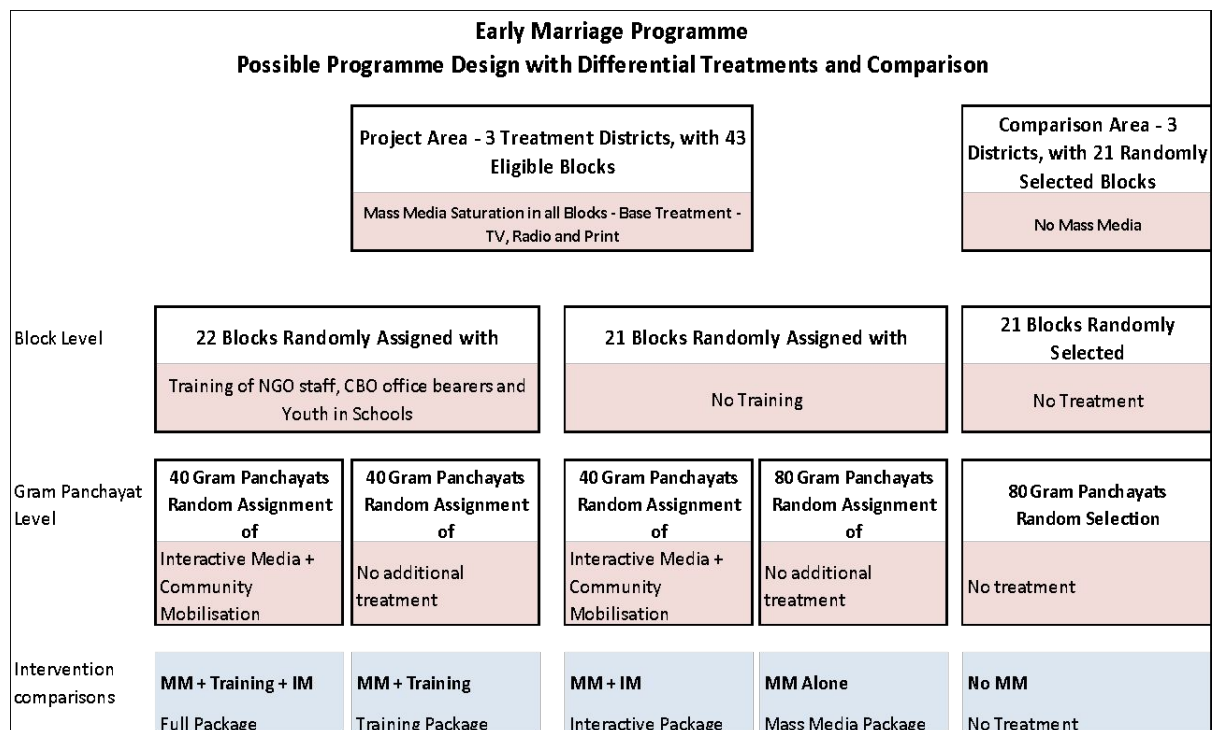


Figure 1 Breakthrough Intervention Plan

### 3 EVALUATION OF THE PROJECT

#### 3.1 Purpose of the Evaluation

The evaluation of the Breakthrough early marriage programme is a cluster randomized control trial which examines changes in impact level indicators such as **age at marriage and incidence of early marriage** to assess to what extent, if any, changes in these indicators are **attributable to the Breakthrough campaign**. To assess the contribution of the programme to these changes and attributability of impact a range of **output, outcome and impact indicators** will be measured and tracked over time in this study.

The programme also consists of three components or separate interventions: **community mobilization, training and mass-media**. The purpose of this study is to examine the extent to which each intervention has an impact on the **knowledge, attitudes, and practices of early marriage** in 3 districts in India.

#### 3.2 Scope and Key Questions

This study will examine the relative effects of the different types of interventions on outcomes and impacts of the programme on knowledge, practices and attitudes related to early marriage. Thus, the key evaluation questions can be presented as follows:

1. What are the impacts of media interventions on knowledge, attitudes, and practice of early childhood marriage?

2. Does block-level training affect the outcomes on knowledge, attitudes, and practice of early marriage? (Are the two interventions complementary?)
3. Which intervention is more cost-effective?
4. Is the combination package (training + community mobilization) worth the additional cost?

For Breakthrough it is important to identify which of their interventions is the most useful and cost-effective in reaching their targets, and whether the combination of all three interventions together adds any significant change that would otherwise not be achieved.

### 3.3 Methodology

The impact evaluation of the Breakthrough intervention is being evaluated using a cluster randomized control trial design. This requires the assignment of the interventions to various clusters in a random fashion at block and gram panchayat levels. This is a panel study where data will be collected in treatment and control areas at baseline, midline and endline. If only a before-after analysis were conducted, isolating the programme effect from other confounding variables would be difficult. Using a panel approach, a cohort of households will be surveyed in the baseline year and in four years time.

The comparison drawn in the study will be between the following groups:

- Between all four intervention packages and control groups
- Between blocks that receive training and those that don't
- Between Gram Panchayats that receive community mobilization and those that don't
- Between states that receive mass-media and those that don't

Given the multi-dimensional nature of early marriage and gender norms associated with it a mixed-methods design was proposed for this study, so as to deepen the understanding of the causes of early marriage and the response to the Breakthrough intervention. The impact evaluation is being designed through a mixed-method procedure, given the type of issue addressed, combining quantitative and qualitative methods. The evaluation proposes a "Sequential Connecting strategy". This approach comprises of one method being applied sequentially after the other, with the findings from each method connecting to the next. The primary (quantitative) method for the evaluation will be followed by the secondary (qualitative) method. The main evaluation questions will be answered by the quantitative method and the qualitative method will be employed for complementarity (elaboration, enhancement, illustration and clarification of the results from the quantitative method), focusing on developing insights into findings that need greater exploration. The quantitative data provides data and analysis related to the extent of impact and its attributability, the qualitative design provides 'in-depth' information on 'why' and 'how' of the changes. Given the sequential design, the qualitative design will get the patterns from quantitative analysis and understand the reasons for change. The following tables bring the design ideas together – the first one captures the timing, weighing and mixing of both the methods, and the second one summarises the reasons for using these two methods together (i.e. why do we need two methods, and what the second method does).

Table 1 Mixed Methods Evaluation Design

Design of Mixed Methods for Impact Evaluation of Breakthrough's Early Marriage Media Campaign		
Timing	Weighting	Mixing
Concurrent (no sequence)	Quantitative	Embedding
Sequential – Quantitative first	Qualitative	Connecting
Sequential – Qualitative first	Equal	Triangulation

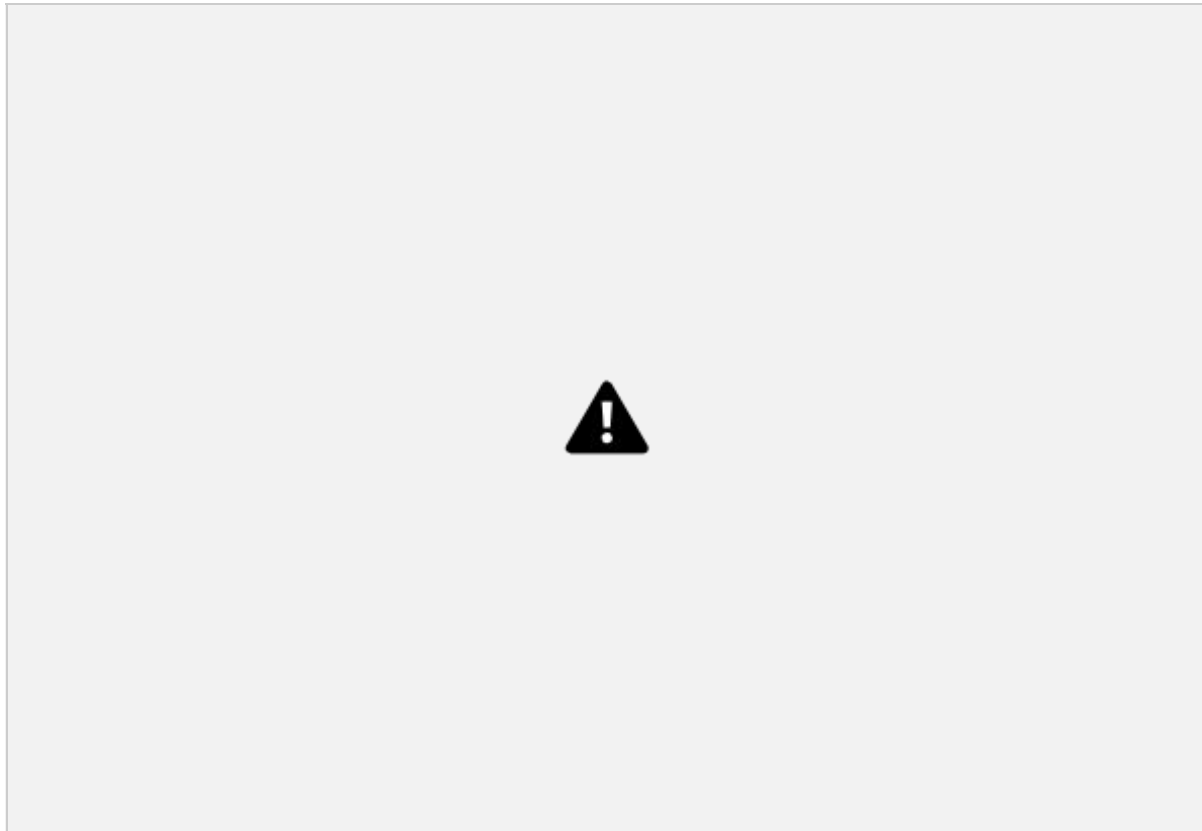
  

Purpose of the Mixed Method Design		
1	<b>Triangulation</b>	Seeking convergence and corroboration of results from different methods and designs studying the same phenomenon
2	<b>Complementarity</b>	Seeking elaboration, enhancement, illustration, and clarification of the results from one method with results from the other method
3	<b>Initiation</b>	Discovering paradoxes and contradictions that lead to a re-framing of the research question
4	<b>Development</b>	Using the findings from one method to help inform the other method
5	<b>Expansion</b>	Seeking to expand the breadth and range of research by using different methods for different inquiry components
6	<b>Convergence and divergence</b>	To identify key points of convergence and also divergence between methods and obtain more insights on the reasons

Table 2 Purpose of Mixed Methods Design

Sequential models are also preferred because they allow for the development of one method based on the insights and findings of investigation through the other method. A sequential mixed-methods design is more resource and time intensive.

The evaluation model that emerges from the programme theory of change is depicted in Figure 2 below. It depicts the causal pathways and key indicators that need to be tracked over the study period to assess the impact of the programme.



**Figure 2 Programme Evaluation Model and Pathway to Impact**

Breakthrough intends to see communities where early child marriage does not take place, and where girls and boys are considered and treated equally. It strongly believes that the early child marriage among the marginalized communities (rural areas of Jharkhand and Bihar) happen due to many deep rooted beliefs and norms at the family and community level. Four key areas that have come out of the formative research and based on experiences of Breakthrough are:

- Perception about the safety and security and harassment of the girls if they are not married early
- Stigma at the household and community against unmarried girls
- Lack of decision making powers and platforms for youth to say no to early marriage
- Deep rooted perception that "Girls are Bad Investment"

Breakthrough's program will address these through an effective media strategy. The overall goal of the program is "reduced practice of early child marriage and equal treatment of boys and girls". The outcome expected is "increased awareness of the community on the ill effects of early marriage and positive attitude and stance adopted by the community against early child marriage". Building on the experiences of Breakthrough in its work on domestic violence (the famous Bell Bajao campaign), it believes in media as an effective strategy to address the issue. Mass media campaign, with single effective messaging, through electronic platforms such as radio and TV (common treatment across the project area) can reach communities at large scale with basic awareness about the issue. This intervention by itself is not adequate to solve the problem of early child marriage. To deepen the impact and move towards attitudinal and practice changes, Breakthrough has designed two intervention packages, which will build on the awareness created in the mass media, with each one having different scale/reach, cost structures and expected effects.

### 3.4 Testing of Impact through Regression Model

To assess the impact of the Breakthrough Programme a regression model will be used in the subsequent reports. To establish the baseline conditions and assess what factors contribute to age at marriage these regressions have also been tested at the baseline. At this stage programme indicators have been excluded which will be brought in at the midline and endline stage.

The following table depicts the regression model which will be tested at baseline. Age at marriage (for those up to 30 years of age and overall) is included as the dependent variable. A number of independent variables have been included as explanatory variables. In subsequent rounds programme indicators will also be used in this model.

Dependent Variable	Variable Description	Data Structure/Range
Age at Marriage up to age of 30 years	Age at the time of marriage in years	0→max (YY)
Age at Marriage overall	Age at the time of marriage in years	0→max (YY)
Independent Variables and Covariates	Variable Description	Data Structure/Range
Economic status at baseline	Progress out of Poverty Index	0 → 100
Social Status	Binary Variables for Schedule Caste and Tribes	0 or 1
Awareness of Schemes	Knowledge of any of the 5 incentive schemes expressed as a proportion	0 → 1
Enrollment in Schemes	Whether any member of the household is enrolled for the schemes	0 or 1
Distance from District Headquarter	Distance of GP from District Headquarter	0→max (km)
Religion	Whether household is Hindu or Muslim or Other expressed as a binary variable	0 or 1
Distance from nearest town	Distance of GP from Nearest town	0→max (km)
Education of Head of Household	Distance of GP from Nearest town	0→max (km)
Access to Media	Proportion of Sources that household has access to	0 → 1
Gender Norms Score	Score on norms regarding gender in the household based on three parameters: mobility, access to education and household share of responsibilities, with 0 being least equal and 1 being entirely equal.	0 → 1

### 3.5 Quantitative Design

As mentioned in the previous sections this is a cluster randomized control trial which utilises a mixed methods approach. As per the first design drafted, four packages of interventions were to be

disseminated in 40 GPs each from across the three districts of Ranchi, Hazaribagh and Gaya. These three districts were to be saturated with the mass-media intervention. In the initial design the intention was to study the relative impact of the training and community mobilization packages and not mass-media specifically. Based on the 3ie review comments, the design was revised to include **three control districts, Nawada in Bihar and Bokaro and Lohardaga in Jharkhand**, which would not receive any intervention. Mass-media channels such as newspapers, television channels and radio stations can only be controlled at the district level. Therefore, adding a control for mass-media within Ranchi, Hazaribagh and Gaya was not possible. The **control districts were selected based on certain key indicators** that might affect the outcomes of the study and reception of the programme. This included **media access, standard of living, literacy, initial condition of gender empowerment, early marriage incidence, and health seeking behaviour** (especially related to sexual and reproductive health).

Based on these criteria, matching districts that can serve as control for the mass-media campaign were selected. For this two sources of district level data (Provisional Census 2011 data and the District Level Household and Facility Survey) were referred.

- In the case of **Census 2011 data** two sets of parameters were examined: Gender Empowerment (using sex ratio as a proxy) and literacy rates (both male and female separately). Both parameters were assigned equal weights.
- In the case of the **DLHS data** 3 parameters were identified: Literacy (rural, male, female), Standard of Living (which takes into account access to mobile phones, TV, and electrification), and finally early marriage and reproductive health related indicators. The third parameter is weighted 40%, while the rest are weighted 30% each.
- **Based on this Bokaro was the closest match to Ranchi; Seraikela Kharsawan and Lohardaga were both potential matches for Hazaribagh; and Nawada was the closest match to Gaya.** Neighbouring districts or districts that have over time been carved out of Ranchi, Hazaribagh and Gaya were included in this comparison.

A second change that was made to the design was the inclusion of a midline survey in 2014, following discussions between CMS, 3ie and Breakthrough so as to provide insights to the programme team earlier than initially planned. Finally the sample size for the study was also increased in the mass-media only intervention areas and the control districts. This was done to reduce the minimum detectable effect size for the impact of the mass-media intervention since this is the least costly part of the intervention. Therefore, 3ie and potential policy-makers would be interested in an even smaller change.

Based on this the total sample size for the study is 3360 households across 280 gram panchayats in 6 districts of Bihar and Jharkhand. All eligible blocks were included in Ranchi, Hazaribagh and Gaya. In Nawada, Bokaro and Lohardaga 21 blocks were randomly selected. The selection of households at the Gram Panchayat level is done using the probability proportional to size technique. The calculations in each GP were conducted by the field investigators after gathering information from the GP headquarter about the population size of all the villages within the GP.

### 3.5.1 Calculation of Household Sample Size

To increase the likelihood of observing differences between different treatment households at

programme level, a sample as large as resources allow, would produce the narrowest confidence interval width and hence the likelihood of observing statistically significant differences. It should be remembered that the resources required to reduce confidence interval widths limits from +/-10% to +/-5% percentage points quadruples the sample size, and similarly for the level of confidence (i.e. the probability of the confidence interval been observed). Therefore in designing surveys, realism must be employed and often practical limitations of funds available for surveys ensures that a confidence limit of +/-10 percentage points 90% of the time is considered adequate. Below the steps required to produce this level of precision are explained. The following are the assumptions made when arriving at the sample size:

1. Desired intervention-level confidence interval precision +/- 10 percentage points 90% of time.
2. Binomial distribution of 0.5
3. Baseline-Endline household attrition rate of one third
4. Design effect of 2.5 based on previous experience
5. Finite population correction factors not utilized

Only when the size of the population is relatively small in comparison to the size of the sample is it relevant to consider the sample size in relation to the population. If this is the case, a finite correction factor is employed, and results in a small reduction in the sample size where the size of the universe is small. With the intervention (40 GPs) as the unit of analysis, the number of households per unit was relatively large for all interventions and therefore finite population correction factors would not have resulted in any meaningful sample size reduction. It follows that the most efficient sampling scheme would sample the same number of households per cohort per sub-universe (training and non-training), regardless of the size of the sub-universe and produce the same level of precision of indicators for each intervention.

### 3.5.1.1 Initial Sample Size Assuming Random-Sampling

$$n = \frac{K^2 * p(1-p)}{D^2}$$

Where:

- $n$  is the required sample size, in number of households to be sampled
- $K$  is the required level of confidence (measured as the standard normal deviate, obtainable from standard statistical tables of the normal distribution)
- $D$  represents the acceptable width of the confidence interval (in percentage points)
- $p$  is the population variability under a binomial (either/or) distribution, where  $p$  = the proportion of positive responses with range  $0 < p < 1$

Substituting values for the calculation of the sample size to result in a precision of the confidence interval width of +/- 10 percentage points 90% of time

$$n = \frac{1.645^2 * 0.5(1-0.5)}{0.10^2} = 67.65 = 68 \text{ (rounded)}$$

### 3.5.1.2 Loss of Households between Baseline and Endline

If the sample was a pure random sample (i.e. no clustering) and there was no loss of households between the baseline and the endline, 68 households per sub-universe would be sufficient to produce estimates with a precision of +/- 10 percentage points 90% of the time.

Panel studies (repeated measures on the same household) inevitably suffer erosion of participating households for various legitimate reasons, and this must be compensated at the outset by over sampling the baseline to provide a strong probability that there will still be sufficient number of "surviving" households sampled during the endline survey to still produce the minimum appropriate level of precision. Previous work with panel studies by CMS indicates anticipating a loss of no more than a 3rd of the households to be a conservative estimate. Therefore the sample size of 68 was multiplied by 1.33, resulting in 90.4 (91) households to ensure against a one-third household attrition rate.

### 3.5.1.3 Design Effect

Resources did not allow for a pure random sample of 91 households for each treatment package and thus clustering was inevitable. Given that the intervention takes place at the GP level, the GP was an appropriate cluster. Previous surveys showed a fairly large correlation in within-GP outcome measures, indicating a strong design effect would need to be taken into account. Previous panel studies by CMS indicate a clustering design effect of 2, though an even more conservative 2.5 is assumed here, giving a total sample of  $91 \times 2.5 = 227.5$  for each of the four intervention packages. This gives an average of 5.7, or 6, households per GP. Given that additional resources required to cover additional households in a GP are fairly minimal, we increased this to 12 households per GP, giving the following sampling schema:

Intervention packages	3
GPs per intervention package	40
Households per GP	12
Households per intervention	480
<b>Total surveyed households</b>	<b>1,440</b>

Intervention packages	2
GPs per intervention package	80
Households per GP	12
Households per intervention	960
<b>Total surveyed households</b>	<b>1,920</b>
<b>Total</b>	<b>3,360</b>

## 3.5.2 Selection of Districts and Blocks

**Ranchi, Hazaribagh and Gaya** were selected by the programme team for their intervention. As explained earlier, matched control districts for the mass-media intervention were also selected

under the revised design. The parameters included in this matching exercise were literacy rates, standard of living, media penetration and access, incidence of early marriage, and initial state of gender empowerment. Based on this analysis **Nawada, Bokaro, Lohardaga** and Seraikela Kharsawan were considered. Out of these Seraikela Kharsawan was excluded on account of the high level of Naxal activity in the district. In Ranchi, Hazaribagh and Gaya there were in all 55 blocks in the three districts where the Early Marriage campaign could be carried out (24 in Gaya, 15 in Ranchi, and 16 in Hazaribagh). However, Breakthrough could not implement its interventions in all of these blocks because several of them fall in Naxal affected areas, nor would CMS have been able to conduct field work there. In Jharkhand 13 blocks in total (6 in Ranchi and 7 in Hazaribagh) and 1 block in Gaya are highly Naxal affected according to the information sheet provided by Breakthrough, and will therefore be excluded from the programme as well as the impact evaluation. This left us with **42 blocks** that can be included in the study. These 42 blocks have been randomly assigned to a treatment group and a control group with 21 blocks each. In the control districts there were in all 30 blocks (14 in Nawada, 9 in Bokaro, and 7 in Lohardaga). Out of these blocks which have high Naxal activity were excluded. As a result the total number of blocks eligible for the sample was 27. Out of these 21 blocks were randomly selected for the study.

### 3.5.3 Selection of Gram Panchayats

In the first three intervention packages 40 GPs were randomly selected from the relevant blocks of the treatment districts. In the mass-media only package are 80 GPs were selected randomly. Similarly 80 GPs were randomly selected from the 21 sample blocks in the control districts. Though ideally block level matching should also be included while selecting the control sample, this has not been possible due to the lack of block-level secondary data.

### 3.5.4 Selection of Households within Gram Panchayats

In each Gram Panchayat 12 households were selected on the field. Since the households might be located in several villages within a Gram Panchayat a probability proportionate to size scheme was used to select households at the village level. Households are sampled from all the villages in each GP based on the total population size of the village, such that the sample is representative of the distribution of the actual population. Only households that have an adolescent girl or boy were included in the study. If the field investigators arrived at a household with no adolescent member they moved to the next household in the neighbourhood.

### 3.5.5 Tools Used

The following tools were administered to collect the Quantitative information:

- **Household Questionnaire (HH):** A set of questions with codified answers were asked to the respondents. The questions were arrived from a detailed information procurement plan (IPP). The IPP was framed based on the Theory of Change and indicators as developed in consultation with Breakthrough.
- **Key Informant Interviews (KII):** Information related to the village and community norms and practices were collected through Key Informant Interviews. 5 KII were conducted in each GP. The following persons were identified as key informants: Anganwari workers,

Panchayat Functionaries, Asha Workers, Religious Leaders, and School Teachers or Principals. Data about community norms regarding marriage and opinions of key informants on gender roles and early marriage was collected through the KII.

- **Gram Panchayat Profile:** The gram panchayat profile consisted of information related to socio economic and cultural profiles of the GP. It included data on availability of basic services and access to facilities.

## FINDINGS AT THE BASELINE

This section brings together the findings of the study, consolidated from the various tools. The status of impact and outcome indicators at the time of the baseline is presented in this section. In subsequent reports the impact and outcome indicators at baseline will be compared with midline and endline to draw conclusions about the impact of the programme.

The findings at baseline are presented in the following five sub-sections as:

- Socio-economic profile of samples; comparison between treatment and comparison
- Current status of Impact Indicators
- Current status of outcome indicators
- Media Habits
- Key Findings and Interpretations

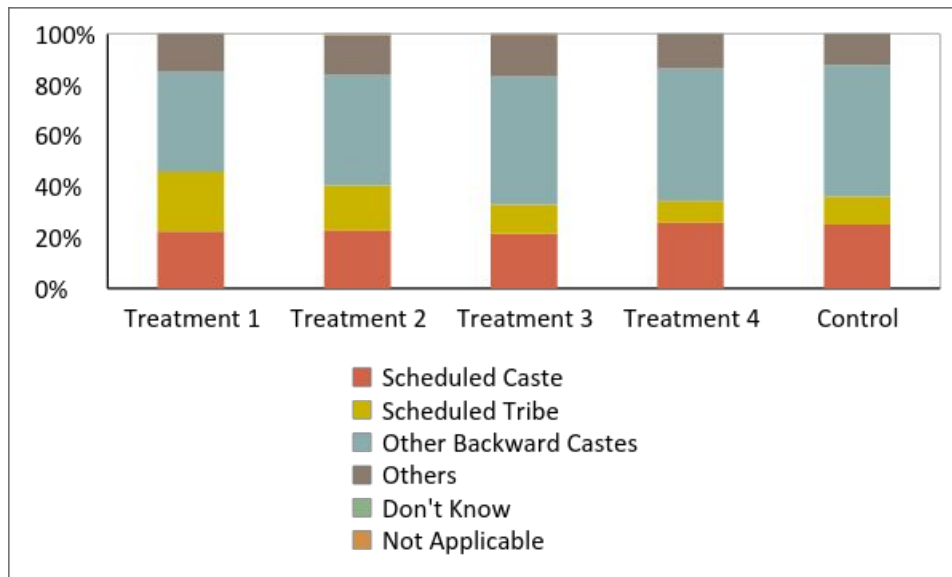
## 4 PROFILE OF SAMPLE HOUSEHOLDS AND GRAM PANCHAYATS

Since this a randomized control trial the households and GPs included were assigned to one of the 4 treatment groups or control group before the data was collected. In this section these 5 groups of households are compared on certain key parameters to see how similar the starting points are. A more similar group at baseline would indicate that the difference between the groups at endline can be more readily attributed to the programme and the randomization mechanism followed by the study has generated a truly random sample.

### 4.1 Comparison between Treatment Groups

There are 4 treatment groups and 1 control group in this sample. Treatment 1 refers to those GPs and households which receive community mobilization, training and mass media interventions. Treatment 2 receives training and mass media. Treatment 3 receives mass media and community mobilization. Treatment 4 receives only mass media. These terms will be used in all the subsequent sections for each of the treatment packages. And the control group consists of the 80 GPs that don't receive any interventions. Figure 3 compares the social profiles of households in the 5 treatment groups.

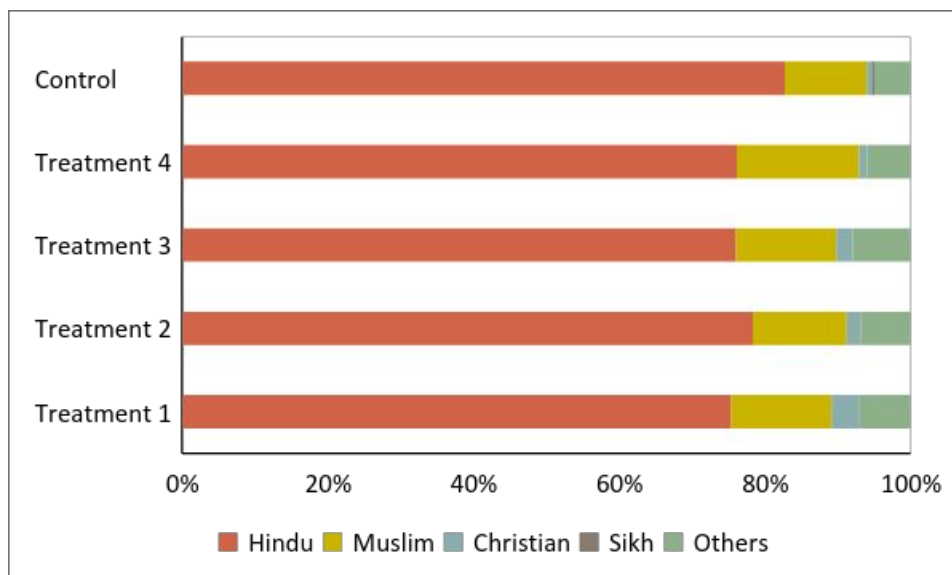
Figure 3 Distributions of Households by Social Group



The general social group profile of households across these 5 groups is fairly similar. The predominant caste group is OBC which constitutes 40 to 50% of the sample. This is followed by scheduled caste households who constitute roughly 20% of the population in all 5 groups. In Treatment groups 3 and 4 and control households the proportion of schedule tribe households is slightly less than that in Treatment 1 and 2.

Figure 4 depicts the distribution of households in the sample across the 5 treatment groups by religious affiliation.

**Figure 4 Distribution of Sample Households by Religion**

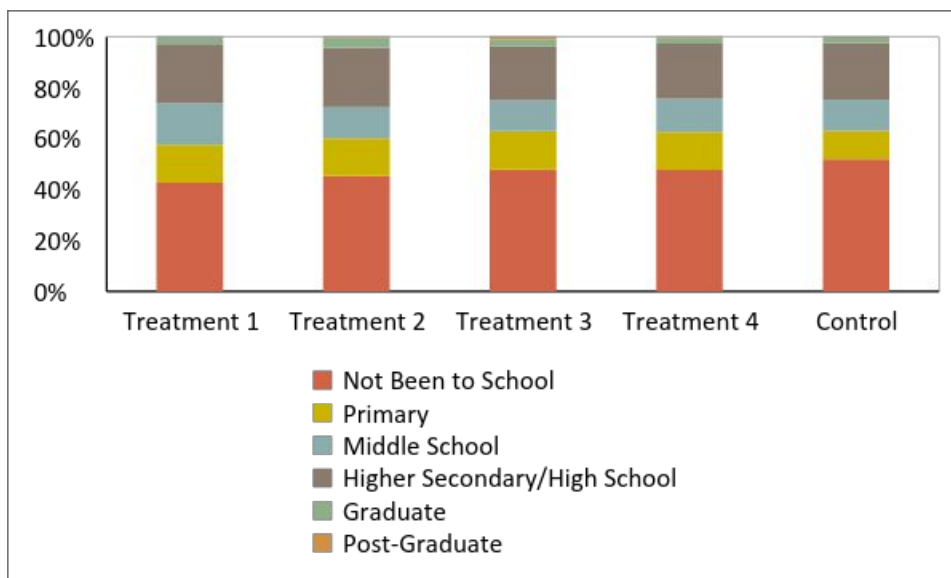


The religious composition of sample households is fairly similar. Close to 80% of all households across the 5 groups are Hindu households. About 10% to 15% of them are Muslim Households. Others (which include Sarna) constitute the next largest group with 5% to 10% of the sample households across the five treatment types. Thus, in terms of religious affiliation the households are

comparable across the 5 groups.

Figure 5 shows the educational profile of the respondents from the sample households.

**Figure 5 Educational Profile of Respondents from Sample Households**

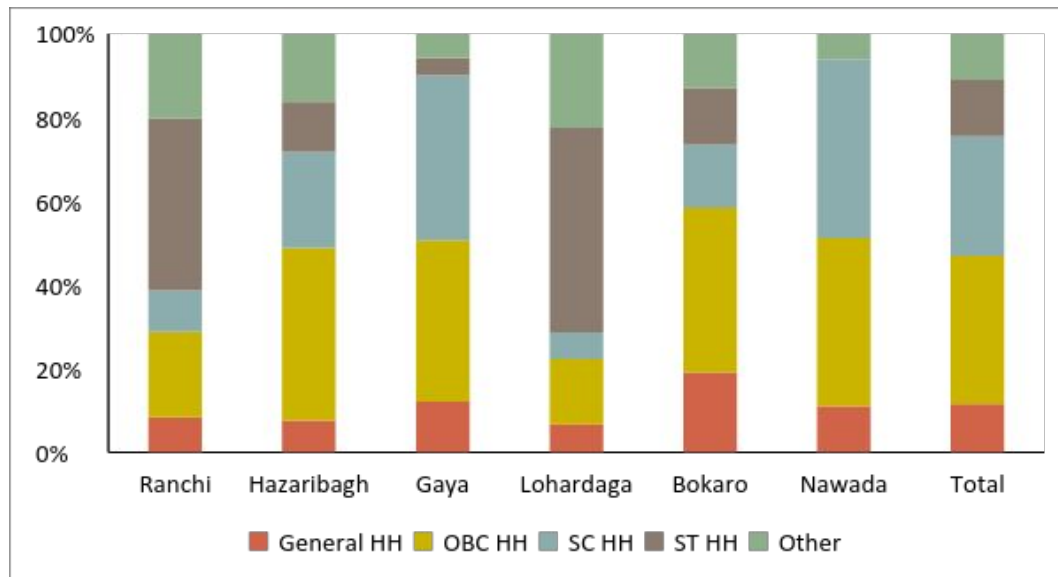


A majority of the respondents in the sample households had not been to school. This number is slightly smaller in treatment area 1 and 2. The next most frequently cited educational level is higher secondary/high school which has been completed by 20% of the respondents. Less than 5% of the respondents are graduates.

## 4.2 Profile of Gram Panchayats in the Sample

Figure 6 demonstrates the distribution of population in the 6 sample district by social group. This data is collected from Gram Panchayat officials for each of the GPs in the sample. The population numbers for each of the caste groups are estimates arrived at by the officials in most cases and may not be exact. The results are presented separately for each of the sample districts.

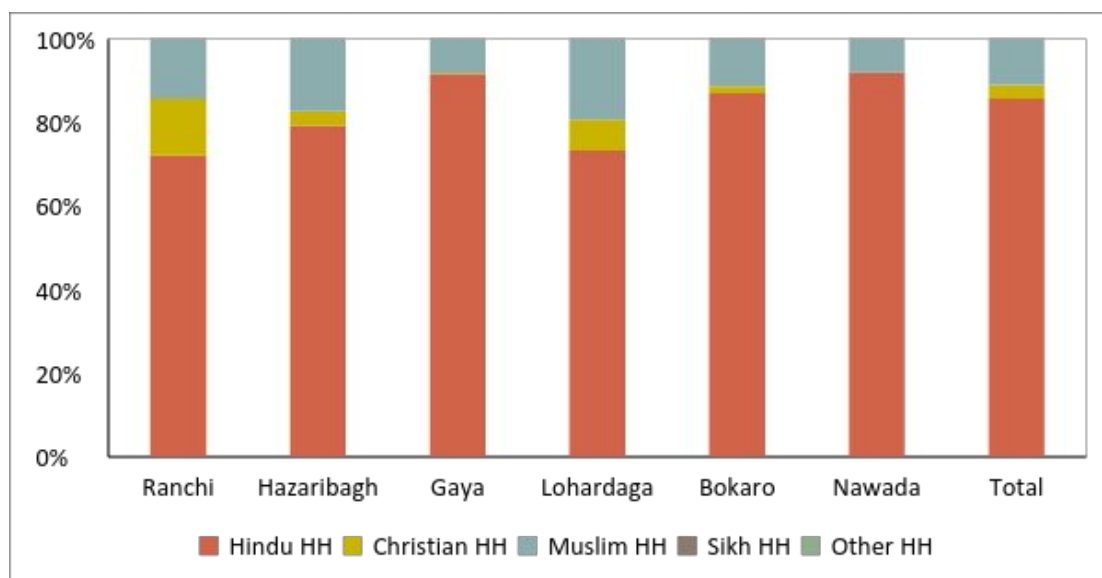
**Figure 6 Distribution of Populations in Sample GPs by Social Class**



The distribution of social groups in the 6 districts differs. While Gaya and Nawada, in Bihar, have a much higher percentage of schedule caste households in Ranchi and Lohardaga the proportion of schedule tribe households is the highest. The distribution of social groups in Hazaribagh and Bokaro is also very similar with OBC households being the largest group followed by schedule caste households. The social group distribution is very similar between those districts that were matched for the purpose of comparison using district-level secondary data. Thus, these results appear to confirm the choice of these 3 districts as matched controls.

Figure 7 depicts the estimated distribution of populations in the sample GPs by religious affiliation. The results depicted here are calculated using data from GP officials on their estimation of the number of households belonging to each religious group.

**Figure 7 Distributions of Populations in Sample GPs by Religious Affiliation**

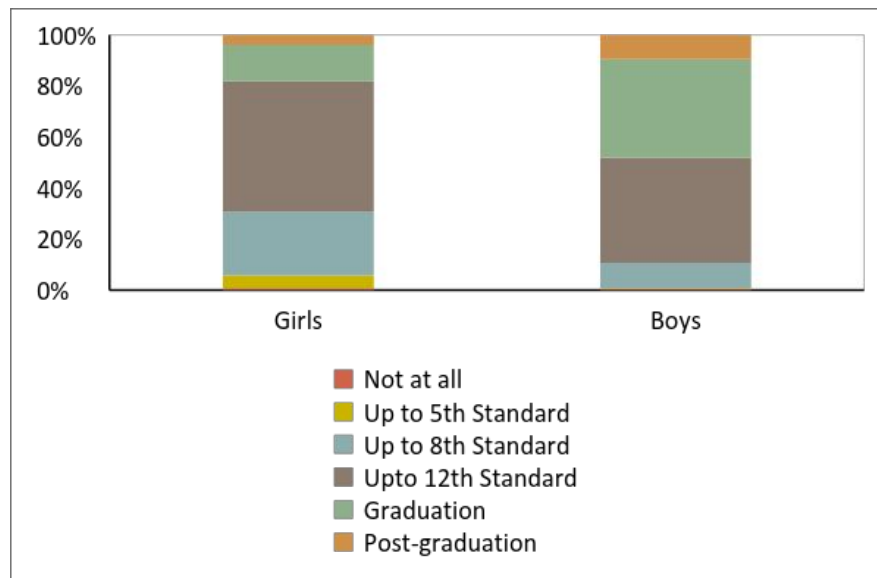


With respect to religious affiliation a majority of the population in the sample area identifies as

Hindu. The percentage is highest in Gaya and Nawada (at above 91%) and the lowest in Ranchi and Lohardaga at 72 % and 73%. These findings also confirm the results of the matching exercise employed earlier wherein three control districts were selected based on certain parameters. Nawada was selected as a matching district for Gaya, Bokaro for Hazaribagh and Lohardaga for Ranchi.

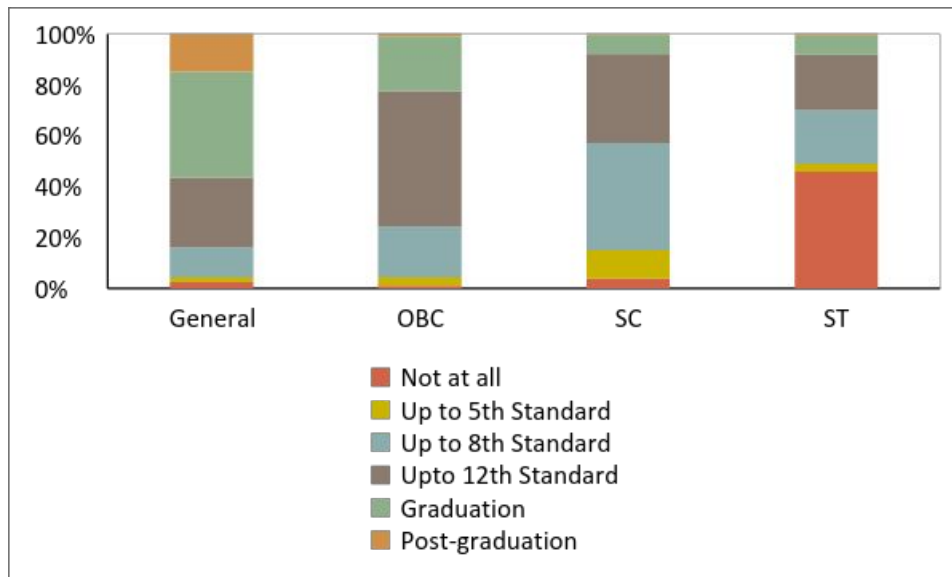
In the GP Profile respondents were asked what the maximum level education attained by specific groups is. Figure 8 depicts the maximum educational attainment by gender in the sample GPs.

**Figure 8 Maximum Educational Attainment by Gender**



The graph presented here depicts the maximum level of educational attainment for each group in each GP. Thus, in 51% of the GPs the maximum educational level achieved by girls is up to 12th Standard. In 25% the maximum attainment for them is up to 8th standard. By contrast, in 41% of the GPs, boys have a maximum education level of up to 12th standard and in another 38.57% of the GPs the maximum level attained is graduation.

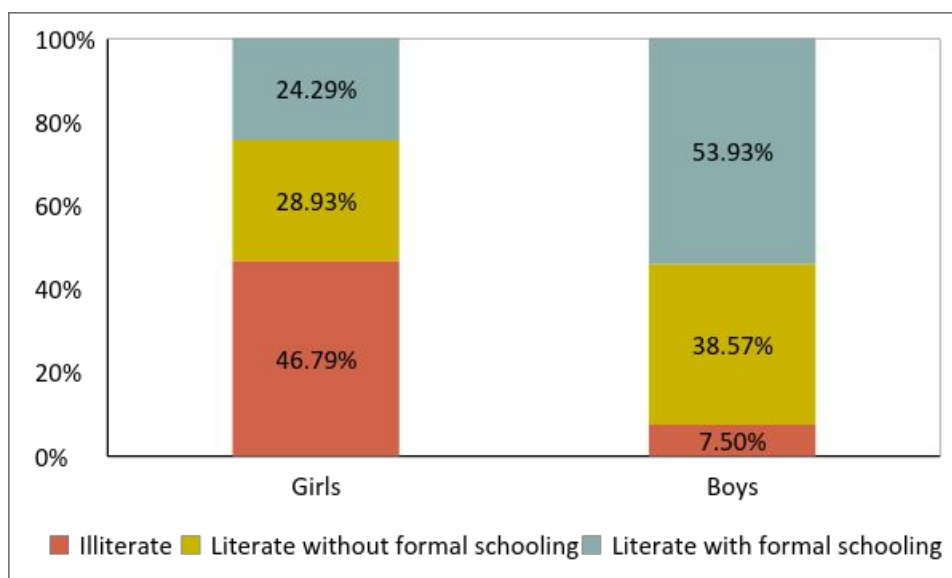
**Figure 9 Maximum Educational Attainment by Social Group**



In 41.43% of the GPs members of the general caste have a maximum education level of graduation. In 53% of the sample GPs OBC households have a maximum educational attainment of up to 12<sup>th</sup> standard. In about 46% of the GPs the maximum educational attainment for scheduled tribe groups is no formal education at all. All of this data is based on information available with and estimates made by Key Informants and Panchayat officials in the GP.

Figure 10 shows the average literacy level among boys and girls in the village. Within the GP profile, respondents were asked whether generally boys and girls in the village were literate with formal schooling, literate without schooling or illiterate. The responses from this question are presented in the figure below depicting in which group all the sample GPs fall.

**Figure 10 Average Literacy Level of Boys and Girls in Sample GPs**

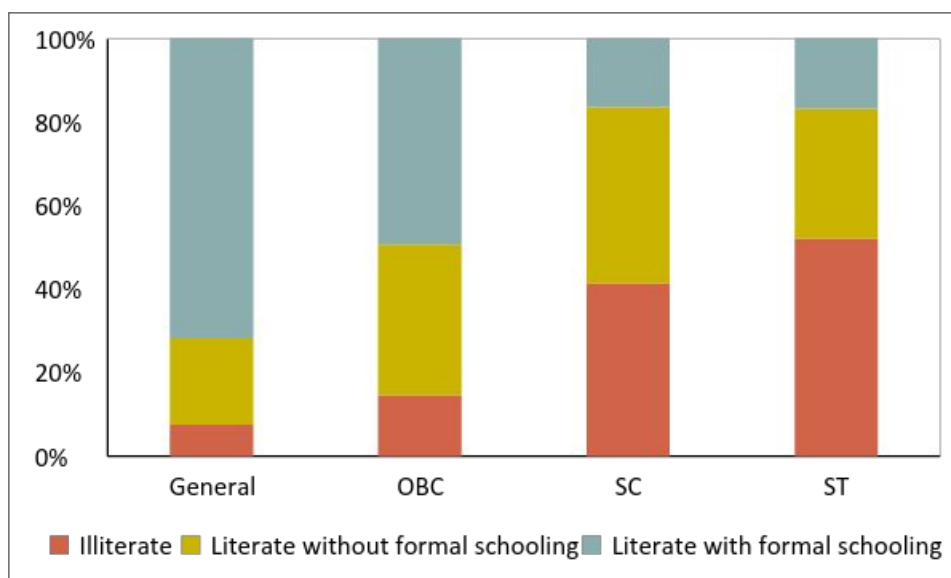


These results show that in a majority of the GPs the average literacy level for boys/men is Literate with formal schooling. For women/girls the average level is predominantly illiterate. In only 7.5% of

the GPs the average literacy level for boys is illiterate.

Figure 11 depicts average literacy levels for the Sample GPs by social groups.

**Figure 11 Average Literacy Levels of Social Groups in Sample GPs**



In 52% of the GPs the average literacy level for schedule tribe households is illiterate. Out of all caste groups this is highest. On the other hand, in 71.7% of the GPs the general caste groups have an average literacy level of “literate with formal schooling”. From the above graph there seems to be a relationship between social group and literacy with general caste members being more likely to have attended formal schooling, followed by OBC households, SC households and finally, ST households. The results presented here are based on the estimates of the key informants interviewed for the GP profile.

### 4.3 Summary

Since this a randomized control trial the households and GPs included were assigned to one of the 4 treatment groups or the control group before the data was collected. In this section these 5 groups of households were compared on certain key parameters to see how similar the starting points are. Treatment 1 refers to those GPs and households which receive community mobilization, training and mass media interventions. Treatment 2 received training and mass media. Treatment 3 receives mass media and community mobilization. Treatment 4 receives only mass media. And the control group consists of 3 districts or 80 GPs that don't receive any interventions.

The **general social group profile** of households across these 5 treatment types is fairly similar. The predominant caste group is OBC which constitutes 40 to 50% of the household sample. This is followed by Scheduled Castes who constitute roughly 20% of the population in all 5 groups. The **religious composition** of sample households is fairly similar across the 5 treatment types as well. Close to 80% of all households across the 5 groups are Hindu households. About 10% to 15% of them are Muslim households. Others (which include Sarna) constitute the next largest group with 5% to 10% of the sample households.

In terms of **educational attainment**, a majority of the respondents in the sample households had not been to school. This percentage is slightly smaller in treatment area 1 and 2. The next most frequently cited educational level is higher secondary/high school which has been completed by 20% of the respondents. Less than 5% of the respondents are graduates.

In addition to the profile of sample households, a profile of the sample GPs is also presented. The results are based on information collected using the GP profile in interviews with the Panchayat secretary or *Sarpanch*.

In terms of distribution of **social groups** the matched control districts have very similar profiles to the treatment district for which they were selected. The two districts of Bihar, Gaya and Nawada, have a smaller schedule tribe population compared to the other districts. They have a higher proportion of schedule caste populations.

The general educational attainment level in the GPs varies on the basis of social group and gender. According to the information provided by the key informants, men tend to be graduates more often than women and attend formal schooling more so than women as well. In terms of social groups, scheduled tribes have the least proportion of graduates while general households have the highest proportion.

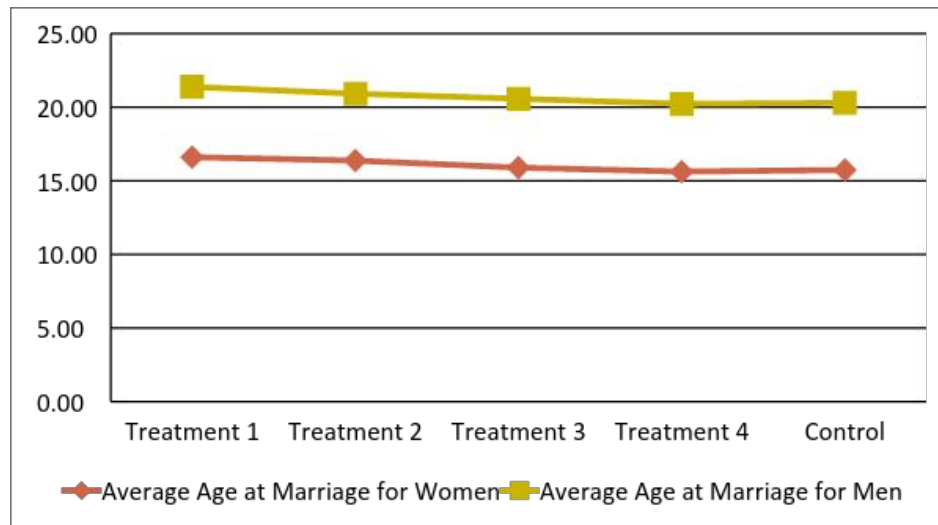
## 5 BASELINE STATUS OF IMPACT INDICATORS

Flowing from the evaluation and regression models presented in the methodology section, this section presents the results from the analysis (including linear regressions) of the two main impact indicators: age at marriage and years of schooling. Incidence of early marriage is also included, though not in the regression model. For the midline and endline reports programme indicators will also be included as explanatory variables. Though it cannot be included here, a difference in difference (DID) analysis will be utilised in subsequent reports to assess the impact of the programme. Regression analysis has instead been utilised to identify factors that affect age at marriage.

### 5.1 Age at Marriage

The first set of baseline findings presented here are on the age at marriage of women and men. The data is presented for different age groups separately, because the programme is particularly interested in targeting those individuals entering adulthood over the course of this programme (i.e. the next five years). In general with each successive age cohort age at marriage would be expected to increase. The average age at marriage is calculated for all ever married members of households sampled in this study. Figure 12 compares the average age at marriage across the 5 treatment groups

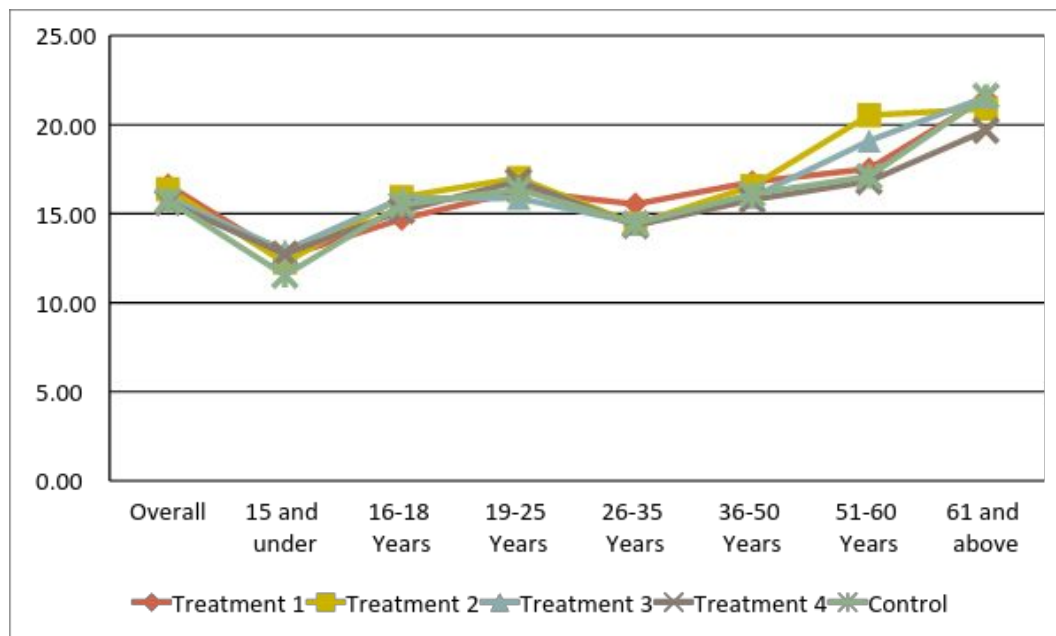
Figure 12 Average age at Marriage for Men and Women by Treatment Group



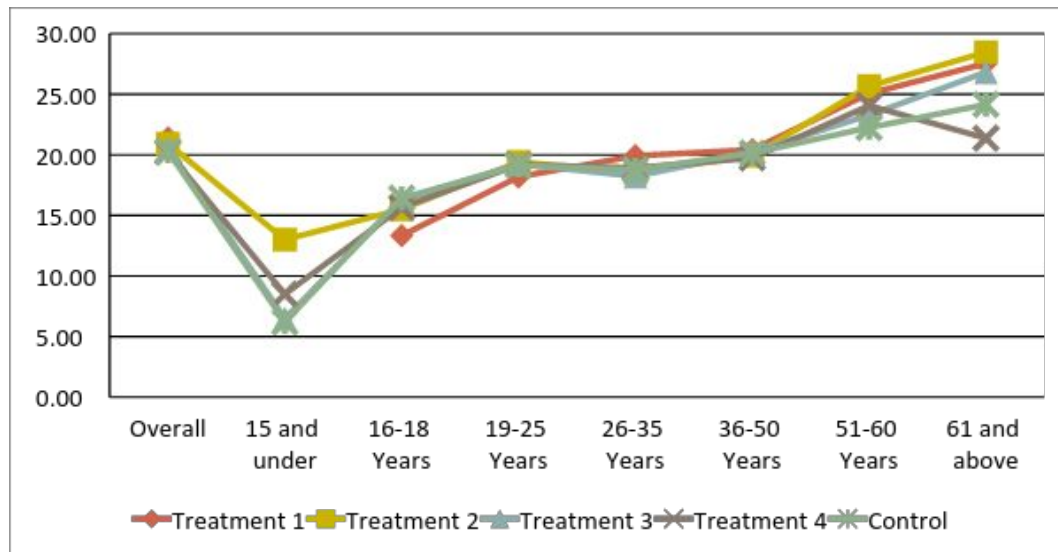
The average age at marriage for women is about 15 to 16 years in all treatment groups. It is slightly higher in the areas that will receive treatment 1 (community mobilization, training and mass media). In the rest of the treatment areas the average age at marriage is about 15. The average age at marriage for men is between 20 to 21 years across all treatment groups.

In Figures 13 and 14 average ages at marriage is presented by separately for 7 age cohorts.

**Figure 13 Average ages at Marriage for Women by Age Groups**



**Figure 14 Average ages at Marriage for Men by Age Groups**



The results show that the average age at marriage by age groups is fairly similar across all treatment types. This indicates that the baseline status of all four treatment groups and the control group is similar. There are some differences in average age at marriage for those between 51 and 60 years of age but this difference could also be due to a relatively smaller sample of individuals in that age range that is available in the data. Furthermore, the focus of the intervention is on reducing early marriage for those who are currently adolescents so the discrepancy in the older age groups should not pose a problem for comparison. The average age at marriage is lowest for those who are 15 and under which is expected. For those above 18 years of age, average age at marriage is lowest for those between 26 to 35 years. Age at marriage tends to be higher in the older age group – particularly 51 to 60 years and 61 years and above. One explanation for this particular result could be reduced reliability of recall for older members of households. Therefore, the age at marriage figures for the older age groups may not be completely accurate.

### 5.1.1 Linear Regression with Age at Marriage

For the purpose of regression analysis there are two versions of age at marriage that are utilised. The first is age at marriage for those who are currently up to 30 years of age. The second is age at marriage for all ever married individuals. For the purpose of measuring the impact of the programme the former is more important, since most people above that age are already likely to be married. However, this significantly reduces the sample size available for the analysis. Thus, a separate regression is also done including all ever married members. Table 3 shows the results for the regression using average age at marriage of men up to 30 years as the dependent variable. The explanatory variables used in the regression include covariates such as religion, social group, distances from state capital and nearest town. It also includes certain factors that the programme will likely to affect, such as gender norms.

Table 3 Regression Results - Age at Marriage of Men up to 30 years of age

Variables	Coefficient	Std. Error	t-Statistic	p-Value
<b>Age at Marriage-Males (Upto 30 years of age)</b>				
PPI	0.0813***	(0.0161)	5.11	0.000
Gender Norms Score	2.173**	(1.004)	2.16	0.031
Awareness of Schemes	0.0281	(0.430)	0.08	0.934
Enrollment in schemes	-1.300*	(0.775)	-1.67	0.095
Distance from District HQ	-0.00111	(0.00152)	-0.72	0.470
Scheduled Caste	-0.721*	(0.428)	-1.68	0.093
Scheduled Tribe	-0.686	(0.846)	-0.81	0.417
Hindu	-1.795*	(1.045)	-1.72	0.087
Muslim	-1.289	(1.193)	-1.08	0.279
Distance from Nearest town	0.0281*	(0.0166)	1.7	0.090
Education of Head of HH	-0.129***	(0.0462)	-2.79	0.005
Access to Media	0.158	(1.291)	0.12	0.903
Constant	18.08***	(1.219)	14.83	0.000
Observations	1,046			
R-squared	0.058			
Standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				

There are 6 significant variables here. The variable with the highest coefficient is **gender norms score** which has a positive effect on age at marriage. The gender norms score is calculated by scoring each household on a scale of 0 to 1 based on responses to questions about gender based division of responsibilities, assets and property, mobility and education levels. In the score 0 signifies an unequal division and 1 signifies an equal division. Thus, the results from the regression suggest that where gender norms are more equal age at marriage is higher for men upto 30 years of age. Apart from gender norms, PPI is also significant and positive indicating that age at marriage is higher in

households that are economically better off. Scheduled Caste groups have a lower age at marriage compared to other social group with the difference being 0.7 years. Hindu households also have a lower age at marriage compared to rest of the population with the difference being 1.8 years all else being equal. Distance from town has a positive effect on age at marriage.

Table 4 has the regression results for age at marriage for women up to the age of 30 years.

**Table 4 Regression Results - Age at Marriage for women up to the age of 30 years**

Variables	Coefficient	Std. Error	t-Statistic	p-Value
<b>Age at Marriage-Female up to 30 years of Age</b>				
PPI	0.0497***	(0.0102)	4.89	0.000
Gender Norms Score	1.172*	(0.631)	1.86	0.063
Awareness of Schemes	-0.535**	(0.272)	-1.96	0.050
Enrollment in schemes	-0.284	(0.449)	-0.63	0.527
Distance from District HQ	-0.00117	(0.00106)	-1.1	0.273
Scheduled Caste	-0.0860	(0.268)	-0.32	0.749
Scheduled Tribe	0.316	(0.522)	0.61	0.545
Hindu	-1.026*	(0.619)	-1.66	0.098
Muslim	-0.0549	(0.710)	-0.08	0.938
Distance from Nearest town	0.0152*	(0.00925)	1.65	0.100
Education of Head of HH	-0.0954***	(0.0272)	-3.5	0.000
Access to Media	0.166	(0.777)	0.21	0.830
Constant	15.09***	(0.756)	19.95	0.000
Observations	1,046			
R-squared	0.058			
Standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				

Table 5 shows the regression results for all households with ever married males.

**Table 5 Regression Results - Age at Marriage for Men**

Variables	Coefficient	Std. Error	t-Statistic	p-Value
<b>Age at Marriage-Men</b>				
PPI	0.0192**	(0.00873)	2.2	0.028
Gender Norms Score	0.0441	(0.550)	0.08	0.936
Awareness of Schemes	0.239	(0.229)	1.05	0.295
Enrollment in schemes	-1.167**	(0.456)	-2.56	0.011
Distance from District HQ	-0.00262***	(0.000877)	-2.99	0.003
Scheduled Caste	-0.310	(0.242)	-1.28	0.199
Scheduled Tribe	0.947**	(0.420)	2.26	0.024
Hindu	-0.726	(0.495)	-1.47	0.143
Muslim	0.189	(0.571)	0.33	0.741
Distance from Nearest town	0.0209**	(0.00812)	2.58	0.010
Education of Head of HH	-0.0730***	(0.0228)	-3.19	0.001
Access to Media	-0.479	(0.693)	-0.69	0.490
Constant	20.93***	(0.630)	33.24	0.000
Observations	3,050			
R-squared	0.029			
Standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				

In this model PPI is still positive and significant however gender norms don't appear to have an impact on overall age at marriage for men. Distance from district headquarters has a negative effect, i.e., greater the distance lower is the age at marriage. Age at marriage is higher in scheduled tribe

households. Education of the head of household appears to have a negative effect on age at marriage in the case of men.

Table 6 shows the regression results for age at marriage for all households with ever married women as the dependent variable.

**Table 6 Regression Results - Age at Marriage for Women**

Variables	Coefficient	Std. Error	t-Statistic	p-Value
<b>Age at Marriage-Women</b>				
PPI	0.00700	(0.00770)	0.91	0.363
Gender Norms Score	0.802*	(0.481)	1.67	0.096
Awareness of Schemes	-0.347*	(0.200)	-1.74	0.082
Enrollment in schemes	-0.805**	(0.402)	-2	0.046
Distance from District HQ	-0.00232***	(0.000794)	-2.93	0.003
Scheduled Caste	-0.0578	(0.212)	-0.27	0.785
Scheduled Tribe	0.851**	(0.364)	2.34	0.020
Hindu	-0.631	(0.431)	-1.46	0.144
Muslim	-0.0313	(0.496)	-0.06	0.950
Distance from Nearest town	0.0166**	(0.00713)	2.33	0.020
Education of Head of HH	-0.0624***	(0.0201)	-3.11	0.002
Access to Media	0.00684	(0.607)	0.01	0.991
Constant	16.37***	(0.551)	29.73	0.000
Observations	3,222			
R-squared	0.024			
Standard errors in parentheses				
*** p<0.01, ** p<0.05, * p<0.1				

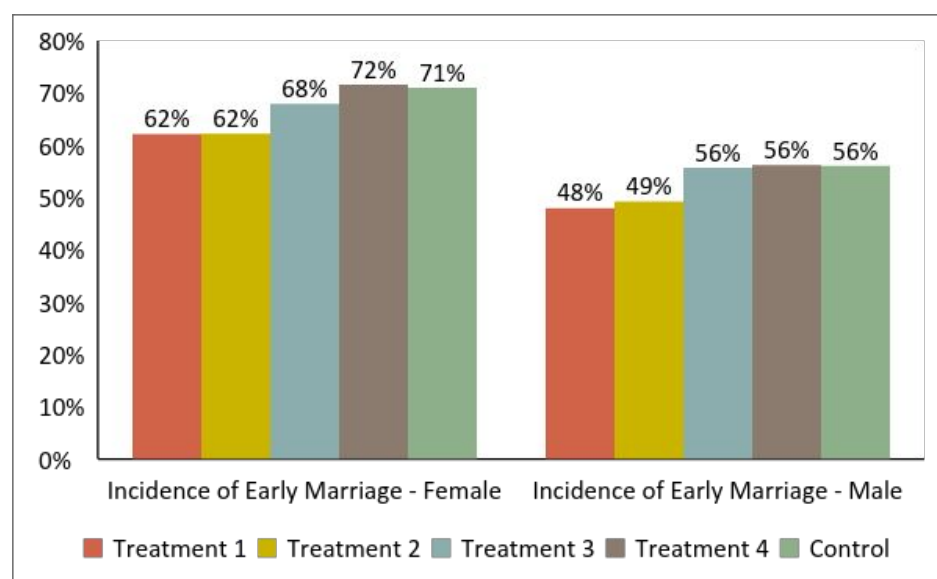
In the case of age at marriage for women, gender norms are significant and have a positive effect on age at marriage. This means that more equal the gender norms in the family the higher is the age at

marriage. Awareness and enrolment in schemes is negatively correlated with age at marriage currently. However, this may also indicate that households where early marriage has taken place earlier are now enrolling young female members into these schemes more frequently, and direct causation cannot be assumed. Households further away from the district headquarter have a lower age at marriage and the results are significant. Scheduled tribes have a higher age at marriage among women and the difference, all else being equal, is 0.85 years.

## 5.2 Incidence of Early Marriage

The previous section reported the baseline status of average age at marriage in the five treatment groups. In this section data on the incidence of early marriage, i.e. marriage of women before the age of 18 and marriage of men before the age of 21, is presented. Figure 15 compares the incidence of early marriage in the 5 groups for men and women. Incidence here is defined as the percent of ever married women and men who married before the legal ages of 18 and 21 respectively.

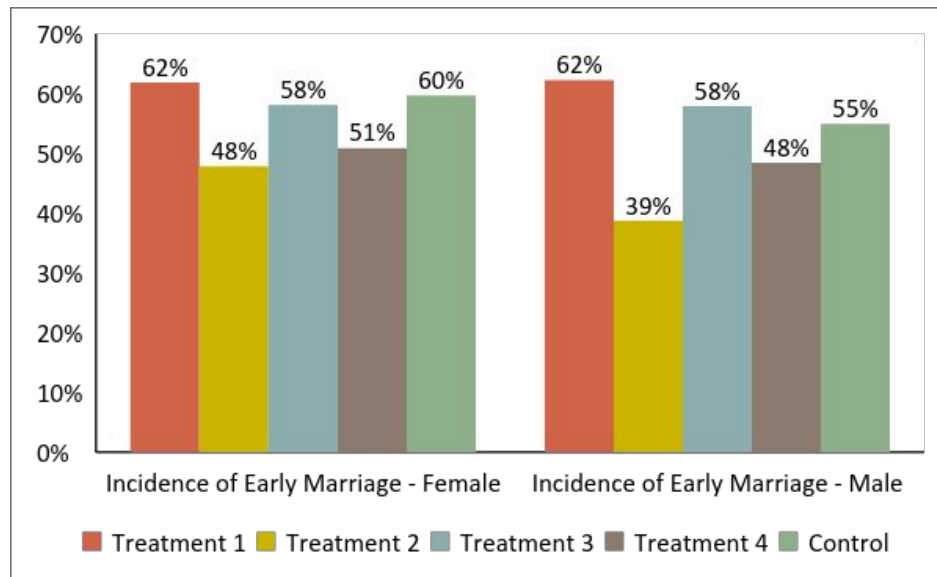
**Figure 15 Incidence of Early Marriage among all Ever Married Individuals**



Overall, the data show that 67% of ever married women in the sample households married before the current legal age of 18 years. For men the overall incidence of early marriage was 54%. When compared across the 5 treatment groups, the incidence of early marriage is higher among women at 60 to 70% while it is about 50 to 60% among men. Overall, the incidence of early marriage for both men and women is higher in control areas and treatment groups 3 and 4 at baseline.

Since the younger age group is the one for which we're tracking changes the incidence of early marriage in this age group is analysed separately. Figure 8 shows the incidence of early marriage among ever married women between 19 and 25 years and ever married men between 21 and 25 years of age.

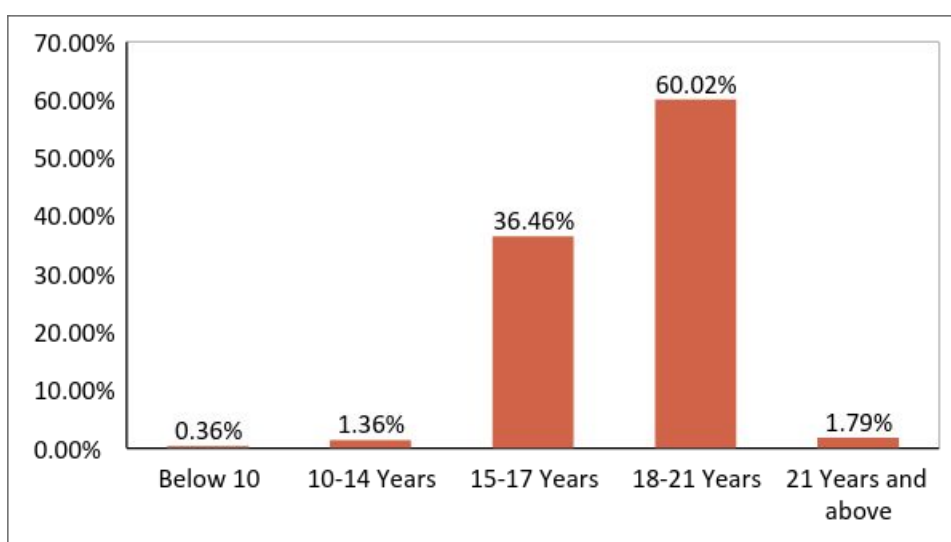
**Figure 16 Incidence of Early Marriage among Women (18-25 Years) and Men (21-25 Years)**



The percentage is higher about women between the ages of 18 to 25 compared to men between. The incidence of early marriage is very similar here for both men and women. It is slightly higher in treatment 1 and the lowest in treatment 2. About 50% to 60% of all married individuals were married early in the sample households.

To address the possibility of social desirability bias in the reporting of age at marriage respondents were also asked about the prevailing marriage ages in the community. This was done assuming that respondents may be more comfortable talking about a general age at marriage than for specific people in their household. Figure 17 shows the general age at marriage for women in the community in the sample households. A majority of the households report that women generally get married between the ages of 18 to 21 years. The next most frequent response is 15 to 17 years. The actual incidence of early marriage (based on member level data) was much higher than this. It indicates that people underestimate the prevalence of early marriage.

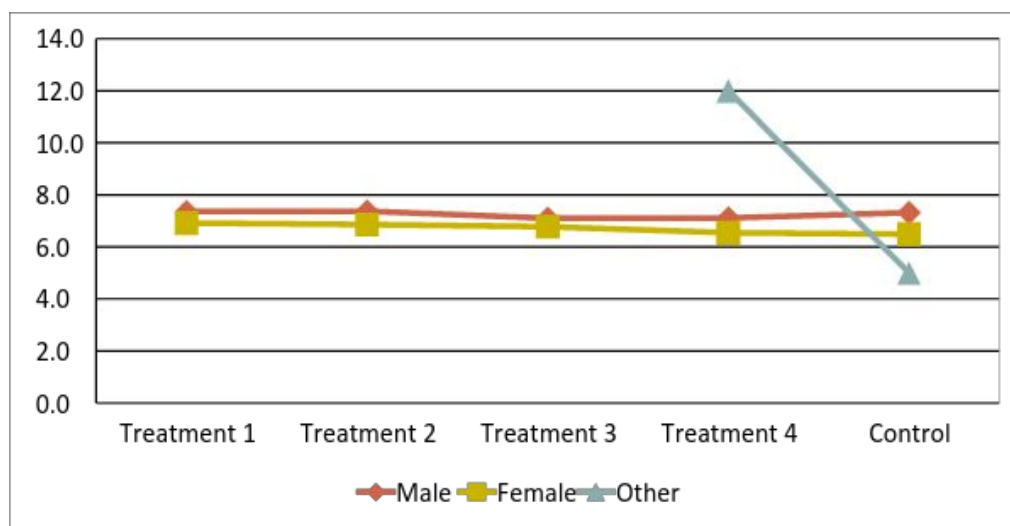
**Figure 17 Prevailing age at marriage of women in the community**



### 5.3 Years of Schooling

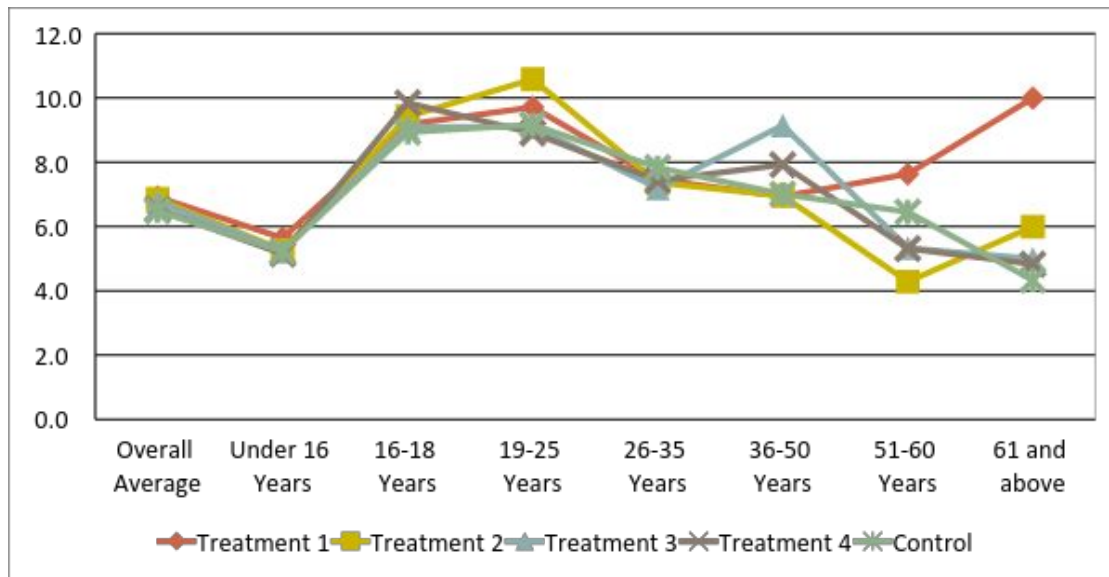
Apart from age at marriage itself, the number of years of schooling is also an expected positive outcome of this programme. It is also a proxy for age at marriage since early marriage is generally associated with school dropout. Figure 18 shows the average years of schooling for men and women across the 5 treatment groups.

Figure 18 Average Number of Years of Schooling across Treatment Groups



Overall the average number of years of schooling is very similar for the sample across the 5 treatment groups. Men tend to be marginally more educated but there isn't a large difference. In Figures 19 and 20 the average years of schooling are also depicted separately for different age groups to assess how this has changed over time and the average schooling levels in the target population of the programme.

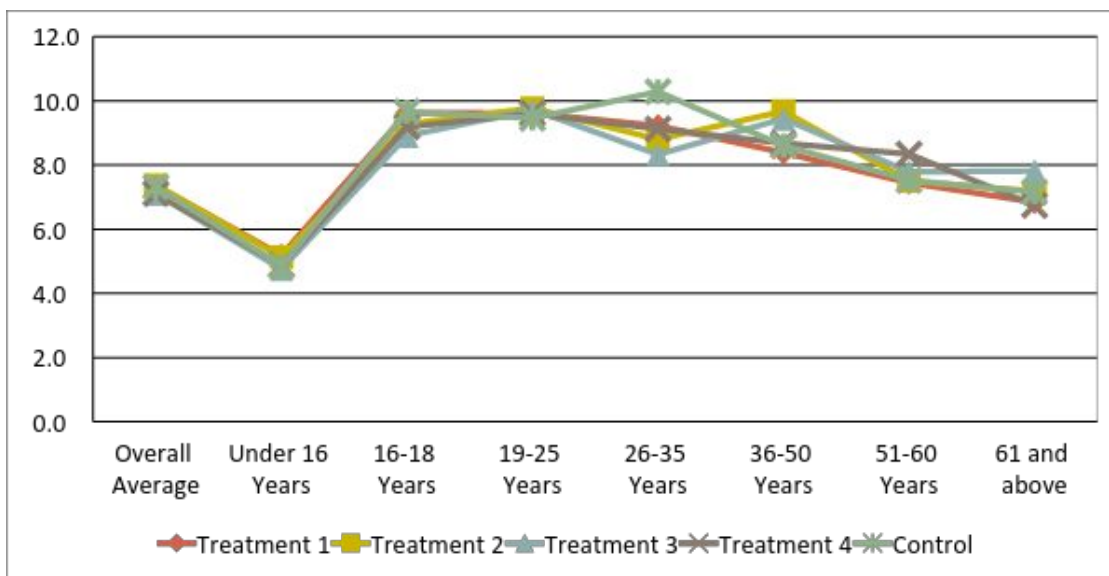
Figure 19 Average Number of Years of Schooling for Women (By Age Group)



The average number of years of schooling in the younger age groups is fairly similar across the treatment types. However from 36 years onwards the average tends to vary a bit more. This may be partially due to fewer number of samples in those age ranges (particularly 60 and above). However, in the lower age ranges the 5 treatment groups are very comparable at baseline.

Figure 20 below shows the results for men in the survey households.

**Figure 20 Average Number of Years of Schooling for Men (By Age Group)**



The average years of schooling for men across all age groups appears to be very similar for all treatment groups. Thus, on this parameter the 5 groups of sample households are highly comparable. The highest schooling levels are in the 19-25 and 26-35 age ranges for men (at about 10 years). For women the highest is in the 19-25 age range also at 10 years. Women between 26-35 years of age and older tend to have attended school for fewer years compared to men in the same ranges.

## 5.4 Summary

Flowing from the evaluation and regression models presented in the methodology section show the results from analysis (including linear regressions) for the two main impact indicators: age at marriage and years of schooling. Incidence of early marriage is also included, though not in the regression model.

The results show that the **average age at marriage by age groups is fairly similar across all treatment types**. This indicates that the baseline status of all four treatment groups and the control group is similar. There are some differences in average age at marriage for those between 51 and 60 years of age but this difference could also be due to a relatively smaller sample of individuals in that age range that is available in the data.

The linear regression results show that Social and Religious groupings and gender norms have a significant impact on the age at marriage. Scheduled tribe households have a higher age at marriage for the overall sample. For the sample of individuals up to the age of 30 Hindu households tend to have a lower age at marriage for both men and women. Finally, households with more equal gender norms tend to have a higher average age at marriage. For the overall age at marriage, distance from the district headquarter is negative and significant. This implies that closer the GP is to district headquarter the higher is the age at marriage in that area.

In terms of **incidence of early marriage** it is higher than 50% of all ever married individuals in almost all the treatment areas. Treatment area 2 has an early marriage incidence of 48% for women and 39% for men. The results on incidence indicate that there is need for interventions to address this issue.

Finally, in terms of **years of schooling** the results are also similar across the five treatment types. For both men and women the average number of years of schooling is 8. Overall, the numbers are similar for men and women members of household. However, the gap between men and women increases for those in older age groups.

The results overall show that, in terms of the main impact indicators, the 5 treatment groups are highly comparable. Thus using DID in the following rounds of survey the impact of the programme can be estimated.

## 6 BASELINE STATUS OF OUTCOME INDICATORS

Outcome indicators for this study were identified in the evaluation model and theory of change. In this section the baseline status of these outcome indicators is established. These outcomes are intermediary steps between programme output and the ultimate impact the programme might have. This includes change at the level of community and individual norms with respect to appropriate times for age at marriage. The following section establishes the baseline status of these outcome indicators.

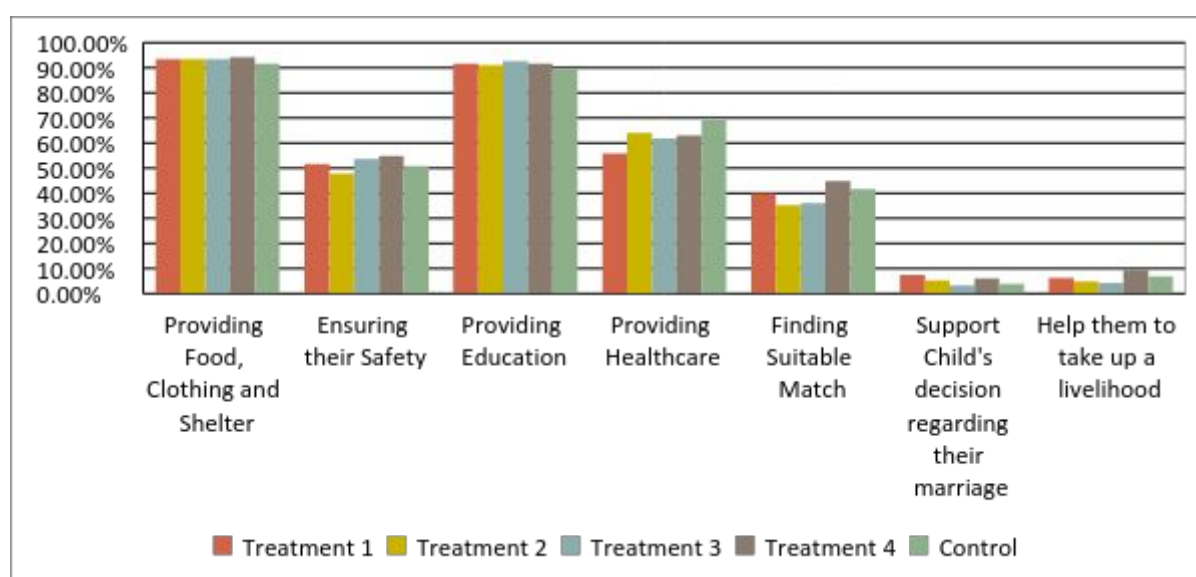
## 6.1 Gender Norms

The goal of the Breakthrough's programme is to use pop culture and mass media to affect change in prevailing gender norms. In this section the current status of gender norms is examined, in the programme area, particularly focusing on three factors: division of household responsibilities, mobility outside the home, access to education and inheritance.

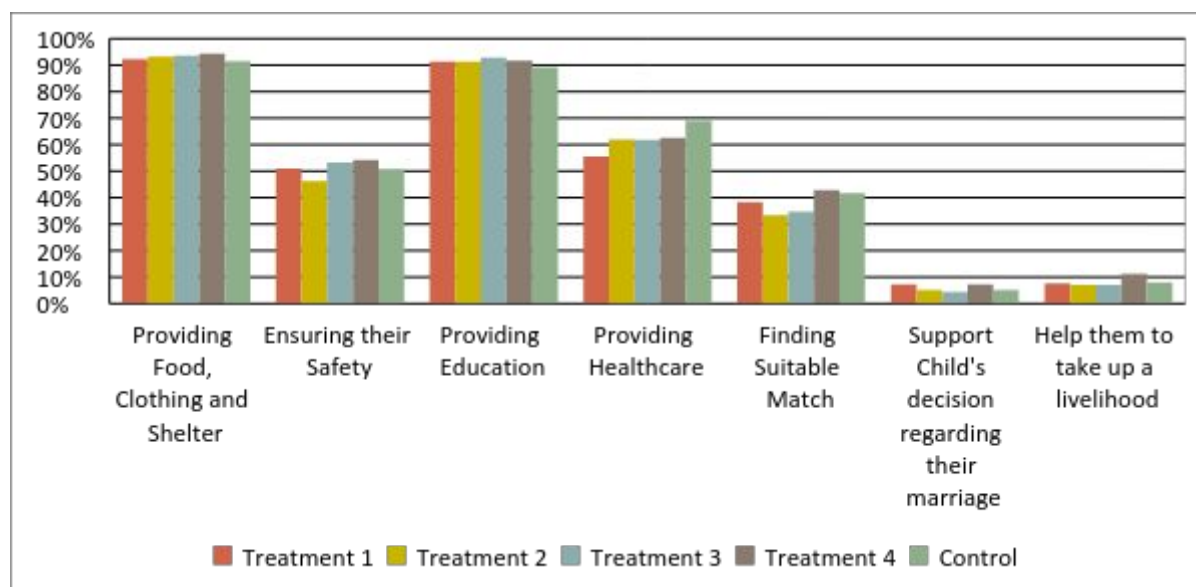
### 6.1.1 Gender-wise Distribution of Household Responsibilities

Figures 21 and 22 depict the baseline status of perceived responsibilities of parents towards their children. All the results are from unprompted responses. The purpose of this indicator is to assess if there are any differences in perceived responsibilities towards male and female children. This question was also included to assess what responsibilities were seen as more important by the households.

**Figure 21 Perceived Responsibility of Parents towards Girl Child**



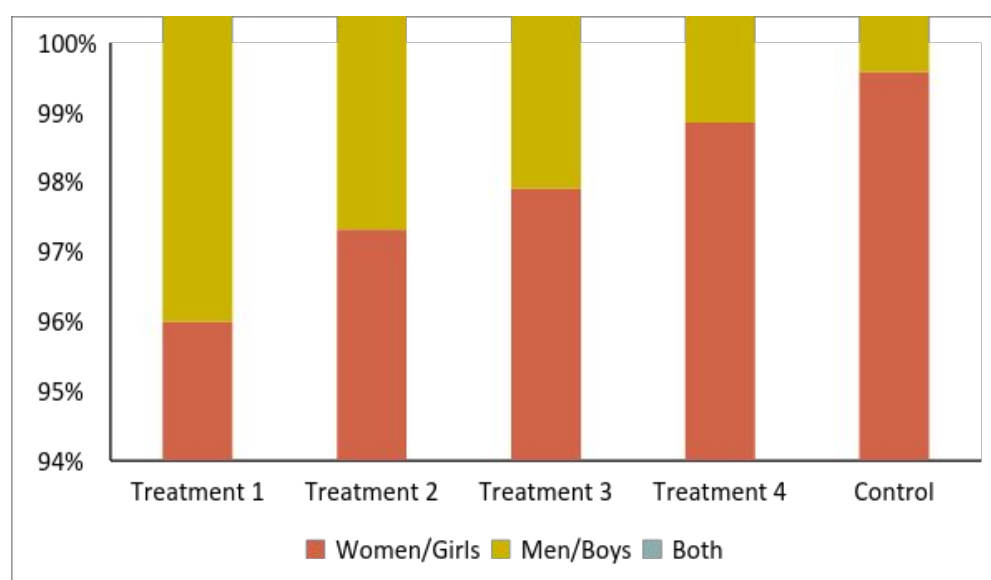
**Figure 22 Perceived Responsibilities of Parents towards Male Children**



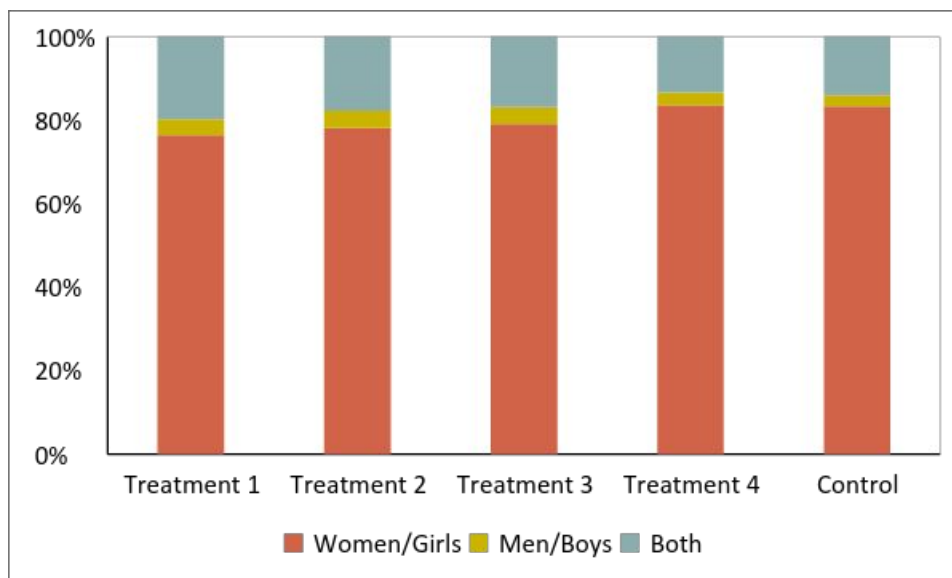
In the household survey respondents were asked what, according to them, were the responsibilities parents had towards their children. There are no significant differences between the responses reported for male and female children. The two most frequently occurring responses were providing food, clothing etc. and providing education. Providing healthcare and ensuring safety were also reported by more than half the respondents. Very few respondents suggested that helping their children in their livelihood decisions or supporting their decision regarding marriage is a responsibility of the parents (less than 10%).

Figures 23, 24 and 25 depict the division of household responsibilities between male and female members. The respondents were asked who in the household performed these three tasks in their home: men, women or both.

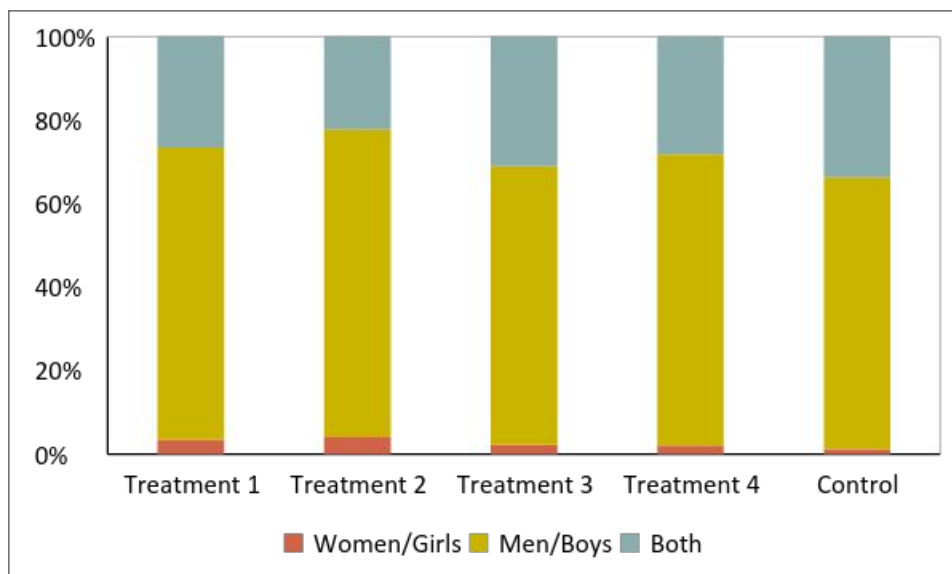
**Figure 23 Division of Responsibility in Cooking and Household Chores**



**Figure 24 Division of Responsibility in Taking Care of Children/Younger Siblings**



**Figure 25 Division of Financial Responsibility in the Household**



Across all groups women are overwhelmingly responsible for household chores and cooking, with over 96% of the respondents in each treatment group saying that women hold this responsibility in their household. Women are also responsible for taking care of children or younger siblings though to a lesser extent. Men are primarily responsible for providing for the household financially. The distribution is similar across the four treatment groups with 65% to 70% of the household reporting that men hold this responsibility. For 22 to 33% of the households both men and women share this responsibility.

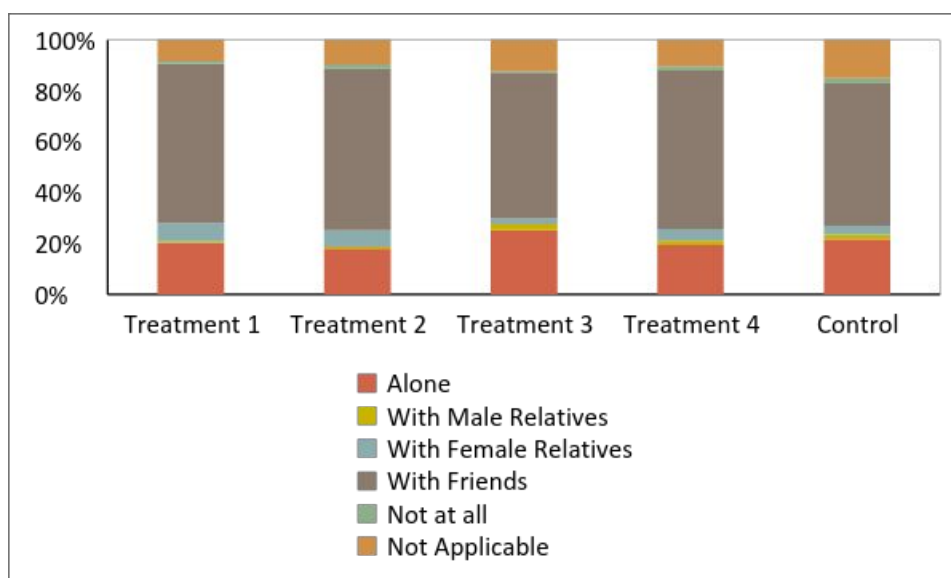
### 6.1.2 Norms on Mobility for Women/Girls in the Household

One of the factors that the formative research showed contributes to early marriage is the fear of harassment and restrictions to mobility of women outside the home. Through its community based interventions Breakthrough seeks to empower women and create safe spaces for young girls in the

community. Thus one outcome indicator that has been included in the baseline is the current status of mobility for women and girls in the programme area.

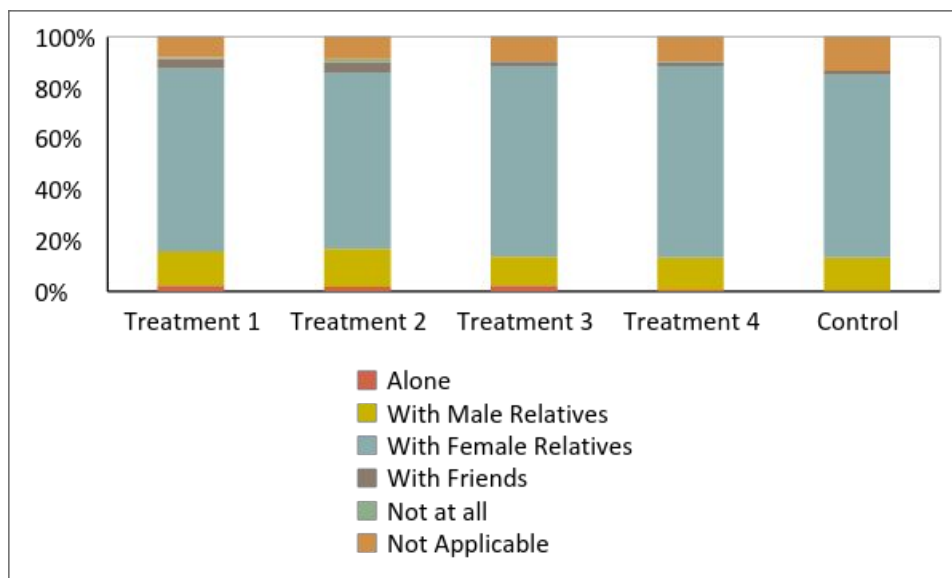
Figures 26, 27 and 28 show the current access to mobility young girls have in going to school, in visiting health centres, and in interacting with male peers respectively. Respondents were asked whether girls in their household usually go to school alone, with male relatives, female relatives, friends, or not at all. Respondents were also asked similar questions about how girls in their household go to health centres or interact with male peers.

**Figure 26 Mobility of Girls while Going to School**



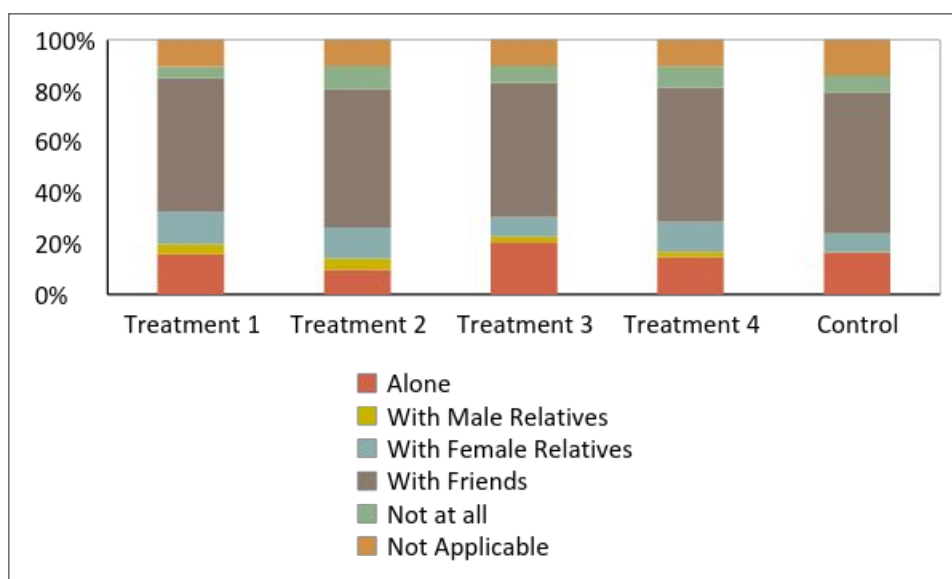
Girls primarily go to school accompanied by their friends, with this being the case in 55% to 63% of the households. The baseline status is fairly similar in all 5 groups. Apart from going to school with friends in about 18% to 25% of the cases they also go to school alone. The not applicable option is for those households where there are no female adolescent members. In only about 1% of the cases do girls not go to school at all.

**Figure 27 Mobility of Girls in visiting Health Centres**



While visiting health centres girls are usually accompanied by female relatives. In about 12% to 14% of cases they are accompanied by male relatives.

**Figure 28 Mobility in interacting with Male Peers**



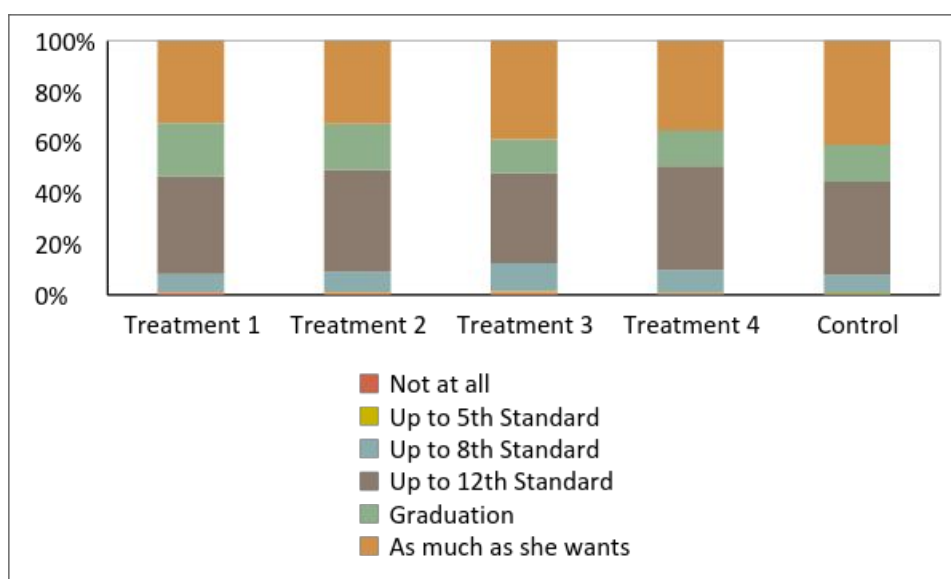
A majority of girls who interact with male peers do so accompanied by friends. This is the only question where 5% to 10% of the respondents gave “not at all” as a response. In all three cases the responses from all treatment groups are very similar, and therefore in this respect the 5 groups are comparable.

### 6.1.3 Access to Education and Inheritance

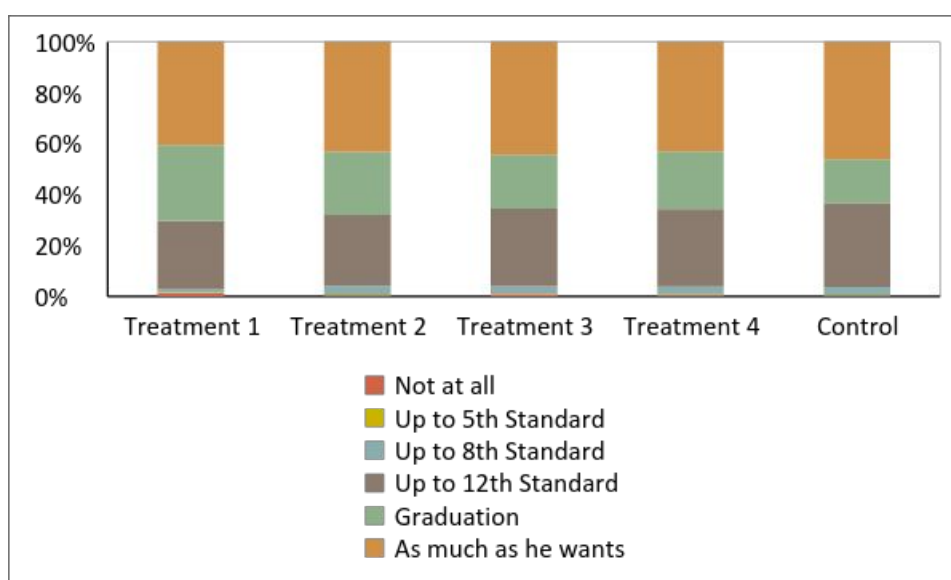
The final parameter included under gender norms is access to education and inheritance for female and male children. Respondents were asked what, according to them, is the ideal level of education for male and female children. The results are depicted in Figure 29 and 30. Figure 29 shows the

responses for female children and 30 for male children.

**Figure 29 Ideal Level of Schooling for Female Children as per Respondent**



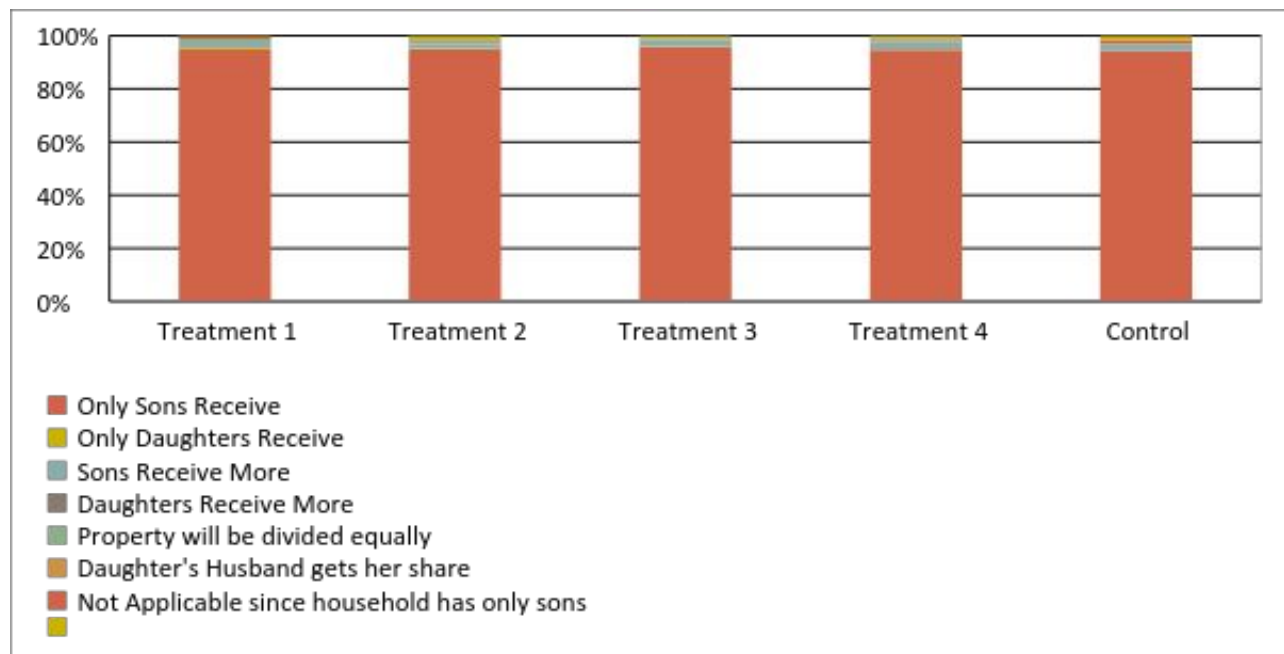
**Figure 30 Ideal Level of Schooling for Male Children as per Respondent**



The results show that for male children the most common response (from 40 to 46% of households) was as much as they want to study. On the other hand for female children the most common response was up to 8<sup>th</sup> standard (38% to 41% of households), followed by as much as she wants. This indicates that education for male children receives a higher priority than for girl children.

Figure 31 depicts the prevailing norms regarding division of inherited property between sons and daughters. Respondents were asked how inherited property is divided in their family and responses were recorded from a set of options.

Figure 31 Division of Inheritance between Sons and Daughters



The results show that overwhelmingly sons inherit family property in the programme area. In all of the treatment groups 94 to 95% of the households reported that sons alone inherit the property. The next most common response was that sons receive a larger portion of the inheritance. All the other responses were reported by less than 1% of the households across the 5 groups. The results show that the 5 treatment groups are highly comparable at baseline. They also show that inheritance is one of the major areas in which disparity between the genders exists.

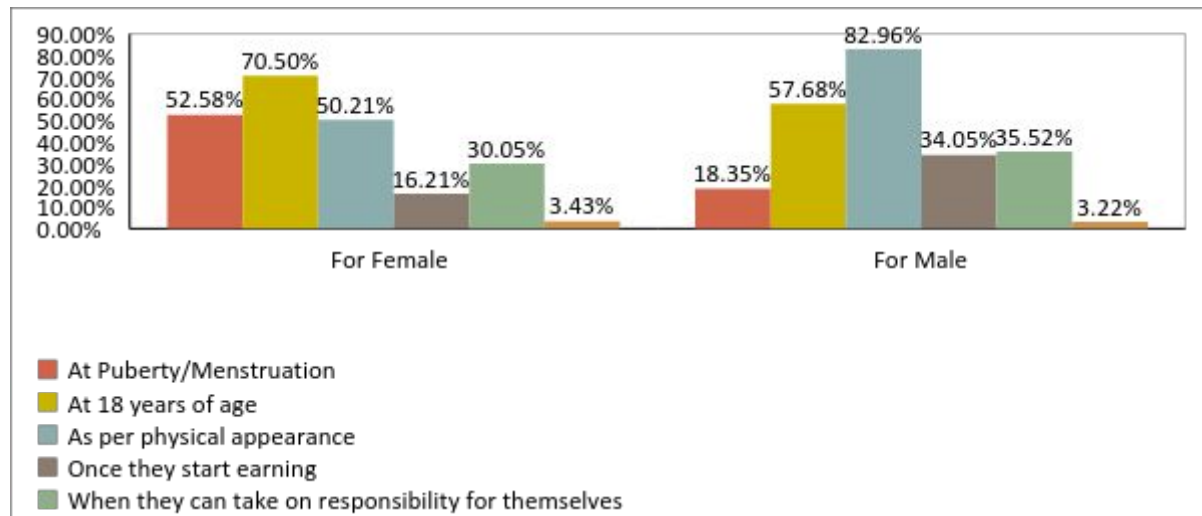
## 6.2 Norms Regarding Age at Marriage

This section summarises results from questions posed to the respondents on how age is determined and how an appropriate age for marriage is decided upon. It emerged from the formative research that while all respondents are aware of the legal age at marriage, adulthood is not necessarily defined on the basis of biological age. Perceptions of maturity play a major role in determination of age and adulthood in the programme areas. Therefore, these indicators are included as outcome indicators. The expectation is that the programme will challenge some of these norms related to appropriate age at marriage and determination of adulthood.

### 6.2.3 Norms Regarding Age at Marriage

Respondents were asked how adulthood was defined or determined for boys and girls in their families. The responses are depicted in figure 32.

Figure 32 Determination of Adulthood for Women and Men



For girls the most popular responses were - 18 years of age, at the time of puberty or menstruation, and based on physical appearance (height, weight and other physical characteristics). For men, the most common response was physical appearance (i.e. height, weight, appearance of facial hair) with 83% of the respondents giving this response. Apart from this for men, 34% of the respondents said that they become adults once they start earning. This number drops to half in the case of girls at 16%.

Figures 33 and 34 show the results for the same question by Treatment type.

**Figure 33 Determination of Adulthood for Girls/Women**

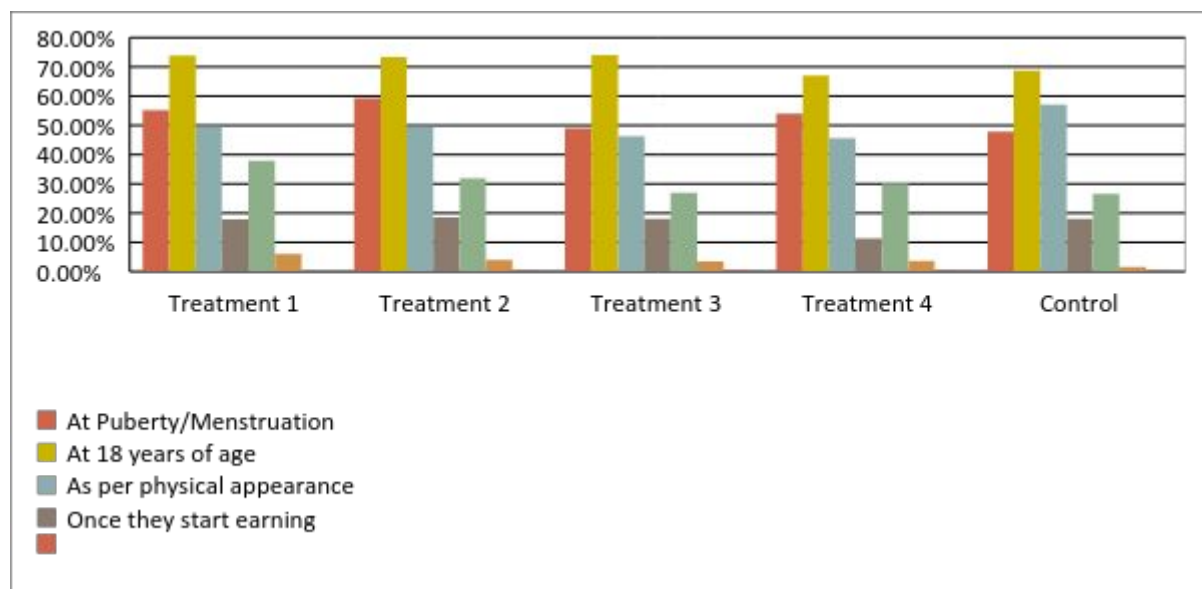
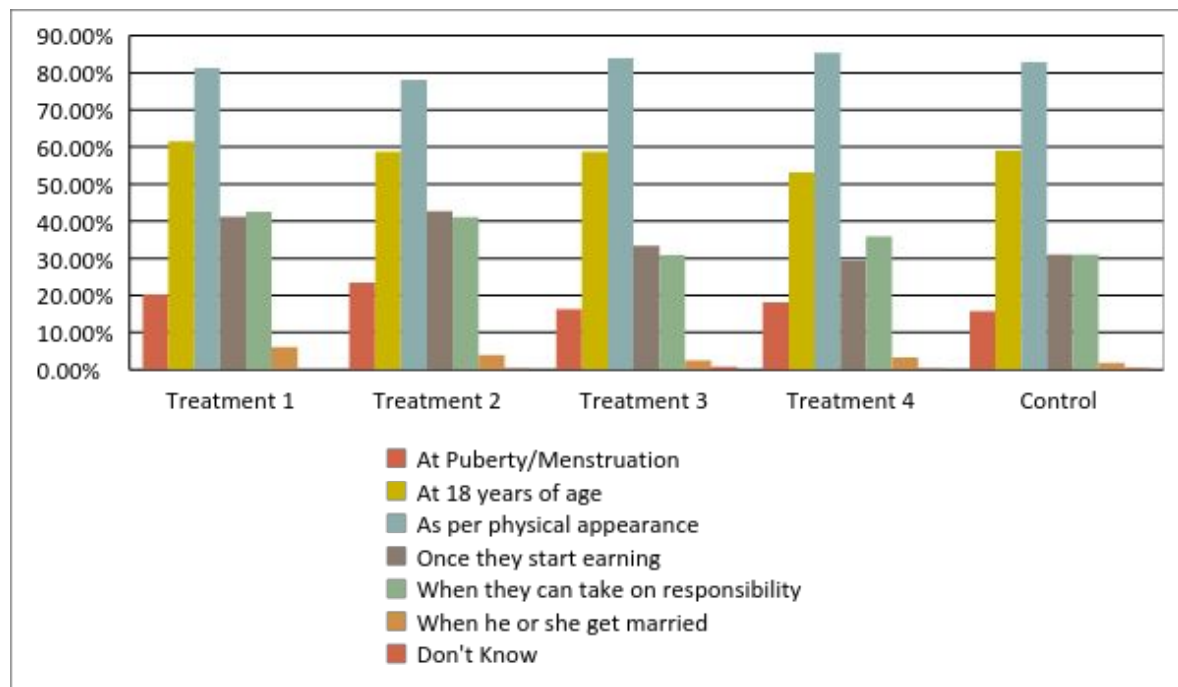


Figure 33 shows that the results are highly similar across all 5 groups. In all the treatment groups “at 18 years of age” and “at puberty/menstruation” were the most common responses. This is followed by “as per physical appearance”. In the control district “physical appearance” was mentioned more frequently than “at puberty/menstruation”.

Figure 34 Determination of Adulthood for Men/Boys

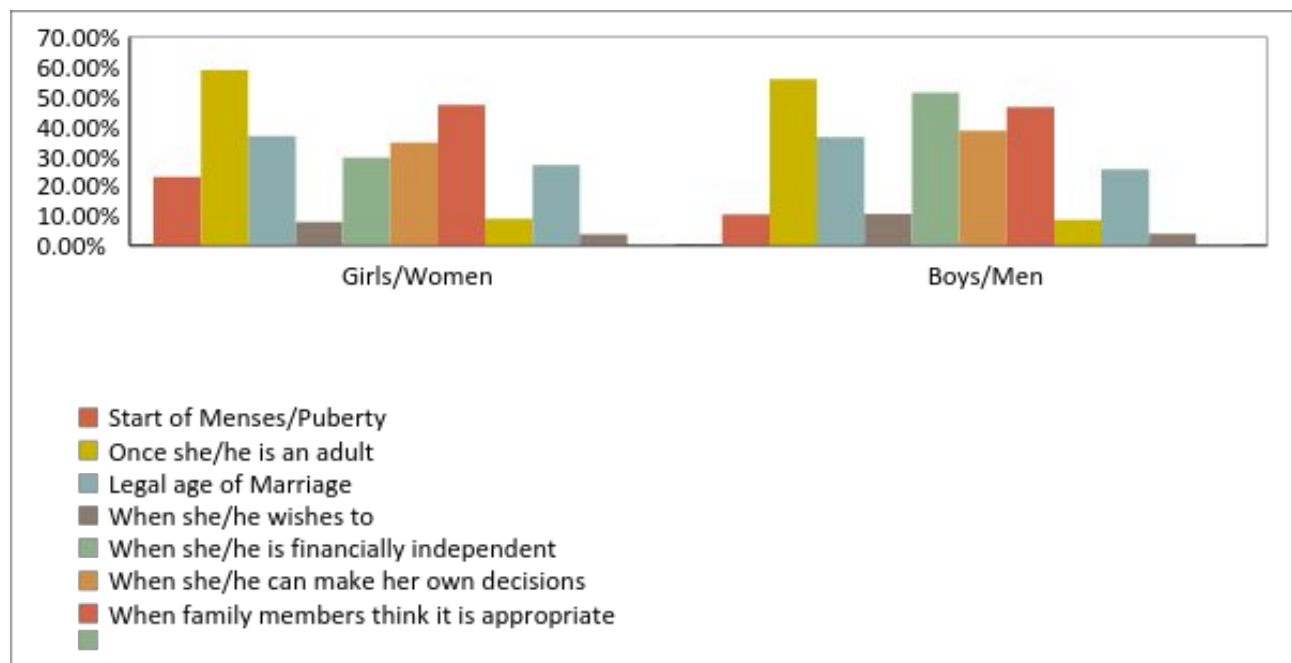


For men, too, the results are very similar across the 5 treatment groups. The most common response with about 80% of the respondents in each group is “as per physical appearance”. Following this the next most frequently cited response is “at 18 years of age”, followed by “when they can take on responsibility”.

In terms of norms regarding determination of adulthood the 5 treatment groups are highly similar at baseline, both in the case of men and women.

Respondents were also asked who they consider or how they determine the appropriate age for marriage of women and men. The purpose here was to get qualitative information as opposed to a number regarding how appropriate ages for marriage are determined. Figure 35 depicts the results from the response to this question.

Figure 35 Determination of Appropriate Age for Marriage



The most common responses with respect to determining an appropriate age for marriage was “once she/he is an adult”. This response was given by 55% of the respondents for men and 58% of the respondents for women. For men the next most common response was “when he is financially independent” at 51% of the respondents. Only 29% of the respondents gave the same response for women. “When family members think it is appropriate” was cited equally for men and women. While adulthood is specified as the ideal age for marriage for women this should be read in context of how adulthood has been defined previously. As stated earlier adulthood is also judged on the basis of appearance or puberty which would mean that the ideal age for marriage would be lower than legal adulthood.

The responses from this question are presented separately for all the treatment groups in Tables 7 and 8.

**Table 7 Determination of Appropriate of Marriage for Women/Girls**

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Control
<b>Start of Menses/Puberty</b>	37.47%	37.32%	22.55%	18.02%	13.96%
<b>Once she is an adult</b>	62.53%	62.47%	59.29%	59.06%	54.69%
<b>Legal age of Marriage</b>	34.74%	36.08%	43.63%	37.29%	33.85%
<b>When she wishes to</b>	8.63%	5.15%	9.39%	6.25%	10.21%
<b>When she is financially independent</b>	33.68%	29.90%	29.44%	25.73%	30.73%
<b>When she can make her own decisions</b>	39.37%	38.35%	34.03%	31.46%	33.75%
<b>When family members think it is appropriate</b>	33.47%	38.56%	43.42%	51.46%	55.63%

<b>According to Norms/Traditions</b>	11.58%	10.31%	7.31%	8.65%	8.33%
<b>When a suitable match is found</b>	28.42%	25.36%	23.59%	27.71%	28.23%
<b>If she is sitting idle</b>	4.21%	5.36%	3.34%	3.33%	3.33%
<b>Don't Know</b>	0.21%	0.21%	0.21%	0.31%	0.42%
<b>N</b>	480	480	480	960	960

The results for the appropriate for marriage of women are similar across the treatment groups. Legal age of marriage was more frequently cited in the group receiving “Treatment 3”, i.e., mass media and community mobilization, compared to all other groups. “When family members think it is appropriate” is also cited more frequently in Treatment group 4 and the control districts compared to the other three groups.

**Table 8 Determination of Appropriate Age for Marriage for Men/Boys**

	<b>Treatment 1</b>	<b>Treatment 2</b>	<b>Treatment 3</b>	<b>Treatment 4</b>	<b>Control</b>
<b>Start of Menses/Puberty</b>	19.16%	16.29%	10.23%	8.02%	5.52%
<b>Once he is an adult</b>	59.37%	60.41%	56.78%	54.90%	51.77%
<b>Legal age of Marriage</b>	34.53%	35.46%	44.05%	36.35%	33.75%
<b>When he wishes to</b>	11.16%	10.10%	11.90%	8.75%	11.77%
<b>When he is financially independent</b>	49.68%	52.58%	53.03%	51.15%	50.83%
<b>When he can make her own decisions</b>	44.84%	46.19%	39.25%	34.79%	34.90%
<b>When family members think it is appropriate</b>	31.58%	36.91%	42.17%	50.63%	56.15%
<b>According to Norms/Traditions</b>	10.95%	10.52%	6.68%	8.23%	8.13%
<b>When a suitable match is found</b>	24.84%	24.12%	21.92%	25.94%	27.92%
<b>If he is sitting idle</b>	4.84%	5.57%	3.76%	3.23%	3.65%
<b>Don't Know</b>	0.63%	0.21%	0.42%	0.10%	0.42%
<b>N</b>	480	480	480	960	960

The responses here too are largely similar. “Once he is an adult” is the most common response across all 5 groups. This is followed by “When he is financially independent”. However, “When family members think it is appropriate” is more common in treatment group 4 and control districts as opposed to the other groups. “Legal age at marriage” is again cited more often in treatment group 3 than elsewhere.

## 6.3 Awareness Indicators

As mentioned in the previous sections the goal of the Breakthrough programme is to affect attitudes knowledge, attitudes and practices related to early marriage. The previous sections have addressed

the practices (in terms of average age and incidence of early marriage) and attitudes (in terms of gender norms and determination of adulthood and appropriate age for marriage). Outcome indicators related to knowledge are presented in this section. This includes awareness of the consequences of early marriage and awareness with respect to incentives and schemes that encourage delaying the age at marriage.

### 6.3.1 Awareness Regarding Negative Consequences of Early Marriage

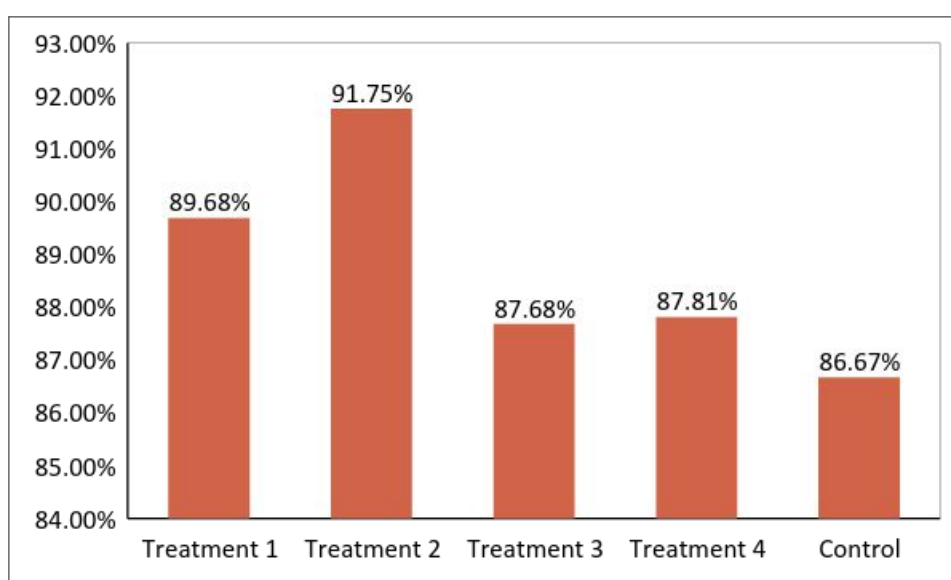
Respondents in the survey were asked whether according to them there were any negative consequences as a result of early marriage. A majority of the respondents said that they believed negative consequences existed.

**Table 9 Whether Respondents believe that there are negative consequences to Early Marriage**

<b>Yes</b>	88.47%
<b>No</b>	9.76%
<b>Don't Know</b>	1.76%

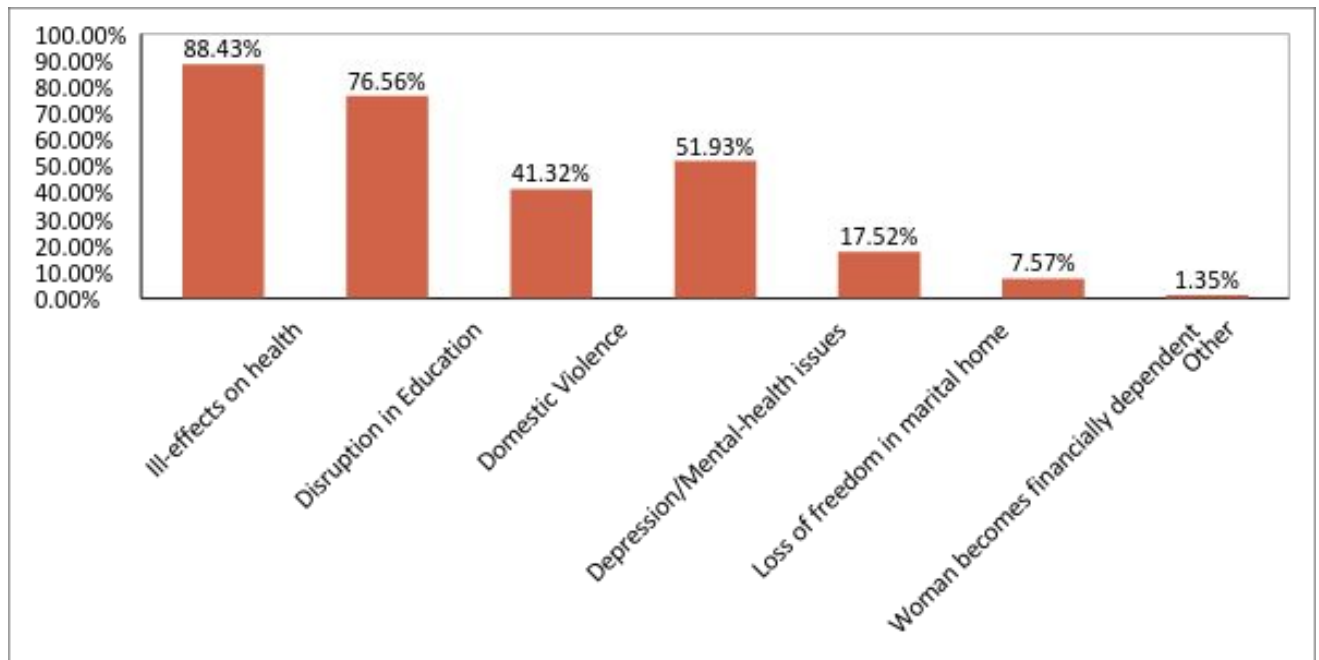
Figure 36 shows the results individually for each treatment group. The results are very similar across all groups ranging from 86% in the control districts to 91.75% in the treatment group 2. Thus, a majority of the respondents already acknowledge that early marriage has negative consequences, though the practice remains prevalent.

**Figure 36 Whether Respondents think that there are negative consequences to early marriage**



Those respondents who responded yes in the above question were also asked what they think these negative consequences might be. Figure 37 depicts the baseline status of the respondents' awareness of possible negative consequences of early marriage. Unprompted responses from the respondents were recorded under seven categories that are listed in the figure below.

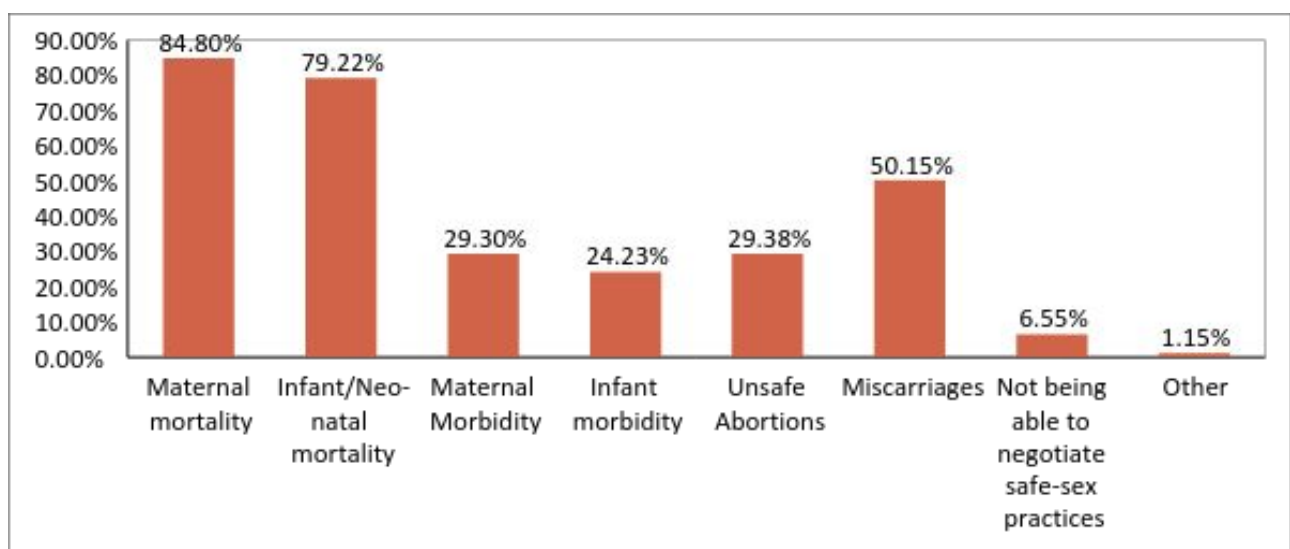
**Figure 37 Negative Consequences of Early Marriage**



The graph shows that the most commonly cited consequence across the sample is ill-effects on health of the woman getting married. Apart from this, “disruption in education” and “depression/mental health issues” are most commonly cited as negative consequences of early marriage.

Respondents were also specifically asked if, according to them, there are negative consequences on health due to early marriage. Figure 38 depicts the negative consequences on health cited by respondents. 95% of all respondents said that there are negative consequences on health due to early marriage.

**Figure 38 Negative Consequences on Health of Early Marriage**

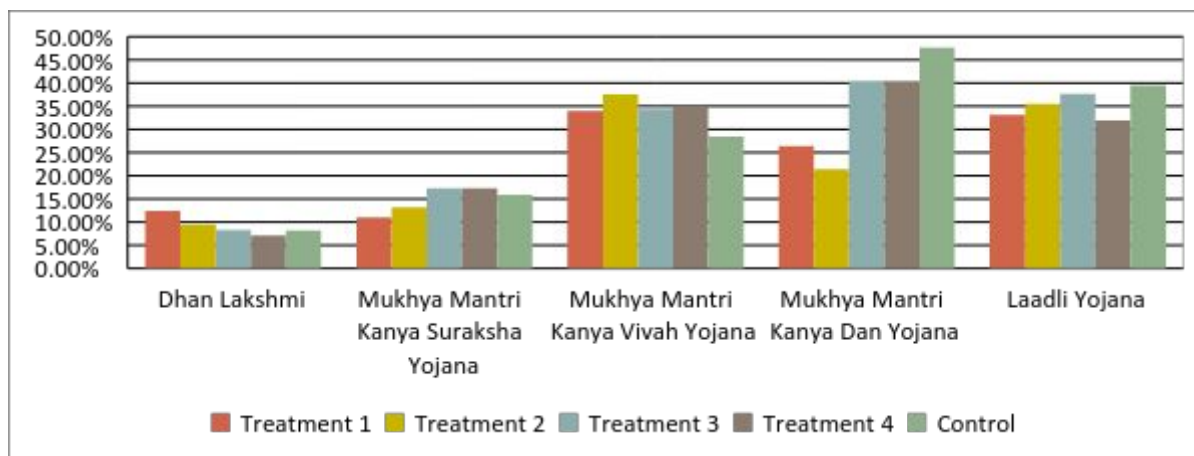


The most common responses from the respondents are maternal and infant mortality. They also cited miscarriages as one negative health effect quite frequently.

### 6.3.2 Awareness of Incentive Schemes

In the survey, respondents were also asked whether they knew of certain government incentive schemes for the education of girls and delaying the age at marriage.

Figure 39 Awareness of Government Incentive Schemes



The awareness of schemes across the 5 treatment groups is fairly similar. Awareness of *Mukhya Mantri Kanya Dan Yojana* is higher in the treatment groups 3 and 4. More respondents were aware of *Ladli Yojana* and *Mukhya Mantri Kanya Vivah Yojana* compared to *Dhan Lakshmi* and *Mukhya Mantri Kanya Suraksha Yojana*.

## 6.4 Summary

There are primarily two types of outcome indicators that have been included in this section. The first are related to gender norms and attitudes. The second are indicators related to awareness and knowledge.

Under gender norms three parameters have been included. These are responsibilities within the household, mobility and access to education and inheritance. In terms of **household responsibilities of parents** towards their children the results are very similar for both male and female children. The highest priority is placed on provision of food and shelter and providing education. In terms of **responsibilities of male and female members within the household** women tend to be seen as primarily responsible for chores and cooking, as well as, taking care of young children and siblings. On the other hand, men are seen as primarily responsible for the finances of the house and earning a living. Thus, in terms of division of responsibilities in the household there are clearly defined gender roles.

**Mobility** was included under gender norms because the availability of safe spaces outside the home emerged as one of the major causes of early marriage in the formative research. In most households girls are accompanied by friends or female relatives when going to school, the health centre, or while interacting with male peers. The results were fairly similar across all the treatment groups

indicating a high degree of comparability between them.

**Inheritance** is where the **most significant disparity** between the genders is evident. In over 90% of the households inheritance goes to the sons alone. Apart from this the next most common response was that sons receive a larger share than daughters. With respect to education, the results show that for male children the most common response (from 40 to 46% of households) was as much as they want to study. On the other hand for female children the most common response was up to 8<sup>th</sup> standard (38% to 41% of households), followed by as much as she wants. **This indicates that education for male children receives a higher priority than for girl children.**

Apart from gender norms, **norms and attitudes related to age at marriage** are also included. Respondents in the household survey were asked how they determine adulthood and the appropriate age for marriage of a girl or a boy. For girls, in all the treatment groups “at 18 years of age” and “at puberty/menstruation” were the most common responses with respect to **determination of adulthood**. This is followed by “as per physical appearance”. In the control district “physical appearance” was mentioned more frequently than “at puberty/menstruation”. For men, too, the results are very similar across the 5 treatment groups. The most common response with about 80% of the respondents in each group is “as per physical appearance”. Following this the next most frequently cited response is “at 18 years of age”, followed by “when they can take on responsibility”.

The most common responses with respect to determining **an appropriate age for marriage** was “once she/he is an adult”. This response was given by 55% of the respondents for men and 58% of the respondents for women. For men the next most common response was “when he is financially independent” at 51% of the respondents. Only 29% of the respondents gave the same response for women. “When family members think it is appropriate” was cited equally for men and women.

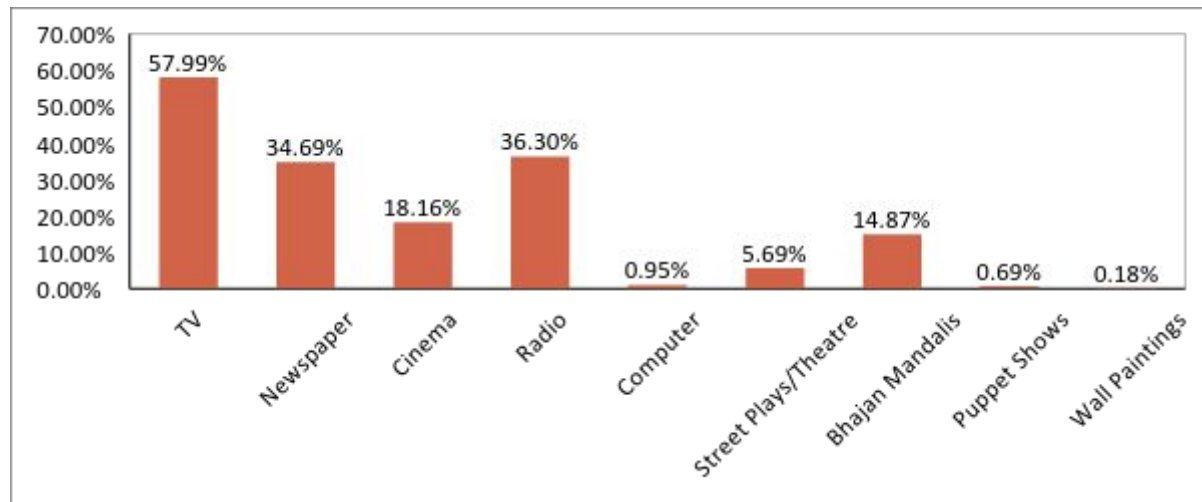
**Awareness with respect to the negative consequences** is very high. 88% of the respondents felt that there were negative consequences to early marriage in general and 95% felt that there were negative consequences of early marriage on health specifically. The most commonly cited negative consequences include **ill-effects on health, disruption in education, depression, and domestic violence**. Under health consequences specifically most respondents cited **maternal and infant mortality and miscarriages** as major negative consequences.

The **awareness of schemes** across the 5 treatment groups is fairly similar. Awareness of *Mukhya Mantri Kanya Dan Yojana* is higher in the treatment groups 3 and 4. More respondents were aware of *Ladli Yojana* and *Mukhya Mantri Kanya Vivah Yojana* compared to *Dhan Lakshmi* and *Mukhya Mantri Kanya Suraksha Yojana*.

## 7 MEDIA HABITS

Apart from the outcome and impact indicators one of the important aspects of this evaluation is the use of media in the dissemination of messages. Therefore, in this section a basic summary of information on media habits of the respondents is presented, especially with respect to television and radio. Figure 40 shows the access to different media sources for the respondents in the sample.

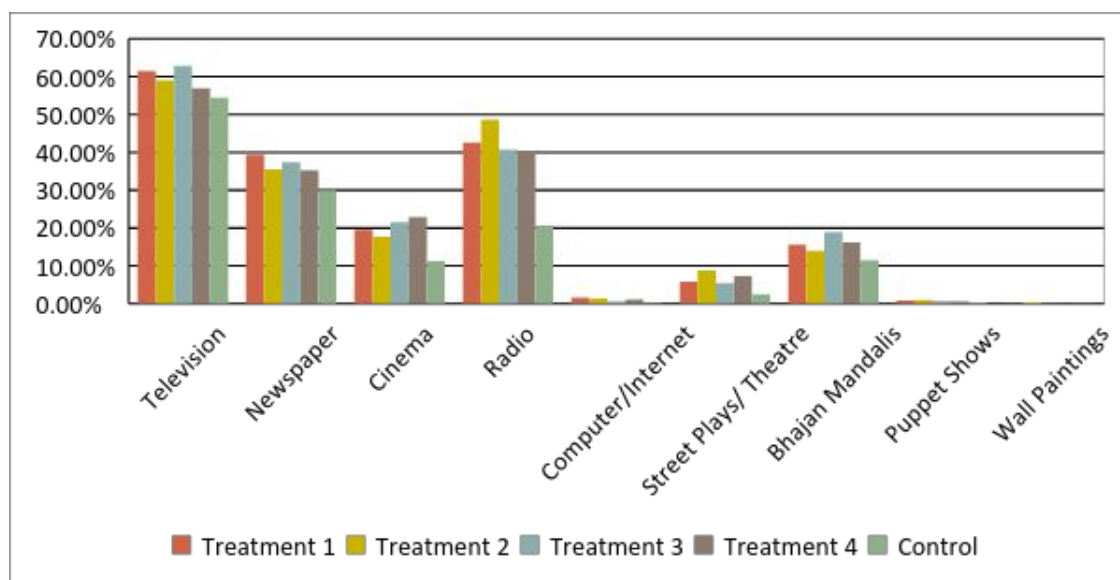
Figure 40 Access to Different Media Outlets



The data shows that television is the most common media source in the sample area with nearly 58% of the households having access to television. Apart from this the other two main sources are radio and newspaper with 36% and 34.69% of the households reporting that they have access to these sources. Wall paintings and puppet shows were mentioned very rarely as a response to this question.

Figure 41 depicts the results separately for all the treatment groups separately.

**Figure 41 Access to Media Sources by Treatment Group**



In terms of access to media sources the patterns are largely similar across all 5 groups. Television is the most frequently available source across all five groups followed by radio, newspaper, and cinema. In the control districts the reach of radio and cinema in sample households is much smaller compared to the other 4 treatment groups.

Respondents who have access to television were asked which television channels they regularly

watch. Figure 42 depicts their responses to this question. DD National is the most popular and is watched by close 64% of those respondents that have access to television. This is followed by Local cable channels and general entertainment channels like Sony, Zee and Star with about 22% to 29% of respondents mentioning these. In the programme area regional channels are not as popular as the ones previously mentioned.

**Figure 42 Television Channels watched regularly**

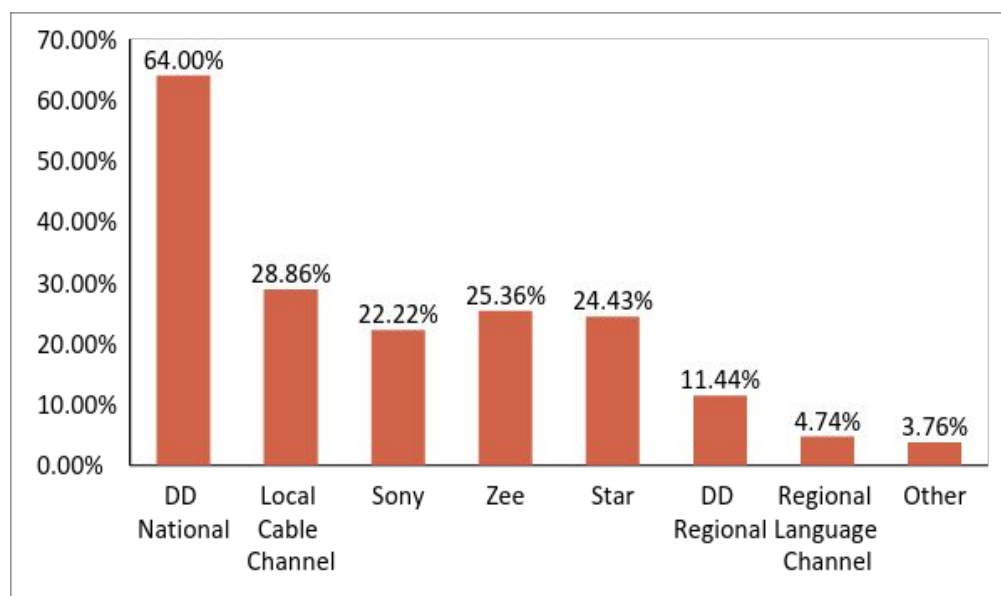
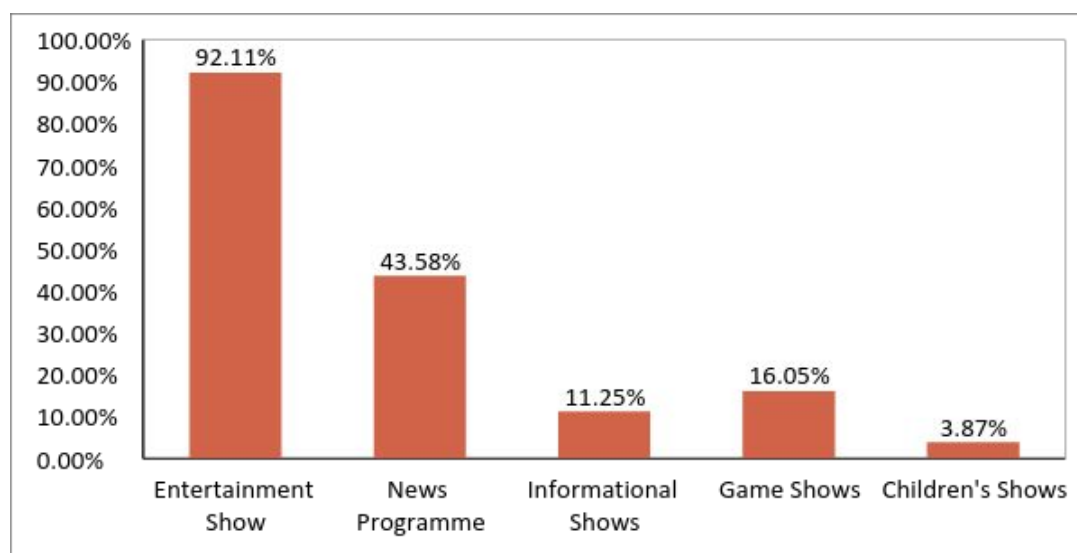


Figure 43 shows the type of programmes that the respondents with access to television watch. Primarily respondents watch

**Figure 43 Types of Television Programmes Watched**



Respondents were also asked when and where they mostly watch television. Most respondents either watch television at home with family or with friends or neighbours. Among the respondents with television the most popular time-slots for viewing are 6am to 12 pm and 12pm to 6pm with 40% of the respondents reporting each.

## 7.1 Summary

This section summarised information on the major media sources available to households in the programme area. The most popular source is television, which about 50 to 60% of the households have access to in all treatment groups. This is followed by radio, newspapers and finally cinema. The other sources are not as frequently accessed.

## 8 KEY FINDINGS AND CONCLUSIONS

The Breakthrough Early Marriage campaign seeks to address the practice of early marriage by utilising pop culture and challenging prevailing gender norms through mass and interactive media interventions. This programme is being implemented in Bihar and Jharkhand and consists of three distinct components: a mass media intervention, training at the block level with NGOs, CBOs, SHGs, Youth Groups and community mobilization. To evaluate the impact of the programme a cluster randomized control trial was designed. Initially the project was to be implemented in 3 districts of Bihar and Jharkhand, within which mass-media would saturate the entire area. The design was revised to include 3 control districts for the mass media intervention. Thus, while the programme is being implemented in Ranchi, Hazaribagh and Gaya the study also includes Bokaro, Lohardaga and Nawada. The control districts were selected using a matching exercise based on secondary district-level data.

There are 4 packages of interventions that will be implemented as a part of this programme. The first consists of all three interventions, i.e. mass media, training and community mobilization. The second is mass media and training, while the third is community mobilization and mass media. The fourth is only mass media. Finally, the fifth group is the control group which receives no intervention. GPs were randomly selected and assigned to these 5 packages of interventions. The household sample was selected assuming 10% margin of error and 90% confidence level.

The purpose of the baseline report is to establish the current status of the impact and outcome indicators, so that comparisons can be drawn in the future to assess the impact of the programme. The impact and outcome indicators flow from the theory of change and evaluation model. The goal of the programme is to use media messaging to change knowledge, attitudes and practices related to early marriage. The indicators presented in the findings section of the report fall into these three areas. The impact indicators include the actual practice, i.e., age at marriage and incidence of early marriage. The outcome indicators include knowledge and attitudes.

An analysis of the social, religious and educational profiles of the households and sample GPs show that the randomised groups are very similar in terms of these parameters.

The average age at marriage for women in the sample area is between 15 and 16 years across all 5 treatment groups. The incidence of early marriage among ever married women is also similar across the 5 groups. For men the average age at marriage is 20 to 21 years. This implies that the practice of early marriage is present for both men and women though the extent may be larger among women. The results here justify the need for programmes to address early marriage. The analyses of the impact indicators include a linear regression model. The factors that have a

statistically significant effect on age at marriage include gender norms, social and religious groupings, distance of the household from district headquarters. In households with more equal gender norms age at marriage tends to be higher. This indicates that addressing gender norms can contribute towards reducing early marriage.

The outcome indicators related to gender norms show that there are disparities between the two genders in terms of division of household responsibility and access to education and inheritance. Women and girls are primarily responsible for household chores and men and boys are seen as the ones responsible for financial sustainability of the household. On average parents wish for their male children to be educated more than girl children as well. The largest disparity exists in the case of inheritance where in 95% of the households only sons tend to inherit familial property. In terms of mobility outside the household girls are generally accompanied by female relatives and friends when going to school, health centres or interacting with male peers.

Awareness of the negative consequences of early marriage is very high. 85% of the households report being aware of general negative consequences and 95% report being aware of health related negative consequences. Health is seen as the primary negative consequence along with domestic violence and disruption in education. The awareness with respect to incentive schemes to delay age at marriage is lesser with the Laadli Yojana being most well known at 50% of the households.

The results from the baseline suggest that there is scope for addressing the issue of early marriage since in this region it is still practiced by a large portion of the population. Households are primarily aware of and recognize the negative consequences of early marriage, however, this hasn't reduced the practice. The regression model suggests that addressing gender norms can be one of the means of reducing early marriage. However, there are other contributory factors as well, including distance from district headquarter. The results also show that the randomisation exercise has produced balanced treatment and comparison groups in terms of the baseline status of the impact indicator, as well as, social group and religious distribution of the population.