



**Yuvaad**

Baseline Survey Report

February 2020

# YUVAA

## Baseline Survey Report

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Acronyms .....	1
Executive Summary .....	2
<b>1. Introduction .....</b>	<b>6</b>
<b>2. Methodology.....</b>	<b>6</b>
<b>3. Characteristics of the respondents.....</b>	<b>10</b>
3.1 Profile of currently married women.....	10
3.2 Profile of husbands on CMWs.....	10
3.3 Profile of mothers-in-law .....	11
<b>4. Family planning knowledge and behaviour .....</b>	<b>12</b>
4.1 Knowledge of contraceptive methods.....	12
4.2 Comprehensive knowledge of modern contraceptive methods for spacing.....	12
4.3 Family planning method-specific knowledge .....	12
4.4 Current use of contraceptive Methods .....	17
4.5 Intention to use Family planning method in future .....	19
<b>5. Fertility Knowledge and Behaviour .....</b>	<b>21</b>
5.1 Menstrual Protection .....	21
5.2 Knowledge on safe period.....	21
5.3 Knowledge on Healthy timing and spacing of pregnancy (HTSP).....	21
5.4 Advantages of HTSP reported by respondents.....	22
5.5 Unintended pregnancy.....	22
5.6 Desired for child(ren) .....	23
5.7 Ideal number of children.....	23
5.8 Son preference .....	24
<b>6. Exposure to family planning messages.....</b>	<b>25</b>
6.1 Acceptance of family planning messages.....	25
6.2 Frontline health worker on family planning outreach.....	26
6.3 Exposure to Family planning message on Community platforms.....	27
<b>7. Reproductive Autonomy .....</b>	<b>29</b>
7.1 Reproductive autonomy among currently married women.....	29
7.2 Freedom from Coercion .....	29
7.3 Interspousal communication .....	30
7.4 Decision making on family planning.....	31
<b>8. Social and Gender Norms in Family Planning .....</b>	<b>33</b>
8.1 Percieved social gender norms.....	34
8.2 Household decision making scale .....	35
8.3 Marital communication scale .....	36
8.4 Gender Norm Attitude .....	36
8.5 Gender Equitable Men (GEM) Scale.....	37
<b>9. Key findings of the baseline study and its implication on the YUVAA intervention .....</b>	<b>39</b>
<b>Annexure .....</b>	<b>41</b>
Annexure 1: Reproductive autonomy scale scoring .....	41
Annexure 2: Key indicators of YUVAA .....	42

# Acronyms

ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BMGF	Bill and Melinda Gates Foundation
CHW	Community Health Worker
CMW	Currently Married Women
CPR	Contraceptive Prevalence Rate
ECP	Emergency Contraceptive Pill
EW	Eligible Women
FLW	Front Line Worker
FP	Family Planning
FTP	First Time Parent
GEM	Gender-Equitable Men
HTSP	Healthy Timing and Spacing of Pregnancy
IUCD	Intrauterine Contraceptive Device
MCPR	Modern Contraceptive Prevalence Rate
MII	Method Information IndexMILMother-in-law
MIL	Mother-in-Law
NFHS	National Family Health Survey
PSU	Primary Sampling Unit
OCP	Oral Contraceptive Pills
YC	YUVAA Corps
YMC	Young Married Couples
YUVAA	Youth Voices for Agency and Access

# Executive Summary

The Youth Voices for Agency and Access (YUVAA) project funded by Bill and Melinda Gates Foundation (BMGF) is an innovative initiative of Pathfinder International India that has strategized to combine social entrepreneurship and focussed communication of family planning messages to Young Married Couples (YMC) for increasing their access to contraceptive choices. In order to ensure that knowledge and information on family planning methods amongst couples is translated to use, the project emphasizes on facilitating a positive shift in the social and gender norms that impact couples' access to and use of family planning (FP) methods.

YUVAA conducted a representative baseline survey in February 2020 in the 10 districts in Bihar (Nalanda, Gaya, Patna, Muzaffarpur and Vaishali) and Maharashtra (Satara, Sangli, Kolhapur, Solapur and Ahmednagar) where the project is being implemented to provide a benchmark for measuring progress in the indicators over the project duration. The survey that was conducted by Population Council Consulting Private Limited with guidance and supervision from Pathfinder International India office. Information was collected from three types of respondents- currently married women (15-24 years of age with zero or one parity), their husband and their mothers-in-law. The survey utilised a cross sectional mixed method approach and collected information through structured face-to-face interviews with respondents.

The survey captures the individual knowledge, attitude and practices about specific family planning methods, fertility preferences, prevailing social and gender norms, reproductive autonomy, availability and use of contraceptive methods. The findings from baseline survey served as useful foundation for informed programming of the interventions.

The results show that overall knowledge of FP methods was found to be low, both amongst the Currently Married Women (CMW) and their husbands in Bihar compared to Maharashtra. Interestingly, factors like younger age, zero parity, living in urban area, higher educational level and standard of living were seen to have a positive correlation with the knowledge of different FP methods.

As a preferred source of information on the FP methods, it is seen that Frontline Workers (FLW) were preferred by CMW compared to their husbands who preferred government facilities and medical shops/pharmacies in both States as source of FP related information. Frontline Workers – Accredited Social Health Activist (ASHA) and Anganwadi Worker (AWW) were considered reliable for methods like Oral Contraceptive Pills (OCP) and Emergency Contraceptive Pills (ECP) by CMW in both States. Government doctors were preferred as source of information for other methods such as Intrauterine Contraceptive Device (IUCD) and injectable contraceptive amongst CMW of Maharashtra whereas CMWs of Bihar preferred to receive information on these from relatives and FLWs.

It is seen that Government hospital and health professionals including private facilities are preferred for availing services like IUCD and Injectables in both the States. Government hospital and Medical shops, pharmacies are most preferred sources for OCP, ECP, and condoms amongst CMW and husbands. Willingness to pay for the FP methods showed variations for different contraceptive methods. More than one fourth of CMWs reported willingness to purchase OCP; nearly one-third and one-fifth of them were willing to pay for IUCD insertion in Bihar and Maharashtra respectively. One-third of CMW of Bihar and one-fourth of CMW

in Maharashtra were willing to buy injectable dose. The willingness to purchase condoms was reported higher amongst husbands compared to CMW themselves.

Findings on the preferred sources of receiving FP messages among CMWs, husbands and MILs show television as the predominant source of FP messages. The messages were largely reported to be acceptable except that some reported that these were not good for children and against the religion. About 76% CMW in both States reported monthly women gatherings as most preferable place to receive information on FP followed by at home. A majority of CMWs (70%) indicated that an interactive mobile app will be preferable as a source of FP messages.

About 16% of CMWs in project area reported currently using any contraceptives, of which 78% were using modern contraceptives. The Modern Contraceptive Prevalence Rate (mCPR) among the target group in Bihar is only 5% which is lower than Maharashtra (22%). The most popular methods with high continuation rates among current users were Condoms, IUCD and OCP. Around 80% of CMW reported that decision to use contraceptives was taken jointly with their husband. The Method Information Index (MII) value was low at 15% among CMW in the overall project area and was reported higher in urban areas, among older CMW, with >12 years of schooling and higher wealth quintiles.

The intention to use FP methods indicates the felt need to avoid pregnancy and to ensure spacing between two births. Amongst the non-users of contraceptives, 60% reported intention to use a contraception method in future, 17% reported intention to use in next one year and remaining CMW and husbands were uncertain. Out of those who reported intention to use contraception in next year, about 48% indicated sterilization and 24% indicated use of condoms. CMWs of Bihar reported higher preference for both sterilization and injectables than the CMW in Maharashtra.

The fertility preferences i.e., the number of desired children among couples were captured during the survey and the findings showed that about 61% of CMWs wanted another child, 14 % were not sure if they wanted another child and 11% reported that it is 'up to God' to have another child. Majority of women (85%) reported that having two or lesser number of children is ideal. The agreement on desired number of children amongst couples (CMWs and their husband) is higher in Maharashtra than Bihar, living in urban areas than rural, among higher educated CMW and who belongs to rich families.

Overall awareness about 'fertile periods' was 60% among CMWs and it is reported lower in Bihar than Maharashtra. Only 40% of these CMWs could mention correct days of fertile period. Overall 89% CMWs reported used hygienic absorbent during menstruation, whereas sanitary napkins in Maharashtra and clothes most commonly used in Bihar. Knowledge on healthy timing and spacing of pregnancy (HTSP) was assessed and CMW reported 20 years as the best age for first pregnancy with an ideal gap of 20 months from marriage. Ideal spacing reported between first and second child was reported on an average of 3 years.

The prevailing social and gender norms have a huge bearing in adoption of Family planning practices such as on number of children, decision making with respect to use of FP etc. Majority of husbands of CMWs (96%) reported moderate to high gender equitable attitudes on Gender Equitable Men (GEM) Scale. CMWs demonstrated a more egalitarian attitude towards 'equity for the girl' with 90% of them agreed that they would like their daughters to be able to work outside of the home to support herself if necessary. However, about one fourth of CMWs also indicated that sons should be more educated than daughters so that they

can do better. The gender inequity is also evident from the mobility restrictions among women for visiting the market, hospital, cinema, and traveling outside their village/premises alone prevalent in both states. In terms of decision making, decision taking by women alone and by young couples in household activities was found to be low in both states, specifically in presence of older family members.

With respect to decision making in matters of child bearing and reproductive autonomy, it was estimated that women alone have very little say. Even though the matters are reported to be jointly decided with husbands, there is a gap in discussions of contraception among couples and lower decision making power with couples in presence of older family members and prevailing community norms which perceived as use of FP methods is negative behaviour.

The baseline study findings underscore that engaging men, MILs through a community approach for promoting gender equitable attitudes and addressing socio-cultural taboos is crucial in addition to educating young couples in order to yield any sustainable positive reproductive health outcomes for young married couples.

# 1 Introduction

The Youth Voices for Agency and Access (YUVAA) program aims to scale up approaches to increase contraceptive use among young married couples and first-time parents (FTP) in five districts each two states in India viz., Bihar and Maharashtra. YUVAA seeks to improve access to contraceptive choices and positively shift gender and social norms by delivering customized family planning (FP) messages to young couples in ten districts in Bihar and Maharashtra by using the combined approaches of social entrepreneurship and innovative communication. The program was initiated in July 2018 in five districts in each state and is delivered by young married couples entrepreneurs known as YUVAA Corps (YC) of YUVAAKAARs. The YUVAA program recruited and trained YC, to promote them as couple-entrepreneurs and change agents to create and facilitate dialogues among young women and men and their immediate influencers. Further, the YUVAA program designed segment-specific, gender-transformative interventions to explore deep insights on couple attitudes and behaviors influencing their FP choices. YCs facilitate discussions about gender and social norms related to FP and healthy timing and spacing of pregnancy (HTSP) using various physical and digital platforms. To design the better program at the ground, YUVAA has conducted a Baseline Survey on key outcome indicators of the project.

## The YUVAA program works to increase contraceptive uptake by doing the following:

- Ensuring the focus of the program is on young people's needs and perspectives
- Providing reliable sources of information, comprehensive counseling, referrals, and doorstep delivery of over-the-counter methods
- Ensuring a gender-equitable approach that aims to reach young men and women equally
- Improving individual agency so that decisions can be made independently
- Encouraging couple communication and joint decision-making, where possible, and fostering an environment that emphasizes and supports delaying pregnancy to a time when couples are physically, mentally, and economically ready.

## The objectives of the YUVAA baseline survey were to explore:

1. Individual attitudes on FP
2. Prevailing gender and social norms on FP
3. Prevailing reproductive autonomy

## The populations of focus in the YUVAA baseline were:

- **Currently married women (CMW):** CMW between the ages of 15 and 24 years with parity zero or one (no child or at least one surviving child at the time of survey)
- **Married men:** Husbands of CMW between the ages of 15 and 24 years with parity zero or One (no child or at least one surviving child at the time of survey)
- **Mothers-in-law (MIL):** MIL of CMW between the ages of 15 and 24 with parity 0 or 1 (no child or at least one surviving child at the time of survey)



## 2 Methodology

A cross-sectional mixed-method household survey was conducted by using a structured interview questionnaire which was administered through face-to-face interviews of CMWs and their husband, and their MILs. The study included both in rural and urban areas in 10 districts of Bihar (Nalanda, Gaya, Patna, Muzaffarpur, and Vaishali) and Maharashtra (Satara, Sangli, Kolhapur, Solapur, and Ahmednagar)

Percentage of currently married women ages 15 to 24 who have intention to use FP for spacing was the most important indicator for YUVAA implementation. Therefore, the proportion of this indicator in The National Family Health Survey (NFHS-4) for Bihar and Maharashtra was used to calculate the required sample size in each state. Between baseline and end line survey, we assumed a minimum 10 percentage-point increase in the indicator to suggest a statistically significant program-intervention impact. Therefore, it is calculated sample size of 870 women (500 in Bihar and 370 in Maharashtra) who have an intention to use FP by assuming a 95% confidence level, 80% power, 1.5 design effect and 5% non-response rate. The number of men (spouses of the CMWs) and MIL was determined to be 50% (435) and 20% (174). Qualitative interview participants were selected from women's, spouses', and in-laws' groups based on high or low index values of marital communication, decision-making power, reproductive autonomy, and intention to use contraception. Experienced gender inequity attitudes were considered for the qualitative survey and the quantitative interview. Altogether, a sample of 50 selected individuals were interviewed from Bihar and Maharashtra.

A multi-stage sampling was done to identify households and eligible participants. The sample was distributed across program districts with probability proportional to size based on the 2011 census. Further, samples were distributed among rural and urban areas at the ratio of 80:20 with one block selected from each district. Weighting sample data, we tried to maximize the representation of the sample in terms of the size, distribution, and characteristics of the study population. Sample weight for eligible women, their husbands, and their MIL was generated for each state separately and jointly with the project area. These design weights were used for computations of state level, as well as project-level, indicators.

A research team was trained to list and map houses, read paper questionnaires, and administer questionnaires using the digital tool (CAPI). The questionnaires were then pretested in Hindi and Marathi languages. The quantitative questionnaire for eligible women captured information on the use of FP, future intention to use, marital communication, attitudes toward FP, reproductive autonomy, gendered social norms, and media exposure. The questionnaire for men captured information on knowledge about FP methods, future intention to use, marital communication, attitudes toward FP, perceived social and gender norms, and exposure to media. The MIL questionnaire focused on knowledge about FP methods and sources, perceived social and gender norms, and community perception toward HTSP. The quantitative interviews preceded the qualitative in-depth interviews for all the respondents. And the in-depth interviews explored marital communication, decision making power, reproductive autonomy, intention to use contraception, and gender inequity.



**Table 1. Sample Size and Response Rate**

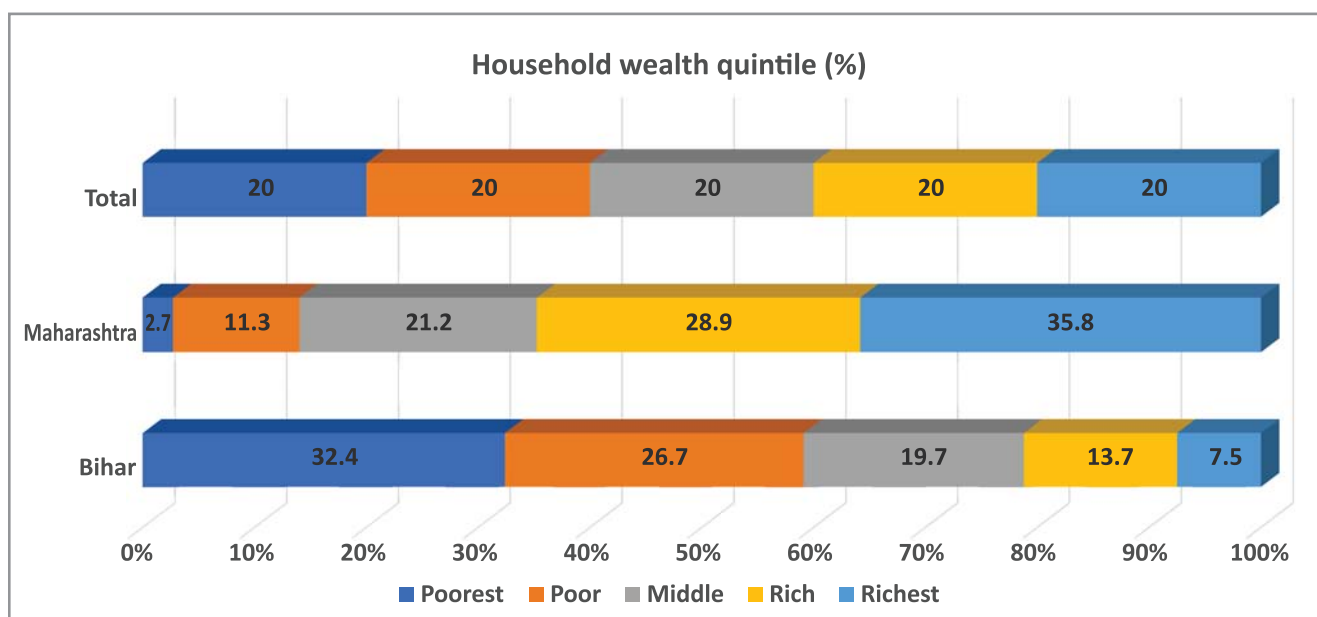
Type of Respondents		Bihar	Maharashtra	Total
CMW (15-24 years)	Targeted	600	456	1056
	Interviewed (response rate %)	546 (91.0%)	383 (84%)	<b>929 (88%)</b>
Husband of CMW	Targeted*	300	228	528
	Interviewed (response rate %)	175 (58.3%)	187 (82.0%)	<b>362(68.6%)</b>
MIL of CMW	Targeted*	300	228	528
	Interviewed (response rate %)	203 (67.7%)	112 (49.1%)	<b>315(59.7%)</b>

CMW: : Currently married woman age between 15-24 with parity 0 or 1 (no child or at least 1 child)

\*Assuming male out migration, all husbands available in selected households where CMW interviewed in each Primary Sampling Unit (PSU) were targeted for recruitment. Similar criteria adopted for MIL.

Results of the survey measured different thematic areas in addition to socio-demographic and household characteristics such as wealth index calculated using the household’s infrastructure (11 items), livestock (6), and durable goods (21). Households were assigned scores based on the number and type of consumer goods they own, ranging from a television to a bicycle or car, and housing characteristics such as the source of drinking water, toilet facilities, and flooring materials. These scores were derived using principal component analysis, divided into five equal categories, each with 20% of the population.

Comprehensive knowledge about modern spacing methods was computed for oral contraceptive pills (OCP), the intrauterine contraceptive device (IUCD), injectables, condoms, and emergency contraceptive pills. Method information index (MII), which measures the extent to which specific information is provided to help women to make informed choices, was computed by considering three questions: Was the woman informed about other methods? Was she informed about side effects of the method used? Was she told what to do if side effects were experienced? The reported value is the percentage of women who responded “yes” to all three questions.



The study used 13 items covering three subdomains to measure reproductive autonomy<sup>1</sup> (see annex1): Freedom from coercion, Communication about FP, Decision making related to FP . The responses for each statement were categorized as strongly disagree (1), disagree (2), agree (3), and strongly disagree (4). The estimates of internal consistency were: Cronbach's Alpha value of 0.861, items mean of 2.68, and item variance at 1.38.

The household-decision-making index scale was computed by considering a set of three questions about decision making on major household purchases, purchases for daily household needs, and visits to family or relatives. Responses for these questions were scored between 1 and 4, where 1 stands for the respondent alone, 2 for joint decisions by the respondent and spouse, 3 for decision by spouse, and 4 for decision by someone else. The estimates of internal consistency include Cronbach's Alpha value at 0.884, item means of 2.06 and item variances at 0.967. The scale was created by summing the scores of items, and a lower score on the scale indicated high decision-making power within the household.

A set of questions on fertility intentions, FP use, and preferred provider for FP services were considered to measure marital communication on FP. The specific statements considered are: How many children to have, When to have children, How much spacing between children, Which contraceptive method to use, When to use contraception, Whom to approach for contraception (preferred health provider). All these questions were asked to women to find out whether they and their husbands discussed them; the responses were coded as yes (1) and no (0). The estimates of internal consistency are Cronbach's Alpha value at 0.875, items mean of 0.674 and item variance at 0.207.



<sup>1</sup> For details, please refer to paper by Upadhyay, U. D., Dworkin, S. L., Weitz, T. A., & Foster, D. G. (2014). Development and validation of a reproductive autonomy scale. *Studies in family planning*, 45(1), 19-41

Women's mobility is defined as the ability to exercise agency within a context of gender inequality and is measured by considering eight statements related to her mobility. The set of questions include: Have you ever been to the bazaar? Have you ever been there alone? Have you ever been to the hospital/clinic/doctor? Have you ever gone there alone? Have you ever gone to the cinema? Have you ever gone there alone? Have you ever gone outside the village? Have you ever gone there alone? Responses for each of these questions were recorded in two categories: yes (1) and no (0). The estimates of internal consistency are Cronbach's Alpha value at 0.733, items mean of 0.418 and item variances at 0.147. The total score of the scale ranged from 0 to 8 and was employed as a continuous variable. A higher value in the score indicated a higher woman's mobility.

The gender-norm attitude was used to measure egalitarian beliefs about male and female gender norms<sup>2</sup>. The measure was constructed using two sub scales: i) belief in and promotion of equity for girls and women (4 items); and ii) belief in maintaining the rights and privileges of men (10 items). The responses for each of these statements were recorded in two categories: agreed (1) or disagreed (0). On the rights and privileges of men subscale, less agreement with men having more rights and privileges than that of women reflected a more egalitarian perspective. Reverse scoring was used for the equity for girls subscale, with 0 representing a traditional response and 1 an egalitarian response. The estimates of internal consistency are Cronbach's Alpha value at 0.657, items mean of 0.705 and item variance of 0.167. Scores were computed as the mean of individual items, expressed as a continuum from traditional beliefs (on the lower end) to egalitarian beliefs. Higher scores on both subscales indicated more egalitarian beliefs.

The Gender-Equitable Men (GEM) scale measured attitudes toward gender norms in intimate relationships or differing social expectations for men and women<sup>2</sup>. GEM scale was computed by considering 23 statements representing four domains: violence (6 items), sexual relationships (8), reproductive health and disease prevention (4), and domestic chores and daily life (5). Responses were scaled as: agree (1), partially agree (2), and do not agree (3). The estimates of internal consistency are Cronbach's Alpha value at 0.897, items mean of 1.916 and item variance at 0.715. The combined or individual scores can be used as a continuous variable or categorized as: low equity, moderate equity, and high equity.

This research was approved by the Sigma-IRB (0051/IRB/19-20) dated 01.02.2020.

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<sup>2</sup> Nanda, Geeta. 2011. Compendium of Gender Scales. Washington, DC: FHI 360/C-Change.

# 3 Characteristics of the respondents

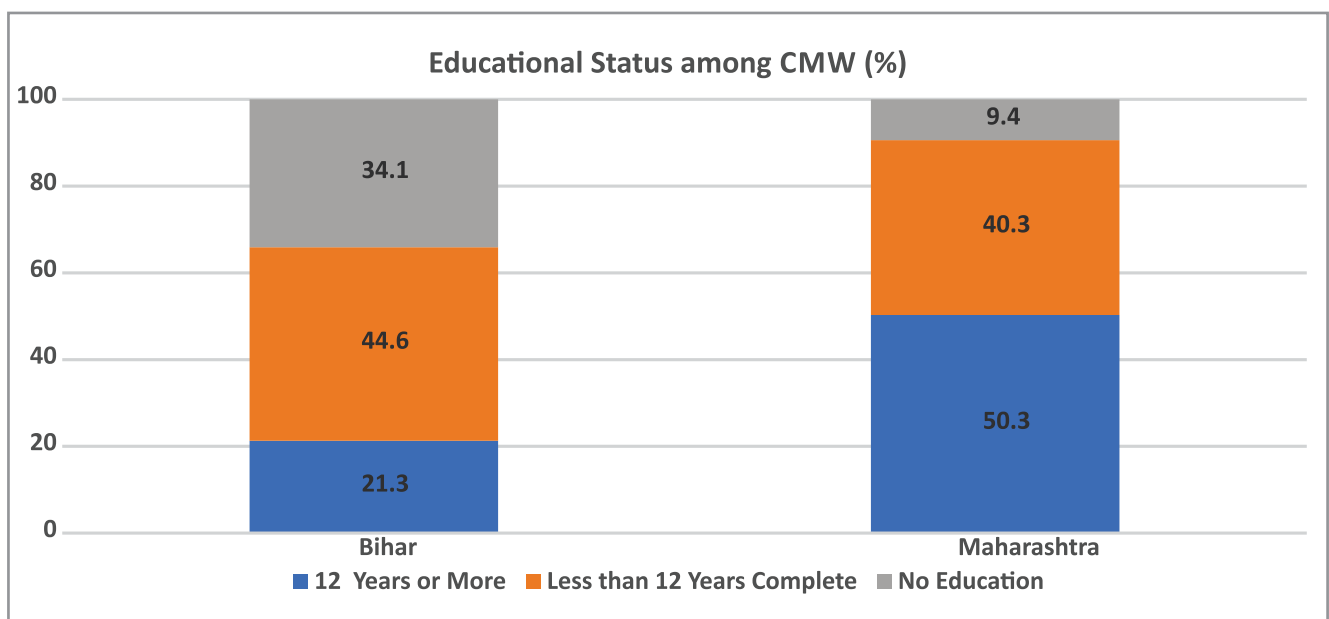
The findings from the baseline survey reveal linkages between FP knowledge, attitudes, and practices and socio-demographic characteristics of respondents including CMW, their husbands and their MILs. These factors include age, parity, education, media exposure, and wealth status of households. These linkages are important to understand in order to design effective strategies for the YUVAA project to benefit project area populations irrespective of their sociodemographic indicators.

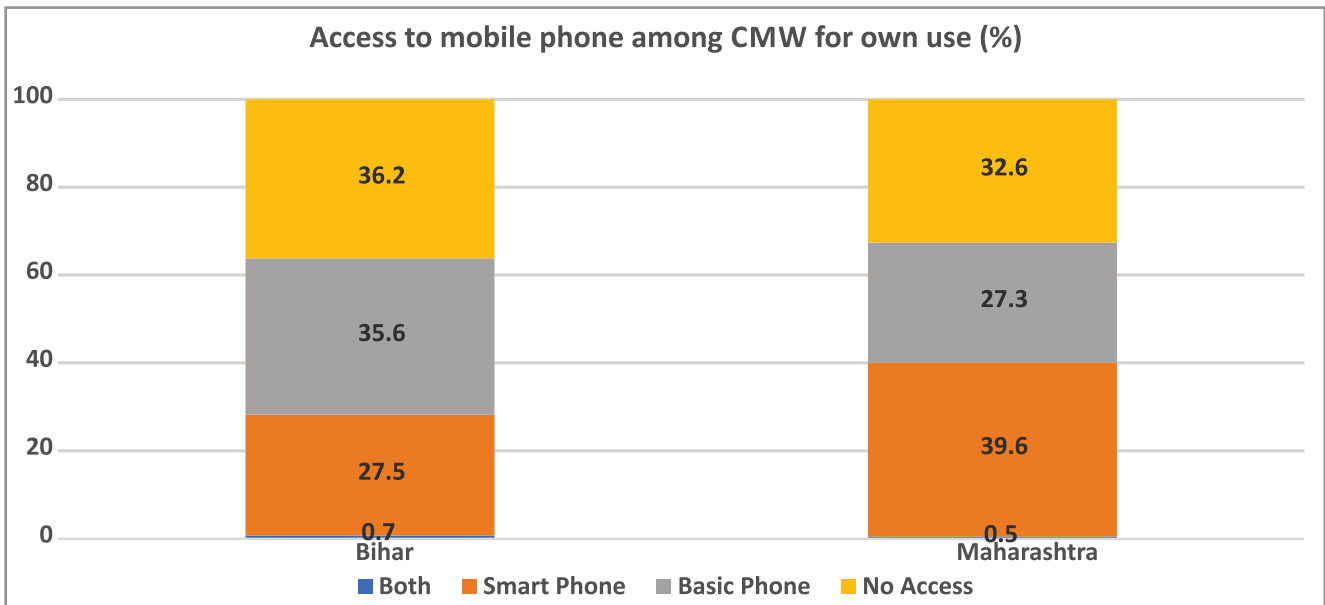
## 3.1 Profile of currently married women

The majority of currently married women interviewed in the project area (64%) were between the ages of 20 and 24 and from rural areas in both states. With respect to parity, 53% of CMW in Bihar and 47% in Maharashtra had no living children, and the remaining CMW in both States were of parity 1. In terms of educational attainment, Maharashtra had higher percentage of CMWs (>50%) than Bihar (21%) with more than 12 years of schooling. Whereas 9% of CMW in Maharashtra had no schooling, 34% in Bihar had never been to school. In addition, CMW by wealth quintile, while Bihar had only 21% CMW in the richest quintile and about 40% in poorest quintile, on the other hand, 65% of CMWs in Maharashtra belonged to the richer and richest quintiles. The distribution of CMW by media exposure shows that nearly three-fourths (73%) had exposure to any media at least once a week, of which television was predominantly reported (69%), followed by print media (24%) and radio (6%). Exposure to any media was lower in Bihar (57%) than Maharashtra (93%); however, the pattern of exposure of different media sources remained same across the states. About one-third of CMW (34%) reported that they did not have access to the use of mobile phones. Among those who had access, a higher proportion of women had basic phones in Bihar. In Maharashtra, the use of smart phones was higher than basic phones.

## 3.2 Profile of husbands on CMWs

Husbands of CMWs, who were interviewed in the project area, Maharashtra had a higher percentage of husbands (54%) than Bihar (36%) with more than 12 years of schooling. Whereas 3% of men in Maharashtra





had no schooling, 23% in Bihar had never been to school. Regarding media exposure, 85% of husbands had exposure to any media at least once a week, of which television was predominantly reported (80%), followed by print media (58%) and radio (10%). Exposure to any media was lower in Bihar (80%) than Maharashtra (94%); however, the pattern of exposure of different media sources remained same across the states. About 10% of husbands reported that they did not have access to use of mobile phones. Among those who had access, a higher proportion of women had basic phones in Bihar. In Maharashtra, the use of smartphones was higher than basic phones. The ownership of smartphones is higher in Maharashtra (80%) than Bihar.

### 3.3 Profile of mothers-in-law

Majority of MILs were illiterate (60%) in the overall project geography. Higher proportion of MILs in Bihar (76%) were unable to read and/or write compared to MIL of Maharashtra (40%). Forty-six percent had exposure to any media, of which 44% reported exposure to television, and 3% reported exposure to the radio, while 31% had no exposure to any media. In Bihar, 35% had exposure to any form of media, of which 33% reported exposure to television. Almost the same proportion of MIL reported exposure to print media in both Bihar and Maharashtra states. More than half of MIL (53%) did not have access to a mobile phone, and the proportion varied from 44% in Maharashtra to 61% in Bihar. Half of the MILs (50%) had smartphones, and 6% had basic phones in Maharashtra. In Bihar, 29% had access to smartphones, followed by basic phones (8%) and both basic and smartphones (2%).

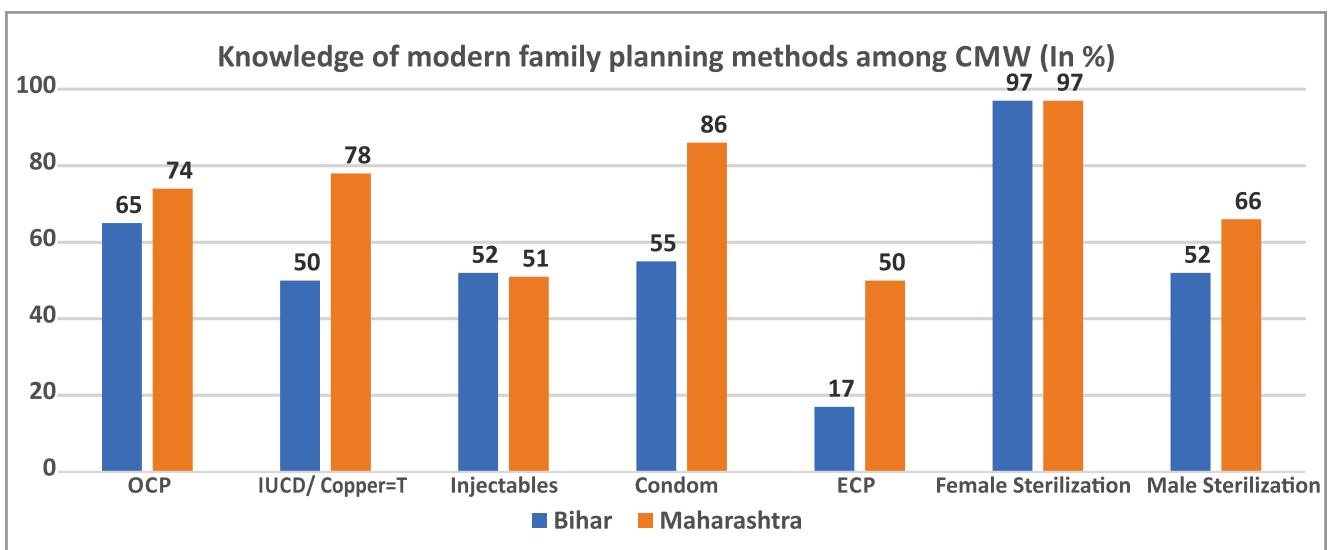


## 4 Family planning knowledge and behaviour

This section presents respondents knowledge and use of contraceptive methods, their sources of contraceptive methods, informed choice on FP methods, discontinuation rates, and reasons for discontinuation. In addition, it also focuses on how men perceive use of contraceptive. It also examines comprehensive knowledge for each modern spacing method: OCP, IUCD/Copper-T, injectables, condoms, and ECP.

### 4.1 Knowledge of contraceptive methods

All CMW and their husbands knew at least one method of contraceptive and about one-third of these knew about emergency contraception. The awareness of FP methods was higher in Maharashtra compared to Bihar. Among modern contraceptives, awareness of tubal ligation was highest in both states, followed by OCP and condoms in Bihar and Maharashtra respectively.



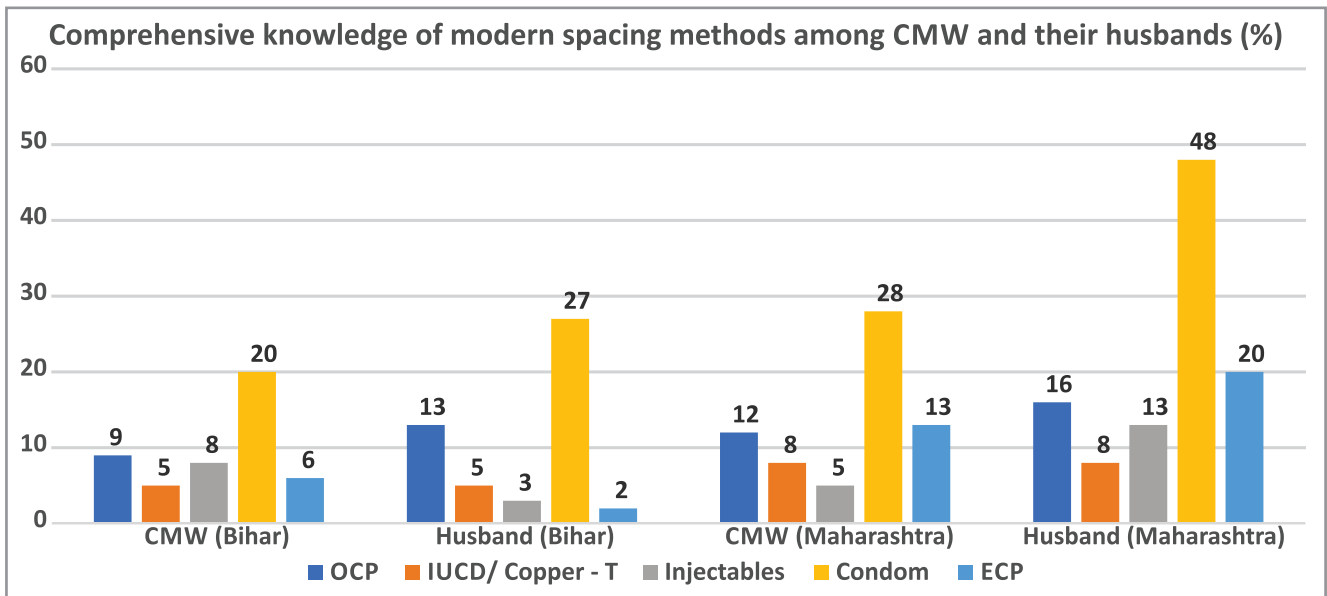
### 4.2 Comprehensive knowledge of modern contraceptive methods for spacing

Comprehensive knowledge of modern spacing methods was assessed using questions on sources of knowledge, sources of access, method of use, and knowledge of side effects and where to go in case of side effects. Awareness of modern FP methods was higher in Maharashtra compared to Bihar. Only 16% of CMWs and 23% of husbands of CMW had knowledge of all five available modern spacing methods (OCP, IUCD, injectables, condoms, and ECP). Further, CMW of parity 1 who were between the ages of 20 and 24, living in urban areas, with higher educational levels, and in higher household wealth quintiles had more knowledge than their CMW counterparts (from age of 15-20, rural areas, lower educational levels and from lower wealth quintiles). A similar pattern in comprehensive knowledge was observed among husband of CMW.

### 4.3 Family planning method-specific knowledge

#### 4.3.1 Oral contraceptive pills (OCP)

Government health providers, ASHA/AWW, friends, relatives, and television are the major sources of OCP knowledge in the project area. Knowledge on OCP, CMW and their husbands relied on relatives and friends



in Bihar and sought information from government health providers in Maharashtra. CMW in Bihar preferred information on OCP from ASHA or AWW, and CMW in Maharashtra preferred government providers as their source of OCP information. Husbands in both states preferred to receive information on OCP from government doctors followed by medical shops/ pharmacies and private doctors in Bihar and Maharashtra respectively.

CMW preferred to access OCP from ASHA/AWW with about one-fifth reporting preference to receive OCP from them. More husbands preferred medical shops followed by government district hospitals in Bihar, while in Maharashtra, district hospitals were the preferred source of OCP.

Respondents' knowledge on how to use OCP on a daily basis was assessed during the survey. Majority of respondents in the project area were not aware of when to start using OCP or the frequency with which OCP needed to be taken. Only 41% of CMW in Bihar and Maharashtra knew that OCP should be taken daily. About one-third of CMW and half of husbands in project area were aware that in the case of a missed OCP, two pills were to be taken the next day. For effectiveness of OCP 43% of CMW in Bihar and 47% of CMW in Maharashtra said that OCP was effective in preventing pregnancy. Husbands had slightly more knowledge of OCP effectiveness compared to CMW in the project area: more than half of the husbands in Bihar and Maharashtra said that OCP was effective in avoiding pregnancy.

Nearly half of CMW in the project area were aware of the side effects of OCP. Major side effects reported by the CMW were intermenstrual spotting and missed menstrual cycles. Other reported side effects included nausea, headaches and migraines, weight gain, and breast tenderness. Additionally, husbands reported mood changes as an OCP side effect. The respondents reported that treatment from any health facility or provider, including Auxiliary Nurse Midwife (ANM)/ AWW, can be sought in case of side effects. Availability of OCP was reported as easy in the project area by a majority of respondents. One-fourth of CMW were aware of the price of a month supply of OCP and said it cost INR 46. Husbands reported this as INR 32. Thirty percent of CMW and 46% husbands were willing to buy in Bihar and about 26% CMW and 16% husbands were willing to buy in Maharashtra. Three fourths of CMW (73% in Bihar and 79% in Maharashtra) and 80% of husbands (77.4% in Bihar

“  
*“No, I will not spend any amount. I will go and get it from the government hospital.”*  
 – 19 years old CMW, Maharashtra”



and 82.3% in Maharashtra) reported have interspousal communication on use of OCP. Ever use of OCP was only 2% in Bihar CMW and 13% in Maharashtra and largely for spacing births.

#### 4.3.2 IUCD/Copper-T

Similar to OCP, Government health providers, ASHA/AWW, friends, relatives, and television were the major sources of knowledge about IUCD/Copper-T in the project area. Friends and relatives were major sources of information in Bihar, while in Maharashtra, government health providers were the primary source. In Bihar, ASHA and AWW were most preferred source of information whereas Government doctors and hospitals were the most preferred source of information on IUCD/Copper-T in Maharashtra in addition private clinics also preferred in Maharashtra. The majority of respondents that are aware that doctors and nurses could insert IUCDs. Awareness of duration of protection and side effects was present in more than half of CMW. The reported duration of protecting pregnancy was three months in project area. About one-fourth CMW and a greater proportion of husbands did not know about side effects. The major side effects reported by the CMW were irregular bleeding for several months (66%), followed by headaches (38%). Other side effects reported by CMW and husbands included lighter or shorter periods or no periods at all, skin blemishes, and nausea. The respondents reported that treatment from any health facility or doctor can be sought in case of side effects.



*“Me and my husband are comfortable in discussing FP. But my MIL takes decision. After having a daughter in the first pregnancy, both my husband and I discussed and decided to go for IUD. My MIL opposed and suggested for a second child. I had to struggle a lot to convince her. Now I am using IUD. It is very difficult to convince in-laws, and they don't understand us. They always try to impose their opinions on us.”*

– A 23-year-old CMW, Maharashtra



Availability of IUCD was reported as easy in the project area by a majority of respondents. Three-fourths of CMW were aware of IUCD/Copper-T price and said it costed INR 80. A smaller proportion of husbands were aware and reported the price as INR 71. Twenty-seven percent of CMW and 42% of husbands in Bihar were willing to pay for IUCD/Copper-T in Bihar, and about 18% of CMW and 29% of husbands were willing in Maharashtra. Majority of CMW and their husbands reported interspousal communication on use of IUCD/Copper-T. Ever use of IUCD/Copper-T was only 6% in Bihar CMW and 11% in Maharashtra and largely for spacing births.

#### 4.3.3 Injectables

Relatives, ASHA/AWW, government health providers, and friends were the major sources of knowledge for injectables for both CMWs and husbands in the project area. Friends and relatives were major sources of information about injectables in Bihar while in Maharashtra government health providers were the prime source of injectables knowledge in addition to relatives and ASHA/AWW. Government doctors and hospitals were preferred source of Injectables in both the states with private clinics additionally preferred in Maharashtra. Husbands were more willing to receive information on injectables from government doctors in both states followed by



*“A doctor in Pune suggested to my daughter-in-law to go for injectable after delivery but that time, we did not hear about that and little afraid to accept. No one told us about injectables before that, and we have not come across anybody who had injectables in our known circle.”*

– Mother-in-law of CMW from Maharashtra



Medical shops/ pharmacies. Respondents in Bihar also preferred to receive information on injectables from medical shops/pharmacies. CMW cited government district hospitals and private clinics as their source for injectable contraceptives, and husbands stated that private hospitals/clinics were their primary source of injectables. Community health centers and primary health centers were also reported as sources of injectable services in Bihar. The findings for known sources of injectables services were similar to the preferred source of receiving injectables for CMWs and their husbands. About one-third of CMW in both States preferred to receive injectables from health professionals.

Half of the CMW and two-thirds of their husbands in project area said they were aware of duration of protection from pregnancy and reported duration as four months and six months respectively. One-third of CMW and nearly half the husbands were aware of the side effects of injectables and mentioned weight gain, irregular bleeding, headaches, and nausea. The respondents reported that treatment from any health facility or doctor could be sought in the case of side effects. Majority of respondents reported easy access to injectables. One-third of CMW were aware of the price of injectables and said that they costed an average of INR 53. A higher proportion (72%) of husbands were aware of the price and reported it as INR 49. In terms of willingness to pay, 33% of CMW and 50% of husbands in Bihar and about 21% of CMW and 27% of husbands in Maharashtra were willing to purchase one dose of injectables. Three-fourths of CMW and 9 out of 10 husbands of CMW reported interspousal communication and felt comfortable discussing use of injectables with their spouses. Ever use of injectables was only 4% among Bihar CMW and 6% in Maharashtra and largely for spacing births.

#### 4.3.4 Condoms

Spouses, friends, relatives, government health providers, and television were reported as major sources of condom knowledge in the project area. In Bihar, spouses and relatives were reported by CMW as sources of knowledge about condoms, and husbands reported friends as sources of the same. In Maharashtra, CMW reported television, government health providers and spouses while husbands mentioned friends as the major source of condom knowledge. CMW in Bihar reported spouses, followed by ASHA and AWW, were the most preferred source of information on condoms. In Maharashtra, government doctors, followed by medical shops/pharmacies, were most preferred by CMW. Husbands in both states were more willing than CMWs to receive information on condoms. Medical shops/pharmacies were the most prevalent sources of condoms in the project areas. Government doctors, community health centres, or primary health centres, and ASHA/AWW were also major sources of condoms.

One-third of CMW in Bihar reported receiving condoms from ASHA/AWW. Almost half of CMW (48%) in both states preferred to get condoms from peers (other young couples). Husbands preferred to get condoms from medical shops/pharmacies in the project area (75%). Accessing condoms was generally reported as easy by a majority of CMW and their husbands in the project area. About two-thirds (78%) of CMW in Bihar and somewhat less CMW (70%) in Maharashtra reported easy to very easy access to condoms. A higher proportion of husbands reported 'very easy access' to condoms as compared to their wives in both states. A quarter of CMW obtained condoms on their own, greater in Maharashtra (35%) than in Bihar (15%). In the case of husbands, 9 out of 10 were able to obtain condoms on their own in the project area.

However, some common prevailing myths associated with condom use were reported. About 23% of CMW and 33% of their husbands think that using a condom reduces sexual pleasure. Further, the belief that condom use is a sign of infidelity was reported by 12% of CMW and 22% of husbands. About 60% CMW knew the price of a pack of three condoms in project area, and the average reported price was INR13. A higher proportion

of husbands (80%) knew of the price and reported it as INR26. A smaller proportion of CMW (42%) were willing to pay for condoms in the project area than husbands (73%). Analysis of information on interspousal communication indicates that about three-fourths of CMWs and 80% of husbands reported being comfortable discussing condom usage with their spouse. Over 29% of husbands in Bihar and 42% in Maharashtra had ever used condoms. While CMW cited delaying first pregnancy as the main reason for use, husbands cited condoms as a spacing method between children.

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*“We buy condoms from medical shops, and it costs around INR30 per each pocket. However, they are available with ASHA workers in the village.”*

*– Husband of CMW 26 years old, Bihar*

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#### 4.3.5 Emergency contraceptive pill (ECP)

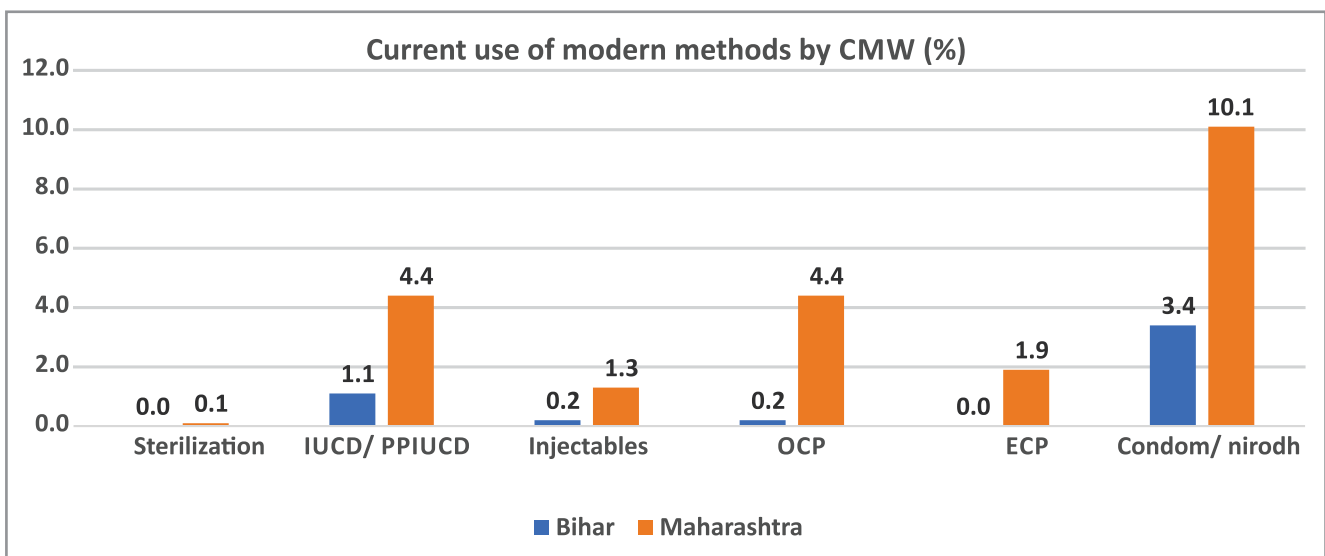
Government health providers, television, friends, and relatives are the major sources of knowledge on ECP in the project area. Relatives in Bihar and government health providers in Maharashtra were the most prevalent sources of ECP information. Additionally, TV and medical shops/pharmacies were also reported as sources of ECP information by respondents. In both states, CMW preferred to receive ECP knowledge from government doctors or ASHA/AWW. Husbands preferred medical shops/pharmacies in Bihar and government doctors in Maharashtra. Private doctors were the other preferred source mentioned by all respondents. Medical shops/pharmacies were the most prevalent source of ECP in the project area, followed by CHC, PHC and private hospitals/clinics. Over one-third of CMW in Bihar reported getting ECP from ASHA/AWW.



CMWs in Bihar and husbands in Maharashtra were more aware of ECP effectiveness and safety than their counterparts. Forty-four percent of CMW and 70% of husband of CMW said ECPs were safe and effective. In terms of knowledge of the mechanisms for action and timing of ECP among respondents, about 37% of CMW reported a belief that ECP induced abortion and killed the sperm, and fewer than 20% of CMW said it inhibited ovulation and prevention of implantation. Husbands reported similarly on the mechanism of ECP action. Regarding dosage of ECPs, the majority of respondents (57.7% CMW and 58.4% husbands) in project area correctly said that ECP should be taken within 72 hours. About 70% of CMWs in project area knew that one dose was enough to prevent pregnancy. A similar proportion of CMWs in both states and husbands in project area responded pregnancy and breastfeeding as contraindications to ECP.

About 52% CMWs and 62% husbands in project area were aware of side effects of ECP and reported nausea, vomiting, abdominal pain, and fatigue. Additional side effects reported by CMW in Maharashtra were menstrual problems, fatigue, and headaches. The majority of respondents reported that treatment from any health facility/ doctors can be sought in case of side effects.

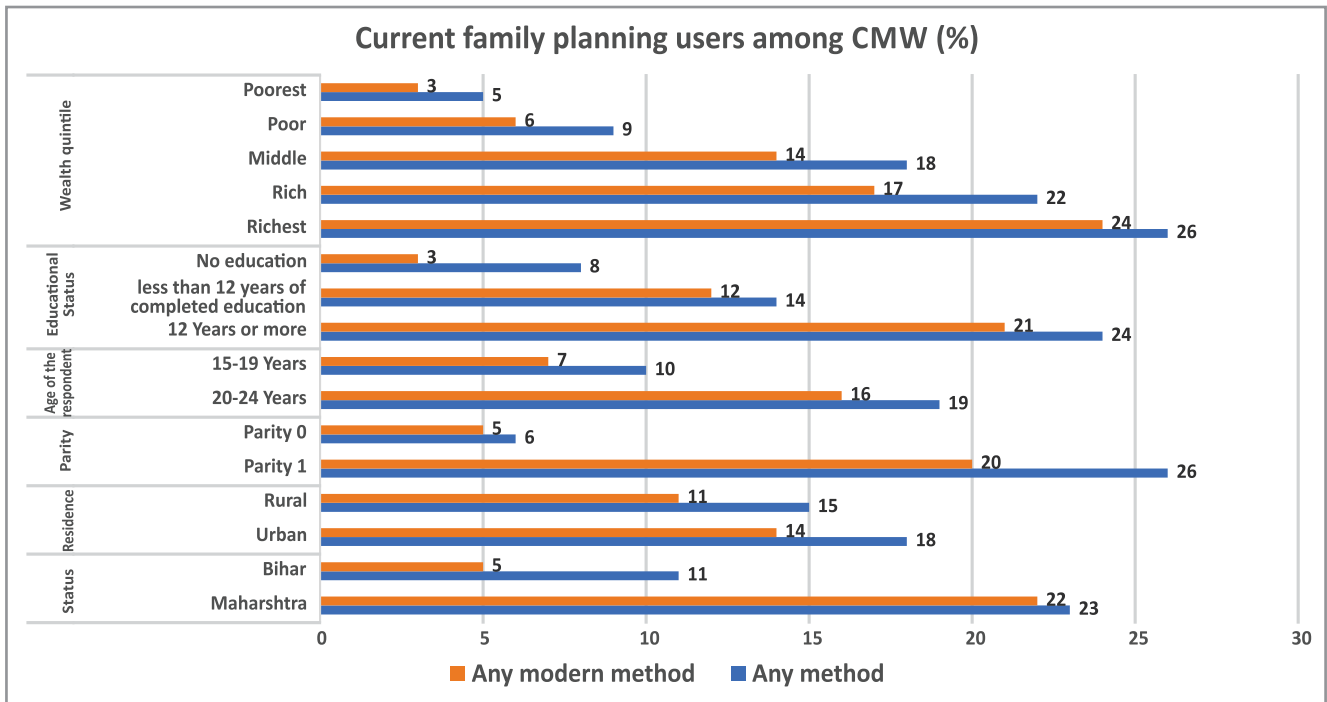
The accessibility of ECP was reported as 'easy' or 'very easy' by more than half of CMW in both the states, while husbands reported 'less easy' access to ECP as compared to their wives . Over one-third of CMW were aware of the price for one dose of emergency contraception and said it costed average INR62. A similar proportion of husbands were aware and reported the price as INR 60. In terms of willingness to pay, 33% of CMW in Bihar and about 36% of CMW in Maharashtra were willing to purchase one dose of ECP. The willingness to purchase ECP among husbands was found the same in both the states, at INR27 for one



dose. Responses on interspousal communication indicates that about 8 in 10 respondents reported being comfortable in discussing ECP usage with their spouse. Only 8% of CMW of Bihar and 7% in Maharashtra had ever used ECP. Use of ECP in the project area was cited to delay the first pregnancy.

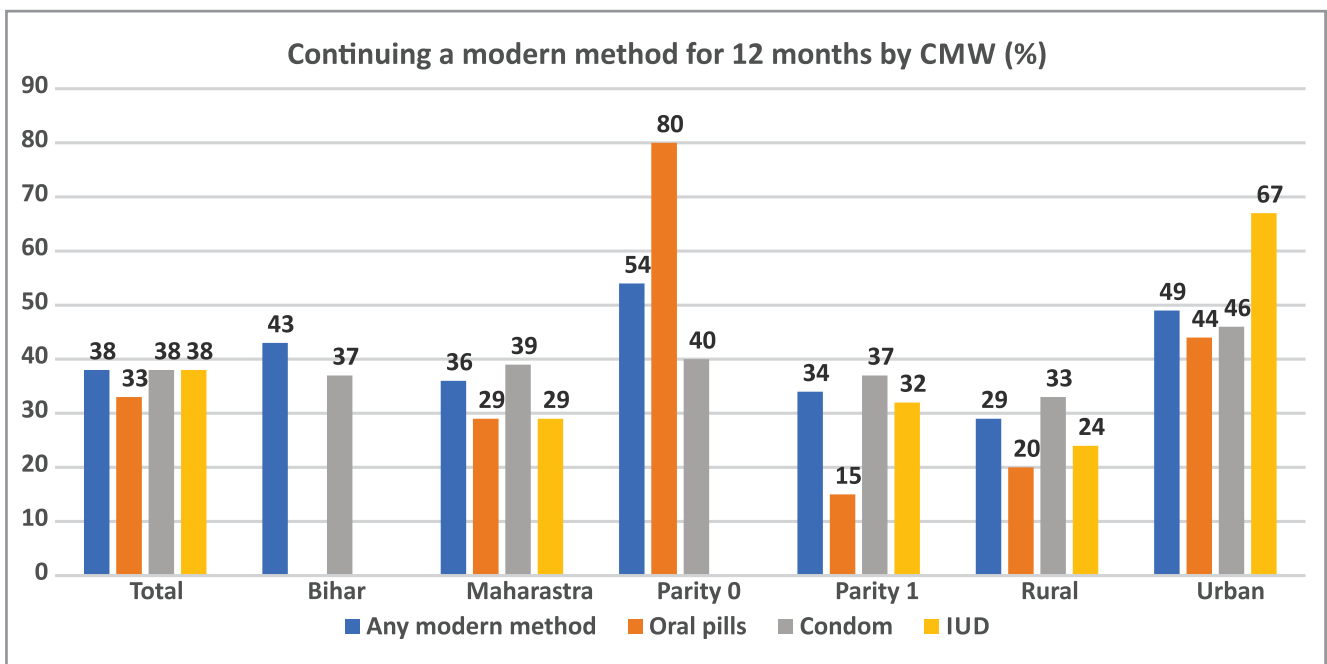
#### 4.4 Current use of contraceptive Methods

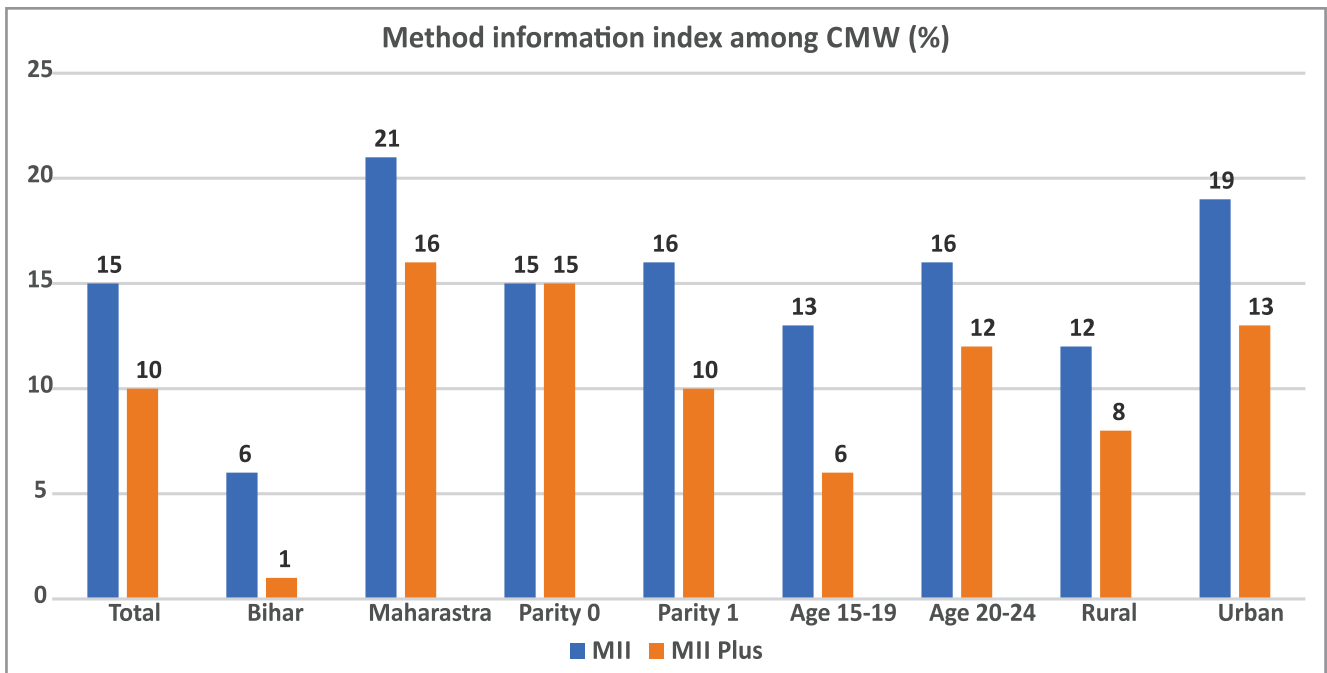
While the total contraceptive prevalence rate (CPR) was 16% in the overall project area, 78% of them are used modern contraceptives. The modern contraceptive prevalence rate (mCPR) in Bihar was only 5%, which is lower than Maharashtra (22%). The mCPR had positive correlation with CMW living urban areas, CMW with parity 1, age (CMW above 20 years), increase education level and higher wealth quintile.



Condoms were the most popular modern method among CMW and husbands, with 6% of CMW and 13% of husbands (18% in Maharashtra and 9% in Bihar) reporting of condom use. These are followed by IUCD (3%) and OCP (2%) in the project area. The Method Information Index (MII) provides information on the level of access women have to information and counselling, including knowledge on other methods and side effects and how to handle them. This index helps compare and track trends in counselling services. The MII was 15% among CMW in the project. MII was higher in older women and in those with 12 or more years of schooling than those with no education. MII was also higher in the richest households than poorest.

Among current users, the highest continuation rate was for IUCD (38% CMW), followed by condoms and OCP in project area. About 49% of CMWs in Bihar and 63% in Maharashtra were satisfied with their FP method. The highest satisfaction rate was reported among OCP users, followed by condom users.

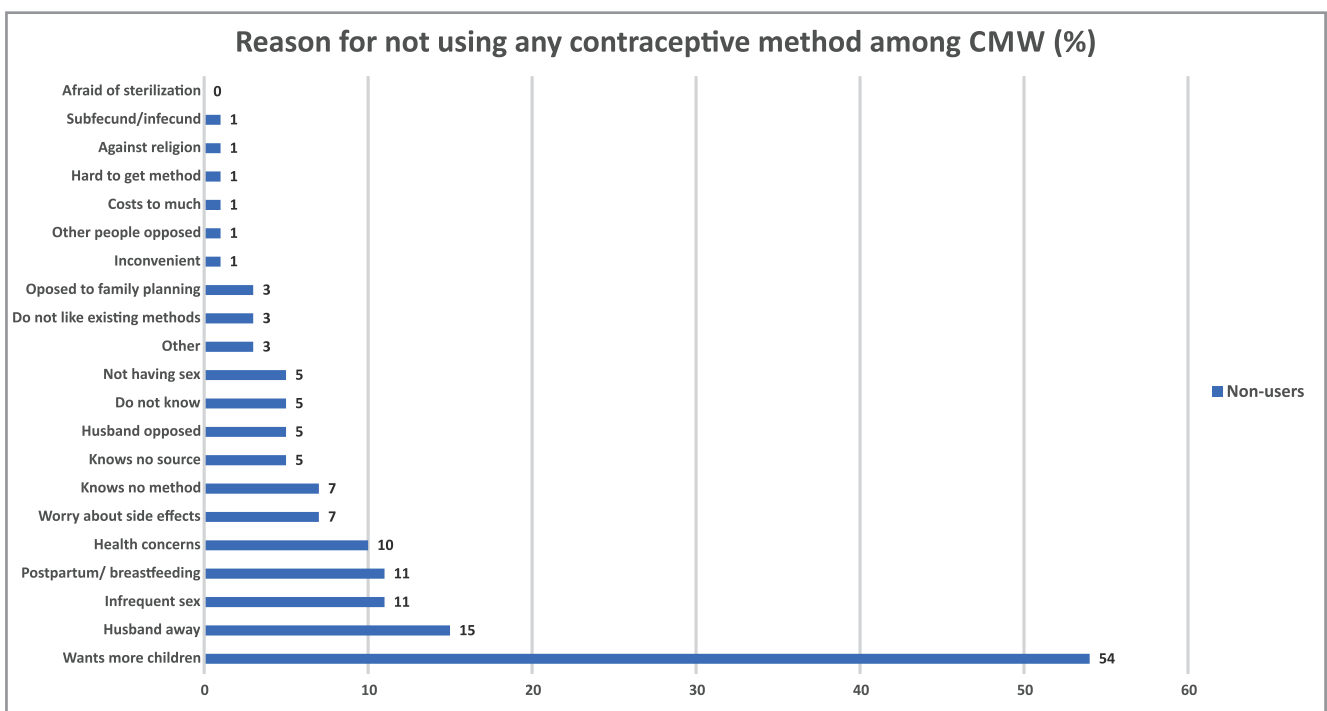




In terms of decision making on the use of FP methods, 87% of CMW in project area reported the decision is made alone or jointly with spouses, while 82% of husbands reported joint decision making. Only 15% CMWs reported making the decision alone. Husbands and CMWs dominated decision making in rural and urban areas respectively. Reported reasons for not using contraceptives included desire for more children (54%), husband being away (15%), infrequent sex (11%), postpartum/breastfeeding (11%), and health concerns (10%).

#### 4.5 Intention to use Family planning method in future

Intention to use FP in the future is an important indicator of the potential demand for FP services. Among non-users, 17 percent wanted to use any method within one year. Respondents from rural areas and parity 1



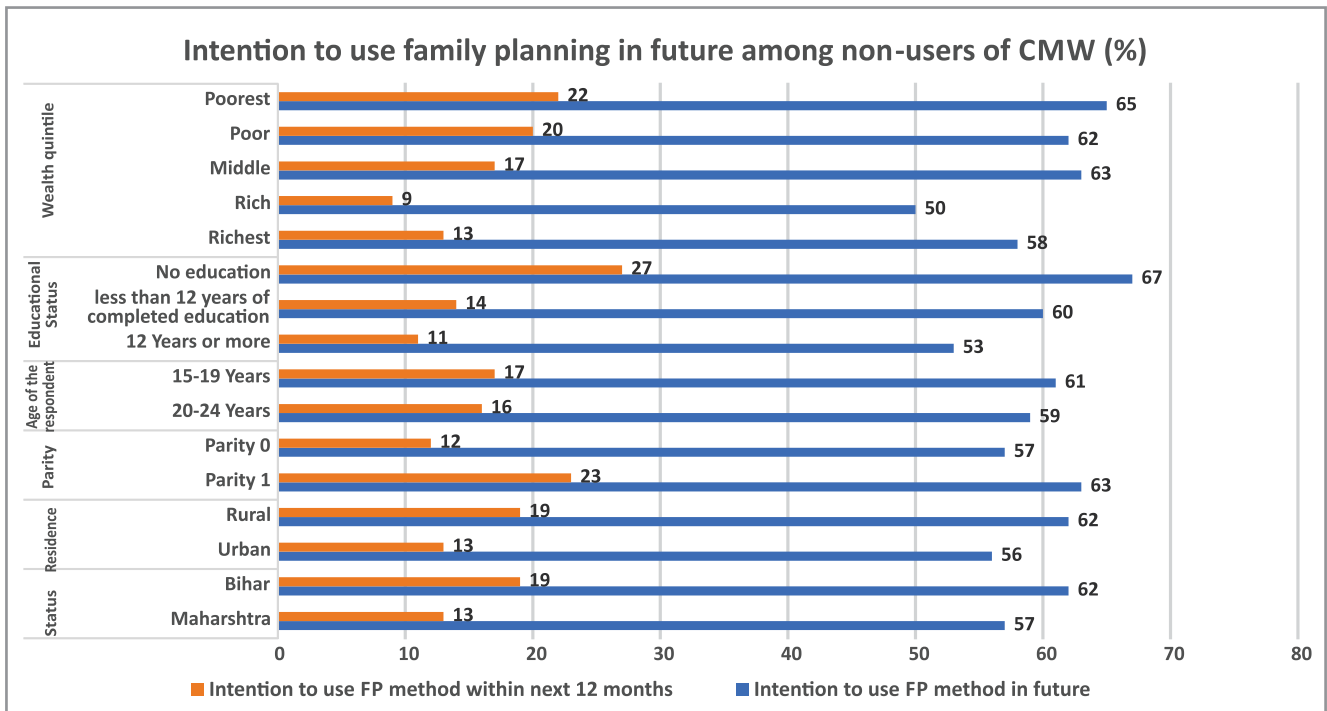
were more willing to use it in next 12 months compared to respondents from urban areas and parity 0 respectively. Interestingly, intention to use contraception had no correlation with education and wealth. Intention to use a method was highest after second birth (33%), followed by first birth (16%) and then third birth (10%) in CMW in project area. Four percent of CMW reported an intention to use contraception within next three months, and 3% reported an intention to use a method

as soon as possible in project area. CMW who were not using any contraceptive methods and intended to use a method in the future were asked about their preferred method. Six out of ten CMW reported that they would like to adopt sterilization in future, 18% preferred to use condoms, and 8% preferred to use injectables. Sterilization and injectables were more preferred in Bihar than Maharashtra. IUCD and Condoms were preferred in CMW with higher educational levels and higher wealth quintile compared to their counterparts.



*“I did not want to have children immediately after marriage, as I was planning to go to Mumbai for work. My mother insisted on having a child immediately after marriage. She told me clearly that I can go to Mumbai once my wife conceives. I could not convince her. Within a year, I had a daughter”.*

– Husband of CMW 25 years, Bihar

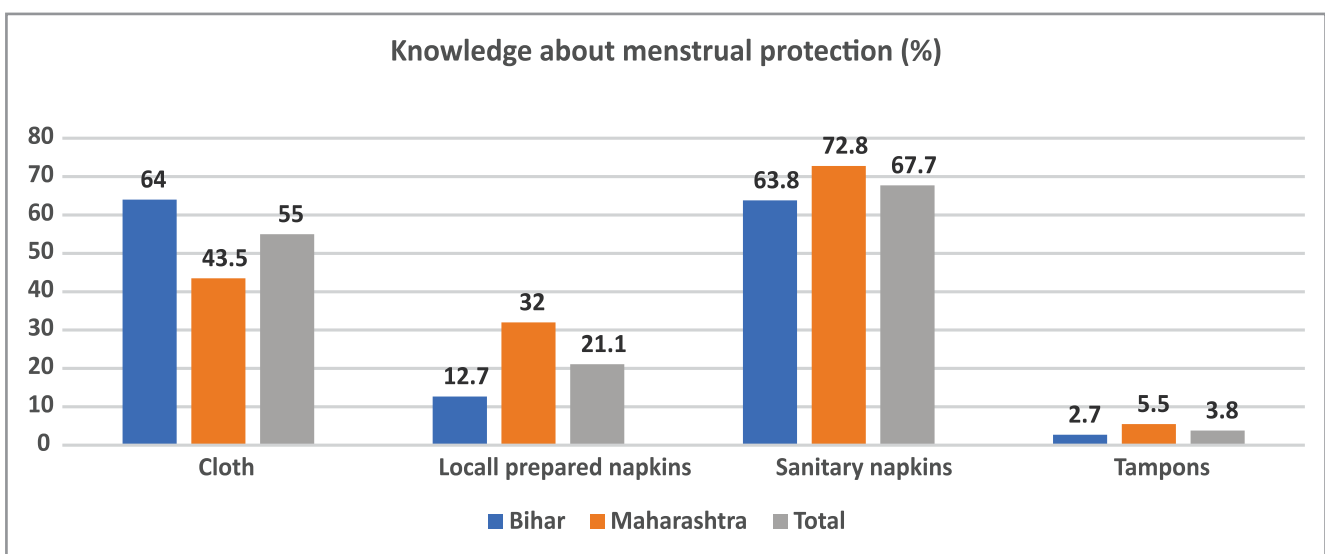


# 5 Fertility Knowledge and Behaviour

This section discusses on menstrual protection, fertility desire, ideal family size, knowledge about fertile periods, and opinions on first pregnancy and spacing between two children and the perceived associated advantages among CMW.

## 5.1 Menstrual Protection

In the project area, 68% of CMW used sanitary napkins, 55% used cloth and 21% used locally prepared napkins. Overall, 89% of CMW used a hygienic method for menstrual protection with cloth most commonly used in Bihar (64%), and sanitary napkins in Maharashtra (73%). CMW with more than 12 years of schooling, in the highest wealth quintile, and living in urban areas were more likely to use hygienic methods compared to their counterparts.



## 5.2 Knowledge on safe period

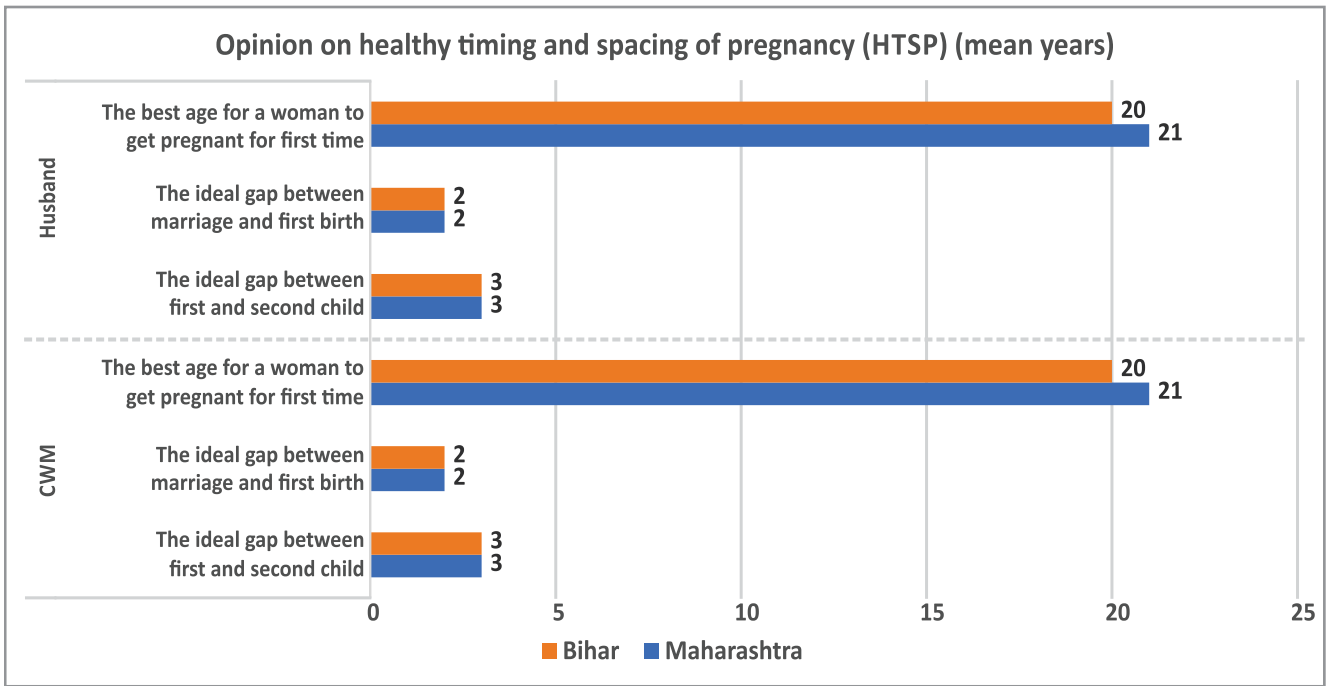
Nearly 60% CMW were aware that there are certain days of the menstrual cycle when a woman is more likely to become pregnant, 11% did not think there was a difference, and the remaining 19% were unaware of the fertile period. CMW in Maharashtra reported more awareness of safe low-fertility periods (67%) compared to counterparts from Bihar (54%). Only 40% of CMW who were aware could name the correct days of fertile period.

## 5.3 Knowledge on Healthy timing and spacing of pregnancy (HTSP)

HTSP helps women and families make informed decisions to delay the first pregnancy and to space or limit subsequent pregnancies for the best health outcomes for mothers and children. The ideal age at marriage was reported as 20 years by CMW in Bihar and 21 years by CMW in Maharashtra. Husbands in both states reported 20 years as the ideal age for women to marry. CMW with higher education status, higher wealth quintile, and younger age reported higher age at first pregnancy compared to their counterparts. The average ideal gap between marriage and first birth was reported at 1.7 years (20



months), which was universal across rural-urban residences, educational status, and wealth quintiles. CMW in Bihar reported a slightly higher gap (1.9 years) compared to CMW of Maharashtra (1.6 years). When asked about ‘the ideal gap between first and second child’, on an average of three years was reported by CMW in the project area. Husbands reported an ideal gap of 2.6 years between the first and second child. CMW in lower wealth quintiles reported a smaller ideal gap compared to counterparts. Wider variations in reported ideal gap were seen in Bihar’s rural areas among CMW with parity 0, no education and who are poor.



#### 5.4 Advantages of HTSP reported by respondents

Respondents were asked about perceived advantages of HTSP for both the mother and child. A majority of CMW said that delayed pregnancy ensured better nutritional status of mother and gave mother and child “more time to understand each other.” Other advantages reported were “better future planning for children” (35%), “better growth of the child” (30%) and “better communication between spouses” (30%). The most common response among husbands was that advantages included “better nutritional status for the mother” (48%), followed by “better growth for the child” (40%), and “better mental health” (38%).

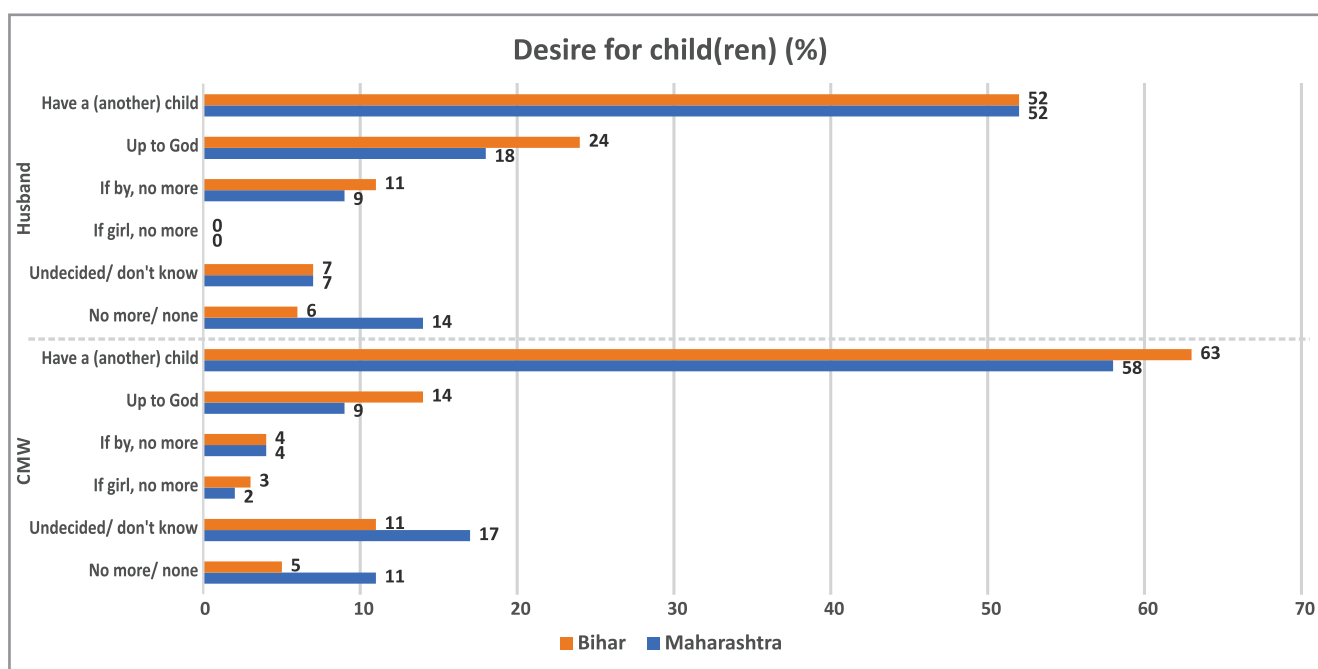
In terms of spacing advantages between two children, about two-thirds of CMW in project area reported there was “more time to understand each other” and “better communication between spouses,” followed by financial stability (53%) and job security (32%). A lower incidence of anaemia among mothers was also reported by one-third of CMW and their husbands in Maharashtra. A similar pattern can be seen in the husbands’ reporting in the project area.

#### 5.5 Unintended pregnancy

Unintended pregnancies were reported by one-third of CMW who were currently pregnant at the time of data collection. More unintended pregnancies were reported in Bihar compared to Maharashtra. Younger CMW with parity 1 who resided in rural areas reported more unintended pregnancies compared to their counterparts.

## 5.6 Desired for child(ren)

Respondents were asked if they would like to have (a/another) child or preferred not to have any (more) children. Women pregnant at time of data collection were asked if they would like to have another child after the one expected now. Nearly two-thirds (61%) of CMW wanted to have another child. However, about 14% of CMW could not decide, followed by 11% in the project area who said it was “up to God.” Husbands reported less desire for another child (52%) than their wives (61%). No association was found between desire for children and education/wealth quintiles. This may be the target respondents were young and had only one child or no children. Eighty-eight percent of CMW in the project area reported that their husbands desired the same number of children as they desired, with more in Maharashtra (95%) than in Bihar (83%). Higher concurrent desire was reported in urban areas, among educated CMW, and among families in higher wealth quintiles in the project area.



## 5.7 Ideal number of children

To assess women’s ideal number of children, CMW and their husbands were asked about the number of children they would like to have if they could start over again. Respondents with no children were asked, “If you could choose exactly the number of children to have in your whole life, how many would that be?” Those who already had one child were asked, “If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be?”

Eighty-five percent of CMW considered two or fewer to be the ideal number of children. Fourteen percent considered three or more to be ideal in the project area. However, the ideal family size varied by state. Three-fourths of CMW in Bihar considered that two or fewer children was an ideal number compared to 97% of CMW in Maharashtra. On the other hand, in Bihar 24% of CMW considered three or more to be an ideal family size compared to only 1% in Maharashtra.

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“First child should be a son and after that do not mind having a child of any sex. Son is a must to continue family name”.

– CMW, 22 years, Maharashtra

”

CMW with no education and who belonged to the poorest/poorer households considered three or more children to be the ideal family size compared to CMW with higher educational levels and of higher household wealth quintiles in the project area. Only 2% of CMW gave non-numeric answers. Among husbands, in project area, 81% considered two or fewer to be the ideal number of children, and 16% considered three or more to be ideal. Three percent of husbands were unable to give a numeric response to the question. Patterns among husbands are similar to those among CMW by state.

### 5.8 Son preference

A strong son preference was observed but was not common across the respondents. Though the majority of the young men and women preferred a balance of both boys and girls, they expressed a strong desire for at least one son. In both states, son preference was deeply rooted in communities where boys are the heirs of the family property. Girls are expected to leave the family at marriage and thus viewed as making no significant contribution to the family. Also, few respondents opined that a couple should have one boy and one girl and that at least one male child was preferred. In both states, few husbands opined that a son was needed to carry forward their family heritage and bear all family burdens.

“

*“ I agree that a daughter should be given preference over son. I don’t differentiate with son and daughter.”*

– CMW, 23 years, Maharashtra

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*“ Yes, in our society, it is customary that son should be there to heritage.”*

– Husband of CMW, Bihar

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# 6 Exposure to family planning messages

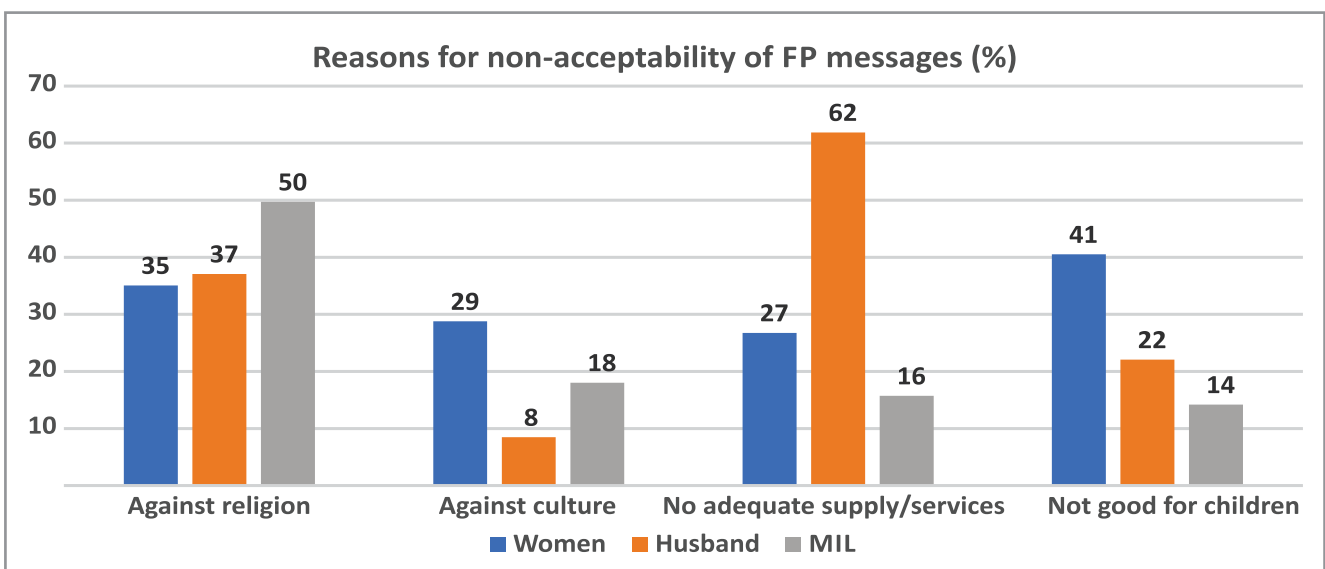
Understanding the sources where young married couples acquired information on FP services is essential to strategize means to convey these messages and therefore, increase access to modern contraceptives. Adequate information helps couples decide about the most appropriate HTSP method, thereby ensuring best health outcomes for mother and new-born child. FP messages are crucial for awareness about the methods available, and the benefits and sources of services among couples. The section of the results presents the sources of FP messages that were heard in the past three months, the preferred modes of information, and the willingness to receive FP messages through interactive mobile games (specifically among young couple).

Data on the sources of FP messages heard by CMWs in the past three months showed that television (45%) was the most predominant source of FP messages in the project area followed by wall hoardings (29%), posters (20%), newspapers/ magazines (17%), drama (11%), and radio (6%). A higher proportion of CMW in urban areas, parity 1, between 20 and 24 years old, with 12 years of schooling, and from higher wealth quintiles reported higher exposure than their counterparts to FP messages in past three months through TV, newspapers, wall hoardings, posters, and radio.

Data on the sources of FP messages heard by husbands in the past three months showed that television (47%) was the most predominant source, followed by posters (39%), newspapers (36%), wall hoardings (31%), drama (11%), and radio (7%). A higher percentage of husbands from urban areas, with women of parity 0, between 20 and 24 years old, with 12 years and above of schooling, and from higher wealth quintiles reported exposure to FP messages than their counterparts. Distribution of mothers-in-law who viewed family planning methods through television in the past 3 months was reported more significantly in Maharashtra (58%) as compared to Bihar (11%).

## 6.1 Acceptance of family planning messages

Respondents who heard FP messages were asked about the acceptability of the messages. Almost all husbands, 87% of CMW and 76% of MIL reported that the FP messages heard in the past three months



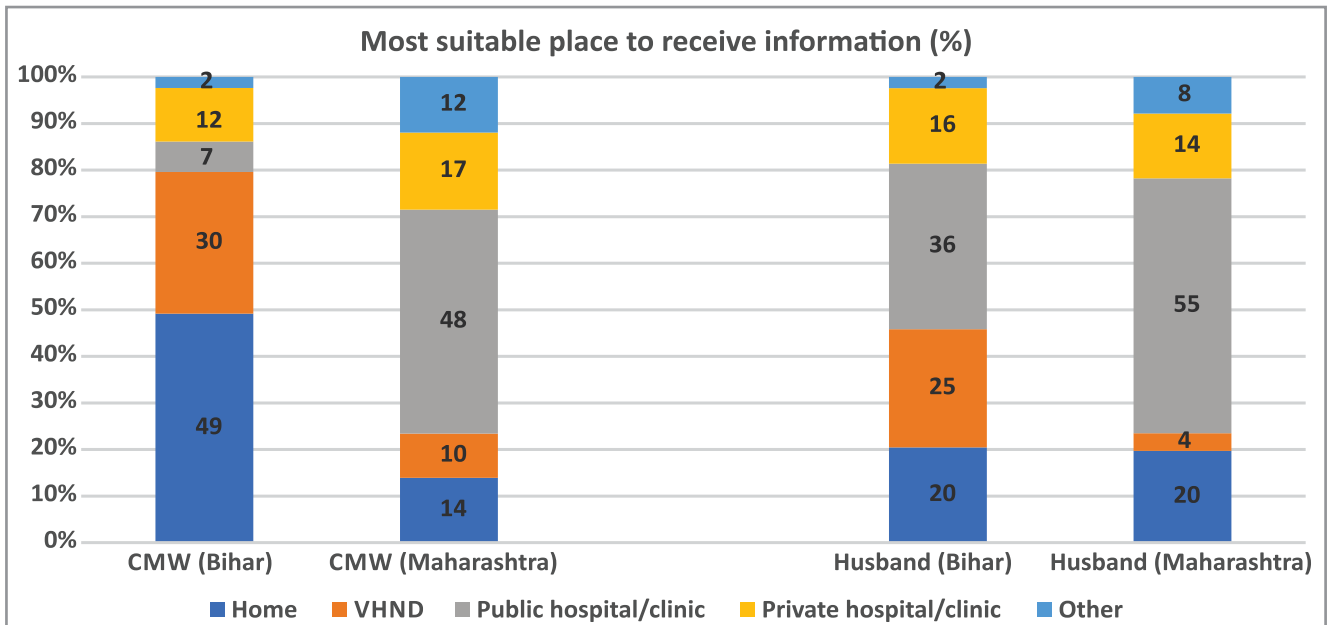


were acceptable to them. More than 90% of respondents in project area including CMW (94%), husbands (94%), and MIL (95%) from Bihar expressed acceptability toward the FP messages heard in past three months, substantially higher compared to the CMW (83%), husbands (93%), and mothers-in-law (68%) of Maharashtra. Though there was not much variation by place of residence for CMW and their husbands, MIL from rural areas reported relatively less acceptability (72%) than those residing in urban areas (81%). Respondents were asked questions to examine the reasons messages were not acceptable. These reasons as cited by CMWs, husbands and MILs were that they were "against the religion and culture," "lack of enough FP services," and "not good for children." A majority of CMW revealed that such FP messages were not good for children (41%), while two-thirds of their husbands said inadequate FP supplies and services were provided in the project area. Notably, half of MIL revealed that FP messages broadcast through mass media were against the religious norms in the project area.

## 6.2 Frontline health worker on family planning outreach

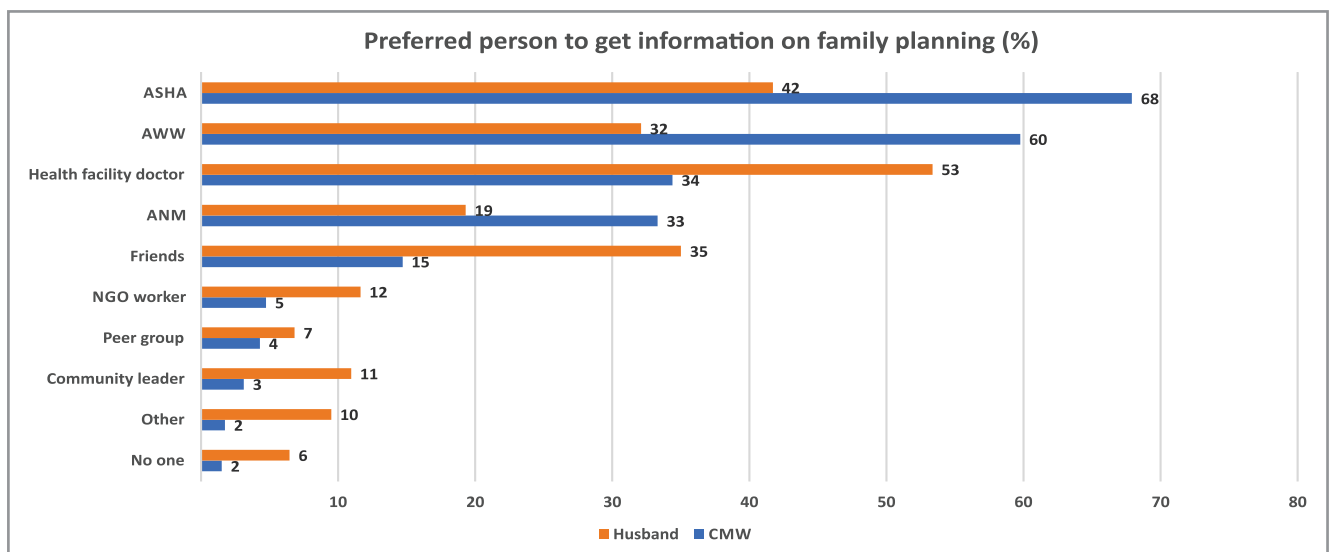
Nearly half of the CMW (46%) had met with community health workers (CHWs) in the previous three months, varying from 36% in Bihar to 56% in Maharashtra. In the last three months, a higher proportion of parity 1 CMW compared to parity 0 CMW met with CHWs in the project area. The CMW with higher educational levels and in higher (richer and richest) wealth quintiles met with CHWs more in the last three months. A majority of CMW met with AWW (76%), followed by ASHA (60%) and ANM (36%) in the last three months. Furthermore, during these frontline/CHW meetings, nearly one-third of CMW discussed matters related to FP, with more in Maharashtra (42%) than in Bihar (20%). Similar information was gathered from husbands regarding contact with frontline health workers in the project area. Over one-third of husbands (39%) met with CHWs, varying from 34% in Bihar to 45% in Maharashtra. A majority met with AWW (73%),

followed by ASHA (49%) and ANM (28%) in the last three months. Furthermore, during these meetings with frontline workers, nearly two-thirds of husbands discussed matters related to FP, with more in Maharashtra (73%) than in Bihar (51%). Visits to any health facility or health camp in the past three months for any reason were reported by 23% of CMW and 32% of husbands. Among the CMW who recently visited a health facility, a higher proportion were in Maharashtra (32%), urban areas (24%), with parity 1 (27%), with above 12 years of schooling (23%) and from the richest quintiles (29%). The same pattern was observed in the case of husbands.



### 6.3 Exposure to Family planning message on Community platforms

Respondents were asked about the most suitable place to receive information on FP. Most of the CMW (49%) in Bihar indicated that “at home” was the best place to receive FP information compared to only 14% in Maharashtra, where a majority of CMW (48%) indicated that public hospitals/clinics were the best places to receive information on FP. The public hospitals/clinics were preferred by CMW of older age groups, with parity 1, from urban areas, higher educational level, and higher wealth quintiles. Similar preferences were reported by husbands in the project area.



Most of the CMW reported that ASHAs are competent to provide FP information (68%) followed by AWW (60%) and doctors/ANM (33%). CMW from Maharashtra, urban areas, and higher educational levels and wealth quintiles preferred health-facility doctors more than their counterparts. A similar pattern was reported by husbands regarding the most suitable source of information. Thirty-five percent of husbands additionally mentioned friends as their most preferred source of FP information. The husbands preferred health facilities, doctors, and friends to receive information on FP while CMW preferred AWW, ASHA, ANM and community leaders.

Of common media sources for FP messages, Gramvaani, a community radio, was reported only in Bihar by CMW (3%), husbands (5%), and MIL (6%). The Antara program to promote injectable contraceptives was heard by about 3% of husbands, 6% CMW, and 5.8% MIL in Bihar. The Antara program was reportedly heard by 15% of husbands, 6% of CMW, and 3% of MIL in Maharashtra. Around 9% of CMW and husbands and 13% of MIL heard FP information through a microfinance group (Self Help Group) in Bihar, while 3% of CMW, 14% of husbands, and 7% of MIL in Maharashtra received FP information through a microfinance group.

About 70% CMW in project area reported that they liked to receive information on health care through interactive mobile games, receive information on family planning (69%), liked to share information with spouses (88%), and felt comfortable in receiving FP services during women's gatherings that happened once a month in the community (76%). Husbands said that they liked to receive information on health care (75%), on family planning (65%) and liked to share information received through the interactive mobile games with spouses (86%).



# 7 Reproductive Autonomy

Understanding and addressing gender and cultural norms is essential in any FP program. Inequitable gender norms influence FP behaviours, such as contraceptive use, pregnancy outcomes, family size, son preference, and the socialization of male children. This section presents data on prevailing gender and social norms that influence FP behaviour among young married couples in the project area.

## 7.1 Reproductive autonomy among currently married women

A woman with reproductive autonomy can control when to become pregnant, when to use a contraceptive, and whether to continue a pregnancy. We assessed women's reproductive autonomy in the project area using the Reproductive Autonomy scale developed by Upadhyay CD et.al<sup>1</sup>. The Scale is a 14-item self-reported measure of individual experiences on the ability to achieve reproductive goals, which comprise three domains: decision making, freedom from coercion, and communication. Women respondents were asked to indicate one response from five options: strongly agree, agree, undecided, disagree, and strongly disagree.

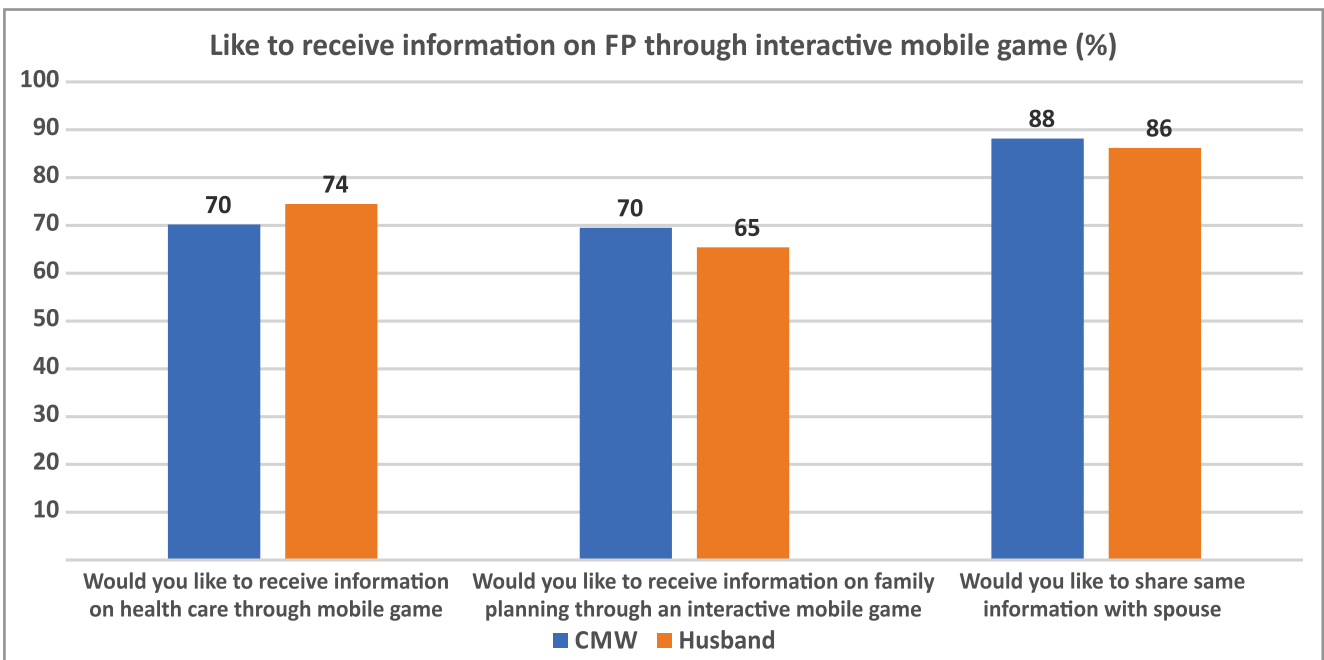


*“Because she is the only one who keeps her baby in her womb. She is the only one who go through the pain. So, she can decide on all aspects of family planning method and number of children”.*

– CMW Patna, Bihar

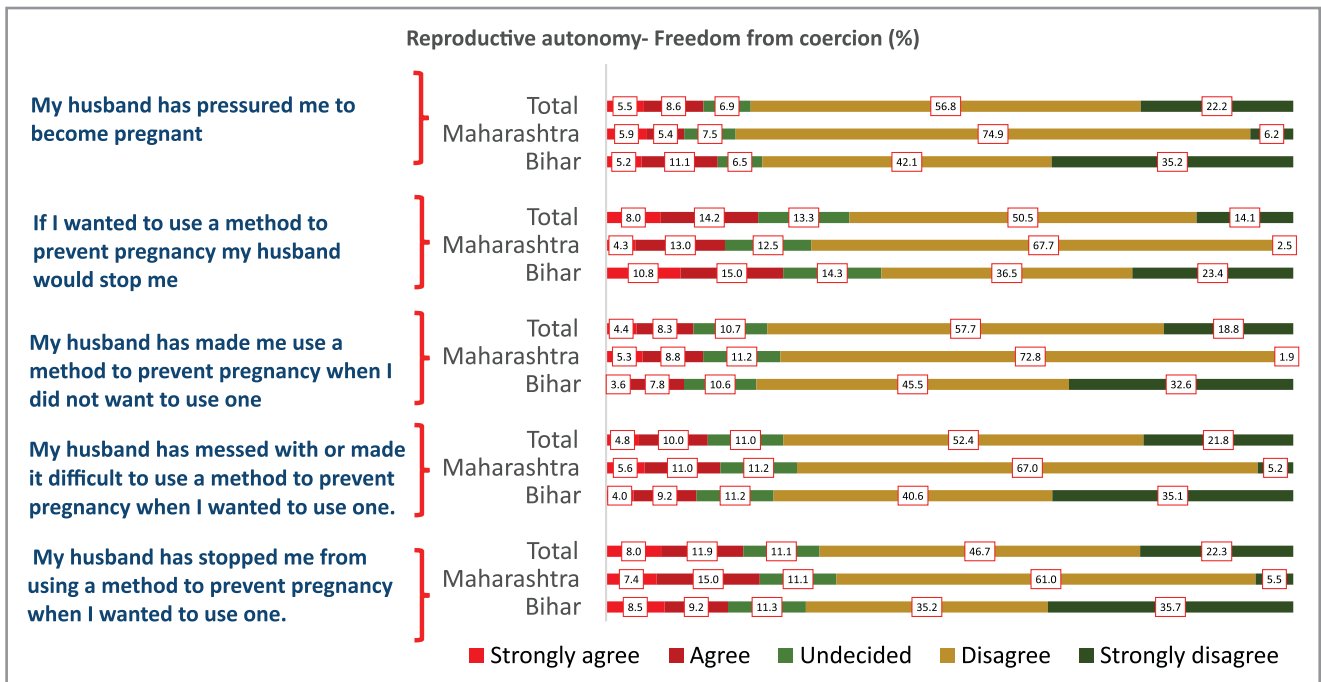
## 7.2 Freedom from Coercion

The freedom from coercion subscale consists of five statements about husbands' coercive acts on pregnancy and contraceptive use. Almost 77% of CMW in Bihar and 81% in Maharashtra disagreed with the statement,



<sup>1</sup> For details, please refer to paper by Upadhyay, U. D., Dworkin, S. L., Weitz, T. A., & Foster, D. G. (2014). Development and validation of a reproductive autonomy scale. *Studies in family planning*, 45(1), 19-41





“My husband has pressured me to become pregnant,” while 16% in Bihar and 12% in Maharashtra agreed, and 7% were undecided in both the states. About 86% CMW in Bihar and 72% CMW in Maharashtra disagreed while 13% CMW in Bihar and 17% CMW in Maharashtra disagreed with the statement, “My husband has messed with or made it difficult to use a method to prevent pregnancy when I wanted to use one.”. Further, 78% of CMW in Bihar and 84% in Maharashtra disagreed with the statement, “My husband has made me use a method to prevent pregnancy when I did not want to use one,” and 11% in Bihar and 14% in Maharashtra agreed. Regarding the statement, “If I wanted to use a method to prevent pregnancy, my husband would stop me,” 60% of CMW in Bihar and 70% in Maharashtra disagreed, while, 26% in Bihar and 17% in Maharashtra agreed. For the statement, “My husband has stopped me from using a method to prevent pregnancy when I wanted to use one,” more than 70% of CMW in Bihar and 66% in Maharashtra reported that they disagree, while 18% in Bihar and 22% in Maharashtra agreed. By and large, a majority of CMW in both states felt that their husbands did not coerce them on matters related to contraception and pregnancy. However, almost one-third of the CMW either agreed or were undecided about coerced situations.

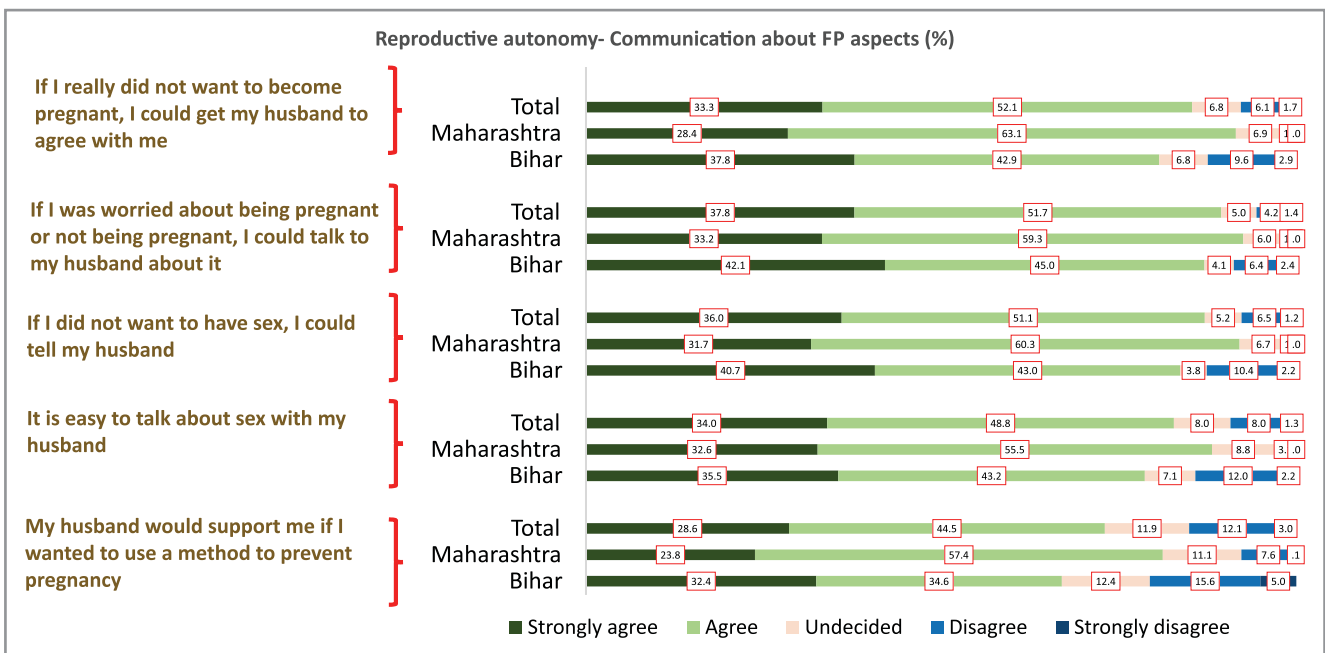
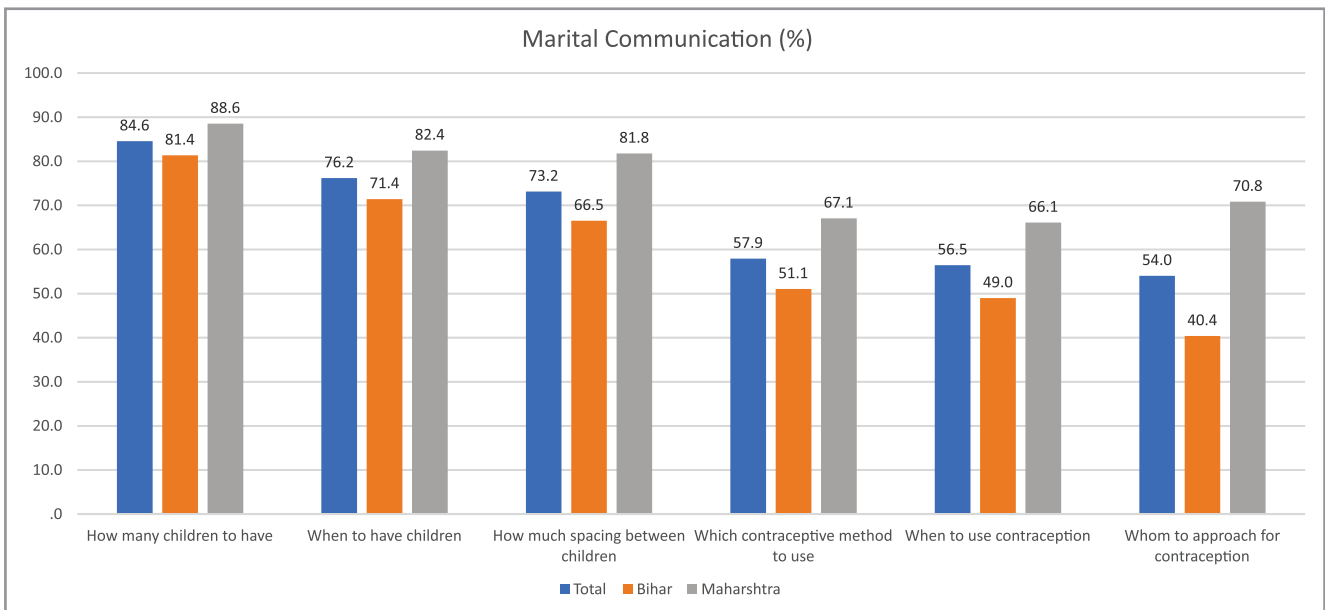
### 7.3 Interspousal communication

The subscale on communication includes five statements related to interspousal communication on reproductive health matters such as pregnancy timing, sexual relations, and contraceptive use. When the women were asked to respond on their extent of agreement with the statement, “My husband would support me if I wanted to use a method to prevent pregnancy,” 61% agreed and 20% disagreed in Bihar, and 81% agreed and 8% disagreed in Maharashtra. Considering another statement, “If I didn’t want to have sex, I could tell my husband,” 84% agreed and 12.6% disagreed in Bihar, and 92% agreed and 1% disagreed in Maharashtra. When women were asked about the statement, “If I was worried about being pregnant or

“But the newly married couples avoid these kinds of methods. And if they are not sexually satisfied with their partners or not able to give birth to a child within 1-2 years of marriage, they would leave their partners. They would prefer these measures only after the first child.”

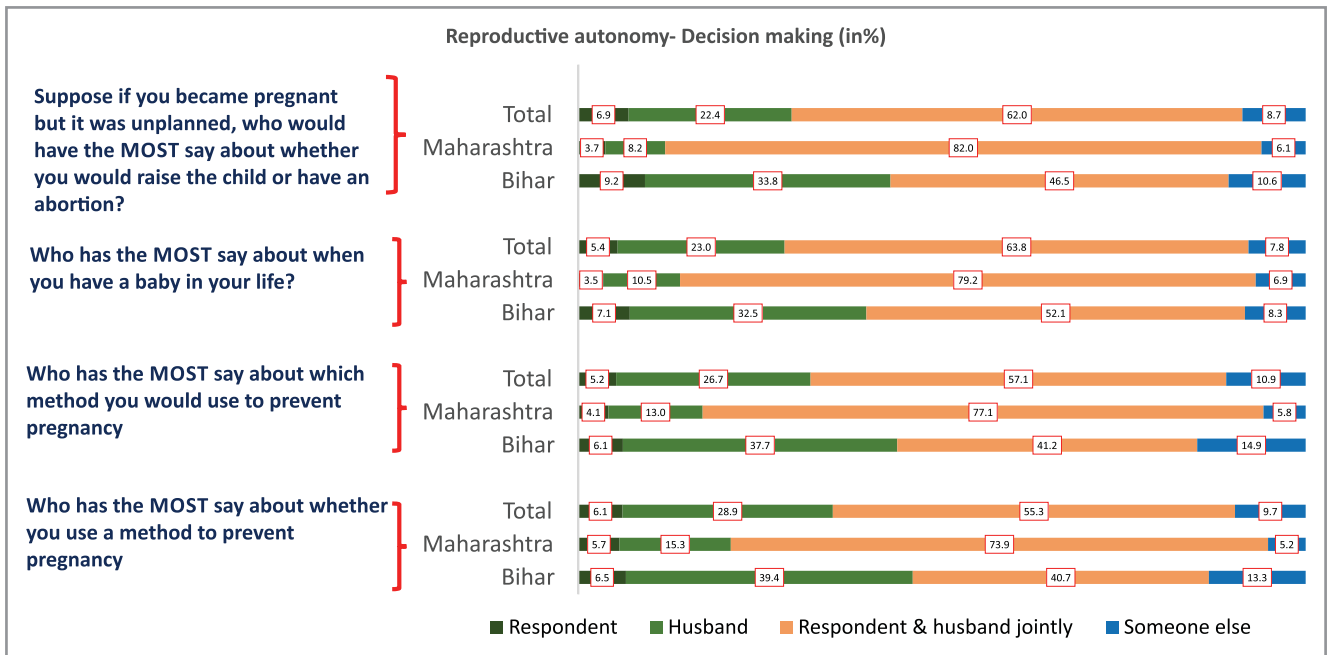
– Husband of CMW, Vaishali, Bihar

not being pregnant, I could talk to my husband about it,” 87% of CMW agreed and 9% disagreed in Bihar, and 93% agreed and 2% disagreed in Maharashtra.. When the women were asked to record the extent of their agreement with the statement, “If I really did not want to become pregnant, I could get my husband to agree with me,” 81% agreed and 13% disagreed in Bihar, and 82% agreed and 2% disagreed in Maharashtra.



### 7.4 Decision making on family planning

The decision-making subscale has four questions, which were asked in order to identify the person with most say in decision-making. Each of these questions had five response options: 1) Respondent 2) Husband 3) Both respondent and husband together 4) Someone else (in-laws/parents) and 5) Others. Before posing questions, the respondents were clearly educated on the difference between, ‘most say’ compared to the ‘final say’ in the decision-making process.



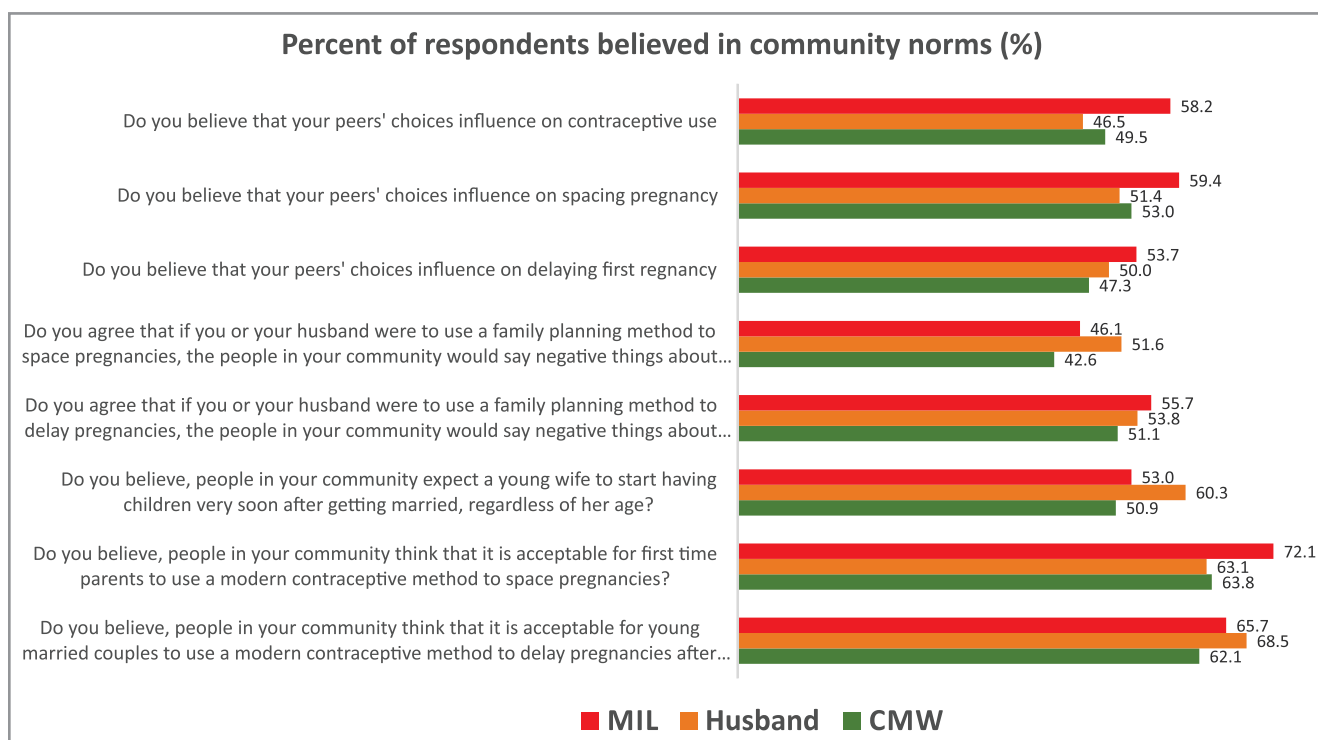
All participants were asked to state who had the final say on use of a method, choice of method, timing of pregnancy, and unwanted pregnancy. Most respondents (41% in Bihar and 74% in Maharashtra) reported that husbands and wives jointly have ‘most say’ on whether to use a method to prevent pregnancy,’ followed by husbands (30% in Bihar and 15% in Maharashtra), someone else (12% in Bihar and 5% in Maharashtra) and women alone (7% in Bihar and 6% in Maharashtra). When they were asked, “Who has the most say about which method you would use to prevent a pregnancy?” 41% in Bihar and 77% in Maharashtra reported a joint decision, followed by husbands (38% and 13%, respectively), someone else (13% and 6%, respectively) and respondent alone (6% and 6%, respectively) in both states. When participants were asked about “Who has the most say about timing of having a baby?” most respondents (52% in Bihar and 79% in Maharashtra), followed by husbands (33% and 11%), someone else (8% and 7%) and the respondent alone (7% and 4%) in both states. When women in Bihar were asked, “If you became pregnant, but it was unplanned, who would have the most say about whether you would raise the child or have an abortion?” most (47% in Bihar and 82% in Maharashtra) reported a joint decision, followed by husbands (34% and 8%), someone else (10% and 6%), and finally the respondent alone (9% and 4%). Though both the ‘respondent and husband jointly’ reported having the final say on contraceptives and pregnancy-related issues, women alone had very little say in both states. The category of “someone else” (in-laws and parents) had more say than CMW alone.

“Only my husband decides on family planning. Because I don’t earn and do household work. He will go outside and earn, and hence he takes decision”.

– CMW, Bihar

## 8 Social and Gender Norms in Family Planning

An attempt has been made to understand the prevailing community norms and respondents' beliefs in them as they affect the FP behaviour of young married couples. When questioned whether use of modern contraceptives by young couples to delay pregnancies was acceptable to people in community, 49 percent of CMW in Bihar and 77% in Maharashtra agreed, with 60% and 79% of husbands, respectively and 65% and 67% of MIL, respectively. Similarly, 56% of CMW in Bihar and 74% in Maharashtra believed that use of spacing methods by first-time parents was acceptable in community and a similar pattern was observed among husbands (59 % and 68%, respectively) and among MIL (69% and 76%) in Bihar and Maharashtra respectively.



When the respondents were asked whether “People in their community expected a young wife to start having children very soon after getting married, regardless of age,” 43% and 60% of CMW in, 50% and 71% of husbands and 44% and 64% of MIL agreed in Bihar and Maharashtra respectively. Further, 44% of CMW in Bihar and 59% in Maharashtra, 52% and 54% of husbands and 44% and 71% of MIL respectively opined that community would say negative things about young couples in case they used FP methods to delay pregnancies. Similar negative opinion of community towards couples using a family planning method for spacing of children was reported by 32% of CMW and 27% of MIL in Bihar; a similar proportion of husbands (55%) from both States and about 68% MIL in Maharashtra.



“I wanted to delay my first pregnancy, as I was in the first year of my graduation when married. So, I want to delay my first pregnancy for two years. I was taking oral pills, as suggested by ANM. But people started passing comments on me as I delayed first pregnancy.”

– CMW, 22 years, Maharashtra

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“My mother pressured us to have a child immediately after marriage. Like her, many women in the community pressure young couples to have children immediately. If the young couple does not have a child soon after marriage for various reasons, then they will speak badly about the young wife. They blame these young women and treat them badly and sometimes blame her as she is infertile.”

– Husband of CMW, Age

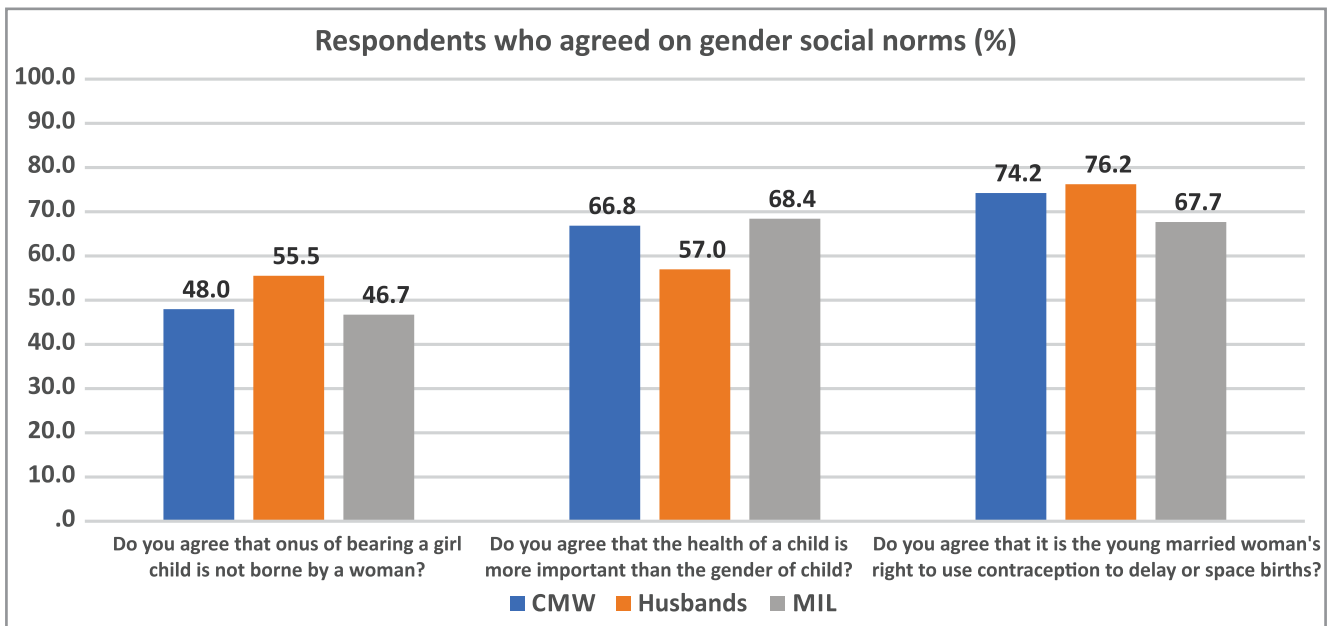
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“it is a common practice in our village that a newly married couple should have children soon after marriage. If anybody doesn't have the child within a year, then older people keep asking about the child. That is why one should not use contraception immediately after marriage, and they should go for a child.”

– A Mother-in-law, 52 years, Bihar

About 53% and 40% CMW, 50% and 48% of husbands and 68% and 37% of MIL from Bihar and Maharashtra respectively believed that young couples' peers' choices to delay pregnancy influenced their decision to delay their first pregnancy. With regards to spacing pregnancy, 53% and 42% of CMW, 53% and 61% of husbands and 65% and 53% of MIL from Bihar and Maharashtra respectively felt that peers' choices influenced young couples. It appears that the majority of MIL (68%) from Bihar as compared to Maharashtra MIL (37%) thought that the young couples were influenced by their peers' choices on HTSP.

### 8.1 Perceived social gender norms



When asked whether they agreed or disagreed on certain aspects related to women's reproductive matters, 35% and 64% of CMW, 51% and 61% of husbands, and 30% and 66% of MIL from both Bihar and Maharashtra, respectively agreed that “the onus of bearing a girl child is not borne by a woman.” For the statement, “Do you agree that the health of a child is more important than the gender of the child?” 49% and 89% of CMW, 52% and 63% of husbands, and 49% and 92% of MIL from Bihar and Maharashtra, respectively, agreed. Additionally, 64% and 87% of CMW, 74% and 80% of husbands, and 57%

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“I cannot delay the pregnancy, because if the whole family wants a child, and I am not ready, so they will not accept my concern.”

– CMW, Bihar

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“When ASHA workers suggested my wife to go for IUD insertion, I have discussed with my friends about IUD. They also suggested the same and convinced me that IUD insertion would not have any complications.”

– Husband of CMW, 38 years, Bihar

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“I wanted to delay first child. I told my wife that we could postpone having a child for one year, and I wanted to use a condom. Many of my friends in the village told me that one should not delay the first child as it leads to health problems in women. After listening to them, my wife was afraid and soon we went for the first child.”

– Husband of CMW, Maharashtra

”

and 81% of MIL from Bihar and Maharashtra agreed that it was the young married woman’s right to use contraception either to delay or space birth. By and large, the proportion of respondents in Bihar who agreed on these matters was comparatively smaller than that in Maharashtra. About 26% of MIL from Bihar and 39% from Maharashtra agreed that a young wife should start having children very soon after getting married, regardless of her age. Furthermore, when asked whether it is acceptable for a woman to decide when to stop having children, 63% and 81% of MIL agreed in Bihar and Maharashtra respectively.

“

“My in-laws are the key decision-makers in our house. I must inform my mother-in-law if I go out for any reason. Most of the time, she accompanies me if we go outside village. I am habituated, and I don’t feel uneasy because of her presence. It is very difficult to talk to ANM or ASHA without her knowledge. Last week, ANM visited and told me about IUD.”

– CMW, Maharashtra

”

The mobility patterns of CMW to the market, hospital, cinema, and outside their village or premises were assessed. About 87% and 75% CMW had ever been to market, 29% and 44% CMW had visited the market alone, about 86% and 85% CMW had ever visited a hospital/doctor and CMW had visited hospital doctor alone from Bihar and Maharashtra respectively. Only 18% in Bihar and 32% CMW in Maharashtra had ever went to cinema. More than 70% of CMWs from both states had ever gone outside of their

villages, of which 28% went alone. Women’s mobility to visit various places alone was low in both states.

## 8.2 Household decision making scale

It appeared from CMW response that critical decisions in households were made not by CMW or their husbands but rather by MIL or other older people. In Bihar, older people made decisions about household purchase in 48% households, with couples making joint decisions in 27% of households, and husbands making decisions in 23% of households. Similar proportions were reported in decisions about daily household needs and about visiting family or relatives.

In Maharashtra, couples made joint decisions about major household purchases in 41% of households. The elderly made these decisions in 31% of households, husbands made these decisions in 19% of households and the CMW

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“Only my parents take the decision. My wife has never made any decision.”

– Husband of CMW, Bihar

”

“

“I have to do everything according to my mother in law, and I will have no choice even to express my views.”

– CMW, Nalanda, Bihar

”

alone made these decisions in 9% of households. Similar proportions were reported for decisions on purchases for daily household needs. Decisions on visits to family or relatives were reported as a joint decision by 49% of households, the husbands' decision by 21% of households, elderly members' decision in 19% of households, and the CMW decision alone in 12% of households. Overall, in Bihar, most decisions were made by older people, while in Maharashtra, most decisions were made jointly by husbands and wives.

### 8.3 Marital communication scale

More than 80% of CMW in both states reported that they discussed number of children they desire with their husbands. Seventy-one percent of CMW in Bihar and 82% in Maharashtra reported discussions about timing, and 67% of CMW in Bihar and 82% in Maharashtra reported discussing spacing with their husbands. Around 51% of CMW in Bihar and 67% in Maharashtra discussed contraceptive methods with their husbands and, a similar proportion reported discussion on when to use contraception. About 40% of CMW in Bihar and 71% of CMW in Maharashtra discussed who to approach for contraception. Discussions on timing and spacing were reported more than discussions on contraceptive use, and less than half CMWs in Bihar discussed the same with husbands.

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*“My husband suggests medicines (pills) over injections. He said that injections are harmful and affect the body. He also said that injections affect kidneys.”*

– CMW, 19 years, Bihar”

### 8.4 Gender Norm Attitude

The gender norm attitude was measured using two subscales: i) belief in and promotion of equity for girls and women (10 items), and ii) belief in maintaining the rights and privileges of men (4 items). CMW were asked a set of questions on the rights and privileges of men, equity for girls, power relations, and violence.

Under rights and privileges, women were asked to record their level of agreement on a set of ten statements. About 79% CMW in Bihar and 84% in Maharashtra disagreed that sons must have more education than daughters. The majority of CMW (87% in Bihar and 84% in Maharashtra) disagreed that daughters should be sent to school only if they are not needed to help at home.” Though most CMW disagreed, a significant proportion of CMW (25% in Bihar and 23% in Maharashtra) agreed that “the most important reason that sons should be more educated than daughters is so that they can do better.” About 84% CMW in both states disagreed that sons should be given priority in case of limited money to pay for tutoring. CMWs (42% in Bihar and 17% in Maharashtra) agreed that “woman should take good care of her own children and not worry about other people’s affairs.

“

*“There is common thinking that male child is our successor. He will look after our family. Girls will be going to marry and leave the house.”*

– Mother-in-law, Maharashtra”

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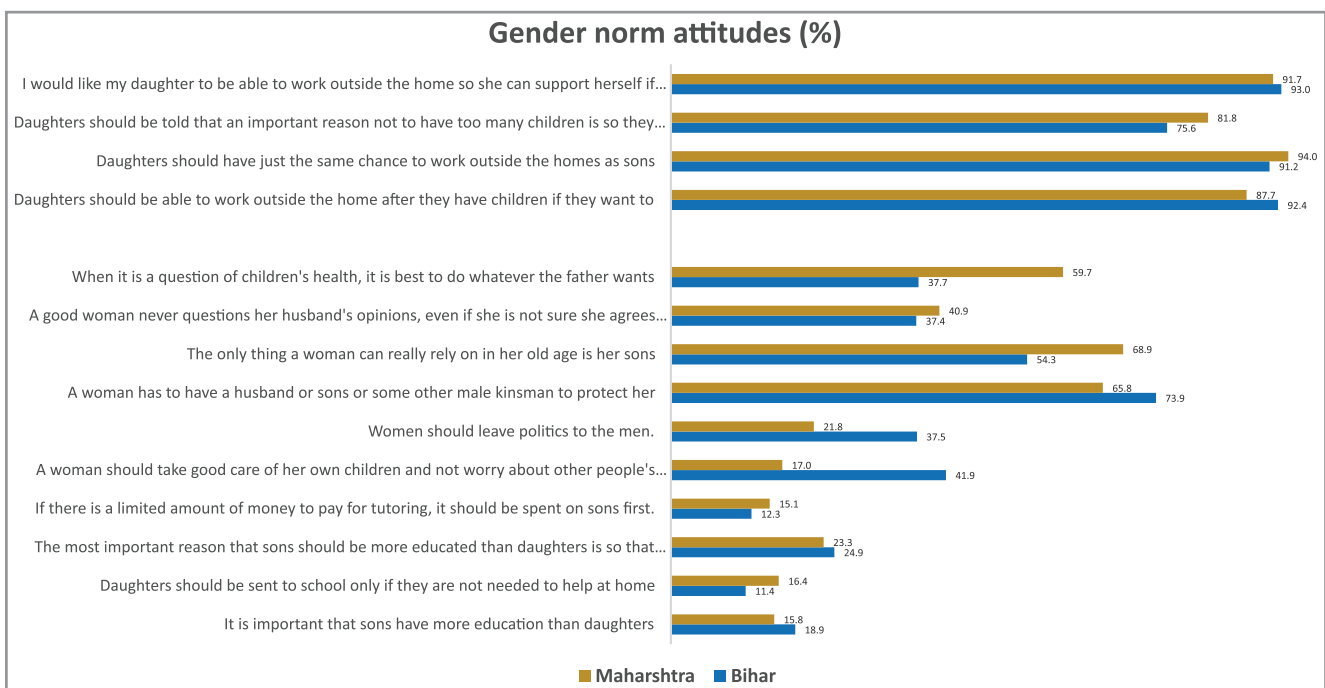
*“Though people feel that one should have at least a son, they don’t take it seriously these days. Girls have equal opportunities, and they do better in many aspects.”*

– CMW, 22 years, Nalanda, Bihar”

On the statement, “Women should leave politics to men,” 38% and 22% CMW agreed while 55% and 73% CMW disagreed in Bihar and Maharashtra respectively. The majority of CMW, 74% in Bihar and 66% in Maharashtra, believed that a woman needs to have a male (husband/ son/ kinsman) to protect her. Almost 61% of CMW (54% in Bihar and 69% in Maharashtra) agreed that an old woman can rely on sons. Around 40% of CMW agreed and 55% disagreed that a “good woman never questions

her husband’s opinion even when she is not sure if she agrees with him.” A higher proportion of CMW in Bihar (61%) than Maharashtra (31%) disagreed that in matters of children’s health, it is best to do whatever the father wants.

Equity for girls’ subscale items included four statements about the daughter’s ability to work outside home and earn income. The majority of CMW (92% in Bihar and 88% in Maharashtra) had an egalitarian attitude concerning their daughters’ ability to work outside the home. A similar attitude was observed concerning the statement, “Daughters should have just the same chance to work outside the homes as sons,” as more than 90% (92% in Bihar and 88% in Maharashtra) agreed. Nearly four-fifths of CMW (76% in Bihar and 82% in Maharashtra) expressed an egalitarian attitude for the statement, “Daughters should be told that an important reason not to have too many children is so that they can work outside the home and earn money.” A similar egalitarian attitude was observed in both states with the statement, “I would like my daughter to be able to work outside the home so she can support herself if necessary,” as greater than 90% of CMW in both States agreed.



### 8.5 Gender Equitable Men (GEM) Scale

The study attempted to understand gender roles and attitudes toward gender-based abuse among husbands of CMW. The study measured attitudes toward gender norms in intimate relationships and differing social expectations for men and women using the Gender-Equitable Men (GEM) scale, considering 23 statements representing four domains: violence (6 items), sexual relationships (8), reproductive health and disease prevention (4), and domestic chores and daily life activities (5). Responses were recorded on a three-point scale with responses: agree (1), partially agree (2), and do not agree (3). The combined were divided into low equity (1-23), moderate equity (24-47), and high equity (48-72).

Looking at the overall GEM scores, 39% of husbands had a high equitable attitude, 58% had a moderate equitable attitude, and 4% of husbands had low equitable attitudes. More than two-thirds (68%) of





“My son married three years before. After two years of marriage, my daughter-in-law had a spontaneous abortion. Doctors told her that she should avoid pregnancy for two more years due to health reasons. Many women in our community always talk about her pregnancy, and that embarrasses my daughter-in-law. Villagers don’t understand, and they simply talk negative things”.

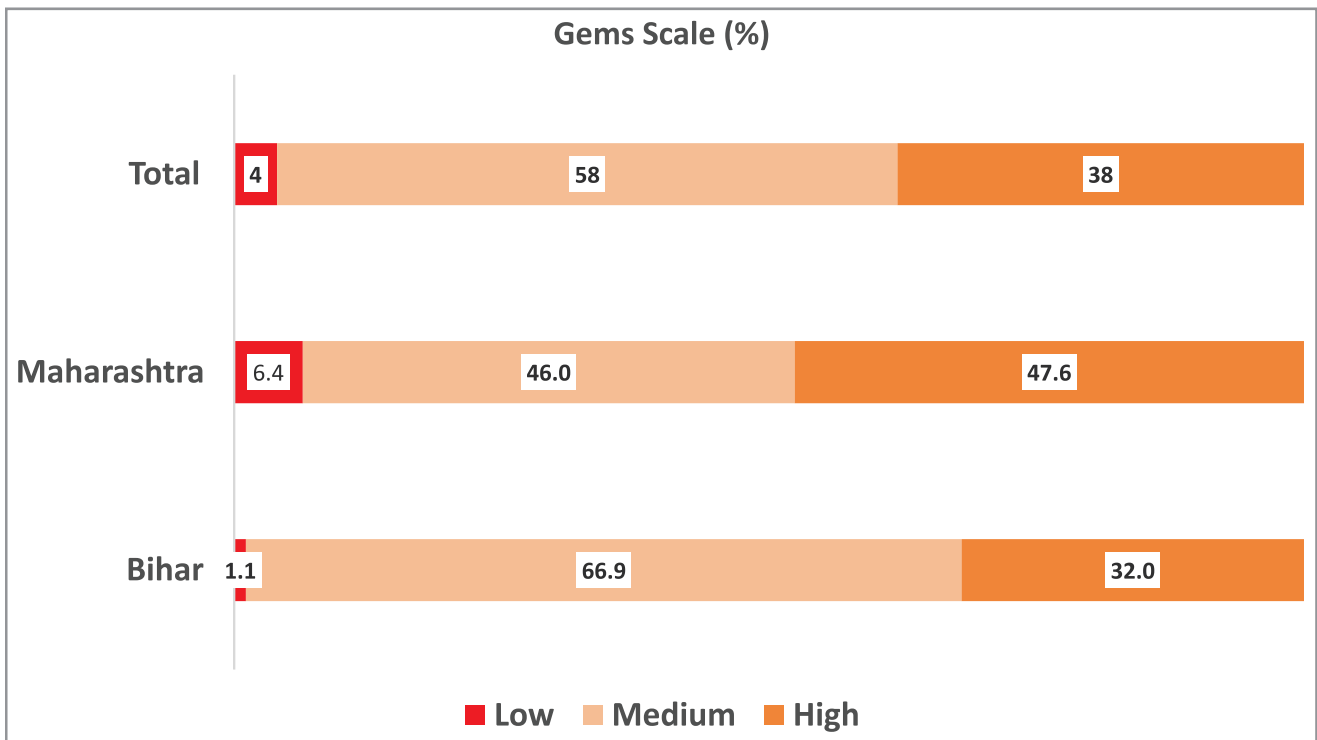
– Mother-in-law, 48 years, Bihar.



“ People in the community say bad things about them (couples who want to space children). They discuss why a couple is not having a child. They call them ‘VANZOTE’ meaning infertile and question about why the couple is not having a child... People start discussing if the couple does not get soon after marriage and question why the couple is not conceiving. Also, think of that there might be some fault in this couple.”

– Husband of CMW, Maharashtra

husbands in Bihar had low/moderate equitable attitudes, while 52% in Maharashtra had low/moderate attitudes. A higher proportion of husbands with women of parity 0 (44%) had a greater equitable attitude than those with women of parity 1 (32%). The proportion of women with low/moderate equitable attitudes were high among parity 1 (66%), ages 15 to19, and with husbands who had less than 12 years of schooling (69%). The proportion of husbands with low equitable attitudes decreased from the poorest to richest wealth quintiles. By and large, gender-equitable attitudes were seen among husbands in Maharashtra (48%), husbands of women ages 20 to24 (41%), among those who had 12 years and above of schooling (53%) and belonged to rich wealth quintiles (49%).



# 9

## Key findings of the baseline study and its implication on the YUVAA intervention

The YUVAA baseline survey was conducted in January-February 2020 in ten project districts in Bihar and Maharashtra to understand current Family Planning knowledge, attitude and practice, social and gender norms related to Family Planning, reproductive autonomy, and the use of digital media (via mobile phones). The data was collected among 929 currently married women (CMW: aged 15-24, with Parity 0 or Parity 1), 362 married men, and 315 Mother in Laws (MILs). Pathfinder designed the survey with guidance from Bill and Melinda Gates Foundation (BMGF), reviewed by BMGF's Full Access Full Choice Project and implemented by Population Council Consulting Private Limited. The baseline results were shared with consortium partners and incorporated in Program Implementation Strategies and setting-up of Result Framework and Result Tracker (RFRT) indicators.

The baselines results indicated that; knowledge of any modern family planning method is high. However, comprehensive knowledge about contraceptive methods is low. Only 16% (Bihar: 9.3% and Maharashtra: 25%) of Currently Married Women (CMW) and 23% (Bihar: 14% and Maharashtra: 33.6%) of husbands of currently married women knew about four reversible contraceptives (OCP, IUCD, Injectable, and condom) and emergency contraceptives. Based on the finding, YUVAA continued its focus on FP knowledge building among YMCs and FTPs through counseling and SBCC interventions, also aligned to the segmentation findings and recommendations to design and conduct need-based counseling depending on the segment. Further, the baseline has shown that government doctors were the most preferred source of FP information in Maharashtra, while in Bihar and doctors/Auxiliary Nurse Midwives (ANM), frontline health workers (Accredited Social Health Activist – ASHA and Anganwadi Worker - AWW) were the preferred source.

Regarding the quality of FP service provisioning, the lower value (15%) of the method information index (MII) indicated a critical gap in the overall quality of FP counseling, availability of contraceptive choices, and FP service provision from all sources of currently available service providers. The CMWs preferred government hospitals to avail IUCD in Bihar, while Maharashtra CMWs also preferred private hospitals/clinics. Husbands were more willing to receive information on injectables from government doctors in both states. This emphasized YUVAA's approach to establish YC as a credible source for quality FP counseling accordingly, a counseling flow and method-specific modules in the capacity building of the YC were included. YCs were also linked with the public health system and providers with formal letters from the district health systems to establish YCs credibility as FP counselors. A referral module was added to the YUVAA interventions to deliver quality referral services. Based on the findings, the supply side referral network of YUVAA assessed and included public sector facilities and the private sector facilities in its referral network.

Another finding that informed the intervention was regarding couple communication; more than 72% of CMWs reported that the decision to use FP was taken jointly with their spouse, and 15% decided independently. Though the discussion about birth and spacing children seems to be high in both the states among users, there is a gap discussing contraception among couples, less than 14% of the husbands and CMWs in total believed that women can initiate discussion around contraception. The data indicated

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<sup>1</sup> Method Information Index (MII): The index is computed by considering three questions: Were you informed about other methods? Were you informed about side effects of the method used? Were you told what to do if you experienced side effects?

that the couple has a limited role in making decisions concerning other household activities, especially in Bihar. Therefore, YUVAA SBCC materials, storytelling method-based job aids, and the "Hello Safal" channel programs introduced stories and characters where women initiate and lead the conversation to place women at the center and emphasize women's role in decision-making.

Another finding related to the non-users; only 17% wanted to use contraception within one year. However, a significant proportion of CMW (28%) and husbands (24%) were uncertain about their willingness to use any method during the following year, indicating that contraceptives' actual intention may be higher. The YUVAA intervention used DL-One application for listing the clients in the project area where non-users were identified, and among the non-users, the uncertain couples were prioritized for counseling.

For information on family planning, seven out of 10 CMW were willing to receive information on healthcare through mobile phones, interactive mobile games. And 88% of them were willing to share the information with their spouse. Using this information, the SBCC counseling tools and job aids were gamified, and during the counseling, individuals were promoted to play the games that would increase knowledge and awareness of the contraceptives and help make an informed decision.

Baseline observed peer pressure to dissuade use of contraception among more than half of the respondents, including CMWs, husbands. Most MILs from Bihar thought that peers influence young couples' choices on HTSP and contraceptive use. Based on this finding, the counseling job aids and communication material developed for YCs included sections on handling peer pressure. Accordingly, the training modules of YCs were iterated, and sections to handle peer pressure were added to the training.

More than 90% of CMW expressed an egalitarian attitude towards gender and agreed to "I would like my daughter to work outside the home to support herself if necessary." According to the baseline survey findings, 57% and 81% of MILs from Bihar and Maharashtra accept young married women's right to use contraception to delay or space pregnancy. Further, the majority of MILs across both states believed that the community accepts YMCs and FTPs choices to use contraceptives to delay (66%) and space (72%) pregnancies. On the other hand, almost half of the MILs believed that people would say negative things about young couples who uses a contraceptive method to delay or space pregnancy. 53% of MILs reported that the community expects a young wife to start having children soon after getting married, regardless of her age. This highlights the inner conflict of the MILs who (at least 50% of the time) might agree with or wish to support young couples' fertility plans and desire to space or delay pregnancy but fears social deviance from the accepted community norm. They continue to seek social validation through her son and DIL fertility. With this insight, YUVAA's initial understanding of MILs as a barrier was changed, and the overall approach to address the MILs' perceived norm was revised. The new approach created opportunities for MILs to learn from role model MILs in their community, thereby reducing MILs' sense of social deviance. The communication was designed to shift MILs outlook from "Log Kya Kahege" to "main apne bacchon ke bhavishya ke liye hamesha unka saath dungii"

The baseline findings have also informed the project in recalibrating the interventions specifically in addressing social and gender norms, increasing autonomy among women, and designing the interactive SBCC interventions.

# Annexure

## Annexure 1

Reproductive autonomy scale scoring		
Subscale domains	Item	Rotated factor loading*
<b>Freedom from coercion@</b> Alpha=0.861 Item means=2.68 Item variances=1.38	My husband has stopped me from using a method to prevent pregnancy when I wanted to use one.	0.816
	My husband has messed with or made it difficult to use a method to prevent pregnancy when I wanted to use one.	0.804
	My husband has made me use a method to prevent pregnancy when I did not want to use one.	0.859
	If I wanted to use a method to prevent pregnancy my husband would stop me.	0.886
	My husband has pressured me to become pregnant.	0.888
<b>Communication@</b> Alpha=0.752 Item means=1.64 Item variances=0.648	My husband would support me if I wanted to use a method to prevent pregnancy.	0.823
	It is easy to talk about sex with my husband.	0.763
	If I didn't want to have sex, I could tell my husband.	0.745
	If I was worried about being pregnant or not being pregnant, I could talk to my husband about it.	0.781
<b>Decision-making#</b> Alpha=0.812 Item means=1.70 Item variances=0.329	If I really did not want to become pregnant, I could get my husband to agree with me.	0.780
	Who has the MOST say about whether you use a method to prevent pregnancy?	0.681
	Who has the MOST say about which method you would use to prevent pregnancy?	0.671
	Who has the MOST say about when you have a baby in your life?	0.845
Full scale Estimates of internal consistency: Cronbach's Alpha Items mean Items variance	If you became pregnant but it was unplanned, who would have the MOST say about whether you would raise the child or have an abortion?	0.826
		0.791
		0.749
		2.03
		0.82
*Rotated factor loading represents how the item is weighted for each factor and the correlation between the item and the factor.		
@Response choices (score is given): strongly agree (1), agree (2), undecided (0), disagree (3), strongly disagree (4)		
#Response choices (score is given): my partner or someone else (1), me and my partner (or someone else) equally, me (3)		

**Annexure 2**  
**Key indicators of YUVAA**

Indicators		Total		State		Parity		Age group (in years)		Residence		No. of Respondents		
		Bihar	Maha	Bihar	Maha	Zero	One	15-19	20-24	Rural	Urban	Bihar	Maha	Total
% of currently married P0 & P1 women (15-24 years) who reported intention to use modern contraceptive method	In future	59.7	56.8	61.6	56.8	57.2	63.0	61.3	58.8	62.5	55.6	488	295	783
	in 12 months	16.5	12.8	19.3	12.8	11.9	22.5	16.9	16.3	18.8	12.9	488	295	783
% Husband of currently married P0 & P1 women (15-24 years) who reported intention to use modern contraceptive method	In future	59.3	66.0	56.2	66.0	59.5	59.0	57.8	60.6	61.4	56.7	152	143	295
	in 12 months	32.9	40.4	27.6	40.4	33.5	32.0	32.2	32.8	36.0	27.5	152	143	295
% of YMCs (15-24, P0 & P1) using a modern contraceptive method	mCPR	12.5	21.7	5.1	21.7	5.0	20.1	6.9	15.7	11.3	14.3	546	383	929
	Oral pills	2.2	4.4	0.2	4.4	1.3	3.0	1.2	2.5	2.0	2.4	546	383	929
% of women using each modern contraceptive method	Condom	6.5	10.2	3.5	10.2	3.4	9.5	4.8	7.3	5.9	7.3	546	383	929
	IUD	2.6	4.4	1.1	4.4	0.4	4.7	0.9	3.5	3.0	1.9	546	383	929
% of YMCs (15-24, P0 & P1) continuing a modern method for 12 months, by method	Injectables	0.8	1.0	0.2	1.0	0.0	1.5	0.0	1.2	0.2	1.4	546	383	929
	Any modern method	38.1	36.1	42.9	36.1	54.2	34.0	16.7	43.0	28.6	49.1	31	84	115
% of women (15-24, P0 & P1) who are currently using modern FP methods, reported source of FP planning methods buy methods	Oral pills	33.3	29.4	*	29.4	80.0	15.4	0.0	43.8	20.0	44.4	2	16	18
	Condom	37.9	38.5	36.8	38.5	40.0	37.2	25.0	44.2	33.3	46.2	21	42	63
% of currently married women (15-24 year, P0 & P1) & their Husband who obtained the FP method she/ he wanted, by method	IUD	37.5	29.4	*	29.4	*	31.8	*	42.9	23.5	66.7	5	20	25
	Injectables	*	*	*	*	*	*	*	*	*	*	3	2	5
% of currently married women (15-24 year, P0 & P1) & their Husband who obtained the FP method she/ he wanted, by method	Government health facility	42.7	47.6	21.4	47.6	17.4	48.9	39.1	41.9	47.6	34.0	9	42	51
	Private health facility	17.9	17.9	21.4	17.9	26.1	16.0	8.7	21.5	9.5	28.3	4	10	14
% of currently married women (15-24 year, P0 & P1) & their Husband who obtained the FP method she/ he wanted, by method	Medical shop/pharmacy	31.6	33.3	21.4	33.3	30.4	31.9	34.8	30.1	36.5	26.4	10	31	41
	Other (Spouse)	7.7	*	35.7	*	26.1	3.2	17.4	6.5	6.3	11.3	8	1	9
% of currently married women (15-24 year, P0 & P1) & their Husband who obtained the FP method she/ he wanted, by method	CMW (any method user)	87.2	88.5	86.4	88.5	85.5	88.4	77.8	89.3	84.0	91.2	58	88	146
	CMW (modern method user)	85.3	88.0	77.8	88.0	82.6	86.0	82.6	86.0	82.5	88.7	31	84	115
% of currently married women (15-24 year, P0 & P1) & their Husband who obtained the FP method she/ he wanted, by method	Husband (any method user)	88.1	89.2	87.0	89.2	90.9	84.8	87.5	88.4	83.3	96.0	23	44	67
	Husband (modern method user)	90.0	87.2	*	87.2	89.5	90.2	90.9	89.5	86.8	95.7	17	43	60
% of currently married P0 & P1 women (15-24 years) who report being satisfied with their current method (by method)	Any method (%)	58.4	62.8	49.2	62.8	50.9	62.8	63.0	57.4	61.7	54.4	58	88	146
	IUCD (%)	33.3	*	*	*	*	*	*	*	*	*	5	20	25
% of currently married P0 & P1 women (15-24 years) who report being satisfied with their current method (by method)	Injectables (n)	2	*	*	*	*	*	*	*	*	*	3	2	5

## List of key indicators of YUVAA

Indicators	Total	State		Parity		Age group (in years)		Residence		No. of Respondents		
		Bihar	Maha	Zero	One	15-19	20-24	Rural	Urban	Bihar	Maha	Total
Oral pills (%)	94.1	*	*	*	*	*	*	*	*	2	16	18
Condom (%)	72.9	73.7	71.8	66.7	75.0	50.0	83.7	75.8	70.4	21	42	63
Other method (%)	42.1	*	*	*	*	*	*	*	*	27	7	34
% of currently married P0 & P1 women (15-24 years) & their husbands who report being un-satisfied with their current method (by method) with reasons	41.6	50.8	37.2	49.1	37.2	37.0	42.6	38.3	45.6	58	88	146
Husband	10.4	9.1	10.6	9.5	10.9	8.0	11.9	11.9	7.7	23	44	67
% of currently married P0 and P1 women (15-24 years) currently using a modern method who would recommend their current method to a friend or family member, by method (by age/marital status/parity)	69.8	81.4	62.8	59.3	72.1	55.9	73.9	66.7	72.1	58	88	146
Husband	88.1	87.0	89.2	90.5	87.0	92.0	85.7	92.9	80.8	23	44	67
% of currently married P0 & P1 women (15-24 years) and their husbands are counseled by different channels [Health workers]	48.3	22.0	62.8	40.7	50.0	20.6	56.5	48.1	48.5	58	88	146
Husband	48.5	40.9	53.2	56.0	44.2	42.9	57.7	40.9	53.2	23	44	67
% of currently married P0 & P1 women (15-24 years) & their husbands, who are using modern reversible method reported whether the provider informed them about side effect	30.7	16.9	37.9	29.6	30.9	20.0	33.9	32.1	27.9	58	88	146
Husband	46.3	34.8	53.2	40.9	48.9	56.0	39.5	43.9	50.0	23	44	67
% of currently married P0 & P1 women (15-24 years) & their husbands, who are using modern reversible method reported whether the provider informed them what to do about side effect	67.4	70.0	66.7	50.0	71.1	66.7	68.4	57.7	80.0	15	34	49
Husband	87.5	62.5	100.0	88.9	87.0	78.6	100.0	83.3	100.0	6	24	30
% of currently married P0 & P1 women (15-24 years) & their husbands, who are using modern reversible method reported whether the provider informed them about other method	35.3	28.6	38.6	30.4	36.6	43.5	33.7	31.7	40.7	31	83	114
Husband	60.3	50.0	68.1	68.2	56.5	60.0	60.5	51.2	76.0	23	44	67
% of young married P0 & P1 women ages 15-24, who are using FP, that reported making decisions about contraception alone or jointly with their husband	14.8	13.5	15.1	22.3	12.3	8.8	16.5	13.6	15.9	58	88	146
Husband	87.3	85.2	87.7	79.4	89.6	84.0	91.3	79.7	93.0	58	88	146
% of married men (husbands of P0 and P1 women in 15-24 age group) that reported making decisions about contraception jointly with their wife	82.1	78.3	84.8	81.8	80.0	70.8	88.4	92.3	75.6	23	44	67
% currently married P0 & P1 women (15-24 years) who report they have discussed contraceptive use with their husband	98.0	100.0	96.6	100.0	97.5	97.1	97.4	95.6	98.8	58	88	146
% currently married men (husbands of P0 and P1 women in 15-24 age group) report they have	98.5	100.0	97.8	100.0	97.8	100.0	97.6	100.0	96.0	23	44	67

## List of key indicators of YUVAA

Indicators	Total	State		Parity		Age group (in years)		Residence		No. of Respondents		
		Bihar	Maha	Zero	One	15-19	20-24	Rural	Urban	Bihar	Maha	Total
discussed contraceptive use with partner												
% of currently married P0 & P1 women (15-24 years) who believe that a woman can/should initiate discussion on contraception with her husband	12.6	11.9	13.3	10.8	14.4	10.1	14.0	14.7	9.5	488	295	783
% of married men (husbands of P0 & P1 women, age 15-24) who believe that women can initiate a discussion on use of family planning	13.0	13.1	11.8	13.8	12.0	17.0	10.4	10.6	16.4	175	187	362
% of currently married P0 & P1 women (15-24 years) & their husbands who have heard of any contraceptive method	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	546	383	929
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	175	187	362
Aware of all 5 modern spacing methods*	16.0	9.3	25.0	12.9	19.1	13.4	17.6	16.1	15.9	546	383	929
OCP(1)	10.1	9.3	12.2	9.5	11.0	7.1	11.8	9.1	11.6	546	383	929
IUCD(2)	6.7	5.4	8.2	6.3	7.1	2.7	8.9	6.6	6.8	546	383	929
Injectables(3)	6.8	8.2	5.1	4.9	8.8	6.3	7.1	6.3	7.8	546	383	929
condom(4)	23.4	19.7	27.9	19.0	27.8	17.5	26.8	21.6	25.9	546	383	929
ECP(5)	8.8	5.7	13.1	8.0	9.7	6.0	10.5	7.0	11.6	546	383	929
Aware of all 5 modern spacing methods*	22.8	14.0	33.6	24.1	21.1	13.6	28.8	19.8	27.6	175	187	362
OCP(1)	13.8	12.6	15.5	14.9	12.7	7.9	17.5	8.3	21.9	175	187	362
IUCD(2)	6.8	5.4	8.4	4.6	9.0	3.6	8.6	4.6	9.7	175	187	362
Injectables(3)	7.7	3.2	13.0	6.2	9.6	6.5	8.5	6.9	8.9	175	187	362
condom(4)	35.9	26.9	47.8	34.4	37.7	32.9	37.8	35.2	37.0	175	187	362
ECP(5)	10.3	2.1	19.9	9.2	11.4	4.3	13.9	7.4	14.5	175	187	362
*OCP, IUCD, Injectables, Condoms and ECP (Response was given spontaneously or after probing)												
**(1) Heard OCP, know when to start taking OCP, know the interval of taking a pill, know what to do if missed the pill for one day or two days, know the source of getting pills, and aware of side effects of pills.												
(2) Heard IUCD, know the duration to protect from pregnancy, know the source of getting IUCD, know who can insert the IUCD, and aware of side effects of IUCD.												
(3) Heard Injectables, know the duration to protect from pregnancy, know the source of getting injectables, and aware of the side effects of injectables.												
(4) Heard condoms, know that using condom is safe, know the source of getting condoms, and know that condom does not reduce sexual pleasure.												
(5) Heard ECP, know that how ECP work, know when to use method and how many ECP tablet required in one dose, know the medical conditions that make ECP unsafe to use, know the source of getting ECP, and aware of side effect of ECP.												
% of currently married P0 & P1 women (15-24 years) & their husbands who respond having heard of any contraceptive method from different channels (YC/GV/ SMS/ WhatsApp/ OBD)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	546	383	929

## List of key indicators of YUVAA

Indicators	Total	State		Parity		Age group (in years)		Residence		No. of Respondents		
		Bihar	Maha	Zero	One	15-19	20-24	Rural	Urban	Bihar	Maha	Total
% of currently married P0 women (15-24 years) & their husbands believe people in her/his community think that it is acceptable for YMCs to use a modern contraceptive method to delay pregnancies after marriage	58.8	47.2	73.3	58.8		54.7	62.3	59.5	57.9	281	171	452
	66.7	55.1	83.3	66.7		59.3	73.8	60.9	75.0	97	90	187
% of currently married P1 women (15-24 years) & their husbands believe people in her/his community think that it is acceptable for FTPs to use a modern contraceptive method to space pregnancies	69.0	62.2	76.8		69.0	59.3	72.9	64.8	75.7	265	212	477
	70.1	69.7	71.4		70.1	66.7	71.4	68.3	72.3	78	97	175
% of currently married P0 women (15-24 years) & their husbands believe people in her/his community expect a young wife to start having children very soon after getting married, regardless of her age	49.1	46.0	52.8	49.1		55.2	43.9	45.8	54.0	281	171	452
	59.0	53.5	65.6	59.0		62.6	55.2	50.0	71.6	97	90	187
% of currently married P0 women (15-24 years) & their husbands agree that if they were to use a family planning method to delay pregnancies, they believe people in their community would say negative things about them	51.2	45.3	58.1	51.2		51.2	51.4	55.1	45.3	281	171	452
	53.3	51.0	53.1	53.3		53.3	53.4	42.6	68.8	97	90	187
% of currently married P1 women (15-24 years) & their husbands agree that if they were to use a family planning method to space pregnancies, they believe people in their community would say negative things about them	40.5	29.7	52.7		40.5	46.8	38.1	38.6	43.3	265	212	477
	53.3	50.6	54.9		53.3	56.3	52.1	50.0	57.6	78	97	175
% of currently married P0 & P1 women (15-24 years) who believe that their peers' choices influenced their own	47.3	52.6	40.1	47.6	47.0	47.0	47.4	49.6	43.8	546	383	929
	53.0	52.7	53.5	52.6	53.4	50.6	54.4	54.7	50.4	546	383	929
	49.5	52.4	45.7	50.4	48.5	46.7	50.9	50.1	48.4	546	383	929
	49.6	49.1	47.9	46.7	53.0	52.5	47.7	47.0	53.1	175	187	362
% of MILs/ SILs (of currently married P0& P1 women, 15-24 years) who have listened to a program on Gram Vaani	51.4	41.7	61.0	47.9	55.4	52.5	50.5	46.3	58.6	175	187	362
	46.3	41.7	49.7	46.9	45.5	50.7	43.2	40.6	54.5	175	187	362
% of currently married P0 & P1 women (15-24 years) who believe that their peers' choices influenced their own	5.9	5.9		6.1	5.7	9.0	3.9	6.8	3.4	203		203
% of currently married P0 & P1 women (15-24 years) & their husbands and MILs agree that onus of bearing a girl child is not borne by a woman	48.0	34.7	63.5	45.9	50.0	42.9	50.9	44.0	53.9	546	383	929
	55.6	50.3	61.5	54.9	56.5	49.3	59.5	52.3	60.7	175	187	362
% of currently married P0 & P1 women (15-24 years)	46.2	30.0	66.1	37.9	54.0	40.7	50.3	40.7	55.1	203	112	315
	66.8	48.6	88.5	64.9	68.8	68.0	66.1	64.8	69.8	546	383	929



## List of key indicators of YUVAA

Indicators	Total		State		Parity		Age group (in years)		Residence		No. of Respondents		
	Bihar	Maha	Bihar	Maha	Zero	One	15-19	20-24	Rural	Urban	Bihar	Maha	Total
& their husbands and MILs agree that the health of a child is more important than the gender of child	56.9	62.6	52.6	62.6	56.4	57.5	51.1	60.5	48.8	69.2	175	187	362
% of MILs/ KOL (of currently married P0& P1 women, 15-24 years) that agree it is the young married woman's right to use contraception to delay or space births	68.4	92.0	49.3	92.0	64.5	72.0	63.6	71.2	61.4	78.7	203	112	315
% of MILs (of currently married P0& P1 women, 15-24 years) // KOL that believe a young wife should start having children very soon after getting married, regardless of her age	67.6	81.3	57.1	81.3	57.8	76.8	63.3	70.2	67.0	69.3	203	112	315
% of MILs (of currently married P0& P1 women, 15-24 years)/KOL that agree it is acceptable for a woman to decide when to stop having children	31.6	39.3	26.0	39.3	25.5	37.4	28.0	34.0	33.5	29.1	203	112	315
<b>Additional indicators: FP2020</b>	70.6	81.3	62.7	81.3	61.4	79.1	60.5	76.3	68.1	74.8	203	112	315
Number of unintended pregnancies	33.4	28.0	35.3	28.0	32.7	35.2	41.6	28.4	39.7	24.8	139	59	198
Method information index	15.4	20.5	5.9	20.5	14.7	15.5	12.5	16.2	12.1	19.3	58	88	146
% of women who were provided information on FP during their last contact with a health service provider	14.5	23.8	7.1	23.8	13.1	15.9	17.3	13.0	16.3	11.9	546	383	929
% of young married P0 & P1 women ages 15-24, who are using FP, that reported making decisions about contraception alone or jointly with their husband	14.8	15.1	13.5	15.1	22.3	12.3	8.8	16.5	13.6	15.9	58	88	146
	87.3	87.7	85.2	87.7	79.4	89.6	84.0	91.3	79.7	93.0	58	88	146

Maha: Maharashtra

## **Disclaimer**

This study was undertaken as a part of Pathfinder's YUVAA program supported by the Bill and Melinda Gates Foundation.

## **Acknowledgements:**

We would like to acknowledge support received from all respondents and Government frontline workers in the survey districts along with field staffs of Population Council and Pathfinder state teams. A special thanks to Akshay Gupta, Neha Kashyap, Arnab Mondal, Vishal Tikhute, Dweepesh Ghosh, and K Laxmi Rao for their support to complete this report.

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Suggested Citation: Pathfinder International (2021). *YUVAA Baseline Survey 2020*

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