Are Young Women in India Prepared to Deal with Sexual and Reproductive Health Issues?

A Case Study of Jharkhand, India

August 2012

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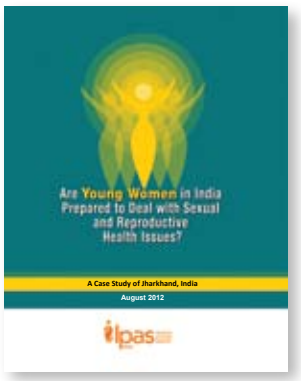

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Executive Summary

There are 114 million young women aged 15 to 24 years in India, comprising 20% of the female population. This magnitude does not only imply the future strength of India in terms of social and economic development; rather this young cohort will lead demographic stabilization and quality of life in future. Although, today's youth are relatively better educated and exposed to modern technologies of social communications, social vulnerabilities persist with marked influence of gender norms, early interruption of school education, early marriage and teenage pregnancy. Despite a strong policy on the minimum legal age at marriage, a sizeable proportion of Indian women get married before 18 years and almost one-fifth of women in the age group of 15-19 years start child-bearing. For many youth, sexual and reproductive health-related experiences are uninformed and unsafe primarily because of lack of awareness and skills in negotiating safe sex and discussing reproductive health matters with their partners and parents.

With social pressure of proving fertility, almost one-third of young women in India give birth before they turn 18 and 53% by 20 years. Almost one-fifth of these pregnancies that resulted in live births are unplanned. A portion of these unintended pregnancies also results in termination of pregnancy. With lack of awareness, young women often approach unskilled and illegal providers, seek out abortion care later in the pregnancy, face postabortion complications and are more likely to delay seeking help for abortion-related complications than adults. According to WHO estimates, adolescent girls (10-19 years) in developing countries undergo 2.2 to 4 million unsafe abortions every year and globally account for 70% of all hospitalizations from unsafe abortion. These often lead to mortality and prolonged morbidity. As estimated by WHO young women account for approximately 46% of unsafe abortion-related deaths every year.

One way to address the gap between awareness of sexual and reproductive health (SRH) issues and service availability and utilization is through youth-focused interventions. Several national policies and programs have committed to act on young women's SRH-related issues in India. However, available evidence on implementation of such program is limited in India. Realizing these gaps, it is decided to pilot a youth-focused intervention to specifically address the information and service delivery needs of young women on various SRH issues including legal and safe abortion. With support from the state government of Jharkhand, this youth intervention is implemented in selected rural blocks of Deogarh and Giridih districts.

To design effective interventions, it is imperative to understand what enabling resources are in place

from the perspective of young women (married and unmarried age 15-24 years). This includes an understanding of the characteristics of young women who use or seek access to existing information and services, their needs, and an understanding of the dynamics of their health-seeking behavior and decision-making processes related to SRH issues, including abortion. Therefore, this study aims to develop an evidence base for understanding the accessibility of SRH and safe abortion services in selected rural blocks of Jharkhand, from the perspective of rural young women. The outcome of this study is restricted to pre-intervention baseline data that was collected as part of a larger effort to develop the intervention strategy and evaluate its impact.

Profile of young women

A total of 1,381 young women (690 married and 691 unmarried) were interviewed. Demographic profile suggests substantial age gap between the married and unmarried young women. On average unmarried young women were three-and-a-half years younger than their married counterparts. This clearly reflects uniform pattern of early marriage. The mean age at marriage of 15.7 years was much lower than the legal minimum age at marriage in India (18 years). One-third of married young women had never attended school and one-fifth had left school with primary education. In contrast to this finding, 67% unmarried young women were continuing their education.

An overwhelming majority (85%) was disadvantaged members of the Scheduled Tribes, Scheduled Castes or Other Backward Classes, and 86% belonged to households with low to moderate living standards. Many reported that they did not work for cash or kind and did not have independent access to income. Even those who were engaged in wage-earning activities were working largely as unskilled agricultural or non-agricultural laborers.

Media exposure

Findings suggest that young women were exposed to various channels of mass media, including television, radio, and newspapers. However, exposures were irregular (2-3 days in a week) for almost all channels of communication. Rural young women were not at all exposed to internet, emails, and social networks. Even with limited access to mass and print media, young women received some information on SRH-related issues through informal sources that were often not trained on the subject, including family members (75%), friends and neighbors (75%), and community-level sources, including ASHAs and Anganwadi Workers (22%).

Young women's agency

This study also highlights the limited agency of rural young women in their daily lives. Irrespective of marital status, young rural young women almost had no involvement in decision-making on their own health care and choosing a health care provider; 92% married and 99% unmarried women had no say on their own health care, while more than 95% young women reported having no ability to choose any particular health care provider for their own health problems. Further, spousal control over their wife's mobility inside the village and decision-making appears to be stricter than parental control over their unmarried daughter's mobility and decision-making.

Agency measured through freedom of mobility and access to money was no way different from poor decision-making. More than 95% of young women were not allowed to go outside their village alone for visiting friends or doctor, or attending social functions. Only six percent young women reported owning a bank account, five percent independently, and one percent jointly with someone else.

Young women's agency measured by their sense of self-worth or self-efficacy also showed limited ability of young women to negotiate with elders, peers, and health care providers to share their opinion, and discuss reproductive health matters. They also demonstrated lack of ability to negotiate sex with their husband. Almost three-fourths of women found it difficult to express their opinion to elders, while almost 80% young women shared their inability to talk to a health care provider on SRH issues. The overall agency scores were substantially low for access to money and decision-making. Age, education, high living standard, exposure to mass media, and two or more living children (for married young women) had significant associations with young women's agency.

Awareness of SRH issues

Findings underscore young women's limited knowledge on menstruation, sex, pregnancy, contraception, and abortion. A majority of rural young women were unaware of the association between frequency of intercourse and the likelihood of pregnancy; over 80% of young women felt that one cannot get pregnant at first sexual encounter, but only with repeated sexual acts. Even married young women were not sure about the 'safe period' where women are less likely to get pregnant. A similar pattern of misconceptions abound on the legal aspects of abortion and contraceptive methods, more so IUCD and emergency contraceptive. Though the MTP Act has existed for more than four decades in India, more than 95% of the young women were unaware that abortion is legal in India, and none of them were aware of the specific gestation up to which abortion is legally allowed in India. Age, education, and marital status were significantly associated with correct awareness, while caste, religion, work status, and family composition had no influence on knowledge of sex and pregnancy and contraception.

Reproductive histories and utilization of SRH

Reproductive histories of rural young women reflect the continuing trends of early pregnancy and high fertility. More than one-third of young married women reported two or more surviving children at the age of 15-24 years. One-fifth of young women had experienced at least one pregnancy loss. Almost one-tenth of rural young women reported completion of desired family size and acceptance of female sterilization as contraception. Even after six decades of official family planning in India young married women had limited preference for any modern spacing methods, including condoms, oral contraceptive pills, and IUCDs.

Gaps in knowledge and poor agency also serve as potential barriers to utilization of SRH and safe abortion services. A majority of young women who reported experiencing abortion had approached a provider who is either not legally allowed to offer abortion or who is posted at a facility that is not approved for abortion care by the government.

Recommendations for pilot implementation

Findings presented in this study portray the fact that rural young women are not well prepared to deal with SRH issues. With lack of awareness, limited exposure to media, and restricted agency, young women face complex challenges in dealing with SRH issues including decision-making, reproductive choices, and utilization of safe health care services.

Thus, an effective approach may be to reach young women in community settings. Important secondary audiences such as outreach workers, peers, and neighbors can be influential intermediaries in reaching young women. Since these individuals typically

provide information on general health, contraception, and SRH issues in their communities, it is intuitive that they are the most frequently cited sources of information for sensitive issues such as family planning and abortion. Use of peers and outreach workers as social influencers may also help address the challenges of reaching a low literacy rural youth population.

Though the finding that a young woman in a joint family is associated with low levels of awareness of SRH issues may seem counterintuitive (as family members and friends are reported as the main source of information), it is likely a reflection of the other family members and friends not being aware of SRH issues. The finding that young women who have any exposure to SRH issues are more likely to have significantly better knowledge of sex and pregnancy, contraception, and abortion, highlights a promising opportunity for this youth-focused communication intervention to improve knowledge. The outcome of this study also suggests that family life or sex education is essential among married and unmarried youth and for both those in school and those who have discontinued their education.

This assessment of young women's awareness of SRH matters and current practices of utilizing health care services for reproductive health issues including abortion and postabortion complications suggests a need for a comprehensive, youth-focused behavior change communication. In addition, interventions intended to address the SRH needs of youth populations must consider the need of highlighting the access to youth-friendly health facilities. This approach will not only raise their awareness but also enable them to translate information into practice through improved agency, including self-efficacy, decision-making, and negotiation skills. At the same time, it is important to build formal or informal peer-networks of young women to ensure social support within the same community. Our findings should be viewed within the context of the study's limitations.

1 Introduction

1.1 Background

There are 114 million young women aged 15-24 years in India, comprising 20 percent of the female population. This magnitude does not only imply the future strength of India in terms of social and economic development; rather this young cohort will lead demographic stabilization and quality of life in future. It is also clearly evident that the success of the Millennium Development Goals will largely rely on the status of young people (UNDP 2000). Although, today's youth are relatively better educated and exposed to modern technologies of social communications than youth of the past, social vulnerabilities persist with marked influence of gender norms, early interruption of school education, early marriage, and pregnancy.

Despite a strong policy on the minimum legal age at marriage, a sizeable proportion of Indian women get married before age 18 years and around 17 percent of women in the age group of 15-19 years have begun child-bearing (IIPS & Population Council 2010). Pre-marital and unprotected sexual exposures among young people are also not uncommon (NIMS & NACO 2008; IIPS & Population Council 2010). A recent study on 'Youth in India' in six states found that 12 percent of young men and three percent of young women reported pre-marital sexual relations. Although there were no significant variations in reported prevalence of pre-marital sex amongst married and unmarried cohorts, the variations were significant among rural and urban youth; rural youth were more likely to report having experienced pre-marital sex compared to their urban counterparts. For many youths, sexual and reproductive experiences were uninformed, unsafe, and for some, unwanted, primarily because of lack of awareness and skills in negotiating safe sex and discussing reproductive health matters with their parents and partners.

The scenario however, is not very different for married young women. The median age at first sexual exposure is 17.8 years, and even lower among women with no education and from the poorest economic strata (16.4 years). With lack of correct information on contraception and social pressure of proving fertility, 30 percent of women in India give birth before 18 years and 53 percent by age 20 (IIPS & Macro 2007). Almost one-fifth of these pregnancies that result in live births are unplanned (IIPS & Macro 2007). A portion of these unintended pregnancies also result in termination of pregnancy (induced abortion). While evidence of unintended pregnancies and abortion among youth is limited in India, there are a few community-based studies which infer almost 41 percent of all abortions occurred to young women (Banerjee et al. 2013).

Evidence also suggests that young women, and more specifically young unmarried women, often face

social, economic, logistical, policy and health system barriers in accessing sexual and reproductive health (SRH) services, including safe abortion. Pregnancy and motherhood outside of marriage are stigmatized in many societies, which may cause unmarried pregnant women to seek abortion. As a result, young women often approach unskilled and illegal providers and face postabortion complications (Banerjee et al. 2009), seek out abortion care later in the pregnancy (Finer et al. 2006; Aras, Pai, and Jain 1987), and are more likely to delay seeking help for abortion-related complications than adults (WHO et al. 2006). Adolescent girls (10-19 years) in developing countries undergo 2.2 to 4 million unsafe abortions every year (WHO 2004) and globally account for 70 percent of all hospitalizations from unsafe abortion (Plan 2007). These often lead to mortality and prolonged morbidity due to unsafe abortions. As estimated by WHO (2004), young women account for approximately 46 percent of unsafe abortion-related deaths every year.

In India, there is no statistical evidence on cause-specific maternal mortality by age, but it is evident from the recent SRS release (RGI 2011) that young women (15-24 years) account for 45 percent of total maternal deaths in India. In addition, unsafe abortion alone accounts for 8-10 percent of maternal deaths in all women. This may be even higher among young women.

Most of these complications and deaths can easily be prevented with improved sexual and reproductive health (SRH) information and care, including safe abortion. Unfortunately, even with developments in every sector, young women are not uniformly aware of sexuality, pregnancy, contraception, and abortion-related issues. Communication campaigns intended to address reproductive health issues either fail to include issues around unsafe abortion (Banerjee et al. 2010) or miss the opportunity to target young women. A recent post-campaign evaluation in Bihar and Jharkhand revealed that youth are apprehensive and unlikely to discuss sensitive SRH issues including abortion with older counterparts who are perceived to have, and often demonstrate, stigmatizing attitudes about youth sexuality (Banerjee et al. 2012).

Studies have also shown poor agency among youth (Jejeebhoy et al. 2010) which often influences young people's sexual and reproductive lives in terms of enabling them to exercise their choice and say in the timing of marriage and choice of partner, to make health-related decisions, to access health services, and to exercise informed choices about whether and when to engage in sexual relations and contraception (Jejeebhoy and Halli 2005).

One way to address the gap between awareness of SRH issues and service availability and utilization is through youth-focused interventions. The rationale behind youth-focused interventions is to promote awareness and healthy behaviors; by creating a supportive environment, young women will be able to act on these health-promoting behaviors. Another aim of such interventions is to increase self-efficacy to engage in these health-promoting behaviors (Strecher et.al 1986). Though behavior change communication (BCC) interventions have successfully been used in India to increase knowledge of contraceptive use, immunization, HIV/AIDS, and safe abortion among women of reproductive age (Sood et al. 2006; Daniel et al. 2008; Banerjee et al. 2012a), they have not commonly been used to address awareness among young women on SRH issues.

Hence, realizing these gaps, it was decided to pilot a youth-focused intervention to specifically address the information and service delivery needs of young women on various SRH issues including legal and safe abortion. With support from the state government of Jharkhand, this youth intervention will be implemented in selected rural blocks of Deogarh and Giridih districts.

To design effective interventions, it is imperative to understand what enabling resources are in place from the perspective of young women (15-24 years). This includes an understanding of the characteristics of young women who use or seek access to existing information and services, their needs, and an understanding of the dynamics of their health seeking behavior and decision-making processes related to sexual and reproductive health and abortion. The purpose of this study is to develop an evidence base for understanding the accessibility of SRH and safe abortion services in selected rural blocks of Jharkhand from the perspective of rural young women.

1.2 Rationale for the study

In India there is a need for focusing sexual and reproductive health of youth to ensure that they have access to SRH information and care in their communities that are effective and appropriate for them (Ipas 2011). Recognizing this importance, several national policies and programs, including the National Youth Policy 2003 (MOYAS 2003), National Population Policy 2000 (MoHFW), and Adolescent Reproductive Health Strategy (MoHFW 2006) have emphasized specific strategies and direction to address the needs of youth in India. However, implementation of these policies and strategies has not yet gained any momentum in India primarily due to lack of evidence on the needs of youth and effective strategies to address those needs (IIPS & Population Council 2010).

Evidence from other countries shows that improved awareness, information, self-efficacy, and care can empower youth to move towards positive behavior change. Young people are the main experts of their own lives (Ipas 2011). In India, however, we do not yet understand the needs of young people regarding SRH issues, including preferred types and sources of information or messages as well as barriers to accessing available health services. This intervention in Jharkhand aims to address those issues and gather evidences through research and implementation in such a way as to be replicated and scaled-up by government and other implementing partners.

1.3 Key research questions

With this backdrop this study aimed to address the following research questions:

1. What are the socio-demographic, economic, and reproductive characteristics of young women in selected blocks of Jharkhand?
2. To what extent are young women in Jharkhand exposed to mass media and other sources of information? What sources of information do they typically rely on for different types of issues?
3. What SRH-related knowledge, perceptions, and practices characterize these young women? And which socio-economic and demographic attributes influence their knowledge of SRH-related issues?
4. What are the levels of agency among young women in terms of freedom of mobility, decision-making, sense of self-worth, and access to money?

1.4 Scope of the pilot intervention

The BCC intervention aims to facilitate young women's involvement in SRH,including safe abortion, by empowering knowledge, attitude, and skills required to negotiate barriers at community and provider levels. Based on the findings of this pre-intervention baseline study and earlier experience of implementing similar intervention with generic population (women 15-49 years) in Jharkhand (Banerjee et al. 2012a), BCC strategies will be developed as guiding framework for this intervention. Selected youth leaders from the same community will take direct lead in developing strategies and identifying information need and information channels to increase young women's

access to SRH including comprehensive abortion care services. Specific activities that are envisaged for this youth-focused intervention include:

- Communication activities led by youth leaders using multiple channels to improve awareness, knowledge, and negotiating skills among young women on SRH issues including legality and availability of abortion services.
- Improving knowledge, skills, and sensitivity of local providers (doctors) and health intermediaries (both government and private) for provision of reproductive health services for young women, including legal and safe abortion.
- Improving access to SRH services to young women at nearest public and private locations.
- Pre- and post-intervention evaluations to assess impact of the intervention and documentation of best practices to facilitate scale-up process.

The subsequent implementation will be planned for two rural blocks—Deogarh (of Deogarh district) and Bagodar (of Giridih district) of Jharkhand consisting of around 432,000 population.

1.5 Structure of the report

The report has seven main sections. Chapter 2 describes the study design while Chapter 3 exhibits socio-demographic and economic profile of young women, their media habits, and exposure and access to SRH information. Chapter 4 examines young women's agency in terms of decision-making, self-efficacy, freedom of movement, and control over financial assets and factors influencing young women's agency. Chapter 5 explores awareness and knowledge of SRH issues including sex, pregnancy, contraception, and safe abortion and examines the influencing factors. Chapter 6 documents the reproductive history of married young women and their experience of receiving abortion and postabortion services. Chapter 7 summarizes the key findings of this study and recommends future direction to guide this pilot intervention in Jharkhand and replication in other states.

2

Study Design

2.1 Methods and data collection

This study presents the pre-intervention baseline data that were collected as part of a larger effort to develop intervention strategy and evaluate its impact of youth-focused communication intervention that will educate rural young women about SRH issues including safe abortion. To support this larger evaluation effort, we employed a rigorous pre-post quasi-experimental research design, two blocks (Deogarh and Bagodar) were selected for intervention and one for comparison (Madhupur) based on similar socio-demographic characteristics at the population level.

2.1.1 Sample implementation

Young women (15-24 years) were selected from three blocks using two-stage stratified random sampling. In the first stage, 23 villages from each of the intervention and comparison areas were selected using probability proportional to size (PPS) sampling (n=46). In the second stage, a detailed household listing was carried out in each selected village to generate two separate universes of households with eligible married and unmarried young women. Seventeen households with at least one married young woman and another 17 households with unmarried young woman were selected using systematic random sampling in each sampled village. Only one eligible respondent was selected per household, and in households with more than one eligible respondent, the Kish table was used to select a study participant.

A total of 1,381 young women (married 690 and unmarried 691) were successfully interviewed. While informed consent was obtained from all participants prior to study enrollment, in case of unmarried young women aged 15-17 years, consent was also sought from a parent or guardian. To protect the participants' privacy, interviewers requested privacy from other household members who tried to intervene or listen. If privacy could not be ensured, the interview was postponed and rescheduled. The overall response rate for the study was 88% for both married and unmarried young women.

2.1.2 Survey instrument

Two separate questionnaires were developed for married and unmarried young women. Respondents enrolled in the study participated in an interviewer-administered survey that collected data on socio-demographic characteristics, media exposure and social networking, sources of SRH information, health-seeking behaviors, knowledge, and perceptions about SRH issues including abortion and reproductive histories for married women. Married youth reporting an abortion answered an additional module on their most recent abortion experience. This module included questions about the abortion information she received from providers or other actors, type of abortion provider and procedure received, and complications experienced, if any.

2.2 Ethical considerations and training

This study underwent ethical review and was approved by the Institutional Review Board of the Centre for Media Studies in New Delhi, India and Allendale IRB in the United States. Almost 20 young women underwent interviewer's training and 15 young men underwent training for house-listing activities. Considering the sensitivity of this study, young female investigators were recruited from the same state and trained extensively through classroom sessions, role plays, and mock interviews. Female investigators were familiarized with each section of the questionnaire and towards the end of the classroom training, field practices were carried out in three villages which were not sampled for this study.

All investigators underwent special training in ethical issues, particularly on informed consent, privacy, and confidentiality. Importance was given to a young respondent's right to refuse to participate or respond to any particular question. In case of unmarried young women aged 15-17, consent was also sought from a parent or guardian. An anonymous reporting approach was applied to ask questions on pre-marital sexual exposure and romantic relations by using sealed envelopes. To ensure confidentiality and privacy, unique identification number was used to link this response to the individual questionnaire. To ensure confidentiality and privacy within the household, only one respondent was selected from each household.

2.3 Analysis and measures

Descriptive statistics are reported for both categorical and continuous variables. Categorical variables are analyzed using frequencies and percentages. For continuous variables, means, and standard deviations are reported. Multiple linear regression models were used to determine the factors associated with different outcome variables; standardized Betas and p-values are reported. This study uses four outcome measures to assess young women's ability to access safe sexual and reproductive health services: agency, knowledge of SRH issues including sex and pregnancy, contraception, and abortion.

To approximate the economic status of the respondents, a standard of living (SLI) index was developed on the basis of ownership of household durables and assets. Households were assigned a score for each asset, and the scores were summed. A high SLI generally means a higher level of income and the ability to acquire other modern amenities that add to one's comfort (Roy et al. 1999).

Agency is defined here as the ability to exercise strategic life choices through personal competence to exert influence over life matters (Kabeer 2001), including personal health (Jejeebhoy et al. 2010). Available literature suggests measuring the agency of young people through the ability to make choices including young people's decision-making capacity, freedom of movement, a sense of self-worth, and access to resources (Malhotra, Schuler, and Boender 2002). Self-efficacy is also measured, which includes a young woman's confidence and ability to negotiate with elders, peers, spouse, and medical doctors and to share her opinion and discuss her own reproductive health choices (Banerjee et al. 2012), including expressing opinion, talking to a provider, helping friends to choose a provider, and negotiating with spouse against forced sex.

In order to assess young women's involvement in decision-making, respondents were asked whether they made the decision on their own, jointly with others or that they had no role in decision-making. We developed a composite index of agency score to measure the overall levels of agency among young women. A weight has been assigned to each of the agency items based on their responses, and a

composite index was developed by adding individual score of all four agency components, including decision-making, choice of mobility, access to money, and sense of self-worth.

To assess overall knowledge of young women on SRH issues, three broad categories of knowledge were examined separately, namely 'sex and pregnancy', 'contraception', and 'legal aspects of safe abortion'. Respondents were asked to share their responses on likelihood of getting pregnant: i) at first unprotected sex; ii) only with repeated intercourse; iii) if had sex half-way between her periods; iv) if had sex during her periods; v) after kissing or hugging; and vi) the aggravated risk of maternal health with pregnancy before age 18 years. Awareness of contraception was assessed in two stages. First young women were asked to report all contraceptive methods about which they heard of (spontaneous and with probe); and second, probed further for specific knowledge of each method they listed at step one. To assess knowledge on abortion-related issues, the questionnaire explored young women's perceptions about: i) legal status of abortion in India; ii) duration of pregnancy up to which abortion is legally allowed in India; iii) legal status of abortion for unmarried women; iv) requirement of consent for young women under 18 years; and v) sources of abortion care services.

A summary index has been generated based on the number of correct responses. An additive composite index was created for all three categories based on correct responses across items, providing a mean knowledge score for each individual respondent, ranging from 0 to 6 for knowledge of 'sex and pregnancy', 0 to 8 for 'contraception', and 0 to 5 for 'abortion'. Thus a higher mean score on any SRH aspect indicates a higher level of knowledge.

To assess the health seeking behaviour of young women for different sexual and reproductive health services, this study asked each married respondent to report the type of health care providers and health facilities they visited last time for antenatal care (ANC), delivery care, and RTI-related issues. In addition, unmarried young women were asked to report the same for menstrual and other health problems.

3

Profile of Young Women

3.1 Socio-demographic and economic characteristics

This section presents the socio-demographic characteristics of married and unmarried young women who participated in this study. As portrayed in Table 1, over half of the rural young women in the combined sample were between the ages of 15 and 17 years. Unmarried women were substantially younger than the married; while 88% young unmarried women were aged 15-17 years, only 21% married youth fell into this age group. This clearly shows a uniform pattern of low age at marriage. The mean age at marriage for the young married women was 15.7 years. The standard deviation was estimated very low (1.7), suggesting a customary trend of marriage below the legal age at marriage of 18 years. The majority identified as Hindu (70%), while 29% identified as Muslim. Young women overwhelmingly reported living in a joint or extended family (married 79%, unmarried 53%). More than three-quarters of the young women belonged to either the Other Backward Classes (68%), Scheduled Castes (13%) or Scheduled Tribes[1] (4%).

While the Government of India aims for universal education for modern youth, schooling was far from universal, particularly for married young women. Almost one-third (34%) of married and one-tenth (9%) of unmarried young women had never been to school. Unmarried young women were relatively better educated than the married counterparts, 83% of unmarried young women completed middle school compared to 48% of married young women. Substantial variations were observed among married and unmarried young women in terms of continuation of education. At the time of interview, 5% married and 67% unmarried young women were in school and college. Leading reasons for school discontinuation were early marriage, poverty, and lack of access to an educational facility.

Over 85% of the young women fell into the low and moderate standard of living category; the main source of household income was from owning a farm or from a daily wage (data not shown). Overwhelming majority reported that they did not work for cash or kind in the past year (married 85%, unmarried 95%). Those who entered into any economic activity were mostly engaged in the informal sector. By contrast, only five percent of young women reported looking for a job.

[1] Under Article 340-342 of the Indian Constitution, the Government of India (GoI) classifies some of its citizens based on their social and economic conditions. Scheduled Caste, Schedule Tribe, and Other Backward Class are the three broad designations for historically disadvantaged caste groups. Scheduled Caste and Scheduled Tribe groups are the most socially and economically disadvantaged groups in India, and the Scheduled Tribes receive the most government support, as they have been farthest removed from mainstream Indian society. The term 'backward class' is a collective term used by the GoI for castes, which are economically and socially disadvantaged (Xaxa 2001).

Table 1: Socio-economic profile of married and unmarried young women in Jharkhand, 2012

Characteristics	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Current age (in years)						
15-17	147	21	608	88	755	55
18-20	291	42	69	10	360	26
21-24	252	37	14	2	266	19
Education						
Never attended school	231	33	63	9	294	21
Primary	128	19	54	8	182	13
Middle	243	35	452	65	695	51
Secondary and above	88	13	122	18	210	15
Currently studying						
Yes	35	5	463	67	498	36
No	655	95	228	33	883	63
Religion						
Hindu	501	73	471	68	972	70
Muslim	187	27	214	31	401	29
Other	2	0.3	6	1	8	0.6
Caste						
Scheduled Caste (SC)	98	14	86	12	184	13
Scheduled Tribe (ST)	27	4	33	5	60	4
Other Backward Class (OBC)	476	69	463	67	939	68
General	89	13	109	16	198	15
Type of family						
Nuclear family	147	21	323	47	470	34
Joint-extended family	543	79	368	53	911	66
Types of occupation						
Farming (family land)	26	4	7	1	33	2
Agricultural labor	30	4	27	4	57	4
Non-agricultural wage labor	28	4	14	2	42	3
Business and salaried	18	3	13	2	31	2
Not working	588	85	630	91	1218	88
Wealth index						
Low	321	47	307	44	628	46
Medium	277	40	282	41	559	40
High	92	13	102	15	194	14
Exposed to mass media#						
Yes	445	65	551	80	996	72
No	245	35	140	20	385	28
Mean age (SD)	19.5 (2.3)		15.9 (1.4)		17.7 (2.6)	
Mean schooling (SD)*	6.5 (3.1)		7.8 (2.4)		7.2 (2.8)	
Mean age at marriage (SD)	15.7 (1.7)		NA		NA	

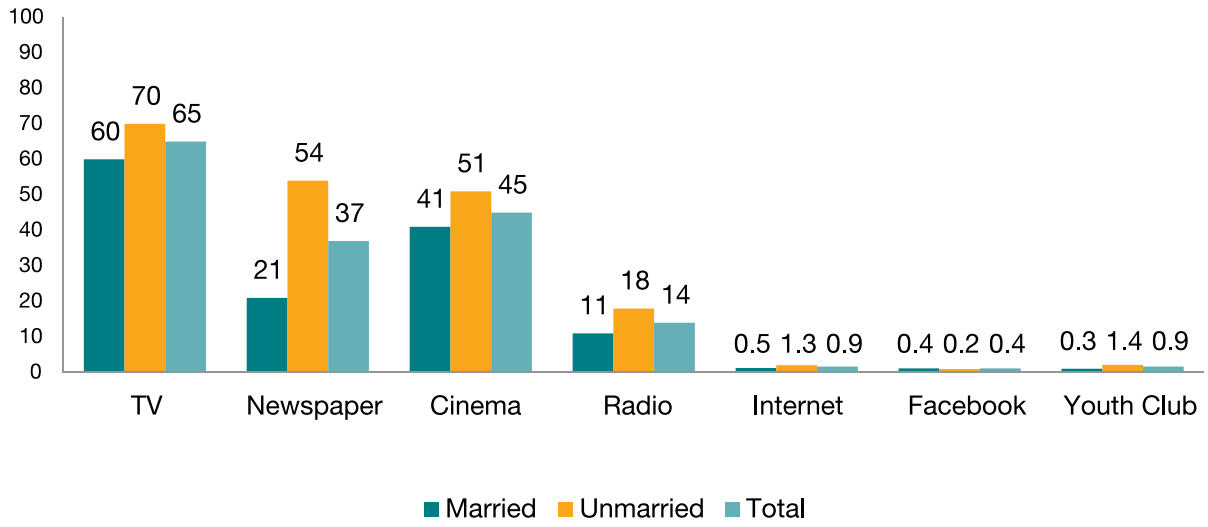
#: Mass media includes TV, radio, newspaper, and movies; *: Average is estimated among those who attended school.

3.2 Media exposure and access to SRH information

Young women were exposed to a variety of media, but typically, more unmarried than married young women reported media exposure (Figure 1). Exposure to television was reported by 70% of unmarried and 60% of married women. The difference was more pronounced for exposure to newspapers. Likely due to education level, unmarried women were more likely to report exposure to the newspaper (married 21%, unmarried 54%) and radio (married 11%, unmarried 18%). However, young women's exposure to mass media was restricted with infrequent viewership. For example, only 22% of young women watched television regularly. Considering the recent growth of access to computer, internet, and social networking sites among urban youths, we asked whether rural youth had any access to such modern pathways of communications. As portrayed in Figure 1, only one percent of unmarried young women were reported to have access to internet, while social networking and youth clubs had not yet diffused to the rural youth community.

In addition to gathering data on young women's exposure to mass media and other modern devices, this study also examined whether they received any information on SRH issues (e.g., menstruation, puberty, white discharge, pregnancy, and RTI), contraception, and safe abortion and their sources of information for different health issues (Table 2). Almost 90% of married young women and 70% of unmarried youth reported receiving some information on SRH and contraception. When asked about having received messages related to abortion, only 10% of women recalled receiving some information on abortion issues. For information about SRH issues women relied most heavily on family members and relatives (73%-75%), friends and neighbors (75%-82%), and community-level sources, including Accredited

Figure 1: Percentage of young women exposed to mass media and social networks [N=1381]



Social Health Activists (ASHAs) and Anganwadi Workers (AWWs) (22%), and Auxiliary Nurse Midwives (ANMs) (4%). A similar pattern emerged for safe abortion. Among those who were exposed to messages, the sources of information were similar to the findings on family planning and SRH, with most young women relying on their friends and neighbors (73%-75%) for information (Table 2).

Table 2: Sources of information on SRH, contraception, and abortion-related issues among young women, Jharkhand 2012 (%)

Information sources	SRH			Contraception			Safe abortion		
	YMW	YUW	TOT	YMW	YUW	TOT	YMW	YUW	TOT
	(N=690)	(N=691)	(N=1381)	(N=690)	(N=691)	(N=1381)	(N=690)	(N=691)	(N=1381)
Received any information	89	69	79	89	74	81	10	3	7
Information sources									
Mass media	17	20	18	22	37	29	13	42	20
Wall sign	2	10	6	9	20	14	1	8	3
Outreach (AWW/ASHA)	27	15	22	29	14	22	20	17	19
ANM/nurse	5	3	4	6	3	4	9	4	8
Family members/ relatives	72	79	75	74	72	73	42	38	41
Husband	34	–	–	38	–	–	17	–	–
Friends/neighbors	71	79	75	80	82	81	73	75	73
Health facility–Public	1	2	1	3	1	2	3	8	4
Health facility–Private	7	2	5	5	1	4	19	0.0	14
Other	1	1	1	<1	<1	<1	1	0	1

YMW: Young Married Women; YUW: Young Unmarried Women; TOT: Total.

4

Agency among Married and Unmarried Young Women

Agency is defined as the ability to exercise strategic life choices through personal competence to exert influence over life matters (Kabeer 2001), including personal health (Jejeebhoy et al. 2010). Available literature suggests measuring young people's agency by assessing their decision-making capacity, freedom of movement, sense of self-worth, and access to resources (Malhotra, Schuler, and Boender 2002).

4.1 Involvement in decision-making

In order to assess young women's involvement in decision-making, young respondents were asked whether they made the decision on their own, jointly with others or that they had no role in decision-making. Findings presented in Table 3 reveal that irrespective of marital status, young rural women almost had no involvement in decision-making on their own health care and choosing a health care provider; 92% married and 99% unmarried women had no say on their own health care, while more than 95% young women reported having no ability to choose any particular health care provider for their own health problem. Since agency is defined as the ability to make "strategic" life choices, like marriage and pregnancy, married respondents were asked about their involvement on deciding the time of pregnancy, while unmarried women were asked whether they can exercise their choice

Table 3: Participation of young married and unmarried women in decision-making on selected matters, Jharkhand 2012 (%)

Information sources	Married (N=690)				Unmarried (N=691)				Total (N=1381)			
	Respon-dent	Jointly	Husband	Others	Respon-dent	Jointly	Parents	Others	Respon-dent	Jointly	Husband/ parent	Others
Own health care	5	3	67	25	1	0.3	94	5	3	2	80	15
Choosing any doctor	3	3	65	29	0.4	0.4	93	6	2	2	79	17
When to get pregnant	9	0.1	88	3	–	–	–	–	–	–	–	–
When to get married	–	–	–	–	2	1	95	2	–	–	–	–
Choosing a friend	71	0.3	23	6	81	0.4	18	0.4	76	0.4	20	3
Spending money	20	2	59	19	26	0.3	69	5	23	1	64	12
Buying own clothes	13	3	62	22	17	1	77	5	15	2	69	14

to decide the time of marriage. In response, only nine percent married and three percent unmarried women reported their ability to influence any strategic life choices. Young women overwhelmingly (married 71%, unmarried 81%) reported their ability to choose their friends on their own; some young women were also involved in making decisions on spending money (married 20%, unmarried 26%) and buying their own clothes (married 13%, unmarried 17%).

4.2 Access to financial resources

To understand the autonomy of young generation to access financial resources, we asked whether they had some deposit in terms of savings account at any bank or post-office or even with in a self-help group deposit scheme. Only six percent young women reported owning a bank account, five percent independently and one percent with someone else (Figure 2).

4.3 Freedom of movement

The third important element of the capacity to make choices includes young people's freedom of movement; this was assessed by asking questions relating to whether young respondents were allowed to visit within and outside the village alone, with someone else or not allowed at all.

Findings presented in Table 4 and Figure 3 reveal that young women had some mobility within the village. However, young unmarried women had relatively more freedom to visit alone any places inside the village compared to their married counterpart. For example, while almost half of the unmarried women reported having freedom to visit a shop (52%) or a friend (46%) inside the village; only 25% of married women had that freedom of mobility. However, the same mobility to any place outside the village was uniformly restricted for all young women irrespective of their marital status.

Figure 2: Access to financial resources among young women [N=1381]

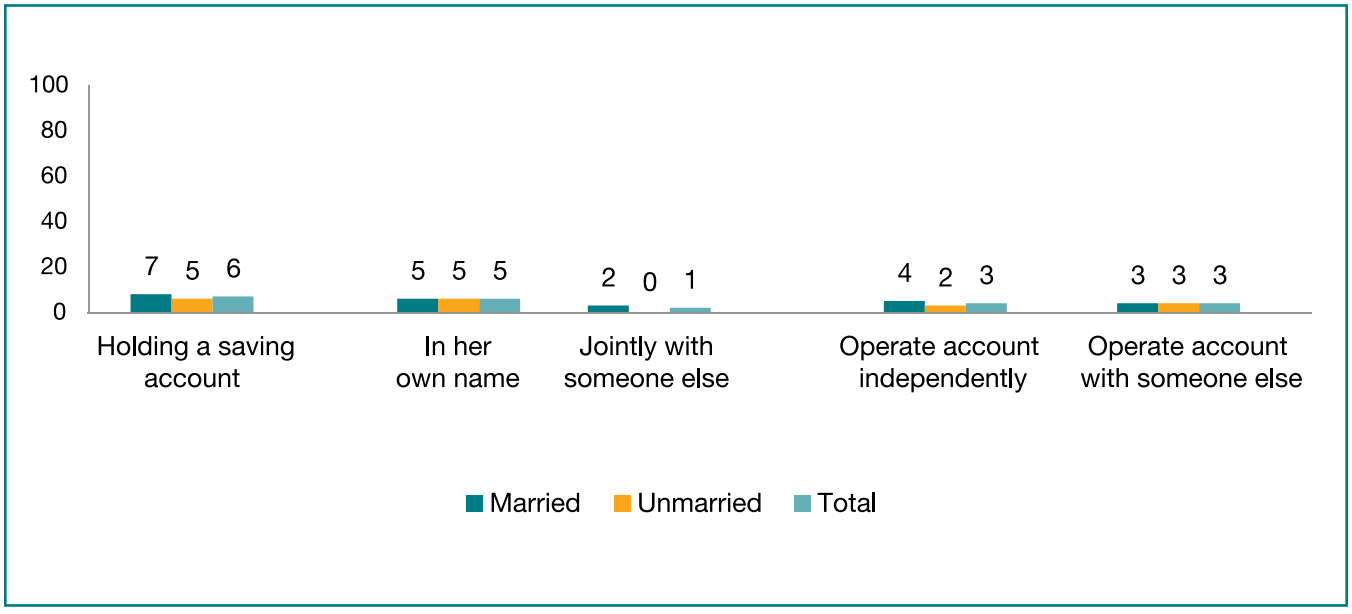


Table 4: Young women visiting alone and expressing self-efficacy, Jharkhand 2012

	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Visiting alone						
Program inside village	96	14	106	15	202	15
Shop inside village	174	25	359	52	533	39
Friend inside village	172	25	318	46	490	36
Program outside village	20	3	23	3	43	3
Shop outside village	26	4	23	3	49	4
Friend outside village	14	2	14	2	28	2
Doctor	12	2	4	0.6	16	1
Self-efficacy						
No difficulty expressing opinion to elders	163	24	159	23	322	23
Can talk confidently to a provider on SRH issues	153	22	103	15	256	19
Can initiate discussing issues related to SRH with my friends	217	31	141	20	358	26
Can help my friends to choose a doctor who provides abortion	146	21	47	7	193	14
Able to say "no" to sex if I don't feel like having sex	238	35	NA	NA	NA	NA

Figure 3: Percentage of young women allowed to visit alone to selected places [N=1381]

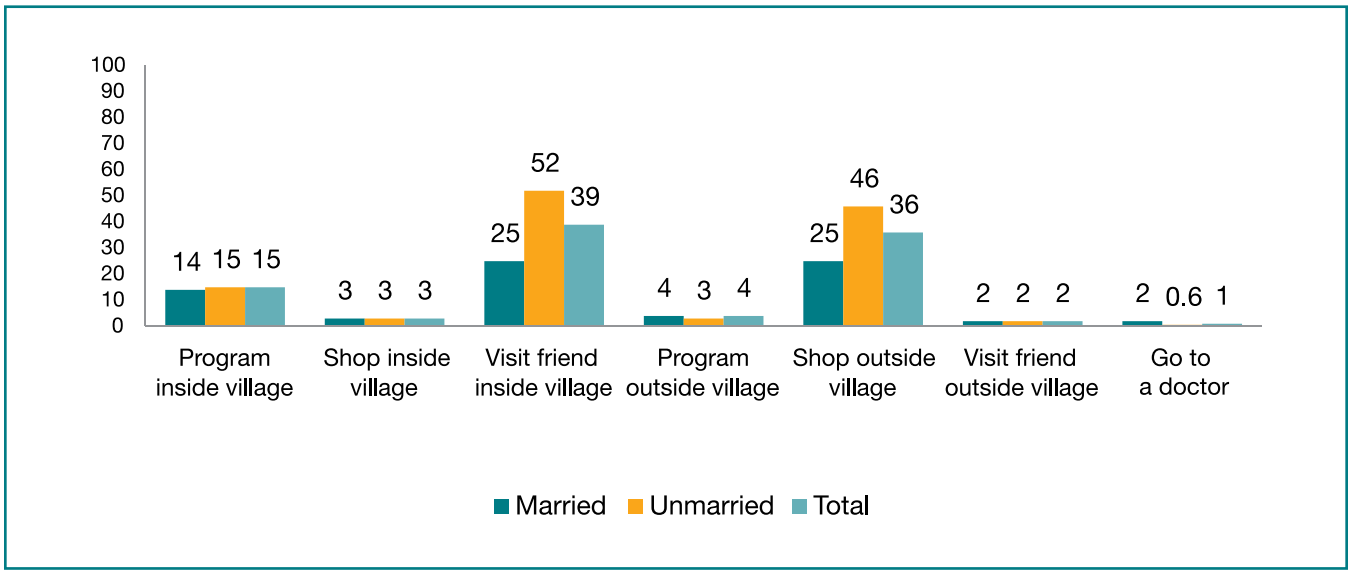
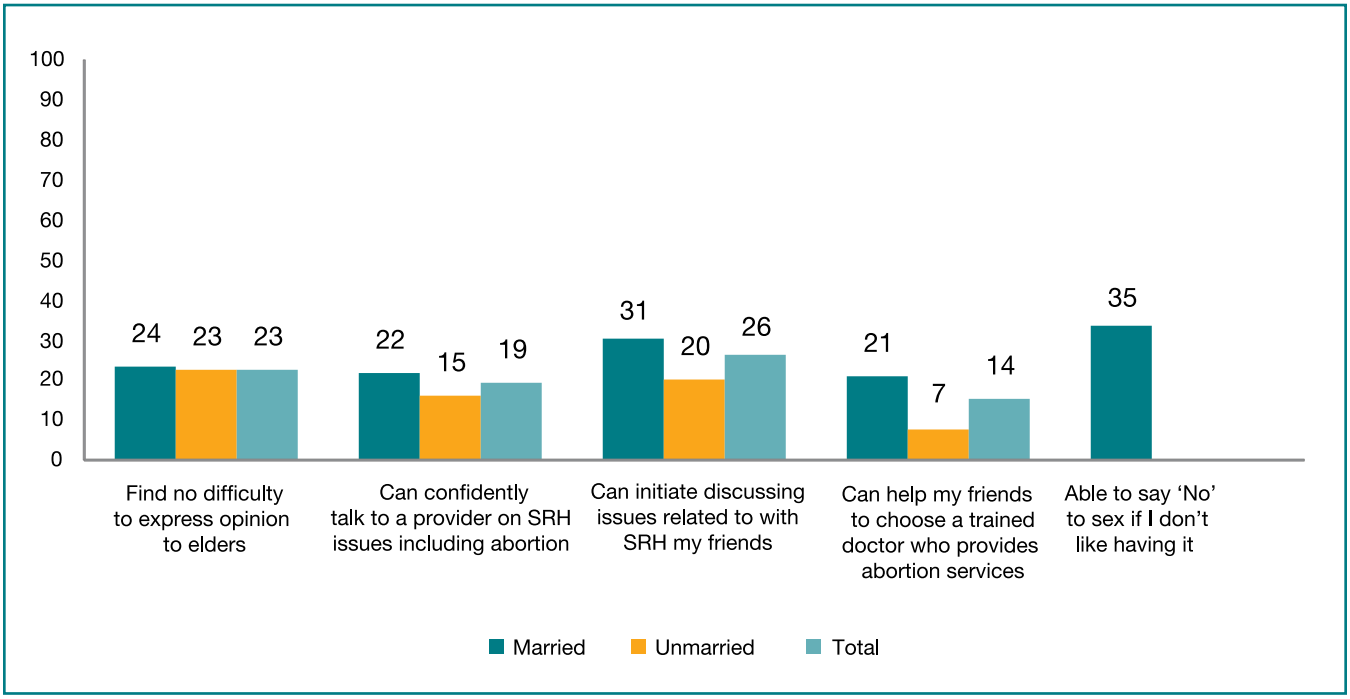


Figure 4: Percentage of young women expressing self-efficacy, Jharkhand [N=1381]



4.4 Self-efficacy

The fourth important element of agency was examined through a sense of self-worth or self-efficacy. Here, self-efficacy includes a young woman's confidence and ability to negotiate with elders, peers, spouse, and medical doctors to share her opinion and discuss her own reproductive health choices (Banerjee et al. 2012), including expressing opinion, talking to a provider, helping friends to choose a provider, and negotiating with spouse against forced sex. As shown in Table 4 and Figure 4, these findings suggest that young women were likely to report low level of self-efficacy in expressing their own opinion and in making reproductive decisions, including initiating discussions on SRH issues.

For example, almost three-fourths of women found it difficult to express their opinion to elders, while almost 80% young women shared their inability to talk to a health care provider on SRH issues. However, married young women expressed relatively higher levels of self-efficacy compared to their unmarried counterparts. For example, 31% of young married women reported their ability to initiate discussions with friends on SRH issues as against 20% unmarried young women. On the other extreme, 65% young married women expressed their inability to negotiate with their spouse for not having sex against their will.

As reflected in Table 5, the mean composite score of agency was 10.5 out of total expected score 33. Although, there was no substantial gap between married and unmarried young women, the agency scores were uniformly low for access to money (0.1 of 3) and decision-making (2.6 of 12).

Table 5: Composite mean score of agency by marital status of young women, Jharkhand 2012

Agency components [score range]	Mean (SD) composite score achieved		
	Married (N=690)	Unmarried (N=691)	Total (N=1381)
Decision-making [score range: 0-12]	2.5 (2.2)	2.6 (1.8)	2.6 (2.0)
Choice of mobility [score range: 0-14]	6.6 (1.9)	7.5 (1.6)	7.0 (1.8)
Access to money [score range: 0-3]	0.2 (0.6)	0.1 (0.5)	0.1 (0.6)
Sense of self-worth [score range: 0-4]	0.9 (1.1)	0.6 (0.9)	0.8 (1.0)
Overall agency [score range: 0-33]	**10.2 (4.0)**	**10.8 (3.1)**	**10.5 (3.6)**

4.5 Factors influencing agency

A multivariate analysis was carried out to understand the possible influences of socio-demographic attributes on overall agency of young women. The results of the multivariate analyses (see Table 6) reveal age(β=0.08; $p<0.05$), secondary level education(β=0.15; $p<0.000$), two or more living children (β=0.13; $p<0.01$), high standard of living (β=0.08; $p<0.01$) and exposure to mass media (β=0.17; $p<0.000$) as influencing factors to lead young women's agency; while young women from joint family (β=-0.09; $p<0.000$) and other than Hindu religion (β=-0.12; $p<0.000$) were more likely to express limited agency.

Table 6: Multiple linear regression results of factors associated with young women's agency, Jharkhand, 2012

	Standardize β coefficients on agency		
	Married (N=690)	**Unmarried (N=691)**	**Total (N=1381)**
Age			
Age up to 18 years (RC)	R	R	R
19-24 years	0.10*	-0.02	0.08*
Education level			
No education (RC)	R	R	R
Primary	-0.08*	-0.06	-0.07*
Middle	0.03	0.06	0.02
Secondary +	0.07	0.30***	0.15***
Marital status			
Unmarried (RC)	NA	NA	R
Married			-0.17***
Ever got pregnant			
Never pregnant (RC)	R	NA	R
Ever pregnant	-0.01		0.01
Children ever born			
No child	R		R
1 child	0.07	NA	0.07
2 children	0.14*		0.13**
3 and more children	0.09		0.08*
Type of family			
Nuclear family (RC)	R	R	R
Joint-extended family	-0.07	-0.10**	-0.09***
Caste			
SC/ST (RC)	R	R	R
OBC	0.14**	0.09*	0.12***
General	-0.10*	-0.03	-0.07*
Religion			
Hindu (RC)	R	R	R
Non-Hindu	-0.12**	-0.13***	-0.12***
Work status			
Not working (RC)	R	R	R
Working	-0.05	-0.05	-0.05*
Living standard			
Low (RC)	R	R	R
Medium	0.05	0.01	0.05
High	0.05	0.13**	0.08**
Exposure to mass media			
No (RC)	R	R	R
Yes	0.22***	0.09*	0.17***

t-tests measuring significance of difference with reference category, significant: * p<=.05; **p<=.01; ***p<=.001. RC= Reference Category.
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5

Awareness of Sexual and Reproductive Health Issues

Available literature uniformly suggests low level of awareness on SRH-related issues, particularly among rural youth population (IIPS & Population Council 2010; Banerjee et al. 2012). An important objective of this study was to explore the extent to which young women were aware of three broad SRH issues related to sex and pregnancy, contraception, and abortion.

5.1 Awareness of sex and pregnancy-related issues

In order to assess knowledge of sex and pregnancy, each young woman was asked to share her responses on likelihood of getting pregnant: i) at first unprotected sex; ii) only with repeated intercourse; iii) if had sex half-way between her periods; iv) if had sex during her periods; v) after kissing or hugging; and vi) the aggravated risk of maternal health with pregnancy before age 18 years. A summary index has been generated based on the number of correct responses. Findings presented in Table 7 reveal that awareness of sex and pregnancy was extremely limited. However, young married women were relatively more aware than their unmarried counterparts.

For example, on average married young women had shared correct responses for almost half of the questions (composite score was 2.9 out of 6), while young unmarried youth could not even offer correct responses to two questions (composite score 1.8 out of 6). Young unmarried women were either unsure or unaware of correct responses for all but one question identifying that women can't get pregnant after kissing or hugging. Even 80% of married young women was not aware of the fact that pregnancy can happen at first sexual encounter (for detail see Appendix Table A2).

5.2 Awareness and knowledge of contraceptive methods

Awareness of contraception was assessed in two stages. First, young women were asked to report all contraceptive methods about which they heard of (spontaneous and with probe); and second, probed further for specific knowledge of each method they listed at step one. Findings suggest that the vast majority of young women (60%) reported awareness and correct knowledge on at least one to two methods (see Table 7). However, once again married young women were more likely to report correct awareness on multiple contraceptive methods as compared to their unmarried counterparts. For example, 63% of married young women reported correct knowledge for at least three methods. This proportion was only 17% among unmarried young women. The composite index score of 3.0 out of 8 for married young women as against 1.7 for unmarried also reflects this difference (for detail see Table 8).

Table 7: Knowledge of sex and pregnancy, contraceptive methods and abortion issues among married and unmarried young women in Jharkhand-India, 2012

	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Knowledge of sex and pregnancy						
No correct response	18	3	99	14	117	9
1-2 correct responses	244	35	449	65	693	50
3-4 correct responses	370	54	139	20	509	37
5 and above	58	8	4	<1	62	4
Mean composite score [range 0-6] (*SD*)	2.9 *(1.2)*		1.8 *(1.1)*		2.4 *(1.3)*	
Knowledge of contraception						
No correct response	0	0	4	0.6	4	0.3
1-2 correct responses	261	38	563	82	824	60
3-4 correct responses	322	47	120	17	442	32
5 and above	107	16	4	<1	111	8
Mean composite score [range 0-8] (SD)	3.0 *(1.5)*		1.7 *(0.9)*		2.4 *(1.4)*	
Knowledge of legal aspect of safe abortion						
No correct response	382	55	488	71	870	63
1-2 correct responses	274	40	186	27	460	33
3-4 correct responses	31	4.5	15	2	46	3
5 correct responses	3	<1	2	<1	5	<1
Mean composite score [range 0-5] (SD)	0.7 *(0.9)*		0.4 *(0.8)*		0.5 *(0.8)*	

As reflected in Table 8, young women uniformly don't have correct awareness on modern contraception, more so on IUCD and emergency contraceptives. For example, only 14% young women ever heard of emergency contraceptives (spontaneous or prompted), while 22% of them who were aware this method had correct knowledge that within 72 hours after the unprotected sexual intercourse this method be taken. A similar pattern can also be observed for IUCD. Almost one-third of young women were aware of IUCD, but around two-thirds of them had no knowledge that IUCD is placed in the uterus. By contrast, a majority of young women reported knowing a place where contraceptive methods are available (see Table 8).

5.3 Awareness of abortion

To assess knowledge on abortion-related issues, this study explored young women's perception about: i) legal status of abortion in India; ii) duration of pregnancy up to which abortion is legally allowed in India; iii) legal status of abortion for unmarried women; iv) requirement of consent for young women under 18 years; and v) sources of abortion care services. Summary findings of this section (see Table 7) clearly reflect that young women had limited knowledge of abortion-related issues (composite score 0.7 and 0.4 out of 6 for married and unmarried young women respectively).

Table 8: Awareness and knowledge of contraceptive methods among young women, Jharkhand 2012

	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Heard of at least one method						
Yes	690	100	689	100	1379	100
No	0	0	2	<1	2	<1
Heard of oral pills (OCP)						
Yes; spontaneously	444	64	285	41	729	53
Yes; prompted	191	28	231	33	422	31
No	55	8	175	25	230	17
Correct knowledge of OCP						
Yes	385	61	160	31	545	47
No	250	39	356	69	606	53
Heard of emergency contraceptive pills (ECP)						
Yes; spontaneously	15	2	7	1	22	2
Yes; prompted	97	14	63	9	160	12
No	578	84	621	90	1199	87
Correct knowledge of ECP*						
Yes	29	26	11	16	40	22
No	83	74	59	84	142	78
Heard of condom						
Yes; spontaneously	186	27	40	6	226	16
Yes; prompted	357	52	233	34	590	43
No	147	21	418	61	565	41
Correct knowledge of condom						
Yes	264	49	24	9	288	35
No	279	51	249	91	528	65
Heard of IUCD						
Yes; spontaneously	90	13	14	2	104	8
Yes; prompted	215	31	119	17	334	24
No	385	56	558	80	943	68
Correct knowledge of IUD						
Yes	158	52	3	2	161	37
No	147	48	130	98	277	63
Heard of female sterilization						
Yes; spontaneously	612	89	564	82	1176	85
Yes; prompted	78	11	122	18	200	15
No	0	--	5	< 1	5	< 1
Know where to get a contraception method						
Yes	644	93	551	80	1195	86
No	46	7	140	20	186	14

Table 9: Awareness about legal aspects of abortion among young women in Jharkhand, 2012

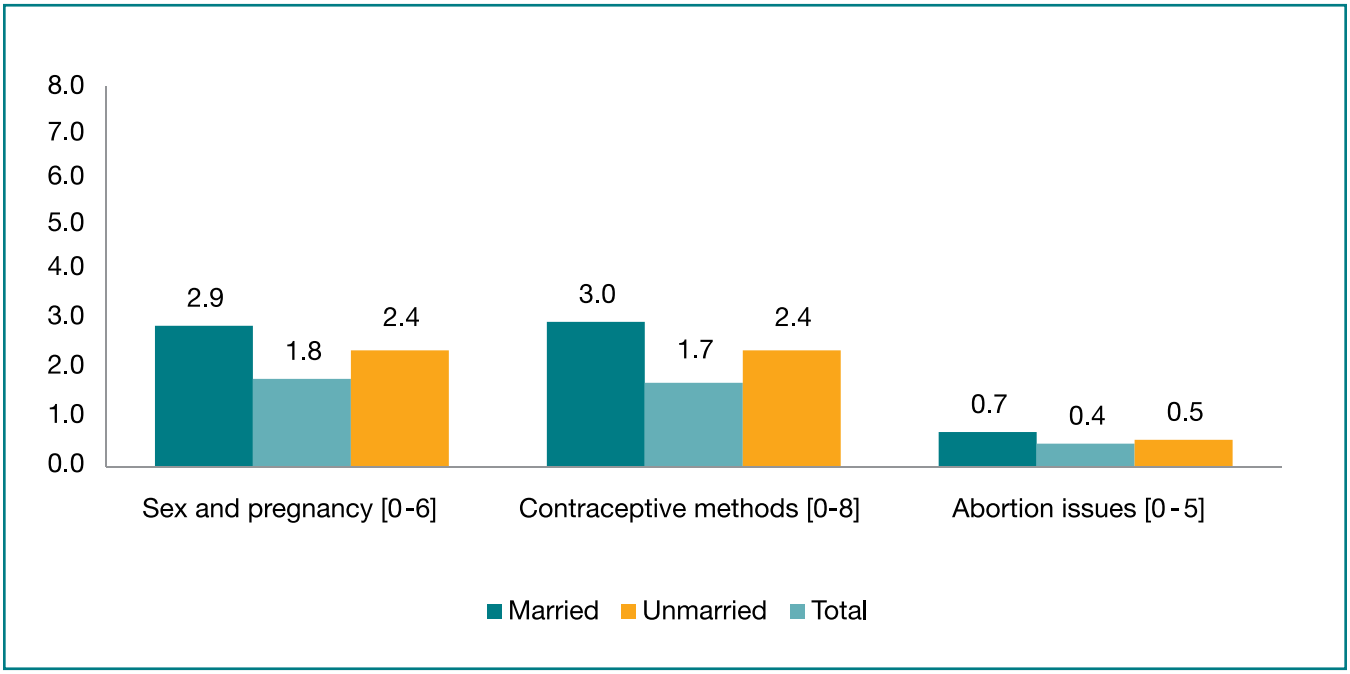
	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Know abortion is legal in India						
Yes, legal	5	<1	8	<1	13	<1
No, illegal	67	10	70	10	137	10
No idea/Don't know	618	90	613	89	1231	89
Know correct and legal gestation						
Correct gestation (20 weeks)	0	0	0	0	0	0
Incorrect gestation	6	1	7	1	13	1
Had no idea	681	99	684	99	1365	99
Abortion is legally allowed for married woman						
Yes	10	1	9	1	19	1
No	103	15	79	11	182	13
No idea/Do not say	577	84	603	88	1180	85
Abortion is legally allowed for unmarried women						
Yes	12	2	12	2	24	2
No	85	12	80	12	165	12
No idea/Do not say	593	86	599	87	1192	87
Woman <18 years require consent to have legal abortion						
Yes	115	17	126	18	241	18
No	88	13	75	11	163	12
No idea/Do not say	487	71	490	71	977	71
Persons who can give the consent*						
Parents	102	89	113	90	215	89
Guardian	42	37	35	28	77	32
Anyone over 18	9	8	8	6	17	7
Other	2	2	1	< 1	3	1

*: reduced base.

Despite the fact that the Medical Termination of Pregnancy Act was passed in 1971, 55% of young married women and 71% of young unmarried women could not respond to any of the five questions asked to assess their awareness of abortion-related issues. Surprisingly, 10% of young women erroneously believed that abortion is not legal in India, while 89% expressed their complete ignorance about the subject (see Table 9). In addition, young women universally couldn't respond to the correct duration of pregnancy up to which abortion is legally allowed in India.

Summary findings presented in Figure 5 reflect young women's limited awareness of most sexual and reproductive health issues, including pregnancy, contraception, and abortion.

Figure 5: Knowledge score on sex and pregnancy, contraception, and abortion issues among young women [N=1381]



5.4 Factors influencing awareness of SRH issues: A multivariate analysis

Table 10 shows the results of multiple linear regression models of the factors associated with the young women's knowledge of three broad SRH-related issues. Adjusting for other socio-demographic and economic variables young women who were in the age group of 19-24 years had significantly better knowledge of sex and pregnancy (β=0.12; $p<0.000$) and contraception (β= 0.15; $p<0.000$) as compared to even younger women. Further, young women who were married at the time of survey were more likely to perceive correct knowledge on all three aspects of SRH issues (β=0.39, 0.43, 0.14; $p<0.000$) as compared to unmarried young women. In addition, education of women had played an important role to influence the awareness level of young rural women, middle and secondary level education had clear edge over no or primary education.

Family composition, caste, religion, and working status of young women surprisingly showed no association with the knowledge of sex and pregnancy and contraception. The one exception was knowledge of abortion. In case of awareness of abortion, young women who are in a joint or extended family or work for cash or kind or belong to other religion were significantly less likely to have knowledge on abortion compared to women from nuclear families, housewives, and Hindu religion respectively. Although standard of living had no influence on awareness of sex and pregnancy, high living standard was positively associated with knowledge of contraceptive (β=0.11; $p<0.000$) and abortion (β=0.19; $p<0.000$). Exposure to any SRH information from any source was found to a have strong association with the awareness level of all three SRH issues.

Table 10: Multiple linear regression results of factors associated with young women's knowledge of sex and pregnancy, contraception, and abortion-related issues, Jharkhand-India, 2012

	Standardize β coefficients on knowledge of		
	Sex and pregnancy (N=1381)	**Contraception (N=1381)**	**Abortion (N=1381)**
Age			
Age up to 18 years (RC)	R	R	R
19-24 years	0.12***	0.15***	0.05
Education level			
No education (RC)	R	R	R
Primary	0.07**	0.06*	0.04
Middle	0.10**	0.12***	0.09**
Secondary +	0.21***	0.24***	0.19***
Marital status			
Unmarried (RC)	R	R	R
Married	0.39***	0.43***	0.14***
Type of family			
Nuclear family (RC)	R	R	R
Joint-extended family	-0.00	-0.04	-0.07*
Caste			
SC/ST (RC)	R	R	R
OBC	-0.05	0.04	0.12**
General	0.06	0.01	-0.06
Religion			
Hindu (RC)	R	R	R
Non-Hindu	0.05	-0.02	-0.09**
Work status			
Not working (RC)	R	R	R
Working	.01	-0.04	-0.12***
Living standard			
Low (RC)	R	R	R
Medium	-0.01	0.04	0.08**
High	-0.02	0.11***	0.19***
Exposure to SRH information			
No (RC)	R	R	R
Yes	0.16***	0.01	0.08**

t-tests measuring significance of difference with reference category, significant: * p<=.05; **p<=.01; ***p<=.001. RC = Reference Category.

6

Reproductive History and Utilization of Reproductive Health Services among Young Married Women

This chapter addresses young women's reproductive history, including pregnancy, and pregnancy outcome, children ever born, pregnancy preparedness, experience of pregnancy loss, and utilization of reproductive health services.

6.1 Birth history and pregnancy outcome

As reported in Table 11, 82% of young married women age 15-24 years had experienced at least one pregnancy. Those who ever had experienced pregnancy had experienced an average of two pregnancies and 1.4 surviving children. Early pregnancy was prevalent; for example, 53% of young women had already experienced at least one pregnancy by age 17, this proportion increased to 83% and 97% for women in the age group of 18-20 and 21-24 years respectively (see Annexure Table A5).

The distribution of young married women by number of surviving children reveals that 69% of young women had at least one surviving child, while 23% reported at least two children and nine percent three or more than three children. Once again age of young women was positively associated with the number of live-births; average number of live-births increased from 0.7 among 15-17 year to 1.2 and 1.9 among young women in the age group of 18-20 years and 21-24 years respectively. The mean number of live-births of 1.9 for the age group of 21-24 years clearly reflects a state of high fertility.

Reporting a pregnancy loss among young women was not uncommon. Every fifth young woman had reported experiencing at least one pregnancy loss (Table 11). Still births were reported by five percent of young women, while spontaneous (miscarriage) and induced abortions were reported by 13% and three percent of young women, respectively. Although, we estimated a positive linear association between age and pregnancy loss, the incidence was even reported by 12% of young married women age 15-17 years.

6.2 Wantedness of pregnancies

To assess the preparedness of pregnancies among young married women, we asked all respondents who ever had experienced pregnancy about their pregnancy planning in terms of wantedness of their current (for those currently pregnant) or most recent pregnancies. Findings of this section as reflected

in Table 12 suggest moderate level of unplanned pregnancies among young women. Around 13% of young women reported that the last pregnancy was mistimed or unwanted. A same line of responses recorded with regard to the wantedness of the current pregnancy among those pregnant at the time of interview. Of those young women who were pregnant at the time of the interview, 13% reported that the pregnancy was either unwanted or wanted at a later time.

Table 11: Reproductive histories and pregnancy outcomes of young married women, Jharkhand 2012

Reproductive histories and pregnancy outcome	Married (N=690)	
	n	%
Pregnancy history		
Ever been pregnant	563	82
Currently pregnant	129	19
Number of children surviving		
0	216	31
1	255	37
2	160	23
3 or more	59	9
Ever had pregnancy loss	141	20
Ever had stillbirth (one or more)	37	5
Ever had miscarriage	90	13
Ever had induced abortion	23	3
Pregnancy outcomes mean#(SD)		
Number of lifetime pregnancies@	*2.0 (1.1)*	
Number of children surviving	1.4 *(0.9)*	
Number of pregnancy loss	0.3 (0.6)	
Number of stillbirth	0.07 *(0.3)*	
Number of miscarriage	0.2 *(0.5)*	
Number of induced abortion	0.05 (0.3)	

Means are calculated for young married women who had ever been pregnant; @: Includes current pregnancy

Table 12: Preparedness of pregnancies among young married women, Jharkhand 2012

	Total	
	n	%
Currently pregnant (n=129)		
Wanted then	108	84
Wanted later	20	15
Wanted not at all	1	<1
	n	%
Previous pregnancy (n=378)		
Wanted then	378	87
Wanted later	43	10
Wanted not at all	13	3

6.3 Use of contraception

Young women who were not pregnant at the time of interview were asked about their current contraceptive use. As reflected in Figure 6, contraceptive prevalence was low among young married women; only 18% reported using any contraceptive method. Among contraceptive methods currently used, surprisingly female sterilization was reported as the most popular method (Figure 7) of modern contraception (53%) among young women, followed by traditional methods (24%), and condom (11%) and oral contraceptive pills (10%). Along with poor awareness, the use of IUCD was extremely low (1%).

Figure 6: Percentage of young married women currenly using any contraception [N=561]

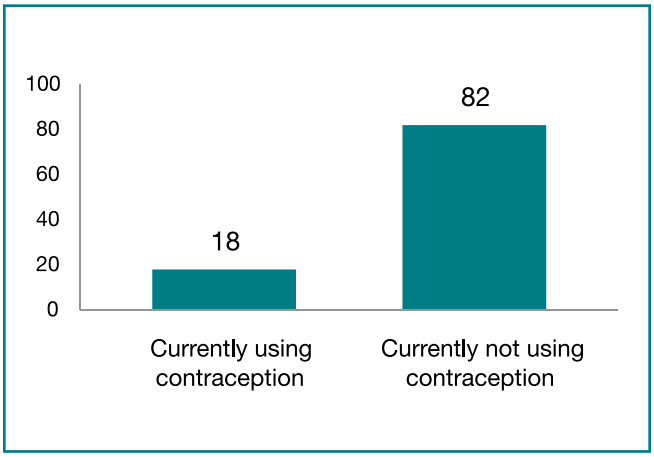
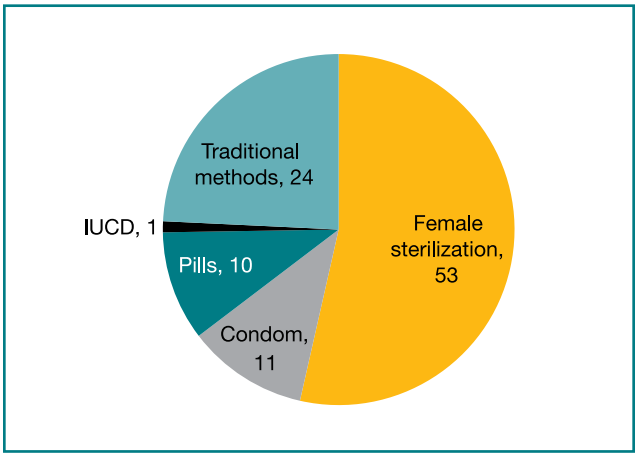


Figure 7: Types of contraception used by women currently using contraception [N=98]



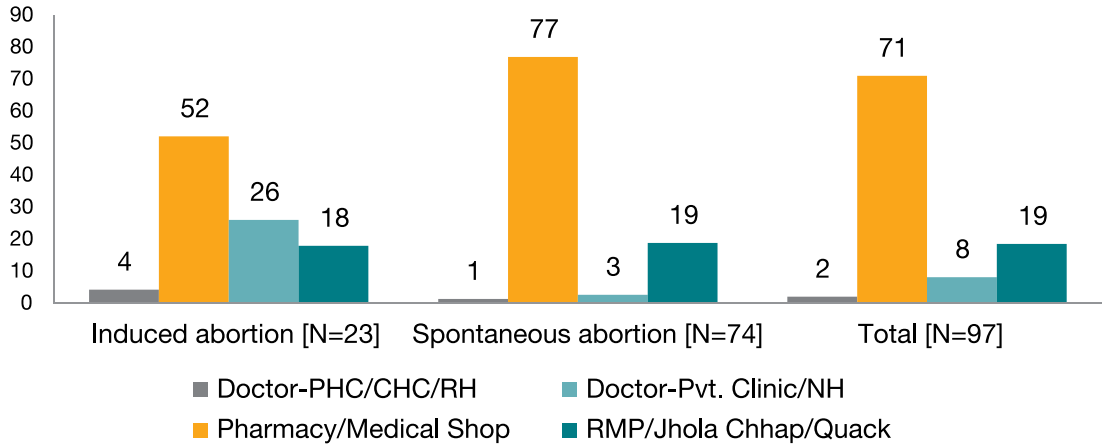
6.4 Utilization of reproductive and adolescent health care services

To assess the health seeking behavior of young women for different sexual and reproductive health services, this study asked each married respondent to report the type of health care providers and health facilities they visited last time for antenatal care (ANC), delivery care, and RTI-related issues. In addition, unmarried young women were asked to report the same for menstrual and other health problems. As reflected in Table 13, an overwhelming majority of young women sought treatment or advice from a private facility (63%, 41%) or provider irrespective of their type of problem and marital status. Another one-third of young married women and two-fifths of unmarried young women had sought services from traditional healers and unqualified rural medical practitioners.

Table 13: Utilization of SRH and abortion services by young women who had induced/ spontaneous abortion (in percentage), Jharkhand 2012

Provider/facility visited	RH & personal health care		Abortion & post-abortion care		
	Married (N=690)	Unmarried (N=691)	Induced (N=23)	Spontaneous (N=74)	Total (N=97)
Public sector					
Doctor—PHC/CHC/RH	9	6	4	1	2
Doctor—Secondary/Tertiary	3	1			
Health intermediaries	9	3			
Private sector					
Private clinic/Nursing home	63	41	52	77	71
Other private					
Pharmacy/Chemist	5	7	26	3	8
RMPs and traditional healers	33	42	17	19	19
Didn't avail any services	6	16			

Figure 8: Abortion care service utilization by young women



For the subset of women who reported having an induced (n=23) or spontaneous (n=97) abortion prior to the survey, a second interview was conducted on abortion practices for their last abortion (Table 13). The majority (52%) consulted a private doctor or nursing home for terminating this pregnancy. A significant portion of these private facilities were not approved to provide safe abortion services. Another 43% of women sought induced abortion services from chemists and rural practitioners who are not legally allowed to provide induced abortion services in India. Although abortion services are virtually free at government facilities and sites approved with trained providers, only four percent of women reported visiting a government hospital. The care seeking pattern was similar among young women who sought services for spontaneous abortion.

7

Discussion and Recommendations

The goal of this study was to develop an evidence base to understand the situation and needs of young women's awareness and access to sexual and reproductive health services in Jharkhand, particularly among young rural women. Our findings concerning young women's socio-demographic profile, exposure to mass media, sources of information on SRH-related issues and awareness of SRH-related issues, agency norms among youth, reproductive histories, and health seeking behavior all have implications for the design of a youth-focused intervention in rural India.

Profile of young women

The study explored the substantial age gap between married and unmarried young women. Unmarried young women on average were three and half years younger than their married counterparts. This demographic variation clearly reflects the social norm of early marriage. The majority of young women reported getting married much earlier than the legal age at marriage in India. School enrolment and education may have substantial influence on early marriage. For example, one-third of married young women had never attended school and one-fifth had left school with primary education. In contrast to this finding, two-thirds of unmarried young women were continuing their education and probably had been successful in delaying their marriage. These findings emphasize the fact that the national goal of universal schooling is critical toward eliminating the social norm of early marriage.

An overwhelming majority of young women belonged to the disadvantaged members of the Scheduled Tribes, Scheduled Castes or Other Backward Classes, and came from households with low to moderate living standards. Many reported that they did not work for cash or kind and did not have independent access to income. Even those who were engaged in wage earning activities were working largely as unskilled agricultural or non-agricultural laborers, suggesting a disconnect between demographic dividends of the young and a lack of market demand for their resources.

Media exposure and sources of information on SRH issues

Although young women are exposed to various channels of mass media, including television, radio, and newspapers, their exposure was irregular (2-3 days in a week) for all channels of communication. This suggests that young women cannot always be effectively reached through electronic or print media. Unlike urban youth, rural young women were also not at all exposed to internet, emails, and social networks. Even with limited access to mass media and print media, young women receive

some information on SRH-related issues. However, for information about SRH issues the young population relied most heavily on informal sources that often, are not adequately trained on the subject. Findings presented in this report highlight family members, relatives, friends, and neighbors, and community-level sources, including ASHAs and Anganwadi workers as the most popular sources of information on SRH issues.

Thus, a better approach may be to reach young women in community settings. Important secondary audiences such as outreach workers (AWWs, ANMs, ASHAs), peers, and neighbors can be influential intermediaries in reaching young women. Since these individuals typically provide information on contraception and SRH issues in their communities, it is not surprising that they were the most frequently cited sources of information for sensitive issues such as family planning and abortion. Use of peers and outreach workers as social influencers may also help address the challenges of reaching low literacy rural youth.

Young women's agency

In the context of this study, agency is defined as the ability to exercise choices through personal competence to exert influence over life matters, including four key dimensions: decision-making, freedom of movement, a sense of self-worth, and access to resources. Findings highlight the limited agency of rural young women. A majority of young women are not able to exercise agency in their daily lives. However, spousal control over their wife's mobility inside the village and decision-making appears to be stricter than parental control over their unmarried daughter's mobility and decision-making. Further research is needed to better understand whether social norms of gender discrimination or relatively better education of unmarried women are influencing the observed differences in agency among unmarried and married women.

Study findings, however, highlight a uniform pattern among married and unmarried young women in terms of freedom of mobility outside the village, decision on strategic life choices like marriage and child-birth, access to money. Agency measured through a sense of self-worth or self-efficacy also recognizes limited ability of young women to negotiate with elders, peers, and health care providers to share their opinion, discuss reproductive health matters, and further negotiating with their spouse to have no sex without her willingness. The overall agency scores were substantially low for access to money and decision-making. Our findings on agency are consistent with similar work in India (Jejeebhoy et al. 2010, IIPC and Population Council 2010).

The results of the multivariate analyses reveal age, education, high living standard, exposure to mass media, and two or more living children (for married youth) to influence young women's agency.

Awareness of SRH issues

Findings demonstrate extremely limited understanding of sexual and reproductive health matters among young people. Irrespective of marital status, rural young women are uniformly not well-equipped to deal with their sexual and reproductive health. Findings underscore young women's limited knowledge on menstruation, sex, pregnancy, contraception, and abortion. The majority of rural young women have expressed complete ignorance of association between frequency of intercourse and the likelihood of pregnancy; over 80% of young women feel that one cannot get pregnant at first sexual encounter, but only with repeated sexual acts. Even married young women are not sure about the safe period where women are less likely to get pregnant.

A similar pattern of misconceptions abound on the legal aspects of abortion and contraceptive methods,

especially for IUCD and emergency contraception. Despite 41% of total abortions in India being reported by young women under the age of 25 years (Banerjee et al. 2013), rural young women are uniformly found unaware about the legal aspects of abortion. Though the MTP Act has existed for four decades in India, more than 95% of the young women in this study are found unaware that abortion is legal in India, and none of them are aware of the specific gestation up to which abortion is legally allowed in India.

The multivariate results provide a clear insight of the factors associated with young women's knowledge of SRH issues. Age, education, and marital status are significantly associated with correct information, while caste, religion, work status, and family composition have no influence on knowledge of sex and pregnancy and contraception. Although the finding that young women in a joint family are associated with low levels of awareness on abortion issues may seem counter-intuitive (as family members and friends are reported as the main source of information), it is likely a reflection of other family members and friends not being aware of the legal aspects of abortion. The finding that young women who have any exposure on SRH issues are more likely to have significantly better knowledge of sex and pregnancy, contraception, and abortion, highlights a promising opportunity for youth-focused communication intervention to improve knowledge. The study also suggests that sex education is essential among married and unmarried youth and both for those in school and those who have discontinued their education.

Reproductive histories and utilization of SRH

Reproductive histories of young women clearly reflect the continuing trends of early pregnancy and high fertility. More than one-third of young married women reported two or more surviving children at the age of 15-24 years. One-fifth of young women had experienced at least one pregnancy loss. In contrast to the urban youth, almost one-tenth of rural young women reported completing desired family size and had accepted female sterilization as contraception. Even after six decades of official family planning programs in India, young women rarely accept any modern spacing methods, including condom, oral contraceptive pills, and IUCDs.

Knowledge gaps and poor agency may also serve as potential barriers to utilization of SRH and safe abortion services. Although public sector health care services are provided free, young women with poor economic background seem to prefer to approach either a private doctor or unskilled rural practitioners. For example, a majority of young women seeking abortion service approached a provider who is either not legally allowed to offer abortion or who is posted at a facility that is not approved for abortion. Again, our findings are in line with other research in India (Banerjee et al. 2012, Jejeebhoy et al. 2006). It is likely a reflection of the fact that public sector SRH services are not available in villages, and women must travel great distances to access these services. Alternatively, it is also possible that young women do not feel comfortable to go to a public sector facility that is insensitive to the specific needs of young women, including privacy.

This assessment of young women's awareness of SRH matters and current practices of utilizing health care services for reproductive health issues including abortion and postabortion complications suggests a need for a comprehensive, youth-focused behavior change communication. In addition, interventions intended to address the SRH needs of youth population must consider the need of highlighting the access to youth-friendly health facility.

This approach will not only raise their awareness but also enable them to translate information into practice through improved agency, including self-efficacy, decision-making, and negotiation skills. At the same time, it is important to build formal or informal peer-networks of young women to ensure social support within the same community.

Study limitations

Our findings should be viewed within the context of the study's limitations. Household surveys rely on self-report by the respondents and reporting and recall bias are possible. Like other demographic and social surveys, the incidence of abortion and knowledge of abortion-related information may be under-reported. The findings of this study are based on three selected blocks and cannot be generalized to the young population of Jharkhand. However, most of the study's findings on young women's knowledge, attitudes, behavior, and practice are in line with other published research in India.We acknowledge some shortcomings to measure the agency among young women. With limited available literature in India, we tried to pose questions that were pre-tested and placed in earlier research conducted among youth.

References

Banerjee Sushanta K, Kathryn L Andersen, Rebecca M Buchanan & Janardan Warvadekar 2012. Woman-centered research on access to safe abortion services and implications for behavioral change communication interventions: a cross-sectional study of women in Bihar and Jharkhand, India. BMC Public Health 2012, 12:175.

Banerjee Sushanta K, Kathryn L Andersen, Janardan Warvadekar, Sangeeta Batra, & Danish U. Khan 2012a. Sharing Messages about Safe Abortion Services: Evaluating the Ipas Behavior Change Communication Intervention in Bihar and Jharkhand, India, New Delhi, Ipas India.

Banerjee Sushanta K, Kathryn L Andersen, 2009. Exploring the pathways of unsafe abortion: A prospective study of abortion clients in selected hospitals of Madhya Pradesh, India. New Delhi: Ipas India; 2009.

Banerjee Sushanta K and Andersen K 2012b. Exploring the pathways of unsafe abortion in Madhya Pradesh, India, Global Public Health, 2012, 7(8): 882-896.

Banerjee Sushanta K et al. 2013. Social and demographic attributes of access to safe abortion: A cross section baseline survey in three selected districts of Madhya Pradesh. Ipas. New Delhi 2013.

Daniel EE, Masilamani R, Rahman M: The effect of community-based reproductive health communication interventions on contraceptive use among young married couples in Bihar, India. Int Fam Plan Perspect 2008, 34:189-197.

International Institute for Population Sciences & ORC Macro, 2007. *National family health survey-3 India, 2005-06,* Mumbai; IIPS.

International Institute for Population Sciences & Population Council 2010. Youth in India: Situation and Needs 2006-2007, Mumbai; IIPS.

Ipas 2011. Young women and abortion: A situation assessment guide. Chapel Hill, NC: Ipas.

Jejeebhoy, SJ and S Halli 2005. Marriage Patterns in Rural India: Influence of Socio-cultural Context in B Cynthia, Lloyd et al. (ed.), The Changing Transitions to Adulthood in Developing Countries: 172-199 (Washington DC: The National Academic Press).

Jejeebhoy, Shireen, AJ Francis Zavier, & Shveta Lalyanwala 2006. Assessing abortion-related experiences and needs in four districts of Maharashtra and Rajasthan, 2006. New Delhi: Population Council.

Jejeebhoy, Shireen, Rajib Acharya, Mallika Alexander, Laila Garda, Savita Kanade 2010. Measuring Agency among Unmarried Young Women and Men. Economic & Political Weekly, July 24, 2010 vol xlv no 30.

Kabeer, N (2001): 'Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment' in Discussing Women's Empowerment—Theory and Practice, Sida Studies No 3, Novum Grafiska AB, Stockholm.

Malhotra, A, S Schuler, and C Boender 2002. Measuring Women's Empowerment as a Variable in International Development on Women, Paper commissioned by the Gender and Development Group of the World Bank and by the World Bank's Social Development Group.

RGI 2011. Special Bulletin on Maternal Mortality in India 2007-09. Sample Registration System. Office of Register General, India. June 2011.

Roy TK, Jayachandran V, Banerjee SK: Economic conditions and fertility: is there a relationship. Econ Pol Wkly 1999, XXXIV: 3041-3046.

Sood S, Shefner-Rogers CL, Sengupta M: The impact of a mass mediacampaign on HIV/AIDS knowledge and behavior change in North India:results from a longitudinal study. Asian J Communication 2006, 16:231-250.

Strecher VJ, DeVellis BM, Becker MH, Rosenstock IM: The role of self-efficacy in achieving health behavior change. Health Educ Behav 1986, 13:73-91.

World Health Organization 2001. Sexual Relations among Young People in Developing Countries: Evidence from WHO Case Studies. Geneva: World Health Organization.

World Health Organization: Commonwealth Medical Association Trust and UNICEF 2006. Orientation Programme on Adolescent Health for Health-care Providers. Geneva: World Health Organization.

World Health Organization 2007. Adolescent Pregnancy-Unmet Needs and Undone Deeds: A Review of the Literature and Programmes. Geneva: World Health Organization.

Xaxa V 2001. Protective discrimination: Why scheduled tribes lag behind scheduled castes, Economic and Political Weekly, 2001, 36 (29): 2765-2772.

Appendix

Table A1: Communication network of young women in case of her personal matters, Jharkhand 2012

Characteristics	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Taking a job						
Mother	12	2	319	46	331	24
Father	15	2	286	41	301	22
Mother/sisters-in-law	84	12	9	1	93	7
Father/brothers-in-law	51	7	–	–	51	4
Brother	1	<1	33	5	34	3
Sister	–	–	16	2	16	1
Husband	512	74	NA	NA	512	37
Other relatives	2	<1	6	<1	8	<1
Friends	1	<1	13	2	14	1
Teacher	1	<1	1	<1	2	<1
Other	–	–	3	<1	3	<1
Nobody	11	2	5	<1	16	1
Menstrual problems						
Mother	39	6	575	83	614	45
Mother/sisters-in-law	184	27	38	6	222	16
Sister	9	1	24	4	33	2
Husband	410	59	NA	NA	410	30
Other relatives	38	6	12	2	50	4
Friends	9	1	39	6	48	4
Sahiya	1	<1	1	<1	2	<1
Nobody	0	–	2	<1	2	<1
Someone bothers						
Mother	62	9	379	55	441	32
Father	10	1	113	16	123	9
Mother/sisters-in-law	56	8	41	6	97	7
Father/brothers-in-law	6	<1	–	–	6	<1
Brother	–	–	49	7	49	4
Sister	2	<1	22	3	24	2
Husband	544	79	NA	NA	544	39
Other relatives	4	<1	12	2	16	1
Friends	6	<1	75	11	81	6
Personal problems?						
Mother	137	20	492	71	629	46
Father	8	1	6	<1	14	1
Mother/sisters-in-law	83	12	26	4	109	8
Brother	1	<1	0	–	1	<1
Sister	6	<1	52	8	58	4
Husband	417	60	NA	NA	417	30
Other relatives	13	2	14	2	27	2
Friends	24	4	98	14	122	9
Other			1	<1	1	<1
Nobody	1	<1	2	<1	3	<1

Table A2: Awareness of sexual and reproductive matters among young women in Jharkhand 2012

	Married (N=690)		Unmarried (N=691)		Total (N=1391)	
	n	%	n	%	n	%
A woman can get pregnant on the very first time she has sexual intercourse						
True	138	20	27	4	165	12
False	400	58	189	27	589	43
Can't say	152	22	475	69	627	45
A woman can get pregnant only with few (more than one) sexual intercourse						
True	563	82	259	38	822	60
False	61	9	33	5	94	7
Can't say	66	10	399	58	465	34
A woman is most likely to get pregnant if she has sexual intercourse half- way between her periods						
True	377	55	62	9	439	32
False	147	21	92	13	239	17
Can't say	166	24	537	78	703	51
A woman is most likely to get pregnant if she has sexual intercourse during her periods						
True	201	29	53	8	254	18
False	325	47	120	17	445	32
Can't say	164	24	518	75	682	49
Pregnancy before 18 years aggravate the risk of mother's health						
True	547	79	493	71	1040	75
False	72	10	27	4	99	7
Can't say	71	10	171	25	242	18
Pregnancy can occur after kissing or hugging						
True	12	2	8	1	20	1
False	614	89	503	73	1117	81
Can't say	64	9	180	26	244	18

Table A3: Percentage of young women who correctly responded on different situations where abortion is legal in India, Jharkhand 2012

Abortion is 'legal' in given situation	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Pregnancy is an accident (contraceptive failure)	192	28	96	14	298	21
Pregnancy is a result of rape	312	45	237	34	549	40
Women's health in danger	338	49	267	39	605	44
Strong chance of serious defect in the baby	255	37	181	26	436	32
Pregnancy beyond 20 weeks	48	7	6	< 1	54	4
Fetus is female	31	5	34	5	65	5
Fetus is male	21	3	23	3	44	3
Woman does not want child	225	33	159	23	384	28
Woman cannot afford a child	235	34	175	25	410	30

*: woman responding abortion is **'legal'** in the given situation.

Table A4: Health seeking behavior of young women in case of antenatal care (for married) or personal health problems (for unmarried), Jharkhand 2012

Characteristics	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Source of seeking personal health care						
PHC/CHC/RH	61	9	38	6	99	7
SDH/DH/MCH	23	3	10	1	33	2
ANM/Nurse	46	7	12	2	58	4
Private doctor	372	54	258	37	630	46
Nursing home	64	9	25	4	89	6
Chemist shop	32	5	47	7	79	6
Ayurvedic doctor	3	<1	5	<1	8	<1
Dai trained birth attendant	10	1	7	1	17	1
Other traditional healer (Ojha)	21	3	38	6	59	4
Village practitioner (unqualified)	204	30	252	37	456	33
Other (AWW, compounder, family member)	11	2	29	4	40	3
No idea/Do not know	35	5	104	15	139	10

Table A5: Reproductive history of married young women, Jharkhand 2012

		Up to 17 years (N=147)		18 – 20 years (N=291)		21 – 24 years (N=252)	
		n	%	n	%	n	%
Ever had pregnancy	Yes	78	53	241	83	244	97
	No	69	47	50	17	8	3
Mean pregnancy (SD)*		1.3 (0.6)		1.8 (1.0)		2.5 (1.3)	
Currently pregnant	Yes	30	20	55	19	44	18
	No	117	80	236	81	208	82
Ever had live-birth	Yes	45	31	206	71	229	91
	No	102	69	85	29	23	9
Number of live-births*	1	35	24	136	47	67	27
	2	9	6	53	18	97	38
	3	1	<1	12	4	46	18
	4+	0	0	5	2	19	8
Mean no. of live-births (SD)*		0.7 (0.7)		1.2 (0.9)		1.9 (1.1)	
Ever had stillbirth	Yes	5	3	12	4	20	8
	No	142	97	279	96	232	92
Number of stillbirths *	1	5	3	11	4	18	7
	2	0	0	1	<1	1	<1
	3	0	0	0	0	1	<1
Mean no. of stillbirths (SD)*		0.06 (0.2)		0.05 (0.2)		0.09 (0.3)	
Ever had miscarriage	Yes	11	8	38	13	41	16
	No	136	92	253	87	211	84
Number of miscarriages*	1	11	8	31	11	34	14
	2	0	0	6	2	4	2
	3	0	0	1	<1	2	<1
	4	0	0	0		1	<1
Mean no. of miscarriages (SD)*		0.1 (0.4)		0.2 (0.5)		0.2 (0.5)	
Ever had induced abortion	Yes	1	<1	9	3	13	5
	No	146	99	282	97	239	95
Number of induced abortions*	1	1	<1	9	3	9	4
	2	0	0	0	0	3	1
	3	0	0	0	0	1	<1
Mean no. of induced abortions (SD)*		0.01 (0.1)		0.04 (0.2)		0.07 (0.3)	

*Means are calculated for young married women who had ever been pregnant.

Table A6: Utilization of health care services among young married women reported experiencing spontaneous abortion, Jharkhand 2012

	Total	
	n	%
Had spontaneous abortion (N=563)		
Yes	90	16
No	472	84
Consulted any provider or doctor after spontaneous abortion? (N=90)		
Yes	74	82
No	16	18
Reason for consulting a provider?* (N=74)		
Had bleeding	70	95
Had fever	2	3
Had complications	1	1
For consulting on next pregnancy	–	–
Other (child died in womb)		1
Who have been visited for complications after spontaneous abortion? (N=74)		
Doctor PHC/CHC/RH	1	1
Doctor pvt clinic/NH	57	77
Medical shop nurse/ANM	2	3
RMP/Jhola chap/Quack	14	19
What treatment has been received from this (these) providers? (N=74)		
Surgical method (name not known)	10	14
MA	19	26
MVA	5	7
D&C	8	11
Took medicine from a medical shop	2	3
Inserted something into vagina	1	1
Injection	10	14
Given medicines directly	21	28
Warm massage	1	1
Saline	1	1
Prescribed medicines	5	7

*: among those who consulted any provider.

Table A7: Quality of services provided as perceived by young married women who reported experience of induced or spontaneous abortion, Jharkhand 2012

	Total (N=94)	
	n	%
Provider counseled women on postabortion contraception		
Yes	26	28
No	67	71
Don't know	1	1
Was there enough privacy at the time of consultation?		
Yes	41	44
No	48	51
Don't know	5	5
Satisfaction with the services received		
Satisfied	82	87
Unsatisfied	11	12
Neither satisfied nor unsatisfied	1	1
Reasons for the satisfaction level of services received		
Recovered after taking medicine	36	38
Had confidence in doctor; had treated earlier	10	10
Aborted using medicines	6	6
Abortion does not take place anymore	1	1
Doctors' behavior is good	9	10
Treatment is effective	3	3
Treatment was effective but costly	7	7
Doctor's behavior is not good	5	5
Pain and cost was less	2	2
Didn't get rest and got aborted	5	5
Now, no problem takes place	3	3
Costly	2	2
Gave good treatment at low cost	7	7
Received good advice that helped later	3	3
Satisfaction with the provider's behavior		
Satisfied	83	88
Unsatisfied	5	5
Neither satisfied nor unsatisfied	6	6

*: among those who had at least one abortion (induced or spontaneous).

Table A8: Perception on place where abortion services can be obtained among young women in Jharkhand, 2012

	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Know the source of abortion services						
District/Urban hospital	69	10	44	6	113	8
PHC/RH/CHC	29	4	22	3	51	4
ANM/Nurse	6	<1	4	<1	10	<1
Private doctor	144	21	85	12	229	17
Nursing home	64	9	21	3	85	6
Chemist shop	9	1	4	<1	13	<1
Dai/TBA	7	1	2	<1	9	<1
Other traditional healer (Ojha)	11	2	4	<1	15	1
Village practitioner (unqualified)	31	5	14	2	45	3
Others	0	0	4	<1	4	<1
No idea/Do not know	483	70	577	84	1060	77
If require, can unmarried young woman access abortion at any nearest location						
Yes	91	13	56	8	147	11
No	230	33	206	30	436	32
Can't say	369	54	429	62	798	58
If No, why do you think unmarried youth have no access to abortion services*						
Fear of defamation in village	97	42	91	44	188	43
It is considered bad/sin for an unmarried girl to become pregnant	74	32	61	30	135	31
Will be ostracized	4	2	1	<1	5	1
Villagers will nag	12	5	9	4	21	5
It is a social stigma	38	16	30	15	68	16
If villagers come to know, they will kill the girl	4	2	5	2	9	2
Parents will kill her	0	–	4	2	44	<1
Doctors will not behave well; will say that it is illegal	1	<1	2	1	3	<1
Girl will be ashamed	1	<1	2	1	3	<1
Doctors will pass bad comments	3	1	2	1	5	1
Girl will be thrown out of home	5	2	7	4	12	3
Muslim community will not accept it	3	1	5	2	8	2
Girl will not be able to get married	4	2	8	4	12	3
Girl will be sent to jail	–	–	1	<1	1	<1

Continued

Table A8 *Continued*

	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Where do unmarried young women go to terminate her pregnancy?						
District/Urban hospital	36	5	17	3	53	4
PHC/RH/CHC	8	1	6	<1	14	1
ANM/Nurse	1	<1	–	–	1	<1
Private doctor	99	14	60	9	159	11
Nursing home	26	4	7	1	33	2
Medical shop	3	<1	3	<1	6	<1
Dai/TBA	3	<1	2	<1	5	<1
Other traditional healer (Ojha)	0	–	1	<1	1	<1
Village practitioner (unqualified)	10	1	9	1	19	1
No idea/Do not know	504	73	586	85	1090	79
Where would you advise your friends to go for abortion?						
District/Urban hospital	39	6	25	4	64	5
PHC/RH/CHC	11	2	12	2	23	2
ANM/Nurse	1	<1	0	–	1	<1
Private doctor	105	15	57	8	162	12
Nursing home	39	6	9	1	48	4
Dai/TBA	3	<1	2	<1	5	<1
Medical shop	0	–	2	<1	2	<1
Other traditional healer (Ojha)	0	–	1	<1	1	<1
Village practitioner (unqualified)	10	1	9	1	19	1
No idea/Do not know	482	70	574	83	1056	77

*: reduced base.

Table A9: Awareness of abortion methods among young women, Jharkhand, 2012

	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Heard about any abortion method						
Yes	206	30	71	10	277	20
No	272	39	299	43	571	41
Can't say	212	31	321	46	533	39
Methods of abortion heard*						
Medicines/injection	172	84	55	78	227	82
Dhulaai	28	14	16	23	44	16
D&C	26	13	4	6	30	11
MA	1	<1	0	–	1	<1
Jadibooti	9	4	3	4	12	4
MVA/EVA	1	<1	0	–	1	<1

*: reduced base.

Table A10: Exposure to message on family planning and its sources of information among young women, Jharkhand 2012

	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Received message on family planning						
Yes	616	89	512	74	1128	82
No	74	11	179	26	253	18
Source of messages on family planning*						
Television	119	19	149	29	268	24
Radio	5	<1	9	<1	14	1
Newspaper	13	2	31	6	44	4
Wall sign	22	4	40	8	62	6
Poster/billboard	31	5	60	12	91	8
NGO worker	1	<1	11	2	12	1
Chemist	4	<1	0	0	4	<1
ANM/Nurse	35	6	14	3	49	4
ASHA/AWW	176	29	73	14	249	22
Dai/TBA	2	<1	2	<1	4	<1
Government health facility	16	3	4	<1	20	2
Private provider	32	5	7	1	39	4
Husband	235	38	NA	NA	235	21
Family member	457	74	367	72	824	73
Friends/neighbors	493	80	415	81	908	81
Street drama	0	–	2	<1	2	<1
Other (books, teacher)	2	<1	5	1	7	<1

Table A 11 Exposure to message on SRH issues and its sources of information among young women, Jharkhand 2012

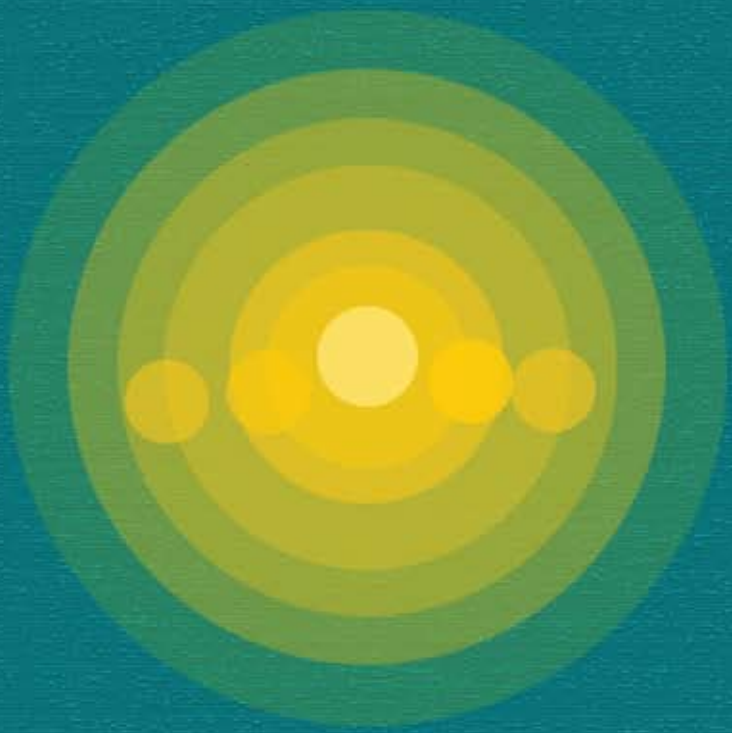
	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Received message on sexual and reproductive health issues						
Yes	617	89	479	69	1096	79
No	73	11	212	31	285	21
Source of messages on SRH issues						
Television	91	15	82	17	173	16
Radio	3	<1	4	<1	7	<1
Newspaper	8	1	8	2	16	2
Wall sign	4	<1	15	3	19	2
Poster/billboard	11	2	31	6	42	4
NGO worker	4	<1	8	2	12	1
Chemist	3	<1	1	<1	4	<1
ANM/Nurse	30	5	13	3	43	4
ASHA/AWW	167	27	70	15	237	22
Dai/TBA	1	<1	1	<1	2	<1
Government health facility	5	<1	9	2	14	1
Private provider	45	7	7	2	52	5
Husband	210	34	NA	NA	210	19
Family member	447	72	375	78	822	75
Friends/neighbors	439	71	368	77	807	74
Street drama	0	–	1	<1	1	<1
Prachar Prasar	0	–	1	<1	1	<1
Other (books, teacher, sister-in-law)	1	<1	12	3	13	1

Table A 12 Exposure to message on safe abortion and its sources of information among young women, Jharkhand 2012

	Married (N=690)		Unmarried (N=691)		Total (N=1381)	
	n	%	n	%	n	%
Received message on safe abortion						
Yes	69	10	24	4	93	7
No	621	90	667	96	1288	93
Sources of messages on safe abortion						
Television	5	7	3	13	8	9
Newspaper	3	4	4	17	7	8
Wall sign	1	1	3	13	4	4
Poster/billboard	1	1	2	8	3	3
NGO worker	0	–	1	4	1	1
Chemist	1	1	0	–	1	1
ANM/Nurse	6	9	1	4	7	8
ASHA/AWW	14	20	4	17	18	19
Dai/TBA	2	3	1	4	3	3
Government health facility	2	3	2	8	4	4
Private provider	13	19	0	–	13	14
Husband	12	17	NA	NA	12	13
Family member	29	42	9	38	38	41
Friends/neighbors	50	73	18	75	68	73

Abbreviations

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
BCC	Behavior Change Communication
BPL	Below Poverty Line
CAC	Comprehensive Abortion Care
IIPS	International Institute for Population Sciences
IEC	Information, Education, and Communication
INR	Indian Rupees
IUCD	Intra Uterine Contraceptive Device
MTP	Medical Termination of Pregnancy
MoYAS	Ministry of Youth Affairs and Sports
NGO	Non-government Organization
NACO	National AIDS Control Organisation
NA	Not Applicable
Ob-Gyn	Obstetrician-Gynecologist
RGI	Registrar General of India
RC	Reference Category
RTI	Reproductive Tract Infection
SC/ST	Scheduled Caste/Scheduled Tribe
SD	Standard Deviation
SLI	Standard of Living Index
SRH	Sexual and Reproductive Health
SRS	Sample Registration System
UNDP	United Nations Development Programme
USA	United States of America
WHO	World Health Organization



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