Study on Gender Equality as an extension of the impact of COVID-19 study in three states of India

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SALIENT FINDINGS

Common gender norms that impact women's participation and productivity

- **Gender roles are assigned at birth and the distinction between the lives of boys and girls is clearly reflected at an early age of 10 years:** Girls claim that they begin to learn household chores at the age of 10, spending increasing amounts of time indoors, whilst boys continue to stay outdoors and active, being socially separated from their female counterparts.
- **Gender norms posed education as optional for women, but necessary and critical milestone for men:** Women sometime rely on education to negotiate or delay age at marriage.
- **Mobility for young women is supervised and gets restricted at puberty:** When girls or young women travel, they travel with their husbands or other family members. Social customs dictates that the young women must not travel unaccompanied by family members, while young men and boys are set free at every stages of life.
- **Early marriage and choice of marriage are typically not in the control of the woman:** The biggest reason for early marriage was reported to be the fear that the girl would not get a suitable groom if she delays her marriage for too long. This impacts the agency and aspiration of young girls who want to build their personal career differently.
- **Gender norms within the household also restricts access to modern technology:** Married women either do not have access to personal phone or they share phones with their husbands.

Impact of gender norms on behaviors of women and other stakeholders

- **The manifestation of traditional gender roles is shifting as domestic and economic status and needs evolve:** As economic burden on men increases in a competitive job ecosystem, men seek more educated and socially equipped spouses so the spouses can independently take care of the home and help to educate their children. By default, due to this demand, girls' parents are paying greater attention to educating their daughters.
- **Women's household work takes precedence over any economic contribution:** The norm for married women is to stay at home and take care of her children or the whole family and so they usually do not have the option to go out and work. These age-old expectations from all stakeholders also dictate their mobility, agency, and aspiration in life.
- **Limited social exposure and inability to contribute financially impacts women decision making within and outside of family network:** Women's aspirations are aligned with the role that is defined by different stakeholders and this further impacts women's ability to take decision on different domains of life, including health and education.

Gendered Social Expectations of Men related to SRHR

- **Men tend to lean towards keeping matters private in terms of social support and feel compelled to tackle familial/spousal concerns on their own**.
    - There is a need for a platform where men feel **comfortable** addressing health concerns, especially SRH - preferably routed through a contemporary – similarly aged man or woman with similar context.
    - There is scope to adopt a cohesive approach that involves men and women equally, in building an understanding of the value of seeking appropriate information and care for SRH, in a timely and consistent manner.
- **Women and men express the concept of 'obedient' and 'good' women based on the normative expectation of preventing pre-marital sexual intimacy at all costs.** In terms of social expectations, girls need to be obedient. Being disobedient would signify that these girls are not within their parents' control and have boyfriends. Girls who focus on dressing up or pay attention to their physical appearance, are labeled as "bad girls" while "good girls" are reported to be those who confined themselves to help in household works.

- **High expectation to have a desired ideal family:** Almost uniform expectations from newly married young women to have a child within a year of marriage followed by completion of desired family size with having at least one male child.
- **Married women should take the onus of using contraception:** Control over family planning to be exercised by the husband, but the onus remains on the woman to ensure spacing or limiting pregnancy.

Factors that empower women to make decisions for themselves

- **Interspousal communication plays an enabling role in women's ability to identify and seek care for SRH issues:** In marriages where the husband is supportive of the spouse and there is a greater communication between husband and wife, it is seen that there is greater ability for the woman to identify and seek substantial care for issues related to SRH.
- **In marriages where men feel themselves to be supportive husbands,** they play a key role in understanding and helping to fulfil the individual aspirations of their spouse, enabling greater agency as well as involving them in critical decisions about the home, children, health etc. In these marriages, resolution for SRH issues, conversations on family planning and decision making on contraceptive use is seen to be collective decisions between husband and wife.
- **Education level enables greater mobility and independence:** An educated woman is able to assert more independence in terms of seeking healthcare, procuring items, and even just mobility.
- **Interaction and constant engagement with community intermediaries like ASHAs:** Interactions with ASHAs help women to take important decisions about their own and family health. It also makes them aware of their health issues. ASHAs seem to be the most trusted influencers which not only empower women, but successfully manage the agreement of other family members who play important role in decision-making.
- **Access to technology does not imply the ability to utilize it effectively for information seeking -** Access to phones is typically given to women by their husbands/families and is not a confidential means of communication as it is typically shared. Confidence in using technology and other resources is a critical catalyst for women to be able to leverage them for improved access to information and health seeking behavior.
- **Adequate information about products available for SRH care:** Adequate information about SRH care, including contraception, menstrual health and hygiene empowers women to take informed decisions about seeking and using appropriate methods.

Areas where women have control versus areas where they do not

- **In cases where women do not have agency or contribution to decision-making in the household, the lack of control cascades into the lack of importance given to the woman's health**. Both women and their families (husband + in-laws) are seen to de-prioritize woman's health in comparison to that of the healthcare needs of other family members namely, elders, male members, and children in the household. Especially when seeking healthcare is contingent on financial resources, the healthcare, and specifically, SRH needs of the woman are given lesser importance.
- **Women tend to exist in social clusters with one another, given that they do not necessarily engage socially beyond these closed groups -** There is an opportunity to leverage this social support to improve women's propensity to identify SRH needs and issues and to depend on one another for support and guidance on how to resolve these needs.
- **Women have some control on** their individual choices, mobility for unmarried, social interactions, seeking general health and SRH care for married women.
- **Women have no or limited control on** wage earning activities, marriage, mobility among married, fertility management and decision, and ability to spend money by her choice and preference.

Men's and women's access and control over resources impacts their ability

- **The decision to seek care:** Decision to seek care is dependent on access to multiple resources like information, financial resources, and mobility which men can exercise as they are mostly equipped with financial resources.
- **Access transport to care:** Men are able to access transport independently either by taking public transport or by driving themselves, or by arranging it with the help of the community, while women have limited ability to access the same.
- **Access social support**: Women have robust, but underutilized networks of support with other women in the community. When in need of assistance, women are able to seek social support and guidance. For men, they are able to seek infrastructural support from peers or community elders in case in need of transport or some other assistance. Further, men are connected with providers from whom they are able to comfortably seek information or services, as required.
- **Access health information**: Men typically have the social engagement, technology resources and access to providers to access health information, while women have limited access to technology, limited mobility and limited social interaction leading to inadequate access to information.

Impact of ability on present SRH behaviors

- **Women who are more educated are able to leverage technology for information, are also seen to be more independent** - A woman in Madhya Pradesh who is pursuing her graduation uses her technology access to resolve not only her own health problems, but also those of other members in the household. Further, the family depends on her to interact with the doctor when anyone falls ill in the house.
- **Women do not have access to role models in order to leverage education and access to technology for greater agency and independence -** Women who grow up in enclosed ecosystems are conditioned to develop themselves for their role as homemakers and for child-rearing. Many of them express disinterest in education, and do not express the aspiration to be independent. A few men and women who witness such role models through entertainment, express individual aspirations for themselves as well as for their daughters. There is an absence of substantial examples in order for women to **register and act on their lack of agency and inability to contribute to decision-making in the home.**
- **More often than not, the sources of seeking SRH information and care (except the ASHA) are funneled via the husband for married women.** It is worth exploring engaging the man with practical implications of compromised SRH needs in terms of long-term financial implications on the family, in order to increase his interest and involvement towards the improvement of a woman's SRH status.
- **ASHA tends to be the default direct source of SRH information and care for (married) women, especially when SRH is not openly discussed between the man and woman.** In cases where the man and woman do not engage with one another extensively on SRH concerns, the woman defaults to seeking assistance from the ASHA.

Long-Term Impact of women's increased ability to take charge of SRHR

- **Ability to identify the appropriate need and time to seek SRH information/services**: Women who are able to access information from the ASHA are also able to identify and seek care for SRHR issues.
- **Ability to utilize available resources to find alternative sources of information, in a crisis**: During the COVID-19 lockdown, women have used their phones to connect with the ASHA. This has created a new ground to replace physical interaction with telephonic interaction and connect with ASHAs and doctors for different health needs.
- **Ability to delay the entire reproductive timeline by extending age at marriage:** Women who have had consistent exposure to information through the ASHA and other women and have delayed age at marriage and their first pregnancies to a stage where their minds and bodies are prepared to cope with the pregnancy.
- **Confidence and conviction to independently seek help for any SRH concerns** without needing to funnel it through a family member: Increased ability to take charge of SRHR puts women in a place

where they have the confidence to seek care for SRH issues anytime, anywhere it occurs. A large hurdle of apprehension, shame, and stigma are eliminated when a woman is equipped to seek care for SRH, ensuring that timely resolutions are sought by women for any issues that emerge.

CHAPTER 1

BACKGROUND AND STUDY DESIGN

1.1 Genesis

Over a few decades, approaches to enhancing Sexual and Reproductive Health (SRH) as a human right of the citizens have gained more traction. A broader set of approaches have been adopted to address the SRH within the country. However, the emergence of the global pandemic-COVID-19 has thwarted the attempts to improve the landscape of SRH and its institutional setting across the country. Outbreaks similar to COVID-19 have been known to have grievously affected SRH services resulting in outcomes such as miscarriages, maternal death and other pregnancy-related issues. As stated in a formal note by UNFPA, for every 3-month lockdown, in cases of high levels of disruptions, up to two million additional women may be unable to access modern contraceptives (UNFPA 2021). In the Indian context, it is estimated that as much as access to 1.85 million abortions might have been compromised in the first three months of the COVID-19 pandemic as there was an absolute shut down of many services- providing agencies despite declaring SRH services as essential (IDF 2021). Access to hospitals, chemists, and pharmacies has been drastically reduced, more so, for women from rural settings.

The lockdowns, social and administrative restrictions, and added stressors related to household issues and economic instabilities have been suggested to have a direct impact on the increase in the incidences of violence against women. With the decrease in the access to information and services to SRH, the situation was aggravated as it disarmed women to take charge of their rights.

With this backdrop, a research study was conducted to understand the impact of the COVID-19 pandemic on young women's access to information and services related to SRH. Further, in addition to understanding this impact, it was important to examine the gender context - gender norms, expectations, impact on the ability to seek care as a result of gender dynamics as this would enable the strengthening of the SRH-focused intervention.

1.2 Research Objectives & Scope of Work

1.2.1 Scope of work

This study aimed to gain a deeper understanding and generate evidence of the gender norms that prevail in the communities' and their impact on young women's ability to fulfill SRH needs, gaps in their perspectives, and the support required to mitigate those gaps. Ipas Development Foundation (IDF) carried out a cross-sectional study to assess the ground reality of SRH Services for young women and Girls in India, during the COVID pandemic in IDF's youth-focused intervention areas in three states including, Goalpara and Nagaon districts in Assam, Chhatarpur and Satna districts in Madhya Pradesh, and West Singhbhum district in Jharkhand. As an extension to that study, this research explored key questions about gender norms and the context within which young women and men operate.

1.2.2 Objectives

This study gathered the gender context of our target audience so it can be integrated into programs focused on building access to SRH information and services. The outcome of this study component will ensure that gender equality considerations are an integral component of IDF's SRH programming.

The specific objectives were to:

- Explore the common gender norms that present barriers to women's participation and productivity?
- Assess different ways that gender norms affect behaviors of the target population and other relevant stakeholders?
- Know what is gendered social expectations of women, girls, men, and boys related to SRHR?

- Explore in what ways are women and girls empowered to make decisions for themselves? In what ways are they disempowered from making decisions for themselves?
- Understand areas of their life that they do exercise a significant amount of control and areas where they have little to no control.
- Identify men's and women's differential access and control over resources that affect their ability to:
    - *Decide to seek care?*
    - *Reach the right level of care?*
    - *Access transport to care?*
    - *Access social support?*
    - *Access health information?*
    - *Get appropriate care?*
- Analyze how the answers to the questions above influencing their current SRH behaviors (such as decision-making, access to information and services, care-seeking, stigma)
- Ascertain the long-term impact of women's increased ability to take charge of their own lives, especially on SRHR.

1.3 Research Methodology & Approach

1.3.1 Methodology

A qualitative study design was adopted to gather open-ended responses through in-depth interview (IDI) techniques. The in-depth interviews aimed at understanding the in-depth perceptions of gaps between the needs and current status of the community's access to SRH impacted due to the COVID-19 pandemic. Most critically, in-depth interviews offered a view into anecdotal evidence surrounding SRH and the disruption of access to its services and information during the pandemic.

The study design adopted a combination of both exploratory and investigative methods depending on the stage of the project. The exploratory research design aimed to explore a problem to provide insights into and comprehension for more precise investigation. While an investigatory approach enabled a nuanced investigation of the problem. The purpose of this approach was to triangulate the data with all stakeholders of the research problem to provide a holistic picture of the emerging patterns.

Using open-ended interview guides two different types of respondents were interviewed by trained and experienced research moderators. These interview guides were translated into local languages and pre-tested before canvassing for the main survey. The study protocol, tools, consent forms, and implementation design were approved by the local ethical board (CMS IRB).

1.3.2 Target Respondents

Given the context of the study the following two types of respondents were targeted for the in-depth interviews:

- Young women and girls of age 15-24 years
- Young Married Men (20-29 years)

Respondents voluntarily agreed to take part in this study and provided written consent and assent (for girls less than 18 years) were included for the in-depth interviews.

1.3.3 The Research Implementation

The data collection activities were carried out in December 2020. Keeping in mind the possible spread of Coronavirus and consequent risks associated with it strong measures were taken to mitigate the potential risks for research moderators and respondents. Following the standard ESOMAR (European Society of Marketing Research) advisory data collection was initiated using a combination of online and offline interactions with all intended study participants.

In the first step, the respondents were identified and screened by a well-trained and experienced field recruiter who followed all COVID-19 protocols to recruit eligible study respondents at the household level and collect written consent and assent for the final IDIs. In the second stage, digital devices were installed for remote interaction with the research moderator. These recruiters acted as connectors to the online research team stationed at the capital city and study respondents located at rural areas. A mix of audio- and audio-visual mediums of the interface was used depending on the online connectivity.

1.3.4 Sample Coverage

The study was conducted in selected districts of three states including, Goalpara and Nagaon districts in Assam, Chhatarpur and Satna districts in Madhya Pradesh, and West Singhbhum district in Jharkhand. A total of 48 IDIs were successfully carried out in six villages across three study states.

Table 1. Distribution of sample respondents covered through IDIs by states and respondent types

Respondents	Madhya Pradesh	Jharkhand	Assam	Total
Young women (15-24 years)	**8**	**8**	**8**	**24**
Young Married Men (20-29 years)	**8**	**8**	**8**	**24**
Total	**16**	**16**	**16**	**48**

1.4 Study Settings

As mentioned, the qualitative study was carried out in three major states of India, including Assam, Jharkhand, and Madhya Pradesh. Study villages were selected randomly from the intervention districts where IDF had youth-focused interventions for the last few years. To set the context of study area, the profile study areas is briefed below:

Goalpara is an administrative district in the state of Assam. Major languages spoken here are Assamese, Bengali, Bodo, Garo, and Nepali. The population here according to the 2011 Census was one million with approx. 49% of the female population and with an overall literacy rate of 68.3%. According to the NFHS 5 (2019-20), 43.7% of the women have availed family planning methods (any method) and the total unmet need of family planning services are found around 17.7% of the women in the district.

Chhatarpur districts in Madhya Pradesh: Chhatarpur has a population of 1.7 million and a literacy rate of 63.7%. In 2011, there were a total of 356,297 families residing in Chhatarpur district. According to the NFHS 5 (2019-20), 53.9% of the women have availed family planning methods (any method) and the total unmet need of family planning services were found around 11%.

West Singhbhum district in Jharkhand

West Singhbhum had a population of 3.02 million. According to the NFHS Survey 4 (2015-16), 15.9% of the women have availed family planning methods (any method) and the total unmet need of family planning services were around 25.9%.

1.5 Profile of the study respondents

- Young women married and unmarried women and girls age 15-24 years
  Married:
  - Mostly in the age group of 20s
  - Belong to agricultural and non-agricultural households
  - Mix of Parities- number of living children varied from 0-2

- Currently co-habiting with spouse
- A mix of current users and non-users of modern contraceptive methods
- Varied education level ranging from primary education to secondary and above

Unmarried:
- Mostly in the age range of 15-20 years
- Belong to agricultural and non-agricultural households
- Currently living in maternal home
- Varied education level ranging from primary education to secondary and above

Married men (Independent sample not really the husbands of the female respondents[1])
- Mostly in the age range of 22-26 years
- Husbands of young women aged 15-24 years
- Number of children varied from no children to 2 children
- Varied education level ranging from primary education to secondary and above

[1] For ethical reasons young men and women were not selected from the same households

CHAPTER 2

RESEARCH FINDINGS

2.1 Common gender norms that impact women's participation and productivity

The norm of 'Gendered Predestination': It is reported by men and women, that though there is equal enthusiasm in a home upon the birth of a girl or a boy child, they are each treated differently in accordance with their predefined roles - the man's role of becoming a **provider** in the home, and the woman's role of being **married into her marital home, and of managing the household and rearing children**. This, according to several men and women, is a norm that impacts the way men and women lead their lives, from the time of birth itself. In response to a question on the feeling of parents when a baby girl is born in comparison to a baby boy, one responded as:

> *"For a boy it will be different i.e., to build a bigger house and for a girl we need to think of her marriage as soon as she reaches the age of marriage". [Young Married Woman (YMW), Assam]*

Increasing emphasis on education for men and women; education is optional for women, but necessary for men: It has been reported by men and women that education has become more prominent in the lives of both men and women compared to earlier periods. Both men and women spontaneously mentioned that they are free to pursue education as far as they would like, and their family can afford. However, upon exploring further, it was observed that education was perceived as being optional for women, as opposed to being a critical milestone for men.

Women relying on education to negotiate/delay age of marriage: With women, there were several instances of them claiming that it is not unusual for women to delay marriage to be able to study further. Men and women stated that things have evolved to a point where if a girl wants to pursue her education, she can choose to marry at a later age. That said, if a girl does not perform well in school or fails, she is likely to be married by her parents sooner, rather than later.

Mobility restrictions on girls commence at puberty: Mobility of young girls and women tends to be restricted to the household and nearby locations within the community. This restriction on mobility increases further when girls attain their puberty. This is typically done to contain interactions with the male gender, and to preserve familial honour by ensuring that the girl in the household does not become romantically involved with a person who is not deemed a suitable match by the parents.

> *"……I think….. our family impose restrictions when girls attain the puberty" [YMW, Assam]*

Mobility for young women is supervised: When girls or young women travel, they travel with their husbands or other family members. This travel is typically personal in nature (to visit family, to purchase makeup materials, to visit a healthcare facility etc.) Unmarried girls across three study states reported that social custom dictates that the young women must not travel unaccompanied by a family member. Further, during the teenage and young adult years the movement outside the home is mostly study or task-oriented that can include going to school, purchasing personal or household items, or for any health-related needs. The concept of leaving the home for leisure is even lesser because of the stated fear that looms in the girl's family for her safety. Even young male members clearly felt this gender specific discrimination. As stated by a male respondent:

> *"M: How does young woman manage? With whom she visits?*
> *R: With my mother.*

M: Does she travel alone?
R: No. It is the rule from earlier days". [Married man, Madhya Pradesh]

Early marriage and choice of marriage are typically not in the control of the woman: Parents getting girls married at a young age and often before the legal age of marriage, is a common practice. This impacts the agency and aspiration of young girls who wants to build their personal career differently.

Men and women spontaneously reported that marriage takes place after 18 years of age. This seemed to be an outcome of widespread sensitization to the legal implications of underage marriage. To this end, men and women reported that men and women go for underage marriage when they wish to marry without the consent of parents.

However, with further probe, t**he biggest reason for early marriage was reported to be the fear** that the girl would not get a suitable groom, if she delays her marriage for too long. Most men and women report having an arranged marriage.

"Yes, girls want to study but some parents don't understand, and they fix marriages of their daughters soon". [Married woman, Assam]

"Post (early) marriage the girl becomes restless, she does not want to study further. She thinks of her marriage only. Some parents also think of getting their daughters married at early age". [Married woman, Assam]

Limitations on interaction between men and women after a certain age: Both men and women reported that after certain age social interactions between girls and become restricted. Boys usually do not have any restrictions to move outside, whilst girls' mobility is restricted, and the expectation is for girls to begin learning household work in preparation for marriage. This often restricts and undermine the ability and skill of girls for other technical and academic works.

Women's default role in the household is to look after the home, family, and children: From the interviews of married men, it was inferred that women are expected to do housework. As social norms dictate, it was viewed as the default duty of women. Even if they were working outside the house, women were expected to prioritize domestic work over all else, if necessary. As mentioned by a man who owns business:

"My wife helps me in my business. She is helping you but sometimes it happens that she is needed at home. She has to skip her shop immediately". [Married man, Madhya Pradesh]

Increase in household chores during the COVID pandemic and lockdown: Since the common gender roles dictate that women are supposed to do household chores, work in the household for married women increased significantly during the lockdown because of increased household chores. It was seen across all the centers that this increased work burden was not recognized by the married men - most of them reported the burden of domestic work to be the same during lockdown. In an interview with a married man the respondent stated as:

"Moderator: Was there any responsibility for your mother? She must be looking after the normal household chores. Your wife must be also helping her. So, during the lockdown did her work increase or decrease?
Respondent: During lock down their workload increased since everyone was at home. They had to manage home and wash the clothes of other family members". [Married man, Assam]

Women's household work takes precedence over any economic contribution: The norm for married women is to stay at home and take care of her children or the whole family and so they usually do not have the option to go out and work. Even if they do, most married women work for the family business or with their husbands in agriculture. The concept that a married woman should 'go out to work' outside her immediate vicinity, on her own is not one that is common or accepted, **except in a few cases where the woman is educated up to graduation and is able to work as a professional**. However, several women do express the inclination to work, knowing that it is likely the family will oppose it.

> *"She might do household work. But she cannot do any commercial work that will earn her some money because her family won't allow her. But she'll want to do something to earn money." [Married woman, Assam]*

Access to technology/mobile phones: From the interviews of married men, it emerged that their wives either do not have their own mobile phones or they share phones with their husbands - even when the phone was reported to be 'owned' by the woman. This is reflective of a lack of privacy in technology access, with some level of surveillance on the woman's use of a phone.

2.2 Impact of Gender Norms on Behaviors of Women and Other Stakeholders

Gender norms impact the behavior of women and their family members in parts of life. Strict demarcation of goals in life segment the pathways and aspiration of young girls and boys and influence every decision in life. This study observed the following norms and their consequent behaviors:

Demarcated gender roles at a young age define aspirations for men (to provide) and women (to fulfil domestic responsibilities): Women aspire to the gender role that is defined for them from a young age. Across study states, women reported that from their childhood days they are 'taught' to take up household work and domestic responsibilities so that they can grow up and fulfil their familial roles as wives, daughters-in-laws, and finally as mother. The expectation that a girl child will grow up and take care of her parents was also pronounced among study respondents.

> *"She will be doing more as she is a girl, boys generally don't prefer doing household work". [Married woman, Assam]*
> *"As the girl grows up, she is asked to clean vessels, bring water and then when she grows up further, she is trained to cook food. She is not allowed to play more. She is given work more. [Married woman, Jharkhand]*
> *"According to me boys or girls both are equal, I am happy with both. I like to have a girl child…..girls understand their parents and take care of them. [Married woman, Assam]*
> *"If daughters are born, they are happy because she will help in work and not fight like boys". [Married woman, Jharkhand]*

Men on the other hand, see themselves as being the ultimate providers and being responsible for the well-being of their families. Thus, within the family and community, from the being the mindset of gender rol

Men are encouraged to pursue education and seek educated spouses: Men are encouraged to pursue education so that they can be eligible for work and take on the role of the chief earner of the family and be able to provide for their own spouse and children. Further, there is a growing prevalence amongst men who are educated, to seek wives who are also educated so that she can take care of the household, children and can help taking right decisions.

> *"In my opinion, if a couple is intelligent and educated even though they have been married at the age of 16 but still they are smart and think of inflation, have knowledge about family planning options, they have 2-3 children by the age of 24. At that time, they get the operation (sterilization)*

done for family planning. Though, presently we see that people do not have more than two children, which is a good thing. And I believe it is beneficial for all." [Married man, Madhya Pradesh]

"Moderator: Your wife is also studying now so who took that decision for her?
Respondent: I took the decision.
M: Did you talk to your parents about it?
R: Yes.
M: What did they say?
R: They agreed for her education after marriage. .
M: Did your wife insist on her studies or you?
R: In my family, everybody is literate so she should not feel that she has not studied". [Married man, Madhya Pradesh]

Gender norms overtake girls' individual aspirations for education: Women imbibe and live by the gender norms, expectations and roles defined for them. For example, education is seen as an **option** for women (whilst it is considered mandatory for men). In several instances, women reported that if they fail in their class examination in school, they do not get any external or internal motivations to continue their study since their destination is marriage and the consequent family duties that come with it. It is a common belief that if they are not married at a young age (19-22 years old) then people "encourage" them to start working, since they don't have anything else to do. **Here, marriage is seen as the primary goal, and if that does not work out then, education or work would be the second option.** However, this stereo-type mindset does not work for a boy child.

- **Few exceptions: Parents' motivation to educate their daughters is the evolving demand amongst eligible men to marry educated girls.** Men have reported seeking intelligent and capable partners who can run their homes and educate their children - resulting in the need of girls' parents to educate them so as to enhance their eligibility for marriage. **Men's need for economic and social support from their spouse are leading to a default upward education graph for women, as parents are now educating their daughters to amplify their marriage eligibility.**

"I told her I left studies, but you can continue your studies…. but she refused to do that. My wife studied till 10th standard and discontinued as she failed in Class X. [Married man, Jharkhand]
"I left studies 3-4 years back. It just happened….And do not want to join again". [Unmarried girl, Madhya Pradesh]

Limited social exposure leads to limited capability of women to recognize and/or articulate their aspirations: Men and women interviewed in this research expressed women's aspirations to be aligned with the role that is defined for women as the caretaker of the household and the children. Most men believed that women pose limited or no aspirations in their life.

…"My wife thinks a lot and tells me to do this, do that, go outside for work, do this. She says I will stay at home and will take care of the work. I go outside for farming work. She says you go outside, and I will remain at home. There is no problem. There is lot of work at home. [Married man, Jharkhand]

" She does not have many dreams. But she wants my salary to be good enough so that all our needs are fulfilled. [Married man, Madhya Pradesh]

Women's inability to contribute financially impact their decision-making ability within and outside of household: Across all three study locations, it was observed that due to lack of economic contribution to the household, young women usually do not take part in the decision-making process in the household -

be it financial, familial, and health related issues. In some cases of exceptions, where husbands strongly **endorse women's participation in household decisions,** they might give suggestions about expense management and groceries which are taken seriously. In a few households, mothers or the eldest female family member take those decisions.

> *"My mother takes those decisions at home; she asks me to save money and bring the necessary items for home. My wife doesn't take any major decisions at home. It is only my mother who takes the decision". [Married man, Assam]*

Domestic work is non-negotiable, no matter the economic value of work done outside the home: Even when women contribute to a family business or agriculture on the familial land, the burden increases as the domestic responsibility takes precedence over all else, for the women who work outside their houses and in their houses.

> *"She works at tailoring shop for some time. She works for 2-3 hours. She doesn't start with me. She starts around 12 noon and goes back at 3 pm. Along with her education, she needs to manage household work, and it is also necessary to give some time to children". [Married man, Madhya Pradesh]*

In some cases, where there is greater inter-spousal communication, men acknowledge the women's burden of work: There was an articulated acknowledgement by some men w.r.t the burden of women's household chores, but no alternatives were provided by the men to divide the burden. These married men stated that their wives do a significant amount of work in the house and take care of the family but hardly they stated of sharing burden of work within the family.

> *"She is doing same kind of activities that she used to do before COVID pandemic. She has a lot of responsibilities at home…… Sometimes, I wonder whether I would have been able to manage all that work if I would have been in her place. ……. We men cannot do as much work as women do. They take care of family at good and bad times. It is very difficult work to do. Wake up early in the morning, do all household chores and it is a lot. This is her daily routine like she remains busy in the household work from morning till evening. [Married man, Madhya Pradesh]*

Access to digital technology does not allow much privacy to women: Women, though they had limited access to technology and the internet, reported not using it as a source of information for their own health and information. Men also reported that their wives share their mobile phones to call their relatives or to watch entertaining events with their husbands. The content that they often watch is related to vocational skills like cooking, stitching etc.

> *"She watches recipes on YouTube" [Married man, Jharkhand]*

- Women tend not to use phones to access social media sites unlike men, who report using social media actively.
- Since women share their phones with their husbands, they appear not to have private access to technology, with the implication that usage of technology is typically monitored, and therefore likely not explored extensively for personal interest. This gender gaps in access to technology restricts women to explore the "new world of information".

Control over woman's mobility transfers from parents to the Mother in-law/ husband after marriage: This leads to a dip in mobility upon marriage as newly married women report being far more restricted in movement, and far more dependent on their husbands to go anywhere outside their marital homes. Typically, mobility increases with increased parity as woman is required to engage with FLWs for her

health, with doctors for her children's health and occasionally make purchases for the household. **Limited mobility results in limited exposure and socializing, thus <u>greater dependence on husband and other family members for information.</u>** This lack of exposure is also seen to limit the possibilities of aspirations a woman has.

> *"M: Okay. Does your wife go outside? Maybe in village, outskirt areas?*
> *R: If she has to travel or for a trip then Maihar is the spot.*
> *M: How does she manage? With whom she visits there?*
> *R: With my mother.*
> *M: Does she go alone?*
> *R: No.*
> *M: Okay. Was it the case before lockdown or is it after lockdown?*
> *R: It is the rule of family and nothing to do with pandemic". [Married man, Madhya Pradesh]*

Childbirth at a young age: Across all the study centers, it is a norm for women to have a child within 1-2 years of marriage irrespective of their age at marriage. Following from the norm of early marriage (sometimes at 16-17 years), the woman is then expected to prove her fertility in the home and to the community.

> *"After one or two years of marriage they become mothers like me. In our area most girls get married by the age of 20 to 21 years. Some of them even continue their studies after marriage". [Married women, Assam]*

Limited social exposure of young women leads to intense apprehensions and incapability to discuss issues pertaining to own health. Women feel apprehensive about addressing their SRH issues openly. This is compounded by the fact that the husband is typically the source of information and the woman is not equipped with the knowledge to identify health/SRH issues at the right time.

Women socialize in networks that constitute other women - including their own relatives like sisters, sisters-in-law, mother, trusted elder women in the community, neighbors, friends etc. Most women reported having a network of other women with whom they consult in case faced with health concerns. Women across three study states have reported having one or two close confidantes with whom they share their experiences and state of mind by way of casual, regular interactions. Other than their husbands, they tend to turn to these women for assistance when faced with an emergent situation.

> *"In case of any health issues, my wife consults my mother first and then does what my mother says". [Married man, Assam]*

In most cases, interspousal communication tends to be limited outside of domestic matters, and lesser so when it comes to SRH: Men and women both reported limited inter-spousal discussions about SRH issues. Majority of men were not aware of the woman's course of action when they deal with health or specifically SRH issues. Most men reported that the mother in-law or ASHAs are the primary points of contact in such situations. Women, however, reported that they typically addressed these issues with their husbands, before anyone else.

> *"She mostly consults ASHAs for such issues. And she always talks to my mother regarding any problems". - Married man, Assam*

> *"I discuss health issues with mother-in-law and husband. I consult ASHA didi, but during pandemic, I did not go out". [Married woman, Jharkhand]*

2.3 Gendered Social Expectations of Women, Girls, Men, Boys related to SRHR

This section describes the gendered social expectations of women, girls, men, boys as reported by the study respondents related SRHR.

2.3.1 Unmarried women

Limit social contact with the opposite gender when they reach adolescence: Most frequently stated intension among girls was to limit the social interactions with boys after reaching the stage adolescents. Men have increasing SRH freedom with the inherent expectation that they are not being controlled by anyone, whilst young women reported experiencing restrictions, especially after they start menstruating, to limit sexual exposure that might risk the family's dignity or reputation.

> *M: What are the changes you can see between a girl and a boy from the age group of 19-20?*
> *R: Girls are mostly not allowed to go out, but for boys there I no restriction". [Married woman, Assam]*
> *M: How do parent guide boys?*
> *R: When boys are grown up, they all scroll together, and girls are told to maintain some distance.*
> *M: Prior information is given to girls to maintain some distance?*
> *R: Yes, it is. [Married man, Jharkhand]*

Gender biased social expectation from unmarried girls: Women and men are cognizant of the contradiction between social expectation of remaining disengaged with the opposite sex, while experiencing growing attraction to the opposite sex at the age 15 or 16 years.

> *Like other unmarried girls, I also felt restless when I was 16 years. I didn't feel like studying, I wanted to be friends with boys. But I did not do anything wrong. Eventually, I had arranged marriage only. [Married woman, Assam]*

Use of mobile phone by unmarried girls are not seen as good practice: As has been reported by the study respondents, girls are judged mostly based on their activities being tied to daily routine. For example, according to a few respondents, a girl is "spoiling her life" if she spends time on her phone, with the assumption that the girl is spoilt because she interacts with boys.

> *"One of my neighbors who doesn't focus on study always spend her time on mobile. She is spoiling her life". By spoiling, I mean, she is in relation with a boy. She is only 15 years old. She keeps talking with him over the phone. [Married man, Madhya Pradesh]*

To marry by their parents' choice: It was reported by men and women that early marriage only happens when it is a love marriage.

> *"No parents will allow their daughter to get married at such an early age. So, it will be a love marriage". - Married woman, Assam*

To avoid doing 'anything wrong': Women and men express the concept of 'obedient' and 'good' women based on the normative expectation of preventing pre-marital sexual intimacy at all costs. While talking about expectations from unmarried girls, study respondents revealed that girls need to be 'obedient'. Being disobedient would signify that these girls are not within their parents' control and have boyfriends. Girls who focus on grooming themselves and dressing up or pay attention to their physical appearance, are labeled as "bad girls" while "good girls" are reported to be those who help around the house.

> *"Yes! Good girls would like to study. At around age 16 she might have some changes in her life regarding her studies. She will become restless, she will get attracted to opposite sex, she'll like*

to groom herself and look attractive. No, she'll pay more attention towards grooming herself and looking good, so she won't want to work a lot. She will want to keep herself neat and tidy. There are two types of girls some girls do household work some do not. Some keep the house clean, some do not. [Married woman, Assam]

"At the age 17-20 years girls are expected to obedient and are being monitored. If they are suspected to have a boyfriend then the parents would think of her marriage". [Married woman, Madhya Pradesh]

"At the age 17-20 years girls become physically ready to get married. They mostly discuss with their friend circle. Even boys too. They cannot share much with their parents. There might be some families where children discuss all these matters to their parents freely which I am not aware of". [Married man, Assam]

Expectations on the age at marriage for girls: Being physically ready is one of the conditions on which the decision of getting married depends. However, some said that the girl should be 18 years and her body should be prepared for motherhood before marriage.

"In my opinion, marriage of a girl should not be done before 18. The body is developed at age 16, but her mind is not developed. She might not have the information like what all happens after marriage, which she should have before marriage. I believe the girl should be ready in every way before marriage whether it is physical or mental. Marriage at 15-16 years are not uncommon in villages". [Married man, Madhya Pradesh]

"Girls will face problems at the time of delivery if she gets married at early age. When they go to the nurse post pregnancy, they say they don't need it and so the nurse gives them medicine for abortion". [Married man, Jharkhand]

To discuss menstrual hygiene and any other SRH problems with the mother, and at most with FLWs, but nobody else: Some unmarried girls reported that these issues cannot be discussed with most people, and they would only be able to discuss menstrual health or reproductive health with their mother, or at most, friends and elder sisters because they are too shy to even share this with their mothers.

"If she needs any information related to health, she will talk about it to her friends. Or her mother." [Married woman, Assam]

"Girls also go through physical changes at this age and they take guidance from their sister in- laws, mother, grandmother, so that they can give them the right guidance. Girls should be educated on menstruation and menstrual hygiene so that they can take proper care for themselves." [Married man, Assam]

2.3.2 Married Women

High expectation to have the first child within a year of marriage: Women are expected to have a child immediately after marriage. It has been reported that women are expected to keep up with their familial roles as mothers, wives, and daughters-in-law and to establish their fertility to the household and in the community.

"After one or two years of marriage girls become mothers like me. In our area, most girls get married by the age of 20 to 21 years. Some of them even continue their studies after marriage. By 20 to 21 most girls get married, and they take additional responsibility for their new family, for her child. She has got no time to think for herself she only thinks of her family and her children. [Married woman, Madhya Pradesh]

"Even if girls get married at the age of 16, they become pregnant right after marriage. She will have a child just after one year of marriage". [Married women, Assam]

Pressure to have at least one male child: This study observed common expectations from young married women to ensure at least one male child. There is a prevalent practice to keep trying in the hope of male child and stop only when a male child is born. If a girl child is born first then people are happy, but eventually they want a son. If the second child is a daughter, then it is unfortunate. Families considered getting operated only after the birth of a male child. This phenomenon was observed in Assam and Madhya Pradesh

"With girl child, some are happy, and some are not. Especially parents desire for a son. Our first child is our happiness no matter if it is a girl or boy". [Married woman, Assam]

"……Yes, they will feel bad that they have two girls, if they will have one boy, then things will be complete, but if they will not get that, then they will feel bad about it. [Unmarried woman, Madhya Pradesh]

"My mother-in-law never had a daughter. So, when I gave birth to a daughter, everyone was very happy. Now, I want one son. Then I could consider completing family by accepting sterilization". [Married woman, Madhya Pradesh]

Married women should take the onus of using contraception: Control over family planning to be exercised by the husband and mother in-law, but the onus remains on the woman to ensure spacing or limiting pregnancy. Men and women reported not having any proactive discussion on family planning. It was seen that married couples generally had communication on contraception before having a child.

"The gap between two kids is decided some cases by women and some cases by men, but they do not have planning it just happens". - Married men, Jharkhand

As responded by a male participant:

"No. I didn't discuss anything with my wife, but I planned that I want a baby after some time. Even I did not use condom then also I didn't let my wife have any oral pills at all". – [Married men, Madhya Pradesh]

A few male respondents said that couples should discuss family planning and wife's opinion is the most important. In some cases, husbands do not plan with their wives, but believe that they are ensuring what is in the woman's best interest, by not allowing their wives to take oral contraceptive pills, or injectables.

"Yes, wife should have some role. And I believe that it should be done after discussing with wife and with proper understanding. Husband should not pressurize if wife is not willing. [Married man, Madhya Pradesh]

To depend on the husband for all SRH related problems: Married women are expected to contact their husbands first for any health issues (specific to women) and then if he does not know, then she is supposed to contact a senior person at family, mostly another female member of the family or MIL.

If she (wife) has any problem I only see to it. She tells me all her difficulties. For health related problem wife can discuss my mother. I tell her and she gives her medicine. Otherwise, can consult a doctor to take medicine. [Married man, Jharkhand]

2.3.3 Unmarried Boys

Expectations from boys are predominantly focused on the anticipation that they do as they pleased to do and will likely get involved in bad habits with friends, and pre-marital sexual intimacy. In general, no

restrictions are imposed upon unmarried boys. Men and women both reported that households with financial constraints expect early involvement of boys for wage earning activities to start supporting the family. And after few years, parents expect to have early marriage of boys with some stable income. Those who are interested in studies have huge flexibility to carry forward the same. However, there awareness towards body changes and SRH are extremely limited.

> "*They face physical changes in their bodies at the age of 13-15 years. They start feeling grown up and they also might have girlfriend. [Married woman, Assam]*
> *"However, those who are good at studies continue their education and they are also mischievous sometimes. They either watch movies, start riding expensive bikes or start smoking cigarettes. I am telling you what I see around me. They force their parents to give them what they want". [Married Men, Madhya Pradesh]*

2.3.4 Married Men

Expected to control and steer family planning decisions: As reported in this study, married men do not talk about SRH related problems openly - it is considered private, and they choose to deal with such issues on their own. It is a societal expectation that men must be the ones to take decisions regarding family planning, as well as SRH needs of their wives. They often take decisions without having much clarity on the subject.

At times, women also reported that there was no interaction with their husbands regarding SRH issues. Only couples who are open and communicative, discuss SRH these issues with their sposes.

Expected to provide for their family and to have children as soon as they are financially stable: After one and two years of marriage**,** married men are expected to have at least one child.

> *"At the age 21-22 years married men should have one child. They have only one not more than one in our village also at this age of 20-21". [Married man, Jharkhand]*

2.4 Factors that empower and disempower women to make decisions for themselves

2.4.1 Overall decision-making

a. Personal decision

Fulfilment of all domestic duties: Individual interests and hobbies can be decided by girls and women contingent on fulfilling all domestic duties. From the interviews of women across three states, it was seen that women were able to take decisions about their free time activities. If they fulfil other duties, do chores, do not need to step out of the house, they can control free time. In most cases, women report housework to be their first responsibility. The concept of individual leisure time is tied to taking up pending tasks in the home.

> *"I do the household work and use mobile phone when I am free, I listen to songs, watch movies on the phone. Sometimes I also read story books". [Married woman, Assam]*

Access, Intention, and Ability to use smartphones: Women who are more educated and have their personal mobile phones, have a social media presence. Women use the phone to connect with people, to gain knowledge and find resources. The most used apps were WhatsApp, Facebook, Instagram, Tik-Tok, and YouTube. Access to mobile phones have also made it possible for women to continue their education during the lockdown.

> *"I love to make handmade things. I learn from YouTube and try to make it". [Married woman, Assam*

> *"I watch various videos. I also have my own YouTube channel where I post my videos. Not only in YouTube, but I also even post my videos on WhatsApp and Facebook and share them*

with my friends. My friends also buy mats from me and they also give me their old clothes as everyone has some unused clothes in their house. - Married woman, Assam

My wife takes classes online and also prepare for the classes."[Married man, Jharkhand]

Education level enables greater mobility and independence: It was reported that if a woman is more educated then she is able to comfortably assert more independence in terms of seeking healthcare, procuring items, and even just mobility.

"... If someone is educated she wants to be independent". [Married woman, Assam]

Husband's support to pursue education: Decision about a woman's education depends on her husband and in laws after getting married. Supportive husbands encourage their wives to continue with their education.

"Her parents and she herself will take those decisions, if she gets married then her husband will decide it for her. If he's a good husband he'll let her study further". [Married woman, Assam]

"I told her I left studies but you can continue your studies, but she is refusing. She failed so she did not repeat. She does not want to study and go ahead in life? [Married man, Jharkhand]

Supportive in-laws: It is reported that a supportive MIL encourages women to take important decision like going for education post marriage and taking a job.

"Yes definitely! My MIL will allow me to for study. My MIL cares for me like her own daughter". [Married woman, Assam]

Interactive relationships: Relationships where couples interact and communicate consistently, here, wives take decisions about clothes, groceries, child's education, and she discusses with her husband. Collective decisions are made.

***M**: Who takes the decision of expenses? how much to spend and who is to spend, who decides all these things?*
R: We both together - Married man, Jharkhand
R: My wife and I discuss about kids' education. She tells me what to bring for the house and I bring. She is a woman, so she only sees what to buy. [Married man, Jharkhand]
M: okay, like if you want to buy clothes or shoes, for you or your wife? Who takes the decision?
R : Whatever we want to buy we do jointly. If she wants something she also goes. - Married man, Jhrakhand

Nuclear family set-up: It is easier for women to manage their own time and taking independent decision in a nuclear family set-up.

" When we are idle we sit and watch T.V. We utilize leisure time by our own choice". [Married woman, Madhya Pradesh]

Exposure to the outside world: With some exposure of outside world women can take many important decisions in absence of other family members. This was seen in almost all study locations.

"Yes! My wife goes to the market for buying clothes or vegetables. She goes to the market when I am not at home and she can take independent decision. [Married man, Assam]

Interaction with ASHAs: Women interact with ASHAs individually and are found to seek information from them. Interactions with ASHAs help women to take decisions about their own and family health. It also makes them aware about their health issues.

"I generally don't ask to anyone rather than sister ASHA. I trust her suggestion. She explains me everything regarding raising my children, issues upon my health. [Married woman, Assam]

b. Marital decision

Pursuing higher education as a tool to delay age of marriage - With the increasing education level, the age at marriage was reported increasing in the community. Education is leveraged as a tool for taking decision and deferring marriage.

> *"I think a girl should be married by 20 to 21 years. Some girls want to continue studies, so they don't want to get married earlier. [Married woman, Assam]*

Supportive community enables the opportunity to choose husbands: Girls have a choice to choose their husbands and have their families pursue the match - this was only seen in Jharkhand dominated by tribal population.

> *"They don't do it we have to find on our own. It happens with their wish and choice and if they go somewhere and like someone then we start to enquire". [Married woman, Jharkhand]*

c. Familial and social decision

Legitimacy: Women are empowered to socialize when there is legitimacy to the interaction.

- When person being socialized with is a trusted member of the community. For example, older women, ASHA, Anganwadi worker.
- If the person being engaged with a friend (known circle)
- If person being engaged with is at a similar life stage (woman of same age)
- If there is no threat of bringing dishonor to the family (not an opportunity for a woman to be disloyal in her marriage)

> *"My wife does not go alone. She goes with the sister or otherwise she goes with the daughter of my elder brother. She goes with them only". [Married man, Jharkhand]*

Support of MIL: With the sanction of husband and MIL, women are empowered to socialize by their own.

> *"….With my mother or with other family member my wife can attend any social function".[Married man, Madhya Pradesh]*

Need for urgent help: When help is needed especially concerns related to health. If help is needed for the well-being of a family member or child

> *"My wife goes to the Angan wari workers (AWWs) for urgent information related to health issues". [Married man, Assam]*

d. Health related decision

Joint decision by husbands and wives: When men and wives talk to each other, they take decisions about health together. Here women also have the space to share their opinions in decision-making.

"Yes; after giving birth to one kid, then after two years we had taken a gap. We have decided jointly". [Married man, Jharkhand]

Constant engagement with ASHA: When a woman engages with the ASHA by herself, she is significantly empowered to take her own health related decisions, sometimes even without any consent from husband or the MIL. This trust in the ASHA by the family is crucial in enabling frequent interaction of the woman with the ASHA without supervision.

> *"I don't know what she is talking to the ASHA about, she never told me anything. She doesn't tell me anything, she keeps the information with herself". [Married man, Jharkhand]*

"Usually, it is confidential discussion. They come to our house every month, but it is not a fixed date. She comes, sits, and talks with her. So they talk in our house only".[Married man, Madhya Pradesh]

2.4.2 Decision-making related to SRH:

Women are empowered to take decisions related to SRH under the following situations:

a. **When woman has support and information from the ASHA**, she is empowered to take SRH related decisions. Consistent and open interaction with the ASHA helps women to seek information and services for SRH needs like pregnancy and contraceptive use, as well as access to any products the ASHA might stock.

"I talked to them regarding which kind of contraception will be good for family planning, so that we've a child after 3 years. She empowered us taking decision by adding information". [Married woman, Assam]

"……. this ASHA worker has given me the couple of options, so I have chosen pills". [Married woman- Assam]

b. **When woman can take decisions independently** in secrecy and by herself and acts in isolation without anybody's interference.

c. **When women are educated and** empowered to take decisions related to SRH. This means greater exposure and ability to seek information from different sources.

"I consult ASHAs if I have any Gynecological issues. I ask them if the Gynecologist will be there at the hospital or not. Because they work in the hospital, so they know these kind of things". [Married woman, Assam (Graduate in Economics)]

"Sometimes I ask for doctor's help. And if I am not able to go to a doctor then I would ask that to older person who has knowledge. I did not go to the doctor recently, but I asked my aunt, who is a nurse. [Married woman, Madhya Pradesh (Higher Secondary)]

d. **When women have strong communication with partner and spouse,** they feel empowered to access information, services and products related to their SRH needs, including contraceptives, and abortions.

"My cousin sister got pregnant. Then her boyfriend gave her a tablet, after taking that tablet it got aborted". [Married woman, Madhya Pradesh]

"After two kids, we are planning for family planning. We both discussed to take this decision". [Married man, Jharkhand]

"She tells me all the things which Asha suggested to do. She tells me everything". [Married man, Madhya Pradesh]

e. **Being equipped with adequate information about products available for contraception, empowers women to take informed decisions about seeking and using contraception.** For example, awareness about the side effects of pills has helped women to choose their choice of contraceptives.

"Condom is much better because it won't cause you any side effects like pills. I do not like pills because of nausea and weakness due to pills. That is why my husband also advised me not to take pills. He also thinks condom is a better option instead of contraceptive pills". [Married woman, Assam]

2.5 Areas where women have control versus where they do not

Some or Limited Control:

- **Individual Choices** - Women do exert control over some individual lifestyle choices such as their vocational interests as well as the entertainment they have access to (TV, phone etc.).

- **Mobility among unmarried girls** - Unmarried girls have greater mobility than married women. For

young girls, there are less restrictions on their mobility, at least within the neighborhood. Restrictions on mobility increases with the onset of menstruation. When a woman is slightly more educated and has a supportive husband, it leads to the woman having the **confidence** to visit places on her own.

- **Social interaction** - Social interaction for unmarried girls going to school is high as school is a space that is out of parents' control and parents cannot restrict social interaction inside the school. However, after puberty, social interactions of girls are restricted, to maintain a distance between them and boys. As the girl approaches adolescence and age of marriage, her control over social interaction further reduces. Married women with concerns about health can interact with ASHAs, health care practitioners and other family members, as well as women in the community and other neighbors. Beyond this, married women do not have great control over their social interactions.

- **Health & SRH among married women**- Married women have comparatively greater control over their health related problems, in terms of being able to identify SRH issues, but may not necessarily have control over visiting a healthcare provider, except for an ASHA, or at most, a nearby pharmacist/quack. Married women can access **information** about contraceptive methods since they get information from ASHAs, but the decision to use contraceptives is typically controlled by the husband. Similarly, supportive partners/husbands enable control for women over decisions like using emergency contraceptives, or medical abortion.

No or Limited Control:

- **Employment** - Typically, women do not have control over the choice of employment as mentioned earlier. But there are two exceptions. One, if the financial status of the family is suffering, the family may permit a woman to take up employment of her choice. The second exception is when a woman is not married, she is able to take on work.

- **Marriage** - Women do not report having control over the age of marriage or the partner of choice as parents tend to be the ones to decide a suitable groom. Only in Jharkhand, a few respondents reported that girls have a choice of partner in marriage. Rarely, continuing education is used as a way to delay the age of marriage, but in most cases, girls have gotten married and left their education or in a few cases, continued after marriage if the husband has been supportive.

- **Mobility among married women:** Married women's independent mobility declines, as it is customary for husbands to accompany them everywhere or some other family member. Women are either not permitted to leave the home or explain that they have access to all comforts and do not feel the need to leave the home, once they are married. Mobility for married women also increases with the absence of other family members (nuclear family) other than husbands and in case the husband is not available. Control over individual mobility also increases for women who work outside home.

- **Health & SRH among unmarried girls**- Unmarried girls are dependent on their parents for healthcare and feel intense apprehensions to share intimate details, especially about SRH. Unmarried girls talk to their mothers, sisters, or friends.

- **When to have children and how many**- At Parity 0 (P0) women have little to no control over family planning - it is expected that a woman must give birth soon after marriage. With increasing parity, **and an open and communicative relationship with the husband,** women tend to gain control over family planning (spacing or limiting or even dealing with an unintended pregnancy) having greater say in the decision to use contraceptive methods.

- **Resources or Financial ability**: Women uniformly have limited control over financial instrument and autonomy to spend money by her own wish. They are completely dependent on their husbands or

parents for unmarried girls.

2.6 Impact of men's and women's access and control over resources

- **Decision to seek care:**
  - The decision to seek care is dependent on access to information to be able to identify the need for care seeking, followed by financial resources and mobility to and from PHC/ facility etc.
  - Men are able to take this decision with ease as they are mostly equipped with financial resources and mobility, as well as the social interaction to seek appropriate advice
  - Women typically do not have sufficient access to financial resources or mobility. However, in case the woman is educated and/or is connected with the ASHA, she is able to garner sufficient information, to approach her husband/MIL for support and seek appropriate care

- **Reach the right level of care:**
  - Reaching the right level of care is dependent on mobility, the available information to understand the level of care needed, and accessibility of providers
  - Men can access the right level of care unless limited by lack of transport or severe financial crisis
  - Women have lesser capability to access the right level of care independently if it extends beyond the village PHC, as they are not independently mobile beyond the limits of their immediate surroundings. Further, women are unlikely to have adequate information about the level of care required, unless the ASHA can guide them.

- **Access transport to care:**
  - Accessing transport to care depends on either ownership of transport, community support or ASHA's support in arranging emergency transport
  - Men are able to access transport either by driving themselves, or by arranging it with the help of the community - during COVID-19 public transport has not been readily available.
  - In some cases, the women/men can reach the ASHA to arrange transport to healthcare facilities (across centres)

- **Access social support:**
  - Access to social support is dependent on the existing social interaction with members of the community
  - Women have robust, but underutilized networks of support with other women in the community - trusted elders, peers of similar age, connected through women like ASHAs, Anganwadi Workers in the villages. When in need of assistance, information, product supply (like sanitary pads), women are able to seek social support and guidance. Some women report seeking information on contraceptives and family planning from this network of dependable women.
  - For men, they are able to seek infrastructural support from peers or community elders in case in need of transport or some other assistance. Further, men are connected with provider side stakeholders like pharmacists, from whom they are able to comfortably seek information or services, as required.

- **Access health information:**
  - Access to health information typically requires access to technology, overall awareness, interaction with providers/FLWs. Increasing education level and comfortable/communicative relationship with husband also enables to gain access to health information
  - Men typically have the social engagement, technology resources and access to providers to access health information
  - Women report having limited/unused access to technology, limited mobility and limited social interaction leading to inadequate access to information. Further, many women report not having

the base level understanding of when to seek health information, and from whom. They rely on someone in the household (husband/MIL) and sometimes on the ASHA.

- **Get appropriate care:**
  - Getting appropriate care depends on information available on the requisite care, provider preferences and financial resources as well as transport available.
  - A man might prefer to take his wife to his preferred doctor/healthcare provider. This provider might not be the best suited for his wife and thus, she might not get appropriate care. Further, transport and financial resources may be required - which can either be facilitated by the husband/father or by the ASHA
  - Women do not usually have control in the process of receiving care since the options are limited between the few nearby providers (PHC/District Hospital/Private Provider/Pharmacist)

2.7 Impact of Ability on Present SRH behaviors

This section captures good practices followed by women and men whose present SRH behaviors are a result of their ability to seek the right level of care, access to transport, access social support, health information and get appropriate care, during the COVID-19 pandemic:

Menstrual Health

- Women were able to leverage support of other women in the community and seek alternatives for purchasing sanitary pads (when they were unable to access the pharmacy due to lockdown) by borrowing pads from other women who had stockpiled pads
- Women were also able to leverage connection with the ASHA using the phone for issues like painful/delayed periods - the ASHA acted as a conduit for the rest of the public healthcare system and facilitated contact with the ANM or a doctor, as required.

Pregnancy & Delivery

- In case of pregnancies that occurred during the COVID-19 lockdown, men and women in Jharkhand and Madhya Pradesh were able to depend on the ASHA to arrange for transport (Mamta Vahan) to facilities to ensure that deliveries were carried out at the district hospital
- In cases where this was not possible, they settled for the PHC where a nurse facilitated the delivery

Family Planning & Contraceptive Use

- In Jharkhand, when contraceptive purchase options were limited due to financial constraints, women depended on other, older women in their network to learn of traditional methods of contraception to prevent pregnancies

2.8 Long-Term Impact of women's increased ability to take charge of SRHR

- **Ability to identify the appropriate need and time to seek SRH information/services**: Women who were able to access information from the ASHA are able to identify and seek care for issues like delayed/painful periods, and even reach out to the ASHA for sanitary pads if required. This is in contrast to women who are unable to identify the requirement for care seeking

- **Ability to utilize available resources to find alternative sources of information, in a crisis**: During the COVID-19 lockdown, women who were able to use their phones to connect with the ASHA were able to replace physical interaction with telephonic interaction and connect with ASHAs for help needed in case of dealing with SRH issues like RTI, inability to seek injectable from a facility and even pregnancy care. In Madhya Pradesh, a woman who is educated and able to use the internet for information and visit the doctor on her own, when required.

- **Ability to delay the entire reproductive timeline by extending age at marriage:** Women who have had consistent exposure to information through the ASHA and other women and have off-set age at marriage by pursuing education, have been married in their 20's and delay their first pregnancies to a stage where their minds and bodies are prepared to cope with the pregnancy.

- **Ability to preserve state of good health by collaborative decision-making with the husband**: In Jharkhand, a man was married to a younger woman who conceived her first child when she was barely 18 years old. After witnessing the toll, it took on her health, he discussed with her that they would delay having the next child for 4-5 years until they could be sure that her body could handle it. This has given his wife the time and space to be prepared for childbirth the next time.

- **Confidence and conviction to independently seek help for any SRH concerns**, without needing to funnel it through a family member: Increased ability to take charge of SRHR puts women in a place where they have the confidence to seek care for SRH issues anytime, anywhere it occurs. A large hurdle of apprehension, shame, and stigma are eliminated when a woman is equipped to seek care for SRH, ensuring that timely resolutions are sought by women for any issues that emerge.

2.9 Discussions

1. **Gender roles are assigned at birth and the distinction between the lives of boys and girls is seen as early as 10 years of age -** Girls claim that they begin to learn household chores at the age of 10, spending increasing amounts of time indoors, whilst boys continue to stay outdoors and active, being socially separated from their female counterparts.

2. **The manifestation of traditional gender roles is shifting as domestic and economic status and needs evolve:** As economic burden on men increases in a competitive job ecosystem, men seek more educated and socially equipped spouses so the spouses can independently take care of the home and help to educate their children. By default, due to this demand, girls' parents are paying greater attention to educating their daughters.

3. **Interspousal communication plays an enabling role in women's ability to identify and seek care for SRH issues:** In marriages where the husband is supportive of the spouse and there is greater communication between husband and wife, it is seen that there is greater ability for the woman to identify and seek substantial care for issues related to SRH.

4. **In marriages where men feel themselves to be supportive husbands,** they play a key role in understanding and helping to fulfil the individual aspirations of their spouse, enabling greater agency as well as involving them in critical decisions about the home, children, health etc. In these marriages, resolution for SRH issues, conversations on family planning and decision making on contraceptive use are seen to be collective decisions between husband and wife.

5. **Access to technology does not imply the ability to utilize it effectively for information seeking:** Access to phones is typically given to women by their husbands/families and is not a confidential means of communication as it is typically shared. Confidence in using technology and other resources is a critical catalyst for women to be able to leverage them for improved access to information and health seeking behavior.

6. **Women who are more educated can leverage technology for information, are also seen to be more independent:** A woman in Madhya Pradesh who is pursuing her graduation, uses her technology access to resolve not only her own health problems, but also those of other members in the household. Further, the family depends on her to interact with the doctor when anyone falls ill in the house.

7. **In cases where women do not have agency or contribution to decision-making in the household, the lack of control cascades into the lack of importance given to the woman's health**. Both women and their families (husband + in-laws) are seen to de-prioritize the woman's health in comparison to that of the healthcare needs of other family members namely, elders, male members and children in the household. Especially when seeking healthcare is contingent on financial resources, the healthcare, and specifically SRH needs of the woman are given lesser importance.

8. **Women do not have access to role models in their immediate vicinity to leverage education and access to technology for greater agency and independence:** Women who grow up in enclosed ecosystems are conditioned to develop themselves for their role as homemakers and for child rearing. Many of them express a disinterest in education, and do not express the aspiration to be independent. A few men and women who witness such role models through entertainment, express individual aspirations for themselves as well as for their daughters. There is an absence of substantial examples for women to **register and act on their lack of agency and inability to contribute to decision-making in the home.**

9. **Often, the sources of seeking SRH information and care (except the ASHA) are funneled via the husband for married women.** In cases where the man and woman do not engage with one another extensively on SRH concerns, the woman defaults to seeking assistance from the ASHA. It is worth exploring engaging the man with practical implications of compromised SRH needs in terms of long-term financial implications on the family, to increase his interest and involvement towards the improvement of a woman's SRH status.

10. **Women tend to exist in social clusters with one another, given that they do not necessarily engage socially beyond these closed groups** - There is an opportunity to leverage this social support to improve women's propensity to identify SRH needs and issues and to depend on one another for support and guidance on how to resolve these needs.

11. **Men tend to lean towards keeping matters private in terms of social support and feel compelled to tackle familial/spousal concerns on their own.** There is a need for a channel where men feel comfortable addressing health concerns, especially SRH - preferably sourced through a contemporary. There is scope for a collaborative approach that involves men and women equally in understanding the value of seeking appropriate information and care for SRH, in a timely and consistent manner.

3.0 Recommendations

1. **Leveraging technology:** Build communication around the technology connect and access that is available to women and men, to be utilized for information seeking and for connecting with the healthcare system. At present, technological connectivity is not translating into maximum utility of the resource.

2. **Amplify the women-only networks:** Consider systematizing the existing, sporadic networks of women to create a larger collective network. Women who are older and experience greater agency and mobility may be appointed as leaders/mentors for younger girls.

3. **Create a man-woman team of resources:** Men tend to be comfortable around other men, and women around women. One can identify and recruit a cadre of educated and socially connected **men and women** who can serve as the base level touchpoint for SRHR information for both the woman, and her husband. This may serve as a work-around for a situation where the man does not participate in conversations taking place with the ASHA.

4. **Inform and involve men in the woman's life 'behind the scenes':** Men who consider themselves

participative and communicative tend to take a greater interest in the life of their spouses. They are reported to be instrumental in enabling women to have greater access to information and services, as well as to take decisions regarding SRH. Subsequently, existing IPC and group communication can occasionally mandate group counseling to sensitize men to women's SRH needs, and to **play up the practical advantage** of the woman remaining healthy to support him in running the home.

5. **Exemplify existing positive spousal relationships:** If possible, amplify examples of women and men who express having comfortable and confident relationships, where the woman trusts the husband to take the right course of action when she goes to him with a problem. It may help to project this as an aspirational image, by demonstrating their contentment in daily life. Good practices adopted by such people may also be inspiring and shared.

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