

Chapter VII

Decision-making and Domestic Violence

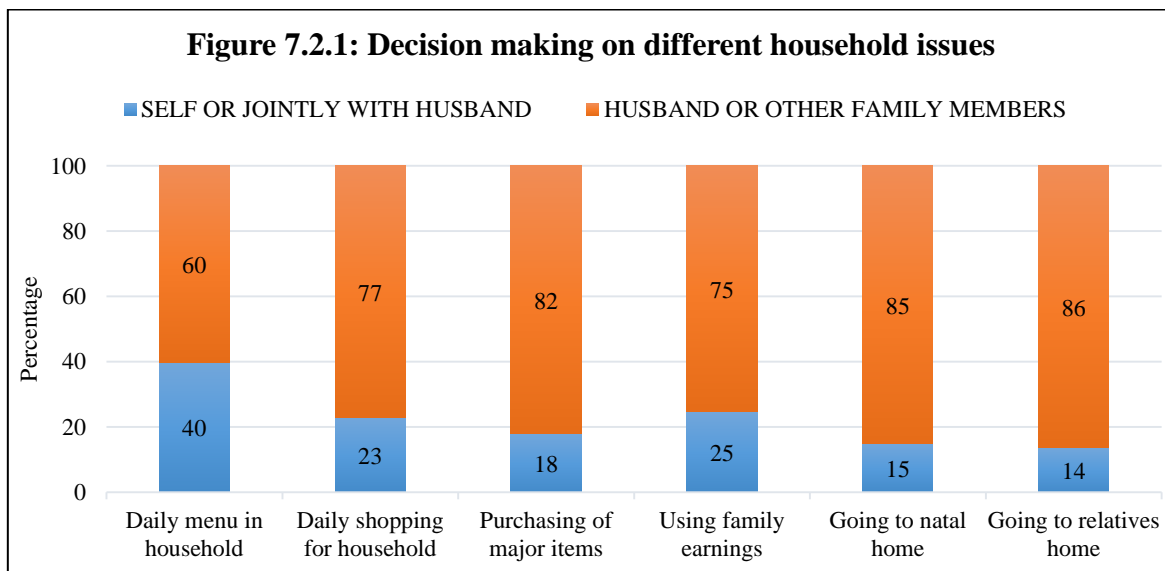
7.1. Introduction

This chapter presents involvement of women in decision-making on different domestic and health issues as well as violence faced by them. Most of the subjects in this chapter are discussed from a gender perspective and analyzed with selected socio-demographic characteristics of young women. In addition to this, analysis also highlights women's consensus on their marriage and fertility.

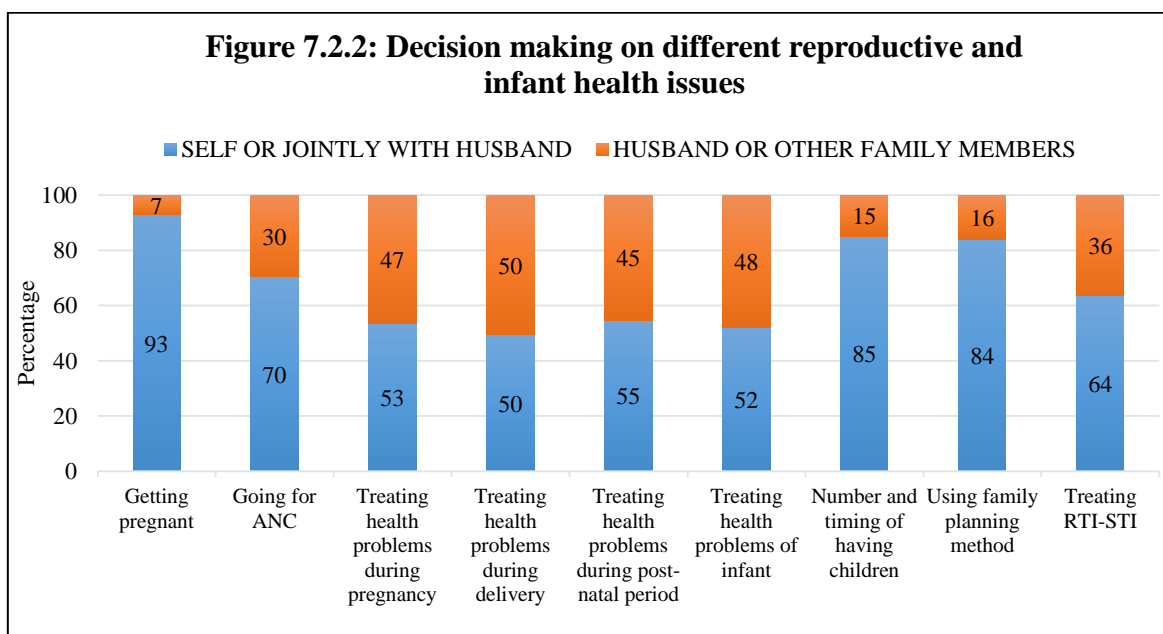
Young women were asked whether their consent was taken or not before taking a decision about their marriage. Ninety-two per cent women reported that their consent was taken prior to deciding about their marriage. Still 8 per cent women were deprived of consensual marriage. They were also asked about their inter-spousal discussion about number and timing of having children. Data revealed that 95 per cent young women and their husbands discussed about it.

7.2. Women's involvement in decision-making

Women's involvement in decision-making on different household activities, reproductive and infant health issues were explored through a series of questions. For each of the questions they were asked if the decision was taken by themselves or husbands or jointly with husbands or mothers-in-law or fathers-in-law or other members of the households. If a woman takes the decision either by herself or jointly with her husband, she is considered as involved in the decision-making.



It was found that in most of the household level issues like decision on daily menu, daily shopping, purchasing household items, spending family earnings, going to natal and relatives' homes, a woman's involvement was poorly reflected. Among all these decisions, women were slightly better (40 per cent) in deciding about daily menu in the household, still 60 per cent said that it was decided by either husband or any other member of the household. Issues where spending of money was involved, only 18 to 25 per cent women were part of the decision-making. These decisions were mostly taken either by husband or other household members. Similarly, more than 85 per cent women reported that they were not involved in the decisions taken about going to natal and relatives' home.



Further scrutiny of decisions related to specific reproductive and infant health issues showed a favourable situation for young women, where at least half or more were a part of the decision-making. Specifically, 93 per cent of women reported that they were involved in deciding when to get pregnant, 85 per cent in the number and timing of having children, 84 per cent in using a family planning method and 70 per cent in going for ANC during last pregnancy. In the decisions related to treatment of health problems during pregnancy, delivery, post-natal period and infant health problems, about 50 to 55 per cent women were involved.

Some of the qualitative findings showed that young women had little or no power in their marital household and were almost entirely at the mercy of their husbands' or mothers-in-

laws' perception of their reproductive and sexual health needs. During the FGD one woman said,

“All major decisions in my house are taken by my mother-in-law. Others have to listen to the decision and we have no other option”.

Another woman said,

When I face any health problem, I tell to my husband or mother-in-law. Sometimes I also suggest to go to the hospital for check-up. But my mother-in-law knows most of the remedies and she suggests treatment at home only”.

Another woman said,

If we will do job and earn money, we will not be depending on them (meaning husband or mother-in-law or father-in-law) for small things to purchase. Then I think we will get involved in major household level decisions”.

Decision-making power (DMP) index: As described in Chapter Three, four different decision-making indices are constructed. They include decision-making power index on domestic issues, reproductive health, infant health and an overall index which combines all of them. The variables considered under “domestic issues” are decisions on daily menu in the household, shopping for the household, purchasing of major items, using of family earnings, going to the natal home and going to relatives home. Similarly, variables under “reproductive health” are decision-making on pregnancy, antenatal care, treatment seeking for health problems during pregnancy, delivery, post-natal period, RTI/STI, number and timing of having children, family planning method use and obtaining health care for self. Variables considered under “infant health” are decision-making on treatment seeking for health problems of infant and obtaining general health care for an infant.

Table 7.2.1: Women’s decision-making power on domestic, reproductive and infant health issues

Indices	Decision-making power of women	Number of women
Decision-making power on domestic issues index		
High DMP	16.7	54
Moderate DMP	33.6	109
Low DMP	49.7	161
Decision-making power on reproductive health index		
High DMP	9.6	31
Moderate DMP	59.3	192
Low DMP	31.2	101
Decision-making power on infant health index		
High DMP	8.0	26
Moderate DMP	45.1	146
Low DMP	46.9	152
Overall decision-making power index		
High DMP	8.0	26
Moderate DMP	31.5	102
Low DMP	60.5	196
Total (N)	100.0	324

Overall it was found that a low proportion of women (8 per cent) had high and more than 60 per cent had low decision-making power. Further analysis of women’s decision-making power on different issues revealed that about 16 per cent had high decision-making power related to domestic issues, but while the decision was regarding reproductive and infant health, only 10 and 8 per cent had high decision-making power respectively. About half of the young women had low decision-making power on domestic issues, 31 per cent had low decision-making power on reproductive health and 47 per cent had low decision-making power on infant health issues. These results indicate that young women had little say pertaining to the decisions related to domestic, reproductive and infant health issues, where husbands or other members of the households mattered.

In addition to different decision-making issues, women were asked if they needed permission of husband or other members of the households, especially mothers-in-law or fathers-in-law to perform different activities.

Table 7.2.2: Women seeking permission from husbands or other members to perform different activities

Activities	Women seeking permission	Number of women (N=324)
To go out for shopping	91.7	297
To go out to meet friends	90.4	293
To go out to watch movie	82.4	267
To go to the health facility	94.4	306
To go out to work	84.3	273
To spend money on her own self	87.0	282

Note: Independent responses, per centages cannot be added.

A majority of women needed permission in doing activities like going to a health facility, shopping, meeting friends, etc. This shows the extent of restrictions imposed on women to perform many of the personal activities.

Women autonomy index: Similar to the decision-making power index, an autonomy index for women is constructed. This index includes questions like if women need permission from husbands or other household members to go out for shopping, meet friends, watch movies, health facility, any work and spend money on her own self.

Table 7.2.3: Women's autonomy

Women autonomy index	Women having autonomy	Number of women
High autonomy	10.5	34
Moderate autonomy	23.1	75
Low autonomy	66.4	215
Total (N)	100.0	324

It was found that about two-third of young women had low, 23 per cent had moderate and very less (11 per cent) had high autonomy.

7.3. Determinants of key reproductive and infant health decisions

The data explained in this section gives the odds ratios from logistic regression models, which assessed the association between selected background characteristics of women and their reproductive and infant health behaviour. Three models of logistic regression analysis were carried out each for women's involvement in taking decision on going for antenatal care, seeking treatment of the infant health problems, number and timing of having children, and using a family planning method. These dependent variables used in the analysis are dichotomous in nature, i.e., 0 "No" and 1 "Yes". The independent or predictor variables used in the analysis are age and education of the women, caste, type of family, number of living children, exposure to mass media, standard of living, distance to nearest

health facility, women's discussion with health service provider about health care, experience of violence, autonomy and gender attitude which are categorical in nature.

Table 7.3.1: Logistic regression results for women's involvement in taking decisions on going for antenatal care

Independent or predictor variables	Odds of taking decision about going for ANC			N (324)
	Model-1	Model-2	Model-3	
Age of women				
15-19 years®	1.00	1.00	1.00	96
20-24 years	2.46**	2.47**	2.41**	228
Educational level of women				
No education®	1.00	1.00	1.00	114
Any education	0.88	0.89	0.90	210
Caste				
SC and ST®	1.00	1.00	1.00	178
General and OBC	0.83	0.87	0.88	146
Type of family				
Nuclear®	1.00	1.00	1.00	113
Non-nuclear	0.99	0.98	0.95	211
Number of living children				
No or one child®	1.00	1.00	1.00	157
Two or more children	0.79*	0.79*	0.77*	167
Exposure of women to mass media				
Low exposure®	1.00	1.00	1.00	82
High to medium exposure	0.54	0.54	0.59	242
Standard of living				
Low SLI®	1.00	1.00	1.00	101
High to medium SLI	0.62	0.62	0.60	223
Distance to nearest health facility				
More than 5km®	1.00	1.00	1.00	80
Within 5km	1.63*	1.63*	1.55*	244
Had discussion about need for ANC				
No®	1.00	1.00	1.00	31
Yes	1.38*	1.38*	1.37*	293
Experience of any violence				
No®	1.00	1.00	1.00	279
Yes	1.99	1.99	2.17	45
Women's autonomy				
Low autonomy®	--	1.00	1.00	215
High to moderate autonomy	--	1.04**	1.26**	109
Gender attitude of women				
Low equitable attitude®	--	--	1.00	48
High to moderate equitable attitude	--	--	1.57**	276

Note: ® Reference category; Level of significance: * $p \leq 0.100$; ** $p \leq 0.050$; *** $p \leq 0.001$

After controlling all the variables, women in the age of 20-24 years were significantly 2.4 times more likely to involve in decision on going for antenatal care compared with women of 15-19 years. Similarly, the likelihood of women's involvement in taking decision on going for ANC services is 1.6 times higher for those who stayed within five kilometers from a health facility compared with those who stayed more than five kilometers. Women who had discussion with a health service provider or any household member about the

need for ANC were almost 1.4 times more likely to involve in the decision on going for antenatal care. However, other characteristics like caste of women, type of family, number of living children, higher levels of mass media exposure and standard of living do not find to have any significant influence on their involvement on deciding about antenatal care. The full model (Model-3) of the logistic regression analysis highlights that the odds of women's involvement in taking decisions on going for antenatal care were 1.3 times more for the women with high to moderate autonomy and 1.6 times more for the women having high to moderate equitable gender attitude compared with their opposite group of women.

Table 7.3.2: Logistic regression results for women's involvement in taking decisions on seeking treatment of the infant health problems

Independent or predictor variables	Odds of taking decision about seeking treatment for infant health problems			N (148)
	Model-1	Model-2	Model-3	
Age of women				
15-19 years®	1.00	1.00	1.00	47
20-24 years	2.08*	2.25*	2.01*	101
Educational level of women				
No education®	1.00	1.00	1.00	69
Any education	1.12*	1.02	0.99	79
Caste				
SC and ST®	1.00	1.00	1.00	99
General and OBC	1.16**	1.30**	1.44**	49
Type of family				
Nuclear®	1.00	1.00	1.00	65
Non-nuclear	1.41	1.26	1.01	83
Number of living children				
One child®	1.00	1.00	1.00	72
Two or more children	0.98*	0.94*	0.80*	76
Exposure of women to mass media				
Low exposure®	1.00	1.00	1.00	56
High to medium exposure	0.69	0.64	0.78	92
Standard of living				
Low SLI®	1.00	1.00	1.00	47
High to medium SLI	0.88	0.98	1.16	101
Distance to nearest health facility				
More than 5 km.®	1.00	1.00	1.00	39
Within 5 km.	0.86	0.89	0.61	109
Had discussion about need for infant care				
No®	1.00	1.00	1.00	17
Yes	1.13*	1.76*	1.62*	131
Experience of any violence				
No®	1.00	1.00	1.00	113
Yes	2.61*	3.39**	5.18**	35
Women's autonomy				
Low autonomy®	--	1.00	1.00	68
High to moderate autonomy	--	2.33**	4.04***	80
Gender attitude of women				
Low equitable attitude®	--	--	1.00	36
High to moderate equitable attitude	--	--	3.84**	112

Note: ® Reference category; Level of significance: * $p \leq 0.100$; ** $p \leq 0.050$; *** $p \leq 0.001$.

Different logistic regression models depict that the likelihood of women's decision on seeking treatment of infant health problems was 2 to 2.3 times higher for women of 20-24 years compared with women of 15-19 years. Though educational level of women did not make any significant difference, women belonging to general and other backward classes were significantly higher in decision-making on treatment of infant health problems. Number of living children, exposure of women to mass media, standard of living and distance to nearest health facility did not seem to have much influence on women's involvement in deciding about treatment seeking of infant health problems. However, women who had discussion with a frontline health service provider or any household member about the need for infant care were 1.1 to 1.8 (Model-1 OR 1.1, Model-2 OR 1.8, Model-3 OR 1.6) times more likely to involve in taking decision on treatment of infant health problems compared with those who did not have it. Results also showed that women who experienced violence were significantly more likely (Model-1 OR 2.6, Model-2 OR 3.4, Model-3 OR 5.2) to involve in decision-making on seeking treatment of infant health problems compared with the women who did not experience it. This could be the other way round where women facing more violence due to their active involvement in decision-making on seeking treatment of infant health problems. After controlling all variables, it was found that the odds of women's involvement in taking decisions on treatment seeking of the infant health problems were almost four times higher for the women who had high to moderate autonomy and gender equitable attitude compared with the women of low autonomy and gender equitable attitude respectively.

Table 7.3.3: Logistic regression results for women’s involvement in taking decisions on number and timing of having children

Independent or predictor variables	Odds of taking decision about number and timing of children			N (324)
	Model-1	Model-2	Model-3	
Age of women				
15-19 years®	1.00	1.00	1.00	96
20-24 years	3.32**	3.51**	3.61**	228
Educational level of women				
No education®	1.00	1.00	1.00	114
Any education	0.36	0.36	0.37	210
Caste				
SC and ST®	1.00	1.00	1.00	178
General and OBC	3.77***	3.87***	3.95***	146
Type of family				
Nuclear®	1.00	1.00	1.00	113
Non-nuclear	0.30**	0.31**	0.31**	211
Number of living children				
No or one child®	1.00	1.00	1.00	157
Two or more children	0.87*	0.89*	0.89*	167
Exposure of women to mass media				
Low exposure®	1.00	1.00	1.00	82
High to medium exposure	0.20	0.21	0.19	242
Standard of living				
Low SLI®	1.00	1.00	1.00	101
High to medium SLI	1.21*	1.22*	1.24*	223
Distance to nearest health facility				
More than 5 km.®	1.00	1.00	1.00	80
Within 5 km.	1.43	1.47	1.51	244
Inter-spousal communication about number and time of having children				
No®	1.00	1.00	1.00	16
Yes	2.13***	2.34***	2.44***	308
Experience of any violence				
No®	1.00	1.00	1.00	279
Yes	6.67	5.84	6.32	45
Women’s autonomy				
Low autonomy®	--	1.00	1.00	215
High to moderate autonomy	--	1.49*	1.33*	109
Gender attitude of women				
Low equitable attitude®	--	--	1.00	48
High to moderate equitable attitude	--	--	0.79	276

Note: ® Reference category; Level of significance: * p<0.100; ** p<0.050; *** p<0.001

Logistic regression results presented in the above table explain that women of 20-24 years were significantly better (Model-1 OR3.3, Model-1 OR 3.5, Model-1 OR 3.6) in taking decisions on the number and timing of having children as compared with the 15-19 year old women. Similarly, compared with SC-ST women, general and other backward class women were almost four times more likely to involve in the decision-making of number and timing of having children. All the three models show that the likelihood of women’s involvement in decision-making on the same was 1.2 times more for women having high to medium standard of living compared with women of low standard of living. The odds of women’s involvement in deciding about the number and timing of having children was 2.1

to 2.4 times significantly high for the women who had discussions with their husbands regarding it. After controlling all the variables in model-3 and excluding “gender attitude” in model-2, it was found that women with the high to moderate autonomy were 1.3 to 1.5 times more likely to involve in decisions on having number and timing of children compared with those having low autonomy. Though women experiencing violence were found much better in taking such decisions, the association was not significant. Higher education of women, type of family, number of living children, higher exposure of women to mass media and gender attitude did not have any significant impact on women’s involvement in deciding the number and timing of having children.

Table 7.3.4: Logistic regression results for women’s involvement in taking decisions on using a family planning method

Independent or predictor variables	Odds of taking decision about using modern family planning method			N (324)
	Model-1	Model-2	Model-3	
Age of women				
15-19 years®	1.00	1.00	1.00	96
20-24 years	5.03***	4.82***	4.48***	228
Educational level of women				
No education®	1.00	1.00	1.00	114
Any education	0.92	0.96	1.07	210
Caste				
SC and ST®	1.00	1.00	1.00	178
General and OBC	0.71	0.66	0.65	146
Type of family				
Nuclear®	1.00	1.00	1.00	113
Non-nuclear	0.72	0.68	0.64	211
Number of living children				
No or one child®	1.00	1.00	1.00	157
Two or more children	0.49*	0.48**	0.45**	167
Exposure of women to mass media				
Low exposure®	1.00	1.00	1.00	82
High to medium exposure	0.38	0.36	0.42	242
Standard of living				
Low SLI®	1.00	1.00	1.00	101
High to medium SLI	2.75**	2.88**	2.74**	223
Distance to nearest health facility				
More than 5 km.®	1.00	1.00	1.00	80
Within 5 km.	2.41**	2.42**	2.10*	244
Inter-spousal communication about number and time of having children				
No®	1.00	1.00	1.00	16
Yes	3.88**	3.21**	2.68**	308
Experience of any violence				
No®	1.00	1.00	1.00	279
Yes	1.23	1.16	1.47	45
Women’s autonomy				
Low autonomy®	--	1.00	1.00	215
High to moderate autonomy	--	1.56*	1.85*	109
Gender attitude of women				
Low equitable attitude®	--	--	1.00	48
High to moderate equitable attitude	--	--	2.73**	276

Note: ® Reference category; Level of significance: * p≤0.100; ** p≤0.050; *** p≤0.001.

Three logistic regression models are carried out to understand women's involvement in taking decisions on family planning method use. Results clearly highlighted that women in the age group of 20-24 years were 4.5 to 5 times significantly more likely to involve in the decision-making compared with women of 15-19 years. Similarly, women in high to medium standard of living were almost 2.8 times higher in using a modern family planning method compared with women of low standard of living. Women staying within five kilometer distance from a health facility were more than twice better (Model-1 and 2 OR 2.4, Model-3 OR 2.1) involved in deciding about a family planning method compared with those who were staying more than five kilometers. The logistic regression models depicted that the odds of taking decision about using modern family planning method were 2.7 to 3.9 times (Model-1 OR 3.9, Model-2 OR 3.2, Model-3 OR 2.7) significantly high among women who had inter-spousal communication about the number and timing of having children compared with those who did not have it. After controlling all the variables it was found that women with high to moderate autonomy were 1.9 times and women in high to moderate equitable attitude were 2.7 times more likely to involve in the decisions on using a modern family planning method compared with their respective counter group of women. The other predictor variables like educational level of women, caste category, type of family, number of living children and exposure to mass media did not seem to have any significant influence on women's involvement in taking decisions on using a family planning method.

7.4. Support and advice received on reproductive and infant health

Favourable situation for women can be generally accessed by the support system they receive in different stages. To understand this, women were probed with different questions related to support received during pregnancy, and visiting health facility for the treatment of different reproductive and infant health problems.

Table 7.4.1: Support received by women in routine household work during pregnancy

	Women received support	Number of women (N=280)
Husband	30.7	86
Mother-in-law	54.6	153
Mother	26.8	75
Father-in-law	2.1	6
Father	0.0	0
Sister-in-law	27.5	77
Sister	9.6	27
Other household members	4.3	12
Support from anyone (N=324)	86.4	280

Eighty-six per cent of the young women reported receiving help in routine household work during their last pregnancy from different people. Specifically, most of the help was provided by mother-in-law (55 per cent) followed by husband (31 per cent), sister-in-law (28 per cent), mother (27 per cent), sister (10 per cent), father-in-law (2 per cent) and other household members (4 per cent).

Table 7.4.2: Person accompanied or present during treatment of health problems occurred during different reproductive stages of women

Person accompanied or present during treatment	During pregnancy problems (N=141)	During delivery problems (N=89)	During post-delivery problems (N=83)	During infant health problems (N=137)	During RTI/STI problems (N=20)
No one/self	2.1	0.0	0.3	18.2	0.0
Husband	73.0	24.7	42.2	51.1	65.0
Mother-in-law	5.7	18.0	8.4	15.3	0.0
Mother	14.2	32.6	24.1	16.1	0.0
Father-in-law	0.0	0.0	0.0	2.9	0.0
Father	3.5	4.5	3.6	2.9	0.0
Sister-in-law	2.1	13.5	8.4	1.5	10.0
Sister	0.7	5.6	0.0	0.0	0.0
Frontline workers	12.1	69.7	38.6	8.0	10.0
Others	7.8	9.0	9.6	5.1	15.0
Any person	87.9	100.0	99.7	81.8	100.0

Note: Frontline workers include ASHA, anganwadi worker, dai, ANM; Others include, other family members.

Women also received accompanying support from different family members and frontline workers while going for the treatment of health problems occurring during pregnancy, delivery, post-natal period as well as for RTI/STI and infant health problems. Among all, the husband was found to be providing major accompanying support to women while going for the treatment of health problems occurring during pregnancy (73 per cent), after delivery (42 per cent), RTI/STI problems (65 per cent) and infant health problems (51 per cent). However, for the treatment of health problems occurred during delivery, about 70 per cent women reported that frontline workers like ASHA, anganwadi worker, dai, ANM, etc., accompanied them. Few women reported going by themselves for seeking treatment for the above mentioned health problems, except for infant health problems. Here 18 per cent women reported seeking treatment for infant health problems without anyone's accompany support.

Table 7.4.3: Person who discussed/advised about reproductive health care with women

Person discussed/ advised about health care	Antenatal care (N=293)	Place of delivery (N=268)	Post-natal check-up (N=91)	Infant care (N=257)	RTI/STI treatment (N=34)
Husband	29.4	23.5	5.5	4.3	26.5
Mother-in-law	13.7	7.8	11.0	15.6	5.9
Mother	6.8	13.1	4.4	21.0	0.0
Father-in-law	2.4	0.7	4.4	1.2	0.0
Father	0.7	6.0	0.0	1.6	0.0
Frontline workers	83.3	84.7	81.3	87.9	58.8
Friends/relatives	7.2	3.0	14.3	10.5	17.6
Others	2.7	2.2	3.3	2.7	2.9
Any person	90.4	88.7	28.1	88.3	10.5

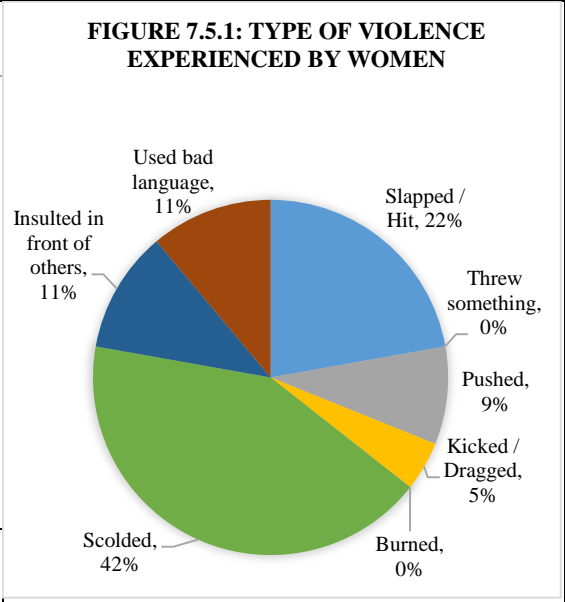
Note: Frontline workers include ASHA, anganwadi worker, dai, ANM; Others include, other family members.

Adopting an appropriate health care practice is important to attain better health and avoid complications. To bring a positive behavioural change in reproductive and infant health care practices, the best health care practices need to be discussed with concerned persons. In the current study women were asked whether anyone had discussed or advised them about ANC, institutional delivery, postnatal check-up, infant care and treatment of RTI/STI problems. Nearly 90 per cent woman said that someone discussed with them regarding ANC and place of delivery. About 88 per cent women said that someone discussed regarding infant care practices, but it was very low for postnatal check-up (28 per cent) and treatment of RTI/STI (11 per cent). Those women who said that someone discussed with them about the need for different reproductive and infant health care were further asked who the person was? Most of the women mentioned frontline health service providers like ASHA, ANM, anganwadi and dai had discussed with them. Though the husband also discussed about the health care needs, it was only 29 per cent for ANC, 27 per cent for RTI/STI treatment, 24 per cent for institutional delivery, 6 per cent for postnatal check-up and 4 per cent for infant care. Mother-in-law and mother is also found to be a person who discussed about different health care practices to some extent.

7.5. Experience of domestic violence

Domestic violence is a serious public health concern that affects the health and well-being of women and families. While the risk factors and types of violence vary across cultures, similar consequences have been observed in the current study. Furthermore, domestic violence during or around the time of pregnancy can lead to unique risks for maternal and child health.

Perpetrators of violence	Experience of violence	Number of women (N=45)
Husband	60.0	27
Mother-in-law	35.5	16
Mother	0.0	0
Father-in-law	0.0	0
Father	0.0	0
Sister-in-law	8.9	4
Sister	0.0	0
Brother-in-law	0.0	0
Brother	0.0	0
Other family members	13.3	6
Violence by anyone (N=324)	13.9	45



Young women were asked about their experience of violence in the past six months. It was found that 14 per cent women experienced some kind of violence. Subsequently, they were asked about the perpetrators and types of violence they experienced. Most of the women reported husband as the perpetrator of violence, followed by mother-in-law which accounted for 60 and 36 per cent respectively. Among the women who experienced violence, 42 per cent were scolded, 22 per cent slapped, 11 per cent insulted in front of others bad language used, and 9 per cent were pushed.

Focus group discussions implied that violence is routine in marriage. Women made these remarks,

“Shouting and using abusive words happens commonly but slapping is rare.”

“We became used to scolding and listening to bad words and so we don’t feel these as violence. This is a part of our life”.

They (husband and other elder members of family) scold if we give our opinion on anything against their wishes. If we ask to go to natal home for a short duration and stay there for a longer period, then we are scolded.”

The triggers of violence reported included refusal for anything said by husband or mother-in-law, domestic quarrels or complaints by family members and overstaying the allotted time in the natal home.

Women also reported that their financial dependence on husband was a major constraint and it often restrains them from many things, meaning thereby that it hinders their empowerment. They said,

“If I want to purchase any small thing like bangles or cosmetic items, I ask for money to my husband. Sometimes he gives me and at other times asks too many questions. I have no other option than to depend on him”.

“They (male members of the family) earn money and we have to depend on them. If we don’t abide by what they say, they will not give money.”

7.6. Gender attitude of women

The gender equity measurement scale is measure to understand gender attitude towards various social norms and behaviour. This scale is constructed considering 38 questions which were subsequently divided into three categories, viz., (1) gender attitude towards gender norms, (2) gender attitude towards sex and sexuality and (3) gender attitude towards domestic violence.

Table 7.6.1: Gender attitude of women towards different social norms and behaviours

Indices	Gender attitude of women	Number of women
Gender attitude of women towards gender norms		
High equitable attitude	30.8	100
Moderate equitable attitude	56.5	183
Low equitable attitude	12.7	41
Gender attitude of women towards sex and sexuality		
High equitable attitude	9.6	31
Moderate equitable attitude	33.0	107
Low equitable attitude	57.4	186
Gender attitude of women towards domestic violence		
High equitable attitude	21.0	68
Moderate equitable attitude	40.7	132
Low equitable attitude	38.3	124
Overall gender attitude of women		
High equitable attitude	16.4	53
Moderate equitable attitude	68.8	223
Low equitable attitude	14.8	48
Total (N)	100.0	324

Overall, a low proportion of women (16 per cent) had high equitable gender attitude and a high proportion of them (69 per cent) had low equitable gender attitude. Subsequent analysis revealed that 31 per cent women had high equitable gender attitude towards

gender norms, 57 per cent had moderate equitable gender attitude and 13 per cent had low equitable gender attitude. Gender attitude towards sex and sexuality showed that about 10 per cent women were in high equitable category, i.e., they did not at all agree to any unfavourable behaviour related to sex and sexuality towards them, while 57 per cent women had low equitable attitude. Similarly, 38 per cent women had low equitable attitude towards domestic violence. This means that most of the women had condoned violence. Further, 96 per cent women conceded that they were responsible for domestic violence and that sensible women never let violence happen. Similarly, 79 per cent women agreed that it was okay for a husband to hit his wife if she cheated him.

7.7. Summary

About 40 per cent women were involved in deciding daily menu in the household, while 60 per cent women said that it was decided by either husband or any other member of the household. In all other cases like daily shopping, purchasing household items, spending family earnings, where money is involved, only 18 to 25 per cent woman were a part of decision-making. These decisions were mostly taken by either husband or other household members.

Decisions related to specific reproductive and infant health issues show a favourable situation for young women, where at least half or more than that were a part of it. Specifically, 93 per cent of women reported that they were involved in deciding when to get pregnant; 85 per cent were a part of decision-making on the number and timing of having children; 84 per cent involved in taking decision on using a family planning method; and 70 per cent in decisions on going for ANC during the last pregnancy. In the decisions related to treatment of health problems during pregnancy, delivery, post-natal period and infant health problems about 50 to 55 per cent women were involved. The overall decision-making power index depicted that a low proportion of women (8 per cent) had high and more than 60 per cent women had low decision-making power. On the contrary, a majority of the women reported needing permission of husband or other members of the household for going to a health facility, shopping, meeting friends, etc. About two-thirds of young women had low autonomy, 23 per cent had moderate and very low and (11 per cent) women had high autonomy. This clearly shows the extent of restrictions placed on women in the course of their social activities in personal life.

The logistic regression results for women's involvement in deciding about going for ANC highlighted that women of 20-24 years were significantly 2.4 times more likely to be involved in the decision about going for antenatal care compared with 15-19 year old women. Similarly, the likelihood of women's involvement in taking decision on going for ANC services was 1.6 times higher for those who stayed within five kilometers from a health facility compared with those who stayed more than that. Women who had discussion with a health service provider or household member about the need for ANC were almost 1.4 times more likely to involve in the decision on going for antenatal care. The odds of women's involvement in taking decisions on going for antenatal care were 1.3 times more for women with high to moderate autonomy and 1.6 times more for women having high to moderate equitable gender attitude compared with their opposite group of women.

Likelihood of women's decision on seeking treatment of infant health problems was 2 to 2.3 times higher for women of 20-24 years compared with women of 15-19 years. Young women who had discussion with a frontline health service provider or household member about the need for infant care were 1.1 to 1.8 times more likely to involve them in taking decision on treatment of infant health problems compared with those who did not have it.. The odds of women's involvement in taking decisions on treatment seeking of infant health problems were almost four times higher for those who had high to moderate autonomy and gender equitable attitude compared with women having low autonomy and gender equitable attitude respectively.

Analysis on women's involvement in deciding about the number and timing of having children depicted that women of 20-24 years were significantly more prone to taking decisions about it compared with the 15-19 years women. Similarly, compared with SC-ST women, general and other backward class women were almost four times more likely to involve in the decision-making of the number and timing of having children. The odds of women's involvement in deciding about the number and timing of having children were 2.1 to 2.4 times significantly high for the women who had discussions with their husband regarding the same issue. After controlling all the variables, it was found that women having high to moderate autonomy were 1.3 times more likely to involve in the decisions on having the number and timing of children compared with those having low autonomy.

Logistic regression results on women's involvement in deciding a family planning method illustrated that those in the age group of 20-24 years were 4.5 to 5 times significantly more likely to involve in it compared with women of 15-19 years. Similarly, women having high to medium standard of living were almost 2.8 times higher in using a modern family planning method compared with women of low standard of living. Women staying within five kilometers from a health facility were more than twice better involved in deciding about a family planning method compared with those who were staying beyond. The odds of taking a decision about using modern family planning method were 2.7 to 3.9 times significantly high among women who had inter-spousal communication about the number and timing of having children, compared with those who did not have it.. After controlling all the variables, it was found that women having high to moderate autonomy were 1.9 times and women having high to moderate equitable attitude were 2.7 times more likely to involve in the decisions on using a modern family planning method compared with their respective counter group.

Eighty-six per cent of the young women reported receiving help from different people in routine household work during the last pregnancy. Specifically, most of the help was provided by the mother-in-law (55 per cent), followed by husband (31 per cent). Women also received accompanying support from different family members and frontline workers while going for the treatment of health problems occurring during pregnancy, delivery, post-natal period as well as for RTI/STI and infant health problems. Among all, the husband was found to be providing most accompanying support to women while going for the treatment of health problems occurring during pregnancy (73 per cent), after delivery (42 per cent), RTI/STI problems (65 per cent) and infant health problems (51 per cent). However for the treatment of health problems occurring during delivery, about 70 per cent women reported that frontline workers like ASHA, anganwadi worker, dai, ANM, etc., accompanied them. Additionally, more than 80 per cent of the woman said that the frontline health service providers like ASHA, ANM, anganwadi, and dai discussed about the health care needs with them.

In this study, gender attitude of the young women was measured through a scale. It was found that there is an unequal gender role of young women in decisions related to domestic issues, reproductive and infant health care. Overall, a low proportion of women (16 per cent) had high equitable gender attitude and a high proportion of them (69 per cent) had

low equitable gender attitude. Subsequent analysis revealed that 31 per cent women had high equitable gender attitude towards gender norms, 57 per cent had moderate equitable gender attitude and 13 per cent had low equitable gender attitude. Gender attitude towards sex and sexuality highlighted that about 10 per cent women were in high equitable category and 57 per cent had low equitable attitude. Similarly, 38 per cent women had the low equitable attitude towards domestic violence.

A low per cent of young women (14 per cent) reported experiencing some kind of violence in the past six months. Most women who experienced it reported that husband was its perpetrator followed by mother-in-law, accounting for 60 per cent and 36 per cent respectively. Women experienced different types of violence, viz., 42 per cent were scolded, 22 per cent slapped, 11 per cent insulted in front of others and 9 per cent pushed. Qualitative findings showed that scolding was common and the triggers of violence included refusal for anything said by husband or mother-in-law, domestic quarrels or complaints by family members and overstaying the allotted time in the natal home. Gender attitude of women towards violence showed that 74 per cent of them had low equitable attitude. This means most of the women had accepted violence as a part of marital life. More specifically, 96 per cent women agreed that they were responsible for domestic violence and that sensible women never let violence happen. Similarly, 79 per cent women agreed that it was okay for a husband to hit his wife if she cheats him.