CBHP
community based health project

Women's Empowerment Project (WEP)

Gender Inequality and Women's Issues in Rural India

Research Report

January 2014

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Executive Summary

Background
Despite women in India legally being afforded much the same rights as men, the reality is that the status of women is one of inequality. Women and girls are systematically and socially disadvantaged in areas such as access to health services, access to education and employment, political and human rights, land rights and social security. Gender related issues such as the dowry system, sex selective abortion, domestic violence and female infanticide are still very much present in contemporary Indian society. The empowerment of women is vital in order to improve the status of females, and ultimately increase their opportunities for enhanced livelihoods.

Aims
- To research the issue of gender inequality and women's issues within Buldana's rural villages (Tanda, Manubai and Khadki)
- To identify the most pressing gender-related concerns as determined by research results
- To devise a well-justified proposal, which targets the very issues identified.

Methods
- Interviews with Village Health Workers
- Focus group discussions with village women
- One-to-one surveys with adolescent girls and women

Results
The results confirmed that within rural India, gender inequality remains rife. The most pressing gender-related concerns within the project villages were identified as being access to education, marriage and employment.

Conclusions
The provision of a service that allowed females to have the opportunity to stay at a safe accommodation in town in order to pursue their education, complimented our research on women's empowerment, and provided a solution to the many girls who were denied an education due to having to remain located in their village. This lead to the establishment of the Dayanand Centre, a hostel in which the aim is to provide accommodation for women and girls who would otherwise be unable to access education and employment services, a space for a girl's sewing class, a computer training class, and possibly a clinic in the future.

Background

According to UN Women (2011), "women perform 66 percent of the world's work, produce 50 percent of the food, but earn 10 percent of the income and own 1 percent of the property". Many forms of gender discrimination have the potential to disempower women and create vast inequalities in society and human development. This is ever so evident in India, where female children are still considered a burden. Women in India are indeed entitled to vote and own property, receive equal pay for equal work, receive equal access to education, and not to be subject to practices derogatory to the dignity of women. However these 'entitlements', are rarely indicative of Indian society and social norms. In fact, official statistics paint a dreadfully different picture.

Despite the general global trend that women tend to physiologically outnumber men, in India, the reverse is the case. As with a lot of Southern Asia, mortality rates still reflect practices related to son preference. While the percentage of women in politics is rising, they still only account for about 10 percent of parliamentary members. Most women in India do not own property in their names, nor do they inherit a share of parental property. 50 percent of males over 25 years old have at least a secondary education, however for females, this figure is only 26 percent. Less than 10 percent of reported cases for crimes against women are pursued through the legal system. Crimes against women, including rape, have jumped by 7.1 percent between 2010 and 2011 (National Crime Records Bureau 2011), although the majority of these assaults go unreported. Despite the dowry system being illegal, it is still very much a common practice especially in rural villages. Gender inequality is a deep-rooted issue in India, and many parts of the world. It is a paradoxical situation that cannot be addressed by a frontal attack on women's issues by targeting women alone. Rather, it requires a comprehensive effort in which communities develop through sustainable and integrated programs that impact and involve everyone (George 2001). These extensive issues and societal trends affecting females - which can be divided into social, economical, political and health issues - will be further explored in the following section.

Social Issues

The picture of females in Indian society is a very complex one. On paper, and by law, they are afforded much the same rights as their male counterparts, in terms of access to education, land ownership and voting rights. In practice, the social status of girls and women falls below that of males in many regards, though none as prominent as the prevailing 'son preference' seen across the country. In the most recent national census (2011), the child sex ratio (0-6 years) sits at 914 girls per 1,000 boys. This is less, still, than the 2001 figure of 927 girls per 1,000 boys (Dasgupta, 2013).

The rationale behind the preference for male children is multifaceted, but tied closely to the dowry system, which is still practiced across both rural and urban India, despite being illegal since 1961 (Dowry Prohibition Act, 1961). The dowry is understood as any item of valuable security given or agreed to be given by one party of a marriage to the other party, or by the parents of either party to a marriage (Dowry Prohibition Act, 1961). Such a system has contributed to the devaluation of women in society, and perpetuated their status as a burden on their family. Nationally, and in 2011 alone, 8,618 female dowry-related homicides were recorded, along with 3,239 female suicides related to dowry issues. Both figures represent an increase from the previous years (Dahwan, 2005).

The low social status of women, together with the prospect of having to pay a dowry for the marriage of their daughters, has seen some families resorting to the practice of female foeticide or infanticide. Also rising in popularity is the costly pre-implantation genetic diagnosis (PGD) procedure, whereby the embryo is screened for its sex before it is implanted, ensuring that only a male embryo is implanted. These practices occur despite the illegality of sex-selective abortion and the 2003 Pre-conception and Prenatal Diagnostic Techniques (Prohibition of Sex Selection) Act prohibiting sex selection before and after conception (Dasgupta, 2013).

The prevalence of abortions is indicative of the inadequacy of family planning knowledge and contraception use amongst Indian women (particularly from rural areas). The 2010 UN World Contraception Use survey indicated that 12.8% of women nation-wide had an unmet need for family planning, meaning that they were sexually active but not using any form of contraception, despite reporting not wanting any more children, or wanting to delay the birth of the next child. Many women, particularly those from rural areas, also indicate that it is their husband who has the most say in the decision to use or avoid contraception, and that disapproval by their husband largely explained cases of non-use (Maulik & Dasgupta, 2013).

There is also evidence suggesting that female children in India receive different treatment to male children, with a trend being revealed for boys being breastfed for longer, receiving more health care, vitamin supplements and having more time spent on their childcare than girls (Barcellos, Carvalgo & Lleras-Muney, 2014; Jayachandran & Kuziemko, 2011). These trends have led researchers to conclude that many parents invest less in young girls because these investments produce fewer returns (Barcellos et. al., 2014). Past infancy, one of the most widely publicised points of difference between boys and girls in India concerns that of education, with numerous policies developed after Indian independence to address girls' and women's education, including the National Committee on Women's Education (1958), National Council for the Education of Women 1959) and the Committee to Investigate the Cause of the Lack of Public Support for Girls' Education (1965). Despite these promising initiatives, data suggests that national secondary school attendance for girls is below 50%, with safety issues, lack of transport, household chores and early marriage as some of the reasons for this low attendance (Sahni & Shankar, 2011). With regard to early marriage alone, the 24 million child brides in India represents a staggering 40% of the world's total, a practice which leaves girls open to domestic abuse, marital rape and the early finishing of their education (Bhowmick, 2013).

The push for girls to gain more education and to widen their career prospects has largely been hindered by the view of women as housewives that still dominates much of India society (Dahwan, 2005). Even amongst women attending college, there is a consensus that the role of women as housewives is strongly endorsed by society. This is despite these women showing a personal preference for attaining a career; something they concluded was view as socially less desirable (Dahwan, 2005). It is evident that the laws in place in India advocating for equality for men and women are not practiced across society, and that females still face great disadvantage in their treatment and access to services from conception, through childhood and to adulthood.

Economic Issues

Indian women's participation in activities is largely influenced by their family's 'statuses' especially in rural areas (Eswaran & Ramaswami, 2013). People from upper classes or castes see it a low-status activity for married women to work outdoors. The restriction is exacerbated by lower castes' attempt to

emulate the customs of upper castes. As a result, married women tend to withdraw from their work when their family becomes more affluent.

Moreover, for rural women who participate in farm activities, although sharing equal responsibilities as men in terms of agricultural activities, their efforts are always considered as an extension to men's work and not fully recognised. Less participation and negligible recognition in work means less income. According to the 68th round National Sample Survey (July 2011- June 2012), in the age group of 15-59 years, 38.7 percent of women in rural areas were in work force, with only 6.1 percent of them earning regular wage or salaries. The corresponding figures for men were 81.8 percent and 13.6 percent respectively.

Problems arise when women rely too much on men's income. Not being financial independent makes it harder for women to gain respect from their family members, which in turn limits their autonomy and chances of making decisions. So providing financial support to women is not only about poverty alleviation, but also about empowering them, hence the success of the microfinance programs in India over the last 20 years. Microfinance programs involve both formal financial institutions and informal ones. Informal institutions include Self-Help Groups (SHGs) acting as intermediation on behalf of formal ones. Data shows that during 2003, 68 percent of micro-entrepreneurs who received financial assistance from SHGs were women (Kote & Honakeri 2012).

Political Issues

Despite the Constitution of the Republic of India ensuring equality for women in opportunities relating to education, employment, legal status, and all other matters, this is seldom the reality for most of India's 586 million or so women, particularly those from a rural background (World Bank/IFC 2011). In fact, a vast majority is still illiterate and uneducated. Notably however, in 1966, Indira Ghandi became the first female Prime Minister of India. Perhaps one of the more progressive steps in modern politics was the development of the *National Commission for Women*, set up as a statutory body in 1992 in order to assess and improve the status of women and their empowerment. It has a mandate to safeguard the rights and interests of women, including a review of laws and interventions, and to secure speedy justice for women. In 2001, the *National Policy for the Empowerment of Women* was passed. Pratibha Patil became the first woman President of India in 2007 (Head of the Constitution). In 2010, the Women's Reservation Bill was passed, requiring that 33 percent of seats in India's Parliament and state legislative bodies be reserved for women. Nowadays, some states reserve even higher amounts of seats.

In an attempt to ensure gender equality, the Indian government has implemented a number of programs, schemes and incentives for women and girls, namely: Hostels for Working Women; Short Stay Homes for Women and Girls; Support to Training and Employment Program for Women (STEP); a National Credit Fund for Women (Rashtriya Mahila Kosh); a Plan of Action to combat trafficking and commercial sexual exploitation of women and children; a Rural Women Development and Empowerment Project; and the National Scheme of Incentives to Girls for Secondary Education in which eligible girls are entitled to a fixed deposit upon passing 10th grade exams (National Resource Centre for Women, 2014; Ministry of Human Resource Development, 2011). Nevertheless, rampant political corruption, discrimination and terrible inefficiencies, among other factors, prevent the majority of Indian women from reaping the benefits of such schemes.

Health Issues

Health inequalities and lack of access to health care for women in India are entrenched and systematic societal norms, manifested in the various socio-economic spheres of the country and the qualitative inferior status of women (Manasee 2006). Women's health is a systematic problem because, not only is it one of the few countries where men and women have nearly the same life expectancy at birth, but also because of the high mortality rates during childbirth and reproductive years (Kushwah 2013).

In 2012, the Indian government began to implement various program aiming to improve access to health services. Integrated Child Development Services (ICDS) program aims at providing services to pre-school children in an integrated manner so as to ensure proper growth and development of children in rural, tribal and slum areas. The basic services provided to pre-school children and pregnant and lactating mothers under the program include immunisation, supplementary nutrition, health check-ups, referral services, nutrition and health education, and pre-school education. The program is implemented through 97,462 Anganwadi Centres (AWCs), 10,901 mini AWCs and 553 Child Development Projects (CDPs) located at taluka / block level.

Indira Gandhi Matritva Sahayog Yojana (IGMSY) was implemented in 2011 in order to improve health and nutrition levels of pregnant and lactating women. A cash incentive of 4000 rupees is provided to each beneficiary during pregnancy and the lactating period in three installments. During the year 2012-13, the benefit under this scheme had reached 37,500 beneficiaries. A similar program, the Supplementary Nutrition Program (SNP) is being implemented to meet the minimum nutritional requirements of children, pregnant women and lactating mothers and to provide health care to them under ICDS in Maharashtra.

Although many health-related programs have been established, it has been found that many of them are not effective, particularly due to corruption or problems in management. Moreover, the present health infrastructure is not fully equipped to address all of the health needs of the population. Given that health is a key development indicator, it is essential to invest in the public health arena. The government and other organisations, therefore, should focus on improving the hospital and paramedical support in the villages, including establishing more PHC sub-centres and ICDS centres.

Buldana profile

Buldana (district) is located on the western border of Vidarbha region of the State of Maharashtra, and consists of an area of 9640 km^2 and a population of 2.59 million. As one of the most backward districts of Maharashtra, Buldana has a per capita net domestic product of 50,772 rupees (Government of Maharashtra Planning Department 2013), ranking as the 31st among the 34 districts in the state. According to the 2001 census, 79 percent of people in Buldana were living in rural areas. About 84 percent of the labour force was engaged in agriculture and related activities. The female work participation rate was 23.5 percent, 2 percent higher than the all-India figure.
One of the major challenges for Buldana is people's limited access to safe drinking water. Based on survey findings (2008), only 46.9 percent of households had access to safe drinking water, which was 41 percent lower than the national average percentage of 87.9. And the percentage of households with water closet latrines was 15.8 percent, 23.4 percent lower than the national average. Furthermore, the ratio of access to health services in Buldana is one of the lowest in the country.

CBHP

The Community Based Health Project (CBHP) is an Indian-based primary health care program which delivers curative and preventative care to the rural villages in the Buldana district of Maharashtra. It is based on the Jamkhed three-tiered model which provides a community-based approach to healthcare: the Village Health Workers (VHWs); the Mobile Health Clinic (MHC); and the hospital/ training centre.

Whilst the core focus of the CBHP is primary health care, it is also pivotal to understand the importance of a holistic approach in achieving community development and positive health outcomes. It is evident, for example, that education has striking impacts on health and mortality (UNDP 2013). In fact, a mother's education level is more important to child survival than is household income, according to the UNDP Human Development Report 2013. Thus, educating a girl is a powerful instrument in terms of enabling greater self-confidence, access to employment, engagement in public debates, and making demands on government for health care, social security and other entitlements. However, education alone will not ensure equity for women. The key to empowering women are also political and social reforms that enhance women's rights, including freedom, dignity, participation, autonomy and collective agency.

Aims & Overview

Project Aims:

- To research the issue of gender inequality and women's issues within Buldana's rural villages (Tanda, Manubai and Khadki)
- To identify the most pressing gender-related concerns as determined by research results
- To devise a well-justified proposal, which targets the very issues identified. The proposal must be in line with both the Millennium Development Goals (MDGs), particularly, MDG 3: promote gender equality and empower women, and CBHP's mission statement: to see health inequality in rural India a thing of the past, and for every person in rural India to be fully empowered to take ownership of their health

The research, later termed the Women's Empowerment Project (WEP), conducted in January 2014, is a collaborative research effort between a team of students from the University of Melbourne in Australia, Dr. Moses Kharat (the founder and director of CBHP India), and the CBHP Buldana volunteers.

The team decided to pursue research into gender equality and women's issues, something that was a noticeable matter within the villages, and reflecting India's society at large. It was further decided that the largest gender disparities were a result of lack of access to education, particularly post-primary school. The CBHP Women's Empowerment Project would therefore target women's education. As previously mentioned, a mother's education is a main determinant of child mortality. In recognising the need to address infant and child mortality rates, UN Women (2013, p6) states that "better educated women space childbirths over longer periods, ensure their children are immunised, are better informed about children's nutritional needs, and adopt improved sanitation practices."

Ultimately, the project attempted to address rural health concerns and livelihood improvement through empowering women with improved access to education. Globally speaking, "gender inequality is especially tragic not only because it excludes women from basic social opportunities, but also because it gravely imperils the life prospects of future generations" (UNDP 2013, p91).

Methodology

The following three methods were employed in order to gather the views of the village communities, particularly the girls and women, and attempt to discover trends and disparities that exist in rural Maharashtra.

1) Individual interview with the Village Health Worker (VHW) in each of the three villages (see *Appendix A)*
2) Focus group discussion with women in each village, ranging from 6-10 women per focus group (see *Appendix B)*
3) One-to-one interviews based on semi-structured surveys: 13 adolescent girls and 7 adult women in each village (see *Appendix C* and *D* respectively)

Results

The results from each of the one-to-one surveys are combined, and are presented for each village below. Despite being quite structured surveys on paper, the nature of the surveys in practice were generally quite conversational, allowing the researchers to gain more of an explanation and opinion on the question or the response. The participants, therefore, often provided additional information over the course of being surveyed.

Qualitative data was also obtained through discussions with VHWs and women as part of the focus groups. Overall, the VHW is the only permanent source of health education, information and supplies in the village. The VHW visits 10 houses a day (Tanda and Manubai) and 5-6 houses (Khadki). She provides basic medicine and medical supplies, but more importantly, educates people in their homes about sanitation (such as hand washing), drinking clean water, nutritious diets, and she supplies sanitary pads for females. Such health initiatives and education are not taught in the village school, especially because the school only goes up to 4th standard (Tanda) and 7th standard (Kahdki and Manubai). However, the VHWs in each village would like to see more health education in schools, as they think this would be more effective.

Tables 1 and 2, and graph 1 below, are a comparison of the villages.

Table 1: Comparison of villages

	Khadki	**Tanda**	**Manubai**
Number of school girls	13	13	13
% who would like to earn own income	92.3%	69.2%	100.0%
Highest level of education (standard)	7	9	10
% of ongoing education	76.9%	38.5%	84.6%

Graph 1: Level of education and average age of girls in villages

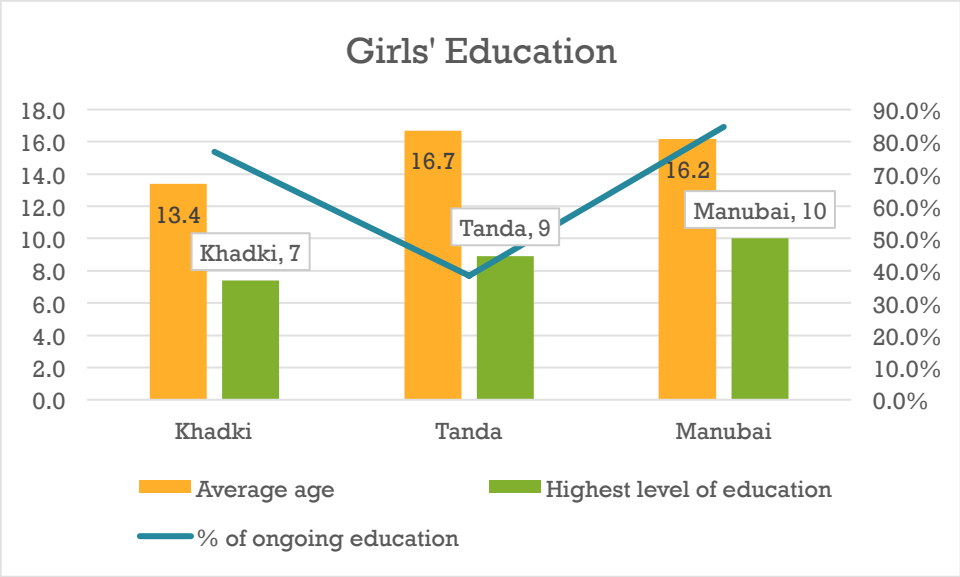

Table 2: Adolescent girls' education compared to brothers (of those with brothers)

	Tanda	Manubai	Khadki
Same level of education	2	12	7
Brother received or is expected to receive a higher level of education	10	1	2

* Those without brothers not included

MANUBAI

Overview

Manubai village is a traditional Indian rural village located 45 kilometres away from Buldana town. It has a population of approximately 700 people, many of which are farmers (CBHP 2013). Whilst not as evident nowadays, a prominent traditional caste system dominated village dynamics, whereby the majority of villagers were considered low caste. Even today, though, Casteism still exists, and the village geographically divides the upper class from the untouchables, or the dalits. This divide is gradually weakening.

As compared to the other project villages, the dwellings in Manubai are considerably more permanent

structures, given that the village has a longer history of settlement.

Almost all of the women in Manubai work as farm labourers, as well as having to complete domestic work. For their labour, women get paid about half as much as males. It was reported that none of the women were earning a consistent income.
Manubai has a government school within the village which provides education up to 7th standard. For further education, students have the option of travelling about one kilometre to attend a government secondary school.

The mean age of survey responders was 16.2 years (range=15-65 years), 7 of who were married. All of these were arranged marriages. The marriage preference of adolescent girls is summarised below in Table 3. When women were asked about the ideal age for their daughters to marry, the majority of responders indicated after 18 years old.

Table 3: Adolescent girls' marriage preference

Arranged marriage	Choice	Does not mind	Does not want to marry
8	3	1	1

Of the adolescent girls surveyed, all had completed primary school. Three of the adult women had completed primary school, three had not received any schooling and one had completed third standard. The highest level of education attained by all participants is summarised in Table 4. Aside from attending school, the adolescent girls interviewed had a number of additional responsibilities, and these are outlined in table 5.

Table 4: Highest level of education achieved

Standard	None	1	2	3	4	5	6	7	8	9	10	11	12	Total
Still studying									1	1	7	1	1	**11**
Completed	3		1	1				1	2				1	**9**

Table 5: Responsibilities for adolescent girls (other than school)

Household chores	Farm labour	Sewing	Look after siblings	Homework
13	1	0	4	2

* household chores included cooking, washing dishes, collecting water, washing clothes
* farm labour was undertaken only on weekends and holidays
* some girls listed more than one responsibility

Five of the participants had never before been to hospital, whilst five others had been only to government hospitals and ten only to private. The participants were asked whether or not they thought there were any barriers that may have previously or could potentially prevent them from going to

hospital and their responses are displayed below in Table 6. Furthermore, the occurrence of smoking and drinking in the family was surveyed, and only one woman indicated that tobacco smoking was a problem and a separate participant mentioned that alcohol consumption was a problem. In both cases the person they were referring to was their husband.

Table 6: Barriers for going to hospital

None	15
Financial reasons	3
Transport difficulties/ distance	2

*No barriers *often* meant that the person did not ever need to go to hospital
*Financial reasons including: lack of money (poor financial condition in family)
*Transport difficulties/ distance including: a lack of buses (sometimes only one or two per day), or hospital is too far away

When addressing domestic violence, 90 percent of participants showed a preference for reporting it to the police. Some women interpreted this question as whether or not domestic violence *should* be reported, and others answered whether or not they *wanted* to report it. Most women and girls did not want to report domestic violence for various reasons. When asked whether domestic violence was a problem or whether it ever occurred, both Tanda and Manubai VHW replied that it wasn't/ did not occur. However our female surveys identified that domestic violence did occur between husband and wife. This was not considered a "problem" as such, because it was always resolved within the community, mostly because the community leader was approached and the issue was dealt with. It appears that the VHW is compelled to deny that domestic violence occurs within the village, for whatever reason.

In terms of income generation, four adult women earned an income through farm labour, with one other selling goats for her income and two others not earning their own income. All but one adolescent girl interviewed indicated a desire to earn her own income one day, and the desired future occupations of the girls is displayed in table 7.

Table 7: Desired occupation for adolescent girls

Nurse	4
Doctor	1
Engineer	1
Police	3
Teacher	2
Pharmacist	1
Seamstress	-
Sewing teacher	-
Farm labourer	-
No occupation (housewife)	1

TANDA

Overview

Tanda village is a tribal village, whose members predominantly belong to the Banjara tribe (CBHP 2013). It has a population of about 800 and is located 30 kilometres from Buldana town. Most of the women in Tanda work with their husbands as labourers on the farms. According to our interview with the VHW, none of the women earned their own income, however our surveys suggest that there are some instances where women may undertake occasional work for additional income. The highest level of education that can be completed at the village primary school is 4th standard. To receive education up to 12th standard, the next closest school is Changdave Vidyalay, a private school in nearby Ubalkhad village, located 3-5 kilometres away.

The mean age of participants was 16.7 years (range 13-50 years), 7 of who were married. All but one of these was an arranged marriage. The marriage preference of adolescent girls is summarised below in Table 8. The mean age at which women wanted their daughters to marry was 17.5 years. Of those women who already had married daughters, the mean age at which these daughters married was also 17.5 years.

Table 8: Adolescent girls' marriage preference

Arranged marriage	Choice	Does not mind	Does not want to marry
12	1	0	0

Of the adolescent girls surveyed, all had completed primary school. Three of the adult women had completed primary school and four had not received any schooling. The highest level of education attained by all participants is summarised in Table 9. Aside from attending school, the adolescent girls interviewed had a number of additional responsibilities, and these are outlined in Table 10.

Table 9: Highest level of education

Standard	None	1	2	3	4	5	6	7	8	9	10	11	12	Total
Still studying										3	1	1		**5**
completed	4						2	1	2	5			1	**15**

Table 10: Responsibilities for adolescent girls (other than school)

Household chores	Farm labour	Sewing	Look after siblings	Homework
16	13	3	0	0

* household chores included cooking, washing dishes, collecting water, washing clothes
* farm labour was undertaken only on weekends and holidays
* some girls listed more than one responsibility
* the girls who sewed were also students of the CBHP girls sewing program

Four of the participants had never before been to hospital, whilst one other had been only to a government hospital, eight to private hospitals only and seven to both. The participants were asked whether or not they thought there were any barriers that may have previously or could potentially prevent them from going to hospital and their responses are displayed below in Table 11. Furthermore, the occurrence of tobacco smoking and drinking in the family was surveyed, and no women indicated that tobacco smoking was a problem. Two women, however, indicated that alcohol consumption by their husbands was problematic. The VHW in Tanda has implemented a program in the village which bans alcohol.

Table 11: Barriers for going to hospital

None	12
Financial reasons	5
Transport difficulties/ distance	8

*No barriers often meant that the person did not ever need to go to hospital
*Financial reasons including: lack of money (poor financial condition in family)
*Transport difficulties/ distance including: a lack of buses (sometimes only one or two per day), or hospital is too far away

When addressing domestic violence, 10 percent of participants showed a preference for reporting it to the police. One woman reported being physically and verbally abused by her husband, and that she

sought assistance from the VHW for her injuries. Again, some women interpreted this question as whether or not domestic violence *should* be reported, and others answered whether or not they *wanted* to report it. Most women and girls did not want to report domestic violence for various reasons.

Three adult women earned an income through farm labour, with one other tailoring clothes for her income and three others not earning their own income. Four adolescent girls did not express a desire to earn their own income. The desired future occupations of those girls who did want to earn an income are displayed below in Table 12.

Table 12: Desired occupation for adolescent girls

Nurse	2
Doctor	2
Engineer	-
Police	-
Teacher	-
Pharmacist	-
Seamstress	4
Sewing teacher	-
Farm labourer	1
No occupation (housewife)	4

KHADKI

Overview

Khadki is a neighbouring village of Tanda, and as a result, has a very similar population in terms of size and tribal background (Banjara tribe). Khadki is located 15 kilometres from Buldana town and has a population of around 860 (CBHP 2013). The village government primary school teaches only until the completion of 7th standard. To receive further education, children must to commute to Buldana town. As in Tanda, the majority of women work on farms, with a few of the women pursuing additional forms of revenue.

The mean age of responders was 13.4 years (range= 11-42 years), 6 of who were married. All of these were arranged marriages. The marriage preference of adolescent girls is summarised below in Table 13. The mean age at which women wanted their daughters to marry was 20 years. Of those women who already had married daughters, the mean age at which these daughters married was 16 years.

Table 13: Adolescent girls' marriage preference

Arranged marriage	Choice	Does not mind	Does not want to marry
12	1	0	0

Of the adolescent girls surveyed, all had completed primary school. Two of the adult women had completed primary school, two others had received no schooling, and three other women had undertaken some primary schooling (two until 4th standard and one until 5th standard). The highest level of education attained by all participants is summarised in Table 14. Aside from attending school, the adolescent girls interviewed had a number of additional responsibilities, and these are outlined in Table 15.

Table 14: Highest level of education

Standard	**None**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Total**
Still studying						1	5	4						**10**
completed					2	1			1	1	1		2	**8**

Table 15: Responsibilities for adolescent girls (other than school)

Household chores	**Farm labour**	**Sewing**	**Look after siblings**	**Homework**
11	1	1	0	0

* household chores included cooking, washing dishes, collecting water, washing clothes
* farm labour was undertaken only on weekends and holidays
* some girls listed more than one responsibility
* the girl who sewed was a student of the CBHP girls sewing program

Two of the participants had never before been to hospital, whilst one other had been only to a government hospital, 15 to private hospitals only and two to both. The participants were asked whether or not they thought there were any barriers that may have previously or could potentially prevent them from going to hospital and their responses are displayed below in Table 16. Tobacco smoking and the consumption of alcohol was not a problem in the families of any of the women interviewed.

There are previous cases of alcohol consumption and smoking in Khadki. The father of an interviewee used to consume alcohol, however he stopped because the doctor told him it was bad for his health. Another interviewee's husband previously consumed alcohol and smoked, however stopped after making a visit to the CBHP clinic. Both the sister-in-law and father-in-law of one interviewee previously drank also.

Table 16: Barriers for going to hospital

None	14
Financial reasons	4
Transport difficulties/ distance	3

*No barriers often meant that the person did not ever need to go to hospital
*Financial reasons including: lack of money (poor financial condition in family)
*Transport difficulties/ distance including: a lack of buses (sometimes only one or two per day), or hospital is too far away

When addressing domestic violence, 60 percent of participants showed a preference for reporting it to the police. One woman reported being physically and verbally abused by her first husband, but she has since divorced him and her current husband does not abuse her.

Two adult women earned an income through farm labour, with one other tailoring clothes for her income and four others not earning their own income. All but one adolescent girl expressed a desire to earn her own income, and the desired occupations for doing so are summarised below in Table 17.

Table 17: Desired occupation for adolescent girls

Nurse	-
Doctor	-
Engineer	-
Police	3
Teacher	8
Pharmacist	-
Seamstress	-
Sewing teacher	1
Farm labourer	-
No occupation (housewife)	1

Discussion

Despite women being legally afforded the same rights as men in most political, social and educational settings, gender disparity remains a large and evident issue in greater India, and particularly in more rural areas. In an effort to better understand and hopefully make a positive contribution towards easing gender inequality, the CBHP Women's Empowerment Project was devised and qualitative and quantitative data was collected from three of CBHP's rural project villages, Manubai, Tanda and Khadki. Conducting surveys and focus groups with both women and adolescent girls, and interviewing the VHW in each village has provided a clearer insight into life for females in rural India, and has confirmed that gender inequality remains rife. Considering the results of the surveys, the three major instances of gender inequality were confirmed as access to education, marriage and employment.

Education

There was a marked difference across all three villages concerning the education of the adolescent girls and the adult women. Promisingly, all adolescent girls had completed at least primary education, as opposed to only 40% of the adult women, suggesting that the education of girls to primary school level is now very common. Education after primary school was less common, particularly amongst adult women, with only 24% of adult women having completed any schooling after 7th standard. All of these women were younger than 30, suggesting that further education for girls is a more recent occurrence. Many more adolescent girls were receiving at least a partial secondary school education. In Manubai, particularly, all but one girl surveyed was currently completing her secondary schooling, and it was a personal choice for this girl to discontinue with her studies. This high rate of continued schooling can be at least partially explained by the fact that there was a secondary school 1km away from Manubai village, and thus transportation was not an issue. Of the girls with brothers, all but one expected to receive education to the same standard as her brother. When asked about the rights of women as opposed to men, though, a few girls in Manubai mentioned that the sexes differ in terms of their access to education, with parents more willing to permit boys than girls to receive education after 10th or 12th standard.

For Khadki, all but three adolescent girls interviewed were still completing their primary school. Whilst they all expressed a desire for further education, it is unclear whether this would actually happen. Of the other three girls interviewed, one had stopped school after 9th standard, but the other two had completed their schooling to 12th standard, suggesting that completing schooling may be quite possible for girls in Khadki. In addition, 7 girls (out of 9 with brothers) expected to receive the same level of schooling as their brothers, and this level was always stated as 12th standard. Despite this optimism about their future schooling, a discussion with the teachers at the Khadki school implied that this would be a more difficult process, as admission to government schools was competitive and attending a private school was usually costly. The teachers did not appear confident that many of these girls would attend secondary school, let alone gain a complete education.

Compared with Manubai and Khadki, girls in Tanda received far less schooling past primary school. Five girls were still studying, but the other eight had all ceased their education at various intervals, but all before 10th standard. Of the girls who had ceased their education, all but one expressed a desire to study more. The high level of school cessation was despite a private school

being located only 3-5km away in a neighbouring village. When speaking to the VHW, it became clear that the fees associated with private schooling were quite expensive; over 3,500 rupees for one year (not including transport or the associated costs of schooling). In comparison, government schools provide a free education, but the nearest government school is in Buldana, and a bus pass for a month of travel would cost between 350 and 500 rupees per student. Despite these high costs, many of the girls surveyed stated that they would have received further education if transport to the private school were easier. They indicated that the cost of the bus to the private school was too high, leaving walking to school as the only option. Both the girls and their parents regarded this as unsafe. Other girls indicated that the bus timings did not match up with school timings, and therefore the bus was not an option. Of the girls still completing school, however, the bus timings was not said to be an issue, so no valid conclusion can be drawn about the effect of bus timing on girls receiving further education. It would appear that the costs associated with pursuing further schooling is one of the major reasons girls in Tanda do not receive schooling to 12th standard and beyond, though it is not clear whether their families would have supported them in gaining further education, were cost not a problem. All of the girls who had brothers expected that he would complete until at least 12th standard, but only two girls expected that they would also reach such a level. This suggests that the cost of schooling is often too great for all children to complete their education, and that the education of boys is valued more highly in families than the education of girls. The women involved in the focus group, who stated that they did not want further education for their daughters, echoed such sentiments. The only further training that these women thought would be beneficial was sewing training.

It was evident across the three surveyed villages that girls quite often receive less education than boys do, and that the education of girls is not seen as necessary or beneficial to all families. Whilst the financial condition of families would surely play a role in deciding whether to send one's daughter for further education, the prevailing view across all villages, but especially evident in Tanda, was that, when capable of sending a child to school, priority should be given to a male child.

Marriage

Across the three villages, the data on age at marriage revealed a trend for marriage occurring before the age of 18. Only three women married after the age of 18 (15 percent of those who are married). Whilst this would have been more of an expected practice for the women in the older generations, the majority of who we surveyed were in fact younger than 30. Within our sample, the youngest married woman is aged 18, and was married at 14, suggesting that the practice of marrying young has not been eradicated.

Women had a general preference for their daughters to marry at the age of 17 or 18, however in reality it occurred much earlier, despite the law prohibiting marriage before 18 for girls. Interestingly, the legal marrying age is different for boys who are entitled to marry at 21.

Along with other barriers to pursuing further education, a family's desire to have their daughter marry before the age at which they would have completed their secondary school education, acts as a significant obstacle for women who would like to attend college or learn a profession. One girl surveyed stated that her neighbours had approached her family and told them not to

bother educating her further, as it would be more beneficial to have her marry.

Speaking with the VHWs and with Varsha Rayurum and Dr Moses Kharat in regards to the barriers facing further education, the prevailing dowry system was discussed. It was suggested that for many families, the prospect of having to pay for their daughter's education was not something that they were willing to do, or were financially capable of doing when they would also have to later pay for a dowry. Speaking to some of the sewing-school students did, however, show that further education of girls might be beneficial for families when it did come to the marriage of their daughters. These girls said that their families would pay less dowry if the daughter had a attained a high level of education, or was skilled, most likely as the future in-laws could appreciate that a skilled and/or educated daughter would contribute financially to her new family, and would thus require a lower dowry. It should be noted that one women stated that she would prefer for her daughter marry only after having completed her education and securing a job. This type of response is obviously not typical of the village population. Furthermore, one girl responded that she did not want to marry. This was somewhat surprising, perhaps even amongst her peers.

For many girls, marriage, or at least the idea of marriage, represented a passing of control from their father to their husband. When asked about the rights of women, girls across all three villages indicated that they currently had to ask the permission of their fathers in order to complete a range of activities, including leaving the village and pursuing further education. Speaking with girls in Khadki, it was suggested that, once married, they would have to ask the permission of their husbands if they wished to pursue further education. This apparently unequal stance in marriage was a perception echoed by women and girls alike, across all villages, with many indicating that their husbands and brothers eat before them, and only the women of the household are expected to complete housework.

Such disparities between the sexes were clearly detected by the women of the villages, and represent a major barrier to be overcome in order to see the empowerment of women be realised.

Employment

In terms of income generation, most women worked as labourers in the farms with their husbands. Most often men and women had different starting times because the women would have to prepare food for the family. This did not necessarily mean that they worked fewer hours on the farm. Women working as farm labourers also got paid less than their male counterparts, although they often did different tasks.

Very few women across the three villages were engaged in paid employment that was independent of farm and/or labour work. Of the three who were, sewing/tailoring and the selling of livestock were the occupations of choice. Despite this trend amongst the older women, the girls of all villages had very different career aspirations - evidence of vast generational differences. 'Teacher', 'doctor', 'nurse' and 'police officer' were common career goals expressed by adolescent girls. Whilst these goals were consistent across adolescent girls of all

villages, it is unclear how achievable these goals really are. Many of the girls surveyed indicated that there were barriers that stood between them and employment in their desired field. Most commonly, financial pressure was this barrier. For some girls, this meant that their parents could not afford to fund further study for any of the children, whereas for others it was the case that their parents could only afford to pay for some children, and thus the boys of the family were prioritised.

It should also be noted that many of the women surveyed did not endorse the career aspirations of the adolescent girls. Women surveyed in Tanda said that the only skill or qualification that they hoped for their daughters to have was in sewing, and for many of those women this skill was one that they hoped their daughters could utilise for their current family. Such a view indicates that many rural women are still not fully aware of, or do not believe that girls can or should pursue the range of skill training and further education available to them. Further, it suggests that women may not endorse their daughter's pursuit of an occupation as it is not their family who will benefit from the income generated by this occupation, but rather their daughter's future husband and children. Seemingly, it is not useful to invest money in further education for their daughter if it will not benefit the family.

Whilst many girls had aspirations for future occupations that were vastly different from those chosen by their mothers, barriers are still in place to prevent girls from achieving these goals. Whilst monetary constraints were a definite problem, it was also evident that many village families were concerned by what their daughters could do to benefit their current family. Thus, further education or skills training in order to allow girls to achieve their occupation aspiration appeared to be undervalued, possibly because it would lessen the time that the girls could help out around the house. Furthermore, the income generated by a girl's occupation may not be earned until she is married. It is therefore important to challenge the prevailing perception in village communities; that girls do not need to have a job, and thus education or skills training to this end does not need to be encouraged.

Through the research conducted across Manubai, Khadki and Tanda villages, many areas of disadvantage, particularly for female residents, were detected. Promisingly, the women and girls surveyed noticed the disparities between men and women, and these were disparities they disagreed with. The fact that girls and women alike wished for a more equal standing with men, and that girls had aspirations for furthering their education and for gaining employment, are all promising steps toward the empowerment of women and girls.

Project proposals

With the intention of addressing the research aim, it was concluded that education, marriage and employment were the most pressing gender-related concerns as determined by research results. In order to provide solutions to address these three factors, the following proposals were devised: night school for women, a private rickshaw, the procurement of sewing machines in villages, and a hostel for girls and women. Each proposal was evaluated in terms of levels of safety, effectiveness, feasibility and sustainability. Given the combined advantages of establishing a hostel for women and girls, and the availability of a suitable building, this option was agreed upon as the most worthwhile, and was shortly

pursued.

Night school
The idea of running a night school is intended to provide educational opportunities to adult women in project villages. According to the news reported by the Times of India, there were 210 night schools across the state of Maharashtra by the end of 2009 (Jaisinghani 2009). Many of the night schools are open to full-time workers who want to further their education. However, in the Buldana area, where most women do not have regular jobs, the advantages of night school are somewhat insignificant or irrelevant. Furthermore, the fact that the classes run at night time makes it difficult for women to attend, due to concerns of both safety and acceptability. In addition, the requirements of a proper location, sufficient facilities and availability of teaching staff put a significant strain on the budget.

Rickshaw
As made evident by the research, the distance between home and school is a factor which may prove just as important as the family's financial condition, in determining whether a girl goes to school or not. For most families that can only afford to send daughters to government schools, parents have to make a decision between high transport costs and long walking distances. Some families would rather bear higher burdens of tuition fees for daughters to go to private schools than to have them walking several hours from school to home.

These factors, together with our finding that bus timings do not always match with school timings, lead to the proposal of arranging private rickshaws to regularly transport girls between school and home. A concern for the lack of safety alone, however, is substantial enough to prevent such a program from being implemented. Meanwhile, it is not easy to arrange the differing routes and schedules of the rickshaws, especially given that different age levels attend class at different parts of the day.

Sewing machines
The level of financial independence is a key factor that determines how much a woman is respected at home and in society. Therefore, equipping women with skills and giving them the opportunity to earn a livelihood allows them to gain respect and have autonomy. The current sewing program being implemented by CBHP has proved to be running well as expected. A recent evaluation of the program revealed, however, that girls who completed the program were then unable to practice and maintain their sewing skills, as they did not have access to a sewing machine. Consequently, it was proposed that sewing machines be provided to graduates. However, it becomes a matter of where to place the machines and who to takes the responsibility of them. A suitable site, that would be safe, accessible and maintained within the village was not determined.

Hostel
Given that the distance to school is a problem preventing girls from attending, the possibility of shortening the travelling distance had been discussed. Establishing a hostel not too far away from schools is a suggestion that helps in achieving this goal. For girls who cannot afford the cost of travel, or for the risks associated with traveling, the hostel provides a relatively safe and secure accommodation option, which is convenient and affordable. Given the nature of a hostel, it is not necessary to limit its availability to schoolgirls only. Further questions on the functions of

the hostel were brought into discussion. Therefore, the proposal of providing a hostel that accommodates both girls and women was suggested, with an intention of addressing the issues of both lack of access to education and lack of shelter (for those wanting to pursue an education). Compared to other proposals, establishing and operating a hostel has greater potential or impact in terms of serving a larger group of people, maintaining safety and providing longer-term sustainability. This option is discussed further in the conclusion.

Limitations

Not surprisingly, the research, and consequently the results, was impacted by a number of limitations, therefore reducing the reliability and validity of the research. One of the most prominent limitations was the language barrier. This presented difficulties in terms of translating our survey and interview questions. With the presence of a couple of Marathi translators, a dialogue was able to occur between the villagers and the Australian researchers, albeit in a somewhat fragmented manner. Fortunately, the translators and the local research team had already established a rapport with the people in the villages, and so the team was less likely to be viewed as strangers or a group not to be trusted. The local team could also guide the Australian research team in terms of cultural appropriateness. Nevertheless, valuable information would have been lost in translation, and some questions were completely misunderstood. A further issue with translation is the fact that there were four researchers conducting surveys and interviews with slightly different wording. Through the process of translation, the meaning of the question has the potential to alter.

Another limitation was the small sample size of participants, as well as the lack of consistency in sampling. For example, the composition of participants varied between villages depending on who was available at the time for interviewing. Khadki village, for instance, had a much younger sample size of girls, as the young schoolgirls were the only participants available on the occasions when we were at Khadki. The small sample size makes it difficult to extrapolate the data to the wider community. A larger research group with the availability of more translators could ensure a larger sample group.

In addition, it was observed that the VHW would sometimes not provide an honest answer, often unintentionally, and usually in order to save face within the village. For example, the VHWs would deny that domestic violence occurs within the village. Through our interviews with some of the women, however, we found that it did in fact occur (though rarely).

Often when conducting the focus group discussions and one-to-one interviews, men were present. This had the potential to influence the women's responses, especially when asked questions directly related to domestic violence, women's rights or arranged marriage, for instance. Furthermore, girls were also often surrounded by their peers when answering survey questions, again influencing their responses, such as how they might like to earn an income one day. Similarly, the focus group discussions were often dominated by one or two (more confident) women, which overshadowed the opinions of others. Evidently, these occasions often resulted in being less of a discussion, and more of a one-on-one interview, despite other participants being encouraged to speak.

Despite being a research topic regarding women's issues, there wasn't any comparison with men and their opinions. No males were included in the interview process, which may have excluded some valuable data from the research. For example, a woman's rights are largely dependent upon the decisions governed by her husband.

Conclusion & Future Directions

Given the perceived benefits of the option of establishing a hostel, this concept was pursued. The proposed aim of the hostel, named the Dayanand Centre (Daya- meaning mercy/compassion and Anand- meaning joy), is to provide accommodation for women and girls who would otherwise be unable to access education and employment services, as well as a space for a girl's sewing class, a computer training class, and possibly a clinic in the future. The provision of a service that allowed females to have the opportunity to stay at a safe accommodation in town in order to pursue their education, complimented our research on women's empowerment, and provided a solution to the many girls who were denied an education due to having to remain located in their village. On the 26th January 2014, Dr. Moses Kharat was handed the keys for this building, which until June would be partly occupied by a primary school (5 rooms). In an attempt to become more efficient (economically, time-wise and resource-wise) all of CBHP's programs and services will operate out of the Dayanand Centre in the very near future, possibly including the provision of accommodation for future Australian volunteers.

Dr. Moses was confident that he would have no trouble in finding and selecting females to be given the opportunity to relocate to the Dayanand Centre. Potential residents would be required to complete a brief application, so as to ensure that CBHP had sufficient information regarding the person, that they were committed to improving their access to education, and that parental consent was given. For those that could afford to do so, a small financial contribution would be required. For the most part, recruitment would essentially be conducted at a personal level and on a case-by-case basis, with the VHW playing a major role in advising and communicating with families.

Of course, there are a number of challenges that arise in regards to the hostel. Such challenges may include: parents' opposition to their daughters staying outside the village; the provision of a trustworthy and reliable security guard and warden; social dynamics of the residents; regulatory issues concerning the care of minors; the fact that the girls still have to commute from the hostel to their place of schooling; the lack of road access to the site; and of course, funding. These challenges, however, are surmountable, and despite the level of effort required, the scope of the impact of the centre is compelling.

One obstacle, however, that was not foreseen, was obtainment of government approval for the hostel. While this process was indeed expected, the strict regulations and lengthy procedures were perhaps underestimated. Government officials conduct numerous inspections at the site, for factors such as security and fire escapes. This process has begun, but has also been interrupted by parliamentary elections in India, thus delaying the approval further. If government approval for the hostel cannot be obtained, the space will need to function as something different. Such functions and services, however, can still operate under the WEP program.

Given these circumstances, Dr. Moses advised us in April, that while the Dayanand Centre was being used as a space for sewing and computer training, as proposed, it also included a beauty therapy training class and handicraft training. The female members of the community identified vocational skills such as these as being important for income generation. The classes have been made available through the hiring of a new full time trainer. Furthermore, while state government permission is yet to be sought for the delivery of advanced computer training courses, basic courses are currently being conducted.

Consequently, all five rooms of the Dayanand Centre are being utilised, as an office for administration, a computer training lab, a classroom, a sewing room and a consultation room. Once renovations are complete, at some stage in 2014, it is expected that the CBHP clinic and VHW training centre will be shifted to this location.

There is a lot of potential for the future of the Dayanand Centre, and the opportunities for the empowerment of women is limitless. A range of other programs and services could be offered as part of the WEP, for example, a community organic garden on site, English lessons, other vocational programs, or even a kindergarten or school. It is anticipated that over time, the locality of the hostel and the proposed functions of the centre may change, as they already have. Initially, a lot of resources will be put into getting the centre completely established and operating.

This research was conducted without the guarantee of funds being available. Dr. Moses, however, advised us that he expected to be able to run the hostel on about 10,000 per month. This included rent, wages for a security guard and warden, and some food. The site is equipped with a rain water tank, well and pump, but would incur costs for electricity. Once, and if, the hostel is filled with residents, and the programs are underway, there is also a huge potential for fundraising campaigns, especially given the tangible results of donations. This is an area for further research.

CBHP is continuously brainstorming ways in which it can expand its services, particularly through new projects. In the near future, Dr. Moses would like to secure his own land in which CBHP can operate from, mostly in order to avoid having rent as an overhead cost. It is imperative that the Women's Empowerment Program (WEP), in all of its components, is continuously evaluated, in order to ensure ultimate effectiveness and improvement. The research conducted as part of WEP has revealed some interesting results. For the volunteers, it was a privilege to witness the establishment of the Dayanand Centre – a palpable solution to the female-related concerns raised as a result of the research. Obviously, challenges will continue to present themselves, however, as we have witnessed already, the CBHP team are more than capable of being flexible, innovative and adaptable.

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Appendices

Appendix A: Interview questions for Village Health Workers

• What are your main day-to-day concerns as health workers?
• What do you think are the major health issues in the community?
• What are the other health issues in the community? (is it common?)
• What are the underlying causes of health problems in the community?
• What do you think of the health system here? Is it effective?
• What current/previous initiatives/programs make a positive contribution to the health of the community? (what works?)
(check the previous initiatives and programs mentioned in the health audit, ask them specifically instead of generally)
• What current/previous initiatives/programs are unhelpful?
(check the previous initiatives and programs mentioned in the health audit, ask them specifically instead of generally)
• What is the average amount of children in a family?
• Are there any women's groups within the village?
• Are there any single mothers or widows? Are they treated differently?
• Are you aware of any cases of domestic violence in the village?
• Is contraception easily available in this village?
• Does the government supply any forms of contraception? Is this use common?
• Do boys and girls learn about family planning and contraception at school? If so, what standard (grade)?
• What age do you think is the ideal age to get married?
• Are there any 'abandoned' girls in this village? If so, what happens to them?

Probing Q's:
• Could you tell us more about that?
• Could you give us an example?
•What do you mean by...?

Appendix B: Focus group questions

Women and Adolescent Girls

• What are your main day-to-day concerns?
• What are your main concerns regarding your health and your family's health?
• What are your main concerns regarding the healthcare system?

Health care/programs/diseases
• Who do people visit for healthcare? (hospitals, healthcare workers, local traditional healers)
• Do you have trouble accessing health care? Is it far away? Can they get necessary medicines?

Gender equality
• Do women face any specific health issues?
• How much schooling do girls usually receive?
• At what age do girls get married?
• Do women work? Is there a difference in the work men and women do?

Education
• What is your highest level of education?
• Do you think girls should go through same level education level as boys? Is it common for boys and girls to receive the same education level? If there's a difference, why?
• What would help girls to receive more education?
• Would you like to study more? What is stopping you (or your children) from doing so?
• Would you prefer to stay in Buldana to further your study?

Families/Reproductive Health ('family planning')
• Were you married? If so, at what age?
• What's the optimum age to get married?
• What do you feel about early marriage?
• How do you feel about arranged marriage and 'love' marriage? Which do you prefer?
• How do you feel about the dowry system?
• What beliefs are there regarding family size? What is the ideal number of children in a family? (activity with each participant given counters to vote on their ideal no. of children)
• Is breastfeeding common? When is breastfeeding stopped?
• How many years apart are children usually born?
• Who is present when you give birth? (Healthcare workers? Traditional healers?)
• Where do you give birth? (At home? At hospital?)
• Is it preferred to have a son/ daughter? Is having a daughter a burden for the family?

Women's rights
• Do you think women receive same rights as men? Do you think they should receive equal rights?
• To ask men: Do you think that women should have the same rights as you?

Appendix C: Individual surveys for Adolescent Girls

Age:
Are you married? If so, at what age did you marry?
Was this an arranged marriage?
Do you have any children? How old are they?
Did you go to primary school?
What is your highest level of education? Are you still studying?
Have you ever been to hospital? Was it a government or private hospital?
What are the barriers for going to hospital? For example, is it too far away? Too expensive?
Do you think women should report domestic violence to the police?
Would you prefer an arranged marriage or to marry by choice ('love marriage'), or you don't mind?
Do you think women have the same rights as men?
What are your responsibilities other than school? For example, house chores, helping parents with their work.
Would you like to earn your own income one day?
How would you do this? Which job?
Are there any barriers to getting this job?
Do you have brothers? Do you expect that you will receive the same level of education as them?
If no, what would the reason be?
Would you like to study more?
If yes, what factors would prevent you?

Appendix D: Individual surveys for Adult Women

Age:
Are you married? If so, at what age did you marry?
Was this an arranged marriage?
Do you have any children? How old are they?
Did you go to primary school?
What is your highest level of education?
Have you ever been to hospital? Was it a government or private hospital?
What are the barriers for going to hospital? For example, is it too far away? Too expensive?
Do you think women should report domestic violence to the police?
Is smoking or drinking common in the family? If yes, by which family members?
Have you ever been physically abused by a family member? If so, what were the consequences? Ie, was it ever serious or did you go to hospital?
What age would you prefer your daughter to get married?
Do you earn an income?
Do you think women have the same rights as men?