Caring for Women?

Household gender dynamics and young married women's access to reproductive healthcare in Bihar, India

Alankrita Anand

PhD

University of York

Department of Sociology

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Abstract

This thesis examines the marital household as a site and a set of relations that shapes young married women's access to reproductive healthcare. I aim to develop a critical understanding of women's care in relation to marriage and the marital household, asking if women *feel cared for*. The study addresses women who married as adolescents, whose reproductive health is usually studied vis-a-vis their contentious legal marital status and biological age, rather than their social position in marriage and household. The research comprises 33 in-depth interviews and 6 focus group discussions with women aged 16-28 (married between 14-19), supplemented by a participatory pilot study and extensive community engagement. The analysis is inspired by constructivist grounded theory.

The study finds that women's conceptualisations of health are embedded in the gender dynamics and gendered relations of the household, and that women ascribe meaning to their experience of health, illness, and care to make sense of their gendered position within marriage and society. While early marriage is typically associated with poor reproductive health outcomes, in the empirical context, young married women make significant associations between the circumstances of their marriage—such as love, compulsion and honour—and their access to care. The husband's socially-conferred authority in marriage is particularly a central force that influences women's access to care. The husband's authority can alternatively result in neglect, but crucially, women navigate authority by seeking care within its limits, and sometimes by challenging it. The study relatedly examines women's decision-making practices and finds that decentering decision-making autonomy in studying women's access to care allows us to understand women's claims on forms of care due to them such as value for their lives, the moral responsibility of husbands to care for them, and love as wives and daughters-in-law, which capture the essence of *feeling cared for*.

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Author's Declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for a degree or other qualification at this University or elsewhere. All sources are acknowledged as references.

Further, part of this work has been already published, and can be found here:

Anand, A. (2022). Decentring decision-making autonomy in locating young women's claims on care in rural India. *Cultivate*, Issue 4, 42-52. Available at: http://cultivatefeminism.com/issue-four-care-decentring-decision-making-autonomy.

Chapter 1
Introduction

1.1 The research problem

In 2012, the Mumbai Police charged a man and his family with abetment to suicide, a crime under Section 306 of the Indian Penal Code, after his wife died by suicide following deprivation of postpartum care and mistreatment upon giving birth to a girl. After an 11-year-long legal battle, a local court acquitted the man and the accused family members, ruling that merely not providing medical treatment does not amount to cruelty (Modak, 2023). The woman's birth family had also made formal complaints of dowry demands, alleging that her marital family had taken gold and other expensive clothing and household items as dowry, and were harassing her for more. Dowry-related abetment to suicide is unfortunately not uncommon even today, but the legal case was principally framed in terms of access to healthcare rather than dowry demands or dowry death, which underscores the family's role and responsibility in a woman's care. At the same time, it also shows that deprivation and mistreatment do not happen in isolation from wider problems like dowry demands and gender-based discrimination. The court's use of 'merely' in the 2012 case, however, presumes that not providing medical treatment is isolated from structural factors and is somehow less intense than other forms of discrimination, which disregards the embeddedness of women's health experiences in their everyday social life. The incident occurred in Mumbai, a relatively well-resourced urban setting, and in a household with resources, which shows that neglect can be practised even when resources are physically and financially accessible.

The case draws attention to the household as a site of neglect, rather than health institutions or the state. This thesis looks further into the household as a site where women's access to healthcare is shaped and contested. The research problem that I address is the influence of household gender dynamics on young married women's access to reproductive healthcare in Bihar, India. The gender dynamics of the household interact with caste and the immediate social context, health systems, and the political background of women's health (Mishra and Roalkvam; 2014; Nandagiri, 2021; Wilson, 2017), and I am particularly interested in how

women navigate these dynamics. Reading the household as a site of care does not discount the state's responsibility towards women's care, and is in fact, a way to place the two relationally in the study of women's health. At the same time, I foreground the everyday gendered relations of the household and marriage as an institution, the emotional bonds and moral claims that sustain them, along with the gendered practices of authority, agency, and resistance. I place this problem in relation to early marriage, centring young married women who occupy a unique social position as young brides in heteronormative family structures, as their position is often considered the least powerful position in the family, and they are understood to have poor access to reproductive healthcare and poor reproductive health outcomes (Barua and Kurz, 2001; Bruce, 2003; Santhya and Jejeebhoy, 2003; Pillai and Gupta, 2014). The study is based in Bihar, a resource-poor state in eastern India, with poor reproductive health indicators. For instance, the most recently recorded maternal mortality rate for Bihar is 118 deaths per 100,000 live births as opposed to the national average of 97 deaths per 100,000 live births (between 2018-2020), which in turn, is among the highest in the world (Sample Registration System, 2022). Bihar also has some of the highest rates of early marriage in India, with 40 percent of women currently aged 20-24 having been married before 18, in 2019-2020, making it an important site to study the influence of household gender dynamics on young married women's access to reproductive healthcare (International Institute for Population Sciences [IIPS] and ICF, 2021).

This introductory chapter provides a background of the key debates that the research problem is located in and responds to, and develops an argument for the study of household dynamics in women's access to reproductive healthcare and, more widely, for the feminist study of women's (receipt of) care. I first unpack the key terms used in the thesis title *Household gender dynamics and young married women's access to reproductive healthcare* in order to provide working definitions for them and to show why they are analytically relevant to the research. This is followed by an account of the historical and discursive contexts in which women's health gains currency and becomes a subject of interest in policy and society. I identify the place (or the lack) of care in these contexts to position my research as a study on care, and to argue for the widening of the meaning of access in studying access to reproductive healthcare. I then locate my use of gender as a category of analysis, which enables the study of care in the manner I propose, and summarise the feminist debates I draw on, especially from the Indian context. The introduction then outlines the regional context of the study to demonstrate how it gives rise to and strengthens the study's questions and aims.

This section also expands upon the debate around early marriage, not to position it as a problem unique to the region and its communities but to show why the extent of early marriage, and the meanings given to it, make it salient as an area of inquiry. Lastly, I provide an outline of the thesis chapters, highlighting the key themes and arguments for each one of them.

1.1.1 Why young women, the household, and healthcare?

The research problem speaks to the key issues around women, marriage, household and care, in relation to each other. Here, I demonstrate the analytical relevance of these issues and explain my proposition to study women's access to reproductive healthcare by expanding the meaning of access to include the household, and by foregrounding caring for women.

First, my study is interested in the experiences of women married as minors, as their sexuality and reproduction comes under additional social, legal and medical scrutiny, being entangled with anxieties around child marriage and forced marriage, adolescent pregnancy and sexual behaviour, and fertility rates and population growth. My initial interest was in understanding the role of the household in enabling care for young brides when the state excludes them from healthcare based on their age (by limiting certain maternity benefits to those above 19, for instance, in order to de-incentivise early marriage and childbearing). But while their position as married women and their reproduction is problematised in law and public health, socially, they are expected to follow the norms that are attendant upon marriage, much like adult married women (Uberoi, 1997). The research problem, therefore, is invested in the debate on early marriage and its relation to women's health.

I describe the study population as 'women', even when it includes minors, because 'adolescent girls' invokes the same language that is used to infantilise and penalise them, while overlooking their social identity and roles as adults.[1] The use of 'women' also draws on the terminology in the study region where marriage, rather than age, is considered a marker of maturity, and married girls, despite their age, are referred to as women. Positioning the participants as 'young married women' also allows my study to present a novel framing of

[1] In research on sexual and reproductive health in India, adolescent girls are usually understood to be 15–19 years old, although the government divides adolescence among girls into early adolescence (10–13 years), mid-adolescence (14–16 years) and late adolescence (17–19 years).

the problem of early marriage, recognising its prevalence and challenges, but understanding women's experiences within it rather than studying the experience of it in the context of moral anxieties and reproductive health outcomes alone. The conceptual framing of 'young married women' is discussed further in the chapter (Section 1.4), and its analytical relevance particularly comes to light in Chapter 4, on conceptualisations of health.

Second, the research problem centres the household, understood as the marital household, or the marital family of young brides. This family is usually made up of the husband and the in-laws, and may include other relatives who permanently reside in the house. The household is understood as a physical space but is consequential as a social entity even when its members do not share the physical space in the everyday. For instance, a married woman temporarily living with her parents, a husband being away as a migrant worker, or a marital couple living as a nuclear unit within the larger household, are all still part of the same household as the social relations of the household remain despite the variations in its physical composition. Conceptually, the household is understood through its locality and the shared activities of consumption and social reproduction that its members undertake, even when they may be temporarily away (Yanagisako, 1979). More importantly, the household is always produced by and representative of the caste and the community it belongs to, and cannot be extracted from it. My study, therefore, examines the household through its relations and dynamics at all times. As Deshmukh-Ranadive (2001) argues, studying gender in the household requires the study of dynamics which are often flattened in the understanding of the household borrowed from economics in which it functions as a single unit. Agarwal (1997), providing a feminist critique of the household in economics, additionally reconfigures this understanding of the gender dynamics of the household to include gender relations beyond the household as well—such as the caste affiliation of its members, their roles in the labour market, and their regulation by the state. I interrogate the household in this shape and form, while being in conversation with, and not discounting, the state and health systems, and the larger political forces within which they act, to develop an understanding of women's access to reproductive healthcare. The household, and its constitution through marriage, is discussed in greater detail in the analysis of marriage, gendered relations and care in Chapter 5.

The third aspect; the use of 'access to reproductive healthcare' in my title deserves particular attention. Access, in this research, includes *feeling cared for*, and encompasses the processes

of access, and the gendered relations of the household that shape them. The literature review (Chapter 2) illustrates why the conventional understanding of access as physical access and utilisation is limiting for this study. Relatedly, in my study, the 'reproductive healthcare' that is being accessed encompasses both institutional care and household-based care which are inseparable and embedded in the everyday practices of care shaped by marriage and the household. The analysis of women's conceptualisaitons of health in Chapter 4 expands upon what being healthy and feeling cared for means for women, and how reproductive health is embedded in multiple dimensions of their health and in their social location as young brides in the marital household. The research, therefore, has multiple and shifting understandings of care, which is sometimes captured by institutional access and quality of care, and at other times, interrelatedly, through the gendered practices of care and neglect in the household. The use of 'access to reproductive healthcare' sometimes elides with access to healthcare, or more simply, to care, in recognition of the difficulty (and inadvisability) of extracting reproductive healthcare from other aspects of care. The study develops these understandings of access and care with due attention to the poor availability of health facilities in the study region and the poor health status of young married women on conventional parameters, and is cognisant of the problem of lack of resources, further discussed in Chapter 2 (Kumari and Verma, 2021). The methodology (Chapter 3) details how these concepts, such as drawing out 'care' from access to reproductive healthcare, have been arrived at through the analytical framework of constructivist grounded theory (Charmaz, 2006).

1.1.2 The place of care in studying women's health

Women's health, especially sexual and reproductive health, has been a subject of interest globally and in India in recent decades, propelled by international agreements such as the United Nations Sustainable Development Goals (United Nations [UN], 2015), national targets for mortality and fertility reduction (Ministry of Health and Family Welfare [MoHFW], 2000), and north-south cash flows via multilateral governmental and non-governmental agencies such as the United States Agency for International Aid (USAID), the Department for International Development of the United Kingdom (DfID), the World Bank (Wilson, 2017). The above avenues of interest in women's health often allude to population control, which is a discourse that is important to the study as it is part of the environment in which women navigate and experience access to care. In India, and particularly relevant to this study, this discourse greatly influences the debate over early

marriage, a connection which I discuss below. In this section, I demonstrate the historical and contemporary centrality of population control in independent India, and locate the heteronormative family and household in it, asking if care features—and if so, how—in any of these debates and structures.

As the Constitution of India was being written in the late colonial period (1930s–1940s), questions of women's health and status were debated by policymakers, social reformers, feminists, and eugenicists. These debates led to the setting up of national institutions like the Family Planning Association of India (and subsequently the transnational International Planned Parenthood Federation), local clinics and health fairs, and the very legal framework of reproduction, which, like many other political contexts, was informed by ideas of nationhood and womanhood (Sreenivas, 2021, Yuval-Davis, 1996). As is evident by the nature of the institutions and activities, questions about women's health were particularly debated in relation to fertility control (Ahluwalia, 2008; Desai, 2020; Sreenivas, 2021). These debates were happening at the peak of the independence movement, when women's roles in society and nation-building were actively being invoked, with special attention to their reproductive and maternal roles as they were expected to nurture the future of the country. Sreenivas (2021) argues that despite what public figures identified as—nationalists, reformers, feminists—most of them eventually aligned with the population control and nation-building agenda, even if they believed in contraception as a liberatory tool for women.

In 1938, P.J. Roham, a member of the Bombay Legislative Assembly, made a speech on behalf of Dr. B.R. Ambedkar, in a resolution on contraceptive adoption, arguing in favour of mass availability of contraceptives. While the larger Assembly debate was on population control, the availability of contraceptives was being argued for on the grounds of women's health and well-being, and to counter the opinion that sexual abstinence could be a possibility in marriage, an opinion most notably espoused by Gandhi who saw abstinence as a form of women's resistance (Desai, 2020; Dr. Ambedkar Foundation, 2014). Thus, P.J. Roham, on behalf of Dr. B.R. Ambedkar, explained:

> "Whenever a woman is disinclined to bear a child for any reason whatsoever, she must be in a position to prevent conception and bringing forth progeny which should be entirely dependent on the choice of women." (Dr. Ambedkar Foundation, 2014, p. 264)

The speech also noted that increasing the then minimum age of marriage for women from 14 to 18 would not be a sustainable solution for birth control, which was proposed by some members of the Assembly, as the minimum age of 14 (implemented in 1929 and increased to 15 in 1949 upon the adoption of the Indian Constitution) was already not being met because of the material and social circumstances of the country's population. While an increase in the age of marriage for women was eventually expected to become common, according to Roham's speech, it could not be an alternative to birth control.

The 1938 resolution was not adopted as it was supported by only 11 members of the Assembly and opposed by 52, but the debate shows that women's bodily autonomy, health and social status (albeit largely within the confines of marriage) were also part of the question of reproduction, nationhood and population control. In other words, population control was not only a technical exercise aimed at nation-building but also imbued with meanings of women's rights and roles in society.

India eventually adopted a national family planning programme in 1952, the first in the world, and followed explicit targets to reduce fertility, mostly through female sterilisations rather than reversible methods. A focus on women's care, therefore, was limited within the family planning approach, just like the birth control approach. The state invested in women's health with the instrumentalist end of nation-building and economic growth (but with due interest in women's roles in society), a trajectory common in several developing countries, owing to global development approaches which sought to regulate population growth (Mohindra and Nikiéma, 2010).

In 1976, India introduced its first National Population Policy, which once again sought to curb population growth and included measures like individual monetary incentives for sterilisation and regulation of central funds to states depending on their performance on population control. Based on the policy, the minimum age of marriage was increased to 18 for girls and 21 for boys in 1978 (the current minimum ages), linking age at marriage to population control as delayed marriage was expected to lower fertility (Sama Resource Group for Women and Health and Partners for Law in Development, 2018). The second and current National Population Policy, introduced in 2000, drew on the global shift from target-driven approaches to fertility to 'choice', a shift credited to the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing, both of which of which centred attention to women's health beyond fertility (Farah, 2005; Mohindra

and Nikiéma, 2010). The new policy, therefore, promoted a 'target-free' approach to contraception, but fertility targets remained in place, with plans to reduce the total fertility rate to the replacement level of 2.1 children per woman by 2045 (MoHFW, 2000). The total fertility rate, according to the most recent National Family Health Survey (NFHS-5, based on data for 2019-2021), has already dropped to 2.0 (IIPS and ICF, 2021). Population control is argued to be central in approaches to women's health even today, often forcefully and violently targeting women from socio-economically deprived castes and communities (Bhatia et al., 2019; Nandagiri, 2021; Sreenivas, 2022; Unnithan, 2022; Wilson, 2018).

The historical background of women's health is dominated by political actors and regulatory frameworks, which is reflected in the literature on it. The family or the household does not always feature in these discussions (except briefly in empirical works), but they are very much interacting with the state and its allied institutions. In the state's public messages in India, the family is more overtly present than in research on reproductive politics, and the very meaning of family is reconfigured through these messages, as it is often limited to the nuclear unit of a husband, wife and child or children (specifically two—a male and a female child). The popular family planning slogan '*hum do, hamare do*' (two of us and two of our children), introduced in the 1970s, is commonly reproduced in conversation and culture, and in recent years, there has been a shift in focus to '*hum do'* (the two of us) to reflect the idea that a couple must first get to know each other (MoHFW, 2018). In both instances, the pictured family is notedly a heteronormative family whose core is a married couple. This image is central to the imagination of a family and is fiercely protected, although it is also challenged in society and law. Women's reproductive health is embedded in this image and imagination of the family, even as it is imbricated in global and national population control agendas and health targets. Even in instrumentalist and target-driven approaches, which arguably dehumanise women, social meanings are being ascribed to women's bodies—what they should look like, what their functions should be, and what their limitations should be, and by extension, what social order should look like. The interest in population control, nation-building and economic growth is, therefore, built alongside the preservation of the household and the family, and household dynamics interact with wider interests in sustaining this, but not without negotiation, challenge and claims on care by women.

In November 2023, the Chief Minister of Bihar, Nitish Kumar, made a public statement on the decline in the state's population, arguing that it was brought about by an increase in

women's education as educated women understand the 'withdrawal method' of contraception, thereby preventing births. The statement drew backlash from the political opposition as well as women's groups because of its crude nature (as it described sexual intercourse in the Assembly) and was seen as an attack on the dignity of women (The Indian Express, 2023). But it did not draw any criticism or attention based on the connotations it made about women's education and health—that women's education is valuable because it leads to a decline in population, that birth control is women's responsibility, and that population control is what matters with respect to women's bodies and sexuality. Kumar's statement also said that husbands obviously want to have sex everyday but as long as the wife knows about the withdrawal method, the problem is solved as there will not be any pregnancy. The question of women's rights, choice, sexuality and care, therefore, was overlooked not only in Kumar's statement but also in the responses that it prompted. The role of gender dynamics, implicit in sexual negotiation, was also normalised rather than sought to be challenged. It is this gap in understanding women's health and care that I am interested in, particularly in relation to marriage and the marital household. While there may be an increase in education among women, a decline in fertility (desirable by the state and by women themselves, and perhaps, like Kumar argues, prompted by education), an improvement in access to healthcare, and an increase in the age of marriage, are women really cared for?

1.1.3 Research aim and questions

My aim is to build a critical understanding of women's access to reproductive healthcare and to develop ways to think about women's (receipt of) care in relation to marriage and the marital household, which, in the study context and in many other social contexts, is the central social relation that shapes women's lives.

Based on the research background and aim, the study asks the following questions:

1. How do young married women understand their reproductive health status and needs?

   The first question seeks to account for the ways in which women experience, understand and ascribe meaning to their body and their health.

2. How do marriage and the gendered relations of the household shape access to care for young married women?

   The second question aims to study the role of social relations, and the dynamics that maintain them, in shaping the need for and circumstances of access.

3. How do young married women perceive and assign meaning to their decision-making within the household, especially with respect to access to care?

   The third question looks at the place of decision-making in enabling access to care—asking what counts as decision-making, and how it is related to feeling loved and cared for.

To examine these questions, I carried out a qualitative inquiry using 33 in-depth interviews and six focus group discussions with young married women in Bihar. This centres women who had married between the ages of 14–19 (they were aged 16–28 at the time of data collection) as the study participants, and embeds their participation in an extensive research process of community engagement. The study was carried out with four collaborators—two affiliated with a regional NGO and two independent. It was preceded by a participatory pilot study, which informed the research questions, and the interview and focus group discussion topic guides. The data was analysed inductively, drawing on the principles of constructivist grounded theory (Charmaz, 2006). The methodological approach of the study is discussed in Chapter 3.

1.2 Locating gender as a category of analysis in feminism

The study of women's care, through the research background and questions described above, is a feminist endeavour. In this section, I locate my research as a feminist study in sociology, which uses gender as the central category of analysis. I use 'gender' in two forms—'gender dynamics' and 'gendered relations', both specifically in the context of the household (and its many interrelations described above). 'Gender dynamics', for my study, is an umbrella concept that incorporates local forms of gender inequality, gender hierarchy and gender norms. My understanding of gender dynamics is derived from feminist theories which dislodge gender as an individual identity and study it in relation to other axes of social identity, and as a product of embodied social norms, and I place these dynamics in the space of the household (Crenshaw, 1991; Davis, 2017; McCann, 2016; Paik, 2014; Rege, 1998). 'Gendered relations' are the relations or the processes that build and sustain the dynamics (for instance, heteronormative marriage—a gendered relation—maintains gender norms and hierarchy). My understanding of 'gendered relations', although implicit in gender dynamics in many ways, resonates with conceptual and qualitative empirical works which study

household, marriage, kinship and caste in India, emphasising the relationships that form the heteropatriarchal family (Agarwal, 1997; Allendorf, 2015; Grover, 2018; Jeffery, Jeffery and Lyon, 1989).

To illustrate how gender encompasses identity and relations, and works as a dynamic, we can take the example of mothers-in-law and daughters-in-law. Research from India shows that the relationship between mothers-in-law and daughters-in-law is not defined by their gender identity as women alone but by their position in the household as wives and mothers, which are positions they occupy owing to the gendered nature of marriage and parenthood. And although they may have shared locations as wives and mothers, the dynamic between these locations can shift depending upon the gender of their children, the caste location and composition of their birth families, their access to and control over household resources, and the nature of their relationship with the men of the household (Allendorf, 2015; Barua and Kurz, 2001; Vera-Sanso, 1999).

There has been debate over the use of gender as a category in feminist research, or about women as subjects of study in feminist research. Rege (2003), writing about the introduction of feminist research and women's studies centres in sociology in India, argues that it is not enough to include women as an additive category in sociology or desirable to separate the study of sociology from a women's standpoint. She argues that feminist perspectives must be used to reconceptualise given meanings in sociology (by deconstructing the public-private binary, for instance) and that 'gender' should be the category of analysis in feminist research as it can account for caste and sexuality, troubling the commonality of a feminine experience (Rege, 2003). In some ways, Rege's (2003) suggestion alludes to an intersectional approach to gender which asks for different axes of inequality, like gender and race, to be studied in their inter-relatedness rather than distinct forms of identity and experience (Collins and Bilge, 2016; Crenshaw, 1991). Intersectionality has been adapted to research and activism in the Indian context, often priming caste as one of the key axes of inequality inter-related with gender. Dalit feminism—a significant theoretical framework and social justice movement in India (and in other parts of South Asia, most notably Nepal), based on the lived experiences of Dalit or 'lower' caste women—has particularly foregrounded an intersectional approach to gender justice. Dalit feminism speaks directly to intersectionality in Black feminist thought and also identifies intersectional approaches in early and contemporary Dalit feminist writings, where the body is experienced as a gendered and caste body (Paik, 2021; Paik,2014;

Sowjanya, 2014). Dalit feminist theory, according to Arya and Rathore (2019), alters and reorients Indian feminism to adequately address gender justice which has historically been dominated by and concerned with 'upper' caste women, and has been central in producing academic knowledge (Da Costa, 2022). Dalit feminism, therefore, is not merely speaking to and of the experiences of Dalit women but for gender justice widely, problematising caste in the understanding of gender.

> "Woman, gender, and community are not a given but contingently constituted through distinct and divergent processes. As a result, they are generative activities. There is no homogeneous Indian woman." (Paik, 2021, p. 134)

Paik (2021, p. 133) also draws attention to "the constitutive role of patriarchy in shaping and maintaining caste" and argues that Dalit feminism offers a framework of looking into the nature of patriarchy. The gender dynamics and gendered relations of the household that this study examines, therefore, identifies gender as co-constitutive of caste, and vice versa—caste as co-constitutive of gender (Da Costa, 2022). Caste forms and influences the gendered dynamics and relations that constitute heteronormative marriage in both inter-caste marriage and intra-caste (endogamous) marriage. In inter-caste marriage, caste-based hierarchies may directly create or influence the gender dynamics of the household, and in intra-caste marriage, caste continues to form the basis of the household, as the family—its norms, status, rituals—is defined by its caste. Studying women's care in relation to marriage and the marital household, therefore, must account for caste. The literature review (Chapter 2) looks at empirical works which explore the intersections of caste and gender in studying health systems and access to institutional healthcare, and the analytical chapters, especially the chapter on marriage, gendered relations and care (Chapter 5), demonstrate how caste location is implicit in experiences of gender and patriarchy within the household and outside of it.

1.3 The study location

1.3.1 Politics, society and a region in flux

The study is located in rural Bihar, and was carried out in two districts, Kishanganj and Purnia, in the northeastern part of the state. The districts were selected because of an interest in the larger region, known as Seemanchal, which translates to 'borderlands.' Seemanchal shares a border with the neighbouring state of West Bengal and a porous international border

with Nepal (like all of northern Bihar). The region, while fairly representative of Bihar in terms of social and economic development, is culturally contiguous with its neighbours across the borders. The region has received attention in social science research and media in recent years, especially in the fields of politics, and the socio-economic consequences of migration and climate change (Ahmad, 2023; Ahmed, 2022; Ahmed, 2015; Khanna and Kochhar, 2023; Levesque, 2020; Mujtaba, 2020; Singh, 2022). It has the highest Muslim population in Bihar, with Kishanganj being the only Muslim-majority district in the state, making it of interest in electoral politics amidst rising Hindu majoritarianism. Seemanchal, especially Purnia, also has the highest population of Adivasi communities in Bihar. Adivasi populations in small local pockets do not receive attention in politics and media in the same way as minority Muslim communities, but their social identity has very much come under threat in the region and has contributed to their marginalisation. Adivasi communities in Seemanchal belong to both Christian and Hindu backgrounds but identify distinctly as Adivasis and have little in common with other Christian and Hindu communities in the region, culturally. In Purnia, not far from the study site, was the site of an Adivasi massacre by landowning 'upper' castes in 1971, which had a lasting influence on the community and its isolation (Chakravarti, 2022; Pankaj, 2022).

These regional and political characteristics are significant to the study, as ideas and identities are produced and reproduced in this context. The significance of caste and religious identities in daily life, and specifically in the context of household, health, access, and care will become evident in the discussion of the methodology (Chapter 3) and in the chapters that follow (Chapters 4-6). Gender, as discussed earlier, is co-constitutive of caste (and vice-versa). In the study field, the English 'caste' and its Hindi equivalent '*jaat*' were often interchangeable with religion and ethnicity, but with the recognition of implicit hierarchy. The study, henceforth, will use 'caste' similarly, unless otherwise specified. The constitutional classification for caste in India, referred to in the study, comprises: Scheduled Caste (SC), Scheduled Tribe (ST), Other Backward Class (OBC), General. SC, ST and OBC are constitutional classifications for caste groups deemed 'low' and/or 'untouchable' by the caste system, tribal and indigenous groups, and educationally or socially deprived groups, respectively (Constitution of India, 1950). Castes with historical privilege—'upper' or *Savarna* castes—are classified as General castes. Scheduled Caste groups often use *Dalit* to refer to their political identity, which translates to 'broken people.' While the literature used in the thesis, along with some field conversations, uses *Dalit* in relation to theories and approaches,

the thesis does not use the term in relation to the study participants as they described themselves as ‘Scheduled Castes’ rather than *Dalit*. On the other hand, participants from Scheduled Tribe groups described themselves as *Adivasi*, as a colloquial term and a political identity.

The areas where the study was carried out were not far removed from the local urban hubs and had both geographical and social connectivity, owing to transport links and the proliferation of communication technologies and popular culture, and migration for education and work. While there was a sense of affiliation with the rural amongst study participants, there was also a challenge to its static image as a backward area, which was conveyed through changes in ideas about health and education between generations, or through access to information and facilities, and ownership of articles signifying modernity (flatscreen televisions, for example). Based on my conversations with women in the field, these material changes were also accompanied by social and cultural shifts, and there was an unmissable aspirational element in the kinds of lives women wanted to lead and the kinds of work they sought to do. This aspiration is perhaps reflected in documented figures like the higher education enrolment rate for women in Bihar, which has jumped from 570,000 to 10,41,000 between 2017-2018 and 2021-2022 (Ministry of Education, 2023). But it is also discernible in everyday social life, based on my field observations and long-term association and familiarity with the region. It is evident in women’s challenge to social norms by seeking material comfort or freedom and choice in marriage, reproduction, and education, even though such challenges may prompt greater regulation of their mobility and lives. Gendered relations and gender dynamics, therefore, come to be shaped and contested within these shifts. Qualitative studies on women’s health and health systems, such as those by Kielmann and Bentley (2003) in the state of Maharashtra and Gjøstein (2014) in the state of Rajasthan have noted similar social flux at different times in recent years, the former calling it a detraditionalised society (principally characterised by women challenging social norms) and the latter referring to their field site as a contemporary and dynamic rural village (principally characterised by an exchange of ideas and commodities between the rural and the urban).

1.3.2 Health indicators and infrastructure

While the cultural and social background of the study area are significant to the research, the health indicators and infrastructure of Bihar are also highly relevant in studying women’s

care. Bihar ranks low on most conventional health parameters for women, especially in aspects of reproductive health such as antenatal check-ups and institutional birth (Kumari and Verma, 2021). It also has a massive dearth of public health facilities, like many other parts of India. For example, Bihar requires 3,597 Primary Health Centres (calculated based on population) but has only 1,702, accounting for a shortfall of 52.68 percent (National Health Mission [NHM], 2021).

The public health system was the most commonly-accessed health system by my respondents in the study areas. It is a multi-tiered system, with sub-health centres (SHC) being the smallest, followed by primary health centres (PHC), which are then followed by community health centres (CHC), and finally sub-divisional hospitals and district hospitals. Apart from these centres, the *anganwadi* network*,* which acts as childcare centres for children aged 0-6 and nutrition hubs for pregnant and lactating women, was key to the rural health system.[2] Women in the study sites accessed *anganwadis* for vaccination, contraceptives and minor aches and fevers. PHCs were accessed for 'bigger' things like antenatal check-ups, childbirth, injuries and non-reproductive health issues. SHCs in the study areas were either dilapidated or not in use, and CHCs and sub-divisional and district hospitals were accessed only in the case of obstetric complications and caesarean sections, or accidents and severe ill-health. The bigger facilities were at least between one and two hours away from the study areas, and hence, not commonly accessed. The literature review (Chapter 2) provides a deeper grasp of the availability and accessibility of health facilities in the region.

Within the local public health system, Accredited Social Health Activists (ASHA or ASHA workers), were the first point of contact, especially for women's reproductive health. An ASHA worker is a frontline health worker in rural areas, appointed under the National Rural Health Mission of India, in 2009. They are recruited locally and are responsible for attending to primary healthcare needs at the village-level, with a special focus on pregnant women and lactating mothers. They are also tasked with providing health information and counselling to women and families (NHM, 2009). Their role in acting as a conduit for the state's health agenda has been widely studied, alongside their activism, labour and knowledge, and they have been found to be instrumental in implementing health programmes, while not being

[2] *Anganwadi* translates to 'courtyard shelter' and was introduced by the Integrated Child Development Services of the Ministry of Women and Child Development of the Government of India in 1975. These are village-level centres and are staffed by an *anganwadi* worker and an *anganwadi* helper.

legally recognised as workers (they are treated as volunteers and paid honorariums) and health providers with ‘scientific knowledge’ (Gjøstein, 2014; Scott and Shanker, 2010; Unnithan, 2022) The social affiliation of ASHAs with local communities is significant to the study as it influences their work, and they are sometimes known to preferentially attend to women from one social group over another (Gjøstein, 2014; Khan, Hazra and Bhatnagar, 2010; Verma and Acharya, 2018).

Private health facilities in the study areas were sparse and limited to dispensaries and small clinics, and the bigger facilities in nearby cities were infrequently accessed because of the distance and the expenses involved. The most common form of private facility at the village-level was what participants referred to as a ‘medical’ which was usually a pharmacy but with an allopathic, homoeopathic or ayurvedic doctor attached to it. This doctor would also be available for on-call for home visits. Women additionally sought care from faith healers and practitioners of indigenous medicine, usually for infertility, leukorrhea and non-reproductive health problems—typically issues that the grassroot public health system does not attend to, or issues that can become emotionally challenging and long-lasting.

Women’s experiences, expectations and ideas of health are forged in this backdrop of facilities and practices, along with the wider politics of women’s health, and the discursive contexts in which women’s reproductive health is produced. In the next section, I return to the debate on age at marriage, to explain its social relevance, not only in the context of women's health, which, ostensibly, is the state’s concern, but in the context of a changing society and its regulation of women’s mobility, sexuality and rights.

1.4 The salience of early marriage

In many ways, early marriage is synonymous with the wider understanding of marriage for this study, as the social norms which constitute early marriage are not different from the norms that constitute the institution of marriage (in the study context) itself; that is, heteronormativity, caste endogamy, and patrilocality. At the same time, early marriage captures attention as a distinct practice because of its associations with child marriage as a violative and unlawful practice. In the case of Bihar, early marriage assumes particular

significance because, as mentioned earlier, 40 percent of women aged 20–24 were married before age 18 in 2020-2021, which is among the highest rates of early marriage in the country (IIPS and ICF, 2021). However, it was not the prevalence of early marriage that was seen as a problem (or as violative and unlawful) in the study area, but the registers in which it happened; love and elopement, compulsion and poverty, honour and anxiety, and their consequences for the lives of women and girls. Such consequences involved the negative influences on their health, social networks, educational and occupational opportunities, while often affording them the positive protection of marriage and care. These registers and consequences, too, are related to marriage itself, and it is important to locate marriage itself as a dominant institution in the social context of the research. As John (2021) argues, child marriage is the form that compulsory marriage takes, as the image of the girl child, even when not married, is a cis-gendered person on the path of marriage and motherhood. Marriage, as discussed later, and in the analytical chapters, was universal in the study area and formed the key social relation for women.

‘Early marriage’, as a term, has gained currency only recently, in the past decade, with research and organisations in India, and in other non-Western contexts, adopting it to signal a shift from customary child marriage to marriage in late adolescence, out of choice, or out of compulsion, based on poverty and lack of educational and economic opportunities. It is also used to make a distinction from forced marriage which families use to police young women for transgressing the norms of expected social behaviour (Gopal et al., 2016; Mehra and Nandy, 2020; Nirantar, 2015). While child marriage, early marriage, and forced marriage apply to men and boys as well, the gendered nature of marriage in India means that it affects their status, honour and opportunity in less intense ways than women and girls (Mukherjee and Sekher, 2017).

As noted earlier, the minimum age of marriage in India is 18 years for women and 21 years for men, and a bill introduced by the government in 2021 has proposed increasing it to 21 years for women as well. The government holds the position that the move will promote equality in education (based on the assumption that postponing marriage enables women’s access to higher education), and improve maternal health outcomes as it is expected to delay childbearing and lower fertility rates (The Hindu Bureau, 2023). The proposal has been met with apprehension from families who cannot afford to provide for their daughters until they are 21 (which indicates both poverty and gender-based discrimination) and additionally fear

that it will increase the dowry expected for an older woman as they are less valued as brides than younger women (Kadam, 2022). Families also fear that it will increase the prospect of their daughters eloping as there would be a longer period where they cannot be lawfully married (and there are few avenues of exploring sexual and romantic relationships outside of marriage) (Mehra and Nandy, 2020). This, in turn, is likely to expose young women to tighter regulation for a longer period of time. Additionally, raising the age of marriage is considered unfeasible in a context where even the current 18-year mark is difficult to meet owing to material conditions and non-implementation of the existing law, in cases of forced child and/or early marriage (Jejeebhoy, 2020).

It is also difficult to read the state's aim to reduce early marriage as a progressive step because its other positions on marriage—such as rules that make interfaith marriage difficult, and the sheer reluctance to recognise non-heteronormative marriages and domestic partnerships as rightful relationships—expose the limitations of 'progress' in marriage to heteronormative and endogamous marriage (The Third Eye, 2021). Lastly, families in India often police early marriage only when it transgresses social norms. Otherwise, it is often arranged by them, and even forced. Mehra (2020) and Patkar (2020) suggest that most cases filed under the Prohibition of Child Marriage Act of 2005 are filed by families against consenting inter-caste and inter-faith couples, rather than forced marriages. It is also telling that the panacea to early marriage, from the perspective of states, development institutions and families, is limited to delaying marriage to the current minimum age of 18. As John (2021) argues, early marriage is easily 'corrected' by increasing the age while the other factors that exacerbate the vulnerability of women who marry young, such as poverty, social location and access to education, are not attended to (Gopal et al., 2016; John, 2021).

In the study area, young women and their families in my study actively contested the foundations and implications of early marriage. While some made no distinction between early and delayed marriage (as marriage was inevitable and, typically, happened in late adolescence; that is, 'early'), others, especially unmarried girls, held on to the minimum age of 18 years as a glimmer of hope to delay marriage until 18, even if they could not (and would not) take their families to court if they arranged their marriage before 18. The new proposal to increase the minimum age to 21 was, therefore, an exciting prospect for those who had finished school and aspired to go to university and work in jobs that they could then be eligible for. Women in the study area had different motivations to delay marriage—the

hope of continuing their education (it is crucial to remember that despite the poor availability and quality of public education, it enables some physical and social mobility, and delays marriage), wanting to stay unmarried for longer as it extends their stay in the birth home and delays the prospect of being married to someone they may not want to marry, and the aspiration to marry someone of their choice. The analysis makes it evident that marriage was not delayed (by women) only to delay childbearing and safeguard their health, and delaying marriage was not the only way to counter early marriage as choice in marriage and being able to 'do' something worthwhile was also important to them, which is further discussed in chapter 4, in participants' construction of a relationship between health and marriage (Section 4.3). The above insights are based not only on participants' accounts but also on field observation, informal conversations, and community engagement events, which are discussed in the methodology chapter (Chapter 3). The study's understanding of early marriage is, therefore, based on the multiplicity of meanings attached to it by different actors—young women, family and state, and the study seeks to be accountable to the local political realities of early marriage (John, 2021). Early marriage is in the background throughout the analysis, even if it may not be explicitly referred to, and the reason it is often not explicitly referred to is because it does not account for a practice distinct from marriage in general.

1.5 Outline of chapters

Drawing on the debates discussed in the present chapter, Chapter 2, the literature review, engages with empirical works alongside conceptual works that have a bearing on the study—paying attention to what is known about a theme and identifying gaps in such knowledge, while also reviewing scholarship that uses methods and has findings that are relevant to the study. The review expands the discussions on 'young women', 'household' and 'care' by examining literature in four key areas—adolescent women's reproductive health; measures and critiques of access; health experiences in relation to marriage and family; and feminist perspectives on women's decision-making. The review, therefore, develops the conceptual framework that guides the analysis that follows.

Chapter 3 discusses the study methodology, outlining the participatory and collaborative aspects of the research, and the community-based recruitment process and its bearings on the chosen tools of in-depth interviews and focus group discussions, while reflecting on the

methodology as a feminist approach. The chapter pays special attention to the interrelated practical and ethical considerations of the data collection, and the researchers' positionality, which complements the emphasis on the intersection of caste and gender introduced in the present chapter. The chapter also discusses the approach to the analysis of data, drawing on constructivist grounded theory (Charmaz, 2006).

Chapter 4 explores what the 'social' means in relation to health, drawing on women's conceptualisations of being healthy and/or ill, which they associate with the gendered relations and dynamics of the household. The chapter argues that health is embedded in the household, and demonstrates that it accounts for embodied sensations, availability and accessibility of resources, women's common gendered position as young daughters-in-law, and their individual household circumstances. The chapter also examines the relationship between early marriage and reproductive health, and finds that while women do indeed discuss their health as adversely impacted by early childbearing, it is equally impacted by the expectation of sexual activity in marriage (irrespective of childbearing), as well as the burden of household labour, highlighting the indivisible impacts on both physical and mental health.

Chapter 5 studies women's gendered position in the household, which remains impermanent in both the birth and the marital household, and asks how care is configured around this position and the social relation of marriage that creates it. The chapter finds that marriage is characterised by acts of 'bringing' and 'keeping' a woman in the household, which grants authority to the husband to care for the wife, while also holding him responsible to do so. The chapter, therefore, argues that it is the authority of husbands which shapes women's access to care, which can manifest in care and responsibility, but also neglect and harm. Women's response to authority, often not neatly categorised as acceptance or challenge, is also studied to illustrate the processes by which women negotiate authority.

Chapter 6 extends the discussion on access, care and gendered relations by looking at the place of decision-making in enabling access to care, which is a key framework used in the literature on access to healthcare. The chapter studies the values and meanings that women attribute to decision-making in the household, with respect to their health and finds that they portray their decision-making practices as processes undertaken by, or with, the husband, with his permission or knowledge, or by oneself, but under compulsion. Based on these explanations, the chapter argues for the decentering of decision-making (especially as

women's autonomy) and for the foregrounding, instead, of women's claims on care. Participants particularly articulated claims on care in three significant ways: value for their lives, the moral responsibility of husbands to care, and love towards them as wives and daughters-in-law.

The thesis conclusion, Chapter 7, revisits the research problem and the three interrelated research questions, and discusses the findings in relation to each. Additionally, it further engages with methodological and ethical questions, reflecting on the feminist ethos of the study. The chapter highlights the key contributions of the study: (i) complicating the relationship between early marriage and women's health, (ii) expanding the meaning of care by embedding it in the household, and accounting for women's sense of *feeling cared for*, and (iii) examining the processes and values of women's decision-making to argue for the centering of women's claims on care. The conclusion also explains the study's limitations, and further scope for feminist research on health and marriage in the study context and beyond, coming back to the central question of 'caring for women.'

Chapter 2

Literature review

2.1 Introduction

This review of literature spans the various themes that relate to the aim and questions of the study—adolescence, sexual and reproductive health, marriage and kinship, measures and critiques of access, conceptualisations of health and care in relation to marriage, kinship and household, as well as women's decision-making and agency. The literature is, therefore, drawn from different disciplines, including but not limited to sociology, women's studies, demography, public health, social anthropology, medical anthropology, and political sciences. Throughout these themes and disciplines, the review pays special attention to the analysis of gendered relations and dynamics in the existing literature, or the gaps in the literature which does not adequately attend to gender. The review builds on the introductory chapter and provides a background to the research problem, demarcating the themes and gaps that have a bearing on the three research questions:

1) How do young married women understand their reproductive health status and needs?
2) How do marriage and the gendered relations of the household shape access to care for young married women?
3) How do young married women perceive and assign meaning to their decision-making autonomy within the household, especially with respect to access to care?

I start by looking at research on adolescent sexual and reproductive health to outline the questions asked in relation to it, and to support my research objective of studying care and gendered relations and dynamics for young married women. In the subsequent section, I look at literature on the parameters of access and inequalities in access, reflecting on the two to bring out critical gaps in predominant, conventional conceptualisations of access. I then look at selected qualitative research that embeds health in marriage, social relations and kinship, offering a nuanced approach to women's conceptualisation of health and the determinants of their access to care. This body of work enables an understanding of the structures and

conditions which women navigate to make meaning about health and claim care, and is relevant to centering the household in my study. Finally, I review conceptual works on women's decision-making, especially in relation to access to care, alongside empirical studies to understand the processes of navigation of authority, and the place of autonomy and resistance in women's claims on care.

The literature is largely drawn from India and from similar socio-political contexts in other parts of South Asia, particularly Nepal and Bangladesh which share both borders and cultural connections with the study region. It also includes some conceptual and empirical works from other parts of the world, to draw attention to the manner in which a theme has been approached or a concept formulated, rather than to suggest similarity of context and findings.

2.2 Young married women in sexual and reproductive health research

The sexual and reproductive health of adolescent girls is a distinct area of study in demography and public health, and has also drawn feminist interest within these disciplines and beyond. It is often studied in the context of the global south, which has a significant proportion of the world's adolescent population and a relatively higher percentage of adolescent pregnancies compared to the global north, which is attributed to marriage, along with lack of resources and information (UN, 2019; United Nations Population Fund, 2023). About 50 percent of such pregnancies occurring within marriage are believed to be unwanted (World Health Organisation [WHO], 2023).[3] In India, research on the sexual and reproductive health of adolescent girls is focused on the question of poor reproductive health outcomes, which are attributed to a combination of age at pregnancy, age at marriage, exacerbating socio-economic circumstances and resource-poor health infrastructures. Some of the research from India, and other comparable contexts, studies adolescent girls as a singular group or adolescence as a period (typically 15–19 years, or 15–24 to include 'young people') while acknowledging married populations among them (Banerjee et al., 2015; Chandra-Mouli et al., 2014; Woog et al., 2015). Other research studies married adolescent girls exclusively or study

[3] The near-exclusive focus on the global south can be both problematic and misleading, as resources (such as those of UN agencies) often do not account for or problematise data from the global north, which may be comparable to the global south. For instance, between 2016-2022, the annual adolescent birth rate in India was 12 births per 1000 adolescents girls aged 15-19, and 11 births per 1000 adolescent girls in the United Kingdom (United Nations Children's Fund, 2022). While the conditions and consequences of adolescent pregnancies differ between and within contexts, the bias in focus portrays adolescent pregnancy as a problem unique to the global south.

adolescent pregnancy as a problem of marriage (Bruce, 2003; Santhya et al., 2010; Santhya and Jejeebhoy, 2007; Santhya and Jejeebhoy, 2003; Singh et al., 2012). Both bodies of research point towards the difference in the reproductive health concerns for married and unmarried adolescent girls, which is determined by the social norms and gendered relations and dynamics that shape sexuality, marriage and reproduction. For instance, unmarried adolescent girls face greater stigma in accessing abortion than their married counterparts—because the stigma is attached to premarital sexual activity rather than the act of abortion itself, making them additionally vulnerable to unsafe abortions (Chandra-Mouli et al., 2014; Woog et al., 2015). Married adolescent girls, on the other hand, face pressure to prove their fertility which means that they are more likely to bear children despite their wishes and have higher unmet contraceptive need as they negotiate contraceptive use within the heteronormative structure of the marital family that demands fertility (Bruce, 2003; Santhya et al., 2016; Woog et al., 2015). Researchers studying married adolescent girls—in their position as 'married' people—have argued that there is a dearth of qualitative research on their experiences, and that marriage remains a gap in studying adolescent reproductive health and outcomes, especially in terms of the specific conditions in which married adolescent girls experience reproductive health (Bruce, 2003; Jejeebhoy, 1998; Rani, Ghosh and Sharan, 2007). My study aims to fill this gap in some measure, and I particularly aim to study early marriage as a site within which the reproductive health of adolescent women is influenced in multiple ways, rather than marriage being a determinant of poor reproductive health alone.

Within the scholarship on adolescent sexual and reproductive health, there are three areas of study that inform my three research questions outlined above. The first is the body of literature that identifies adolescent pregnancy as a problem because of its widespread prevalence and its health consequences, sometimes problematising the widespread prevalence of adolescent pregnancy itself. Such literature widely acknowledges that adolescent girls, despite their marital status, have poorer health status. Some of the qualitative research on the subject, however, troubles the exclusive and linear connection between age and reproductive health outcomes, arguing that adolescent pregnancy receives the kind of attention that it does because it is seen as a moral problem rather than a problem with adverse physical and social consequences for women. While this body of research recognises that age is (one of the factors) consequential for reproductive health outcomes, it asks to account for other factors or areas of vulnerability such as gender discrimination and lack of resources (Cherry, 2014;

Haberland, Chong and Bracken, 2003; Hasnat et al., 2020). Given these intersecting influences, critical feminist perspectives have argued for interventions that address gender dynamics that are oppressive to young people, through processes such as collectivisation of women and girls around core issues of violence, gender, sexuality, and education, rather than measures to reduce age at marriage and pregnancy alone (Fattah and Camellia, 2020; John, 2021, Gopal et al., 2016; MacLeod, 2014; Pillai and Gupta, 2014). When read in the background of larger research on women's health and adolescent health, the focus on age and adolescence, devoid of a focus on gender dynamics is resonant with literature on adolescent girls more widely, especially quantitative research in demography and public health. While women's health is a political issue, at least within feminist frameworks where it is related to bodily integrity and rights in the context of multi-sited patriarchal violation, adolescent girls are a largely depoliticised group whose health is a question of social and national development, especially in the discourse on early marriage, adolescence and reproduction (Bessa, 2019; Bhog and Mullick, 2015; John, 2021).

The second body of research that informs my study examines what about early marriage puts adolescent girls at risk of greater vulnerability than women who marry in adulthood, and impacts their physical and mental well-being. Khanna et al. (2020), for instance, found that difference in age with male partners and gender differentials and discrimination negatively impact the mental health of married adolescents (15–19) whom they found to be at significantly greater risk of depression than unmarried adolescents in their study from rural Maharashtra. Violence, especially sexual violence, is a related area of research on adolescent girls, early marriage, and health. Reports and studies argue that sexual violence within marriage is found to be higher among married adolescents than older married women or women who marry at an older age as adolescents and younger women have lesser agency compared to older women owing to their age and position in the marital household (George and Jaswal, 1995; Jejeebhoy, Shah and Thapa, 2006; Raj et al., 2010; Santhya et al., 2007).

A third body of research on the sexual and reproductive health of adolescent girls in India—married and unmarried—focuses on access to institutional care, and more specifically on utilisation (this body of research uses the terms adolescent girls and women interchangeably). Such literature has found that healthcare utilisation among adolescent girls is low because of the intersecting influences of their age and gender (and marital status when married) which exposes them to greater regulation by family, society and state (Barua and

Kurz, 2001; International Centre for Research on Women [ICRW], 2016; Santhya et al., 2016; Singh, Rai and Singh; 2012). This body of literature often studies utilisation through a social determinants of health framework—which centres the causes behind the causes of health and illness such as socio-economic status, rural–urban residence, level of education and environmental factors (Wilkinson and Marmot, 2003), especially studying the influence of factors such as social identity (caste and religion), education and rural-urban residence, on access to care. For example, Singh, Rai and Singh (2012) find that for rural married adolescent women in India, the net effect of education on utilisation (higher education leading to higher utilisation) is overtly linked with low age at marriage and early childbearing, making the connection between maternal (higher) education and utilisation of care punctuated by social norms and gendered relations. Research that asks such questions of access is important for my study as it demonstrates the scale of inequality in access, but the gap here is that the social dynamics—indicated by conundrums such as utilisation being low despite education being high—needs further study, especially through qualitative methods. A similar example is the research on women's decision-making in matters of health, which does not account for the dynamics and negotiations which influence decision-making, instead focusing on demographic factors and autonomous actions alone (subsequently discussed in the review in Section 2.5).

The recognition of gender dynamics on healthcare utilisation is evident in some of the qualitative research and intervention-based reports by development agencies, which recommend a collective approach to improving utilisation which involves families and communities, rather than seeking to build individual autonomy (Banerjee et al., 2015; Barua and Kurz, 2001; ICRW, 2016; Mumtaz and Salway, 2009; Rani, Ghosh and Sharan, 2007). Barua and Kurz (2001), for example, find that families enable access to care for married adolescent women not out of concern for their health but out of the worry that ill-health keeps them away from household labour which is the daughter-in-law's gendered responsibility in marriage. My study further examines such situations, where the health and care of young married women may not be only related to age at marriage but equally to household dynamics and their gendered position within it, and yet asks what early marriage and its consequences mean to women. The literature on adolescent sexual and reproductive health largely identifies early marriage as a problem, and specifically a determinant of poor health, which is both resounded and challenged in the context of my study, but crucially, I use the above literature to ask similar questions of marriage itself. As argued in Chapter 1, my study

does not identify child (early) marriage as a distinct cultural practice but as the form that compulsory marriage takes (John, 2021).

Having drawn out some of the debates around adolescent sexual and reproductive health, and discussed its relevance and adaptation to my study, I now turn the focus to access, which is frequently studied in relation to adolescents (as discussed above). The question of access was key to the conceptualisation of my research problem, and was complicated by literature that asks critical questions of the determinants and outcomes of institutional access. The following section, therefore, looks at debates around the significance of access, noting how household dynamics and social circumstances create demand for access.

2.3 Access to care: Definitions and debates

Access is understood as the possibility of physically and financially accessing health services whereas utilisation refers to the actual uptake of the services, the former often being a determinant of the latter. Access is defined and measured through various parameters such as availability of services (round-the-clock Primary Health Centres, basic infrastructure such as toilets and electricity, ambulances, human resources), information about health services and the accessibility of such information (Arokiasamy and Pradhan, 2013; Debnath et al., 2023; Hazra, Khan and Varma, 2013; Khan, Banerjee and Nandi, 2019; Ravichandran, 2014).

Studies have frequently found a severe lack of availability and accessibility of health facilities in rural India, particularly in the study region. For instance, Debnath et al. (2023) found that only 54.46% of Primary Health Centres (PHC) in the least developed districts across the country, which includes Purnia,[4] were functional round-the-clock and only 45.6% had regular power supply in 2012–2013, based on the most recent periodic District Level Household and Facility Survey, published in 2014. 76% of the PHCs were within 5kms of the places they were meant to serve and 87% were connected by a metalled road, but only 25% had at least one functional ambulance. Hazra, Khan and Varma (2013) had previously found, in 2010–2011, that the average time taken to reach a public or private health facility in Bihar was three hours. Kishanganj also has poor availability of health services, and was found to be

[4] Least developed districts, assessed on various socio-economic parameters, are part of the Indian government's Aspirational Districts Programme (2018), which is funded by the World Bank.

among the bottom five districts (out of 640 districts) in terms of PHCs conforming to the Indian Public Health Standards (Khan, Banerjee and Nandi, 2019). Health facilities, both public and private, are also rendered inaccessible because of the high out-of-pocket expenditure involved. India has among the highest out-of-pocket health expenditure rates in the world which are known to plunge families into debt and poverty, compounded by the lack of facilities and malpractice at health institutions such as negligence and cheating (Drèze, Khera and Somanchi, 2021). Recent statistics show that out-of-pocket expenditure has pushed 8 percent of the population below the poverty line[5], largely owing to outpatient care, and that Muslims and deprived castes have been most affected (Sangar, Dutt and Thakur, 2019). In Bihar, The average out-of-pocket expenditure for birth in a public health facility was 1,784 INR (approximately 17.20 GBP) in 2015–16, and increased to 2,848 INR (approximately 27.30 GBP) in 2019–20 (Kumari and Verma, 2021).

The above studies study the availability and accessibility of general facilities, but those that specifically study reproductive health facilities find a similar dearth, although they usually emphasise access to institutional births, and sometimes antenatal care, while excluding other types of care such as sexual health, abortion and contraception. Interventions, likewise, are aimed at improving institutional birth rates, even though they may result in a simultaneous improvement in allied services such as antenatal care (Creanga et al., 2020). Debnath et al. (2023), above, noted a severe dearth of facilities in PHCs in least developed districts, but found that 90.79% of the PHCs in these districts provided antenatal care and 97.82% of them provided labour care (the institutional birth facility that PHCs are supposed to provide). The disproportionate emphasis on institutional birth as the central marker of access and of reproductive health helps understand the limitations of access, as it points to the unaddressed question of quality of care in access and utilisation. This gap is also highlighted in research on the Janani Suraksha Yojana (Safe Motherhood Scheme)[6] which has frequently found that despite a significant jump in institutional access for birth (for instance, Gupta et al., 2012, found that institutional birth increased by 42.6% within two years of JSY implementation), there has been no proportionate decline in maternal mortality. Studies have attributed this gap

[5] The poverty line for India has been most recently estimated to be 1,622 INR (15.57 GBP) per month for rural areas and 1,929 INR (18.52 GBP) per month for urban areas, although these figures are considered arbitrary by many (State Bank of India, 2024; Rajora, 2024).

[6] The Janani Suraksha Yojana (JSY) is a conditional cash transfer scheme launched in 2005 to incentivise institutional birth. The scheme entitles women who give birth at public health facilities to 1,000-1,400 INR (9.60-13.44 GBP), depending on whether they live in urban or rural areas and high performing or low performing states. Bihar is classified as a low performing state.

to the poor quality of care at most institutions such as the lack of trained healthcare providers, disrespectful care, scarcity of essential drugs, irregular electricity and running water supply, as well as the lack (or lack of incentivisation) for antenatal and postpartum care (Chaturvedi, D'Costa and Raven, 2015; Gupta et al., 2012; Jehan et al., 2012; Powell-Jackson, Mazumdar and Mills, 2015).

This body of literature, while using the conventional understanding of access as utilisation, highlights the nature and extent of inequality in access, especially on the basis of caste and economic status, and in doing so, sometimes brings forth the complexity and limitations of associating greater access with better health outcomes (Dommaraju, Agadjanian and Yobiku, 2008; Patel, Das and Das, 2018; Saroha, Altarac and Sibley, 2008; Verma and Acharya, 2017; Yadav, 2014). The inequality in access is reflected in poor health indicators and status among marginalised groups such as the prevalence of anaemia, infant mortality and maternal mortality (Bhanderi and Kannan, 2010; Chandra, 2021; Horwood et al., 2020; Mahapatro, James and Mishra, 2021; Sanneving et al., 2013; Sharif, Das and Alam, 2023).

Quantitative research on access is important in addressing my research aims as it helps establish the scale of problems in the health system, the dearth of facilities and the inequalities in access, which in turn influence women's navigation of access and care in and though the household. Qualitative research, on the other hand, helps contextualise the figures of institutional access by highlighting the social interactions and dynamics that shape their availability and quality. For instance, Karvande et al. (2016), in their study of public facilities in Bihar and Jharkhand (formerly part of Bihar), found that health providers, both frontline health workers and quacks, used non-recommended labour-inducing drugs such as oxytocin because women and their attendants pressured them to administer such drugs. Another example quoted in the study is that of a government ambulance service in Bihar becoming defunct because of a vehicle breakdown, which led to attacks on health providers by the local community, and subsequently, a reduction in services as providers feared that there would be backlash if a new or upgraded service became inaccessible in the future.

Qualitative studies have also found that access to reproductive healthcare is sometimes undesirable or laden with apprehension because of poor quality of care, negligence, and discrimination. For example, Koritsanzky's (2011) ethnography from a resource-poor village in Uttar Pradesh shows how the nature of institutional access—characterised by distance and

poor quality of care—only worsened women's condition when they were in labour or in pain. The institutions that women in Koritzansky's (2011) study accessed further discounted their social processes of care which see birth as an event where women assist each other, additionally making the experience of access isolating. The study found that women who lost fellow women to childbirth because of poor institutional care wished that they had facilitated home births for them so that they could have been there when their loved ones were in pain, even if they would have lost them. Other qualitative studies, from Bihar, similarly, note the rupture of social support in institutional access in their study from Bihar, noting that it is particularly marked for women from 'lower' castes who are discriminated against by health providers and health institutions (Khan, Harza and Bhatnagar, 2010; Patel, Das and Das, 2018).

Research has also found more active rejection of institutional care by women. For example, Basnyat (2011), writing about Nepal, argues that women perceive the home as a space where they can regain control of their bodies as opposed to hospitals where they feel neglected, apart from understanding the home as a caring space and birth as a cultural event shared with women, like the women in the study contexts discussed above. Thus, she writes:

> "Nepalese women's decisions to create biomedical interventions as the alternative do not stem from ignorance but rather from the understanding of meanings within the women's own contexts. The women also discussed maintaining health in their villages without access to medical facilities, through available resources of family and community" (Basnyat, 2011, p.131).

Basnyat (2011) makes note of the cure-oriented culture in Nepal (you go to the doctor only when something is wrong), but also speculates that one of the reasons behind low institutional access may be the reluctance to give up a day's paid work and the difficulty of putting aside a day's household work. Decisions around access are, therefore, still shaped by physical, economic, cultural and bureaucratic inaccessibility, despite constituting an active rejection of institutions.

Chandra (2021), in her study from Uttar Pradesh in India, also challenges the linear understanding of access which attributes low access among Dalit women to their 'ignorance', arguing that health workers discriminate against them and also create an unequal dual system

of care, recommending policy-identified harmful practices like quack practitioners and labour-inducing drugs for Dalit women while recommending standardised care at public health facilities for other women. As Chandra explains:

> "Hence, the question of why Dalit women do not go for institutionalised forms of delivery has nothing to do with their behaviour or conservative attitude; rather, it is linked with the institutionalised form of inequality and the existential compulsion…" (Chandra, 2021, p. 196).

Other qualitative and quantitative research on caste and access has also found institutionalised forms of discrimination, including untouchability, delayed and substandard care, and withholding of information, making women resort to home births and other home-based forms of care, restricting access (Dommaraju, Agadjanian and Yobiku, 2008; Khan, Hazra and Bhatnagar, 2010; Kumar, 2002; Patel, Das and Das, 2018; Saroha, Altarac and Sibley, 2008; Yadav, 2014). Access, in terms of utilisation, has also been found to be low for minority communities in several Indian contexts, especially among Muslim women (Kumar, 2002; Sanneving et al., 2013). Some literature on access and utilisation has also been critical of the emphasis on institutional access in studying women's health, arguing that it is designed to make women buy into a logic of modernity and individualism, and perform good citizenship, thereby disciplining and regulating their needs and choices (Basnyat, 2011; Mishra and Roalkvam, 2014; Van Hollen, 2003). For instance, in Van Hollen's (2003) study on modernity and birth in Tamil Nadu, women wanted to access new technologies of maternity care (countering the notion that 'lower' class and caste women are averse to modern technologies), but it was health institutions, and the people in power who constituted it, that they perceived as discriminatory and bureaucratically inaccessible, influencing their understanding of access.

The above bodies of literature provide significant critiques of access, but it is important to note that the overarching reason for not wanting to access institutions has been found to be rooted in discrimination and fear, and in the poor quality of services. The above studies, therefore, look into reasons for avoiding or resisting institutional care that arise from social position and material conditions. My study recognises the influence of these factors and dynamics (as they may shift) on women's access to care, but crucially, puts the everyday gender dynamics of marriage and the household in conversation with them. Sahu and Hutter's (2012) comparative study of contraceptive use among Muslim women in Bangladesh and

India, exemplifies the intersections between identity, accessibility, utilisation, social norms and family and gender dynamics. The study found that Muslim women in India (a minority religious group) had lower access to contraception than Muslim women in Bangladesh (where they form the religious majority) because the Indian state promotes female sterilisation as the key method of contraception, which is proscribed in Islam, causing women to get caught between a state approach which is incongruous with their religion-based contraceptive needs, and their personal reproductive aspirations to limit their number of children. In contrast, the authors argue that the Bangladeshi state promotes temporary contraceptive methods, such as the daily contraceptive pill, which are conducive to the needs of its Muslim women. The research found that women in both countries transgressed religious and social norms, often at high risks, and accessed sterilisation and abortion without the knowledge of their partners and families to realise their reproductive aspirations, thereby negotiating the multiple but intersecting social structures of state, religion and family. Simultaneously, women also interpreted religion in a flexible manner and defended practices like abortion as a necessity in dire conditions even if it went against their religious beliefs. Women's access to care, in the form of utilisation, is therefore, made meaning about within the local conditions of availability and accessibility, and the everyday household dynamics which includes wider norms of gender and caste, discussed in the subsequent section and in Chapter 4.

Qualitative literature on access, within the framework of utilisation, demonstrates that access is a process that encompasses multiple actors, resources and norms beyond those of healthcare facilities and providers within them (Basnyat, 2011; Koritzansky, 2012; Patel, Das and Das, 2018; Sahu and Hutter, 2012). My study expands access to reproductive healthcare beyond utilisation, by foregrounding the household and its gendered relations, sites and processes of care, to encompass the influence of *feeling cared for* (discussed in Chapter 1). The following section, therefore, brings attention to my second research question—How do marriage and the gendered relations of the household shape access to care for young married women? I draw on further literature on women's meaning-making about their health, to shift the attention from access as the focal point around which health is shaped and studied, to women's gendered position within the household, particularly in relation to the gendered relations of marriage and kinship.

2.4 Embedding health in the household, marriage, and kinship

The household, as the introduction to the study (Chapter 1) discusses, is not a singular unit but defined by its dynamics and interactions with external factors like caste and the labour market (Agarwal, 1997). Qualitative research from South Asia, and other parts of the world, has highlighted that women's health is connected to the household—it is influenced by the physical environment of the household, its caste and income status, and the relations and norms that constitute it (such as marriage and gendered labour). For instance, Yang, Bekemeier and Choi (2016), in their study from an impoverished region in Nepal, found that women's health was principally influenced by the resources of the household, typically the lack of money which prevented them from seeking institutional care. But the lack of money did not only influence women's health directly (by limiting their access to care) but also indirectly as it meant not being able to afford care for other family members which in turn caused tension to them (manifesting as women's ill health). A woman, therefore, can be healthy only when there is peace—when husbands and sons do not have addictions which in turn lead to quarrels; when family members are healthy and the household not troubled by frequent illness; when children have stable education and employment; and when wider issues like drug addiction in the community are addressed. These conditions are deeply gendered and the authors attribute them to social norms and gender roles which burden women with the responsibility of care for others (Yang, Bekemeier and Choi, 2016).

A harmonious home environment has been found to be significant to women's health, both in terms of the everyday environment (such as the absence of domestic violence) as well as the background of the marriage (love, caste, dowry, migration) which informs the dynamics of the household (Allendorf, 2012a; Allendorf, 2015; Jafree, 2020; McCauley et al., 2020; Yang, Bekemeier and Choi, 2016). Tension in the household—brought upon by disputes with the husband and in-laws, alcoholism among husbands, distress about finances, burden of household labour—is found to lead to tension in the body, experienced through headache, insomnia, dizziness, and specific conditions like leukorrhea, sometimes overlapping with mental disorders (discussed in Chapter 4) (Krishnakumari et al., 2014; Rashid, 2008; Trollope-Kumar, 2001; Weaver, 2014). Jafree (2020) particularly highlights the wider significance of kinship and family (within which the household is located, especially as conceptualised in my study) for South Asian women, noting that filial piety, operating within

patriarchal and feudal structures—is highly relevant to South Asian women, and must not be abandoned in the study of women's health.

The above body of literature recognises that the relations that constitute the household and lead to good or poor health, operate as dynamics, and hence, are subject to challenge by women. For instance, Kielmann (2002) found that younger married women in rural/peri-urban Maharashtra problematised their gendered household labour and the conflictual household relations they were expected to deal with, drawing linkages between their labour and their health, and thereby recognising certain issues as health issues, unlike the older generation for whom work and its adverse health outcomes had been normalised. The women in Kielmann's (2002) study made sense of symptoms like vaginal discharge in the context of their physically strenuous household work while private practitioners interviewed in the study attributed these symptoms to calcium deficiency. Such difference between women's meaning-making of their body and health, and health establishments' explanations of their health solely in medical terms, has been noted in several studies on women's health that account for gendered social contexts including labour, marriage, norms, and hierarchies (Krishnakumari et al., 2014; Iyengar, Pelto and Iyengar, 2014; Rashid, 2008).

Establishing that health needs to be understood in relation to the gendered relations of the household, I now review three studies from among a selected body of social anthropological literature that places women's meaning-making of their reproductive health in marriage, kinship and society. The selected studies frame reproductive health as a question of gendered relations, which is close to the objectives of my study which seeks to examine these connections in the context of early marriage and the marital household, in wider reproductive health (rather than specific issues), and in the empirical context of Bihar. The three studies concern pregnancy loss and/or miscarriage (Qureshi, 2020; van der Sijpt, 2014; van der Sijpt and Notermans, 2010) and female-selective abortion (Unnithan-Kumar, 2010), and I particularly draw attention to the nature of their qualitative inquiry and analytical approach which frame women's reproductive health as social issues rather than health issues, while bearing the intersection between them in mind.

van der Sijpt and Notermans (2010) and van der Sijpt (2014), study pregnancy loss in rural Cameroon, where kinship structures are vastly different from South Asia (albeit still patrilineal), but the ways in which women are positioned in these structures, and act and

make sense of their health within them, is relevant to my study. The papers notably discuss 'pregnancy loss' rather than miscarriage, in recognition of the social meanings that miscarriage conveys and the arbitrary distinction between induced and non-induced pregnancy loss, an arbitrariness also noted in Qureshi (2020). At the outset, van der Sijpt and Notermans (2010), position pregnant bodies as social bodies, and fertility as an issue situated squarely within social relations and dynamics, especially those of marriage and kinship. This positioning enables the authors to show "what is socially at stake for pregnant women" (p. 384). This question is crucial to pregnancy, among other reproductive and non-reproductive health issues in my study as the timing, order, number, termination and progression of pregnancy all have social implications for women in my study population. The meanings of pregnancy loss, in van der Sijpt and Notermans (2010), in terms of both experience and reason, correspond to the circumstances and changes in women's lives, sometimes strategically so. They are influenced by their relationship with their husbands, the very circumstances of their marriage, the desire to have children, and by inescapable physical labour owing to poverty. The meaning of pregnancy loss was often "an idiom to express complaints and social commentaries" (van der Sijpt and Notermans, 2010, p. 388). At the same time, the 'need' to assign meanings to pregnancy loss arose from the need to position oneself as a 'good wife' in the marriage and the household, by having a legitimate reason for pregnancy loss, and a reason where one is positioned as a sufferer. The larger background in which this need arises is the social significance of fertility rather than fertility and miscarriage as individual and private events (van der Sijpt, 2014).

The other significant aspects of women's meaning-making in van der Sijpt and Notermans' (2010) study are the shifts and variations in the meanings assigned to loss, which, according to the authors, range from something common like work or the women's worm (a disease believed to affect women), to something abstract like god, or to a specific person, such as a relative, who was perceived to have cursed the woman. These variations were also visible in Qureshi's (2020) study and not only in the context of miscarriages (which were usually attributed to curses when it involved others, but frequent pregnancies and young age when it was one's own), but also in the wider context of feeling unwell, as they usually corresponded to the status of the relationship with one's husband or mother-in-law.

Qureshi's (2020) study on the experience of miscarriage in Pakistan, therefore, similarly locates its meanings for women in their social context. Miscarriages were expressed as *bacha*

girna (falling of the child) and *bacha zaiya hona* (wasting of the child). 'Falling' was attributed to women's poor health such as a weak womb and body, excessive physical labour, carelessness about diet, and evil spirits. A key socio-cultural practice that informs the study background is that an early pregnancy must not be immediately shared with everyone around, even when it has been confirmed through a test and not merely speculated on by the delay of a menstrual period. This practice is attributed to the potential ephemerality of early pregnancies, captured in the chapter title *Some babies cannot be stopped from falling*. The study also notes that the use of the term baby (*bacha*) for an early pregnancy marks a departure from the earlier distinction between a blob of flesh for the earlier part of the pregnancy and baby for the later part when life was believed to have entered the foetus, noted by similar studies in northern India by Jeffery and Jeffery (1996) and Pinto (2008), which are contiguous with the regional context of Qureshi's field. This change is attributed to the absorption of the language of new medical technologies of pregnancy testing which add value to an early pregnancy and provide provisional personhood to the foetus. Nevertheless, an early pregnancy is expected to remain concealed as it remains precarious. These shifts, drawing on interactions between biomedicine and culture, are similar to shifting understandings of access (Basnyat, 2011; Kielmann, 2002), but are additionally valuable in understanding how such interactions may be influenced by gendered relations—such as the need to be 'careful' during pregnancy to position oneself as a good wife.

Qureshi's (2020) study also draws attention to the meanings of miscarriage in the context of the gendered dynamics in which pregnancy may happen. For instance, two of the study participants, who were troubled by repeated undesired pregnancies because their husbands rejected contraception, used offhand language and laughter to talk about their miscarriages as they were not imbued with a sense of loss, but instead, perhaps, relief. This example is also used to highlight the continuity between induced and non-induced miscarriage as the participants used the English word 'fuse' to describe what happened to the foetuses, which, in the regional vocabulary, means to kill. The example does not necessarily indicate that the miscarriages were induced, but describes the value and meanings assigned to pregnancy (and the subsequent miscarriage) depending upon the context of the pregnancy and the relationship with the husband.

Another significant observation that the study makes is that the success of a pregnancy is not only associated with the pregnant woman's caution or carelessness but also her marital

family's treatment of her. The pregnancy, therefore, becomes a space to negotiate and pass the buck between the birth family and the marital family. A woman in the study, for instance, complains about her daughter's in-laws for not taking care of her by fulfilling her needs and comforts during pregnancy. The mother-in-law, in turn, asks the mother to take her back to the birth home where she can get better. The mother-in-law is also occupied with the future health of the foetus rather than the present health of the daughter-in-law:

> "I had to have a word with Kiran's *saas* (mother-in-law) on the weekend. Kiran has been suffering from low 'bp' and she fainted. Her *saas* told me to come and collect her because the room is too hot, she didn't want the baby to get affected... // ...There is some problem with the pedestal fan in Kiran's room. The capacitor is broken and needs to be fixed by a *mistri* (workman)... // ...[So] I had to speak to her *saas* about getting the fan fixed. 'Do we have to pay the *mistri* for you?'" (Mother-in-law, quoted in Qureshi, 2020, p.124).

The study uses this example to illustrate the tensions in passing the buck between families, but it also opens up several other questions about women's position in marriage and the marital household and the ways in which it affects young married women's health, such as questions about who has the authority to care, which my study addresses. Qureshi's (2020) study, therefore, is not only an analysis of the meanings of miscarriage, but also a larger commentary on gendered relations, interactions with biomedicine, and changing concepts of health and gender roles.

Unnithan-Kumar's (2010) study on female-selective abortion in Rajasthan, India, examines how women's attitudes towards female children and female-selective abortion, and reproductive technologies broadly, are influenced by the dynamics that characterise marriage—family and gender hierarchies, and gendered marital obligations. The study also includes interviews with health practitioners to understand their position on female-selective abortion, which is found to straddle morality (helping the woman seeking female-selective abortion) and illegality (performing a criminalised activity).

Female-selective abortion, more commonly known as sex-selective abortion is known to be practised by pregnant women (upon knowing or speculating the sex of the foetus), to protect themselves from violence and deprivation, and to protect their status, should they be blamed for successively bearing girls (Kaur and Kapoor, 2021). In a highly contradictory perspective,

a participant in Unnithan-Kumar's study (2010) says that women practise female-selective abortion out of anxiety for the future of the girl child, which will be characterised by dowry and misery if they have bad marriages, much like the lives of the mothers and other older women. The study argues that this anxiety also points to the centrality of marriage in determining women's quality of life, and that of their born and unborn children, which merits attending to the ideological, social and economic significance of marriage in creating a gender divide.

The study also comments on abortion in general, noting that it has been documented to be preferred to contraception in many parts of the world as it allows women to display wifely compliance and availability for sex without having to negotiate and challenge power to use contraception. At the same time, it provides relief from repeated childbearing. Abortions become a way to space births, and in the regional context of the study, are considered a way to strengthen childbearing because they are understood to 'clean' the womb (the colloquial word for abortion being *safai* meaning 'to clean'). Abortion, and especially female-selective abortion, therefore, does not carry a moral message or burden, and is accessed by women in their own interest and in the collective interest of the family. Unnithan-Kumar (2010) argues that prenatal testing becomes a technology to alleviate the moral dilemma involved in abortion, rather than a cause of it. This is so because testing detects the 'abnormal' (female) status of the foetus and enables making a decision that will prevent the trauma of giving birth to female children. In this context, health practitioners who illegally provide prenatal testing facilities see their role as helpers to women who are oppressed by their circumstances, and also do it with the understanding that a girl child in this context will be highly neglected if she is born. Unnithan-Kumar (2010), therefore, helps trouble and add to the conceptual perspectives (moral, legal, operational) on female-selective abortions by studying how it is made sense of and used by women, and is relevant to my study, especially in studying contradictory and shifting perspectives on local interpretations of issues like abortion which dominate popular discourse.

This body of literature, based on the selected studies, is relevant to the aims of my study because it allows for new questions that dislodge predominant understandings of health that revolve around medical conditions or access as the focal point, and probes how women conceptualise them. For instance, I ask what is significant in the question of access—what is accessed or who enables it? Or, how do women make sense of their ill-health and recovery,

and how does this process correspond to their position in the household and the nature of their gendered relationships? As mentioned above, I ask these questions in the context of early marriage (being compulsory marriage) and in Bihar, an understudied regional context.

Having considered literature on how women conceptualise their body and health in relation to their gendered position in the household, the following section reviews literature on women's decision-making in matters of health, to understand its associations with care (what I refer to as *feeling cared for*), as well as its wider meanings for women's agency and social position.

2.5 Women's decision-making: accounting for gendered relations

In this section, I engage with conceptual and empirical works on women's decision-making and women's agency, opening up questions around autonomy, action, bargain and resistance, which speak to my third research question of how young married women perceive and assign meaning to their decision-making within the household, which is taken forward in Chapter 6. Women's decision-making is studied in demography (including the National Family Health Survey of India), public health, and feminist studies, and has also been a subject of critique, especially when studied in the form of decision-making autonomy or making decisions independently rather than participating in decision-making or navigating household dynamics to make decisions. I review these studies to identify why decision-making may be considered a suitable measure of women's agency and position in the household, what areas of decision-making are valuable in studying women's access to care, and what are the ways in which decision-making can be studied beyond autonomy.

Decision-making autonomy is widely studied as a predominant indicator of women's access to healthcare and the understanding of autonomy deployed in most studies is to have control over one's life, which is different from determinants of access like age and education. For instance, Bloom, Wypij and Das Gupta (2001, p. 68), in their widely cited study on maternal care utilisation in Uttar Pradesh, define such autonomy as interpersonal control which involves "the capacity to manipulate one's personal environment through control over resources and information in order to make decisions," in turn drawing on Basu (1992), Dyson and Moore (1983) and Miles-Doan and Bisharat (1990), frequently cited in literature on autonomy. Jejeebhoy and Sathar (2001), reflecting on women's autonomy in India and

Pakistan, similarly define autonomy as the control women have over their lives, which includes control over resources and access to information, authority to make decisions and freedom from constraints such as those on physical mobility. But their definition significantly includes equality in the marital relationship and the ability to forge equitable power relationships within families. Researchers in other regional and cultural contexts have operationalised a similar understanding of autonomy, which accounts for family relationships, and have studied women's health outcomes with reference both to mutuality and hierarchy, intimacy and compromise (Agarwala and Lynch, 2006; Arteaga, et al., 2020; Dharmalingam and Morgan, 1996; Mason and Smith, 2000; Muhanguzi, 2015; Mullany, Hindin and Becker, 2005).

Several studies from South Asia have found a positive relationship between women's autonomy (using control over life choices as the definition) and uptake of reproductive healthcare, particularly antenatal care and care during birth, as well as contraceptive use (Mistry, Galal and Lu, 2009; Rahman, Mostafa and Haque; 2014; Nigatu et al., 2014), but some have also found that women with greater autonomy—who made decisions about their own care—were from wealthier households, in paid employment, and often older in age as compared to women who had lesser autonomy, raising questions about the determinants of autonomy (Batura et al., 2022; Haque et al., 2012; Nigatu et al., 2014). This body of research is largely quantitative and studies autonomy as an outcome of factors (such as age and education) or a determinant of actions (such as utilisation of services), leaving less room for the study of negotiations and for unconventional paths and consequences of autonomy. Other research, reviewed below, takes more critical approaches to women's autonomy, studying how it is forged in the context of gendered relations.

For instance, while the role of male children is commonly understood to be a determinant of women's increased autonomy in the household (as it is supposed to consolidate their position by being the mother of a male heir), Heath and Tan (2018) propose that it is having daughters that increases women's autonomy, in the context of Asia. The authors argue that women who have daughters need to negotiate more with their husbands for their children's care and education than women who have sons, as daughters are likely to receive less attention from the husband, making them worth 'fighting for' and in the process, increasing their own autonomy. Women with daughters also tend to seek paid work outside of the home, which, according to the authors, increases their mobility, once again increasing their autonomy. An

example like this destabilises ideas of what women's autonomy is conventionally associated with and also, in my reading, the very meaning of autonomy. Is autonomy a product of dire circumstances (where it must be exercised to fulfil a basic need), and does such autonomy then align with the definition of being able to control one's choices? Within feminism, there is considerable debate over what autonomy constitutes as well as what its implications may be. For instance, Mishra and Tripathi (2011), recognising that autonomy is often interchangeably used with empowerment and agency, argue that autonomy implies independence while empowerment can be achieved through interdependence as well, but women themselves must be significant actors in the process of empowerment, which, in turn, alludes to agency (Govindasamy and Malhotra, 1996; Kabeer, 1999; Kabeer, 1998; Malhotra and Mather, 1997). What is of greater interest to my study is the meaning and value assigned to concepts such as autonomy and empowerment. For example, Mishra and Tripathi (2011) find that women in northeastern India have a high level of autonomy, especially when measured through freedom of movement, but such freedom of movement (and hence, autonomy) is an outcome of the compulsion to go out to earn a livelihood in difficult circumstances, rather than an outcome of access to education and employment, and hence not associated with empowerment. On the other hand, women in southern Indian states have high access to education, employment but less say in controlling their lives, and hence, less autonomy. The authors, therefore, recommend studying the cultural and social influences that shape women's autonomy, agency and empowerment (or autonomy and agency even if there is no empowerment) as the determinants and implications of these concepts are contextual.

It is questions of the kind discussed above (Heath and Tan, 2018; Mishra and Tripathi, 2011)—what constitutes autonomy, what gives rise to autonomy, and how it is consequential to women—that I seek to ask of women's decision-making processes and motivations in my research, using qualitative inquiry, which researchers studying decision-making autonomy have recommended (for example, Mishra and Tripathi, 2011; Osamor and Grady, 2016; Senarath and Gunawardena, 2009; Thapa and Niehof, 2013).

According to Kabeer (1999), in social science literature, women's agency tends to be operationalised as decision-making, which aligns with the use of decision-making autonomy in demography to study women's social status, discussed above. Kabeer (1999) argues that such an understanding of agency as decision-making disproportionately emphasises action, overlooking the roles of bargaining, negotiation, deception, manipulation, subversion,

resistance, and reflection and analysis in studying women's gendered political position. Decision-making, in the form of observable action, also highlights individualism, which may be limiting when applied to non-Western contexts (also noted by Allendorf, 2015; Kabeer 2011; Madhok, 2004; Mumtaz and Salway, 2009; Patel, 2004, and discussed in Chapter 6). The agency framework proposed by Kabeer (1999), therefore, includes both observable action and a 'sense' of agency, which is implicit in processes like bargaining, resistance and reflection. In the specific context of the household, this approach is resonated in Agarwal's (1997) use of 'bargaining' which involves both cooperation and conflict in the household, and is inherently connected to the structures of caste and class, which are usually considered to be external to the dynamics of the household. Agarwal (1997), writing in the context of Indian households, argues that women's lack of overt protest in the household is not a sign of compliance, but a strategy to uphold their status by perceiving and responding to the risk of protest. Drawing on a quote from Sharma's (1980) study of women's labour in northwestern India where women say that they do backbreaking work but still have no money and must cast their eyes down in front of men, Agarwal (1997) argues that the overt appearance of compliance does not indicate that women do not have a correct perception of their best interests. Instead, compliance can be a survival strategy arising from the constraints on women's ability to act overtly (indicated by not having access to money) to pursue those interests, also argued by George (2002), Kohli (2017), Thapan, (2009). Kabeer (1999, p.8), in response to Agarwal (1997) also suggests the "uncomfortable possibility" that women may not want autonomy, an idea further explored in Chapter 6.

The other body of research that troubles autonomy is literature from South Asia that studies the role of emotional bonds and filial relations in analysing women's position in marriage, family and household, especially in relation to access to healthcare (Agarwal, 2007; Allendorf, 2012a; Furuta and Salway, 2006; Madhok, 2004; Mumtaz and Salway; 2009; Jafree and Sastry, 2020; Unnithan-Kumar, 1999; Vera-Sanso, 1993). Allendorf (2012a), for instance, examines the role of the quality of marital relationships on women's agency, and quoting Basu (2006) on the need to account for emotions in the study of reproductive health, writes:

> "Perhaps, once a suitable survey instrument has been designed, it will be found that love, if only it can be sustained, is as empowering as other 'demographic' variables like education and economic independence" (p. 190).

Allendorf's (2012a) study finds that it is getting along with the husband and mother-in-law (having a high quality of relationship) that enhances women's agency, and accounts for greater variation in women's agency in accessing care than demographic variables like age and education. The role of love in women's decision-making autonomy (as observable action) has also been studied in relation to love marriages where studies have found that women who had love marriages or had some choice in marriage, implying autonomy before marriage, have greater decision-making autonomy within marriage (not specifically in relation to access to care) but that such autonomy is also influenced by the relations women share with their in-laws and with their natal kin, and by factors like dowry (Brault, Schensul and Bankar, 2018; Deshpande and Banerji, 2021).

Mumtaz and Salway (2009), in their study on reproductive health in rural Pakistan, argue that it is not only emotional bonds but also structural bonds that tie women and men, and all household members, together. However, this bond is most significant for women (as daughters-in-law) because gendered inequalities in access to resources mean that they have strong interest in maintaining family ties. The "degree to which a woman is embedded in her marital family," the most significant of her social ties, determines her access to its resources and her gendered position within it, which in turn influence her access to care (p. 6). In this context, the role of social relations, rather than autonomy and independence, comes to be valued in enabling access to healthcare.

This body of literature, which studies household relationships in a qualitative manner, is significant to my research as it recognises and probes the quality of women's relationships and makes note of their own understanding of their actions or the lack thereof, often at odds with established discourses of autonomy and independence. Following from these alternative ways to understand women's actions in relation to their social affiliations, I also briefly look at literature on resistance, which is an element of Kabeer's (1999) agency framework, and relevant to this study as women's actions or inactions, in the face of their husbands' authority, can sometimes potentially be read as resistance. As Agarwal (1997) notes, resistance is sometimes difficult to infer because women's overt behaviour may be that of conformation with or partial acceptance to unequal social norms, out of fear or the belief that there is no other option. Agarwal (1997) also argues that, methodologically, women's covert behaviour (of resistance) is probed in contexts where they can express themselves freely and through tools like participant observation, and by paying attention to the manner in which they

discuss acts of resistance—sometimes through narratives of other women. Aggarwal (2004) in a review of women's resistance (especially in relation to family and household), argues that resistance has to be studied in actions like the appearance of compliance, complaining and pleading ill-health, withholding sex, and in silence and cultural articulations like songs. Kalpagam (2000), writing in the context of India, argues that a feminist politics must account for everyday acts of resistance in the sphere of intimacy—not only sexual (such as withholding sex) but also in the space of care, such as covertly resisting care-work, further arguing that life in its everyday aspects is a set of transactions hinged upon the bargaining strength of women.

My study recognises women's actions and interactions (and sometimes inaction) with their husbands and marital families as acts of bargain, which can take on meaning as acts of resistance, decentering the individualised idea of autonomy in studying women's decision-making and instead analysing women's motivations behind decision-making and the value and consequences of such decision-making, particularly in relation to access to care.

2.6 Conclusion

My review of literature, drawn from multiple disciplines, provides an overview of the areas of debate and discussion that have a bearing on the study questions, in terms of the background they provide on relevant issues (such as early marriage), the gaps they illuminate, the methodological approaches they use, and the reconceptualisation of given meanings that some of them undertake, such as the critical studies on decision-making autonomy.

The chapter, through literature, has problematised the three interrelated areas of inquiry of the study discussed in Chapter 1—young women, care, and household. First, the literature on age at marriage and reproductive health, largely drawn from demography and public health, has built a case to centre women married as adolescents in qualitative research, which my study consciously does. This body of literature has also allowed my study to develop critical questions about the influence of young women's gendered position in the marital household on their health, rather than their age at marriage alone.

Second, the literature on availability and accessibility of health facilities, and inequality in access, has established the state of health infrastructure in the study region, within which women in the study population experience and make meaning about their health, alongside the household. Critical perspectives on access, reviewed in Section 2.3, have also drawn attention to social contexts in which women avoid or reject institutional care. My research develops such literature on women's access to healthcare by expanding notions of access to include other sites and forms of care, and grappling with shifts between these meanings of access.

Third, the literature on women's meaning-making about health in relation to their position in household and kinship has demonstrated the centrality of gender dynamics and relations in understanding and articulating experiences of health. This body of literature, like the critical literature on access, has also expanded the meaning of access and care for my study as it identifies marriage and the marital household as sites of care. I develop this body of work further by centering the household as a material space as well as a set of hierarchical relations, which is implied in studies on marriage and kinship, but often not explicitly studied. I also build on it by foregrounding the experiences of women married as adolescents.

Fourth, the literature on women's decision-making autonomy, drawn from demography, feminist studies and public health, has established the conceptual limitations of autonomy for my study, setting the stage for the critical study of women's decision-making, which pays adequate attention to the role of bargain and emotional bonds. Feminist literature on women's decision-making particularly lays bare the tensions in valuing decision-making autonomy as a measure of access to care. I further develop such scholarship by looking into the ways young married women want to be cared for, what relations and actions enable access to care, and what meanings they attach to decision-making practices in the household.

In the following chapter, I discuss the methodological approach of the study, detailing the development of the research design, its implementation, and the tensions and challenges involved in it. The chapter will also reflect on how the questions raised through the literature review were sought to be operationalised through the research design, which is then accounted for in the subsequent analytical chapters.

Chapter 3

Research methods, relations, and reflections

3.1 Introduction: In search of a participatory approach

My research, as established, follows a qualitative framework and a feminist philosophy. In this chapter, I start by reflecting on the genesis of the project and the principles and methods that it set out to explore in order to fulfil its aims and underpin its feminist claim. The chapter then outlines the practicalities and debates involved in setting up the research as a field-based project, detailing the process, outcomes and ethics of collaboration, and also the meanings of community and field. It then discusses the use of in-depth interviews and focus group discussions as feminist tools, and how their operationalisation reflected ethnographic practice and problematised ethical standards as individualising processes. This is followed by an account of the analytical approach, based on constructivist grounded theory (Charmaz, 2006), including a reflection on how it was used in the stages of data collection. The chapter concludes with a discussion of social dynamics and positionality in the field, extending descriptions of the study area in the introduction and setting the context of the arguments in the analytical chapters.

3.1.1 Feminist inspirations and considerations

The research problem was developed during my time working in a development media organisation in India, which worked with the action-oriented approach of report–advocacy–impact. With respect to reproductive rights, correspondents from different parts of rural North India reported on the common problems of poor public health infrastructure, low reach of maternity welfare schemes, and the state's population control agenda. They then amplified the problems by taking them to the concerned government officials and advocating resolutions that would involve working together with those affected, hoping to lead to positive change. Some of these stories provided glimpses into the household—its members, relations and resources—and raised questions about how households shape women's reproductive health. This was the problem that sparked my interest, along with the report–advocacy–impact approach. Feminist participatory action

research (FPAR) appeared to align with what I wanted to do, and debates among practitioners of the method also helped re-imagine action beyond the tangible 'impact' approach of development organisations (where change must be measurable and its nature predetermined), including the one where I started to think about this study (Reid, Tom and Frisby, 2006).

In FPAR, crucially, participants are involved in setting and owning the research agenda and methods, in analysis and reflection, and in creating knowledge and developing action. Its principles also centre structural change, and involve a shift of power along multiple axes but especially between researcher and participant (Asia Pacific Women in Law and Development [APWLD], 2019; Fine, 2007; Krumer-Nevo, 2009; Tolhurst et al., 2011). My research design could not entirely fit into the FPAR approach, logistically so because the study required institutional ethical clearance which would ratify (hence, set) the agenda and the methods without the participants. An organised FPAR exercise was also difficult to implement as the participants' commitments towards their families and constraints of household work had to be respected for both logistical and social reasons, and the fieldwork had to be completed within limited time and resources. FPAR, therefore, does not necessarily fit the way in which participation emerged in the research but it informs and inspires the research, guiding the research activities, and becoming valuable in thinking about how the research understands and practises action, feminism and participation. Throughout the chapter, I reflect on participatory processes and participatory moments in the fieldwork, along with the 'operationalisation' of feminism, and particularly look back on action in the conclusion of the chapter. Here, I briefly describe what a feminist approach was envisioned as for the study.

Most organisations I considered or discussed collaborations with, including Project Potential, did not use the word 'feminist' or its Hindi equivalent *naarivadi* in describing themselves, and many of them did not specifically work on gender. However, they recognised gender as an important axis of inequality and worked with the aim of empowerment and social justice, and often used feminist principles in their work. According to the Asia Pacific Forum on Women, Law and Development, a pioneer of FPAR in the region, a feminist approach means that gendered power relations are interrogated at all levels of the research, that women's (participants') experiences are recognised and validated and that the researcher also shares and contributes to the knowledge of gendered experience, and that practical barriers to women's participation in research be considered and addressed (APWLD, 2019). For me, a feminist approach means centering the experiences of women (in the study objectives itself)

and interrogating gender-based relations and inequalities, while understanding gender in terms of relations and dynamics, and being co-constitutive of caste. Second, it means working in a way that is enabling for women and sensitive to their social circumstances. For example, making sure that their participation does not antagonise their families whom they need to maintain social ties with, even if that can be perceived as acquiescing to social norms (Jafree and Sastry, 2020). And third, it means ensuring that the research tools and analytical frameworks do not reinforce hierarchical structures, much as the researcher-participant relationship may be inescapably hierarchical, owing to the nature of research, and in the case of my study, hierarchies of income, caste and social mobility (discussed in Section 3.3) (Acker, Barry and Esseveld, 1983; APWLD, 2019; Guru, 2002; Letherby, 2003; Roy, 2021). To realise these feminist principles, I sought to work with organisations and individuals who would share the same aspirations and facilitate participatory research. The following section describes the collaborative element of the research, extending the discussion on feminism and participation, while simultaneously detailing the institutional and logistical levels aspects of the collaborations.

3.1.2 Research collaborations: processes and implications

I had been familiar with the development sector in rural India through past media and research assignments but as an employee or representative of NGOs rather than as an individual seeking research collaboration. I wanted to collaborate with organisations rather than individuals to gain access to institutional resources (frameworks, programmes, networks) and to be able to use the analysed data to contribute to related existing or new programmes. I started my search for a collaborating organisation in the Seemanchal region by narrowing down three types of NGOs, those that work on sexual and reproductive health and rights (SRHR), especially in compliance with government schemes, those that work on development projects with women and girls (livelihoods, education, sports), and those that work as advocacy organisations (such as non-political party affiliated labour rights movements). Each of these would shape the research in different ways. The first would allow me to situate my research at the cusp of medical sociology and social policy or to situate it within an existing sexual and reproductive health programme, such as a comprehensive sexuality education programme. The second would allow me to start or form the basis of a new project with a pre-existing cohort of women and girls engaging with other aspects of development such as education and livelihoods. The third would allow me to place

reproductive health in the rights framework that often draws on the language of the left in India and of women's movements therein. The aim of the research would remain the same, but the manner and the channels through which the research would be approached in terms of recruiting participants, engaging with families and communities, analysing and potentially using the data would be different.

Eventually, I collaborated with Project Potential (PP hereon), an NGO that loosely fits into the second category. PP works with a two-fold approach, by creating economic opportunities for local youth (whom they test, train and hire) who then implement development projects or campaigns on health, education, and livelihoods in their respective communities. As a researcher trying to build networks with the development sector, PP's interest in research as a tool for programme development and youth engagement informed my decision to collaborate with them, along with their location in rural Kishanganj and their vast network of local youth working on campaigns related to health and livelihoods. Additionally, despite initially wanting to work within existing institutional frameworks and approaches (such as SRHR, or early marriage as forced marriage), I realised that working with an NGO that allowed greater flexibility and independence, rather than predetermined approaches, was more suitable for a study that aimed to centre participants. From their perspective, PP hoped that taking my project on board would expand their engagement with health, which, at the time, included health screening (Covid-19 and tuberculosis), enabling access to government schemes, working with public health centres and frontline health workers, and counselling families in cases such as long-term tuberculosis treatment. It would also introduce qualitative research to their team members who had formerly used surveys and questionnaires for project development.[7] And for selected associates (the individual collaborators and pilot participants), the research would provide an opportunity to engage with a new project, which was also a financial incentive.[8] Eventually, PP identified two women from among their

[7] Introducing qualitative research to the team was expected to happen naturally to some extent as we frequently discussed the study and academic research more broadly. Eventually, I designed and conducted a research workshop for their team of 25 working on Covid-19 vaccine uptake, and helped develop a research agenda for a menstruation-related grant that they (PP) later received.

[8] The individual collaborators from PP worked with me for a defined number of days each month, and on these days, they were remunerated by me rather than PP. While negotiating a collaboration, the PP management had suggested that I offer an hourly pay higher than them so that the work is both a professional and a financial incentive. The collaborators in Purnia and the pilot participants were also remunerated at the same rate, and I obtained approval from the Ethics Committee to remunerate the pilot participants for their role as collaborators, and to be able to use their data as participants, ensuring that there was no conflict of interest between the two roles.

employees (Bharti and Rumi) who would act as the key collaborators, both of whom were working on the Covid-19 vaccination campaign and had formerly worked on education programmes and menstrual health campaigns.

Alongside PP, an NGO working on sexual and reproductive health was also finalised for a similar collaboration, in the other study district, Purnia. They had previously hosted doctoral researchers and were willing to enable access to the field but they were not as open to expanding beyond the SRHR framework. This collaboration did not work out because of potential tensions between approaches, along with sampling preferences (discussed below on page 60), and because of logistical constraints as they were headquartered in the state capital of Patna and had just begun operations in Purnia. Later, one of their associates, in her personal capacity, volunteered to recruit collaborators locally from among her mentees in Purnia. She selected two women, Binita and Sangita, one of whom had been volunteering on a project addressing high dropout rates among girls, while the other was gearing up to join the project. This is how the research in Purnia was established.[9]

In both districts, the collaborators worked on recruitment, community engagement, risk mitigation, preliminary analysis (based on broad themes identified from anonymised data) and focus group discussions. The collaborators in Kishanganj, Bharti and Rumi, additionally worked on the pilot. As co-researchers on these tasks and key partners in shaping the study, their real names are used, as with Project Potential (with permission from both). I sought collaboration from different types of NGOs for different reasons—approaches, interests, and location, but eventually, it was not so much the type of organisation but the individual collaborators who influenced how the study was approached. Early marriage became the key theme through which the research was introduced to and discussed with prospective participants, not so much because of an institutional investment in the subject but because of the collaborators' personal experiences and immediate association with it, which they knew would be a strong shared ground with prospective participants. The research collaboration, therefore, was a site of participatory work, and the individual collaborators deeply shaped the study. Apart from their relatability with early marriage, they also shaped the study as women working for and with their communities. For instance, Binita recommended we share

[9] I have chosen to not name the NGO as it was not a collaborator, but have included details of the discussion with them as it was significant to the development stages of the project. The associate is also not named, as requested by her.

information about the safety and legality of abortion in community meetings as women wanted such information even though we had made clear that the research was not about sharing information and knowledge (*sikhana*, 'teaching' literally) and that we were not subject experts on specific health issues.

A key characteristic of the development sector in India, as elsewhere, is that organisations work with, or often for, deprived groups. For India, this means historically oppressed castes and tribes, along with low-income groups. The only demographic criteria that I had in my proposal to prospective collaborators was women who had married as adolescents, and who were currently aged between 16–22. In my discussions with prospective institutional collaborators, one of the most common questions I was asked was about my social and demographic target group. The NGO that was contacted for Purnia, with whom a collaboration did not work out, specifically focused on Dalit and low-income Muslim communities. Not working with a marginalised community, from their perspective, amounted to not engaging with fault lines based on caste, ethnicity and religion. The question of selecting a particular group to work with was a difficult one for the research and my position within it as a researcher from a Savarna (or 'upper' caste) Hindu location, with greater access to material and cultural resources than most prospective participants. While the research included participants from castes 'higher' or the same level as my own, the majority of participants came from groups categorised as Other Backward Classes or groups demanding to be included in the Other Backward Classes category based on historical and ongoing deprivation. The issue of selecting a group is contentious because on the one hand, development institutions value working with marginalised groups, often with the aim of uplifting them (a practice which is also criticised for being instrumentalist and disconnected from lived experiences), and on the other hand, categorically recruiting from among marginalised groups reifies certain groups as data, denying them subject position, and building theories (as a Savarna researcher) based on their lives (Guru, 2002; Xaxa, 2020).

Project Potential also wanted to know if I was looking at a particular group to work with. They explained that as a relatively new organisation experimenting with youth engagement, they were currently creating job opportunities for young people across communities by running large-scale programmes, but the target of these programmes (tuberculosis screening, education, flood relief, COVID-19 vaccination campaign) were marginalised communities like Dalits and Adivasis. The reason I did not want to narrow the research population down to

a social group was for fear of the study labelling a particular caste, tribe or religious group as a community practising early marriage and forced marriage, or accounting for poor reproductive health. This could unintentionally reinforce popular myths and deliberate misinformation perpetuated by the Hindu political right about high fertility among Muslims (while the fertility rate for Muslims in India has seen the sharpest decline among all communities in the last 30 years, see IIPS and ICF, 2021; Purohit, 2019; Rajesh and Kataria, 2023), and early and consanguineous marriage being a feature of Muslim and Adivasi societies (while it is practised in various Hindu groups as well), as well as Adivasi aversion to modern medicine. Early marriage in India is far more common in rural areas than in urban areas and among low-income groups, as it is fuelled by a lack of financial resources and poor access to education and employment opportunities for girls and women (IIPS and ICF, 2021; Mehra and Nandy, 2020). The research, therefore, was expected to be carried out in the rural parts of Kishanganj and Purnia, with no other criteria. This was not to indicate that caste and other axes of identity were less relevant to the study, but as I argue in Chapter 1, caste is read as co-constitutive of gender, and the research problem approached intersectionally, and wary of the contentions involved in recruiting participants from particular caste and ethnic groups.

Eventually, the study sample was drawn from groups that the individual collaborators worked with, which largely overlapped with their own social locations. As a result, the participants in Kishanganj were primarily a mix of Surjapuri Muslims, Rajbangshi Hindus, and Adivasi Hindus.[10] A small minority of participants belonged to Scheduled Caste and General caste Hindu groups, and were living in mixed-caste neighbourhoods or were in inter-caste marriages. In Purnia, all the participants were Adivasi Christians as the collaborators were Adivasi Christian women and wanted to work with women from their community. The local church, which doubled as a community centre for several Christian-majority villages around, became the hub of all research activities, especially community engagement.

[10] Surjapuri Muslims and Rajbangshi Hindus are ethnic minorities in the Seemanchal region of Bihar, especially Kishanganj, and have small populations in the neighbouring areas of West Bengal, Assam, Nepal and Bangladesh. Both groups have contested caste and ethnic status. Surjapuri Muslims are currently categorised as a general caste but seek inclusion in the other backward class (OBC) category, while Rajbangshi Hindus are categorised as OBC in Bihar but Scheduled Caste in West Bengal and Scheduled Tribe in Assam.

3.2 The field

3.2.1 Reflections on 'community' and 'field'

'Community' and 'field' came to be two terms that were widely and loosely used in the data collection phase, by the collaborators and their institutional mentors, in PP's daily work, and by myself. In the context of the research, community is predominantly used in the context of community engagement—an ongoing process of formal meetings and informal conversations and interventions which supplemented recruitment and data collection.[11] For PP, community refers to the people they work with and for, either collaboratively or in a one-sided manner (such as distribution of goods or relief material). This is the case for several NGOs in India where community refers to beneficiaries, who may or may not be represented in the NGO. In this iteration, it can be a top-down concept. A critical perspective on the use of the term community in academia is that it is used as shorthand for caste by Savarna scholars to circumvent engaging with caste. I came across this perspective through my engagement with anti-caste circles at the social sciences institute I was associated with as a graduate student in India, and could identify it in conversations, teaching and writing. Community, in such usage, becomes a sanitised term which connotes cultural differences rather than structural inequalities. In Purnia, the collaborators used 'community' very sparingly but the participants frequently used 'caste' to describe themselves as Adivasi and Christian in opposition to me, non-Adivasi and Hindu. In fact, it was only among non-Hindu groups that participants noted that I was from a different caste. In some Hindu households, participants or their families asked the collaborators and me about our caste (when we were new to the area or wearing religious markers), but they meant to ask whether we were Hindu or Muslim rather than our caste within the caste system. In no way does this indicate that my caste or the caste of the collaborators was irrelevant to Hindu families, as was evident in conversations about diets, rituals and festivals, and in comments about social identity, which I discuss later in this chapter.

Over time, I have come to realise that community is a term I find no association with for myself. Partly, it is because of conscious but complicated attempts to distance myself from

[11] I categorise a few participant and family meetings with the collaborators and me as interventions as the participants requested these meetings to talk to their partners about participation, to dispel doubts their families may have about the research, and to seek help and protection against domestic violence.

my caste and religion, which has sometimes narrowed avenues of more productive but difficult forms of engagement that dismantle caste and enable just practices in the everyday. And partly, it is because I have not been based out of one place for very long, geographically. My mixed-caste neighbourhood in India or my neighbourhood during my PhD in the UK, for instance, are not my community as we share no common and collective goals. In many ways, 'community' for me has also always been on the outside, and in the context of my academic work, in the 'field.'

What is the field? asks Rajagopalan (2021) in her reflection on positionality in ethnographic research. As an academic and activist, she describes 'field' as the real world site of research, the people whose lives the researcher studies, the disciplines of the researcher's work, and the real world which should be the context of social science and humanities research. I find these descriptions useful in contextualising my usage of 'field' and 'fieldwork' and its iterations by the collaborators. For me, fieldwork was the term used to describe data collection and the larger period of my stay in Bihar to those not involved in the research, such as friends and family. With the collaborators, I used the term to distinguish field-based work (interviews, FGDs, community meetings) from project development and analysis. At Project Potential, fieldwork is the bedrock of all their work, and as such, "going to the field" was a phrase used everyday and to refer to a village or a neighbourhood, rather than an activity. *This is my field* is a common expression used by social workers, NGOs and journalists that marks geographies and social identities, despite being used in a disembodied manner. Referring to an area as one's field also comes with a sense of deep responsibility and pride. In Purnia, before selecting Binita and Sangita as collaborators, their mentor had discussed with me that she had 'fields' in different blocks of the district and could 'give' me any of those fields.

Writer Arundhati Roy, in her satirical novel on Indian society and polity, *The Ministry of Utmost Happiness*, comments on the presence of researchers and scholars in Delhi's designated protest area, Jantar Mantar.

> "PhD students from foreign universities working on social movements (an extremely sought-after subject) conducted long interviews with the farmers, grateful that their fieldwork had come to the city instead of their having to trek all the way out to the countryside where there were no toilets and filtered water was hard to find" (Roy, 2017, pp. 106).

The ‘field’ in social science research, and in development research, is often reflective of this chasm between (what is thought of as) the urban and the rural, the liberated and the oppressed, and between experience and knowledge. In this context of the field, and of ‘communities’ becoming the subject of research, Narayan’s (1989) essay on feminist epistemology provides a useful reminder that research must not idealise or romanticise oppression while ignoring its material implications owing to the fact that oppression may give someone an epistemic advantage. I read this alongside Guru’s (2002) critique of social science research in India, which argues that the emphasis on lived experience in the social sciences pushes Dalit and indigenous communities to become data and to produce data, and never theories and concepts, which remain in the precincts of Savarna scholars. This is coupled with poor material conditions that deprive the former of academic opportunities. The concern of reproducing this hierarchy was often discussed in the field, especially within Project Potential, and was sought to be engaged with through participatory methods where members of the study population engaged with the agenda, but it is an enduring tension for this research and the structures of academia within which it is located.

The field, for me, did not represent a chasm but certainly reflected distance. It was a place I travelled to and sometimes lived in temporarily, and it was demographically and geographically different from my home in urban Purnia, and drastically so from the university. It was also not a routine place of work for me, as it was for Rumi and Bharti, and for Binita to some extent. But at the same time, because the research was my only and full-time engagement with the field, it was present outside of interviews, FGDs and community meetings. This idea of the field perhaps finds some resonance with what Rajagopalan (2021) refers to as the ‘real world’ which should be the context of social science and humanities research. During periods of work in Kishanganj, I was stationed at the PP office, which accommodated a small number of employees and guest associates. While being outside the office (literally, carrying out meetings, interviews or FGDs) distinguished fieldwork from non-fieldwork (the rest of the time spent in the office, working on the PhD or otherwise), the office continued to be part of the field as my presence there was associated with the research, and because conversations and ideas often spilled over into this time and space outside of the literal ‘field’, resembling ethnographic practice and making the field all-pervasive. In Purnia, my presence in the field was less immersive as I did not live with an individual or institutional collaborator, but the long hours I spent at the church, and

sometimes in the village, allowed, or even compelled, me to make observations and conversations that strengthened my association with the field.

Extending this imagination of the field, I argue that my family home (where I lived during a considerable part of the fieldwork year) also became part of the field as I noted decision-making processes in instances of care-seeking, along with household dynamics and gendered relations, albeit not in the context of early marriage. The field also extended to new spaces for the collaborators, who, like me, looked into their own households, gendered relations and decision-making practices. The field (including their homes and immediate communities) was also a place of advocacy for them as their roles in their respective organisations and projects was underscored with the responsibility of engendering social justice. It was difficult for them to tear one role away from the other, but the tension between their roles as researchers and social justice advocates enriched the research. The collaborators engaged with participants and participants' families and addressed and questioned customs, practices and challenges, which the research interview was often unable to do as I prioritised listening to participants' experiences and opinions. The collaborators' perspectives on various issues of gender, society and marriage were welcomed by participants and actively engaged with. For me, on the other hand, the field sometimes seemed limited to a site of research (even when it was experienced in the everyday) rather than advocacy. This was compounded by the fact that I was only present in the field (as the real-world site of research) for the research, unlike the collaborators who visited the same places and interacted with the same people for different projects and purposes. I sometimes considered this to be a loss as I was not around for the more hopeful, active and 'action' oriented events in the field or within the NGO and the church, which signified my distance from the field, although the question of what counts as 'action' remains.

With the above description of my act of anchoring myself in the field, while being distant at different times and for different reasons, I turn to the operationalisation of the pilot, recruitment and the informed consent process to understand the field activities I carried out while I was there.

3.2.2 The pilot: An exercise in participation and assessment

The study pilot was designed as a five-day event in collaboration with Project Potential, who selected five participants from among their networks, all of whom were young married women aged between 21-23 years, married between 17-19 years. A key method by which feminism is practised in FPAR is by ensuring that participants set the research agenda, and I sought to use the pilot as a research activity that implements this practice. Towards this end, the pilot was not only a conventional test of the research tools but a process where the participants assessed the research objectives and documents (including the participant information sheet, consent form, interview and FGD topic guides), provided feedback on the experience of the interview and FGD interactions, and made recommendations on related themes to cover. They were remunerated for their involvement, for which I procured additional ethical clearance as they were both participants whose data I was using, and collaborators who worked to develop the study. But despite the attempt at participation, the research agenda had already been set in many ways, as the pilot took place only after a thorough (but not unchangeable) process of literature review and the development of a research design. Moreover, the pilot participants, being associates of the institutional collaborator, were not always positioned to provide a clear assessment, which was evident through frequent iterations of "if the NGO is doing something new (the research) it must be good", and "if you have been studying this for a year, you must be doing it right." This was not only a result of their association with the organisation but also reflective of the power dynamic they shared with me as the researcher, which meant that I had 'studied' a problem, making me the expert, as opposed to them, who were 'assisting' me in my work. The research agenda was, therefore, set based on engagement with scholarship, development practitioners and organisations, and subsequently amended based on the evaluation (somehow partial, as I explain above) by the collaborators and the pilot participants.

3.2.3 Recruitment and the informed consent process

After the pilot, women's participation was sought based on a conventional informed consent process, which included a Project Information Sheet (PIS) and a consent form, both of which were pre-approved by the Economics, Law, Management, Politics and Sociology Ethics Committee of the University of York (Appendix 1-2). The consent form was signed by most participants and those who could not write provided verbal consent which was

audio-recorded. Participants aged 16-18 also gave consent by themselves, which was a decision informed by the World Health Organisation's guidance for ethical considerations in research on sexual and reproductive health with adolescents, which states that minors in their late adolescence are treated as adults or ‘emancipated minors’ in various contexts such as abandonment or death of guardians, legal orders, and marriage. Emancipation can be both legal and social, and a minor girl may be afforded decision-making authority vis-a-vis her health and the health of her child, in the context of care-seeking and research (WHO, 2018). India does not have legal provisions for emancipation of minors but marriage traditionally marks maturity, especially for girls (Bhog and Mullick, 2015; Pillai and Gupta, 2014). In addition to respecting the decision-making capacity of adolescent women and enabling greater visibility for them in research, there were further ethical grounds for not seeking consent from guardians. Marriage in India means that girls and women are no longer under parental (or paternal) control, and as such, the husband becomes the guardian. In this context, seeking consent from parents, husbands or in-laws can amount to acceding to the patriarchal idea of women and girls always being someone’s ward rather than having a sense of personhood.

In spite of selecting the study population (aged 16 and above) after careful consideration and ethical clearance, I was wary of the risks associated with recruiting young women for a study on household dynamics, particularly women who are daughters-in-law, arguably a disadvantaged gendered position. Such risk was sought to be alleviated through different channels, principally community engagement, discussed below. The possible causes of risk—disapproval of husbands and families, my position of authority as a researcher and a person with social and economic capital, and the state’s punitive stance on early marriage—are subsequently discussed in Section 3.6.2.

Community engagement was identified as a precursor to recruitment, and an ongoing process, based on the experience of organisations and researchers working on sexual and reproductive health (Dasra, 2019; ICRW, 2016; Society for Nutrition, Education and Health Action [SNEHA], 2019). In both Kishanganj and Purnia, the collaborators began by identifying areas with high rates of early marriage. In Kishanganj, the collaborators then arranged visits to these areas and met the frontline health workers and anyone else who may act as a

gatekeeper, such as government school teachers or village council members.[12] We then made door-to-door visits in the selected villages, introducing ourselves and explaining the research, eventually inviting women to a community meeting at an accessible location. In Purnia, the collaborators used the church and particularly the weekly mass as a space to hold discussions about the research, rather than going door-to-door.

As mentioned earlier, the collaborators were keen on approaching the research problem from the perspective of early marriage. As we went door-to-door in Kishanganj, it became evident that this was an entry point that encouraged greater conversation than reproductive health. Young women who had been pushed into early marriage asked us to counsel parents of unmarried girls, arguing that their lives had "already been ruined." Older family members, on the other hand, sometimes asked us to warn unmarried girls against early marriage, attributing increased elopement to mobility and social media, while others spoke of the need to get girls married early, owing to fear of elopement and high dowry if they marry when older. Early marriage expanded the conversation in many directions—customs, laws, economic needs, dowry, health, honour. To some extent, it also led to fear among prospective participants who were reluctant to share their age during recruitment and insisted that they were 18 at the time of marriage, even if they said otherwise in community meetings or casual conversation. In one village, where I had recruited three study participants, a health worker warned them against engaging with me on the pretext that I might initiate legal action against them and their parents for marrying before the age of 18. This concerned the participants who then brought it up with me, but were happy to participate once I explained the law and my role as a researcher to them. It took us several conversations and discussions on the anti-child marriage law to assure people that we were not going to take action against those who had married before the age of 18, in that it is neither legally possible nor do we take a punitive stance against early marriage. In Purnia, where early marriage appeared to be more common, and was inevitably self-arranged (as it often is among Adivasi groups in the region), there was little fear about punitive action, likely so because the collaborators and I were not associated with an external authority but rather, the local church, a trusted institution. The study had originally proposed to recruit women aged 16-22 but I extended the age bracket as many (relatively) older women had greater freedom to engage with outsiders and participate

[12] Government employees, like school teachers, are often involved in various activities at local administrative levels, outside of the institutions they are anchored at. They are particularly involved in outreach activities and therefore, become gatekeepers in many communities.

in the study. As Table 1 illustrates, the sample comprised women aged 16-28, but with only a couple of them being in the 25–28 bracket. However, all the participants had been married between the ages of 14–19.

At the first community meeting, which was arranged in a village in Kishanganj, we invited the local *anganwadi* worker to assist us in facilitating a discussion on young women's health, and then introduced the research and its objectives, distributing copies of the Project Information Sheet to women who met the participation criteria, based on standard ethics compliance practice. The meeting was held in the home of a PP associate and was attended by about 20 women, mostly daughters-in-law. One of the women was particularly interested and said that she would speak to her husband about it and have him explain the PIS to her as she could not read. I assumed that her wish to confer with her husband was an exception, not realising that many women's decision to participate would depend on discussion with and permission from their husbands. When we went back to the village to follow-up with the interested women, it turned out that none of them were ready to participate because their husbands, parents or in-laws had asked them not to. It was not only a matter of literacy and comprehension because even women who read the PIS themselves and women whose husbands lived away consulted the husbands, telephonically when required, and declined participation based on their husbands' advice, even if they had been enthusiastic originally. The reasons (based on their husbands' advice) the women shared with me was that it was not necessary or useful to participate in such activities. This echoes Jafree, Zakar and Anwar (2020) who discusses South Asian women's conflict between their research ethics and their personal ethics of time and loyalty towards the family, especially when research involves discussing the family. Conflicts like this emerged time and again in scheduling and seeing through interviews and FGDs. Prospective participants who expressed apprehension about participating because of lack of permission from their husbands and families (and whose husbands and families spoke to us indicating discomfort about young women participating in a non-routine activity including outsiders) were not included to avoid risk to the women. Wickramasinghe (2010), in her work on feminist research methods, argues that the ethical implications of each issue has to be prioritised vis-a-vis the desire to represent the perspectives of the participants accurately. Women who expressed being at risk of restrictions or violence were, therefore, not involved. However, there were grey areas in this process as some women wanted to participate and did not want to say no immediately, and also participated at the risk of backlash, which is discussed later in this chapter (Section 3.6.2).

After the first community meeting, the collaborators and I realised that men reading and interpreting the PIS from their perspective was a hurdle. In the community meetings, we would discuss what research is and why we are doing it, but the men only had access to the PIS, which, though self-explanatory, could lead to apprehension as it mentioned examining household dynamics. In subsequent community meetings, we asked women if they would like a copy of the PIS to read or have it read by family members or if we should have a private meeting to discuss it thoroughly. We also encouraged them to read and discuss it among themselves, as they may have similar experiences and apprehensions, rather than discuss it with their husbands and families in the first instance. A few women took the PIS and discussed it with their friends and neighbours but most of them wanted the collaborators and me to explain it to them. I continued to encourage women to read the PIS themselves if they could read, but very few women wanted to. One of them, who eventually participated, specifically asked me not to give her the PIS as it could create problems for her at home. Wherever the collaborators and I went, it was the paperwork, or simply papers, that sparked apprehensions. In a social context where documents and forms are associated with those in power, a printed document was far from a sign of assurance. Two sections of the PIS particularly posed problems—the section on data protection and the section on disclosure of illegal activities. Data protection is key to research ethics but the mention of a data protection law, data storage, and the right to withdraw data, worried participants. The law, in terms of courts and policies, is out of reach and even punitive for many in the research context, making protection under law hold little meaning. Similarly, explaining how data will be stored and analysed using the University of York's secure cloud service also led to concerns. The collaborators then pointed out how the internet or 'net' as it is called colloquially, is synonymous with 'viral' and therefore, worrying. 25 out of the 33 study participants did not allow audio-recording out of confidentiality concerns, arising from the use of audio technology.[13] This means that for most interviews, the 'transcript' is reconstructed from notes taken in Hindi and sometimes translated on the go. These notes have captured the essence of what participants said and accounted for the tenor and manner, noting laughter, silence and discomfort. In the consent process, trust in the collaborators and me was key, and getting the law involved in this relationship was not welcome. Many times, participants consented during

[13] In the pilot study, four out of five participants had consented to audio-recording, which led me to assume that most participants of the main study would also do so. But the pilot participants had possibly consented to it based on the trust they had in PP as their associates.

recruitment but later asked what I was going to do with what I was writing. The consent process, therefore, was an ongoing process rather than a one-time event. Consent was explained to participants as an individual and autonomous act, as it is conceptualised in research ethics, but at the same time, it was rooted in the collective space of the household and community. Having support in participation from husbands or other relatives, or knowing that a friend too is participating, enhanced women's ability to participate and interest in participating. Other studies have also demonstrated that women in South Asia and elsewhere consult partners or families before deciding to participate in research (Baker, Lavender and Tincello, 2005; Jejeebhoy and Sathar, 2001; Wazaify, Khalil and Silverman, 2009; Rodrigues et al., 2013; Tharawan et al., 2001).

The second section on disclosure of illegal activities, towards the end of the PIS, was to ensure that I comply with legal regulations on reporting domestic violence and sexual abuse, self-harm and harm to others. This section prompted responses such as "nothing is wrong" and "I don't face these problems, my family is good." I would attribute part of this problem to the wording of the PIS which once again, emphasised law and legal protection, but I would also attribute this to the way in which the collaborators and I spoke about the research, which may have predominantly focused on the 'problems' side of household dynamics. This was an approach we consciously changed in subsequent recruitment discussions, and assured women that we were not there to interfere in their personal lives, but the "nothing is wrong" response came up in some of the interviews as well.

The contract of informed consent, as conceptualised in Western contexts and imported elsewhere, is based on a process of individualisation, which often proved to be a mismatch to grapple with (rather than a hurdle to be overcome) in the socio-cultural context of the study. The objective of the informed consent process was to keep participation ethical and collaborative, which I argue was realised even though it was not always as methodical as the binary answers on the form. Consent, as I argue above, was an ongoing rather than a one-time event and was not determined by the consent form but navigated throughout the research - by sensing, asking about and intervening in instances of discomfort, without being paternalistic or unfair. It also meant digressing from standard practice such as distributing the Participant Information Sheet and emphasising data protection through law, on account of contextual realities where such activities could only alienate. In the complexities involved in applying a culturally contrasting process, the recruitment process also became an important space for

participation as women challenged the standardised consent process by raising questions about it (*Why do you want to make written note of all this, saying yes or no?*) or rejecting it (*Everything is fine in my home, this is not needed*), and expressing consent through parallel processes (*I am doing this because I trust Bharti*). At times, they also 'broke' clauses in the consent form such as their agreement to not share personal information about themselves, fellow participants or others in the FGD, as it was more usual to share such things in a group than to keep the conversation regulated. While the community meetings influenced the research agenda and questions because of the concerns women raised about their households and health, it also became a site where women extensively engaged with the consent process, which the research design did not anticipate.

3.2.4 The study participants

The study involved 33 women as the key participants, aged between 16–28 years, who were recruited from five villages in Kishanganj and two villages in Purnia. The participants came from different communities, as described above, and there was no attempt to recruit more participants from one community over the other for representational purposes as the study was not designed as a comparative or scaleable study. The method of sampling used was purposive and largely based on how the community engagement in a particular area was perceived, rather than having a strict numerical requirement from each village. The 33 study participants were the only women who came forward to participate (except those who wanted to but were at risk from their families), rather than being recruited from a larger pool of women who wanted to participate. The social identity of the participants, as discussed earlier, corresponds with the social identity of the collaborators and the 'fields' they worked in, and therefore, is not entirely representative of the region's social demographics but represents most groups. An area in which the study sample's representation is surprisingly different from national estimates is that of the nature of marriage. Two out of the five pilot participants and a striking 17 out of the 33 study participants had had self-arranged or 'love' marriages, while nationally, only 10% of Indians are believed to be in self-arranged marriages, although a much higher number (60%) have a say in choosing their partner (Banerji and Deshpande, 2021). Seven of these were inter-caste and inter-faith marriages. This background is important to the study, as the analysis will demonstrate, and also counters the singular narrative of early marriage as forced marriage, as other recent studies have also done (Gopal et al., 2016; Mehra and Nandy, 2019; Nirantar, 2015; Roy, 2017).

The table below presents an overview of the participants' name, age and caste affiliation. It mentions the wider communities they belonged to along with the constitutional classification under which the community falls based on caste, ethnicity and income—General, Other Backward Class (OBC), Scheduled Caste (SC), Scheduled Tribe (ST). Scheduled Caste. All names used are pseudonyms, the use of which the participants and I mutually agreed upon. In my interactions with the participants, I did not ask them what their caste affiliation was, except when they mentioned an intercaste marriage and/or mentioned one party's caste. Sometimes, they told me about their caste affiliation in describing their neighbourhood or marriage, which is common practice, and at other times, I already knew of their caste because of the collaborators' description of or affiliation with the area. Participants and their families also asked me about my caste in general conversation, which was also not out of the ordinary.

Table 1: Overview of the participants' name, age and caste affiliation

S.No	***Name***	***Age at time of interview***	***Caste affiliation***	***District***
1	Aruna	15/16	Adivasi Christian (ST)	Purnia
2	Divya	21	Adivasi Christian (ST)	Purnia
3	Kaveri	21	Rajbongshi Hindu (OBC)	Kishanganj
4	Khushi	19	Surapuri Muslim (General)	Kishanganj
5	Kiran	19	Hindu (SC)	Kishanganj
6	Komal	20	Hindu (caste unknown), formerly Muslim	Kishanganj
7	Koyal	22	Hindu (caste unknown)	Kishanganj
8	Laali	22	Surapuri Muslim (General)	Kishanganj
9	Leela	24	Hindu (caste unknown)	Kishanganj
10	Meena	25	Adivasi Christian (ST)	Purnia
11	Nalini	23	Hindu (OBC)	Kishanganj pilot
12	Nargis	18/19	Surapuri Muslim (General)	Kishanganj
13	Nikhar	20	Surapuri Muslim (General)	Kishanganj

14	Nusrat	19	Surapuri Muslim (General)	Kishanganj
15	Poornima	20/21	Adivasi Hindu (ST)	Kishanganj
16	Priyanka	23	Hindu (General)	Kishanganj pilot
17	Punam	27/28	Adivasi Christian (ST)	Purnia
18	Radhika	18	Rajbongshi Hindu (OBC)	Kishanganj
19	Ranjana	18	Rajbongshi Hindu (OBC)	Kishanganj
20	Rita	22	Hindu (SC)	Kishanganj
21	Rubeena*	17	Surjapuri Muslim (General)	Kishanganj
22	Saloni	20	Hindu (SC)	Kishanganj
23	Saroj	19	Adivasi Hindu (ST)	Kishanganj
24	Savitri	23	Adivasi Christian (ST)	Purnia
25	Seema	21	Hindu (OBC), formerly Muslim	Kishanganj
26	Shabana	17	Surapuri Muslim (General)	Kishanganj
27	Sharmina	18	Surapuri Muslim (General)	Kishanganj
28	Sheela	21	Hindu (caste unknown)	Kishanganj
29	Sheena*	16	Surjapuri Muslim (General)	Kishanganj
30	Shyamolie	16	Adivasi Hindu (ST)	Kishanganj
31	Sonali	17	Surapuri Muslim (General)	Kishanganj
32	Sonam	21	Hindu (OBC)	Kishanganj pilot
33	Soniya	20	Adivasi Christian (ST)	Purnia
34	Subhadra	24	Hindu (caste unknown)	Kishanganj
35	Sumitra	26	Adivasi Christian (ST)	Purnia
36	Sunita	23	Adivasi Hindu (ST)	Kishanganj pilot
37	Suvidya	20	Adivasi Christian (ST)	Purnia
38	Tara	18	Rajbongshi Hindu (OBC)	Kishanganj
39	Tarana	22	Surjapuri Muslim (General)	Kishanganj

				pilot
40	Urvashi	19/20	Adivasi Hindu (ST)	Kishanganj

*Rubeena and Sheena were recruited only for focus group discussions as they were friends with the other members of the group and wanted to be part of the discussion, and this arrangement was welcomed by the collaborators and me as it was a sign of women's interest in and engagement with the research, and because it tapped into natural modes of group conversations as FGDs are expected to do (Wilkinson, 1999). Rubeena was soon to be married while Sheena was unmarried. They are not included in the participant figures elsewhere, which comprises 33 study participants and 5 pilot participants. The data from the pilot and the main study are not treated or analysed differently, as it was only the manner of recruitment that was different, while the interview questions kept evolving throughout the data collection period.

The age at which participants in the sample were married varied between 14–19 years. Although the age of husbands is not noted in the table, I tried to document it to understand the average age of men in marriages which are understood as early marriage for women. They were aged between 24–35, except one who was 20, and the age gap between women and men varied between 1 year to 17 years, and was usually greater in arranged marriages. It is important to note that the ages women mentioned for themselves and for their husbands were often estimated ages, as up until recently, it was not very common to record births and mark a child's date of birth in rural areas. Some of the participants referred to their national identity card (Aadhar Card) to give me their 'official' age although the age displayed on such cards itself was arbitrary as it was based on estimates and the cards made in the last few years and not at birth. Binita, Sangita and I encountered particular dilemma in recruiting Aruna who said that she was either 15 or 16. Binita and Sangita tried corroborating her age by calculating it in relation to theirs and some others but to no conclusive end. Eventually, we recruited her based on her interest in participation and because her participation (and her circumstances as a young married woman) was no different from her fellow participants who may have been sure of their age. The arbitrariness of age is relevant socially and analytically because it illustrates the gap between policies and popular discourses about the 'right' age for marriage and people's lived realities which are not governed by calculated age.

Most women in the sample lived with their marital families, comprising one or both in-laws, unmarried and married brothers-in-law (and their wives and children), unmarried sisters-in-law, and the occasional relative. Fathers-in-law were often absent as they had passed or their health was in decline, and were not significant social actors despite their erstwhile status as family patriarchs. The household also comprised the participants' children, most of whom were very young (0–5 years) and did not usually have a bearing on women's definition of their household, much as their gender was of significance. The birth and marital homes for most women were not very far away geographically but were poorly connected because of the lack of intra-rural roads and transport, making visits infrequent for most (although social restrictions on mobility too were at play here). In the study region, marriage usually happens within short distances because of limited geographical and social mobility and because the communities in Seemanchal (especially those represented in the study) are mostly concentrated in the region. This is considerably different from the more widely-studied North Indian context where marriage is often defined by long-distance migration. Out of the 33 study participants, 15 had husbands who were migrant workers in metropolitan cities and sometimes in nearby towns, reflecting the large-scale labour migration from Bihar (Iqbal, 2023).

3.3 Research tools and tensions

3.3.1 In-depth interviews and focus group discussions: Enabling fair participation

The research uses semi-structured in-depth interviews (IDI) and focus group discussions (FGD) as its tools, with the aspiration to do so in a feminist and non-oppressive manner (Acker, Barry and Esseveld, 1983; Letherby, 2003). IDIs suited the study because of the gap identified in literature on married adolescent women's sexual and reproductive health (Chapter 2, section 2.2), which typically studies age at marriage and reproductive health outcomes, missing the crucial space of the (gendered) marital relation itself, which requires qualitative exploration. IDIs were also desirable because of the potential sensitivity of the study themes, as they would enable privacy and confidentiality which other methods like participant observation would not, and for their adaptability, although they are arguably already structured. Their potential exploitative nature, particularly the risk of building dependency and signalling trust while mining for data, was noted and sought to be avoided. I

aimed to prioritise respecting participants' wishes or cues to avoid, circumvent or end discussions, and reassure them that despite the interview's interest in enquiring about household dynamics through examples, it was not a demand for information about their private relationships (see Appendix 3 for the interview topic guide).[14] The FGDs, which were designed to supplement the interviews, were chosen to introduce group interaction into the topic and also to enable anonymous discussions (Wilkinson, 1999). However, participants were not particularly concerned with anonymity in groups, and the FGDs became similar to the interviews in many ways, and compounded the arguments participants made there. The FGDs in fact reassured us that participants were comfortable in sharing the information that they did in interviews as they shared similar things in groups, or spoke similarly about their lives and families, suggesting that they did not grow emotionally dependent or distressed by sharing such things, although they sought help and intervention when they wanted to, and sometimes advice. These issues are further reflected upon in the section on research relationships below (Section 3.6).

In the initial research design, I planned to carry out two in-depth interviews with each participant, interspersed with a focus group discussion. This format was followed in the pilot, but the first interview with the pilot participants covered many aspects which were meant to be asked in the follow-up interview. As a result, the pilot participants did not have as much to share in the follow-up interviews but they approached it more informally and comfortably than the first interview, which encouraged me to retain the follow-ups for the main study, although eventually, they were very difficult to arrange logistically as participants were often unavailable and it was difficult for me to schedule time for reflection and analysis amidst packed days on the field. Only one participant, Radhika, participated in a follow-up interview.

The reasons for participants' unavailability present several issues of hierarchy in the research relationship, social and cultural contrasts, as well as reflections on the (sometimes) disorderly nature of research despite meticulous planning. Participants were unavailable owing to reasons ranging from seasonal work to pregnancy and birth to migration. A few of them had consented and participated while their migrant husbands were away and were reluctant to

[14] The interview topic guide, like the consent form and the participant information sheet, were originally in Hindi. Some linguistic subtleties may have been lost in translation but the guide represents the core questions and structure.

resume participation once their husbands were back. Restrictions on mobility, owing to childcare and household work, added to the hindrances. Festivals were another reason behind women's unavailability, as they typically fast, observe rituals, and make preparations for food and worship for the family. Of all the reasons, I made note of festivals as particularly irksome disruptions in my field diary. I tried to recognise that participants both valued and needed to participate in festivals for personal and social reasons, and that they were often unavailable because of increased workload at home during these periods rather than celebration. But at the same time, this reason often stood in conflict with what I considered to be a hierarchy of important events. This was compounded by the nature of certain festivals, such as festivals where women fast for the long lives of husbands, which are rooted in patriarchy. Conflicts of this kind over customs and beliefs, and sometimes superstition (the belief that it is inauspicious for daughters to travel on certain days of the week, for example), made it difficult for me to accept women's reasons for unavailability. This perhaps ran counter to my assurances during recruitment about participants having the right to pause, end or withdraw their participation without giving a reason at any point. I also started to realise that I found it irksome because it hindered women's participation in the study, rather than it being a conflict for feminist politics that I wanted to address or reflect upon comprehensively, in terms of what women's roles in such events mean for household dynamics, and how they shape women's gendered position in the household.

Apart from practical reasons for unavailability, the collaborators and I speculated that reluctance to continue participation could have been another reason, albeit not explicitly articulated. The reasons behind such reluctance may have been that participants did not have much to share in subsequent discussions or because they did not find it useful, or because the main interview was not in line with their expectations and my description of the project. None of the participants expressed outright reluctance to participate, and in fact, asked me to come back whenever I wanted to, but when I wanted to go back for FGDs and follow-ups, it was often difficult to reach participants over telephone calls and in-person. A couple of times, the participants asked me to visit at a particular time but would not be around when I visited. At the time of recruitment, when I would explain the right to withdraw, participants often said "Why will I withdraw?" or "Why will I have any complaints?" Participants said this after discussing the participant information sheet, giving me their assurance quite assertively. But because the consent process was premised on trust and assurance rather than the contract that

the consent form represented (even though it was always used), withdrawal was likely to be as complex as participants would not want to withdraw without giving me a reason.

An ethical issue that arises in carrying out research in India is that inequality, especially based on gender, caste and income, can disempower people in a manner where those being invited to participate may not realise that they can refuse to participate. A study with HIV patients in southern India, for instance, found that one-third of the participants were unaware that they could refuse to participate (Rodrigues et al., 2013). The Indian Council of Medical Research, which lays down guidelines for health research in the social sciences under its aegis, also locates vulnerability in situations where the participant is able to give consent but is unduly influenced by the expectation of benefits or by fear of retaliation (Indian Council of Medical Research, 2018). These factors may have been at play despite the assurances in the participant information sheet that one could leave the study without reason and repercussion. Dependency on Project Potential as an institution that provides services in the study areas, and on the church in Purnia as a spiritual and social resource (and my involvement in both institutions as someone who had a 'project' on their hands), may have led to fears about dropping out and potentially impacted consent. However, I also want to make note of the high level of informality with which participants approached the research, more so in a culture that does not run according to appointments and contracts. Their calendars, unlike mine, were not determined by the research activities, and they could have chosen to prioritise other activities and therefore, been unavailable for follow-up interviews and focus group discussions.

Eventually, the study involved 33 main interviews (25 in Kishanganj and 8 in Purnia), 6 focus group discussions (5 in Kishanganj and 1 in Purnia), and one follow-up interview (in Kishanganj). 17 out of the 33 interview participants participated in the focus groups, along with the two additional FGD participants recruited later. The interviews and focus group discussions were conducted by myself between November 2021 and June 2022. The collaborators (one each) were present in the FGDs as moderators. There were no COVID-19 lockdowns in the study region in the course of the fieldwork and generally fewer cases of COVID-19 as opposed to urban areas, and therefore, the pandemic had little impact on the data collection and the study's objectives and questions with respect to health and care.

3.3.2 A note on ethnographic 'elements'

The protracted recruitment process, especially in Kishanganj, meant that I spent long periods in the field outside of the days when I had specific activities planned. This length of time, along with the community-based nature of the recruitment also meant that I went through several gatekeepers and engaged with many people outside of the study sample. Such community engagement was compounded by the presence and role of the collaborators who often knew the families we interacted with in other capacities as well, and knew much more about the social dynamics of the place itself. I attended a few activities at the church in Purnia, including a mass as I happened to be around. In Kishanganj, I sometimes accompanied the collaborators while they did some other work (because we would then go for a research activity together), and once got unintentionally involved in a ration distribution drive by Project Potential. In such times, I tried to ensure that my presence would not have undue influence on women's desire to participate, their families' regulation of it, or on the data shared with me. I usually did this by making clear that I was only helping the team in tasks like ration distribution, when someone asked me about my role in an ongoing activity. At the same time, I did not exclude myself from such activities entirely as I was often asked or expected to participate and help out. The activities described here hint at what I call ethnographic 'elements.' While I did not carry out a methodical participant observation with a predefined cultural or social group, I interacted with several people and observed several activities which had an indelible influence on my analysis. Such influence is also seen in other qualitative works that use interviews, surveys and/or mixed methods, which I have drawn on, such as Chandra (2021), Mumtaz and Salway (2009), Roy (2017), and its methodological value is argued for or suggested in social science research by yet others (for example, Hampshire et al., 2012; Mannay and Morgan, 2015; Pinsky, 2015).

In keeping with this immersive relationship with my field, I have included some observations and some very brief interactions, such as things participants or their families did before or outside of the interview (in interacting with me). In three different interviews, I have also recorded what a sister, a mother, a grandmother, and a mother-in-law said as data, as what they said was valuable, not new or private information about the participant, and because it was said as part of the conversation, and built on what the participant was saying. The sister and mother's presence had made the participant (Sharmina) comfortable and encouraged her to speak further, as they often affirmed the things she said. In the case of the grandmother,

she was simply present doing her chores and was enthusiastic about her granddaughter's (Tara's) participation and my interest in the subject of early marriage. Koyal's mother-in-law was present as she was helping with the newborn baby while Koyal fed her toddler. She voluntarily left after some time and Koyal's demeanour or the nature of our conversation did not change in her absence. Apart from accounting for the participants' comfort, I have decided to include these interactions based on the nature of the informed consent process (which as I argue, was premised on trust and interest, rather than the paperwork) and the larger community-based data collection process, as well as data dissemination which I discuss in the following section.

3.4 Field activities: Interviews, FGDs, dissemination meetings

3.4.1 Interviews: The space and the speakers

The recruitment process was designed as one rooted in the community, and in practice too, it usually happened in the presence of friends and family, and so did many of the interviews. It is neither possible (owing to the architecture and social space of rural homes) nor appropriate to conduct interviews privately (owing to apprehensions around women's engagement with outsiders), nor always desirable by participants. When I arranged the first pilot interview, the participant assured me that no one would be home and that she would be able to make enough time. To my surprise, her in-laws were home, which made me think that there may have been some miscommunication, but with subsequent meetings with participants, I realised that privacy meant being comfortable in the presence of family members rather than being entirely alone. In the first few interviews, as I was grasping this understanding of privacy, I would ask participants (sometimes indirectly) if they were comfortable with those who were around, and they would often say "But it's only my sister" or "Can't she stay? She won't interrupt." Some participants requested the visiting collaborator to be present during the interview, especially if they knew the collaborator well. At the same time, some women also actively sought privacy, owing to embarrassment and awkwardness in discussing sexual and reproductive health, especially if the men in their households were nearby, while others sought privacy when those present made interruptions that they did not like, especially if it was about the research or about me.

In one interview, around five women from the participant's household and neighbourhood joined in, which made me unsure of carrying on, and I stopped asking questions to the participant directly. But at one point, when a new woman joined and asked why so many people were listening in, the women in the group promptly answered that these are things important for women to talk about and that they would at least like to listen. Eventually, it turned into a discussion on the wider impacts of poverty and addiction among men that women disproportionately bear, and recognition of the participant's particular situation.

Participation, in terms of agenda-setting, was not built into the design of the interview as participants were told what would be discussed, but as the above example suggests, they often 'owned' the agenda by choosing to discuss the theme or aspect most important to them, in relation to the study objective, and in the manner they wanted to. At other times, they also asked why certain questions were asked or not asked, indicating an engagement with the topic guide and the purpose of the study. The research, therefore, was participatory in an organic manner, and even in conflict with the nature of FPAR as planned participation. Other feminist research has also demonstrated the need for an open-ended approach to studying reproductive health, to include aspects of illness beyond specific issues and analyses beyond biomedicine (Basnyat, 2011; Chatterjee and Fernandes, 2014; Rashid, 2008; Wijesiriwardena et al., 2020). Wijesiriwardena et al. (2020), for instance, started their study on access to abortion in Sri Lanka by saying that they wanted to talk about abortion, but as respondents spoke about wider concerns about sexual and reproductive health and rights, along with sexuality, they recorded these interviews as they were, adopting the approach as a consciously feminist one.

The collaborators and I used the term *prajnan swasthya*, Hindi for reproductive health, but we followed it up with women's health, *auraton ki sehat*, to avoid limiting discussions to pregnancy and birth and to keep it open-ended, only mentioning that we wanted to talk about these things in relation to early marriage and health. Owing to this broad remit, and our position as women who want to talk to 'women's issues', a participatory approach developed organically as participants saw the research interactions as conversations (rather than a structured 'study') and spoke about what was most significant for them to share in relation to their health rather than strictly about reproductive health.

I am also wary of the extent and the consequences of my emphasis on 'participation' although, as I mentioned above, I am not worried that participants discussed things despite discomfort, because of the nature of their participation in the FGDs and the ways in which they negotiated their exit from the study (discussed above on page 79). My concern is less about the data they may have shared because of this skewed relationship and more about whether they wanted to 'participate' in a *research study*. Would participation in a programme or scheme have been more beneficial? Would an information scheme have been more welcome? I reflect on some of these questions in the study conclusion (Chapter 7) and also reflect on my exit from the field later in this chapter (page 93).

3.4.2 Focus group dynamics: Challenging ideas of sensitivity

The focus group discussions were designed to supplement the interviews, and particularly explore gendered decision-making practices with respect to reproductive health. The research involved 7 focus groups (including one pilot group), which were attended by 3-5 participants each. They usually took place in homes of participants where a small group could be accommodated. In Purnia, both FGDs took place in the church. I played the role of the key moderator in all the FGDs while the collaborators took notes and sometimes moderated as well. The discussions were based on a vignette, drawing on participatory feminist methods (Ayrton, 2020; Cross and Warwick-Booth, 2015; Gubrium, Krause and Jernigan, 2014). In the pilot, two different vignettes were used, one on contraception (women's sterilisation) and the other on abortion, and the pilot participants suggested using the second one as it would bring out a richer discussion.[15]

Based on the pilot, the scenario given to the study participants was: *Reena is a 19-year-old from rural Kishanganj/Purnia who has been married for a year. She finds out that she is pregnant but does not want to have the baby. What should she do next?* It was meant to prompt participants to build the story based on their experiences and the experiences of women around them, while maintaining confidentiality. The term abortion was not used in the vignette but it came up in the response almost immediately, and participants in all FGDs had conversations on abortion, body, decision-making, gendered authority and women's

[15] Only the second pilot focus group discussion, on abortion, has been used as data.

position in marriage.[16] Focus groups are used as a feminist tool as they are expected to reduce artificiality and decontextualisation by tapping into natural modes of communication and enable collective meaning-making, also making it more reciprocal and less exploitative (Wilkinson, 1999). Designing the FGD as a story-building activity was expected to enable women to share their perspectives on a subject (rather than their experiences) more easily than interviews which are based on questions that are designed by the researcher and are one-on-one interactions. For example, a study with adolescent mothers of Latin American descent in the United States used digital storytelling where focus group participants created personal narratives through pictures and short videos. The researchers found that the method enabled participants to move past the government-led top-down approach which sees adolescent pregnancy only as a problem, and to exercise agency by talking about things they cherished and things they lost in their journey as young mothers (Gubrium, Krause and Jernigan, 2014).

While the vignette approach was very helpful in enabling a dynamic discussion, participants often wanted to bring up personal experiences. In one of the first FGDs, one of the participants (whom I had stopped from sharing a personal example, reminding her of the potential confidentiality problem) asked towards the end of the discussion if she could now talk about her example because it was relevant and something she wanted to share with her fellow participants. The decision to use vignettes to enable confidentiality, therefore, was not always applicable as women saw the FGD as a place to share their experiences with each other. The example that I refer to above was about domestic violence, which the participant recounted with humour, which was echoed by the fellow participants. Humour and subdued laughter arose in discussions least expected (by me), such as getting abortions secretly, wanting to get sex-selective abortions, abandonment by husbands, neglect by families, and revenge by participants (strategic activities considered revenge, such as deliberately cooking improperly). These situations challenge the many concerns and regulations around dealing with ‘sensitive’ topics in research, which are related to relationships of power, violence and illegal activities. Grover (2018), in her study of kin support in love marriages among urban poor communities in Delhi, also makes the observation that family dynamics, discrimination, violence, and love were openly discussed among women and with the researcher. The categorisation of some of these issues as ‘sensitive’ is presumptively based on caste and

[16] The data from the FGDs is sparingly used in the study as it is sometimes very focused on abortion, meriting a separate discussion.

class-based (and patriarchal) ideals of propriety that regulate what women should engage in publicly (Sharma, 2011). Situations in which participants used humour or took initiative also challenged my concerns about participants' safety which may have been rising from paternalism on my part. For example, when I sensed risk to a participant because her husband did not want her to participate and was unhappy with me telephoning, I stopped following-up with her for the FGD, but she wanted to attend it despite the risk (which she recognised as a concern but did not label as a 'risk', a common English word used colloquially) and eventually attended it, saying that she had handled the problem in her own way.

3.4.3 Dissemination meetings

The fieldwork, more specifically the data collection period, was closed with two dissemination meetings, one in each district. These meetings had been planned at the outset as a coordinated event to share data themes, as part of the larger community engagement. The discussion in the dissemination meetings, therefore, supplemented the interviews and FGDs as it extended those conversations, although they were not recorded as data for ethical reasons and because they were not one-on-one conversations or organised group discussions. While several participants attended the meetings, they attended it as community members rather than participants and the particulars of their participation was not discussed to maintain confidentiality.

In Kishanganj, the meeting was attended by some of the participants, their neighbours and families, unmarried women and girls (they had particularly been encouraged to attend by their mothers), staff from the nearby health centre, the local auxiliary nurse midwife[17], and the headmistress of the school the meeting was held in. Early marriage emerged as the key discussion point in the meeting, especially in relation to women's choice and rights (such as love marriage) rather than but not divorced from health. In Purnia, abortion emerged as the main topic of discussion, as women wanted to use the meeting as an opportunity to learn more about safe methods and available services. The legality and morality of abortion was noticeably not discussed as it was common practice among married women. The attendees in

[17] An auxiliary nurse midwife is also a frontline health worker appointed under the National Health Mission. In the study area, they were in charge of vaccinations for women and children, and facilitation of institutional births.

both meetings were only women, as advised by the collaborators and some of the participants.

The dissemination meeting followed from a responsibility to keep participants and their families (who were usually invested in their participation) informed and involved, as they would often ask what the interviews and FGDs were for. It was also a means of reassuring participants that their confidentiality would be maintained and their information abstracted to themes (from which they could not be identified), and a means of assuring families that what the participants discussed would cause no harm or threat to their marriage and family. However, these meetings were also exercises in public engagement as it led to newer discussions and invited feedback on the data themes, some of which was incorporated into the analysis. For instance, in Kishanganj, there was extensive discussion on early marriage, with conflicting opinions. A few young married women (not necessarily married as adolescents) defended their decision to get married as a choice and argued that it is important for girls to be independent through education and employment so that they are capable of exercising choice in marriage. Others, especially unmarried girls and older women, suggested that girls marrying of their own choice restricted the freedom of other girls (as their families would fear elopement and dishonour). These conflicts and dilemmas have informed the study's analysis of early marriage and its consequences, especially in cases of love marriage. The dissemination meetings, therefore, acted as another site for participation and led to a discussion of different perspectives from different groups such as married and unmarried women, and health workers and the women they facilitated care for.

The dissemination meetings were the last field-based activity associated with the research, although the collaborators and I stayed in touch about the research for a little longer and continue to stay in touch in our personal capacities. Neither Project Potential nor the individual collaborators have any ownership of or access to the data, and have only been made familiar with anonymised examples and the data themes for preliminary analysis. The process of exiting the field, and its remnants, are discussed in Section 3.6.

3.5 Analytical framework: Constructivist grounded theory

The analysis is based on an interpretive process, drawing on some of the methods and principles of Charmaz's (2006) constructivist grounded theory (CGT). CGT was developed from Glaser and Strauss' (1967) grounded theory, which proposes that theory is obtained from data, and fits the data, rather than the data fitting a pre-existing theory or framework. The originality of the (researcher's) theory is proven by presenting the data as evidence for conclusions, and using a codified procedure to analyse data. Questions about the codes arise from the researcher's reading of the data and not from an earlier framework applied to them. The 'constructivist turn' in grounded theory notedly recognises the positionality of the researcher and emphasises creation and construction of theory, rather than its emergence (Charmaz, 2006).

A significant feature of both constructivist grounded theory and grounded theory is that it is ongoing and starts at the data collection stage, and the method allows the researcher to direct, manage and streamline the data collection. I consciously adopted the principles of constructivist grounded theory in the early analytical stages but the participatory design of my research, especially the pilot, allowed for an early reading of the data to assess the significant and developing questions and categories (from the perspective of the study population represented by the participants, and from my reading of the data). This process mapped on to the CGT method of theoretical sampling, as the emerging questions were then sought to be pursued in subsequent interviews. For instance, love marriages (and what they mean to participants) arose as a significant category in the pilot, and was subsequently incorporated into the study interviews as a lens to understand care. This process was also followed in the main study, logistically enabled by the punctuated design and nature of the data collection which allowed for periods of analytical reflection and initial coding. Coding, in grounded theory and constructivist grounded theory, attaches labels to segments of data that depict what each segment is about. One of the early codes identified was that of 'care', as the data on decision-making (which was how the interview originally posed the question) indicated that participants were talking about care or the lack thereof, rather than decisions. As discussed in Chapter 1, 'care' has a shifting articulation, owing to its development into a category through coding. CGT is also a comparative process, with data being compared with data, code with code, and code with category. Once I consciously adopted CGT as a method, I compared data with data to build the analysis. This is evident in the analytical chapters,

where I draw on multiple participants' differing or similar experiences of an issue (neglect, for instance) to develop an explanation of the processes that enable neglect. I also paid close attention to participants' special terms, or 'in-vivo' codes, noting that everyday terms in the data could indicate larger processes, and I read the data, particularly such codes, against the power dynamics that I discuss earlier in this chapter. I also used the memo-writing method (not in the CGT form initially) which enabled theoretical sampling and the development of theoretical categories.

Constructivist grounded theory emphasises that researchers 'hear, see and sense' everything while developing the analysis, which was a principle also made necessary by the ethnographic aspects of my research, and in reconstructing the data after the fieldwork as I did so in conjunction with my field notes. The interpretive nature of CGT also calls for an imaginative understanding of the data and the phenomenon under study, and "assumes emergent multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual" (Charmaz, 2006, p.126-127), all of which aligns with feminist ethnographic practice, notably by Visweswaran (1994) who asks researchers to recognise both situated and situational knowledges, arguing that knowledge may be produced in and for a context, and that recounting lived experience is not to be used to pin down truths but as a means of reading ideological constructions. CGT aligns with feminist research more broadly as it asks for the researcher's reflection on their positionality by emphasising construction rather than emergence of theory. In this manner, CGT also enables a relationship with the participants, which is an important feature and debate in qualitative feminist research.

CGT has been an important tool in re-engaging with the participants through the analysis, and by remaining close to the participants' specific terms, it has enabled their participation in building the theory. At the same time, I am cautious of labelling this as their voluntary participation because as researchers, "we choose the words that constitute our codes" (Charmaz, 2006, p.47). While in the field, I went over my notes after each interview, reconstructed them, and eventually began to notice parallels and contradictions between interviews, and/or between interviews and FGDs. At other times, I also noted parallels and contradictions between the data and what I thought about a particular instance or experience, or between the data and other feminist works on marriage and gendered relations. So, while CGT has allowed the study to represent participant's accounts closely, I note that the co-construction is initiated and built upon by the researcher.

I now extend this discussion of positionality and research relationships by discussing the specificities of my social position and what it meant for the fieldwork, and largely, for the research.

3.6 The research relationships

3.6.1 Identity, positionality and social relations in the field

During the recruitment and the interviews, when participants said that things were fine at home and that they were happy, they sometimes followed it up with "why will I lie?" Women said this while describing husbands and mothers-in-law as caring, their homes as comfortable spaces, and their lifestyles as satisfactory. "Why will I lie?" was not prompted by specific questions but by my presence and position in the field as an outsider from an urban and relatively upwardly mobile location. I was also perceived as an NGO representative, which in turn is perceived as an institution that identifies and solves problems for people. Most participants shared and discussed 'problems' of health and household relations quite willingly and not always with expectations of solutions from me, but when it came to the positive aspects of their lives, they wanted to qualify and reassert what they were saying. I attribute this to the general idea of quality of life being better for those who live in urban areas and are educated and mobile, as opposed to those in rural India, especially women, who are often stereotypically characterised as helpless. When participants felt the need to insist that they were not lying about their lives or aspects of it being good, it was reflective of this chasm and power dynamic. The other space where this power dynamic was reflected was in my conversations about the research with people from my social circles, who would sometimes ask me if the women I engaged with were 'aware' of health needs and issues and if their situation was any better than what it (presumptively) used to be. Women insisting that their household situation was good, especially in the context of loving husbands and mothers-in-law also seemed to be their way of displaying affinity and identifying with their families (while honestly describing their household situation too), as opposed to the collaborators and me as researchers, social workers, outsiders.

If participants positioned themselves in opposition to me as a researcher and an outsider, they also positioned themselves in the same social bracket as me owing to my gender as a woman, and also my age which was only a little higher than those of most participants. In interviews,

participants often used the common phrase “you know how it is”, indicating commonality of experience or simply knowledge of such experience as young women (despite differences of caste and urban-rural location). Participants sometimes assumed that I was married (which I am not), in talking about shared experiences, but did not entirely retract their stance of “you know how it is” when I clarified that I was not married, as heteronormative marriage is near-universal and the experience of it known even by those who may not be married.

Religion and caste were also highly consequential, in an all-pervasive but normalised manner. Families, especially older members, would sometimes ask me what my religion was to invite me to dine with them. Sometimes, it could be unintentionally inquired about or made evident by asking me if I would eat meat (and the kind of meat), a strong marker of caste and religion in India. At other times, affiliation with caste and religion would arise in conversations about customs and festivals. Direct questions, comments and references to one’s caste and religion were common, as they are in social life, and did not indicate tension (from my perspective). But a more value-laden way in which the association with caste and religion played out was when participants, collaborators, health workers and others in the field, made stereotypical and derogatory comments about specific groups, with the assumption and confidence that it was safe to make such comments in my presence (especially when they knew or confirmed that I was Hindu, and then positioned Muslims as a ‘problem’ group). In some of these cases, especially if it involved the collaborators or PP associates, I would discuss it further and challenge it. In other cases, when it involved health workers or those I was only intermittently associated with, I would cut the discussion short or circumvent it. But it was with participants that I found this discussion most difficult to navigate, as I did not want to challenge them but still wanted to address what they said through a follow-up question which might prompt another perspective from them, or through general discussion in larger meetings like FGDs or dissemination meetings (Letherby, 2003).

Social identity among participants and in the area came up in several interviews and focus group discussions, and in other field interactions. They emerged in the form of conversation starters, questions, complaints, and even explanations—for instance, a participant could argue that another woman’s experience is a particular (negative) way because of her social identity. Dominant Hindu and Muslim groups particularly targeted Adviasi groups, both Christian and Hindu, with derogatory and stereotypical comments, as they were considered different from non-Adivasi or ‘mainstream’ communities. A lot of such targeting was to do with the

differing value systems among Adivasis who fall outside of the caste system that is followed in different forms and measures among Hindus, Muslims and Christians in the region. For instance, as I note in this chapter, love marriages were common among Adivasi communities, as was briefly living together before marriage, which was seen as a sign of immorality and impropriety by others. Adivasi households were also materially poorer than most other communities, which furthered their marginalisation, particularly by landowning Muslim and Hindu households. Adivasi women, because they were engaged in paid labour outside of the home, were not easily available to participate in the study, which became a 'problem' for the logistics of the study, which, as the collaborators noted, was not a problem among Muslim women in Kishanganj. Framing the unavailability of Adivasi women as a problem, as opposed to the availability of Muslim women, overlooked the socio-economic background and material conditions of Muslim households in the region, which were much better off than Adivasi households (and was the reason why women in these households did not have to engage in long hours of manual labour). Discussions like these were taken up with the collaborators during the fieldwork and also shared with the larger team at Project Potential, as they wanted me to bring field observations back to them as an outsider and a researcher studying their fields and networks. However, tensions around caste and social identity remained and it was only possible to address and alleviate them because we had the space of an NGO which premises itself on social justice and creates the space for collective engagement, even if not substantially realised. Caste, therefore, was co-constitutive of gender and always present in the field as it is in everyday life.

3.6.2 Risk as a reflection of research relations

Risk to participants was identified as a potential ethical concern in the research, especially in the form of backlash from families if they perceived participation as a transgression, an unnecessary activity or an activity that harms the family (Dasra, 2019). Additionally, participants could be at risk from me or my position as a researcher with access to their data and association with a university in the global north (for instance, the risk of data travelling to places that participants didn't expect or were not told about). There was one case where the research, in my opinion, exacerbated the risk of violence for a participant as her husband did not approve of her participation. I say 'in my opinion' as the incident was not recounted as 'risk' by the participant in question who also said that she 'dealt' with it (referred to earlier in the chapter on page 85). For some other participants, risk from families did not materialise as

violence but as suspicion that the participants were up to something by meeting me repeatedly or visiting the health centre repeatedly, which potentially compromised their future mobility. In two cases, I cut short the interviews realising that my visits and interactions with participants' family members was leading to potential discomfort and tension. However, there was always a fine line between creating the conditions where participants could participate (like talking to their husbands when they requested) and interfering in their marital relationships (which husbands could construe my approach as). In all of these cases, the collaborators were better positioned to speak to husbands and families, as they often knew them and had a more permanent presence than me, and as I mention earlier, were encouraged by their position as NGO workers.

In two cases, participants requested help in protection against domestic violence, and in a third case, in filing for a divorce. For all three, the collaborators and I suggested putting them in contact with a regional NGO working to prevent and address domestic violence against women, and providing legal aid to them. One of the participants, who spoke to the NGO, albeit reluctantly, wanted the collaborators and me to intervene by speaking to her husband and 'warning' him. I was sceptical of this as I feared that it may put her at additional risk (as backlash for getting an outsider involved) but she insisted that I visit her and meet her husband, which itself might 'scare' him as he will realise that she knows people who work for women. While many participants told their husbands about their participation for advice or permission, the participant in question here had informed her husband about her participation as a threat: *I am going to tell these people about everything that you do.* Rumi and I visited her in her marital home thrice, once in the presence of her husband, and we spoke to him (about her general well-being) and assessed her situation and safety. After this, the NGO was again contacted at the participant's request, the details of which are not documented as part of the study to respect her privacy.

The collaborators and myself, especially myself as participants knew that I was leading the project, therefore, symbolised authority for participants and their families and communities. For some participants, this new social relation was leveraged to improve their status and position in the household, which meant that our authority did not affect them negatively, but for others, it may have signified a distance which they did not want to breach. For me, as the researcher, it created a huge responsibility to not exploit the authority intentionally or

unintentionally but to use it when it could help participants move towards a goal, while ensuring that it does not lead to harm in the long run.

Stacey (1988, p. 23), argues that feminist ethnography can be more oppressive than positivist traditions because the researcher's entry into the field is "an intrusion and intervention into a system of relationships" which the researcher is more free to leave, and therefore, it can lead to betrayal, echoing Letherby (2003) on qualitative methods widely. My relationship with the field, after exiting it, continues to reflect this risk. While I stay in touch with the collaborators and have visited Project Potential since, I have minimal contact with the participants (two of whom have since contacted me for reasons unrelated to the research, mentioned below), and often wonder what they might remember and make of the project and how far removed their embodied selves are from it at this stage. Wickramasinghe (2010) raises the question of where the feminist researcher's responsibility of raising consciousness begins and ends, given the intersecting inequalities that characterise research contexts. If the consciousness-raising goal of feminist research is fulfilled but individual participants are unable to take action in their personal lives and as a result, are subjected to threats or deprivation, then "the aim of political action may be fulfilled, but what of the ethical?" (Maynard and Purvis, 1994; Wickramasinghe, 2010, p. 159). The research, in some ways, appears to have ended with the political action of 'consciousness-raising', which we collectively on the field did by naming a problem—women's care—and unravelling it. This is not to suggest that women's landscape was devoid of consciousness and action before the research but that the research was a designed intervention into that landscape, and hence, was an exercise in consciousness-raising. The ethical action that Wickramasinghe (2010) asks of, remains unknown, as the researcher(s) are no longer in the (specific) field, although perhaps subsequent contact from participants to seek help with domestic violence and to facilitate divorce may count. Roy (2021), reflecting upon her ethnographic doctoral project with those in diametrically lesser positions of power, writes that:

> "Perhaps it is only when researchers acknowledge the inconsequence of their engagement that they can attempt to disrupt the hierarchies between researcher and researched. The nonchalance of many participants towards academic research practice can constitute counter-hegemonic assertion and disrupt the elite structures of institutional knowledge production processes that sanction ethnographic research."

Roy (2021) also calls into question the positioning of the doctoral thesis over the relationships built with the participants, which is the positioning that I refer to when I think of the distance between the thesis and the participants' embodied selves.

A sense of personal investment, ownership and attachment, has been inevitable in my project, and as Roy (2021) argues, it is a question of feminist practice and, sometimes, guilt. Following DeVault (1990), I value personal investment in terms of (feminist) experience as the research shaped and challenged my personal (and inextricably political) values around marriage, household and gendered relations, and allowed me an extended period of meaningful and often fulfilling time with fellow women. But I also value personal investment as a methodological practice, recognising that it has led to co-creation of meaning. Such personal investment is reflected in the manner in which arguments are identified and concepts like 'care' and 'agency' named, through the technical method of constructivist grounded theory which equally recognises the researcher's particular role in co-construction, and through the specific tools such as ethnographic observation.

3.7 Conclusion: Finding action

To conclude this chapter, I come back to the discussion of locating action in the research. In the course of the fieldwork, I thought of action in relation to the specific methods of FPAR, and more widely, in terms of the implications of the research for the participants, in conjunction with feminist reflections on action discussed above (Letherby, 2003; Roy, 2021; Wickramasinghe, 2010). It was a question that arose from participants' expectations and from my own expectations as a feminist researcher, where I often asked myself "what are we *doing*?", especially while in the field.

I started out with the idea of action as social change, while not assuming that social change was not happening or not possible before and outside of the research. Reid, Tom and Frisby (2006) argues that an idealised understanding of action as social change can disregard smaller and achievable personal or local actions. Action, therefore, is a multifaceted and dynamic process which can involve speaking to validate one's experiences or taking a step towards changing one's circumstance, and significantly, is not presumed to have begun by participating in research. It can be argued that the research was action-oriented or

action-enabling for some participants who mentioned that participation gives them a chance to share their problems, a good reason to leave the house and housework, and an opportunity to learn something new (which several participants expected from participation). As discussed before, selected participants also sought separation from their abusive husbands and intervention to stop domestic violence, through the study's channels. While the decision to separate or seek intervention was not an outcome of participation, activities associated with the research (interviews, FGDs and informal meetings) were spaces where such decisions could be discussed and supported. These individual acts—ranging between taking a break from household work to seeking separation—happened in a gendered social context, and involved navigating household dynamics, and included transgressions when women participated despite resistance or lack of encouragement from their husbands and families. Women's participation in the study itself, therefore, may constitute action. In field interactions, women in the study area generally, outside of the cohorts of participants, also articulated their hopes and plans for change in community meetings and casual field visits, reflecting individual aspirations that were rooted in collective experiences.

I am wary of subsuming all of these examples under 'feminist action' because it was not necessarily perceived as (political or organised) action by the participants and by other women. Moreover, many participants, despite appreciating that the research was an opportunity for social interaction and public participation, often asked "what will happen or what will you do, now that I have shared these experiences?", which indicates that they expected action to be something more tangible and collective, and circles back to my question of "what are we *doing*?"

'Finding action' remains an ongoing conversation in feminist research, and in this study, it is a conversation that is deeply influenced by the collaborative nature of the study as I was always offered new and different perspectives on academic research by the collaborators who were researchers, activists, and women with experiences related to early marriage. The research, therefore, was an opportunity for me to engage with feminism and intersectionality in the everyday, importing these philosophies and frameworks to a place outside of research conventions, where they were adapted and developed. The chapters that follow this chapter will demonstrate how the methodology, including the analytical framework, operationalises a feminist construction of knowledge about women's care.

Chapter 4

Unpacking young married women's conceptualisations of health

4.1 Introduction: A social constitution of body and health

This chapter analyses the ways in which young married women make meaning about their health in the context of marriage and the marital household, especially in relation to their gendered position and role within these sites. Such meaning-making is built on women's experience of their bodies as both individual and collective bodies, and their engagement with health systems and predominant discourses on (reproductive) health in their communities and in public health messaging. The chapter builds on conceptions of the body as an entity that is socially inscribed, and conceptions of health as an experience that is at once individually embodied and socially constituted. (Scheper-Hughes and Lock, 1987; Mathur, 2008; Thapan, 1995; Sabala and Gopal, 2010).

The socially constituted experience of health is reflected in research on health inequalities which has consistently found that women from marginalised backgrounds—deprived castes and classes, minority groups, and rural backgrounds in the case of India—have poorer health compared to those from dominant castes and higher income groups (Dommaraju, Agadjanian and Yobiku, 2008; Saroha, Altarac and Sibley, 2008; Verma and Acharya, 2017). In my research, participants made meaning about their health in the context of marriage and the marital household, as mentioned above, but they also embedded marriage and the marital household in their wider social contexts. Participants described their experience of health within marriage through the experience of poverty, rural residence, forms of labour, and the intersection of these factors with gender dynamics and gendered relations. In the field, women often positioned themselves in opposition to an 'other' (typically another social group rather than an individual, or attributed the otherness to the individual's social group) whose life and health was defined by manual labour, discrimination, uncontrolled fertility and unstable relationships. This was often encapsulated by "it is not like that for us" and "these things happen in your/their caste." Likewise, they also positioned their embodied selves in opposition to those whose life was determined by material comfort. For instance, a participant's relative, during a recruitment meeting, remarked how the ideal weight and body

would be different for me as I came from an urban location and had a different lifestyle, much as I would (presumably) share the common experience of reproduction with women in the study area. Such meaning-making corresponds to Scheper-Hughes and Lock's (1987) conceptualisation of three perspectives from which the body may be viewed—as a phenomenally experienced individual body-self which is distinct from other bodies, a social body which serves as a symbol to make sense about relationships between nature, society and culture, and a body politic which is produced through the wider politics which regulate bodies individually and populations collectively. The authors also weave emotion (rooted in culture rather than biology) through these three perspectives on the body.

My analysis takes note of the body as a sum of these 'three bodies', and health as an experience produced and lived through these interlocking sites, but I emphasise the social, as conceptualised by the study participants. This understanding of the social aligns with Scheper-Hughes and Lock (1987) but it also involves making sense of body and health in a collective manner. While there is significant discussion on collectivism in Scheper-Hughes and Lock (1987), it is located in culture rather than everyday lived experience. The collective element and language is a striking feature of the literature on women's body and health from India, perhaps because of its association (or the association of its writers) with women's movements, but it is also evident in anthropological works in India and beyond (Jeffery, Jeffery and Lyon, 1989; Qureshi, 2020; Unnithan-Kumar, 2010; Van Hollen, 2003). I use Van Hollen's (2003) ethnographic work on modernity and medicalisation of birth from Tamil Nadu in southern India to explain this further, as it explicitly makes the argument about women's experience being collective, beyond phenomenological. Van Hollen (2003) argues that the women in her study were not opposed to allopathy and technology but to the institutions and actors that operationalised medicalisation. Women, therefore, were not concerned with the aggressions of the medicalised health system on them as individuals (although the individual body was the site where they experienced it) but on what it stood for—the further marginalisation and disciplining of the poor and 'lower' caste woman's body.

> "And rather than feeling as though the individual phenomenological knowledge of their bodies was being discredited, many women felt as though the collective knowledge of their bodies and of the bodies of their babies was being not only discredited but ridiculed and deemed dangerous, even criminal. Their critique was not so much a lament over the loss of the individual's experience as it was a

> condemnation of how their collective rights were being denied" (Van Hollen, 2003, p. 172-173).

This articulation of individual health experience as collectively rooted is significant to the analysis as this chapter does not only ask how health is conceptualised and experienced individually but also what it says about women's gendered position, or how women conceptualise it as a commentary on their gendered position.

The social, according to the participants' articulations, accounts for the different dimensions that inform their everyday circumstances—local conditions, material resources, and gendered relations and dynamics. These articulations often align with empirical works from India and South Asia such as the Kielmann and Bentley's (2003) work on 'thresholds of morbidity' and Qureshi's (2020) explanation of 'some babies cannot be stopped from falling', and works that study tension as an idiom of distress, and more widely, literature on social determinants of health (see for example—Basnyat, 2011; Chandra, 2021; Rashid, 2008; Sanneving et al., 2013). However, unlike the social determinants framework which proposes 'causes behind the causes' of health and illness such as socio-economic status, rural-urban residence, level of education and environmental factors (Marmot and Wilkinson, 2003), participants proposed 'associations' between social circumstances and their health, rather than demonstrable causes such as caste, income, or gendered relations. In other words, the emphasis was on the *processes* through which factors like caste, income and gender influence health, rather than the factors themselves.

The social constitution of health is also typically the social constitution of illness, as illness is the register through which people make sense of health. This chapter, therefore, uses health to mean and understand illness as well, as participants mostly responded to the opening interview question on health through discussions of illness. The social constitution of health also does not exclude biological aspects of health, which research studying the social in relation to health has to be cautious about (Monaghan and Gabe, 2022). Participants often described a health concern through the English 'problem' or the Hindi/Urdu *beemari* (illness), denoting something that requires care, especially institutional care. Intensity and urgency of the problem, along with availability of care and access to care became central in defining a health problem as a medical issue. At the same time, women perceived their health needs to be wider than health 'problems' that could be (potentially) fixed through

institutional care. Health needs, understood as *kami* or lack, encompassed everything that women believe they needed for good health and well-being—money, facilities, rest, social support, and a harmonious home environment and interpersonal relationship with their husbands. Health needs, therefore, are ongoing, subjective and dynamic, and exist even when a woman may be healthy in a medical sense.

The chapter is divided into two broad parts. The first part, comprising Section 4.2, explores how health is experienced in terms of the social, by highlighting how participants placed their experience of health in their social relations, and how patterns and perceptions of health corresponded with their household dynamics. The chapter then looks at experiences of health specifically anchored in the household, articulated through weakness and tension, and also asks what talking about weakness and tension means to women. The second part of the chapter, comprising Sections 4.3 and 4.4, looks into the relationship between early marriage and reproductive health, by centering participants' construction of this relationship, which locates health as a problem of marriage itself, and extends it beyond reproductive health. Finally, the chapter looks into what makes pregnancy and childbirth central to the health of young married women, from their perspective, beyond the literature and the public health approach that identifies it as a significant site of study.

4.2 Embedding health in the household

When participants described health problems, they spoke about the physical pain and discomfort that they went through along with the feelings of sadness and anxiety that the issue had caused or exacerbated, often leading to a discussion of the social circumstances that may have intensified the experience of the issue. They did not immediately name conditions when describing what had happened, possibly because of the gap between biomedical and regional terminologies, dualities between medical and lived experiences, and the power hierarchy in doctor-patient interactions which obscures diagnoses and treatment (Fochsen, Deshpande and Thorson, 2006; Iyengar, Pelto and Iyengar, 2016; Monaghan and Gabe, 2022; Sabala and Gopal, 2010). In some interviews, the participant and I tried to establish the condition after going back and forth on terms and symptoms, but the participants' focus seemed to be on the feelings associated with the symptoms. Apart from embodied feelings, they also spoke about the practical hassles and economic costs of accessing care. And lastly,

they spoke of the role played by husbands and families in their recovery and ongoing care, or the neglect practised by them. Health, therefore, is experienced in the body (through discomfort and feelings) and made sense of in the social context in which it is being experienced, or in relation to the institutions and gendered relations that the body interacts with. This articulation of health also speaks of the indivisibility of physical health and mental health, and embeds health in marriage and the marital household, which, in this study, is identified as the key relation and site which shapes the immediate social worlds of women.

4.2.1 Weakness as a problem that encapsulates multiple dimensions of health

The embeddedness of health in the household, and the indivisibility of physical and mental health is most prominently understood through participants' accounts of 'weakness.' There were some common expressions that participants used to describe their health, the initial expression often being "*theek hi hai*" which translates to "it is okay", but in a punctuated manner, indicating that one's health status is okay, but not ideal. It could be followed up with there not being any health 'problem', referring to an absence of illness but indicating that there was something wanting. *Theek hi hai*, however, was fairly subjective as it could be followed by the participant sharing that they sometimes had fevers and coughs, which was universally accepted among participants as something minor and common, with easily accessible remedies. At other times, it could be followed up with something major like a difficult pregnancy or birth, miscarriage, or long bouts of ill-health. *Theek hi hai* was sometimes an expression that came up together with an articulation of weakness. "*Wahi kamzori*..." which is to say "same old weakness" or "you know..weakness", perhaps indicating how there is nothing new, unique or specific to discuss. The discussion that follows, drawing out from weakness, helps understand the dynamism in meaning-making about health, demonstrating how it is made sense of through embodied feelings and through shifting perceptions of the social. The discussion on weakness also affords us to ask what weakness (and its many explanations) stands for and means for women to experience and to speak of, or not speak of.

The first and the most common definition of weakness as articulated by participants was its embodied experience—physical strain on the body, accompanied by dizziness, and a simultaneous feeling of being in distress, uncared for, and helpless (not helplessness in an immediate sense but in the sense of having no possibility of respite). The persistence of

weakness, therefore, was the most striking and distressing part of it. Some of the participants were or had been on medication for weakness, supplements locally available as *takat ka dawai* (medicines for strength), but weakness was something to manage rather than recover from, with the exception of weakness in the traditional postpartum period which was especially attended to.

Despite its prevalence and persistence, weakness was not listed as a health issue in the first instance in interviews unless it was debilitating or if the participant was seeking treatment for it. To understand this incongruence between weakness being a common concern yet not coming up as a health issue, I started asking participants if they were able to carry out their daily routine without difficulty—typically involving household work, childcare and paid work, and sometimes leisure—to understand if they experienced any weakness and if it inconvenienced them in any way. I recognised that the daily routine of participants was itself a cause or exacerbator of weakness for many, but by asking them if they could do their daily work, I sought to establish a threshold for weakness based on the factors that shaped them. The second definition of weakness, then, emerged as the inability to carry out the activities that one usually does. Research from South Asia shows that women consider not being able to do their daily work to be a sign of illness (Basnyat, 2011; McCauley et al., 2020). Kielmann and Bentley (2003), writing about thresholds of morbidity, also show that women see their work as a cause of illness, but, at the same time, see not being able to work as a sign of being ill.

> AA:…And what about weakness?
> Kaveri: Weakness, hmm, if you do household work, you will have some weakness in your body.
> AA: Hmm, I suppose.
> Kaveri: I don't feel that weak that I won't be able to do anything. If you can't do anything, lift anything, then that is called weakness. But if you can do it, and you eat well, then it's minor.
>
> (Kaveri, 21)

A third definition of weakness was that it is bound to happen with some amount of household work. Participants expected a certain level of tiredness and weakness because of

physically-demanding and time-consuming household work. The resultant weakness was usual and bearable for some but debilitating and unacceptable for others, depending upon their circumstances in their household and the support they had or did not have, rather than only the intensity of the work and their individual health status. I argue that weakness was not normalised even by those who believed that it was expected or those who did not mention it in the first instance, because it was still recognised by them, and was associated with household work and the gendered nature of its burden. Kiran's experience of weakness, below, locates weakness in household work, and also in the larger background of gendered norms in marriage. I also pay attention to the consequences of this experience for Kiran.

> AA: Can you give me an example of a time you were unwell? What happened and what did you do?
>
> Kiran: Sometimes I get a fever, I take medicines or go to the doctor..what else?
>
> AA: What about your pregnancy?
>
> Kiran: I did not have any problems during my pregnancy.
>
> AA: And what about weakness?
>
> Kiran: Not that much.
>
> AA: What I mean to ask is, do you have problems with your daily chores because of weakness?
>
> Kiran: I get tired but I still work..(*laughs*) You have to do some work in your marital home, after all.
>
> (Kiran, 19)

Kiran did not challenge the source of her weakness because it did not happen in extraordinary circumstances. Her husband and in-laws did not force her to work and did not deliberately increase her workload, so the work she did was usual and perhaps instrumental in maintaining her position as a loved daughter-in-law, especially when she did it without complaint. She also had help and support from her birth family who lived in the same neighbourhood, alleviating the feelings of helplessness that some other participants associated with weakness.

Among those who recognised weakness as a debilitating problem, a few challenged the circumstances that led to weakness. For instance, Urvashi threatened her husband with going back to her birth home because she could not handle the amount of work which his parents (her in-laws) expected her to do. She asked her husband to separate their household from the in-laws (live as a separate financial unit) because it was not possible to sensitise them to her experience of weakness. While he took the initiative to separate their household, they continued to live in the same house and share common spaces as well as tasks (between the women of the household), but to a lesser extent than when they lived together. Sharmina, similarly, asked her husband to intervene to lessen her workload which was causing her immense weakness. She believed that her in-laws deliberately made her do things that would harm her, such as fetching water from elsewhere when it could easily be arranged for in their own home. Her husband, however, did not intervene, and she continued to have to do all the work. While her complaint was about her weakness, it was equally against her in-laws for perpetrating harm and her husband for not taking any action.

In some other instances, the circumstances that led to weakness were not challenged or resisted at all because there was no space and scope to do so. For instance, Saroj did not consider speaking to her husband because he was uninvolved, being away as a migrant worker and more generally and because there was no foreseeable alternative given her position as the only daughter-in-law in the household. She also did not see speaking to her in-laws to lessen her workload as an option.

> AA: How is your health generally?
>
> Saroj: I used to feel very dizzy, I took medicines worth 600 rupees (approximately 5.76 GBP) for that. Now it's fine.
>
> AA: Do you still feel weak? Do you manage your household work easily? (Saroj had already mentioned having severe blood loss and weakness as an outcome of a miscarriage in the beginning of the interview, and later mentioned a subsequent miscarriage.)
>
> Saroj: It's a bit difficult to manage two kids and also do the household work. I have to do all the work, I'm the only daughter-in-law. In-laws are not going to understand that, they will think I'm being lazy. I did all the work when I had a difficult pregnancy also.
>
> (Saroj, 19)

Saroj made sense of her weakness in relation to her physical symptoms, the expenditure incurred in accessing care, and the reasons she had to do household work—because of social norms of labour and the disbelief and neglect that her in-laws' harboured against her. She also mentioned miscarriages, loss of blood, 'bad' blood, all of which provide medical explanations for her severe weakness, and were experienced in the social backdrop of her in-laws' neglect and her husband's lack of involvement.

Like Saroj, several other participants also mentioned symptoms and diagnoses alongside social dimensions, or presented symptoms and diagnoses through social dimensions. For instance, when Ranjana was diagnosed with anaemia during a routine antenatal check-up, she did not tell anyone nor adhered to the precautions she was advised by the health worker because she could not afford to pause her daily wage work and could not afford long-term medication. While financial pressures were salient in her compulsion to not seek further care, the reason she did not tell anybody was because her husband would not have cared (his lack of involvement in the pregnancy and her mother-in-law's outright rejection of care had signalled this to her) and her birth family could not afford to do much for her care (and to an extent, *would* not, because it was supposed to be her marital family's responsibility—a line of argument discussed in Chapter 5). Ranjana's experience of anaemia itself, and of the diagnosis, was not very significant in her interview. It was spoken of as part of a series of technical events that I had asked her to recount, such as which health facility she had visited and what procedures she had undergone. Ranjana recognised that she had had, and probably still had, anaemia but made sense of her symptoms (like dizziness) in response to her household circumstances, or as "everything going on at home", an expression that I explore later in this section.

According to the National Family Health Survey-5 (2019–2021), 63.5 percent of women in Bihar aged 15–49 are anaemic. At the national-level, the corresponding figure is 57 percent, and both the state and national-level figures for the same period are slightly higher at 65.7 percent and 59.1 percent, respectively, for women aged 15–19 than for women aged 15–49. (IIPS and ICF, 2021). Drawing on these figures, I would sometimes mention the high prevalence of anaemia among women in India in the interviews to understand if participants were associating weakness with anaemia, both as an outcome of anaemia, and more broadly, as a concern located in medical issues. Anaemia turned out to be the most common diagnosed

condition among the participants (reported by 10 out of 38 women), typically diagnosed during antenatal check-ups and characterised as less blood or bad blood. But like Ranjana, most participants mentioned it only briefly in recounting their recent health history, or briefly in relation to weakness and dizziness, both common registers to convey anaemia in India (Bentley and Parekh, 1998; Chatterjee and Fernandes, 2014), because the diagnosis of anaemia was a singular event while the experience of weakness was pervasive. Some participants were taking iron supplements for anaemia while others had taken them in the past but stopped because they were expensive. The medical encounter, therefore, was brief, unlike the everyday embodied experience of weakness, which corresponded with the social dimensions of their lives, characterised by the gendered relations of the marital household. The example of anaemia, therefore, allows us to locate the social in medical explanations of weakness.

Chatterjee and Fernandes (2014) also found that anaemia was normalised as a part of pregnancy because of the belief that the pregnant body was providing for two bodies. Additionally, older women in the community had not sought treatment for it during their pregnancies, and hence, it was not categorised as a health issue even though it impacted women's health status. In my study, anaemia was neither normalised nor considered alarming, it was only one of the factors that aggravated overall ill health. Bentley and Parekh (1998), in an earlier study on perceptions of anaemia in four Indian states, found that women attributed anaemia to repeated pregnancies and a poor diet because of poverty but also because they eat last, a clear outcome of gendered household dynamics, although the study does not look into it further. A study on perceptions of iron and folic acid supplementation among frontline health workers in Bihar found that they did not consider anaemia to be widely prevalent among pregnant women. The health workers also believed that the reasons behind anaemia were poor diet, frequent pregnancies and lack of rest, which they in turn attributed to poverty, lack of awareness, low priority of women's status, and family tension (Wendt, Young and Marorell, 2013). The health workers' perception of anaemia and action to counter it also echoes women's perception of it as a concern located in the social circumstances of their lives. Following from anaemia, which is an example of finding the social in the medical, I turn to 'tension', where overlaps are found between mental and physical feelings, and associations between social stressors and physical symptoms.

4.2.2 "Everything going on at home": Overlapping tensions of the body, mind and household

Kaveri's experience of her health was the experience of her marriage and household, and vice versa. Her health saw periods of highs and lows, often corresponding with the social circumstances and relations of her marital life. I use an excerpt from Kaveri's interview to illustrate how health is made sense of in everyday life rather than instances of care-seeking or periods of illness alone, and how mental health and physical health are indivisible in the experience of tension, even if they may be affected by parallel concerns.

> AA: Can you give me an example of a time you were unwell, after your marriage?
> Kaveri: Before I got married, I did not have any health problems. Two months after marriage, I had a lot of problems. First, I got married at a young age, so it had an impact. Second, there was some tension at home at that time related to our marriage.
> AA: At home meaning, birth home or marital home?
> Kaveri: Marital home. There was some discussion between them.
> AA: Discussion between them meaning?
> Kaveri: Meaning between my birth family and marital family. It was a love marriage, so both parties had not consented to it. After we had sex, two months after the wedding, I fell ill. Before that, I did not have any problems. After that, even when my periods would come it was bad, so they were both bad.
> AA: Sorry, I didn't understand what you meant by both being bad?
> Kaveri: Parents/pains (inaudible)
> AA: Parents..?
> Kaveri: Yes, both were bad at the time.
> AA: You mean both sets of parents were unhappy?
> Kaveri: Hmm, they were both unhappy. So when I fell ill after those first two months, I was quite sick, so I took advice from my husband. One has to take advice from one's husband. I spoke to him and then after a mutual conversation, we realised that we should go see a doctor. My husband just wanted me to get better soon. So we went to a nearby doctor for advice, not very far. With the medicines we got from there, I started to feel better. The doctor said that this happens when people marry young, when younger people have sex, it leads to many kinds of problems. The doctor advised us to think and be careful before doing anything.
>
> (Kaveri, 21)

Kaveri's account of her health shows how she was *feeling* while being physically unwell—tensed or emotionally distressed, and why—because of conflicts at home. She

experienced her physical illness alongside the tensions in her family because they intersected, being outcomes of her marriage. Her health issue arose from sexual activity but she made meaning of it in the context of her marriage—it being early (at the age of 16) and disapproved by both families—bringing attention to social associations. The love marriage had disrupted the social norm of arranged marriage and led to dishonour for the families and discomfort for Kaveri, and particularly for her rather than her husband because of gender norms which associate honour with women. Additionally, the issues she faced with her sexual health were attributed to her young age (by the doctor and by the authority of biomedicine at large), and by extension, to her decision to get married in conflict with the state-sanctioned minimum age of 18. Kaveri found herself on the wrong side of socially, legally and biomedically prescribed norms, all of which assigned different and sometimes conflicting meanings to women's sexuality. Her tension about her health and her relationships with her birth and marital families, therefore, was infused with the tension in the marital household around her decision to marry (not because it was an early marriage but because it was a love marriage). It was perhaps also infused with the tension in her birth home but she did not face this on a daily basis as she lived in and associated herself with her marital home after marriage. Her recovery, likewise, coincided with the family's concerns around her marriage settling down, even though it was aided by medical treatment as she mentioned getting medication from the doctor she had consulted. A year into the marriage, the household was once again tense because Kaveri had not had a child, which, according to her mother-in-law, was against the norms in their caste. This caused tension for Kaveri once again and impacted her feelings about her health and body (as a female body that could not reproduce), even though she reported that she was completely physically healthy as she was able to eat well, work at home and outside, partake in leisure activities and look like she was in good health. Such dynamic meaning-making about one's health and body, rooted in the social context of household and kinship, is also noted in other studies on women's health (see for example, Kielmann and Bentley, 2003; Pinto 2011; van der Sijpt, 2014).

'Tension', a term that Kaveri sometimes used, was a term frequently used in participants' explanations of their health status, often closely associated with weakness. It has been widely studied as an idiom of women's distress in the Indian context, and elsewhere, and is understood through symptoms like tiredness, body ache, anger, irritation, rumination, and sleeplessness, often attributed to tense situations in the household, owing to tense interpersonal relations, conflicts around identity and caste, and burdens of gendered labour

(Atal and Foster, 2020; Simpson, 2001; Weaver, 2017). Tension is associated with health in a cyclical manner—poor health leads to tension (about the poor health and its social implications), and tension manifests in poor health, specifically in conditions such as leukorrhea (Rashid, 2008; Trollope-Kumar, 2001).

Weaver (2017), in her study from North India, argues that women make sense of their physical symptoms of ill-health through the tension they have. Weaver found that tension is caused by social factors such as conflicts at home and aggravated by lack of support, and then tension is said to cause problems like high blood pressure and dizziness. Weaver's study particularly assessed if the physical manifestation of tension corresponds to the typical symptoms of psychiatric disorders, and how tension may then become a register to understand mental healthcare (the study finds that tension does not map on to depression and anxiety neatly, as measured by the Hopkins Symptoms Checklist 25, but includes elements of both). Atal and Foster (2020), in their study from low-income settlements in Mumbai, examined how women talk about their psychological distress in their own terms and social contexts (rather than in correspondence with psychiatric disorders) and found that there were two articulations of mental illness: tension and madness (*pagalpan* in Hindi, associated with drastic life events and extreme behaviours). Tension was commonly attributed to family relationships and conflicts, arising out of alcoholism in husbands, financial disputes, and the forced fulfilment of gendered social roles such as being a good wife, and it was consolidated by poverty. It had physical manifestations like palpitations and insomnia, making it a health issue, for which care or 'management' was sought within women's social networks (friends, non-political collectives, church), but not at institutional facilities.

A woman's tension, in the above explanation (Atal and Foster, 2020), and as discussed earlier, is infused with tension in the household. Several participants spoke of tension in the household, and in some of the recruitment meetings and interviews conducted in marital households, such tension was immediately palpable to me. In three households, the daughters-in-law and mothers-in-law lived in the same building (as different family units) but did not interact with each other because of disagreements over the distribution of finances and workload, and in one case because the marriage was a love marriage that the mother-in-law disapproved of.[18] In other households, tension manifested as violence against the

[18] These buildings are typical rural family houses—single-storeyed buildings with rooms centred around a courtyard. Each son may have a room (or more) and a kitchen for themselves and their wives

daughter-in-law, threats of separation (made by both husband and wife, but with gendered consequences), deprivation of care and general lack of support. Verbal arguments and physical violence were usually sporadic but tension lingered on as an ongoing feeling of distress.

In a discussion on health needs, Radhika made a direct association between violence against women (generally, not in her personal experience) and weakness. She also attributed such violence to disrespect towards women. Violence against women, both intimate partner violence and wider domestic violence, are considered public health issues, but Radhika was also evoking an association between violence and the resulting weakness—not because of the physical aspect of violence but because of the distress it creates for women. Sharmina, whose in-laws were violent towards her despite claiming (in her account) to not have any relations with her, also said that their lack of care and constant arguments make her feel weaker: "I feel very weak, but they don't care. I do the cooking. My in-laws only crib about things and argue with me, they stop me from doing things. I feel even weaker with all this going on." Sharmina's experience of weakness relates to what Radhika argued about violence resulting in weakness.

Feeling weak with everything going on at home was a common articulation of weakness, and shows how weakness was associated with aspects of participants' lives that arose from social relations, even if they also had medical explanations.

Punam did not live with her in-laws (she used to but they had passed) and was not subjected to violence from anyone, but she too felt weak with everything going on at home:

> AA: What about *kami* (lack/needs) at the household level?
>
> Punam: Oh there is so much *kami*. I live alone. I have five family members. Two of the three kids, the older ones, go to school and I pay for their education. My husband will neither run the house nor look after the kids. He has no concern for the kids. There is so much tension, this operation (sterilisation) is not happening. I can barely handle three kids, how can I have more?
>
> AA: And how does the *kami* (lack/needs) impact your health?

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and children, which becomes an independent unit within the larger household. But the courtyard (*aangan* in Hindi) remains a common space for interaction and social activities, and is considered a cultural symbol of belonging.

> Punam: There are so many types of problems, obviously it has an effect on the body. I feel weak all the time.
>
> (Punam, 27/28)

At the time of her interview, Punam's main health concern was that she was unable to get sterilisation done because the doctor she was consulting did not want to do it until her illness went away. She did not mention what illness it was but associated it with painful periods, blood loss and bad blood. When I specifically asked later, she mentioned a cyst but was unsure what that meant in medical terms or if she had the correct term. If she was to get the operation now, it would involve removing her uterus which was a more elaborate procedure that she could not afford. Getting sterilised was important and urgent to her as she could not afford to raise any more children, and was not in a position to use any other types of contraceptives. Her bouts of ill health, together with financial difficulties and indifference from her husband (which furthered her ill health), were the problems that made Punam feel weak. It is also worth noting that she described her living situation as 'living alone' despite living in a family of five (husband and three children), indicating helplessness as a result of not having the conventional support of family and kin.

Unlike Punam, Ranjana did not complain of weakness in daily life, even though she had untreated anaemia during (and perhaps also after) her pregnancy and found it difficult to maintain a nutritious diet because of her mother-in-law's interference into what she ate, how much she ate, and insistence that her sustenance was a diversion of the household resources. I interviewed her in two parts, owing to her availability, and she had had a fall on the day I met her for the second part, and had been to the Primary Health Centre earlier in the day. When Bharti and I asked her if she wanted to meet us on another day, she said that the fall was not a big deal and that she sometimes feels dizzy because of "everything going on at home." Her mother-in-law and brother-in-law were abusive towards her, especially because of a difference in caste, and her husband was either indifferent or abusive, making for both a tense household and tension in Ranjana's everyday life. The fall reflects the pervasive nature of tension despite being a rare incident (unlike everyday weakness), because of the way in which Ranjana made sense of it and dealt with it—by resuming her day and commitments like the fall did not demand further attention and could not be addressed beyond immediate institutional care at the Primary Health Centre because it was rooted in ongoing tension.

Writing in the context of sub-Saharan Africa, Backe et al. (2021) found that women suffering from 'thinking too much' (expressions of depression and anxiety) connected such suffering to gendered power dynamics which manifested as mistreatment and neglect from from partners and in-laws, physical, verbal and emotional abuse, and the lack or misuse of financial resources. Ranjana's worry about everything going on at home arose from similar gendered power dynamics—and in the socio-regional context—the dynamics of caste, and in this instance, it also resulted in an event of physical injury.

Tension is also studied in terms of its manifestation in specific physical conditions, most notably leukorrhea. Leukorrhea is closely associated with weakness and is known to be a widely prevalent problem in South Asia (Kielmann and Bentley, 2003; Krishnakumari et al., 2014; Rashid, 2008; Trollope-Kumar, 2001). In my study, a few participants mentioned having leukorrhea and seeking treatment for it, sometimes only for the accompanying weakness. Discussions in community meetings also showed that there was some confusion about the underlying cause of leukorrhea as many believed that it was related to degenerative bone health, caused because of tension and the physical strain of household labour, coupled with poor nutrition. Leukorrhea, therefore, was not an isolated experience of the body but made meaning about in terms of the social. In Rashid's (2008) study with married adolescent women in Bangladesh, the participants referred to their ongoing stress as 'worry illness' (*chinta rog* in Bengali), and drew a connection between their socio-economic position, their mental stress and the physical manifestation of it in white discharge and accompanying weakness. Although the women in Rashid's (2008) study sought care for the specific health issue of white vaginal discharge through formal and informal care providers, they located it in structural problems of poverty and gender dynamics, aggravated by early marriage. This articulation and explanation of illness brings out the indivisibility of biomedical and social processes in producing health, illness and care, and to borrow from Trollope-Kumar's (2001) study on white discharge among Bangladeshi women, encompasses women's emotional concerns as well.

It is not only that tension manifests as physical problems but also that physical problems lead to tension—immediate tension about the body, tension about accessing care and about meeting expenses, and related tension about other aspects of one's health (one type of physical illness leading to weakness and further tension, for example). Such tension is often not about the individual body but about how it may impact the (gendered) body's social

functions and by extension, how it may impact a woman's social position and roles. Laali, a 22-year-old participant, had suffered from two difficult pregnancies, one of which she recounted as a near-death situation. Both the pregnancies required c-sections and incurred high expenditure of up to 40,000 rupees (roughly 384 GBP) each. During her second c-section, the doctor had diagnosed her with a 'tumour' and advised against becoming pregnant for another five years. Her husband, following the doctor's advice, insisted that they should not have more children at all if it could harm her. Laali, however, was tense about the situation. Her tension was not about her physical health, which was evidently poor (based on the history and diagnosis), but because the poor health did not enable her to have more children. This led to tension about her situation because she had two daughters and no sons, which impacted the prospects of her sustenance as well as her position in the marital family. Her husband, although insistent that they did not need more children, lived away as a migrant worker leaving her by herself to deal with questions and insecurities about not having a male child. Additionally, these questions are typically asked of women rather than men, and Laali, being one of two girl children herself, knew of the material consequences of not having a son. Her tension, therefore, was to do with her social position which informed and intersected with the physical problems that her individual body endured.

Tension as a marker of ill health also comes up in wider articulations of what being healthy means to women, beyond specific conditions like weakness, dizziness and leukorrhea which are seen as physical manifestations of tension. McCauley et al. (2020), for instance, in their study with women utilising antenatal and postnatal care in public facilities in Delhi and Islamabad, asked what good health and ill health means to women during pregnancy, and found that tensions, violence and alcohol abuse in the family to be examples of bad health alongside the presence of disease. Good health, on the other hand, comprised good diet and weight, absence of disease, and a supportive family environment. What stands out in MaCauley et al. (2020) is that women expected inquiry and care about the mental and social dimensions of their health and well-being from health workers.

The social associations of health are recognised by health workers as well, like in the case of health workers in Bihar attributing anaemia to women's tension among other factors (Wendt, Young and Marorell, 2013). A study from rural North India found that husbands also consider tension to be a leading cause of their wives' illness, alongside weakness (Singh and Arora, 2008). Tension, therefore, is a widely recognised part of gendered ill-health and is used to

study mental health, weakness, specific conditions such as leukorrhea, and also women's understanding of health.

Trollope-Kumar (2001) argues that complaining about white discharge and weakness is a way of 'speaking through the body' and communicating a complex set of messages about suffering, social conditions and ceaseless distress. Burgess and Campbell (2014), although writing in the specific context of South African women affected by HIV-AIDS, draw on Nichter's (2010) 'idioms of distress', to similarly argue that poor women use idioms of distress to speak about their health problems experienced against the backdrop of economic hardship and the inability to bring about structural change. It also points to the importance of tension as a register to study women's health, and the importance of studying meanings of women's weakness—and I argue—the meanings of talking about weakness as well. Atal and Foster (2020, p. 410), drawing on a feminist reading of women's accounts of tension in their study, argue that tension is used by their participants "as a metaphor for their sense of powerlessness in the face of gendered oppressions." I similarly argue that by talking about weakness, through anaemia, tension, or incidents of ill health, women are talking about their embodied position of being a woman, as weakness encompasses all the feelings associated with the body and the social contexts that the body inhabits. The normalcy and universality of weakness also makes it a socially acceptable way to discuss one's embodied position of being a woman. The descriptions of weakness in my study show how health is socially constituted, but also that it is made sense of in a collective setting. One woman's weakness is not unique to her, even when brought upon by changes in the individual body, but is to do with her gendered position as a woman, and more specifically as a daughter-in-law, which is a position occupied by most women around her, in a social context characterised by patriarchy, poverty, and resulting neglect. The emphasis on weakness also brings out a sense of suffering which is highly gendered (implied by *you know how it is*, there is no respite) which is a way to talk about one's social conditions and gendered position, even though it may be challenged in individual and collective ways (but the suffering remains) and health itself may see periods of betterment.

In the second part of the chapter below, I turn to early marriage as a site where the above meaning-making—of weakness, tension, general health in the context of the household—is happening, and bring attention to what it is about early marriage that shapes such meaning-making or enables it in a certain way.

4.3 Early marriage and health

Globally, early marriage is considered a key public health issue because of its associations with poor reproductive health outcomes for women and girls, despite debates over the age of reproductive maturity (Cherry, 2014; MacLeod, 2014). In the global south, early marriage is also mired in concerns around high fertility rates, and this seeming connection between early marriage, high fertility and poor reproductive health outcomes is key in India's public health messaging. This section presents how participants constructed a relationship between early marriage and health, drawing on their lived experiences and discourses drawn on from state and society, and demonstrates their negotiation of these discourses (for instance, knowing or believing that early childbearing can be problematic but still wanting or needing to have children). The discussion contributes to wider discussions on age at marriage and reproductive health outcomes, discussed in the introduction (Chapter 1) and the literature review (Chapter 2).

4.3.1 "After marriage and children, weakness never goes away"

I asked Punam,

> AA: Can you tell me about a time you were unwell in the last few years?
>
> Punam: After getting married, I have only been ill. Before marriage, I had never seen a doctor or gotten an injection.
>
> (Punam, 27/28)

Punam did not draw an immediate connection with her age, but with marriage itself. Punam had been married at 14-15 years of age, which was likely to have been out of choice as that was the norm in her community. But it is important to note that early marriage was also the norm in her community (like most other communities). Punam's experience of early marriage, therefore, is the experience of marriage itself, and vice-versa. As noted in the introduction (Chapter 1), early marriage is not a unique cultural practice but is part of the structure of marriage and society (John, 2021). In this context, despite the reference to doctors and injections, Punam's illness was also to do with mental distress (see page 110), and was a way of talking about the (inescapable) consequences of marriage for women.

Marriage was a common point of comparison in tracing health histories for several other participants as well. The common areas of comparison were weight, strength and menstrual cycles, and also the loss of a healthy lifestyle (which includes work, rest and leisure), characterised by overbearing household responsibilities and reduced freedom of mobility (which meant lesser scope for leisure). Many participants especially referred to changes in their reproductive health as the point of comparison or change as marriage meant becoming a reproductive body.

> After marriage and children, weakness never goes away.

Leela, who was married at 16, had three difficult pregnancies and had difficulty giving birth each time, which she attributed to her age at pregnancy (prompted by her age at marriage).

> When women become pregnant at 17-18, the womb is not developed, the foetus will not get care in the womb itself. You will be weak and your child will be weak. At that age, it is next to impossible to have a normal delivery, our bodies (vaginal canal/womb) don't expand. During my delivery also, I was told I will have to get a c-section after trying normal (vaginal birth).
>
> (Leela, 24)

When I asked her what might be leading to weakness, she said that it was because of "the pressures on the body and mind." The pressures on her body arose from the work involved in taking care of three children and from doing household work, and the pressures on her mind seemed to arise from a sense of loss over opportunities she could have had if she had not been married against her wishes at 16. Her husband and in-laws had stopped her from studying after marriage and her in-laws continued to stop her from seeking paid work outside the home. Leela was particularly upset that she could not fulfil her aim of joining the police force as she felt that she was unlikely to regain the physical strength required for such a job, even if her in-laws would eventually permit it. In the focus group discussion a few days later, Leela again mentioned wanting to work outside the home and having tried to get vocational training many times, indicating that this was an issue that continued to bother her and created distress. It is evident that Leela made meaning about her body and health problems—the complicated pregnancies and difficult births, excessive workload and loss of opportunities, the tension all of this caused—in continuum. She particularly attributed the problems to early marriage, and

I argue that this association was made stronger by the fact that it was an arranged marriage in which she had not had a say.

It was striking that participants across both love and arranged marriages disapproved of early marriage and childbearing, largely. Sonam, a pilot participant who was in an arranged marriage, had a healthy pregnancy and birth at 18. In her interview, she referred to her pregnancy as a 'mistake', saying that her husband and she did not know better at the time—that delaying childbearing is the correct thing to do. Delaying children is considered the right thing to do in public health messaging, and has previously been endorsed and incentivised by the government in an attempt to curb population growth (Ruhl; 2002; Yardley, 2010). However, her husband and she had wanted a child (or did not actively not want one), could afford to have one, and were happy to have one. I argue that Sonam's construction of her pregnancy as a mistake positions her action, decision and experience in relation to popular messages about changing norms—that one should delay marriage and plan pregnancies. It shows her process of meaning-making about her pregnancy, and places it in both lived experience and discourses about women's status and health.

Kaveri was in a love marriage and had been trying to have a child since she was 16. But she too felt strongly about early marriage and pregnancy being wrong and leading to weakness:

> Weakness is bound to happen, especially if a girl has gotten married at an early age. In fact, that is when it will start, because she is still a child. If she is married as an adult, then it's fine, even when she has babies (as an adult), she will have less weakness.

Her opinion on problems in early pregnancy contrasted sharply with her need to have a child. She was under immense pressure from her in-laws and community to have a child, and personally, she had also wanted to have a child early on (soon after marriage) so that she could raise the baby while her husband and she were still young and active. Kaveri was, therefore, responding in a compound way to her personal wishes (of raising a child while young), social norms of having children soon after marriage, the widespread experience of women undergoing difficult pregnancies (attributed to young age), and the socio-political and biomedical message of delaying pregnancy. Unlike Kaveri, Leela had gotten married and had children when she did not want to do either, but she too was aware of the medical and the moral associations made with early marriage and pregnancy, and had responded to it by

withholding information about her age from the doctor during her first pregnancy, which was 17 at the time, out of fear of being reprimanded.

These messages about delaying marriage and pregnancy were reinforced by health workers and other frontline workers, and, while it resonated with women's lived experiences, they became problematic as they were often meant to chide and shame. The underlying concern, therefore, was not necessarily or exclusively about the health of young women, but also about modernity, progress and discipline. A small number of participants—Nikhar, Shyamolie and Shabana—maintained that early pregnancy did not have an adverse impact on their health. But Shabana also argued that early marriage was wrong, because she had an arranged marriage when she did not want one and missed the comfort and familiarity of her birth home, additionally feeling that it had cut her off from educational opportunities and curbed her mobility. The three of them spoke of their non-problematic experience of pregnancy concurrently with the support they received from their husbands and/or mothers, reiterating that health is experienced at the intersection of several processes, rather than singularly through age or the body.

4.3.2 The toll of household labour and sexual labour within (early) marriage

Early marriage, as noted in the introductory and the literature review chapters, has been closely linked to poor reproductive health outcomes at the national level in India, and in the global south more broadly (Haberland, Chong and Bracken 2003). This connection was widely reflected in the field, by participants, collaborators, health workers, and sometimes husbands and families as well. However, while it was reflected, it was not entirely reproduced (especially by participants) as women challenged the limitations and presumptions of the association, as illustrated by Leela's concerns around her wider health and ambitions. Marriage, for women, implies changes before and after becoming sexually active, moving to a new home and developing new familial relationships, and taking on more household work. It is, therefore, not limited to becoming a reproductive body, which (as previously explained) is how the state views the association between marriage and women's health. Participants particularly emphasised household labour and sexual activity in marriage as the two other sites which influenced their experience of health after marriage.

Women and girls are known to engage in extensive unpaid household labour outside of marriage (especially before marriage), but in marriage, they are expected to do it within stricter conditions and with dire consequences if they do not, such as threats of being cast out (discussed in Chapter 5). As several participants discussed, household work was expected, even if unfortunate, but marital families could also use it to deliberately harm women. In early marriage, women are pushed into this risk at an early age, with less room for negotiation because of their position as young brides. Early marriage is also related to the loss of home and comfort that participants reflected when they spoke of the disruption that marriage (even if self-arranged) had caused. The birth home was associated with a sense of comfort even if there was work to do there, as it was an environment where one had greater space for negotiation. In the study area, the burden of household labour was also heightened because of the household structure where women typically lived with their in-laws, especially in the early stages of marriage, and had to work according to their in-laws' expectations, especially the mother-in-law.

In Nargis's experience and opinion of early marriage and health, household labour was quite significant even though she had been pregnant and had a child at 14, which is almost universally considered harmful to the body, including in the study area.

> Nargis: I wanted to go to the nearby town (with private facilities) during my pregnancy. In fact, I told my family that I will not see a doctor unless it's that particular doctor.
>
> AA: So, everyone agreed with what you wanted.
>
> Nargis: Yes.
>
> AA: That's great, and this is a big facilitator. Now what about barriers? Are there any household-level barriers?
>
> Nargis: There are some barriers once you get married..you can't go outside (for leisure) so much then. And there's a lot of work at home. Girls should not be married early, they are unable to do so much work at such a young age. This (early marriage) is wrong. I still don't know how to do some chores. Too much work also leads to weakness.
>
> (Nargis, 18/19)

Nargis had given birth thrice between the ages of 14 and 18 and despite fears around poor health implications such as birth complications (induced by her community rather than her experience, according to her), the pregnancies and the births had not been difficult. It was household work that she brought up a central problem of health in early marriage. The association between marriage and household labour is widely recognised in society and in research, but is overlooked in the state's discussions on the harms of early marriage for women.

Second, there was a very strong idea that sex, typically initiated upon marriage and a constant part of marriage, has an adverse impact on the body. In one of the focus group discussions in Purnia, a discussion on why the character in the FGD vignette (Reena, 19 years old) might want an abortion led to a discussion on the adverse effects of sexual activity on the body:

> AA: But Reena wants an abortion in this case, so what may the reason be? (after discussing why she may not want or need an abortion)
>
> Savitri: She's young, so age is a factor along with her health at this age. It's better to wait 2-3 years to have a child.
>
> Sumitra: See, her health is already gone once she's married. She will be ill or weak anyway, because of sex. And additionally, her body is too young for it.
>
> Savitri: Yes, she can become unhealthy because of marriage (sex) also…
>
> (FGD Group 1, Purnia)

The other FGD participants agreed with Sumitra that Reena is going to become weaker because of sex and will get even weaker with a pregnancy. They suggested that she could get an abortion on grounds of her health but that too would be harmful for her body as any unnatural interference (first sex and now abortion) would cause harm at a young age.

The question of sexual activity being harmful to health is related to questions of consent and coercion in sexual activity, as participants were concerned about the persistence of sexual activity, indicating that it may have been unwelcome not only because of its consequences (the likelihood of pregnancy) but because of its occurrence itself. Participants pointed towards this connection by drawing on their own experiences or that of others, or through the

meanings they made about their sexual health. Kaveri, for instance, connects her experience of sexual health to the social relation of marriage and women's roles in it:

> AA: So you didn't feel weak or have pain during sex after that (taking the medicines the doctor prescribed)?
>
> Kaveri: I did. Twice or thrice after that, as well as now sometimes.
>
> AA: But it's better with the medication?
>
> Kaveri: Yes, it is. Whenever I have difficulty (while having sex), my husband understands. So we don't have sex very often. My husband says that it's enough if you're around me, I don't want you to go through so much pain.

Kaveri's husband saying that her being around him is enough, and her mention of it in the interview in response to my question on medication, is significant as she is not only explaining how she got better but also explaining the *context* in which she got better, which is her husband understanding her problem and not insisting on having sex when it can be harmful for her. This context became evident as she eventually commented on the extent of sexual coercion faced by women in marriage, a fact commonly known by women and well-documented in research (Jejeebhoy, Shah and Thapa, 2006).

> Kaveri: Say I don't want to have sex, then I have to talk to him nicely, not angrily, not coldly. If I say it nicely, he will understand. My husband always understands but I can only speak for myself, I don't know how other people's husbands are. Men usually want sex all the time, or they want children after having enough children..so some women end up bleeding all the time. But we have never had such a problem, and hopefully, we never will. I hope not.
>
> (Kaveri, 21)

Other participants discussed sexual health through their experiences of contraception, as they encountered difficulty negotiating contraceptive practices with their husbands and there was shared anxiety among women around avoiding repeated pregnancies. In some ways, this pointed towards the question of consent. Tarana felt very strongly about the need for husbands to seek consent and to use condoms. By placing consent and condoms in the same space, to argue that men exercise control over women, Tarana points to how negotiation of sexual

practices is part of negotiation of consent (even when explicit violence—which Kaveri points to—is absent), and how they impact the body in different but related ways. This is illustrated in Tarana's explanation of the purpose of marriage:

> AA: Let us talk about the role of the marital relationship now, on decision-making vis-a-vis reproductive healthcare.
>
> Tarana: The purpose of marriage is to support one another. But it's very common for husbands to force sex on their wives everyday. It impacts the woman's body. Husbands also don't use contraceptives, they keep putting the conversation off for another day or making excuses. Condoms are the most important thing, most women want their husbands to use condoms. When they don't, the women have to get an abortion, and that again has an impact on the body.
>
> (Tarana, 22)

For participants who were struggling with contraceptive non-use and the related anxiety of unwanted pregnancies, contraceptive use was at once about their bodily autonomy, sexual and reproductive health, and mental and physical health. It did not only have an immediate bearing on the body—through sex, pregnancy, miscarriage and abortion—but also a consequent bearing on the mind, with the additional long-term financial and emotional impacts of having to raise a child, and the very emotional burden of preventing pregnancy. None of the participants in my study mentioned being coerced into sex or facing sexual violence when they spoke about sex without contraception (or otherwise) but the references to helplessness about their health and the difficulty of raising more children indicate that sex without contraception was not always straightforwardly consensual. The inability to negotiate contraceptive use and sexual practices at large, articulated by helplessness and resignation, suggest that sexual health is embedded in sexual relations which are influenced by gendered power and the performance of heteronormative sexuality (George, 2002).

There is a significant body of literature on women's unmet contraceptive need and on the unfair burden of family planning that women bear, in India and elsewhere (Grover, 2018; Kimport, 2018; Suri and S, 2022; Whittaker, 1998). However, the question of unmet contraception does not typically ask questions of consent. Literature on sexual violence in marriage, on the other hand, although accounting for direct impacts on health, does not talk about complexities in the negotiation of sexual practices. Jejeebhoy, Shah and Thapa (2006)

use ‘unwanted’ sex as the starting point rather than ‘forced’ sex to assess the nature of non-consensual experiences and investigate the experiences of women after they say no to sex, in India. The study also places non-consensual experiences alongside perceptions of gendered power in marriage such as the husband’s perceived rights to beat his wife if she disobeys his elders, uses contraceptives without his permission, neglects their children, and finds that unwanted sex is more commonly experienced by those who believe that husbands can beat wives under these circumstances. In a qualitative study on sexual relations and negotiation within marriage in suburban Mumbai, George (1998), found that safer sexual practices were not on the agenda for negotiation. The study includes an example where a woman wanted to negotiate condom use to protect herself from sexually transmitted diseases but did not do so for fear of her husband suspecting her of sexual activity outside of marriage because she knew of condoms. The example demonstrates the complexity behind negotiating contraceptive use, as it goes beyond access and decision-making, and involves gendered power. Other studies have explicitly looked at the impact of sexual violence in marriage on sexual and reproductive health for young women in India. Santhya and Jejeebhoy (2003), for instance, find that the experience of physical and sexual violence is associated with higher reporting of gynaecological morbidity, and recognises unwanted pregnancy, pregnancy complications, pregnancy loss and induced abortions as consequences of physical and sexual violence. This body of research recognises the connection between non-consensual sexual experiences (and the gendered power that enables it) with unwanted pregnancies and related health issues, but the two bodies of research—unmet contraceptive need (a vast area of study) and sexual consent do not speak to each together, making the understanding of sexual and reproductive health bereft of feminist critique.

Sen (2018), writing in the context of India, argues that in sociology, the study of social institutions such as the forms of marriage, family and kinship, are devoid of inquiry into the concept of consent. Sen argues that consent is presumed both before and within marriage—and that the discussion within sociology (and anthropology and history) is either focused on increasing the age of marriage or a transformation towards self-choice in partner selection. In contrast to this, she argues that in feminist literature, consent arrives mainly and usually in the discussion on sexual violence where is is the absence of consent which creates the presence of violence. In other words, there is less attention to the presence and negotiation of consent (Sen, 2018). This gap is significant to the present study as it addresses consent within early marriage, studying its negotiation and possible absence, as well as its health

implications for young married women, even when violence may be absent in the women's accounts. The participants of my study show how part of the problem of early marriage is marriage itself, echoing John (2021) on compulsory marriage rather than early (child) marriage being the underlying problem. Women also bring to light the role of the circumstances of marriage in influencing their experience of health, furthering the idea of a social constitution of health.

The following section looks at the significance of pregnancy and childbearing in marriage, and the kind of care it entitles young women to, owing to the significance of their fertility, their age, order of pregnancies, and because of pregnancy being a legitimate site of care. The reason that I focus specifically on pregnancy and childbearing is both due to its discussion by the participants themselves and because of the centrality of reproduction in literature on women's health, especially adolescents and young women.

4.4 The centrality of reproduction and reproductive health

Reproduction, as already established, is central to the lives of young married women in India, and to marriage more widely. It is believed to elevate the status of women as they go from being daughters-in-law of the household to mothers in the household, which ties them more inextricably to the marital family, additionally elevating their status if they are mothers to sons. Childbearing proves women's fertility in marriage and demonstrates the performance of idealised heteronormative sexuality (George, 2002). In this section of the chapter, I discuss what makes reproduction central and pregnancy a legitimate site of care, which demands a different type of care from the family, although such care continues to be anchored in the family's social responsibility towards daughters-in-law more broadly.

4.4.1 Fertility and childbearing: old anxieties and new meanings

The study participants were expected to have children in marriage by family and society, but it was also a personal goal for many, independent of the pressures. Not having children within a year or two of marriage was almost always detrimental to women as it raised questions about their fertility, causing distress to them and tension in their families. Men were not known to be questioned in any of the instances that participants knew of. Sunita referred to

this problem as a type of ‘anxiety’ that women harboured. Sunita and her husband were open to the prospect of having a child soon after marriage but when she did not conceive within a few months, she got worried that she may never be able to, and sought care, after which she had a baby.

> AA: Tell me about a time you were ill and how you got better.
>
> Sunita: I don’t really have any problems as such, but after I got married I had a problem, which is a problem in every family for women..about children. Then I took some medication and my condition improved and now I have a daughter…
>
> AA: Can you tell me about it in greater detail, if you don’t mind?
>
> Sunita: When I came to know that there was some talk about this problem in the family, I got a little worried. You know how women have anxiety *(ghabrahat)* when they don’t have a child yet and don’t know what might happen. So I went to the doctor. He prescribed a syrup and asked me to have three bottles of it. After 2.5 bottles, I was able to become pregnant.
>
> (Sunita, 23)

The anxiety that Sunita spoke about was about the body and specifically her reproductive body but it arose from the social norms that govern women’s role in marriage and position in the marital household. Women face the threat of neglect and separation if they are unable to have children, while their personal emotional burden of wanting a child is simultaneously neglected by those around them. This threat is heightened in a context where adoption and assisted reproductive technologies are not easily accessible, and sometimes, not socially acceptable. Apart from the impact on feelings about themselves and their bodies, not having children also impacted participants' interpersonal relationships with their husbands and mothers-in-law. Meena, a participant who had a love marriage, said that her husband stopped loving her when she did not get pregnant soon after marriage. Her mother then helped her with indigenous medicines and the community with prayer, after which she was able to have children and her relationship with her husband improved.

While the inability (or suspected inability) to bear children led to anxiety among women and neglect towards them, voluntarily delaying the first pregnancy led to suspicions and assaults on their wider sexuality and moral character. Only two participants had delayed their first

pregnancies, doing so to buy time to further engage in academic studies, and had been at the receiving end of unwarranted advice and unwelcome attitudes about their intentions to do what they pleased rather than follow social norms. Some others had also wanted to delay their pregnancies but had gotten pregnant and decided to have the children, based on advice from their husbands and families to not get an abortion.

Overall, in the study, childbearing was normalised as a part of life, but with a clear distinction being made between previous generations where people were believed to be having children mindlessly and the participants' generation where fewer children were associated with greater opportunities and aspirations for them, and was *the right thing to do*. At the same time, this did not necessarily intensify or attach greater value to everyday mothering or parenting practices as the family planning discourse in India, in its grassroot operationalisation, continues to be disciplinary. The state, in its public health messaging, seeks family planning (and very specifically, a decline in fertility) principally on the pretext of women's health but as I discuss in Chapter 1, the colonial and transnational legacies of population control continue to have a bearing on the rationale and the approach to fertility reduction. While there are some references to family planning leading to a better standard of living and a healthy family life (such as the slogan *chhota parivar, sukhi parivar* or 'small family, happy family'), the nation in the study area, especially promoted by health workers and development sector associates, was that having fewer children is a sign of civility and modernity. Motherhood did not become particularly venerated now that having children was considered to be a more thought-out activity. Apart from the political implementation of family planning, this can also be attributed to the fact that there continues to be a scarcity of financial resources (increasingly so with rising cost of living and precarity of labour markets) which makes raising children difficult despite having fewer children, and also to the wider notion that having children is the norm, making it no more than ordinary. Women's personal goals to have children were also guided by this norm, much as the norm itself is infused with social messages around fertility and family.

4.4.2 Care in pregnancy

If childbearing was a part of life, so was pregnancy, but the pregnant body was treated as an exception in the larger terrain of women's health, as it was perceived to be a site more deserving of care than the non-pregnant body. Pregnancy was not seen as a health issue but it

was recognised as a time when the body (and by extension, the person) was in a different state and in need of special care, partly based on the assumption that pregnant women need others to look out for them and partly on the gendered position of being a pregnant woman (who is seen as deserving of greater sympathy than non-pregnant women). Pregnancy did not seem to command greater care because it would make the woman a mother (notions of motherhood were not at play) but because the body was in a different, and often difficult, state, as women were known to experience pain, discomfort and changes in mood. In the study, pregnancy being a legitimate site of care was exemplified in four ways: through the custom of going to the birth home, getting and expecting care in the marital home, being entitled to institutional care, and having pain and discomfort recognised and social support provided.

The common Indian custom of women spending the first pregnancy in the birth home underscores the need for care and rest during pregnancy, and indicates that such care is not possible in the marital home. However, the restriction of the custom to the first pregnancy also reflects the limitations on women's care and the limitations on the perception of the pregnant body as an exception. The first pregnancy is then somewhat a window to be treated better than usual, and is an extension of the care accorded to daughters as temporary members of the birth home who deserve some 'pampering' before they get married and go to their marital home. Pregnancy is a legitimate reason to go to the birth home—making the pregnant body (especially the first-time pregnant body) a unique site of care.

Some of the study participants stayed on in their marital homes during their first pregnancies—if they had eloped and their parents were upset with them, if their birth homes were far away, or if there was no one to do the household work in the marital home in their absence. In such cases, they usually received the required care in their marital homes, but had to carry out their regular household work. Care received in the marital home or by the marital family is significant in understanding pregnancy as a site of care because participants shared the issues they faced during pregnancy with family members and usually received timely care as opposed to pains, fevers and weakness which they did not always disclose considering them to be minor or long-term issues such as weakness which they knew would not be understood and treated. Nalini, for instance, did not tell her marital family about headaches and weakness because it would be a long and stressful process—they would not immediately provide care for her, she would then have to call her parents, and if the in-laws found out,

they would disapprove because they did not want her discussing their household matters with her parents, all of which would lead to added tension for her. But during her pregnancy, she told her marital family about the issues she faced and they enabled care for her, even if they did not like to provide for her and did not care about her well-being generally.

In her study with women living in a resettlement colony in Delhi, Kant (2014) argues that the support women receive during their first pregnancy is also accompanied by control as it is a time to socialise women into the norms and hierarchies of the marital household. In subsequent pregnancies, both support and control decline. The support Nalini received was certainly accompanied by control, but she was also controlled outside of her pregnancy. For some other participants, who were cared for in their marital homes—Koyal and Suvidya—support did not seem to emerge as control. Research suggests that marital families, particularly mothers-in-law, are invested in their daughters-in-law's pregnancies because they are supposed to be carrying the heir of the family, especially if it is hoped and believed to be a male child. This reasoning, however, is not very relevant in families and communities with limited material, cultural and social capital to inherit, which are determined by caste and class, and did not seem to be relevant to any of the participants or their families in my study. Mothers-in-law expected grandsons but did not make special investments in their daughters-in-law's pregnancies, in the experience of the study participants. A male child also did not trump other reasons to neglect daughters-in-law such as difference in caste and lack of dowry, and therefore pregnancy was not provided for as a form of providing for a prospective male child. It remained a site of care independent of these reasons.

A related example of pregnancy being a site of care is that participants expected care from their marital families during pregnancy even if they did not get it. Not receiving care during pregnancy was a matter worthy of complaint and reaction, as opposed to lack of care at other times. For example, Saroj had remained in her marital home during both of her pregnancies as there was no one else to do the household work, something which she found particularly difficult:

> I had a difficult pregnancy, but I did all the work even then. My in-laws will just think that I am being lazy if I don't do the work. My second pregnancy was so painful…
>
> (Saroj, 19)

Saroj had also suffered from two miscarriages, one of them particularly painful, but did not expect the same kind of care and concern for recovering from miscarriage that she did during her pregnancies. She did all the work during those periods too but did not complain about it specifically, even though she complained about a general lack of care and poor health. Saroj had two sons but that did not change anything for her as having sons was not ritually valuable to her marital family, and her husband continued to be away and uninvolved (although not actively neglectful), making her vulnerable to poor health during her pregnancies and in the postpartum periods. Saroj continued to live in her marital home during her pregnancies, without the expected care, although her birth family was able to come to attend to one of her births. Unlike Saroj, Ranjana and Radhika, upon not receiving the care they expected from their husbands and marital families, and instead facing neglect, decided to go to their birth homes as an act of protest. They did not go to their birth homes in the customary manner where both families are involved, but on their own with no assurance of going back to the marital home. Radhika's birth family was able to provide for her care, although not to the same extent as her husband's, while Ranjana paid for her antenatal care from her own meagre income.

The expectation of care that participants had during pregnancy was of both specific access to institutional care and of wider concern for their well-being, which manifested as support. Women's difficulties during pregnancy were usually recognised and reaffirmed by those around them. For instance, when Sheela recounted her struggles with lower back pain during pregnancy, her sister immediately joined the conversation to expand on the severity of the pain. The issue was never resolved (because the right kind of care was not found) but her birth family empathised with her as she spoke about her pain. This happened in the marital home too, with other participants, where other women in the household voluntarily spoke about the participant's difficulties with pregnancy and birth. Even with lesser concerns like vomiting, women had the assurance of other women that this was not unusual (so it wasn't ignored by others), even if this assurance was sometimes based on presumptions. Such recognition of pain was very different from the everyday weakness or occasional illness discussed earlier in the chapter which in-laws tended to view with suspicion, believing that it was an excuse to shirk work. Relatedly, women's anxieties around their health was also recognised during pregnancy. Participants were often taken for additional check-ups or to a different facility if they or their husbands felt dissatisfied with one. Money permitting,

families enabled and even preferred consultation at private facilities, especially if they suspected that something was out of the ordinary about the pregnancy. Pregnancy also allowed women greater likelihood of getting rest, both in the birth home and in the marital home. If this rest could not happen, it was a source of complaint by women against their husbands and in-laws. Overall, then, pregnancy was a time of greater social support, as was birth and the immediate postpartum period.

Pregnancy is also a dedicated site of care in the state's health agenda, presented as safe motherhood and related to lowering maternal mortality, and in the long run, fertility and population. Pregnancy, therefore, becomes the only time most women receive institutional care, as part of self-arranged or ASHA-facilitated antenatal check-ups, which acts as an important site for diagnosis of related and unrelated conditions like anaemia, renal and cardiac conditions. The availability of maternity services has become relatively common in recent years, with the introduction of the National Health Mission in 2005 and the recruitment of ASHA workers in 2009, making pregnancy visible and indicating that it is worthy of care. The change in availability, as discussed earlier, changes the perception of a health issue and the need for access. The perception of pregnancy as a time of care and as a life event for which care is available, therefore, differs by generation. Participants felt that mothers-in-law especially did not want to accord special status to pregnancy, based on their own experience of pregnancies when the availability of care was different, or because their individual circumstances had not allowed them special care or rest.

> Radhika: They will say that everyone gets pregnant, why should we spend so much on you?
>
> AA: Who usually says this?
>
> Radhika: The mother-in-law. Father-in-law also maybe. If the husband is good, he won't say this, but if the husband is bad…The mother-in-law also says - I also gave birth, I did not have to spend on anything, why should we spend on you?
>
> AA: Hmm I hear that this happens because mothers-in-law are from a different generation.
>
> Radhika: Yes, the facilities weren't there then, but today, births don't take place at home, times are very different today.

(Radhika, 18)

A similar discussion in a focus group discussion shows that it is not only about the availability of care and what it represents (a modern, comfortable and medicalised way to manage pregnancy and birth) but also about the kind of care accorded to a woman more widely:

> Meena: Yes, Reena (vignette character) has to think about her health and age if she is pregnant (and consider an abortion accordingly) - if I have a child right now, I will become weak later. Even her mother and mother-in-law will realise this…
>
> Suvidya (interrupting): Oh, they won't!
>
> Savitri: True! They will say it's your business, you do what you want.
>
> Sumitra: Exactly, they will say oh look we had so many children without any medicines.
>
> Meena: I agree, but it's not like that nowadays.
>
> Suvidya: Yes, even the smallest village has a medical store now.
>
> (FGD Group 1, Purnia)

Women, therefore, made sense of their health needs in response to the availability of care, social norms and customs, and their relations with their husbands and marital families. As suggested earlier, the significance of pregnancy and childbearing is not altered by early marriage as it is happening in the same structure as marriage in general. Love marriages also did not change the expectation of care during pregnancy, although women often spoke of it as an enabler for other forms of care and general well-being. The focus on pregnancy and childbearing can be argued to amount to an essentialisation of women's bodies as reproductive bodies, and pose a limitation to the study of women's health. However, reproduction is central to marriage, and particularly in the early years of marriage, which, in the study context, is also early marriage. The research was specifically designed to study reproductive health, and the participants, in responding to it and centering pregnancy and childbirth, expanded the understanding of reproduction in marriage, enabling an understanding of the social context in which health is produced. By centering pregnancy

and childbirth, participants connected their experiences of reproductive health to other aspects of their health (such as mental health) and to the gendered relations of the household, thereby expanding rather than limiting the discussion on reproductive health.

4.5 Conclusion

This chapter responds to the research question: *How do young married women understand their reproductive health status and needs?* The research question itself was conceptualised through an engagement with statistical data, prevalent narratives, and health discourses, based on which it sought to account for the ways in which young married women experience and ascribe meaning to their body and health. The chapter, therefore, has drawn on participants' articulations of their health experiences through the different terms used by them—problem, *kami* (need), *kamzori* (weakness), tension, and studied them in the contexts in which they were used—neglect, compulsion, care, labour, using constructivist grounded theory (Charmaz, 2006). Participants' terminologies and the contexts they used them in together encapsulate that health is experienced in the body (indivisible from the mind) and made sense of in the social circumstances in which it is being experienced. The understanding of health, therefore, shifts with shifts in the gender dynamics of the household, and of wider society.

The key argument that this chapter has made is that health is socially constituted, and its novel contribution is that it has specifically located such social constitution in the household, particularly in its gendered relations and dynamics, which are sustained by marriage, caste and kinship. The chapter, therefore, extends discussions on the social determinants of health to encompass the social processes that influence women's health and shape its very meanings. The chapter has made these arguments in the understudied empirical context of contemporary rural Bihar, which, as Chapter 1 discusses, is a society in flux characterised by changing social dynamics and mobility, alongside widespread early marriage and persisting poor health indicators.

This chapter has also argued that health is a site to make sense of the social. By attributing certain meanings to embodied sensations, women are able to make sense of their social circumstances, and particularly of their gendered position within (early) marriage. Such

meanings coexist alongside biomedical meanings and are in fact used to place biomedical explanations of illness in social moulds.

Further, the chapter has responded to the connections between early marriage and poor reproductive health, analysing what makes early marriage unique (or not) in the study of health, and how women both reflect and challenge this connection, based on their lived experience. It has particularly foregrounded the overlooked questions of consent, sexual health and labour in discussions on age at marriage and young women's reproductive health. Such framing of the 'problem' of early marriage has crucially brought together divergent areas of work such as feminist perspectives on women's sexuality (which accounts for their sexual rights and labour within marriage), and early marriage which often remains focused on associations between age at marriage and women's role in social and national development. The chapter's arguments set the stage for further inquiry into the nature of the gender dynamics of the marital household, and the processes that influence them, with the aim of understanding how they then shape women's access to care, which is tied back to how women conceptualise their health.

Chapter 5

Marriage, gendered relations, and the husband's centrality in care

5.1 Introduction: Locating access in marriage and household

This chapter centres the gendered relations of the household to understand how they shape access to care for young married women. The chapter interrogates households as units of analysis and problematises the role of dynamics within them and their interaction with other institutions, including the researchers and the institutions they represent, to comment on women's care—particularly in relation to access to reproductive healthcare. The chapter analyses the processes through which participants seek and are given (or not given) care, the centrality of marriage and husband in care, and some of the ways in which women respond.

The analysis marks a progression from women's conceptualisations of health discussed in Chapter 4, which were markedly rooted in and understood through household dynamics, to an understanding of how access to care is perceived, and enabled and inhibited, through marriage and the household. The chapter draws on the discussion in the introductory chapter (Chapter 1) about the shifting focus between access to reproductive healthcare and care, and aligns with the second research question: *How do marriage and the gendered relations of the household shape access to care for young married women?*

As discussed in Chapter 2, access was a key question that shaped the research problem for my study, as the unavailability, inaccessibility (economic, physical, bureaucratic) and poor quality of care, is widely acknowledged by research in the study area and within the study population (Baru et al., 2010; Barua and Kurz, 2001; Santhya and Jejeebhoy, 2003; ICRW, 2016; Patel, Das and Das, 2018; Sanneving at al., 2013). These factors remained relevant to the research and were frequently brought up by participants in describing the health infrastructure around them along with their health needs, as the chapter will demonstrate. But participants' descriptions of access to institutional care were often accompanied by a discussion of the conditions of seeking access, including the circumstances. For instance, if a

pregnancy was unwanted—because the husband refused to use contraception or advised against an abortion—then accessing care for the pregnancy was made sense about in relation to the circumstances that led to it, such as lack of care about the wife's consent or wishes. Women made meaning about the need for access, and more widely, for care, both in relation to what health meant to them (see Basnyat, 2011), and the role that gendered relations and household dynamics play in it, as was evident in the discussion of weakness, anaemia and tension in the previous chapter (Chapter 4).

The chapter will first situate the participants as daughters-in-law, drawing on references made to 'home' and the simultaneous association and dissociation of the daughter-in-law from this space and sentiment. This illustrates the functioning of household dynamics and the centrality of marriage in women's lives, both among the study population and in wider society. The chapter then makes a brief commentary on the nature of and expectations from marriage, based on the participants' experiences and their accounts of changing social norms. This is followed by a discussion of what I conceptualise as 'bringing' and 'keeping', the key processes that underpin heteronormative marriage and accord authority and responsibility to husbands. I then analyse access to healthcare within this structure of marriage, and argue that it is the centrality of marriage and the ensuing authority of the husband which shapes care and neglect.

5.2 Situating the daughter-in-law in the marital home

As the collaborators and I sought prospective participants in the study field, we particularly tried to look for married women who were daughters-in-law of the households we approached rather than married daughters who were visiting their birth homes, or living there temporarily or permanently. Sometimes, we quite literally asked if an interested participant was a daughter-in-law or a daughter (a categorisation also noted in Gjøstein's (2014) ethnography from Rajasthan), while they were obviously both, remarking that we were keen on recruiting daughters-in-law. The reason was that daughters-in-law living in the marital household would certainly have the experience of navigating the dynamics of the marital family and household, and at a practical level, they were likely to be available over a period of time, unlike married daughters who were usually visiting for brief periods. Daughters were, however, almost always more available to meet and talk than daughters-in-law as they

had fewer restrictions on their mobility, because of social norms and because they were highly familiar with their neighbourhood and village. They also did not have much household work because they were guests or could pause their work more easily, as well as discuss their marital family without the fear of being overheard by them. Some of the participants, whom we met in their marital homes, asked us to arrange the interviews and focus group discussions in their birth homes or villages as they would be more comfortable and available there. In effect, we positioned participants as daughters-in-law even when they were daughters living in their birth homes. This section, therefore, outlines how this position and identity is constructed, followed by the construction of home.

The position of the daughter-in-law in the marital household is influenced by the combination of marital status and gender (that is, being married women), age, and the caste location of both their birth and marital families. In popular imagination, this position is typically constructed in opposition to the daughter of the household, who is expected to be loved and cared for, albeit less when compared to the son of the household, a distinction which is visible in household aspects like the time spent on household work by daughters, daughters-in-law and sons across communities (Agha, 2021; Singh, Pattanaik and Singh, 2023).[19] Four of the study participants, who felt fortunate to be very well loved and taken care of, described their in-laws' disposition towards them with the phrase "just like their daughter." The position of the daughter-in-law, therefore, is primarily constructed by gendered relations defined through marriage and vis-a-vis the husband and in-laws rather than the gender identity of being a woman alone. Although the daughter is at the opposite end of this position, it can be argued that the daughter's position is similarly constructed by gendered relations right from birth as she is expected to become a daughter-in-law and go to her 'real' home, which is both symbolic and material as she is often cut off from resources and inheritance in her birth home.[20]

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[19] The daughter-in-law is often positioned in opposition to the mother-in-law in research, but as Singh, Pattanaik and Singh (2023) find, the time spent on unpaid caregiving activities by mothers-in-law (579.8 minutes per day) in rural areas is much closer to the time spent by daughters-in-law (586.7 minutes per day) than the time spent by daughters (350.2 minutes per day). Rural men, on the other hand, spend 98 minutes per day on such unpaid activities.

[20] Daughters have coparcenary rights to ancestral property in India but property continues to be customarily given to sons in many cases. In the study sample, some participants came from landowning households but did not indicate that they would eventually have or claim a share. Only 16% of women in rural landowning households in India own land, constituting only 14% of all landowners and owning only 11% of the land. Women are also more likely to own property as widows than as daughters (Agarwal, Anthwal and Mahesh, 2021).

The idea that a married woman is a member of her marital household and not of her birth household is informed by social norms of patrilocal residence, but the underlying belief is that women, by birth, are destined to be members of another family, conventionally encapsulated by phrases like *paraya dhan* which means 'girls are someone else's wealth or property' or 'raising a girl is like watering someone else's garden.' While these phrases are falling into disuse, and increasing mobility and means of communication have alleviated the disruption of married women's relations with their natal kin, the ritual underpinnings and material consequences remain. Because the daughter is expected to become a member of another family one day, it entitles her to love and pampering in the birth home, greater independence than what she would have in her marital home, and at the very least, lesser labour than a daughter-in-law (Gupta and Negi, 2021, Singh, Pattanaik and Singh, 2023). Love and pampering, however, are time-bound and do not extend to rights of inheritance and maintenance and are contingent upon moral and honourable behaviour (Grover, 2009). As Shabana put it:

> In your mother's house, all the happiness and comfort is there.
> Mummy does all the work for me.
>
> (Shabana, 17)

Shabana's experience of living in her marital home was not negative but she missed the material comforts of her birth home which had better infrastructure and the social comforts of having friends and family around. When she visited, she did not have to do much at home and her mother took over all her childcare responsibilities. At the same time, she remained a daughter-in-law even in her birth home. When Rumi and I first met Shabana, she asked us to speak to the parents of girls who had not been married yet so that they would not be pushed into the same situation as her (another prospective participant referred to such a situation as "ruin"). Shabana was also reluctant to participate in the study because she thought that her parents would not allow her to do so as she was married, and contrasted this with the time when she was unmarried and would go out to perform in plays in schools and participate in other public activities. Eventually, she participated on the condition that she would not have to leave the house for any research activities.

In her study on transnational marriage and migration of British-Pakistani Muslim women, Mohammad argues that "their impending dislocation often has a profound impact on women's lives from the moment of their birth so that they are never quite at home and are denied true belonging" (Mohammad, 2015, p. 596). I use references to 'home' as a data code to analyse how participants positioned themselves in relation to home and household, given the cultural background of daughters and (dis)belonging, to eventually analyse how this association influenced their experience of care. Nalini explained that:

> This is mummy's home, my home is in Purnia.
> (Nalini, 23)

In this statement, Nalini was clarifying that the house I met her in for the pilot recruitment process was her birth home. At the time of the interview, Nalini had been living there for several months, and was considering separating from her husband because he did not provide for her or their child and because her in-laws were abusive. No one from her marital family called her back nor did her parents insist that she go back to the marital home, although she believed that they found it financially difficult to provide for her and her child. Nalini's 'home', however, remained the marital home, as she remained a member of that family by marriage. Like Nalini, a few other participants also referred to their marital homes as their primary or default homes, even if they did not live there permanently, and despite the circumstances of their married lives.

In the study region, and in many parts of northern India, the birth home is referred to as the *maike* or mother's home and the marital home is referred to as the *sasural* or in-laws' home. 'Mother's home' does not mean that the mother owns the house or is the head of the household, but is based on conventional ideas of femininity and motherhood wherein a woman makes a home. *Sasural* can be used for men's marital homes as well, but *maike* is exclusively used for women's birth homes. Men do not need to trace their relation with their mother's home because it is inherently their home in terms of lineage, belonging, and material inheritance. This patriarchal construct of home also means that, in patrilineal and patrilocal societies, men living in their *sasural* for long periods and additionally without an income are derogatorily referred to as guests who have overstayed their welcome, but these cases are exceptions (only one study participant's husband lived with her in her birth home), and men's sense of space is not divided by *maike* and *sasural*.

Abraham (2010), in her study of the production of gender and space in north India, argues that women articulate their framing of space through the categories of natal and conjugal houses and neighbourhoods, rather than public and private. A participant in Abraham's (2010) study, for instance, likened her experience of working outside of the home for the first time as coming to her *maike*, as she was free from the suffocation of the *sasural*. More widely, women's migration upon marriage has been written about as experiences of homelessness (in the new home), immigration, diaspora, forced migration and sudden displacement (Prasanth, 2016; Sharma and Paliwal, 2017; Qureshi and Rogaly, 2018). In my study, marriage migration was not defined by a big geographical distance for most participants (except during the initial period for Saloni who had moved to Delhi with her husband and for Sonali who was set to move there), and was not associated with (market) labour, but it was associated with a sense of leaving and a loss of home.[21] More significantly, as Mohammad (2015) and Prasanth (2016) write, there is a denial of true belonging as women occupy the position of an outsider in the marital family, despite being 'destined' for it since birth. Prasanth (2016) also argues that this experience can be more intense in inter-caste marriage.

Seema had been in an inter-caste and inter-faith marriage for five years, and did not visit her birth family often because of geographical distance and the difference in religion and caste, as she now followed her husband's religion and came to be associated with his caste. Seema's family rarely visited her because it is not customary to do so and, when they did, they could not dine with her because of the difference in religion and caste. This norm had not been imposed by anyone, but Seema felt compelled to follow it, despite the fact that it upset her to not share a meal with her parents. When I asked Seema if she likes living in her marital home and neighbourhood, in the context of her husband being a migrant worker and her *maike* being far away, she said that she does, following it up with "this is my home now." This can

[21] Women form the largest group of migrants in India and marriage is considered the biggest reason for such migration. Agnihotri, Mazumdar and Neetha (2012) suspect that the way migration data is collected in the Census and in other government surveys masks women's labour migration as marriage migration as it asks for a singular reason for migration rather than multiple reasons, making marriage emerge as the primary reason because that is what women report owing to social mores. Rao and Finnoff (2015), however, disagree that women's labour migration is masked as marriage migration, arguing that it is likely to be marriage migration. Instead, they draw attention to the conditions in which such migration is increasing, such as increasing urban-rural inequality and falling sex-ratios because of which migrant brides are brought to urban areas (rather than the convention of women migrating with husbands).

be interpreted as the lack of an option, but because Seema repeatedly spoke about being comfortable and happy, it was not only the lack of an option but also the conventional security of marriage and the material comfort of a house that made her associate herself with her marital home. Her in-laws also defended her when relatives and neighbours raised questions over her identity as her marital family belonged to the 'highest' Hindu caste in the village while her birth family belonged to a 'lower' Muslim caste. It is, however, important to note that Seema had converted to Hinduism upon marriage (she did not indicate force but the conversion had been inevitable as it is common for women to convert to the religion of their husbands). In this context, the loss of home and identity is evident, because in effect, Seema lacked the option to associate herself with her former home even though it did not impact her materially.

Seema's neighbour and fellow participant Saloni was also in an intercaste marriage but geographically her birth and marital homes were not far apart from one another, nor was there any animosity despite initial apprehensions about how she would be treated marrying into the a Brahmin household while coming from a Scheduled Caste community. Saloni had spent very little time living in her marital home as she first lived in Delhi with her husband for a few months after marriage and then in her birth home during her pregnancy and after her daughter was born. But she also referred to her marital home as her 'home' saying that she cannot keep living with her mother and will need to 'go home' eventually. Seema and Saloni had fairly different circumstances owing to their birth and marital families' response to their decision to marry out of faith and caste, but made the same references to home.

I now use excerpts from Sharmina's interview to illustrate how the above established gendered position of women in the home (or in relation to the home) influences their access to care, and what such access means for them. The interview was one of the first study interviews, when the focus of the topic guide was very much on access (especially the steps involved in institutional access), but Sharmina's responses explicitly linked the availability and accessibility of healthcare with her circumstances within her household. In her account, health facilities in the area were both available and accessible. She had been to the regional Primary Health Centre for antenatal check-ups and childbirth, visited private facilities in neighbouring cities for ultrasounds, received contraceptives and health information from the local ASHA worker, and been attended to by a doctor who would come to her marital home

on call.[22] These experiences of access, however, were not isolated from the social relations, dynamics and processes in which she accessed them, and more widely, the social context in which care was forged. In the excerpt below, Sharmina draws attention to the need to look at care more broadly than the services to which people have access.

> AA: Let's talk about how health-related decisions are made in your household. Tell me about your delivery (birth), where did you go..who took you there?
>
> Sharmina: I went to the PHC in the town, *but* [emphasis added] my parents did everything. For the ultrasound, I had asked my husband for money but my husband's elder brother warned him against giving me any money, and so he didn't.
>
> (Sharmina, 18)

Apart from active deprivation of money, Sharmina also described the deprivation of care that she was subjected to in her marital household, adding that her in-laws (including her brother-in-law) deliberately increased her workload, physically and verbally abused her, and stopped her from living in the house (she lived in her parents' home during such periods). As discussed in Chapter 4, being deprived of money, feeling weak, and being uncared for are issues spoken about in the same breath (see page 109 for Sharmina's concerns with weakness and violence). They may vary in severity now and then, but are not conceptualised separately as health issues and family issues, but as one because they together contributed to a feeling of being (un)cared for, and made a woman weak—a state encompassing physical ill-health and mental distress.

> Sharmina: I have to fetch water in my marital home, that is very difficult for me. I tell my husband to install a hand pump, but my in-laws tell him not to.
>
> AA: Where do you go to fetch the water from?

[22] It was unclear who the 'doctor' was. It could be a doctor trained in allopathy or homoeopathy, or it could be an assistant or apprentice to an allopathic doctor, attached to the 'medical' mentioned in Chapter 1 (page 25). Their credentials were not well-known but they were very well-understood by those who consulted them and they were not perceived as quacks. as they were an accessible source of help rather than people who intended to harm or cheat them. Instead, they were perceived as rural doctors, distinct from doctors in PHCs and private centres.

> Sharmina: I go to another person's house. It's about five times a day and it's very difficult for me. Moreover, that family does not want me to collect water from their hand pump/water resource. So I tell my husband but (he doesn't do anything).
>
> AA: So getting water is very difficult for you. What about other chores? You must be doing other chores as well.
>
> Sharmina: Yes, but cooking and all is not so difficult, this is the most difficult. My husband only listens to his sister, brother, and parents. His sister threatens me. They don't let him listen to me saying "she (Sharmina) has no understanding yet. She's young, she doesn't know things." He does not give me any money either.

Sharmina situated her concerns in the dynamics of her household. As I argue in the study introduction (Chapter 1), a household does not only comprise those who share a physical space. Her husband's sister did not live with them but was in a position to threaten to cast her out, and her husband, too, was susceptible to the demands of his family despite living away as a migrant worker. Her in-laws' disposition towards her was premised on greed for more dowry, and emboldened by the fact that she did not have much financial support or protection from her birth family. They inferred that she did not have support because she did not have able-bodied male guardians, and Sharmina confirmed that this was indeed the reason she did not have support, especially in terms of material resources and social capital, even though her parents and sister cared for her well-being in their individual capacities. While Sharmina usually received the medical care she needed, with the help of her mother and sometimes with her husband's initiative, she was not *cared for*.

In terms of reproductive health, Sharmina had a healthy pregnancy and birth the first time around and had her second child in the course of the fieldwork. When I asked her how her husband and she make decisions about reproductive health, giving the example of the number of children, she said that he does not listen to what she wants, revealing that she did not want to have the second child at the time.

> Sharmina: I didn't want another child right now but he said since it's there, then let it be. If there is a difference of opinion with respect to fertility desires, he will not listen to me. No one else will do anything either, *they only beat me up* [emphasis added].
>
> AA: Does your family get involved in your (you and your husband's) decisions about contraception, plans on having children and so on? If so, how?
>
> Sharmina: No, my mother-in-law does not give me any advice.

AA: Do you want to get advice from her?

Sharmina: Yes, I do. But she says that she has nothing to do with me. She does not care for me. *Nobody helps me* [emphasis added], so then I call my mother.

Even here, Sharmina's repeated emphasis is on the neglect and violence, rather than her health status or her access to care. In contrast to her experience with her marital family, her account of her birth family's role in her care, especially her mother's role, was a positive one as they stretched their resources to meet her needs and cared about her well-being. However, I argue that in some aspects of her care, her mother's role in understanding her needs and enabling access was also shaped by social norms, rather than what Sharmina wanted. For instance, soon after Sharmina spoke about not wanting another child at the moment (quoted in the above excerpt), her mother, who was present during this part of the interview, said, with contentment, that Sharmina's marital family was happy with her with respect to her childbearing capacities as she had a boy while the other daughters-in-law had girls: "They want her to have the second child, they don't ask her to terminate the pregnancy, like families sometimes do." So, while her mother took care of her and enabled access to institutional care, which her husband also did later in the pregnancy, neither of them considered or understood Sharmina's feelings about the pregnancy, amounting to a lack of care or care within socially sanctioned norms, in my reading of their actions.

Despite the severe deprivation of care and violence from her husband and in-laws, Sharmina continued to associate herself with the marital home and wanted to live there. At the time of the interview, she had been living in her birth home for several months because her marital family did not let her come back, but she wanted to go back as she identified belonging to the marital family and living in the marital home as her right:

AA: And where do you ordinarily live?

Sharmina: I have been living here in my birth home because my in-laws don't like to have me around, they don't let me come back.

Sharmina's sister: Yesterday, she went there in the morning but they sent her back. They don't behave well with her, and beat her up.

Sharmina: *Nods in agreement*

AA: Even when your husband is around?

> Sharmina: Yes, it doesn't make any difference to any of them. They even threaten me with a knife.
>
> AA: What else do they do?
>
> Sharmina: They ask for more dowry, but we don't have that kind of money. Till now, they keep asking for dowry and beating me up. My husband also does not talk to me properly.
> [Sharmina then asked for support and we had a conversation on the sources of support and the role the collaborators and I could play in it. As noted in the methodology (Chapter 3), this conversation has not been recorded as data, and was taken forward outside of the study.]
>
> AA: So I can understand that you prefer to live here. Do they ask you to come back sometimes, since you mentioned that you'll be going in January when your husband comes?
>
> Sharmina: No, if I go, I will go out of my own choice (*marzi*), no one is calling me back. It is my home, I will go.
>
> (Sharmina, 18)

Sharmina framed her desire to go back to her marital home as her decision, arising out of a right to being a member of the marital family and having a stake in the resources of the marital household. Since her husband and she lived as an independent financial unit despite sharing the physical space of the larger household, it was only this unit that she was associating with and did not mention wanting love from in-laws as some other participants did. It was a claim on 'home' that she primarily wanted, based on the normative idea of belonging to the marital home. Her sister and mother also agreed that her marital home was her home and that she should be able to live there. Except the long stays during first pregnancies (discussed in Chapter 4), married daughters typically live in their birth homes only when something is 'wrong', and although many things were 'wrong' in Sharima's circumstances, the desire to adhere to a norm, along with the conventional social and material security it brings, was stronger.

In her study of marriage and kin support in the slums of Delhi, Grover (2009) refers to these extended stays in the birth home as women's moral right to parental refuge, especially in arranged marriages. But such refuge, Grover's (2009) research shows, can disrupt women's married lives as it poses a challenge to patriarchal norms of belonging. In my study, three participants—Suvidya, Ranjana and Radhika—went to live in their birth homes as a warning

to their husbands to treat them well. This led to further animosity between them and their husbands as they had transgressed the social norm of living in the marital household (and providing care to its members), although their husbands did not retaliate with violence and eventually took the initiative to convince them to come back and assure them that they would be treated well. In Ranjana's case, the brief separation led to some discomfort in her birth family as well as they expected her to live in her marital home. Seeking refuge, therefore, involves negotiations with the birth family as well because the resources of the birth household are now for the sons and their wives and children, including prospective wives and children if they are not married (Chaudhry 2021; Grover, 2009; Pinto, 2011). This was evident in Sharmina's case as well when she was living in her birth home (as refuge) and needed protection from her abusive marital family. While her parents wanted to help her, it was her half-brothers (her father's first wife's sons) who prevented any substantial help from the birth home altogether as they controlled the material resources and social capital. Drawing on Grover (2009), a right to refuge also implies that women do not have a right to residence in the birth home, making women turn to the marital home to seek rights to residence and belonging, which participants like Sharmina were compelled to do.

Underpinning these ideas of home is a movement from the birth household to the marital household, which is preordained even if it actually happens only upon marriage. In the following section, I briefly discuss what marriage means to the women in the study or what they expected out of it. I then look at the literal processes which enable the movement from one home to another upon marriage—'bringing' and 'keeping', and study the gendered values that these processes inscribe to both parties in the marriage. I argue that the specific acts of bringing and keeping, which are sustained by gender norms, confer authority and responsibility to men as husbands. In subsequent sections of the chapter (Sections 5.4 and 5.5), I go on to show how such authority is instrumental in influencing women's access to care.

5.3 The centrality of marriage

In the study context, marriage is inherently characterised by women's dislocation, and conventionally and historically, by their subservience. While accounting for the gendered relations of this structure, I draw attention to the dynamics involved, and to women's shifting

perceptions of marriage. This allows for an understanding of not only the structure but also the dynamics within which ‘bringing’ and ‘keeping’ and the accompanying authority and responsibility happen. I draw particular attention to participants’ understanding of marriage as a partnership, that is, while the husband has authority, the marital relationship is where authority can be negotiated with, rather than other sites and relationships characterised by authority such as the authority of parents in the birth home before marriage.

Sunita, the first pilot participant I interviewed, articulated such an idea of a partnership in describing her marriage. Sunita and her husband had an intercaste marriage, overcoming significant opposition from their respective families, and she said that her husband was her biggest source of support. He was essentially someone she could turn to to share her problems and seek advice, and someone she could negotiate with in everyday household matters or larger questions like further studies, even when her in-laws or parents were not open to negotiation. Such partnership continues to happen, or is aspired towards, within unequal gender norms.

> “If you have a good partner in life, everything is fine.”
>
> (Sunita, 23)

As explained in the methodology (Chapter 3), half of the study participants were in love marriages, which compels the study to approach marriage differently from the way it conventionally is studied in research on kinship in South Asia—focused on patrilocality, labour and social reproduction (much as those aspects remain important), and also differently from the predominant understanding of early marriage as forced or unwanted marriage, and a problem of development and culture. Several qualitative studies have looked into the rising practice of love marriage in India, albeit largely in urban contexts. Such literature especially focuses on shifting power dynamics between marital couples, impacts on relations with kin, life within inter-caste marriages, and the ideals of romantic love (Chaudhry, 2021; Donner, 2002; Disha, 2023; Grover, 2018; Mody, 2022). I suggest that the increasing (visible) possibility and acceptance of love marriages, coupled with changing social norms in other arenas such as women’s education and employment, impacts the perception and expectation of marriage itself, whether love or arranged. As with noting changes in health status and needs between generations (see Chapter 4), participants also sometimes made note of their mothers’ lives being different in marriage because that was a different generation.

Participants, therefore, expected a level of mutual understanding and a caring relationship, encapsulated by Sunita's articulation of 'a good partner', despite the authority that husbands hold in marriage. Sunita's particular use of the English 'partner' rather than a word for husband, especially captures the aspiration for an equal relationship. This shift in the idea of marriage as a partnership is also reflected in the changing norm of living as independent nuclear units and not as part of the joint family. However, love marriages (and marriages where there is greater mutuality and care) continue to occur within the limited structure of heteropatriarchal marriage and do not result in a change or reversal in gender roles or a change in material realities. Even so, there was a marked expectation of support from one's husband among the study participants, which rested on the recognition of marriage as a partnership, and on the recognition of the husband's authority in or despite the partnership—accorded to him through gender (as a man) along with his gendered position as the son of the household, and his access to material resources and social networks. Participants sought support from their husbands in both love and arranged marriages and in marriages where the husband was older, wealthier, or from a dominant caste or religion, as discussions on decision-making in the following chapter will demonstrate.

In this context of marriage, women associated husbands as the key actors in *bringing* them (whether in love or arranged marriage) and associated authority (over them) and responsibility (towards them) with the process of bringing, and subsequently, *keeping*. The authority of husbands is socially legitimated, and granted by societal conventions (of patriarchal and endogamous societies, in the case of this study), and followed through at the level of households and marital relations. I argue, in what follows, that men specifically gain such authority through and in marriage, in addition to their general hegemonic position within family, market and society. The socially-sanctioned authority of husbands, especially in matters of health, is also reinstated through public institutions. For instance, health practitioners may take husbands' consent to perform sterilisation on their wives, even though spousal consent is not required for sterilisation, but socially, a woman's care (and body) is considered to be under the authority of the husband (Feder, 2020; NHM, 2006). At a wider level, such authority is also coded in policy. For example, upon marriage, women's legal documents carry the names of their husbands, while men's documents at all times, and women's before marriage, carry the names of their fathers, as signs of identification and guardianship, reflecting the structures and hierarchies of social authority. I use examples of husbands 'bringing' women in marriage migration (from *maike* to *sasural*) from existing

literature, along with excerpts from selected interviews from my study, to illustrate how the authority of the husband works in marriage, and towards what ends, drawing attention to how it is perceived and responded to by women.

After exploring the notion of 'bringing', I turn to consider the related notion of 'keeping', which enables me to explain how husbands become invested not only with authority over their wives but also responsibility for them. Having established the nature of heteronormative marriage in the study context, I now argue that ‘bringing’ and ‘keeping’ signify more than the process of marriage migration; they embody the gendered values attached to such migration, which is the authority and responsibility of husbands towards their wives. And in the final sections of the chapter (Sections 5.5), I turn to explore how these dynamics influence women's access to care.

5.4 ‘Bringing’ and ‘keeping’: Exercises in authority and responsibility

As I spoke to women who were now daughters-in-law, they described their association with a new family as being *brought* into the marital home, through the Hindi *lana* (bring/brought) or *leke aaya* (he brought me here). Bringing is a common colloquial term for marriage, which is characterised by patrilocal residence in the study area, but by attending to the specific contexts in which it is used by participants (when they used it as an explanation or justification for something, for instance), I argue that it alludes to the functioning of gender dynamics, and has consequences for women’s care. ‘Bringing’ is a migration that unfolds concurrently with household-based practices that typically curtail women’s mobility, disrupt their social relations after marriage, and increase their gendered dependency (Chatterjee and Desai, 2020).

‘Bringing’ has been noted as a term to refer to marriage in other studies as well and, in what follows, I draw attention to the contexts in which it has been discussed. For instance, in Agha’s (2021) study on women’s navigation of kinship and patriarchy in rural Pakistan, a participant’s use of ‘bring’ is interpreted as marry, but I also note that the term is specifically used by the participant (in Agha’s study) to refer to the subservient position that a woman conventionally occupies in marriage, and the violence that men can perpetrate if such subservience is challenged. Thus, “A man brings [marries] a woman to serve him. If a woman

does not do the man's work and starts arguing with him, he will definitely beat her…" (Agha, 2021, p. 236).

In another use of 'bringing', in Jeffery, Jeffery and Lyon's (1989) widely cited ethnography on reproductive labour from rural North India, a chapter title reads *Did we bring you here just to see your face?*, drawing on a quote from a mother-in-law, and on the idea that women are brought to perform labour for the entire household, even when the act of bringing is associated with the husband.

Jejeebhoy, Shah and Thapa (2006, p. 66), in their study of non-consensual sexual experiences among young people in India, draw on George (2002) and cite a similar quote from one of their participants, which also indicates that bringing is associated with subservience, and in this case, particularly pervasive and non-consensual sexual activity: "Don't make a noise, you must bear the touch of a man. This man has married you and brought you here for this."

Lastly, in what follows, I draw on another mention of bringing in Jeffery, Jeffery and Lyon's (1989, p. 187) study, where a participant notes that "girls are good because you can give a daughter away. But boys are better because they receive a bride, they bring people in and continue the family." This iteration of bringing, while referring to marriage, also refers to what bringing does for the social reproduction of family and caste, and implicitly evokes a woman's reproductive labour. It also connects bringing to ideas of home and (dis)belonging, illustrating a woman's transitory place.

The above associations with bringing are inherently negative, indicating that bringing is not just to marry but about control and subservience, enabled by the socially sanctioned authority of husbands. This could, in turn, mean that marriage itself is an exercise in control, but as iterations of bringing (and subsequently, keeping) in my data will show, it is a much more complex process involving differing perceptions of authority by women as well as challenges to it. I draw on excerpts from my interviews with Kaveri and Ranjana, both of whom mentioned being 'brought' into the marital home but had different experiences and expectations from the process and from their husbands, to show how bringing, and its associated authority, can have different connotations and consequences for women's care.

5.4.1 'Bringing': Associations with household and marital dynamics

Kaveri was in a love marriage and was having difficulty conceiving (discussed in Chapter 4). In a discussion of her fertility needs and care-seeking plans, Kaveri began to describe her position in the marital household and her identity and role as a wife, which also shed light on the centrality of the husband and of marriage itself, and its implications for her care in the sense of larger welfare.

> AA: Okay. So like you said, your husband fell ill and that was more urgent (than your fertility care), so that's perhaps how we make decisions sometimes…
> (interrupted by Kaveri)
>
> Kaveri: Look, after marriage, it is more important to take care of your husband than your parents. Meaning your mother may have carried you in her womb for nine months and given birth to you, but *your husband has also brought you to his home* [emphasis added]..even then, I think..my parents brought me up..but after marriage, I have come to my husband's home, my husband is my everything now. Thinking about parents is a bit far away now.
>
> (Kaveri, 21)

Kaveri was explaining that her commitment towards her husband was a response to him marrying her and bringing her to his home. Kaveri's husband also displayed a sense of commitment towards her care and welfare but she did not frame this as his responsibility (as a consequence of marrying and bringing her) but as affection for her as his partner. Kaveri's husband exercised authority in their marriage, structurally, being in charge of greater resources than her and by being the husband. But crucially, he used these resources, including social resources such as his position as a son within his family, to enable her welfare. In other words, he took responsibility for her welfare. His authority, therefore, was not perceived as oppressive by Kaveri, instead becoming a source of support. It was *through* his authority that she was cared for, rather than outside of it or by challenging it. Kaveri accepted her husband's position of authority (and the general authority of husbands in marriage), and acknowledged it by speaking to him about her problems first and following his advice (discussed further in Chapter 6, page 188). However, she drew a line at violence, which she did not personally face, but as she said, many married women did. The distinction participants made around violence positions it as an illegitimate exercise of power, different from the authority of husbands which is socially-legitimated and (as I subsequently argue) central to women's care

as it enjoins them with responsibility. Kaveri made a distinction between what is important versus what is wrong in a marital relationship. In her account, it was important for women to share their problems with their husbands, not make decisions on their own, and take care of husbands (as quoted above). On the other hand, husbands perpetrating physical and sexual violence against women, including non-consensual sex, was categorically wrong (discussed in Chapter 6, page 120). While participants drew distinctions between the authority of husbands (which I subsequently argue, is present at all times) and illegitimate exercises of power (which manifested in limited instances of violence, in participants' perspectives), it is notable that this analytic distinction could not always be mapped neatly onto women's accounts. This is so because women's perceptions of their husbands' actions were contingent on the nature of the marital relationship and the shifts in it, part of the shifting gender dynamics of the household. In the following sub-section, I use excerpts from Ranjana's interview to illustrate a different perception of being brought in and of the husband's authority in marriage, owing to differing household circumstances and the dynamics of the marital relationship.

The circumstances of Ranjana's marriage were vastly different from Kaveri's. Like some other participants, notably those in arranged marriages or those who did not want to get married when they did and possibly to whom they did, she associated bringing with the husband's responsibility to care for her but there was a lesser or no expectation of affection from him. Ranjana's husband had met her at a tea factory that both of them worked at. He wanted to marry her but when a meeting between them led to rumours of them being in an illicit relationship because they were from different castes, her parents immediately got her married to him against her wishes, for fear of dishonour. Ranjana's mother-in-law and brother-in-law disapproved of the marriage because of the difference in caste (her caste was 'higher' and her ethnic background was different) and subjected her to verbal abuse and material deprivation. Ranjana held her husband responsible for not intervening to stop the abuse and deprivation because he was the one who had married her and brought her to his house.

> AA: What are some household-level factors that affect your health? (asked when the participant was back from the health centre following a fall, which she attributed to tensions in the home, as discussed in Chapter 4).

> Ranjana: There are many things like that. When I eat at home, my mother-in-law taunts me about how much I eat. She casts an evil eye on me. She says that I am a burden, I am from another caste and I have come like a witch into her home. This affects my health because I am unable to get the nutrition I need. My father-in-law is nice though, he treats me like his own daughter.
>
> AA: What do you try to do to address this problem?
>
> Ranjana: I complain to my husband, telling him that I eat only from what he earns or from what I earn for myself. But then my husband says this is your matter, I don't want to get involved. I tell him how can you not support me if you are my husband, *you married me and brought me here* [emphasis added], but he doesn't.
>
> (Ranjana, 18)

Ranjana sought support from her husband in her relationship with her mother-in-law because he had conventional authority in the marital relationship (which enjoined him to be responsible for her) and also hegemonic authority in the household as the eldest son of the household. But he did not use his authority to intervene and support her. Furthermore, he exercised power over her through physical violence and regulations on her mobility and activities (such as her participation in the research, discussed in Chapter 3, page 85). While violence was universally understood as an illegitimate exercise of power among the study population, regulation of women's mobility and social activities, although often unwelcome, were seen as legitimate manifestations of the authority of men, and largely went unchallenged. Ranjana, however, perceived it to be an interference and a source of deliberate harm, and hence, part of the violence he perpetrated on her. I attribute her perception of his action as illegitimate (or as socially legitimate but worthy of being challenged) to the relationship she shared with himself and his family—which was marked by control and inhospitality, and the very circumstances of her marriage—where he had brought her in without her consent or a willing arrangement made by her parents. She outrightly defied his restrictions by going out when she wanted to, and retaliated to the violence through everyday acts such as not cooking his food properly, conceptualised as forms of resistance in some feminist literature (Thapan, 1995; Agha, 2021).

The authority of the husband was evidently at play in both marriages, as it was the husband's disposition towards the women that determined their position in their respective households, and their access to care, because it was the husband who could mobilise resources and act

upon his responsibility to enable care. However, while Kaveri's husband did so, Ranjana's did not, owing to the everyday dynamics of their respective marriages and households. Consequently, Kaveri and Ranjana perceived the conventional authority of their husbands differently, and also responded to it differently, with Kaveri accepting it as an enabling factor while Ranjana sought to invoke it so that her husband would show responsibility and enable care for her, rather than out of respect for such authority or for his superior position as the husband. In the quotes cited above, from Agha (2021), Jejeebhoy, Shah and Thapa (2006) and Jeffery, Jeffery and Lyon (1989), bringing is directly associated with subservience, and with violence, which is reflected in Ranjana's experience of being brought in and her consequent position in her marital household, even though she resisted it. For Kaveri, bringing was associated with a sense of responsibility towards her husband (she had to think of him first and perform care labour for him) but her position in the marital household was not subservient and she did not face violence.

The act of 'bringing' a woman is followed by the act of 'keeping' her, and is a process illustrative of the responsibility that the authority of husbands enjoins them with. In the following sub-section, I examine the importance of 'keeping' in setting up the meanings and expectations of care in marriage, and its creation of (and dependence on) women's position in the marital home.

5.4.2 'Keeping': A conditional responsibility in marriage

'Keeping' (*rakhna*) is colloquially used to mean providing for wives and/or taking care of them. This iteration of keep is different from upkeep, but close to legal maintenance. The expectation therefore is of the bare minimum in terms of taking care of someone's material needs, while 'keeping her well' (*achhe se rakhna*) involves attending to emotional needs as well. At a fundamental level, keeping quite literally means that the woman has to be able to stay in the marital household—she must have the space and security of a house, access to material resources, and the husband's will to stay married and faithful. Although keeping was identified and analysed as an analytic code that emerged from the data, I have come across iterations of it in discussions within and beyond the research context. As participants and collaborators used keeping to express different but related processes, I recounted the frequent use of the term in a family court in urban Mumbai where I worked as a graduate intern, in a very different cultural and regional context. The court, run by women and based on Muslim personal laws, aimed at reconciliation between couples and often asked men to 'keep' their

wives properly, using the term to encompass material provision, emotional care, and refraining from violence. *Keep her with love* was a common piece of advice used in the court, and hinged upon the husband's behaviour, which in turn was influenced by his authority and responsibility.

To illustrate how keeping is underscored by gender dynamics in my study, and how it is always conditional, I draw on the background of Seema's marriage, in relation to which she used 'keep' to talk about being loved and taken care of. Seema's marital family had welcomed her despite differences in caste and religion, and she identified their home as her home (as discussed on page 138), adding that she had all kinds of modern comforts in her marital home like a smartphone and a flatscreen television, and did not need to engage in paid work outside of the house. Her marital family had welcomed her saying that "girls have no caste," indicating that it was not controversial to have her in their family as women can be subsumed into another family's culture and identity. Seema had converted upon marriage and had also had her name changed. The fundamental idea behind girls not having a caste is that a woman's identity is inconsequential and can be erased or altered, and it also speaks to the dislocation of women upon marriage which makes them part of another household and culture, although never fully (Mohammad, 2015). For Seema, her in-laws saying "girls have no caste" was crucial to their acceptance of her, and provided a comfortable space for her when she needed it. She did not express a loss of identity but certainly a loss of being different and distant from her parents, saying that she sometimes wondered how different her relationship with them would be had she not eloped. Being kept, therefore, usually happens in a context where there is no other option (not only because of distance and animosity with one's birth family but also because women 'belong' to the marital family after marriage). Being 'kept' and especially being 'kept well' is also contingent upon their adherence to a new household and its norms, and therefore, conditional.

The conditionality and precarity of 'keeping' is evident in the threats women receive of being cast out if they do not perform extensive household labour, do not bear sons or any children at all, and if families suspect them of having affairs. Saroj and Radhika, whose respective in-laws thought that they shirked work each time they complained about ill-health, particularly expressed the common retort of marital families: *we can get another daughter-in-law if you do not do the work*. In practice, families may not cast out their daughters-in-law easily but the threats convey that women (and their lives) are replaceable. In

some other cases, husbands and marital families did indeed cast daughters-in-law out, or tried to, if they were dissatisfied or felt that the daughter-in-law was straining their resources without bringing enough in (through dowry and labour). Sharmina's in-laws, for instance, constantly tried to cast her out, barring her from the household and its resources, which she actively challenged by insisting that she will live in the marital home. The husbands and marital families of Nalini and Ranjana also tried to cast them out (or push them to leave) by neglecting them and physically and verbally abusing them, after which they often took refuge in the birth home. Soniya, the only study participant who had separated from her husband, had also been cast out, along with her child, because her husband did not want to be with her anymore. In her words, he did not *keep* her, and eventually *kept* another woman.

Keeping, therefore, is the responsibility of the husband, and to some extent, the marital family. Not keeping, especially when the woman has fulfilled her social roles—borne children and particularly sons, performed the household labour expected from her, not gone to her *maike* too often, remained faithful—amounts to non-fulfilment of responsibility. The socially-sanctioned authority of men, therefore, is not limitless but comes with attendant expectations of responsibilities that must be fulfilled.

Keeping, or being kept, was desirable to participants at all times—as it provided a sense of care, home, and honour, beyond subsistence. Grover (2009) found that in the backdrop of high economic instability (in urban slums in Delhi, but applicable to my regional context as well), the ideal husband was someone who would take (normative) responsibility for his family and that this responsibility or fulfilment of economic needs was considered synonymous with love. If such responsibility was not fulfilled, marital tensions would arise, akin to the tensions in my study when women were *not* kept—when they were cast out, threatened to be cast out, or not adequately provided for—which also amounted to an exercise of power, especially when they were deliberately deprived of resources and care (rather than not provided for because of a lack of resources). My findings, however, differ from Grover's (2009) on fulfilment of economic needs being synonymous with love. In my interviews with participants whose husbands did not want to provide for them or did not ask after them (about their health and well-being in the marital home, and other personal wishes), fulfilment of economic needs was seen as the bare minimum a husband could do even if he did not care about the wife's emotional well-being. Fulfilling economic needs and ensuring basic welfare was considered to be the husband's moral responsibility as he was in a position

to provide, and because such provision was expected in exchange for dowry and women's care work for him and the family. This understanding of care is further discussed, in relation to other formulations of care, in the subsequent Chapter 6.

There were only two cases in my study where husbands (Divya's and Nusrat's) did not have the resources to provide. Divya's husband lived with her in her birth home and did not draw significant authority through the marriage as he did not 'bring' her. Likewise, he was not expected to 'keep' her as it was her parents who provided for both of them while he did not have a stable income, and more importantly, because she did not live in his household. His incapability to provide was not considered problematic by the family (perhaps because of the circumstances in which the marriage had been arranged) but it also meant that it was her parents, and particularly her mother, who took care of her health needs, including fertility decisions. He had minimal contact with his village and community after his parents had passed, further diminishing any authority he may have drawn from social connections. Nevertheless, I argue that he continued to have some authority, or at least a privileged position as her husband and a man, while Divya still occupied the gendered position of a wife and daughter-in-law (or a married daughter), and provided care to him, performing her conventional role as a wife.

Unlike Divya, Nusrat's husband had brought her in, and then failed to provide for her, although she continued to live in the marital household. Her marital family was cognisant of the fact that her husband was unable to provide for her and that her ill health went unattended to, but they, along with Nusrat, were also aware that he suffered from addiction and struggled to provide. Nusrat's husband, therefore, kept her in the literal sense of not casting her out but deprived her of care, because of his own issues with addiction, and according to her, because he simply did not care about her after marrying her even though it was love marriage. His neglect towards her was lamented by his family but not addressed as it was his responsibility to provide for her as he had brought her in (strengthened by the fact that it was a love marriage where he must have brought her of his own volition rather than an arrangement made by them). It was only when Nusrat was severely ill that the family and neighbours stepped in and asked her husband to make arrangements for her care as it was his responsibility to do so, because he was supposed to be the figure of authority in her care. The authority and responsibility of men, therefore, is directly linked to women's access to care, and can result in both care and neglect.

The ideas of ‘bringing’ and ‘keeping’, in this section, illustrate women’s understanding of the gender dynamics of marriage and the marital household. My aim in the remainder of the chapter is to explore how women experience the operationalisation and navigation of authority in practice and to consider its implications for their care.

5.5 Authority and responsibility: Implications for women’s access to care

To understand the relation between the authority and responsibility vested in men to enable care for women, I juxtapose the role of a woman’s parents with that of her husband in her care. A woman’s parents may be concerned about her health and want to do something about it, but they are not responsible for it (after marriage) as they have lesser, or no, authority over her, or less authority to care for her. It is the husband who is responsible for it as the woman is now considered his ‘ward’ and a member of his household, as he has brought her in and now keeps her. So, for example, when Ranjana had a fall in her birth home, her family took her to the health centre, but telephoned her husband to come and take care of her as it was his responsibility primarily and he had to be informed at the very least, even though the incident had not occurred in the marital household. They were not shirking responsibility but respecting his authority over her and reminding him that this entails responsibility towards her, especially because he did not always use his authority to fulfil his responsibility towards her. Conversely, when Nalini fell ill in her marital home and telephoned her parents about it, her mother-in-law warned her against sharing matters of the marital household (her illness and the care she was receiving or not receiving) with her mother, as she was supposed to get care through her husband and in the marital household and not through her parents. The experience of both women shows the role of men in their wives’ care, and also shows the boundaries of home and the channels of care that women navigate.

Having argued that the authority of men is drawn from their position in marriage and the household, maintained through the acts of bringing and keeping, and the simultaneous shifting identity and (dis)location of women between households, I argue, in the following subsections, that it is through the authority of men, exercised in different measures, through different processes and towards different ends, that women are cared for. I also argue that authority is at play in both care and neglect, the two being a dialectic. Even when there is

genuine love and care for the wife, and a sense of responsibility, it is operated through authority. With each illustrative example, I also draw attention to women's perception of and response to authority and reception of care, and the consequences of such response and reception for their care.

5.5.1 Neglecting responsibility towards women's care

As has been established, care was primarily sought and given (sometimes without explicitly being sought) through the authority of the husband. So, when Radhika found out that she was pregnant, she spoke to her husband about the next steps in her care. When I asked why, she said since he had married her and brought her into his house, then he is the person primarily responsible for her. Radhika described this sense of responsibility by using the Urdu word *farz*, meaning duty. After she spoke to him about her care during pregnancy, he spoke to his mother who contacted the local ASHA worker (as men have little contact with ASHA workers) who then arranged for a routine antenatal visit at a public hospital. The ASHA worker asked her husband to come along for the visit, and Radhika added that he wanted to come of his own volition too. When I asked her who made the decision to go to the health facility, she presented the decision and the initiative as her husband's:

> Radhika: My husband asked me if I wanted to go (to the health facility). I said I will go if it's going to be good for me.
>
> AA: And was there anything that you wanted to do/anywhere you wanted to go?
>
> Radhika: I didn't want to go to any hospital, I just wanted to come back to my parents' home.
>
> AA: So did you say this to your husband?
>
> Radhika: Yes, I told him and my mother-in-law, both of them were happy with it.

A few months after this interview, I was able to meet Radhika for a follow-up interview, during which she recounted the same incident of coming back to her birth home during her pregnancy. However, this time she said that she came back without telling anyone, contrary to what she earlier said about telling her husband and mother-in-law and them being happy about it:

> Radhika: My mother-in-law did not even want to accompany me for my delivery

(birth), she would say it's someone else's child (implying that the father was someone other than the husband), so I thought I might as well come home (to my parents'). I didn't tell my husband either, I just came home. See, you can't take care of women just with food and nutrition, it's much more than that. I will divorce my husband now. He does not give me one penny also, nor any clothes or other items. He spends it all on alcohol and then beats me up. But he is not even leaving me.

AA: Have you spoken to someone about this, for help?

Radhika: I went to the police station for legal advice, but they said that a divorce is not possible. I am following up.

(Radhika, 18)

Her account of her husband (and her mother-in-law) in the follow-up interview was starkly different from the first interview when she said that he facilitates care for her and that her mother-in-law also played an enabling role. This difference reflects a shift from presenting an appreciation of the husband's authority (when it was perceived or presented, to me, as responsibility) even when it was not entirely desirable (perhaps to present a normative picture of accepting the husband's authority) to challenging him when he exercised power in the form violence and deprivation, further backed by dowry harassment from his family. The difference in accounts may have been made possible because of the gap between the two interviews and our social interactions in-between, which made Radhika share a different perspective with me (an outsider), and it may have been triggered by a particular instance of violence or the longstanding neglect. Radhika was possibly producing what Visweswaran (1994) refers to as situational knowledge or knowledge produced in and for a context, and I read her shifting accounts for their value in constructing a narrative around gender dynamics rather than pinning down what exactly happened (see Chapter 3, page 88). Radhika was the only participant who actively wanted to separate from her husband at the time of data collection, making her case unique, but her emphasis on his responsibility to care for her, and her subsequent decision to leave when he did not, points to his centrality in her navigation of care, the centrality of marriage, and to shifting forms and perceptions of authority. It also points to the complex nature of the authority of husbands in marriage, which, although socially-conferred and universal, is also constantly negotiated by both parties. Radhika had received the institutional care that she was entitled to during her pregnancy and birth, and had

had the support of an ASHA worker. While her account of her husband and mother-in-law's role was conflicting, it did not impact her access to institutional care adversely. She also seemed to have received adequate care at home, especially in terms of nutrition, but as she says "you cannot only take care of women with just food and nutrition," bringing attention to the conditions of care and support that must accompany access for access to be meaningful.

5.5.2 Determining the terms of women's care

I now use Subhadra's example to illustrate how care is expected to happen through (the authority of) the husband, even when there may be no animosity and both partners may be on the same page about the type of facility to be accessed. Subhadra was in a love marriage and had four daughters. Like most women with only daughters, she too faced pressure to have a son, and regretted that she could not give "happiness" to her husband. However, as with some others, her thoughts on not having a son were shifting rather than being a constant source of worry and pressure. Her husband loved her and was happy with the four daughters they had, but she indicated that he also worried about not having a son. Her mother-in-law expected a male child but Subhadra considered this to be an emotional need on her mother-in-law's part and not one that constituted overt pressure. Subhadra also maintained that eventually, she will decide if she wants another child or not, "if I want it to happen, it will, if I don't, then it won't." What was constant in her range of thoughts and opinions was that her husband supported her and did not have a differing opinion at any point. He had also supported her in studying and working after marriage, despite opposition from others in the community. Her mother-in-law and her late father-in-law had also been supportive. Subhadra's husband continued to exercise authority through all of this—and it was his authority that created the supportive conditions for her to study and work. However, his authority became more visible when it came to be challenged by her. During her second pregnancy, Subhadra wanted to get an abortion without telling him, to avoid having more daughters, and she was challenging his authority by not seeking care through him (the abortion itself was not a challenge as he would have been on the same page as her about the desired number and gender of children). Eventually, she did not get an abortion as she was worried about his reaction to not telling him if he found out later, especially if something went wrong in the procedure. While she did not get the abortion, she adopted *Antara*, the injectable contraceptive available at government facilities and through ASHA workers, without telling him or anyone else at home. The

contraceptive led to excessive bleeding and made her unwell, and she then had to tell her husband and mother-in-law about it, both of whom scolded her for adopting the method without asking them. The husband and mother-in-law possibly scolded her out of concern for her health, but implicit in the concern is that she should have discussed it with a source of authority (her husband, principally, or mother-in-law) even though she procured it from a health worker. In my understanding, Subhadra did not tell her husband and mother-in-law about accessing the contraceptive, and hypothetically, the abortion, because of two factors - she had the resources to access these facilities by herself and often did things on her own, and she may have had some doubt or fear that they would disapprove of her decision. In both ways, she was challenging their authority, especially the husband's as her mother-in-law did not have the same kind of authority over her (as mentioned above, it was more of an emotional association). Subhadra's husband was not neglectful at any point, nor did he do anything that inadvertently caused harm to her health. In fact, he provided care whenever she needed it, but, crucially, expected the care to happen within the limits of his authority, or *through his authority* which made him the person who had to be responsible for her. Subhadra's challenge to him (by taking the contraceptive without routing it through him), and his response (maintaining his authority by chiding her), again points to the negotiation of authority in marriage, and its implications for women's care.

In the study of women's negotiation of men's authority (and their responsibility), fertility decisions present a unique site to understand how these attributes operationalise women's access to care. While institutional access is enabled by conditions such as availability, accessibility, and the role of several actors—husband, family, health workers, fertility decisions are less publicly visible and are often negotiated within the marital relationship, albeit with influences from family, law and society. As discussed in the introduction to the study (Chapter 1) and in the literature review (Chapter 2), institutional access alone does not account for better reproductive health outcomes and to women's sense of feeling cared for. I use excerpts from interviews where women differed from their husbands on their fertility desires, or navigated where they stood in relation to their husbands' fertility desires, to show how authority works in the garb of care, and also comes to be challenged.

Sonali, like many newly married women, faced societal pressure to have a child. She was 17 years old at the time of the interview and had gotten married a few months ago through an

arranged marriage. Her husband, however, was of the opinion that they should have a child only after a few years because pregnancy and birth could harm her health at her young age.

> "My neighbours and relatives wonder why I have not conceived yet. But my husband is very nice, he says that we don't need to have a child now as I am very young, he says that we can think of it after 2-3 years."
>
> (Sonali, 17)

Despite her husband's seeming support and concern about her health, Sonali considered having a child because she had to deal with the societal pressure single-handedly while he lived away as a migrant worker. However, she too did not want to have a child right away. Her husband and she had not been using any form of contraception and she had been pregnant right after her marriage, and during the interview, both of which had ended in miscarriages. At the beginning of her second pregnancy, she had been wondering whether to carry it to term or terminate it, and her husband advised carrying it to term saying that the pregnancy was god's wish.[23] He assured her that he would look after her health and would be there for her if something goes wrong. His assurance of care was important to her, and was a manifestation of his responsibility, conveyed by "he is very nice" and "he said he will maintain (take care of) me." At the time of our interview too, he asked me to give her advice on care during pregnancy, before leaving us to speak in privacy.[24] However, such care had been preceded by his authority which enabled him to 'advise' her to carry the pregnancy to term, which was once again presented through/as care.

Sonali's personal desires shifted between wanting a child to relieve societal pressure, wanting a child because she eventually wanted to have one and liked babies, and not wanting a child because it could harm her health (based on what she had heard from her husband, and what she had experienced)—reflecting the dynamic nature of pregnancy desires and

[23] The idea that it is god who gives children and takes children away was widespread across communities in the study area. It was not attributed to religion and religious texts but usually to morality, and also possibly prompted by the high infant mortality rate in Bihar (46.8 deaths per 1,000 live births), which indicates that having a child cannot be taken for granted (IIPS and ICF, 2021).

[24] Sonali's husband had read the participant information sheet, after which he asked me to advise her on nutrition and care during pregnancy. I told him that I was not well-suited to offer advice, drawing his attention to the participant information sheet and emphasising the research objective, after which he left us to speak in private.

decisions—which do not into fit neatly into choice and family planning. Her husband's opinion to not have a child for a few years, yet not enable access to contraception (while she did not have the means to access contraception or information about contraception), and then carry the pregnancies to term, together with his assurance of care was also something she navigated. After her second miscarriage, she was more certain about not having a child soon, but continued to articulate it as her husband's concern for her health: "*he has said* [emphasis added] that we do not need to have a child right now." Once again, he assured her of his care by reiterating that he will be there for her (expressed responsibility), but he did not enable access to contraception, and she did not challenge him. It is important to note that although she spent extensive periods of time in her mother's home, her mother too did not encourage the use of contraception even though she could access them—perhaps out of respect of the husband's authority and responsibility in the matter, and because she was invested in Sonali having a child right after marriage as it was believed to be the right thing to do. The quality of care that Sonali received is likely to have been good and accessed in a timely manner, but the circumstances in which she needed care are underscored by the gendered dynamics of marriage and wider gendered relations where she needs to entrust her care to her husband and also perform her role as a daughter-in-law and have children.

The authority of husbands can be used to facilitate care or impede care and likewise, it can also be used to practise neglect, sometimes in the garb of care. Sonali's husband may not have neglected her in an immediate sense (in case of emergency or pain) but he neglected her wishes, especially when it was so closely tied to her health and well-being. Neglect, therefore, is not only practised through outright deprivation but also by ignoring or dismissing women, and her experience, in my analysis, can be understood as neglect. When Sonali's husband advised her, his advice did not come with force, but given the structural hierarchy of marriage (and particularly their arranged marriage where he was much older and more upwardly mobile), his advice held significant weight and would have guided her actions. In this manner, he exercised authority over her, considered socially legitimate as husbands advising wives is considered to be their prerogative, and additionally, in this case, his authority was accompanied with assurances of care, or responsibility. But while she accepted his advice (and arguably, his authority), she also had opinions to the contrary and considered getting an abortion during the second pregnancy. She shared this opinion in the interview, and possibly with him as well, even though she was unable to act upon it. Sonali's act of sharing this opinion and being in two minds about the pregnancy shows that she

navigated his authority and the opinions and advice offered by her family and community as well, most of whom wanted her to have a baby immediately. Her health had been severely impacted during both miscarriages but nobody held her husband responsible for it as it did not involve force, but instead encompassed access to timely care.

5.5.3 Influencing the circumstances in which women require care

Suvidya's experience of accessing institutional care provides another example of husbands enabling access of the highest quality they can afford, but influencing the circumstances that the need for care is forged in. Suvidya had an interfaith and intercaste love marriage and her husband asked after her and assured her of his care during her first pregnancy, and took her to private facilities. At the time of the interview, Suvidya had two daughters and did not want to have any more children, but her husband insisted that they have a third child because he wanted to have a son. I had posed the question about navigating conversations about the number of children as a hypothetical situation, to assess how the dynamics in their marriage played out, especially given her birth family's influential status which gave them some power over her husband's role in her care. But the question about the number of children was something that she already navigated (along with her husband's authority and societal expectations), as suggested by her responses at different times during her interview and the focus group discussion she participated in.

> AA: I want to understand how reproductive health decisions are made, who all are involved?
>
> Suvidya: Everyone is involved. If I had a son and a daughter, everyone would have said I should get the operation (sterilisation) now. But they want me to have another child, like his sisters…
>
> AA: Let's take the example of contraception, what if you want to get the injection and he wants you to get operated (sterilised)?
>
> Suvidya: See, he wants me to get the operation..I mean the final goal is the same - to not have children. So if I tell him about the injection, he will not have a problem with me taking it.
>
> AA: Okay, and what about the number of children itself?
>
> Suvidya: In that case, if he says three, it will be three.

(Suvidya, 20)

AA: What do others think about this (the FGD character Reena wanting an abortion)? Suvidya?

Suvidya: I think what Savitri (fellow participant) is saying is fine.

Sumitra: What if the husband does not agree?

Savitri: Yes, both have to agree.

Sumitra: Exactly, the husband has to agree.

Suvidya: *Whatever the husband says is what will happen.* [emphasis added]

(FGD Group 1, Purnia)

If Suvidya were to have a third child against her wishes, she is still likely to receive good care from her husband like she did during her first pregnancy. Such care can also be revoked if women challenge the authority of their husbands in deciding what is best for their care, like Suvidya did during her second pregnancy although she did so out of compulsion. But if she followed his advice and entrusted him with her care, it is likely that he would enable the best care that he could, and so would her birth family if he did not. In a conventional sense, access and utilisation would be happening, but the circumstances in which access would be required and enabled, would be undesirable and arising out of a lack of concern about what Suvidya wanted, calling into question whether Suvidya would *feel cared for* or not.

I also note that exploring the exercise of authority is a complex process, from a feminist perspective. For instance, in the above example, "if he says three, it will be three" would constitute a violation of reproductive rights in feminist rights-based discourses. In my interpretation, too, it appeared to be an exercise of power over Suvidya. However, husbands deciding how many children their wives should bear is socially legitimate in the context in which women are speaking. The understanding of the husband's opinion as socially-legitimated authority is further compounded in this case because the husband wanted a third child as the two they had were daughters, which the wider community supported as they too believed that it was important to have a son (while Suvidya did not necessarily share

the belief). Suvidya signalled that she would have to accept his authority, but her prospective acceptance of it was not uncritical, as she expressed what she would have ideally wanted in the interview, and reiterated (as a complaint) that husbands have the final say in the number of children in the focus group discussion she participated in. Agha (2021), in her study of the household in rural Pakistan, argues that certain controls are not understood to be power by women living in stringent patriarchal kinship structures, but at the same time, women characterise the social circumstances of control and dependency as unfair circumstances.[25] As with Suvidya, in some other instances, the authority of husbands was respected but only out of the lack of another option, and resignation to it.

5.5.4 Drawing authority from knowledge and benevolence

In contrast to Suvidya, Komal and Laali faced a situation where their husbands did not want more children while they did, making the situation unique among the study sample, and possibly in the wider social context, as most accounts on fertility decisions from India focus on women's struggles to limit fertility and non-cooperation or lack of concern from their husbands (George, 1998; Kimport, 2018; Suri and S, 2022; Whittaker, 1998).

Komal had one child and wanted another one because she felt that children need companionship, but her husband was of the opinion that they should not have another child. She, too, navigated this difference based on both personal desires and social norms. As the excerpt shows, her husband's opinion (or authority) on the matter is presented as responsibility and care because he was trying to do what he believed was best for her. Additionally, it was also based on the authority accorded to him as a knowledgeable man, being someone with a relatively high level of formal education.

> AA: What if there is a difference of opinion on a particular decision, like the number of children?
>
> Komal: He actually wants only one child. I tell him, look, there's no guarantee of our lives, it's better to have two children so that they have companionship.

[25] Agha (2021) draws on Lukes' (1974) influential definition of power as the capacity to bring change and/or to resist it, essentially understanding it as dominance. In her application of Lukes (1974), power is argued to be always present (whether it is naked, hidden or latent) but it is hidden power that most often works to maintain control in the household.

AA: Why does he want only one child?

Komal: So that we bring her up well and fulfil all her needs. My husband also says that the opinion of others should not matter, only your (Komal's) choice should matter. You know he sees how much women go through during pregnancy and childbirth. He's educated like you all.

(Komal, 20)

Komal's husband had advised her to stop using contraceptive pills (which the ASHA worker had given her) as it could harm her health, according to what he knew, and had not suggested alternatives. Komal again attributed this to him being educated, and planned to get herself sterilised after having another child. This plan indicated that she would challenge his perspective on the number of children despite appreciating the care and responsibility he showed towards her. Komal had access to contraceptives through the health worker (there was both accessibility and availability) but her husband disallowed such access, on account of *caring for her*, which she accepted. His care and support of Komal was also achieved and strengthened by his progressive stance of a single girl child being enough, which Komal mentioned while speaking about his reluctance to have another child, indicating that he is a thoughtful and educated person who cares for her well-being.

Laali was in an arranged marriage and had agreed to get married at 17 because her parents could not afford to provide for her, as they had only two daughters and no sons and hence, did not have a significant source of sustenance. Laali herself had two daughters, and wanted a son, owing to social norms and material conditions, with her own upbringing and early marriage being an example. Both of Laali's pregnancies and births had been difficult and required c-sections in private hospitals (previously discussed on page 112). The doctor who carried out her second c-section had advised her to have another child only after five years. Her husband, however, did not want her to have another child if it would put her at risk in any way.

AA: What if there is a difference of opinion over when you want the next child?

Laali: You have to listen to the doctor in such matters, right? Husband can say let's have the next child in four years instead of five years, but we will have to go by the doctor's advice.

> AA: What if you don't want a third child and your husband does?
>
> Laali: He is the one who doesn't want a third child! (laughs) He says that if it poses any kind of threat to me, it's not worth it, we don't need another child. But I want another child, I have two daughters, I want a son. You need a son, right? You tell me? But my husband does not want another child at the cost of my health. He says god has given us these children..it's true, god gives what he wants. Let's see now, the doctor has said there is no danger after five years though.
>
> (Laali, 22)

Despite having a different opinion from her husband, Laali also maintained that it was between the two of them to decide (his authority, therefore, was negotiable) and that no third party would be involved except doctors—who represented medical authority. Medical authority is different from the kind of authority that husbands and other family members and social groups may have as its social basis is less enduring and intimately significant than the latter, and as a result, it does not necessarily supersede the authority of husbands, Komal's experience of accessing contraception being an example. However, it is drawn upon to resist the authority of men, or to negotiate and convince men to 'allow' a certain type of access to care or a certain decision.

Laali's husband did not want another child due to concerns for her health, indicating love and care. His authority afforded him the responsibility to care for her in this manner—*to be able to say what is best for her*. By advising her to have another child, Suvidya's husband did not want to do anything at the cost of her (physical) health either. As I suggest, he possibly would facilitate the best care for her that he could afford. Both Laali and Suvidya appreciated their husbands' care, even if they wanted to act otherwise, and used the English word 'support' to describe it. Komal, whose husband did not want her to have another child, but also advised against contraceptives, also said that her husband was supportive.

The authority of husbands also manifested as support when they helped women navigate health systems and consult doctors. When Kaveri was reluctant to consult a doctor for the problems she faced with her sexual health, her husband insisted that they go to the doctor and subsequently discussed her symptoms with the doctor after he examined her, and then conveyed the diagnosis to her. Kaveri perceived and presented her husband's insistence as

care, as did other participants whose husbands insisted that they see a doctor. Their authority as men, who are capable of navigating public spaces and must be the ones navigating it, was therefore perceived as their responsibility.

Priyanka's husband similarly spoke to the doctor instead of her when she developed abdominal pain as she did not want to speak to the doctor and was generally afraid of doctors and injections.

> I used to have bad stomach pain 1-2 months after my marriage, even before marriage I used to have pain…but after marriage, suddenly I had the same pain in the left side of my abdomen. My husband said that we should see the doctor but I didn't want to go, I was scared because I am scared of injections, so I said I won't go but my husband insisted and said there can be a bigger problem later. So we went to the doctor and they did an ultrasound and said there was some swelling. The doctor then suggested that I conceive within a year but even then I did not. (giggles)
>
> (Priyanka, 23)

Priyanka seemed to position this as an act of responsibility and care on part of her husband, which I argue that it was, but it was combined with his authority to take initiative in a culture where married women are often dependent on husbands in their navigation of institutional care, and doctor-patient interaction (see, for example, Yellappa et al., 2017, the role of social relations in navigating diagnostic systems in rural South India). While Priyanka's husband used his authority to initiate care for her, he also exercised it in deciding what part of the diagnosis to share with her. He did not disclose that she had uterine swelling and only relayed that the doctor had suggested conceiving in the coming months so that there would not be a problem later. Priyanka was reluctant to have a baby at the time as she was pursuing a university degree. Her husband then spoke to her mother, disclosing the diagnosis to her, who also advised Priyanka to have a baby soon (without disclosing the diagnosis, again) but she refused. Eventually, her husband told her of the swelling. This did not upset Priyanka, indicating that she accepted his authority to not tell her as a form of concern for her well-being, but at the same time, and significantly, she refused to go ahead with a pregnancy at the time. She had a healthy pregnancy and baby two years later and was happy with her

decision to delay pregnancy. Priyanka perceived her husband's concealment of the diagnosis as a form of care and she also perceived her decision to delay pregnancy to be in her best interests, rather than a challenge to his authority. Her explanation for this dynamic between them was that she had a love marriage, which meant that there was lesser control. At one point, sensing that I was trying to assess if there was an element of pressure, Priyanka interrupted me to explain that she had a love marriage.

> "By the way, I had a love marriage. Like love..and then arranged (laughs). No one forced me to have a baby."

Participants often explained that their marital relationship was premised on care and had room for negotiation because it was a love marriage. While it did not do away with the authority of men, such authority manifested differently, or was perceived differently, especially in the form of responsibility. Participants in love marriages continue to occupy the same positions as wives and daughters-in-law of a household as other women but there was a greater sense of being cared for. This dynamic is further discussed in the following chapter which specially looks at the area of decision-making.

5.5.5 Responding to authority

Husbands were expected to have authority in marriage, which was summed up by reactions like "because he is the husband" to my questions on why husbands exercised authority in certain situations. But while the existence of such authority was universally recognised, it was not uncritical. In the interviews and FGDs, and sometimes to their husbands, women expressed that they wanted something different from their husbands, even when the authority was perceived positively as responsibility and for the wife's 'good' (for example, Laali's difference of opinion from her husband on the number of children, page 167) Such expression presents critical reception to authority, challenging the social foundations of authority. At other times, authority was recognised as something unfair and a reluctant trade-off ("the husband pays for everything, after all"), and sometimes met with resignation, which, again, is a critical reception of authority. Resignation was expressed to me in the interviews, and to fellow participants in the focus group discussions, which suggests that it was socially shared among women rather than offered as a visible response to husbands.

Women's responses to authority are difficult to categorise as either acceptance or challenge because they often involved elements of both, especially in expressions of resignation. However, in some instances, participants recounted a confrontation with their husbands, typically when the actions of the husband were perceived as illegitimate. In some of these cases, especially those involving violence, women's response was also supported by those around them. The perception of authority and the response to it is further explored in participants' presentation of their decision-making practices in the following chapter.

5.6 Conclusion

As highlighted in the review of literature (Chapter 2), concerns around access to care tend to centre on institutional access and inequalities within it. This chapter has widened the discussion on women's access to care by analysing the factors, circumstances and processes that precede and produce it within the household, and lead to inequality in access. The chapter has built on the continuities between care, access to care, and reproductive healthcare, discussed in Chapter 1, Section 1.1.1, and demonstrated how they overlap. In the examples discussed in this chapter, institutional care was sometimes happening despite the woman not wanting it (see Radhika's conflicting accounts of her husband facilitating access, for example, on page 158), or it was happening but without a sense of *feeling cared for* in the manner that it was felt married women must be cared for (through the resources and concern of the husband, as with Sharmina, see page 143). At other times, women accessed institutional care by themselves but such access was deemed inappropriate because it has not been routed through the husband, challenging the authority of the husband, and transgressing the domains of his responsibility (such as Subhadra adopting the injectable contraceptive, see page 159-160). And in yet other cases, husbands exhibit concern and enable care in the best interests of their wives (displaying responsibility), but it is not aligned with what women want. So while women may *feel cared for*, such care may not account for wider gendered social norms. Laali, for instance, received love and care from her husband who did not want her to have more children so that they could have a son, but she felt that she needed a son for social status and material provision. The analysis, therefore, has also complicated the meanings of *feeling cared for*, by studying it in the context of the household gender dynamics that young married women inhabit and the negotiations they make within these dynamics.

The chapter has examined the nature of marriage for young married women in the study context, and argued that 'bringing' and 'keeping' signify more than the process of marriage migration but form the basis of the gendered values attached to such migration, that is, granting husbands with authority over wives and enjoining them with responsibility for their well-being. Based on such analyses, the chapter has argued that it is marriage and the centrality of husbands, and their particular authority and responsibility within marriage, that influences access and enables care for women, alternatively causing neglect. Apart from the processes through which men exercise authority and have responsibility (bringing and keeping), women's reception of authority—appreciation, acceptance, resignation, challenge, and resistance—is also significant to the analysis in this chapter. The analysis supports the rationale for the study's focus on the space and the gender dynamics household, and its argument of studying the place of care in marriage and the household (Chapter 1, Section 1.1.). By highlighting how marriage and its destined dislocation influence women's position in the household, and how gendered authority and responsibility influence their care, the chapter has also contributed to discussions on early marriage and women's health which focus on age and vulnerability, by expanding the focus to include the gender dynamics of the marital household.

The discussions in this chapter map on to the next chapter, which further unpacks the authority of men in women's care by analysing it in the specific context of decision-making, especially in matters of reproductive health. The chapter will also discuss the roles played by other household and non-household members in decision-making, like mothers-in-law and health workers, while illustrating how the centrality of the husband abides. The chapter, drawing on the discussions here, will crucially raise the question of how women perceive decision-making (a site and process involving authority), and provide perspectives on women's claim to care.

Chapter 6

The methods and meanings of women's decision-making

6.1 Introduction: The significance of studying decision-making

In this chapter, I look at the place of decision-making in enabling access to care, asking how young married women perceive and assign meaning to their decision-making within the household, with respect to their reproductive health. The chapter pays particular attention to how decisions made in instances of institutional access and in discussions of family planning may or may not account for a sense of *caring for women*, and crucially, offers perspectives on women' claims on care in marriage and from a new household. The analysis in the chapter builds on the previous chapter's location of women's position in the marital home, which in turn, is constructed through the practice of marriage, which confers the husband with authority and responsibility for the woman's care.

Decision-making is a dominant area of study in women's health in demography, feminist studies, public health, and in combinations of two or more of these fields, commonly studied as decision-making autonomy (women making independent decisions) or through the roles women have in decision-making, such as having a say or the capacity to negotiate. The National Family Health Survey of India, like other Demographic and Health Program (DHS) surveys, asks women about their decision-making in matters of their health, major household purchases, and visits to family or relatives. In the NFHS, participation in decision-making is used as one of the six indicators of women's empowerment, the others being engagement in paid work, property ownership, ownership and operation of a bank account, independent use of a mobile phone, and use of menstruation management products among women aged 15–24 years. Between the last two NFHS surveys (2016 and 2020–2021), of all Indian states, Bihar saw the biggest jump in women's decision-making, from 75.2% to 86.5% (IIPS and ICF, 2021). Researchers studying decision-making and access to care in South Asia have cautioned against taking such figures at face value as women may report autonomous decision-making as joint decision-making out of respect for husband's authority, and because autonomous decision-making is often neither possible nor desirable, or simply not important (Allendorf, 2010; Furuta and Salway, 2006; Senarath and Gunawardena, 2009). My study

sheds qualitative light on how such decision-making may have played out in relation to the gender dynamics of the household, in the social context of rural Bihar, although it is not an exercise in corroborating the figures.

As the literature review (Chapter 2) establishes, individual autonomy is conceptually inadequate to capture women's actions and motivations with respect to decision-making in the household, in the context of the study, as it does not account for the social circumstances of households shaped by the gendered relations of marriage, caste and kinship. This chapter, therefore, asks what meanings and values women attach to decision-making and how they envisage a role or a share in it to maximise their interests, particularly analysing women's negotiation and presentation of decision-making. While Chapter 5 has argued that access to care must be routed through the authority of husbands (through knowledge, resources, love), this chapter analyses what happens in the actual, practical facilitation of care, and notably brings in the role of other actors and processes that navigate the authority of men without overstepping it.

The chapter first addresses what counts as a decision, based on the kind of health issue that the decision is about and who makes it, showing that the perception of a decision is highly gendered. Second, the chapter situates decision-making in the household, drawing on the daughter-in-law's position discussed previously (Chapter 5) and looks at women's need for collective decision-making, or the need to devolve decision-making to other members of the marital household. This is then followed by and juxtaposed with women's negotiation of decision-making with their husbands, which is influenced by the nature of marriage as a partnership. Establishing that decision-making is both complex and at times undesirable, the chapter then asks what happens if we de-centre the focus on decision-making and particularly women's decision-making autonomy in studying women's access to care. It argues that we instead ask what being cared for means to women, accounting for their position in the marital household as its newest and youngest members, and as daughters-in-law, and their expectations of love, care and responsibility from men, upon which marriage is premised.

6.2 What makes an action a decision?

I now look at what counts as a decision, which brings forth the role of gendered relations and gender dynamics in attributing meanings to actions taken towards young women's care. To begin to address the question, what makes an action a decision, I come back to Radhika's experience of accessing antenatal care, which she presented differently in two different interactions with me, emphasising her husband's initiative in enabling access in the first interview, and his general neglect (along with the mother-in-law's neglect) in the follow-up interview (discussed in Chapter 5, page 158). The following excerpt from her first interview illustrates how different people were involved in enabling care, and the values that Radhika attached to their respective roles.

> AA: And when did you move to your birth home, during your pregnancy?
>
> Radhika: In the fifth month of my pregnancy. Then I went to the city for another ultrasound, but it was not a free service.
>
> AA: Whom did you go with this time? (the first time, she had gone with the ASHA worker in her marital village).
>
> Radhika: My mother took me there. The ASHA worker in my marital home had advised me to get another ultrasound once I got to my birth home.
>
> AA: What if I ask you who exactly decided this...(interrupted with a response)
>
> Radhika: My husband did. He gave me the money for the ultrasound.
>
> AA: Okay so your husband made the decision and gave you the money, I also see that many people were involved in it - ASHA worker, mother-in-law, mother..
>
> Radhika: Hmm.
>
> AA: And what about you? Did you also say what you wanted to do?
>
> Radhika: My husband asked me if I wanted to go (for the ultrasound). I said I'll go if it's going to be good for me.
>
> AA: And was there anything that you wanted to do/anywhere you wanted to go?
>
> Radhika: I didn't want to go to any hospital, I just wanted to come back to my parents' home.
>
> (Radhika, 18)

In Radhika's description of accessing care, the role of the ASHA worker appeared to be key as she enabled access and advised her on it. Later in the interview, in a discussion of her unmet health needs, she also raised the absence of an ASHA worker in her birth village as a barrier in accessing information and care. But when the term 'decision' (*faisla*) was explicitly used by me and reproduced by Radhika, it was promptly associated with the husband, implying that it was obvious. This was the case for several participants in both study districts, who associated a decision with the person who paid for the activity. Out-of-pocket expenditure in health is significantly high and, in the context of limited household resources, it is not surprising for decisions to be associated with the person who pays for a facility (Kumari and Verma, 2021; Sangar, Dutt and Thakur, 2019; Shahrawat and Rao, 2012). The association of financial support with decisions regarding access to care also connects to Grover's (2009) argument of material provision being synonymous with love, although my analysis identifies material provision as a responsibility within marriage (discussed in Chapter 5).

As I argue above, in the actual instances of facilitation of care, many parties other than the husband were involved, albeit without overstepping the husband's authority. Mothers and mothers-in-law did not necessarily make the key decision, such as going to a particular hospital at a particular time, but they usually approached the ASHA worker who then made the decision (typically agreed with by everyone), or they discussed the matter at home and convinced the men in the family (usually the woman's husbands and sometimes their own husbands) who had the material resources to enable access. Their decision-making, therefore, had to be endorsed by the authority of the women's husband (their son or son-in-law). While I refer to the actions of the mothers and mothers-in-law, and certainly of ASHAs, as decision-making, participants did not. They instead perceived such actions and roles as support and care when their mothers and mothers-in-law carried them out, indicating that they *did* something for their daughters, *cared about them*, even if they did not make the specific decisions.

> Shabana: I don't like living there (marital home). In your mother's home, all the comforts are there. Mummy does everything for me. My mother always takes care of me. I don't have to work much here.
>
> (Shabana, 17)

For many women, mothers also enabled access to care for health issues outside of pregnancy and childbirth, such as aches and pains, infections, non-communicable diseases, general weakness and fatigue, and more significantly, as Shabana says, lessened their burden of household labour and took over their childcare responsibilities as well.

In matters of reproductive health, mothers and mothers-in-law typically approached ASHA workers in the first instance, who were instrumental in making decisions and enabling access to care, as they were trained and paid to do so (Gjøstein, 2014; NHM, 2009). But if the role of mothers was described as care, the role of ASHA workers was described as a series of events without a value like care being attached to it. It was understood as their work, and it was not challenged although the authority of husbands could challenge it (for example, Komal's husband advised her against using the contraceptives that the ASHA worker recommended, see page 166). ASHA workers are supposed to accompany women to these facilities, which they did in most cases, especially for childbirth, if not for antenatal care visits. They are also tasked with advising pregnant and lactating women on nutrition and hygiene, and with providing information on contraception and family planning. The ASHA workers, therefore, were *doing what they do* when they were facilitating access to institutional care, as it was considered routine work rather than a consciously formed action which would count as a decision. When they offered advice, which is also part of their job, although often unknown to women, it was perceived as an extension of their work, and sometimes as advice from an elder as they were older women from among the participants' communities. ASHA workers were sought out for their resources and medical knowledge, but they were also trusted because of their association with the family and community rather than the institution of public health that they represent.

The role of ASHA workers, therefore, was one of facilitation, whereas the role of mothers was associated with care and with doing something nice for their daughters. The following excerpt from Shyamolie's interview further illustrates the role of mothers in enabling care, but I use this example to draw attention to the description of the mother's care (in not only Shyamolie's health but also her husband's health) in juxtaposition with the immediate association of decision-making with the husband.

AA: So who played a key role in the decisions that were made during this episode of illness (jaundice)?

Shyamolie: My mother.

AA: Okay, so once you went back to your parents' home, what did your mother do?

Shyamolie: She spoke to my father, he suggested we consult the *mahat* (faith healer).

AA: And how did you feel about the decision?

Shyamolie: Meaning?

AA: To what extent were you content with it? Did you want to go elsewhere too?

Shyamolie: I was content with it, since I was not feeling well.

AA: Had you been to the *mahat* before?

Shyamolie: No.

AA: And how did you find the experience?

Shyamolie: I liked it actually, I got better with the herbal medicines I got from him. Other medicines were not working (She had previously mentioned that the faith healer had recommended that she stay away from her marital home as it was not good for her well-being, which she then followed, although her husband also came to live with her in her parents' house.)

AA: In this case (jaundice), you said that your mother played the key role. Who usually makes such decisions in your household?

Shyamolie: Before doing anything, I tell my husband. And then I do whatever he says.

(Shyamolie, 16)

The interviews were designed to understand how participants define decisions, who plays key roles, and how women place themselves in decision-making as household activities, by participating, accepting or challenging them. But in the beginning of most interviews, I usually asked participants to describe what happened in a particular instance of illness or institutional access that they had mentioned. "Who made the decision?" or "Who played a key role?" would be asked only later, and sometimes particularly to understand to whom participants attributed a decision or decision-making authority when multiple people were involved in an action. "What happened?", on the other hand, would unfold in terms of whom participants spoke to first and then what that person did, or the series of events that followed

such as visiting a particular hospital, and sometimes, the neglect that they were subjected to, not only in that instance of care, but broadly in their marriage. These were the contexts in which the data emerged and was analysed for 'moments' of what I categorised as decision-making, in order to understand the role and perception of gendered relations and household dynamics in women's access to care.

The analysis also shows the type of health issues and circumstances in which decision-making assumes importance as a household activity and is seen as a decision by participants and their families, as opposed to those where it may be an individual activity and a regular activity rather than a consciously made decision. Issues that require time and money, such as a caesarean, would become matters of household decision-making as opposed to less 'serious' issues not requiring urgent institutional care, such as anaemia during pregnancy which is not typically considered worthy of concern (Chatterjee and Fernandes, 2014). This maps on to what was categorised as a health problem which would require institutional care as opposed to wider concerns like weakness (as discussed in Chapter 4). A concern like weakness, although wider, is also serious and located in household dynamics. But decision-making is reserved for issues which involve the collective interest of the household rather than a woman's personal struggles with home and family. So if the remedy for a problem involved home-based care or better nutrition and rest, it would not be a subject of household discussion but for the woman to negotiate with the family and implement, sometimes making it more difficult than a decision being taken for her.

The analytical exercise of finding decision-making in the data shows that decisions about access to care involve multiple actors, whose roles women assign different values to—authority to husbands as decision-makers, care to mothers as enablers, and duty to ASHA workers as health professionals. Certain actions also assume greater importance as decisions as opposed to others, possibly because they are less value-laden or less radical. Laali's differing experiences of care with the different health issues she faced perhaps illustrates this contrast. During both of her difficult pregnancies, her husband, father-in-law and other family members, had promptly made decisions and taken her to different hospitals, based on the quality of care and the expenses that they could afford. Her husband was also particularly concerned about the impacts of a future pregnancy on her health, and insisted that they should not have any more children (discussed in Chapter 5, page 167). On the other hand, her family did not consider her long-term weakness to be a matter of decision-making as it was

normalised and at best, required rest (which she was expected to manage), and not money, travel or time on part of the family. She attributed her weakness to the toll of her household labour, and found it difficult to take rest when needed as her in-laws thought she was shirking work. Decision-making, therefore, often assumes significance in matters of institutional access and not in other sites and forms of (required) care, but it nevertheless allows for an understanding of the gendered relations and dynamics within which the actors act, and the attributes that are assigned to them owing to their gendered position.

In the following section, I look at how young married women seek involvement in decision-making from the marital family, particularly in-laws, and pay attention to why they may seek such involvement. In the course of developing this discussion and towards the end of it, I also look at how such involvement differs from the involvement of husbands and what that says about women's position in marriage.

6.3 Situating decision-making in household relations

6.3.1 "Who else is greater than the husband and mother-in-law?"

Rita was of the opinion that women should consult everyone in the marital family, especially the husband and mother-in-law, before going ahead with a decision (about reproductive health). She drew her opinion from an experiential understanding of household and kinship relations, which had not been negative or tense for her, but which she needed to maintain.

> AA: Has there been a time when you didn't tell anyone that you were unwell?
>
> Rita: No, I always tell my husband.
>
> AA: Anyone else you tell about being unwell?
>
> Rita: Yes, I also like to ask/seek advice from my mother-in-law, it's usually husband and mother-in-law, who is greater than (more important than) them, after all.
>
> AA: So why do you think that it's important for you to seek advice?
>
> Rita: I don't want to do anything alone, I will ask everyone. If everyone is happy with me and likes me, I should also keep them happy, right? That's why.

(Rita, 22)

Rita grew up in the same neighbourhood as her husband and had a love marriage. Both families were initially upset with their decision to elope, but eventually accepted it and asked them to come back home. Rita mentioned time and again that the neighbourhood was her home and everybody was like family, so there was little difference between her birth family and marital family. However, she also alluded to the centrality of her husband and mother-in-law, and by positioning them as the most important people in her life, she positioned her actions (especially her decision-making) in relation to them.

> AA: Does anyone else (apart from your husband) get involved in your reproductive health decisions?
>
> Rita: Hmm..one's mother-in-law can always say that one should have more children, and well she has the right to say so, being the mother-in-law. And it's true..Is one child enough? That too I have a girl. Although my mother-in-law also doesn't want me to have another child right away, she also understands. After all, she is also a mother. I have no pressure, everyone is happy with me. I can rest or take a break whenever I want to (from paid work as a tailor and unpaid work at home).
>
> AA: Can you tell me a little more about your work (as a tailor)? You said that it sometimes causes some physical stress..
>
> Rita: I had already learnt the tailoring work before I got married, so I decided to do it here after getting married. It's all my wish, I do it because I want to and I can also stop whenever I want to. Nobody is a stranger (*paraya*) to me here.
>
> (Rita, 22)

Rita's decision-making in matters of (paid) work was made possible owing to three factors, the first being her proximity to her birth family, who were not only geographically close but also belonged to the same caste and village as her marital family, adding a layer of security. The second factor was her love marriage, which participants often drew on to explain why their husbands cared about them, as a love marriage is underscored by mutual interest and affection, rather than transactional and unequal arrangements. The third factor was her fulfilment of her role as a daughter-in-law, which is discussed in the previous chapter. She depended on her husband and mother-in-law for advice (based on the former's authority and

the latter's authority and experience as a fellow woman) and referred to them as the most important figures in her life. This last factor, which is encapsulated by 'keeping them happy' is perhaps the most significant factor that enabled her to make decisions in matters of her work and also enabled care for her through the marital family. While Rita indicates mutuality—*they keep me happy so I should too*—her position as a daughter-in-law makes the act of keeping each other happy structurally different for the two parties. For a daughter-in-law, keeping in-laws happy could involve relentless household labour or bearing children depending upon the in-laws' advice, and could be done so that they are 'kept' well in the marital household (also argued in Agha, 2021). While Rita did not seem to have to go out of her way to please her in-laws, from what she said about her position in her household, she still kept them happy by going to them for advice and listening to them. It is interesting to note that Rita made independent decisions about her paid work but consulted her husband and mother-in-law about health issues and particularly fertility decisions. She is likely to have done so because fertility is a family issue and perhaps a more significant issue, more so in her experience as she had only one daughter. On the other hand, her home-based paid work was not a family issue (or not an area of regulation or decision-making by the family) as she did not work for the family's sustenance but out of interest and a small additional income. She used the example of her ability to work independently to show that her marital family treated her like their own: "nobody is *paraya*" (as opposed to the daughter-in-law's general dissociation from both families, discussed in Chapter 5), and allowed her the space to work without restrictions which another family may not have allowed their daughter-in-law.

6.3.2 Seeking household involvement in decision-making

Unlike Rita's in-laws, some in-laws did not get involved in the lives of their sons and daughters-in-law, either because they had fallen out over financial disputes or because the daughter-in-law was from a different caste (which caused tension about differences and loss of honour), and sometimes because they didn't live in the same house or neighbourhood. In some of these cases, participants sought active involvement from them as it would create a support system and fulfil the role that a family is supposed to play.

Sonam, who lived with her husband and in-laws, felt that there was little involvement from the in-laws. Sonam's first pregnancy was unplanned (a 'mistake', discussed previously in Chapter 4), and she had spent most of it, along with the period post-birth, in her birth home.

She had decided to carry the pregnancy to term after several consultations with her birth family. They had advised her against an abortion citing moral repercussions, especially when there was no justifiable reason for the abortion such as illness or finances.[26] Once she came back to her marital home, she continued to receive good care through her husband who provided for her financially, and without any objections from her in-laws, but she wanted the in-laws to be more involved in decisions about her care. In a hypothetical discussion about sterilisation, I asked Sonam about her in-laws' involvement (after she had mentioned that they were not very involved), because such involvement, especially by mothers-in-law, is often seen as an interference by women, especially when it involves advice about childbearing that women feel conflicted about—such as having more children to have a male child.

> AA: You said that your in-laws don't participate much. Do you want them to be a bit more involved in reproductive health-related decisions?
>
> Sonam: Yes, I want that but they don't.
>
> AA: In what way do you want them to be involved?
>
> Sonam: They should also know, be happy, share their opinion and thoughts. I will also feel like someone is there to say these things, I will feel good and happy. If everyone stays together (*milke rahe* - indicating social intimacy rather than physical togetherness), you feel happy, right? That is something I want.
>
> AA: Okay. If they would be more involved, like if everyone stays together (*milke*), how would it impact your health?
>
> Sonam: See, if the elders say something, it's for your good. No one will say or do anything bad. No one wants something to go wrong in their own family.
>
> AA: Okay, I asked you this because very often, we think that in-laws always interfere, but I suppose what you said also happens.
>
> Sonam: Yes, a family should be involved.
>
> (Sonam, 21)

[26] The moral discourse around abortion varied in the study area. Generally, abortion within marriage was considered acceptable if there was a 'justifiable' reason for it, such as lack of resources to bring up a child, poor health of the pregnant woman, frequent pregnancies, the possibility of the birth of a girl child after several or 'too many' girl children, and sometimes, not wanting a child.

Sonam was already receiving the care she wanted, and had been happy with the decisions made by her husband, and by her parents during her pregnancy and post-birth when she lived with them. Her expectation of involvement from her in-laws, therefore, appears to be based on the understanding that elders are there to take care of daughters-in-law and advise them, strengthening decision-making in the household and creating a sense of *caring for* the daughter-in-law.

Shyamolie, similarly, expected greater involvement from her in-laws in her reproductive health decisions. She was expecting her first child and wanted them to be involved.

> AA: Does your family get involved in your (you and your husband's) decisions about reproductive health?
>
> Shyamolie: I only have a relationship with my husband, not with the rest of my (marital) family.
>
> AA: Can I ask how you got married?
>
> Shyamolie: My husband married me and brought me here, he used to work near where I used to live in West Bengal. He liked me and I liked him too.
>
> AA: Okay, yes I remember you had a love marriage. So, do you want the rest of your (marital) family to participate in your decisions?
>
> Shyamolie: It's just the two of us who make decisions. Who else will care to participate? It would be nice if they would be involved though.
>
> AA: In reproductive health matters?
>
> Shyamolie: Yes.
>
> AA: Can you tell me why you would like it that way?
>
> Shyamolie: So that..well, it's one family..and if they are ready to take care of the child, it helps. So it's not just our (husband and my) decision to make.
>
> (Shyamolie, 16)

In Shyamolie's case, it was both customary and strategic to get her in-laws' involvement in her family planning decisions as it was for both childcare and to maintain social norms of what a family should look like. Like Sonam, Shyamolie's natal kin lived far away and her marital family were the only people she knew in her marital village. Her husband fulfilled her health needs but lived away for certain periods as a migrant worker, so while her care was

routed through him and also attended to by her mother, she did not have day-to-day support from either of them. Drawing on the ideas of home and belonging for the daughter-in-law, and being kept, I argue that both Shyamolie and Sonam sought belonging through their in-laws' involvement in decision-making. Patel (2004), writing on the relationship between status and autonomy, argues that women's identity is forged through their association with the home and family (in the context of marriage). For Shyamolie, the association with the family primarily seemed to be about belonging and having a social network, which would then consolidate her identity as a daughter-in-law of the household, and of the community. While she wanted her in-laws' involvement to have childcare support, she also valued social association in itself along with the normative idea of what a family should look like. Within this normative family, her husband would continue to hold authority, having brought her (the term she uses in the excerpt above) and would continue to be the central figure in her care, while the in-laws would be present and involved. As mentioned above, Shyamolie did not attribute decision-making to her mother even though her mother made key decisions in her care, as well as her husband's care, when they had jaundice. Later in the interview, she also attributed decision-making solely to her husband, unlike the excerpt above where she said that both of them make decisions. This, and other examples shared below, resonate with Senarath and Gunawardena's (2009) and Furuta and Salway's (2006) suggestion that while women may report joint decision-making as their husband's sole decision, they may do so to defer to their authority.

Apart from the centrality of the husband, filial piety plays a big part in South Asian women's ethics and decision-making (Allendorf, 2012b; Jafree, Zakar and Anwar, 2020), but there are subtle differences between the ways in which Rita, Sonam and Shyamolie sought their in-laws' involvement in decision-making. For Rita, it appeared to be more strategic—*they keep me happy so I should do*—and it enabled her to claim the position of a good daughter-in-law. But for Sonam and Shyamolie, while it was related to their sense of identity as daughters-in-law, it also seemed to be a necessity for their health and well-being, given their social isolation in their new homes, and their concerns around their reproductive health. At the same time, there is an element of 'letting' in-laws get involved in these and several other cases, so that they can fulfil their role as elders and be content that they are in that position, which consequently allows women (as daughters-in-law) to be loved and cared for in a normative manner. Participants sometimes sought mothers-in-law's involvement in decision-making (even when they may not have needed it) or accounted for their wishes while

making decisions, to keep them happy and maintain a harmonious home environment. They also recognised the value of a child in stabilising relationships with in-laws and consolidating their own position in the household, took care of in-laws even if they did not live together or share an amicable relationship with them, and understood the strategic importance of not seeking paid work outside of the household as it could be a sign of the marital family's poor economic and social status, and draw disapproval. These actions were part of women's 'sense of agency' (Kabeer, 1999), rather than a lack of autonomy or a devolution of decision-making autonomy to in-laws and family. As opposed to in-laws, husbands were default decision-makers (the decisions being attributed to them even if they did not make it alone) as they had the authority and the responsibility to make the decisions. When in-laws did not get involved in the care of their daughters-in-law, the complaint was often of not receiving love and advice from elders, rather than non-fulfilment of responsibility towards them.

6.3.3 Negotiating decision-making and household gender dynamics

Associating with the marital family can be a way to develop individual interests, some of which arise out of the compulsions of childcare, social support and material resources. This type of association can involve a bargain with both family and patriarchy, and can also be a way to maintain normative family relations, in the interest of the whole family rather than individual interests alone. Agarwal (1997) argues that the lack of protest in intrahousehold bargaining does not signify adaptation or acquiescence and could instead signify a strategic decision on part of those considered 'subordinate' and might reflect their awareness of the risk that protest can lead to. Many of the study participants were aware of the risks such protests could lead to, but the ways in which some of them described their actions vis-a-vis their family, especially the mother-in-law, also emphasises the importance of emotional bonds, which indicators of decision-making (making decisions about purchase, mobility or health by oneself) sometimes obscure.

Subhadra, for instance, was sure that she did not want to have more children, after her four daughters, and knew that the decision would ultimately be hers. But she wanted to make this decision without hurting her mother-in-law, not only out of 'fear of protest' but because she cared about her mother-in-law, who had been supportive of all her pursuits since her marriage.

> I am quite sure that I do not want to have more children (after having four daughters). But my mother-in-law doesn't like this, she says that I do whatever I want by myself, I never ask her. She says that she also needs a grandson. So I haven't gotten sterilisation done yet, and so I haven't broken my mother-in-law's heart yet. But you know, if I want it (another child), it will happen, if I don't, it won't. That's all there is to it.
>
> (Subhadra, 24)

The confident but non-defiant stance points to the complexity of the decision-making framework, and the difficulty of accounting for emotional bonds within it: *I haven't broken her heart yet*.

Rita, Sonam and Shyamolie, along with others like Savitri and Priyanka, categorically wanted to involve their mothers-in-law in decision-making, while Subhadra only wanted to take her desires into account. For Sonam, Shyamolie and Savitri, the mother-in-law not giving them any advice amounted to not giving them love, and not caring about them. Rita, whose mother-in-law was involved, called it a 'right' that the latter has as a mother-in-law—a close family member. Priyanka, whose mother-in-law similarly got involved, called consulting the mother-in-law 'compulsory' so that she does not feel sad about not being involved despite being the mother-in-law (again, a close family member). Priyanka's mother was an ASHA worker who advised her in all health matters, so she turned to her mother-in-law simply to honour her position as someone who was close to her and cared for her, rather than expertise. And like with the other participants, her husband was the central figure of authority and advice, as discussed in the Chapter (see page 168). In some of these cases, such as with Sonam and Shyamolie, the father-in-law also played some roles and was expected to be involved or provide some advice. All of these examples reflect the importance of situating decision-making in the gendered relations of the household—honouring hierarchies, taking strategic actions, and turning to family for love and care.

6.4 Decision-making between partners: Mutuality and hierarchy

I now bring attention back to the centrality of the marital relationship to understand how the value of decision-making attributed to husbands operates in practice, and how it is different from the values attributed to the actions of mothers, mothers-in-law and other parties. As the Chapter 5, and the above, argues, authority principally rests with the husband. It is therefore the husband whose authority is recognised, as opposed to in-laws who are seen as elders whose wishes and emotional needs should be respected where possible, and their conventional role as advisors sought out. In-laws, especially mothers-in-law with respect to this study, may hold some authority but it never oversteps the authority of the husband. Moreover, when in-laws become overbearing, it can be a source of complaint and disagreement, during which the husband is expected to be involved. But in-laws do not get involved in the husband's authority in marriage, unless there is an exercise of illegitimate power such as violence. At the same time, as the previous chapter discusses, marriage is the relation where there is a sense of partnership (which does not exist with in-laws who are seen as elders), however skewed towards the husband owing to gendered relations. Therefore, it is important to unpack how such authority and partnership operates at the level of individual instances of decision-making, and how women may bargain, even as the authority of the husband in enabling access to care ensues. If it is the husband who holds authority, it is the husband through whom negotiations can happen.

6.4.1 Making decisions *with* the husband

The most common way to express this process was 'making decisions *with* the husband.' As the data below illustrates, *with* the husband includes bargains, strategy, conflict, and resignation on the part of women. It also includes presenting decision-making as a process carried out with the husband, when in fact, it may have been carried out by the woman herself. Making decisions with the husband, therefore, is not done outside of the authority of the husband but through or within it. This is exemplified by Kaveri's interview:

> AA: I want to ask you a few more things about the household and your marital relationship. Whenever you have a reproductive health-related decision to make, like the time you were in pain after sex, then it was decided that a doctor should be consulted, so in this case, your husband had given you the advice…(interrupted by Kaveri)

> Kaveri: Both of us did, he suggested it first then I also agreed. I said - if you say so, let's go. Okay, I will go. If the doctor's advice helps, it will be good, both families will also be happy. Parents will be happy, mother-in-law will also feel good. So we were both in agreement in this decision.
>
> AA: This is what I want to understand, when both of you have to make any kind of decision...(interrupted by Kaveri)
>
> Kaveri: Yes, both of us make it.
>
> AA: Hmm, you discuss it together.
>
> Kaveri: Yes.
>
> (Kaveri, 21)

Kaveri further insisted that decision-making must be mutual. Women should not make decisions on their own because that will lead to a chasm in the relationship which is not good for anyone. She added that they should make decisions with their husbands first and then involve mothers, mothers-in-law and others because partners should share everything with each other first, because after marriage, one's husband is everything. She did not make the same association for the wife (the wife being the key figure in the husband's life, for instance), and it is difficult to tell if she meant that husbands too should make decisions together with wives. A close reading of the above excerpt suggests that the decisions about her care were initiated by her husband, which she agreed with, because of his initiative and authority and also the belief that he was taking responsibility and making the right decision. While the mutuality of the decision-making appears to be doubtful, there is mutual interest in the goal of the decision - that her health gets better. This goal is also presented as one shared by other members of the family, who are not present in the decision-making itself, but whose feelings and inclinations are considered in the process. The presentation of the husband's decision-making as the couple's decision-making is significant as it is not only a sign of women according decision-making to the husband rather than themselves, but also because it reflects the understanding that someone close to you makes decisions for you because they care for you, and it is made in some form of consultation with you, which you agree with. I particularly make this argument based on the structure of marriage, and the position of women as daughters-in-law (and in the case of the study participants, young women) who are building a life in a new household.

It is difficult to establish whether what Kaveri did in relation to pain during sex constitutes joint decision-making or not (where both partners have a say and the final decision is acceptable to both) but in this case, what I emphasise is why decision-making happened in a particular manner (initiated by the husband and portrayed as a mutually satisfactory decision) and what implications it had for Kaveri's health and care. A few other participants similarly said that they make decisions *with* their husbands or "we make decisions together", but their accounts of decision-making indicated that the element of mutuality and the process of negotiation was happening within a structure of gendered authority, which participants sometimes themselves articulated in the interviews, and recognised and challenged in their homes.

6.4.2 "If it's a yes from him, it's a yes from me"

This was a common response in the interviews, particularly as a follow-up to what participants thought of a decision that they said their husbands made, or as a response to questions on conflict in opinions and decision-making.

I present an extended version of the excerpt from Komal's interview, used in the previous chapter (page 165), to ask when "if it's a yes from him, it's a yes from me" is used, and whether it always indicates control.

> AA: What if there's a difference of opinion on a particular reproductive health decision?
>
> Komal: What kind of a decision?
>
> AA: Say, the number of children you should have?
>
> Komal: He actually wants only one child. I tell him, look, there's no guarantee of our lives, it's better to have two children so that they have companionship.
>
> AA: Why does he want only one child?
>
> Komal: So that we bring her up well, and fulfil all her needs. My husband also says that the opinion of others should not matter, only your (my) choice should matter. You know he sees how much women go through during pregnancy and childbirth. He's educated like you all.
>
> AA: So do you push for your decisions in such cases?

> Komal: I don't. My husband makes decisions. If he says yes, then it's a yes.
>
> (Komal, 20)

Komal did not say "if he says yes, then it's a yes" with particular resignation, especially given the preceding conversation where she presented his opinions as decisions made for her welfare (even centering her choice, ironically). However, she also did not say it with finality, as demonstrated by her rationale for having more than one child which she shared with him, indicating that she negotiated with him on this matter. Komal and her husband had an interfaith marriage amidst stiff opposition from both families, and lived as an independent household unit even as their relationship with their respective families improved. Although Komal did not mention her love marriage as a reason she was able to share a more equal relationship with her husband than many others, her description of the circumstances of her marriage and relationship with her husband indicated that it played a significant role in giving her room for negotiation, bringing attention to the quality of relationships (Allendorf, 2015; Allendorf, 2012b; Deshpande and Banerji, 2020). At the same time, it is difficult to establish whether she was able to negotiate with him on the subject of contraceptive non-use as that was premised on his 'knowledge' and was not a social norm like having more than one child. Decision-making, therefore, takes different forms depending on the type of decision being made.

For other participants as well, *If it's a yes from him, it's a yes from me* was not necessarily an uncritical stance, as it was often said with resignation, indicating criticality and challenge. The descriptions that several participants provided about the way they went about a certain health issue or a household issue showed that they actively made and negotiated decisions, to fulfil individual and collective interests. And when they did not, they shared feelings of frustration and resignation. In the interviews, it is also likely that participants attributed decision-making to husbands and shared their challenge to it minimally to convey that their lives are 'normal', and that they are a part of their families in a normative way.

The decision-making authority of husbands was made sense of within a structure of gendered relations, and was sometimes respected out of need (when a woman does not have access to resources or is already burdened with problems), resignation because nothing can be changed, or fear of violent retaliation (Agha, 2021). At other times, it was recognised and challenged

by seeking involvement from others like mothers, mothers-in-law and ASHA workers, or lying to find a way around a decision such as passing an abortion off as a miscarriage, or taking 'revenge', as Ranjana described her defiance when her husband controlled her mobility and decisions, and became violent. Sumitra's account, below, shows the tension between attributing decision-making authority to husbands, while actually undertaking actions that count as decisions by oneself. The presentation of the husband's authority as key, even though it was not necessarily so, reflects how decision-making is associated with accepting the husband's authority.

> AA: Okay. What if your husband and you have a difference of opinion over some (reproductive health) decision?
>
> Sumitra: Now that's worrisome! That causes tension. But I guess I will do what he says. He is the one who earns after all.
>
> AA: And have you ever made a decision by yourself?
>
> Sumitra: Yes, I do things by myself. I can do things myself. It is something I have to do, I have no other choice (*majboori*) when my husband is not here. Even for my ultrasounds, I went to the city by myself, alone. (brightens up) I do all the work on my own, I take care of the house, the children and the fields. I can also talk to people when necessary to get my work done. In fact, I know everything about farming also - from getting the land on lease, growing the crops, selling them and managing the finances. My husband only knows how to earn money!
>
> (Sumitra, 26)

Sumitra reiterated her stance on husbands holding ultimate decision-making authority in the focus group discussion on access to abortion. Both in the interview and the FGD, she sometimes used the word *maalik* for husband which means owner but is also used for husband in some parts of the study area.[27] In the FGD, she used the words 'guardian' and '*maalik'* consecutively to explain why husbands have decision-making authority. The word guardian came up in a few other interviews, first, to refer to a father-in-law who was consulted before making an appointment with a gynaecologist; second, to refer to in-laws who did not allow a participant to continue her studies after marriage; and third to refer to a

[27] Notably, *maalik* is also used locally to refer to 'upper' caste landowning men, perhaps reflecting the gendered constitution of caste and vice-versa.

mother-in-law who did not care about her daughter-in-law's health and well-being. Guardian is a commonly used word in the North Indian vocabulary and is used to refer to anyone ranging from parents to in-laws and husbands (and not just a person stepping in in place of a parent), and as is evident by the above uses, it is someone who makes decisions or should be making decisions or be involved.

Sumitra: What if the husband (*maalik)* does not agree (to abortion)? He won't.

Savitri: Yes, both (husband and wife) have to agree.

Sumitra: Exactly, the husband has to agree.

Suvidya: Whatever the husband says is what will happen.

AA: Meena, what do you think?

Meena: Whatever everyone says will be done.

AA: Who is everyone here?

Meena: In-laws, and the whole family actually.

Savitri: Yes, the in-laws also have to agree.

Sumitra: I think it only depends on the husband, these days only the husband's opinion matters. And they married to have a child, right? And the husband is the guardian, the *maalik*. And of course, even in-laws will want a grandson.

(Later in the FGD)

AA: So can Reena (fictional character) get an abortion citing health reasons?

Meena: If she has brains (is smart), she will have the presence of mind and say this.

Savitri: Exactly, girls don't have brains in these matters!

Sumitra: But we're losing sight of the fact that her husband may still want a child!

Meena: The husband also needs to listen sometimes, right?

Sumitra: But that doesn't usually happen, it's always the other way round.

Suvidya: Yes, not all husbands listen.

Sumitra: And well, they pay for everything.

Meena: Let me give you my own example, my husband listens to me.

Sumitra: If I ask my husband to listen to me, he will say, "are you the master now? Are you giving orders to me?"

Meena: If the husband does not relent, she can seek help from neighbours also.

Savitri: Yes, she can ask her neighbours.

Sumitra: She can also lie about it (lie about getting an abortion by saying it was a miscarriage).

Savitri: Yes, with someone else's help.

(FGD Group 1, Purnia)

Sumitra made decisions about accessing healthcare and acted on them on her own, including physically accessing an ultrasound service alone which only one other study participant reported doing. She did so because her husband lived away as a migrant worker, and used the word *majboori* to describe the circumstances of her decision-making. She later mentioned that she got all her three children admitted to a boarding school and that she provides for them with the money she earns by working in the farm, but she had referred to her husband as the provider in both the initial part of the interview and in the FGD. Sumitra's actions can be aligned with Kabeer's (1999) agency framework, encompassing observable action when she accessed health facilities, managed the finances, and made decisions about her children's education, and a sense of agency when she spoke about managing everything on her own with pride. Likewise, while she acknowledged the unequal share of power between partners in the FGD, she exhibited a sense of agency in suggesting that a woman can lie about getting an abortion, and agreeing with her fellow participants who said that you can cover things up with the help of friends. Such agency, however, arose from compulsion, which was an undercurrent throughout her interview and in the FGD.

6.4.3 Tell, inform, ask: Negotiating decision-making

While *if it's a yes from him, it's a yes from me* indicated articulation of gendered authority, even if women's actions signalled that they were challenging such authority or negotiating with it, the other expression, which indicated a higher degree of negotiation, was 'telling.'

Participants used the words ‘tell’, ‘inform’ and ‘ask’ interchangeably in describing decision-making for reproductive health issues and other household issues in which they are involved. Here, I use an excerpt from Kiran’s interview to show how ask and tell may be used.

> AA: You have been married for 5-6 years, so you were probably 14 or 15 when you got married.
>
> Kiran: Yes.
>
> AA: Do you see a difference between the early years and now, in terms of decision-making?
>
> Kiran: Hmm..meaning?
>
> AA: Let’s take an example. You came to the community meeting the other day. If you had to come to the same community meeting five years ago, would you have to ask someone?
>
> Kiran: *I would have to ask my husband* [emphasis added]. You *should ask* [emphasis added] your husband if you are going somewhere.
>
> AA: And did you ask him the other day?
>
> Kiran: No, but *I told him about it later* [emphasis added]. I still have to ask him (at this stage in the marriage).
>
> (Kiran, 19)

Here, Kiran used ‘tell’ and ‘ask’ interchangeably although she possibly could get away with only telling now rather than asking. The example I had given her—the community meeting—was also an example of a relatively minor decision as it was a community meeting in her village, with fellow women, and about health. But the emphasis on *I have to ask*, after saying that she told him about the meeting retrospectively, shows that telling is a way of taking permission or assuring the husband that nothing is being done without his knowledge. While telling one’s partner about an event can be understood as common practice between partners, it was gendered in this case, and it is a question of decision-making and authority when read together with the problems encountered in the recruitment for this study, where husbands often stopped women from participating.

Kaveri, who was from the same village, had not spoken to her husband about her prospective participation either. She had not been able to attend the community meeting as she was not around on the day, but Bharti and I had later visited her privately to talk to her about the research. She expressed an interest in participating and asked us to come back another day for the interview. When I went to interview her, her husband was sitting in the verandah across the courtyard, out of earshot, while she filled out the consent form. Just as I was about to start the interview, she said that she would like to inform her husband, "He won't have a problem but I should tell him, how will he feel if I'm just talking without telling him?" Asking the husband was not always done out of social obligation or fear, but was sometimes done to consult them and get their help and their opinion. And in Kaveri's case, it was done so that the husband didn't feel bad or left out of her activities and decisions. In her interview, she also said that both partners should first share things with each other, but she also knew that the social context of marriage was gendered, and that men often held power over women and exercised violence.

Saloni similarly *told* her husband about her decisions, and about her whereabouts, so that he would know.

> AA: Okay. And how do you usually make decisions?
>
> Saloni: My mother advises me on most health-related issues. But I do some things on my own too, I go to places on my own. *I tell my husband where and with whom, but he doesn't scold me, he just wants to know if someone is with me* [emphasis added]. I can go wherever I want, I have loved wandering around since I was a child and he's known me and my habits for so long.
>
> (Saloni, 20)

Her insistence that her husband doesn't scold her when she goes out implies that scolding could be a common reaction to a woman going out, which the experience of some other participants shows, and which is culturally well-known. Saloni's marriage was also a love marriage, which can arguably enhance women's decision-making capacity, especially if the couple has known each other for a long time before marriage (Banerji and Deshpande, 2021).

For Saroj, the experience of marriage had been different from Saloni for several reasons—it was arranged when she did not want to get married, her husband was a migrant worker, she was relatively isolated from her birth family, and her marital family was struggling financially. Saroj also faced communication barriers with her husband because he lived away

for long periods. He enabled access to institutional care for her when he was around and to the extent that he could afford, but while he enabled care for her miscarriages, he did not take any initiative to prevent repeated conception, which Saroj believed was the key reason behind the miscarriages and her continuing ill-health. Therefore, he used his authority to practise neglect even though he enabled care to her in the sense of institutional access.

> AA: As you said, when you had a miscarriage, you took some medicines to get better. I want to understand how the decision was made. So whom did you speak to first?
>
> Saroj: I first spoke to my husband about it, I didn't tell my in-laws. He said let's get medicines, so we went to the nearby urban centre.
>
> AA: And did you want to go there?
>
> Saroj: Yes, I wanted to go there.
>
> AA: So who usually makes such decisions?
>
> Saroj: The decisions are made by my husband. Because if I tell my in-laws, they will just think that I am being lazy and complaining to avoid my work in the household.
>
> AA: Okay. Say you wanted to go to a bigger city, which is further away but has more facilities, instead of the nearby urban centre. What would you do then?
>
> Saroj: I would tell my husband.
>
> AA: And what might he say, what do you think?
>
> Saroj: Hmm he might listen..we'll see.
>
> AA: I mean, who would make the decision to go to one place or the other?
>
> Saroj: Both of us would make the decision, based on what's good and what's not. It's usually just us, I don't involve my in-laws because they will think I'm avoiding work.
>
> (Later in the interview)
>
> AA: Have you ever made a decision about your reproductive health by yourself?
>
> Saroj: Myself? How can I make a decision myself? *I usually speak to my husband* [emphasis added].
>
> (Saroj, 19)

‘Telling’ (and asking or speaking to) served different purposes in each of the above excerpts, it acted as permission for some participants and assurance of trust for others, but in all cases, participants emphasised the undercurrent of mutuality (within a system of dependency created by the patriarchal family order) in telling, asking, informing or speaking to their husbands. For Kiran, it was an act of upholding trust and her husband’s socially-sanctioned role as her guardian. For Kaveri, it was an act of reaffirming trust in a partnership. Although Saloni and Komal differed in their decision-making processes (Saloni sometimes made decisions by herself or asked her mother while Komal depended on her husband), both conveyed that their husbands made, endorsed, or wanted to be aware of their decisions out of concern for their well-being. For Saroj, telling or speaking to their husbands was somewhat about seeking permission but it was also about conveying that she depended on her husband as women do, even though her husband did not always fulfil her needs.

Telling was almost always the first step in negotiating care. As Kaveri put it, “you become capable of doing something when you share your problems with your husband.” I argue that such capability is routed through the authority of the husband. Tara, who had been married for a much shorter period than Kaveri, also emphasised that “you *have* to tell your husband”, which was reaffirmed by her grandmother saying to her “it is the law, you are not capable of doing anything until you tell someone.” Telling was about negotiation, and it typically happened with husbands as the marital relationship—whether love or arranged marriage, living together or temporarily separated—was the primary site for negotiation. Mothers, mothers-in-law, and other families were involved in women’s decision-making but as carers, advisors and helpers, they were not those whom women actively negotiated decision-making with.

6.4.4 Claiming decisions

For four study participants, childbirth was a time when they acted alone in making decisions, and emphatically claimed that it was their decision to make. In two of the four cases where they did this, there were medical complexities involved, and in one of those cases, the participant in question even defied the attending doctor’s plan of action. This strong need or urge to make decisions at a crucial point seemed to arise out of concern for the child they

were about to have, and for their own safety and well-being, along with a sense of being the (gendered and maternal) body that was going to give birth.

> Khushi: Before my delivery (birth), I was in a lot of pain for two days. We went to the Public Health Centre and the staff/doctor said- we will not take responsibility for the child. Right then, in that condition, I got up and said—then why should I take the risk of giving birth here? Let me go somewhere else.
>
> AA: So you made the decision to go elsewhere?
>
> Khushi: Yes, obviously this is my decision to make.
>
> (Khushi, 19)

It is perhaps the materiality of birth, along with the register of motherhood, that made Khushi and Subhadra (below) claim decisions, which they did not always do (or did not do as emphatically) in other arenas of their (reproductive) health.

> During one of my births, the doctor had recommended a c-section because the vaginal canal was too narrow but I absolutely refused to enter the operation theatre, saying that I'd rather die than get a surgery (out of fear of a surgery and the well-being of the foetus). Eventually, the doctor agreed and I had a healthy baby.
>
> (Subhadra, 24)

Koyal and Meena, both of whom had two children each, had decided to have their respective second children at home, despite having the resources for physical and financial access to health institutions, because they felt like that was best for their babies' well-being. Koyal said that her mother-in-law made most reproductive health decisions for her. Her mother-in-law, who was present just as I was asking this, interjected saying that it's not just her but also her son (Koyal's husband) who makes decisions, and indicated that her husband plays an active role in her care. But with respect to the home birth, Koyal firmly said that it was her sole decision, in her mother-in-law's presence. A related area in which participants made decisions was with respect to the health of their children. While they wanted their husbands to be involved, they did not negotiate or wait for their involvement, but went ahead with what they thought was right, if the child required urgent care.

Overall, the participants treated questions of decision-making with nuance and caution—attributing it to husbands, underplaying their role, and connecting it to their needs

as young brides in a new household, in the process drawing attention to the gendered structure within which decisions are made. In the following section, I look at instances where decision-making was categorically rejected or disapproved, to understand how the gendered dynamics of marriage, and women's gendered position more widely, makes decision-making by oneself undesirable.

6.5 The undesirability of making decisions alone

As established in the literature review (Chapter 2) and reiterated in the introduction to the present chapter, the autonomy paradigm is inadequate to understand women's decision-making and agency in the South Asian context, particularly in the context of marriage and family. Having addressed the role of emotional bonds, dependency and men's authority in determining how decision-making is understood by women, I turn to look at participants' articulations of autonomous decision-making and why it is undesirable.

The first articulation of autonomous decision-making to consider is *majboori,* a term that came up in several excerpts above. It is an Urdu/Hindi word used to connote compulsion or the lack of a better option, along with a sense of helplessness. The word came up in many interviews, and its usage by women has been noted in other studies on reproductive health (Gondouin, Thapar-Bjorkert and Rao, 2020; Mumtaz and Salway, 2009; Sahu and Hutter, 2012; Unnithan-Kumar, 1999). When participants recounted making a decision by themselves, very few mentioned instances when they actively wanted to make the decision. In most cases, it was *majboori* that made women make decisions, especially if husbands were away or uncaring, if the family didn't support them, if there was an urgent medical need, and if the concern at hand was the health of children.

> AA: Have you ever made a decision by yourself?
>
> Meena: Yes, I make decisions by myself/based on what I think (*apne mann se*) and my husband agrees with me. If I have to get medicines when my husband is away, I will call him, he might say go or don't go or go with someone, but if it is absolutely necessary (*majboori*), then I have to go by myself.
>
> (Meena, 25)

Unlike the development and policy lexicon where decision-making autonomy is closely associated with empowerment and progress, it is not a desirable or aspirational activity in the lives of many young women as it is associated with dire circumstances and signifies lack of support (Kabeer, 1999). Moreover, in the social and geographical context of this study, autonomy—understood as doing things individually—is not a possibility if women have no control over money, little education, or no access to public facilities because they do not exist, are unsafe or exclude them in other ways. Kabeer (1999, p.8), also raises the "uncomfortable possibility" that not all women may want the option of autonomy, citing Razavi's (1992) empirical work from Iran, and her own empirical work from rural and urban Bangladesh. Taking the example of women who had newly acquired access to greater economic resources in Bangladesh, Kabeer (1999) argues that women act in diverse ways, some actively rejected patriarchal authority within the family, others rejected the 'official' interpretations of such authority/constraints, forwarded by dominant sections of society, and redefined them to accommodate agency, and yet others acquiesced to their position of lesser value and even justified it based on biology and/or divinity, or status quo. Such reactions, according to Kabeer (1999), may not always be strategic compliance (Agarwal, 1997), but the outcome of different realities and histories.

In the field, I interacted with several women, young and old, married and unmarried, and with varying education levels, for whom decision-making held varying levels of significance. For unmarried girls and women working on development programmes within and outside of the collaborators' networks, autonomy was highly valued, cherished and aspired towards. For young married women, it was often not worth thinking about because getting things done was more important (such as access to care), especially when the situation was characterised by *majboori* or helplessness. For older married women, especially mothers-in-law and other matriarchs (especially older women whose husbands were no longer socially active, ill or had passed), autonomy in mobility, financial matters and access to care was something they exercised but it was normalised (and hence not considered autonomy) as it was associated with their age rather than gender.

If *majboori* was a big factor that led to (undesirable) autonomous decision-making, fear of blame and backlash was a factor that prevented participants from making decisions when they wanted to. In other words, making decisions alone led to fear. Nargis, whose husband lived in Delhi, was sometimes sceptical about making health-related decisions by herself, but

did so nevertheless. Her birth and marital families did not approve of this and constantly warned her that she would have to face the consequences herself if something went wrong. Their concern, however, was with Nargis going out of the house by herself, which they anticipated would have consequences like risk of shame and violence (something 'wrong') rather than the consequences of her making health-related decisions. Nargis continued to make decisions although she mentioned "seeking forgiveness" from her family for making decisions by herself. She was reluctant to share the details of the particular decision with me. Nargis had a supportive husband and marital family and lived very close to her birth family, allowing her mother and sister to support her and assist her in raising her children. Her fear of repercussions was not fear of physical violence should she do something 'wrong' by making decisions by herself, but fear that she would hurt her husband and/or mother-in-law who cared for her well-being. A few other participants, like Saroj and Sumitra, indicated fear of violence if they did not listen to her husbands or adhere to their decision, while Ranjana had faced such violence.

But the desire to make decisions with someone, particularly husbands, did not always arise out of need, respect for partners' caring disposition or fear of repercussions and violence, but also because autonomous decision-making was perceived to have a negative value. Such an understanding of autonomous decision-making was gendered and it was women's autonomous decision-making that was undesirable. The words *marzi* and *manmauji* were particularly used to express discontent with such decision-making. *Marzi* translates to choice, but additionally has a strong undercurrent of individuality, along with irresponsibility or no need for responsibility. *Manmauji*, similarly, means whatever the heart desires, and is not a positive value as it indicates selfishness. Kaveri used the term *marzi* to describe how some women make decisions by themselves but said that that was not the right way as decision-making should be mutual between partners. Her reason was mutual love and respect rather than women being incapable of making decisions, indicating that making decisions by oneself can reflect poorly on one's relationship with one's family.

If there was an undesirability of making decisions alone, there was also a desirability that the husband make decisions. In some ways, this is related to the responsibility of husbands to care for their wives. Kabeer's (1997) study from urban Bangladesh, for instance, shows that women were generally happy with their husbands making decisions but chose to control the finances when the husbands refused their responsibility—such as providing for the family,

and particular things like daughters' welfare and education. As long as men observe their responsibilities to their households, women consider the issue of who 'controls' their wages to be irrelevant. Such complexities were visible in my study—where women seemingly willingly let husbands make decisions and control resources, as it appeared to benefit them. At other times, they possibly positioned themselves as wives who let husbands take charge in the interview, even though they clearly held control, such as Sumitra. At the same time, some of the participants in my study also premised the desire for men to make decisions on love and partnership, a crucial and understudied perspective. The following accounts from Sunita and Shyamolie reflect why women actively wanted their husbands to make decisions, and how it reflects the centrality of the husband discussed in the previous chapter (Section 5.5).

Sunita had been married for a few years and was of the opinion that her husband should make decisions for her, much as that did not mean that she was not involved in the process.

> Sunita: I just leave it up to my husband. First of all, I don't really make decisions by myself. I make my decision and then leave it up to him, and then whatever he thinks is appropriate, he tells me that. If he feels like the advice he has from others is sound, then he thinks okay I should not do this this way (but do it based on the advice).
> See, in life, if you have the right partner, everything will be alright.
>
> (Sunita, 23)

For Sunita, her husband making decisions for her meant that she had one less thing to do or take responsibility for (and through the process of marriage, it was his responsibility), especially when she was already burdened with housework and childcare. But importantly, it was also a sign of a loving partner who would take care of her.

Shyamolie, who was also in a love marriage like Sunita, said that "I like that my husband makes decisions for me", suggesting that she always asks her husband and then does what he says. At 16, Shyamolie was the youngest study participant and in a love marriage. In practice, her mother seemed to make more decisions than her husband in her care, and she wanted her in-laws to be involved, but she associated decision-making with her husband and liked being taken care of (discussed above, page 177). Shyamolie also had shifting responses to questions

of decision-making in her interview. When I first asked her if anyone else got involved in the decision-making process between her husband and her, she said that it was only the two of them, without challenging my question which pre-positioned decision-making as something that both partners are involved in. But towards the end of the interview, when I categorically asked her if she makes decisions, she said that she does not do anything on her own: "I do what my husband says." In practice, as I explain above, it was her mother who made most decisions, but Shyamolie positioned her husband as the key figure.

With these examples in mind, I now turn to what women wanted when they did not want to make decisions on their own, because of *majboori* and *marzi*, and argue that they wanted and claimed care from their husbands and marital families.

6.6 Decentring decision-making to centre care

In many of the interviews, questions about how decisions were made (the process) and who made them were met with answers that began with a description of who cared or did not care for the participant. Care was articulated as "being nice", "listening to me", "thinking of me" and even "chiding me." On the other hand, lack of care in the marital household was expressed by explaining instances where participants had to reach out to their natal kin or make a decision (and take on an expense) by themselves.

I identify three different ways in which women make claims on care, or three different formulations of care: 1) *care as value*, which is based on the fundamental idea that women's lives have intrinsic value, 2) *care as a moral responsibility* which positions husbands and marital families as caregivers to married women, an idea that forms the basis of many filial responsibility norms globally, and 3) *care as love*, which is based on dependency and emotional bonds, and sometimes bound up with patriarchal benevolence. I propose these formulations, which can co-exist in women's experiences, as ways to understand what caring for women constitutes.

The first formulation of care—as value—is best understood through expressions that articulate the opposite of it—"they don't care about me" or "it makes no difference to them", usually directed at the husband's family, which indicates indifference and neglect. Families

were indifferent and inattentive towards their daughters-in-law in as far as their health needs like rest, nutrition or institutional care were concerned. The burden of household labour, which women frequently raised as a determinant of their health (see chapter 4), was not in itself seen as a sign of lack of care as women acknowledged it as their work, but the lack of concern—not acknowledging that the daughter-in-law is tired or not knowing that she is having a difficult pregnancy—was a sign of lack of care. Such indifference could possibly be attributed to the conventional expectation of household labour from women, which normalises women's burden of household work—If the mother-in-law was able to do the same amount of work, why can't the daughter-in-law do it? but the undercurrent of this expectation too is the negative value assigned to women's lives and well-being.

Neglect is evident when families categorically deny care or deprive women of whatever access to care they may have by controlling their material resources, disrupting their relations with care-givers, and subjecting them to violence, or by neglecting to account for the woman's needs and wishes, as some husbands did, causing harm and distress to the women. Underlying indifference, neglect and deprivation is the devaluing (undermining of value) of women's lives, which is what women pointed to in complaining about the lack of care. An outright expression of undermining women's lives is telling daughters-in-law that they are replaceable. For example, Saroj, a participant in a focus group discussion said that if a daughter-in-law is unable to do the household chores when she is unwell, the in-laws can threaten them by saying that they will get their son remarried, "go away if you can't do the household work, we can get another daughter-in-law." Similarly, another participant's in-laws, who refused to call a doctor when she was unwell, told her that they do not care if she dies because they can get their son remarried.

Although most participants did not actively seek acts of care, they sought the underlying principle behind acts of care, which is to be valued, and which could be expressed through simple acts such as an acknowledgment that they need rest when they are unwell. Radhika referred to this principle, that I call value, as respect, "families don't respect daughters-in-law." In the Indian context, respect for women is closely tied to a patriarchal and brahminical sense of modesty, which is accorded to 'good' women. Radhika used the Urdu term *izzat* for respect, denoting value, further evidenced by the examples she used to illustrate lack of respect—dowry violence, material deprivation and female infanticide. The idea of women's lives being valuable is fundamental in principle but, in the context of structural

inequality, claiming recognition of their lives as intrinsically valuable simultaneously becomes a claim on care.

The participants in my study did not frame their claim on care as a right, and certainly not as a legal right, but as something that should arise as concern on part of their marital families. Valuing women's lives features as a theme in scholarship on women and girls' health and development, frequently through the empowerment framework where women's capabilities are sought to be recognised and harnessed towards social development. But in this framework, the underlying principle is not necessarily intrinsic value but value towards an end, or utilitarian value (Wilson, 2017). For example, Bhog and Mullick (2015), writing about the collectivisation of adolescent girls in India, argue that girls are always viewed as tools in a process of economic and social change, often by a crude cost-benefit method. In contrast, when women claim care as intrinsic value for their lives, a more fundamental claim is made on being valued within the family, which is seen as a natural site from which to claim care, as opposed to the state.

The second kind of care that women claimed was that of the husband's moral responsibility to take care of them, which I discuss through various examples in chapter five and in the present chapter through examples where women wanted husbands to make decisions. Being taken care of was seen as a right within marriage. "If my husband has married me, he must take care of this (her mother-in-law's difficult attitude towards her)," said Ranjana, who was not on good terms with her marital family since she got married.

Although women in general usually conceptualise this type of care as the moral responsibility of their husband, it has a strong economic foundation, and is articulated in most maintenance laws in India which make it incumbent upon men to provide for their wives (separated and divorced as well), minor children, unmarried adult daughter, and parents, if the latter groups cannot provide for themselves. It is based on moral thought and a conventional understanding of masculinity, and also on social and economic discrimination and deprivation that create gendered dependency (Grover, 2018). In my study, this type of care was also seen as a bare minimum expectation which could be fulfilled out of moral and social obligation even if their lives are not fully valued, and where women did not receive it, they sought it for their children. Women's claims on care of this kind, although closely represented in maintenance laws, were social and moral claims rather than legal ones. For some women, it was also a claim on material or monetary care and also on social support, and perhaps emotional support

as well. This kind of support, therefore, was also considered a moral responsibility or a right within marriage, rather than a responsibility borne out of love and concern. Ranjana's demands for support from her husband, for instance, were not about love but about financial security and strategic support.The implications of making such a claim on care as the moral responsibility of the husband is almost always more strategic for women (as it was done to seek a particular outcome, usually material provision) than making a claim on care as value, which, while fundamental in principle, is not necessarily met. It is also more strategic when compared to claims on care as love, which is discussed below and is affective in nature.

The third formulation, love, was a common lens through which women claimed care, or articulated being cared for. The words used to describe love were close to "nice", "thoughtful" and "caring" and were mostly used to describe husbands and mothers, and sometimes in-laws. Dependency and emotional bonds are evident here in the conceptualisation of and claim on care, and, in line with Mumtaz and Salway (2009), I want to examine their role in shaping care within the context of gender inequality within the family and society. While care as financial support, and social support in navigating household dynamics, was claimed as the husband's moral responsibility, emotional support, which frequently translated to husbands making decisions for their wives, was perceived or laid claim to as a sign of love. The idea that, in a healthy relationship, the husband will do what is best for his wife, and therefore, the wife can leave all decisions to him, is seen as desirable by many study participants. Wanting to be cared for in this manner can possibly be placed in Kabeer's (1999) definition of agency as it illustrates negotiation and bargaining through the lens of love and care—I trust you to take care of me and somewhat give up my autonomy (in terms of observable action), but I like being taken care of and/or need to be taken care of. But what is noteworthy here is that the husband's decision is inherently supposed to be the right decision.

Implicit in love and care, especially the kind that thrives upon dependency, is also the infantilisation of women, which assumes greater importance in the context of my research as care is being studied from the perspective of very young women. Husbands and in-laws were said by respondents to frequently use their daughter-in-law's young age as a reason to prevent them from making decisions or from considering their perspectives on health and care both out of concern for her well-being and to exercise power over her, often in an intertwined way. The infantilisation of women can take the shape of control in the garb of care, and also

assume more violent forms. *It is for your own good* is a common expression of love and care directed towards women and young people. This idea of care has been critically theorised as 'patriarchal benevolence' which suggests that men exercise privilege and power in the garb of care and equal treatment (Delacollette et al., 2013; Sudhir and Jayaraj, 2022). In the study data, patriarchal benevolence is perhaps at play in cases where women utilise a particular type of care because their husbands insist on it, premised on the belief that the husbands care enough to make a suggestion or a decision. However, not all incidents of women claiming this type of care can be categorised as patriarchal benevolence. Young women, often overburdened with household work, having poor access to information and lesser exposure to institutions (such as health systems), actively sought their husbands' involvement in the form of decision-making, as explained by Sunita above: "I just leave it up to my husband. First of all, I don't really make decisions by myself…See, in life, if you have the right partner, everything will be alright."

As discussed earlier, women sought care in the form of involvement from in-laws as well, as it demonstrated togetherness of the family. Seeking involvement from the in-laws is also strategic as it affirms the daughter-in-law's position as someone who is respectful and dependent on the husband's family (rather than being someone who acts on her own volition).

This type of care (as love), though premised on love, can include value as well, in both intrinsic and substantial ways. A concept that possibly comes close is Thoits' (2011) expression of 'social support', in turn drawn from Rosenberg and McCollough's (1981) concept of 'mattering' which refers to the belief that one is important to another person, receives attention from them, and depends on them for the fulfilment of specific needs. The role of dependency and emotional bonds in claiming care, or the formulation of love as care, is relatively difficult to establish in comparison to care as value or care as moral responsibility. Women did not actively seek love as care, or did not articulate it, as opposed to seeking to be valued and seeking to be provided for. However, those who experienced this kind of care, especially in a love marriage, always mentioned it and its role in their access to healthcare and overall well-being without being asked. In fact, they used love as a justification for their (positive) experience. The study of love and emotional bonds, challenges predominant measures of autonomy that study the relationship between women's age, education and income, among other factors (such as property ownership and use of

menstruation management products in the National Family Health Survey), while also questioning the value of autonomy for women's lives (Allendorf, 2012a; Basu, 2006).

Moving beyond the autonomy paradigm that emphasises individual action, in understanding women's decision-making, allows for a nuanced understanding of the institutions and relations that shape gender inequality, insights into the values and motivations that shape women's contextual approach to gendered authority, and a way to account for their reflexive capacities to formulate and articulate their preferences, rather than the ability to make decisions that result in action alone (Kabeer, 2011; Madhok, 2004; Mumtaz and Salway 2009). My research draws on these perspectives and suggests that studying needs and motivations for care as well as their claims on care, enriches and extends approaches on access to care which are predominantly rooted in the biomedical framework (which assumes that seeking care is based on a rational assessment of needs) or exclusively focus on health status (such as the prevalence of illness) (Kuhlmann and Annandale, 2012). My study, on the other hand, embeds women's health in the everyday household, and the structures of caste and kinship in the case of South Asia. Decentring and challenging autonomy to study care, more specifically women's claims on care, also has implications for a feminist positioning on care, which, so far, has largely been developed in relation to gendered care labour and social reproduction (Himmelweit and Plomien, 2014). In the three formulations of care that I describe—care as value, care as moral responsibility, and care as love—whether or not women made decisions by themselves, or negotiated decision-making, they claimed care for themselves, which is not typically studied as a way in which women position themselves in relation to care. The women in my study occupied the position of daughters-in-law in the marital household, fulfilled the social roles expected from that position, and drew on the nature of heteronormative marriage in the study context (characterised by patrilocality, patriarchy and dependence) to negotiate authority and claim care. Their accounts of care and neglect, in instances of institutional access or otherwise, points to the central question — *are women really cared for?* While there are several instances of affection, concern and care towards women in the data, the question of caring for women is a wider question about young married women's collective gendered position in the household and in wider society.

6.7 Conclusion

This chapter has analysed the ways in which women describe their motivations and actions vis-a-vis decision-making in matters of accessing care, and how they seek to maximise their interests within the dynamics of the household. The chapter has initiated its exploration of decision-making by studying what counts as a decision, which places decision-making in the gendered relations and gender dynamics of the household, while maintaining the emphasis on the centrality of the husband. After identifying what constitutes a decision, the analysis has examined the actions or the steps involved in making decisions, identifying the roles of different parties and studying the participants' presentation of the actions. The chapter revisits the gendered position of the daughter-in-law to understand how women navigate this position and strategically use it to maximise their care when possible, by involving the husband (his authority and his responsibility) directly by 'letting' him make decisions, or indirectly by 'telling' him about a decision. This analytical approach has allowed moving away from studying decision-making as decisions made by oneself, by another person, and joint decision-making, to studying the dynamics of decision-making, which provides critical insight into decision-making figures and what they signify for women. To build an understanding of what decision-making signifies, the chapter has also examined the values that women ascribe to decision-making, when it is done by husbands, by themselves, or through negotiations. The chapter finds that making decisions by oneself is not a valuable/empowering exercise nor one associated with progress, it is propelled by compulsion and dire circumstances (for instance, a decision needs to be made when a woman is very unwell), and in fact, often undesirable when done autonomously by women as it signals a lack of support from the husband and from the wider household.

The chapter has built on critical literature on women's decision-making autonomy, such as works by Allendorf (2012a); Basu (2006); Kabeer (1999), Mumtaz and Salway (2009), by examining the values and consequences of decision-making for women. Based on such critical examination, it has argued to decentre decision-making (especially in the form of autonomy) and offered ways to understand how women want to be cared for, especially in their circumstances as young brides in new households. The analysis has attended to the ways in which women articulated being cared for, or more often, being uncared for and neglected. It has also closely studied and presented participants' understanding of *caring for women* in

terms of valuing their lives and personhood, taking responsibility for them, and emphasising the understudied aspect of love and emotional bonds in marriage.

Chapter 7
Conclusion

7.1 Introduction

The conclusion to the thesis is an exercise in both summary and reflection, and a space to raise larger questions about caring for women, and what it means to take a feminist approach to research. I first look back at the conceptualisation of the research problem and trace how the questions were developed. Next, I revisit the three research questions and reflect on how the analysis has been accountable to them, and to the larger research problem—the influence of household gender dynamics on young married women's access to reproductive healthcare—highlighting the novel contributions of the thesis. I then draw attention to the challenges involved in designing the methodology and how its operation contributes to feminist knowledge production. And finally, I discuss the limitations of the scope of the study and conclude by discussing further areas of research, and their implications for feminist questions of care, especially in relation to young married women in India, and in comparable social contexts.

As I discuss in the study introduction (Chapter 1), the research was conceptualised upon noticing the absence of attention upon the household in media and development narratives of maternal health in India. In research, there is considerable focus on the availability, accessibility and utilisation of healthcare by women through schemes and facilities. I started my literature search from this area of work, and found much about the influence of income, caste, age, education, mobility and autonomy on women's utilisation of care in India (see, for example, Arokiasamy and Pradhan, 2013; Sanneving et al., 2013; Singh, Rai, and Singh, 2011). Some of the research in this area has also looked at the role of the mother-in-law, and sometimes husbands, in influencing women's access to reproductive healthcare (Allendorf, 2015; Barua and Kurz, 2001; Thapa and Niehof, 2013). But the household as a set of relations appears sparsely in this body of literature, or is not explicitly named as a problem. My study, therefore, identified the influence of household gender dynamics on women's access to reproductive healthcare as its research problem. The novel focus of the study's approach to the household is that it has embedded women's health in the everyday household, and in the structures of caste and kinship, and asked how young married women are cared for

in the everyday. The study retained the initial focus on reproductive health, but has also shown how reproductive health is part of women's wider health and well-being in the household rather than being limited to fertility, pregnancy and childbirth, or to individual instances of institutional care.

The other aspect of the research problem was that of early marriage. In the thesis, I have positioned early marriage as a problem for the study, but also as a practice that is not distinct from marriage, more broadly, in the social context, as it is shaped by the common structures of caste and heteronormativity, and by practices like patrilocality and dowry. While the thesis has positioned the study participants as 'young married women', it is notable that they made only occasional references to their (young) age. Partly, this is because early marriage formed the background of the study and was implicit in the discussions, and partly because the individual participants' age at marriage was not unique, but rather, part of their social world. My emphasis has been on the nature of the early marriage, whether love, intercaste, arranged or forced, rather than the specific age at which it happens. There are two reasons for this, the first being that age is neither universally calculated in rural India nor necessarily considered a marker of maturity (discussed in Chapter 3). The second reason is that an overemphasis on age can disregard other factors of vulnerability such as, poverty, caste, patriarchy, and poor healthcare. Focusing on age as the singular dimension of the problem also suggests that it can be easily rectified by raising the minimum age of marriage (John, 2021). At the same time, I recognise the significance of young age in marriage as it curtails women's social opportunities both symbolically and materially, pushes adolescents into adulthood, and impacts their sexual, reproductive and mental health, albeit in ways more complex than what appears in predominant discourses on early marriage and health (discussed in Chapters 2 and 4).

Thinking about age in relation to marriage also proved to be a moment of feminist reflection for me. Would it be acceptable to me if someone from my immediate social circles (that is, someone urban, economically secure, and living a life where one can afford greater choices) would be married at 17 or even 20? Certainly not if it were forced and perhaps not even if it was out of choice, because in the 'modern' world of my social context, and that which many women in the study area inhabited or aspired towards, delayed age at marriage is a marker of progress for women. I was cognisant of this tension as I analysed accounts of women who had been married early out of choice, willing arrangement, or force, and I did not want to

treat them, their circumstances and their choices differently from those of other women I know personally and professionally. Equally, I did not want to impose normative standards of progress onto my participants and sought instead to hear what they had to say about the meaning and significance of early marriage, being mindful of not unfairly influencing the data and the analysis.

The debate over early marriage is ongoing in feminist discourse, and is studied for its implications for health, rights, development and social change (Gopal et al., 2016; John, 2021; Santhya and Jejeebhoy, 2003). The significance of my study is its *combined* focus on early marriage and the marital household. The study has examined the gendered relations that make marriage, and the household dynamics of the marital household where such relations (complemented by state and society) operate and are negotiated. I particularly aimed to understand the influence of such marital and household dynamics on women's access to care, and to develop ways to think about women's (receipt of) care in marriage, a central social relation in the study's context. In the following sections (Section 7.2 and 7.3), I look back at how this aim has been unpacked through the three specific research questions and made novel contributions to knowledge, and subsequently (Section 7.4), I look at how the methodology has enabled such exploration of the research questions.

7.2 Revisiting the research questions

7.2.1 Conceptualisations of health

How do young married women understand their reproductive health status and needs?

Women's experience of health, most commonly expressed through the experience of illness, was not necessarily incongruent with national statistics on health status and access. For instance, 65.7 percent of women aged 15-19 in Bihar are reported to have had anaemia in 2020-2021 (IIPS and ICF, 2021), a figure supported by other contemporary studies (Chauhan et al., 2022; Kumar et al., 2022; Sharif, Das and Alam, 2023), and in the qualitative accounts provided in the present study. My study did not set out to corroborate or contest statistics on women's reproductive health and neither was it designed to be scalable beyond Bihar and its cultural and geographical neighbours, but there was a congruency between figures and the experiences I studied. Importantly, by carrying out a study of household dynamics, the

research has been able to interrogate *how* women conceptualised their experiences of conditions like anaemia, or of early childbearing. The first conclusion I draw in relation to conceptualisations of health is that, in the experience of young married women, health is socially constituted, the novel finding being that it is particularly constituted by the dynamics of the household. A difficult experience of childbirth, while reminiscent of physical and emotional distress, was also experienced through the woman's location at the time (in the birth home, considered a space of care, or the marital home), the kind of resources that were, or were not, mobilised for the required care, and crucially, by whom. Additionally, it was experienced through the very desirability or undesirability of the pregnancy, the sex of the child, and the quality of the marital relationship. Reproductive health, therefore, was found to be embedded in multiple aspects of women's health, marital lives and larger social position.

The second conclusion I draw is that speaking about health experiences is a register to talk about the shared experience of occupying a gendered body and a gendered position within household and society, which is defined by marriage, and often marked by subservience and helplessness. This came to the fore in the analysis after a pattern emerged showing that health experiences were often spoken about through the collective 'we' or 'us' when talking about problems that were, on the face of it, experienced in and by the individual body. Research in India and other socio-regional contexts has similarly traced women's articulations of health, illness, and access to care, to their life circumstances and the dynamics of their social relations (Atal and Foster; 2020; Basnyat, 2011; Pinto, 2011; Qureshi, 2020; van der Sijpt, 2014; Van Hollen, 2003). I add to this body of work by emphasising that such social associations are also shared and collective, and the collectiveness is a register to articulate wider gender dynamics in marriage, beyond one's own circumstances.

The third conclusion I draw is that early marriage has implications for women's health, but that these are not limited to reproductive health outcomes. The analysis in Chapter 4 has shown a desire and a need to adhere to public health norms on women's reproduction amongst participants, such as the norm to delay childbearing. But equally, childbearing is influenced by social norms such as those that value women's (proven) fertility and son preference, personal goals of having and raising children, and performing heteronormative sexuality by embedding oneself in the marriage and marital household (George, 2002) (see, for example, Kaveri's contrasting opinions on early childbearing, page 116). Several study participants located their ill-health in marriage, reflecting the state's position to some extent.

But they did not reproduce this position uncritically, as they emphasised the role played by the specific circumstances and nature of marriage, along with or independent of its timing. Particularly, they spoke of how the scale and nature of household labour, and the expectation and consequences of sexual activity—repeated, unprotected, and perhaps unwanted—negatively impacted their reproductive health, and caused mental distress and specific medical conditions (such as anaemia), feeding into a difficult social environment with no respite.

7.2.2 Marriage, gendered relations, and care

How do marriage and the gendered relations of the household shape access to care for young married women?

In Chapter 5, I examined the nature of marriage and its ensuing gender dynamics, and concluded that marriage—characterised by bringing and keeping a woman—has implications for women's care as it accords the authority to care to the husband and concomitantly, enjoins him with responsibility. Women's natal kin and other relatives may have the desire and the wherewithal to care for them, and health workers may have the obligation and expertise to care for them, but neither have the *responsibility* to care for them, as they do not have authority over married women. Therefore, I argue that caring for women is expected to happen *through* the authority of husbands. Upon 'bringing' women, husbands are expected to mobilise economic and social resources in their care, use their privileged gendered position as sons to enable a caring space in the marital household, and to take initiative in navigating health systems and in deciding the most suitable type of care and how it should be accessed. If these roles are fulfilled, women are being 'kept well', a desirable position in marriage as it signals being taken care of. However, husbands do not always use their authority to keep women well; they can also use it to perpetuate neglect, both knowingly and unwittingly. While marriage is widely characterised by migration (and its gendered social consequences) in India, and other parts of South Asia, my study offers insights into the social significance of marriage migration in women's care, through the oft-used terms 'bringing' and 'keeping.'

The husband's authority to care had varying and overlapping responses from women, including appreciation, resignation and confrontation. The study has also found that while authority is central and socially legitimated, it is also *negotiated* in marriage, through the shifting dynamics of the marital relationship and the wider household. The participants

perceived their husbands' authority with criticality, even when it was meant to be for their 'good', and at other times, they sought to invoke it to fulfil their care needs, indicating a process of negotiation (see, for example, Ranjana's simultaneous invocation of and challenge to her husband's authority, page 150-151).

Placing women's care in marriage and the household demonstrates the importance of a shifting but comprehensive understanding of care, which accounts for the availability and accessibility of facilities, the processes and circumstances of access, and a sense of *feeling cared for*. My study has found that access is shaped in and by the household, and I conclude that the predominant focus on utilisation within existing research undermines the gendered relations, dynamics and negotiations that significantly influence women's access to care, and therefore, obscures what women value in their care.

7.2.3 Meanings of decision-making

How do young married women perceive and assign meaning to their decision-making within the household, especially with respect to access to care?

Decision-making was one of the themes the research problem began with because of its predominance in demographic and feminist studies alike (for example, Bloom, Wypij and Dasgupta, 2001; Jejeebhoy and Sathar, 2001, IIPS and ICF, 2021). As established in Chapter 2, decision-making is principally conceptualised in terms of individual autonomy and action rather than participation in decision-making processes in the household, or the gender dynamics within which decision-making happens. Decision-making, in its form as individual autonomy, was part of the interview topic guide (Appendix 3) and a question significantly discussed in the pilot study. But eventually, the interviews made evident that autonomy was not a topic of interest to participants as it was neither suitable to the social context nor desirable because it was a sign of lack of support or a negative value for women. Consequently, the study turned its attention to what counts as a decision, a novel approach in the study of women's decision-making, and found that a 'decision' was often associated with the husband even when he may not have been central to it, as husbands command the conventional authority and responsibility to make decisions for women's care. Women categorised the actions of husbands as decisions, while similar (or even more instrumental actions) by their mothers were categorised as acts of love and care, and crucial actions by

health workers were categorised as part of their work. This signified the gendered nature of decision-making and the gendered relation of marriage itself.

Studying decision-making processes in this manner helped interpret participants' self-positioning as *young married women* in the household, who should take advice from everyone, obey their husbands (as they are the ultimate source of authority), and not personally assume the burdens or the risks associated with decision-making. Therefore, the goal, for women living within the specific social context of being daughters-in-law in ill-resourced rural households, was to maximise their care rather than make or claim decisions per se. The most common articulation of women's role in decision-making was that they were doing something *with* their husband, or that they were in *agreement* with their husbands after the latter had consulted them. But the study also found that women's description of their roles in certain instances of decision-making sometimes suggested contradictory practices, as they evidently initiated or made some decisions by themselves.

Given the above context, that women did not associate decision-making autonomy with increased access to care or a sense of care, the study analysed the data on decision-making to understand how women wanted to be cared *for*. Based on such analysis, I identified three articulations of care: value for women's lives; the moral responsibility for husbands to care for them; and love towards women as wives and daughters-in-law. I argue that these formulations of care are valuable in the study of women's care, as they place such care in the social context of the household, rather than individualising it.

7.3 Key contributions

7.3.1 Re-imagining the 'problem' of early marriage

The study contributes to scholarship on adolescent reproductive health and early marriage and health in India and in other contexts within the global south. As Chapter 2 demonstrates, the interest in adolescent reproductive health is largely limited to the negative impacts of early marriage (for example, Santhya et al., 2010; Singh et al., 2012; Woog et al., 2015). My study explores these impacts qualitatively, and finds that although this resonated with

participants, that significantly, it is marriage itself—rather than early marriage as a practice—that participants identified as an event that alters their body, health and wellbeing.

The framing of the 'problem' of early marriage in the study has crucially brought together divergent areas of work such as feminist perspectives on women's sexuality which account for sexual rights and labour within marriage, and the study of early marriage in demography and public health which remains focused on associations between age at marriage and women's role in social and national development. Additionally, my study has added the household to these bodies of literature. This is an important contribution as the negative experiences of marriage found in research (including the present study), are inextricable from the experience of a new household and new social relationships, and from disrupted opportunities and former comforts.

The study also offers a critical understanding of early marriage itself. I build on feminist works that locate early marriage in compulsory marriage and heteronormativity, and as a problem which is part of gendered inequality, poverty, lack of resources and opportunities (see John, 2021; MacLeod, 2014). My study adds critical insights on women's lives *within* early marriage, which is characterised by a new social world and new hierarchies and dynamics, and within it, both neglect and care in the complex ways that I discuss in the analysis (Chapter 5). Here, I once again draw attention to the central figure in the thesis—the young married woman—whom I have chosen to refer to as 'woman' rather than 'girl', owing to the social context. The 'adolescent girl', in development discourses, evokes ideas of victimisation, or, on the other end of the spectrum, images of empowered individuals with potential for personal and social development (Bessa, 2019; Bhog and Mullick, 2015; Wilson, 2017). These framings often miss the everyday lived realities of adolescents in many local contexts. My framing of 'young married women', therefore, is significant and its deliberate use novel as it accounts for the lives of married adolescents beyond the fact of age (while not erasing age), and asks how they make sense of their position and role in marriage.

7.3.2 Expanding the meaning of access

The study expands the meaning of access to include care, specifically, *caring for women.* I locate care in the key relations and spaces that young married women inhabit, bringing attention to the influence of marriage and household in determining the kind of care women

receive and the ways in which they receive it. The study, therefore, adds new insights to the (largely quantitative) literature on access to reproductive healthcare, especially in the context of Bihar where both availability and accessibility are low (Debnath et al., 2023; Kumari and Verma, 2021; Ravichanran, 2014). It builds on such literature by adding qualitative perspectives on why a health facility may or may not be accessed by women, from the particular perspective of the gender dynamics of the household, troubling the idea of access as utilisation. Other studies have also troubled this predominant understanding of access by foregrounding the role of caste, gendered social relations and social practices of care (for example, Basnyat, 2011; Chandra, 2021; Koritzansky, 2011). My study particularly contributes to this critical engagement with access by examining the people and processes that participants attached value to in recounting instances of access to care, and demonstrating that women's *feeling of being cared for* in and through the household, especially the husband, is a central part of access to care.

Locating care in marriage and the household also builds on qualitative literature on marriage that centres the dynamics of contemporary marital relationships in South Asia. My study provides insights into the everyday negotiation of authority, social roles, and care in marriage, in a social context marked by enduring patriarchy but new expectations around marriage and partnership (Chapter 5, Section 5.3). The novel contribution of the study in this regard is that it is able to position early marriage as a problem of age *combined with* the influence of the marital household (Section 7.3.1), and ask questions of the household and the marital relationship in the manner that research on marriage, rather than 'early marriage' would ask. The study has shown that marriage, for young women, is constituted by love, emotional bonds, moral claims, gendered hierarchies and norms, rather than their age alone, making the former significant areas for further research.

7.3.3 Shifting from autonomy to care

The study decentres a focus on women's personal autonomy, especially when measured as individual actions, and instead studies decision-making practices in the household to analyse the actions and values that women employ to maximise their interests, especially looking at the importance of bargaining and household relations. Feminist scholarship from South Asia has previously dislodged this focus, arguing that the structures of family and marriage make autonomy inadequate and also raise the possibility that women may not desire autonomy (for

example, Kabeer, 1999; Mumtaz and Salway, 2009). My study contributes to this body of work by studying how young married women in the study context perceive and present personal autonomy, which is usually in the undesirable register of *majboori* (compulsion). The novel contribution of my study lies in its exploration of sites and processes of care that may be more valuable to women (as young daughters-in-law) than personal autonomy. These formulations of care, constructed through an engagement with participants' terms and narratives (Charmaz, 2006), are intrinsic and fundamental value for women's lives, moral responsibility (of the husband) for their well-being in marriage, and love towards them as wives and daughters-in-law. A significant feature of the terms and narratives that women articulated, was that they were presented as claims, or as forms of care due to them. The formulations of care, and women's nature of presenting them as claims, present new dimensions in the feminist study of care by centering women's *receipt* of care.

7.3.4 In summary: Addressing the research problem

In sum, the research problem has studied the influence of household gender dynamics on young married women's access to reproductive healthcare in Bihar, and found that the marital household, and marriage itself, shapes women's experience of body, health, illness, and subsequently, their access to care. The study's focus on the household contributes to an understanding of how households function as dynamic bodies constituted by gender, caste and kinship, which act in the social and political context that they exist in. This approach to the household disrupts its perception as unitary bodies whose income and caste location singularly influence women's access to (institutional) care, as often studied in the social determinants of health approach. The embeddedness of health in household dynamics and gendered relations expands the meaning of 'access to care' as it shifts the focus to the relationships and the spaces that enable care in a biomedical sense and in the sense of embodied feelings and emotions. The study has placed young married women at the centre of the research problem, and specifically studied household relations from their perspective, in a heteropatriarchal social context of marriage. The gendered position of young married women in the household is created through marriage and through the inherent dislocation that marriage implies in the study context. Women inhabit the household and its relations as someone who is brought into the household—by the husband, making him central—but does not fully belong. In this context, and in the context of high gendered dependency and low social mobility and opportunities for young married women, the household, and particularly

the marital relationship, assumes significance as the central site that influences women's care. Women's body, health and care is created in the household—through marriage, fertility, reproduction, physical labour, caregiving, and through the material aspects of the household—its resources and its space, which in turn are formed by its social location and the caste that defines it.

In the following section, I reflect upon the methodology of the study, highlighting the contributions and the tensions in doing research with young married women on early marriage, household dynamics and care, and discussing how the methodology enables the study of certain themes, tensions and questions described above.

7.4 Reflections on methodology: Operationalising feminist practice

7.4.1 Efforts towards a meaningful collaboration

My reflections on methodology addresses two interrelated aspects—the significance of the research collaboration, and the tensions around operationalising feminism, participation and action. As I discussed in Chapter 3, I was open to collaborating with different types of organisations, and the interest in collaborative research was initially driven by an interest in 'action', that is, potentially making a difference by improving women's access to reproductive healthcare. This interest in action, in turn, emerged from finding the answer to the 'so what?' question. So what if household gender dynamics influence women's access to care? What do we do? But as the fieldwork progressed, I came to realise that this question preempted what was yet to be known about the household, and about women's claims on care. Nevertheless, it came up time and again, especially when participants asked me what I was going to do with the data, sometimes in the middle of an interview. Such questions were often accompanied by questions about where I lived, what I did, and sometimes how much I earned, signalling that I was expected to 'do' something because I possibly had the means to do so. For the collaborators, action was part of their daily work at their respective organisations and, in the field, they were perceived as people who would 'do' something for local communities, especially provide information or financial aid, or implement programmes (such as skill development programmes). Their early approach to the field for this study, therefore, was centred on 'doing' and 'changing'. This particularly involved discussing early

marriage in the study areas with the intent to explain to people that it was wrong. As I mentioned in the methodology (Chapter 3), their perspective on early marriage was entirely valid as it was something they navigated and because delayed marriage is a widely-accepted marker of modernity and morality. Therefore, all of us, collectively, had to step back from our social and individual experiences to be able to form an inquiry which was non-punitive in nature. The slow and protracted nature of the recruitment allowed us to understand participant's needs and interests, and to rethink what we thought and how we felt about early marriage, how we conceptualised access and decision-making autonomy, and how we understood 'action' in relation to research. At the end of the fieldwork, we were not necessarily on the same page about what action might have constituted, as the collaborators saw the successful completion of the fieldwork and their roles and growth within it as feminist action in and of itself, as did Project Potential. On the other hand, I still find it difficult to locate action in the carrying out of fieldwork (which, to me, was a means to the end of finding answers to the research questions, which may be actionable in some forms) although I identify it in the participants' thoughts and actions within and beyond the research. In retrospect, action perhaps constituted, or arose within, the day-to-day research activities and particularly the interviews and focus group discussions as these were spaces where the participants articulated opinions, registered protest, and reflected on the gender dynamics of the household. These conversations were two-sided and also involved my participation (and co-construction initiated by me as the researcher) in discussing the household, marriage, and care.

Although my initial interest in collaboration was propelled by the aspiration of action described above as making a ‘positive difference’, I soon realised that the kind of fieldwork that the study entailed would have been near impossible without the collaborations. While I could have identified gatekeepers through other channels, such as acquaintances from past development sector projects, or frontline health workers through *anganwadi* networks, we would not have been able to make this kind of an investment in the field together. The collaboration allowed us to re-develop the research problem for ourselves and debate feminist values. It also enabled building trust with married adolescents and their families who may have feared being penalised by government functionaries and NGO representatives working on a preexisting programme or policy compliance. But despite the efforts towards meaningful collaboration, the collaborators sometimes worked strictly as gatekeepers, identifying participants and arranging meetings and interviews, often taking me to the venue, and then

having to wait while I carried out the interview. This practice carried the risk of exploitation, which has lately come under the spotlight as graduate research students in universities in the West are being known to 'outsource' extensive research tasks or the groundwork to (often underpaid) research assistants in non-western contexts like India (Chattopadhyay, 2024). To prevent the process from becoming exploitative, I ensured that the collaborators were involved in critical tasks such as feedback on the framing of research questions and the process of analyses (see Chapter 3, page 59), rather than only technical tasks (such as lining up interviews) much as the latter required equal if not greater deftness and criticality.[28] At Project Potential in Kishanganj, and to an extent in Purnia, I also organised regular check-ins with the collaborators' mentors to ensure that the project was meaningful and skill-developing, while also providing collaborators with an additional income (see footnote 8 on page 58).

The discussions on the collaborative aspects of the study in Chapter 3 present a documentation of the processes and debates involved in setting up a research collaboration, particularly for doctoral projects, and provides a useful resource for future work seeking to centre the experiences of young married women in rural India, or designing feminist research within the development sector in India. The debates around fieldwork—whom to collaborate with, how to approach a topic like early marriage, and how to manage conflicting perspectives—are as significant as the logistics of the collaboration, and, again, contribute to debates in feminist ethics in research (Letherby, 2003; Visweswaran, 1994). The research methodology has enabled asking questions in specific non-normative ways. For example, spending extended periods in the field and making community engagement a formal part of the process, showed us that early marriage was both an emergent and a sensitive subject and people sometimes assumed that we would see it as a 'wrong that needed to be righted.' This engagement helped us develop our framing of early marriage, and place our experiences in perspective. Questions around early marriage were, therefore, not framed as "at what age did you get married?" or "how did marrying early impact you?" (unless the participant suggested or mentioned it) but rather, explored through questions about care in the marital household, questions about the birth home and family, and how the participant got married. This non-normative framing enabled participants to speak about marriage rather than 'early

[28] Only data themes and minimal anonymised data were shared with the collaborators, to maintain participants' confidentiality. Yet, as discussed in Chapter 3, the collaborators were present in the focus group discussions and in parts of a few interviews, and hence, were familiar with some of the data.

marriage', which in turn allowed the analysis to spotlight the lived realities of young married women, and what is of significance to them with regard to their marriage and care.

In the following sub-section, I reflect further on what it means to operationalise a feminist methodology and how it can account for wider feminist politics.

7.4.2 What does a feminist politics mean in research?

One of my key goals, as with most research, was to facilitate an open and enabling space for participation, which entailed respecting participants' time and social obligations (discussed in Chapter 3, Section 3.3.1), and their experiences and perspectives—which form the basis of the data. However, at times, I found it difficult to agree with what they said and also found it difficult to challenge them, as my task was to listen, and to facilitate a comfortable space where they would be at minimal risk (including risk of shame or discipline from me).

An area in which I particularly struggled to grapple with participants' perspectives was the enduring issue of the husband's authority, which is reflected in the discussion in Chapter 5 (page 164-165). Instances that were clear examples of a husband exercising his patriarchal influence (to me) were seen as forms of love and care for participants in some cases (see Sonali's experience of pregnancy on page 160-163, for example). It was useful to go back to the aim and questions of the study to navigate what participants were saying about the kind of care they wanted or what they perceived as care in the context of early marriage, a new social world for them, and the experience of being 'brought in' and being 'kept.' While the research acknowledges, and even demonstrates, that participants make meaning about their relationships, health and care in their social context, the social context cannot be left untouched by criticality if characterised by discrimination and deprivation. One of the first instances in the research where this dilemma arose was during the recruitment process where we respected the circumstances of women who were at risk by not insisting on their participation (even if they wanted to participate). On the one hand, it was important to minimise prospective harm to them, but on the other hand, I was left wondering if giving into an unjust system leaves it unproblematised, and if it is fair for feminist research to be limited to recruitment, data collection and analysis, devoid of wider responsibility towards the study population whose concerns it is invested in (Roy, 2021; Wickramasinghe, 2010). I have tried to do justice to unanswered (or unasked) questions of oppression and discrimination in the

analysis, by putting participants' accounts into conversation with other research as well as my ethnographic observations and academic training. But the discomfort with 'studying' instances of injustice (even when solely perceived as such by me) and addressing it only in written analysis remains.

The methodology, and particularly the year spent in the field, has been central to the study because of its extent and immersiveness. While I continue to reflect on the question of 'action' in relation to the research, I am also aware of the significance of the nature of the fieldwork—long-term, semi-structured, community-based—in enabling the kind of exercise in knowledge production that the thesis has been able to undertake. As discussed above, 'action' was present in several moments and conversations as they were political feminist conversations, and a different methodology (such as one designed with health institutions or one carried out in a more curated environment) would not have contributed to the same understanding of the embeddedness of women's care in the household.

To conclude this section on methodology, I briefly come back to the question of action in research. I sought 'action' as a researcher committed to feminist principles and methods, and owing to my larger interest in the social development of a region that has been my home for a long time, and my place of work, intermittently. As I recounted earlier, 'action' (in terms of positive change) was difficult to identify in the everyday activities of the study, and looking for it could also presume that there was no action before or outside of the research. Nevertheless, the research created feminist engagement and enabled participatory spaces, especially in the pilot, the focus group discussions and the dissemination meetings. The dissemination meetings, a less common feature of field research, particularly served as sites where feminist engagement—rather than categorically 'action'—among participants, their families and acquaintances, was compounded. The attendees in these meetings echoed some of the analytical themes shared and debated others, also using the meetings as information sessions and social events. As mentioned in Chapter 3, the meeting in Purnia was partially devoted to discussing the legality and safety of abortion as it was something women wanted to know and the collaborators and I could gather the information for. Both meetings were attended by women who knew one another and were followed by refreshments and some time to relax and chat, extending the structured conversations on health and marriage to more informal ones.

In the following section, I discuss limitations of the scope of the study, taking into account both practical reasons as well as dilemmas like those discussed in the reflections on methodology.

7.5 Limitations of the scope and methods

The scope of the study demands that it rein in certain questions, while being cognisant of other questions and debates to which the central questions relate. First, while the study contributes to scholarship on women's health, and particularly their reproductive health, it is limited to understanding health within the institution of heteronormative marriage. The household, as I argue, is part of wider discourses on women's health and sexuality, but the study does not always interact with wider discussions on women's sexuality in India, and globally, limiting itself to the immediate experiences and social worlds of the participants.

Second, the study is located in the specific regional context of northeastern Bihar, which has its unique socio-political background (as do other regions), and is therefore, not always comparable or scaleable to other parts of the wider region. As I detail in Chapter 3, the sampling method was based on the collaborators' social location, networks and interests, and hence is not representative of the demography of the region. I am cognisant of the debates in recruitment decisions, and have engaged with them through literature and discussions with individuals and organisations (discussed on page 60) and make note of the fact that certain social groups are overrepresented and underrepresented. I also note that daughters visiting or temporarily residing in their birth homes were easier to recruit and that we avoided recruiting those who faced risk from their families, which possibly excludes women whose experiences of the household and gender relations may differ from that of the study sample. Chapter 3 also notes the large-scale male out-migration from the region, the prevalence and consequence of which becomes obvious in the analytical chapters that follow, but nevertheless, the consequences of male out-migration on women's health and care remain understudied and is an important area of further research.

Third, although my analysis mentions instances of domestic violence and/or intimate partner violence, and also dowry, these issues are not discussed at length, except in relation to sexual health and violence. These omissions may appear to be a gap as these issues are commonly

studied in relation to India (Kalokhe et al., 2017), but these are neither deliberate omissions nor normalised issues. The study was not designed to ask about domestic violence but it has been recorded as data when participants mentioned it, and analysed in relation to the background the participant mentioned it in. The study, therefore, is cognisant of the widespread prevalence of domestic violence and dowry harassment and does not intend to decentre it in talking about marriage.

In the following section, I briefly discuss how some of these limitations can be overcome in further research, and widely, the directions that qualitative feminist research on marriage, health and care can take in India, and in other social contexts.

7.6 Implications and further scope

Social and developmental narratives on women's sexual and reproductive health in India and elsewhere in the global south are usually centred on the 'wrongs' such as poor health indicators, lack of facilities, deprivation of rights. In the case of adolescents, the central question continues to be age at marriage. As my study has demonstrated, while these are relevant narratives and questions, they turn the focus away from everyday gendered relations in the study of women's health. My study, therefore, has implications for the feminist study of women's health and care, which centres their lived experiences and social contexts to ask what *caring for women* may look like for women themselves.

With regard to the specific findings of the study, I identify areas of further scope and future research, in the empirical context of the study and perhaps in similar contexts in South Asia. First, the study has widened the scope of engagement with early marriage in India, which is of interest amidst calls for an increase in the minimum age of marriage for women from 18 to 21. The research shows that early marriage requires qualitative engagement and also engagement beyond associations with reproductive health outcomes. While my research centres young married women in this endeavour, the study of early marriage would also benefit from the *simultaneous* perspectives of the families of girls, who, as my study shows, have wide-ranging views on early marriage—girls run away by themselves, girls need to be provided for, and that early marriage relates to preserving family honour.

Second, while there is considerable study of the mother-in-law and daughter-in-law relationship with respect to women's reproductive care in South Asia, especially India (see, for example, Anukriti et al., 2020), my research points towards the need for further study of the dynamics of the marital relationship, contextualising it in the wider household. My research also highlights the significance of studying women's negotiation in marriage, within patriarchal conditions. While this is a longstanding tradition in feminist studies, in relation to this study, the marital relationship merits further engagement for its role in women's care.

Third, the study of women's formulations and claims on care, discussed in Chapter 6, merits further study for the novel perspective that it brings to a feminist study of care, by centering women's receipt of care within household relations and dynamics. Particularly, it would be of interest to researchers to explore whether care in these forms—fundamental value for women's lives, moral responsibility of husbands to care, and love as wives and daughters-in-laws—is valued in other social contexts of marriage in South Asia, and perhaps in other contexts where the notion of individual autonomy is not predominant.

The study's approach of *caring for women,* broadly*,* has wider implications beyond the empirical context of Bihar, and is relevant to areas of research beyond the household as well. The question of whether women feel cared for is an important one in all the social spaces and relations that women occupy, and with regard to access to reproductive healthcare, it is an important question to ask of and within health systems, policies and technologies, and within social norms and cultural practices around women's reproduction.

7.7 Conclusion

The thesis opened with an example of a legal case of a family neglecting their daughter-in-law in Mumbai, depriving her of care when she was pregnant, and harassing her with dowry demands. The case possibly made it to a court of law, and to the news, because of the extent and nature of the neglect, which had resulted in loss of life. The court's ruling, as I argued, undermined the level of neglect by saying that 'merely' not providing medical treatment does not amount to cruelty. As my research has shown, the minimisation of the impact of neglect in this example is symbolic of a much wider lack of care for women, and more widely, a lack of care for women's lives at the level of the everyday household. The

predominant discourses on access to healthcare in India seldom account for the dynamics of the household in studying women's access to care, and when they do, it is often centred on utilisation of institutional facilities. Unlike the Mumbai case, many women in my study utilised institutional facilities, much as they were sometimes inadequate, but as many of them expressed—their marital families did not care about or for them. The flipside is also relevant. When women felt that someone, especially husbands, took an interest and initiative in their care, they attributed it to love, responsibility and concern, once again highlighting the value of care rather than only the availability and uptake of health facilities. My research has aimed to develop ways to think about women's care in relation to marriage and the marital household, and has demonstrated and argued that *caring for women* is crucial in thinking about young married women's health and illness, as it is constituted by the gendered relations and dynamics that they inhabit and navigate in marriage.

Appendices

Appendix 1

Informed Consent Form (translated from Hindi to English)

1) Have you read, or has someone read to you, the Information Sheet of the project in a language that you understand?

   Yes ☐ No ☐

2) Do you understand what the project is about and what taking part involves?

   Yes ☐ No ☐

3) Do you understand that the information you provide may be used for presentations in the future, at universities, conferences, non-governmental organisations and health centres?

   Yes ☐ No ☐

4) Do you know that if you decide to take part and later change your mind, you can leave the project without citing a reason, and can retract your data up to three months after your last interview?

   Yes ☐ No ☐

5) Do you know that you have the option of raising any concerns with me, or with the collaborators who will route your concern to the University of York?

   Yes ☐ No ☐

6) Would you like to take part in the project and participate in the two interviews and one focus group discussion?

   Yes ☐ No ☐

7) If yes, is it okay to audio-record your interviews and your contributions to the focus group discussion?

   Yes ☐ No ☐

8) Do you agree to maintain confidentiality and anonymity for your fellow focus group participants?

   Yes ☐ No ☐

Participant's name: _____

Interviewer's name: _____

Date: _____

Appendix 2

Project Information Sheet (translated from Hindi to English)

Background

My name is Alankrita and I am conducting a research study called *'The effects of household gender dynamics on married adolescent girls' access to reproductive healthcare in Bihar, India'* for my PhD qualification at the University of York in the UK. The research is being supported by Project Potential in Kishanganj. I would like to invite you to participate in the research. Before deciding to participate, please read this project information sheet (PIS) carefully and let me or the study collaborator (Bharti/Rumi/Binita/Sangita) know if anything is unclear or if you would like further information.

1.1 What is the purpose of the study?
The purpose of the study is to understand the health needs of women who are married early, and how the relative power of their household members, along with the social and economic circumstances of the household, affects the decisions women make about their own health. I am particularly interested in decisions about reproductive health issues such as contraception, fertility and childbirth.

1.2 Why have I been invited to take part?
You have been invited to take part because as a young married woman, your needs and experiences don't always find a place in health policy, research, or practices. Speaking to you will help me understand the specific situation of married adolescents in a comprehensive manner.

1.3 Do I have to take part?
No, it is entirely your choice. If you wish to take part, I will discuss the project with you and then ask for consent. If you consent to participate but change your mind later, you can withdraw from the study and I will erase all the information that you have given me. If you eventually want to withdraw, please let me know by December 31, 2022. After that, your information will have been analysed and I won't be able to erase it.

2.1 What does the research process entail?
If you wish to participate in the research after going through this information sheet, you can get in touch with Bharti/Rumi/Binita/Sangita. You can also contact me directly via a telephone call or text message. You can discuss this PIS with your family and friends if you want to, or you can inform them of your decision to participate if you wish. The final decision must rest with you. You can ask questions about the study to any of us before making a decision.

If you decide to participate, I will seek consent based on a form. You can see this form now if you like. Saying yes to the form means that you understand and are content with the

objectives and the process of the research. When you say yes or no to parts of the consent form, I will audio-record it on my mobile phone along with your name and the date, or mark your responses in the form along with your name and date. As stated earlier, you can withdraw your consent (and by extension, your data) by 31 December 2022.

After you have consented, we will carry out interviews and focus group discussions. There will be 25-30 participants altogether. The interviews will be between you and me, and in the groups, there will be 4-6 participants from neighbouring areas. If you permit, I will audio-record the interviews and the group discussion. If not, I will take handwritten notes. During the interviews, I will take care of your privacy and ensure that a third person does not become privy to your personal information, and I will also give you a made-up name. In the focus group discussions, participants will certainly know who their fellow participants are but we will make sure that we do not share personal experiences about anyone. Instead we will discuss the issues through made-up instances. For example, "Preeti, a 17-year-old, misses a period and gets worried, whom can she talk to?" The interviews and group discussions will take place at the nearest *anganwadi*, and I will take care of your travel arrangements and expenses, if any.

After all the interviews and group discussions are done, I will analyse the data and subsequently write my thesis - on health experiences and challenges, power and rights in the household and in law, and what women want. I will submit this thesis to my university, and the plan is to subsequently present and use it at organisations like Project Potential, to develop and strengthen health programmes.

2.2 What are the benefits of participation for me?

By participating in the study, you will have a space to discuss reproductive health comprehensively, which we women often cannot openly do. otherwise we tend to discuss only when associated with childbirth or medical treatment. When we talk to doctors and nurses, we only talk about the illness rather than the everyday experience of health or decision-making in matters of health. In this study, we can discuss things beyond illness, such as bodily rights and mental well-being. You possibly think about these things and talk about them as well, but the research will be a curated space to discuss such things with fellow women, and with me, all of which may provide new perspectives on women's health. Discussing things together, and collectivising, is highly valuable for women, as you may have seen from the prominence of self-help groups in Bihar, and the research gives us a chance to discuss things together. As you (in Kishanganj) will be participating in a project affiliated with Project Potential, you will also have access to their networks and resources, which the collaborators and I can further enable for you. For instance, a group of young married women participated in a small-scale evaluation of this study (the pilot), which is a type of opportunity you could subsequently seek involvement in through the collaborators.

The information that you share will be highly valuable in understanding the reproductive health experiences of young married women, and will assist in further research and programme development. I want to work on this theme in the future, and several scholars

across countries are working on this too. Administrative units of the government also make use of such data on health, as do health institutions. For example, it was after years of research that domestic violence came to be recognised as a public health issue, which has been a significant development in addressing domestic violence. So, while the research may not benefit you immediately and personally, you will be contributing to an important subject, and your participation will be invaluable.

2.3 What are the risks of participation for me?

Discussing reproductive health can involve recounting negative experiences about reproductive rights, health centres or about power at home. Moreover, you will be sharing these personal experiences with me, whom you don't know very well, so it's possible that the discussion might cause you some distress or hesitation. To avoid distress and embarrassment, we will discuss the topic through examples when needed, and you can choose to not answer certain questions.

There is a chance that you may become dependent on the research or the research relationships, as it will be a group of women and women get few chances to come together and talk. We (including me) have to understand that this is a short-term engagement and we may not be able to change anything, we are here to understand the issues faced by young married women further, so that we can work on it further.

If you are unable to fulfil your household and other responsibilities because of your time commitment towards the research, it may invite backlash from your family or employer who can ask you to drop out of the study or forcefully do so. This can impact your future mobility, such as meeting friends or visiting your birth home, and harm your mental well-being. Furthermore, if there is a dispute at home which your family attributes to your participation in the research, then in extreme cases, the backlash can manifest in violence. To prevent this, the community meeting gives families the opportunity to ask questions about the study's objectives and process, and additionally, I recommend informing your family about your decision to participate. If required, I can hold additional community meetings to keep your families feel involved and less alienated.

3. What will you do with the information I give you?

As stated earlier, I will record what you say via audio-recording or handwritten notes. I will then type out everything from the recordings and notes, and translate it all to English. Your information will be stored securely on applications on my password-protected mobile phone and laptop; I can demonstrate how they work if you wish to see.

I will share the written notes with my research supervisors at the university who are guiding the research, and with the collaborators but these will be anonymised notes - they will have your made-up names and all references to people, locations (up to block-level) and

organisations will be removed to protect your privacy. I will hold on to your data for five years after completion of the research, after which I will delete it. As mentioned earlier, you can retract your data by 21 December 2022.

It is my personal responsibility to involve you only after taking informed consent. At the institutional level, the research has been permitted only after a thorough ethical evaluation by an academic committee at the university, which has ensured that the information will be handled securely. As the university is located in the United Kingdom, your data will travel overseas but will be legally protected at all times.

4. Legal and ethical responsibilities

4.1 All the data collected in the research will be protected under the General Data Protection Regulation (GDPR) of the United Kingdom. India does not have a similar law but the GDPR is adopted in India in some cases. Ethically, I will take your consent via the consent form and protect your data.

4.2 I will use your made-up name in all research analysis and discussions to maintain your privacy. Your real name will only appear on the consent form, which will remain in my possession and it is my responsibility to keep it safe.

4.3 If you give me any information that discloses an illegal activity, I will be obliged to follow up on them under the research rules. I will talk to you about it after the interview and give you the options to consult legal aid organisations, counsellors, child welfare committees or family courts. Rest assured that I will not make any decisions without consulting you first. I will also have to notify counsellors and legal authorities if you mention the risk of harming yourself or harming others. None of these conversations outside of the interviews will be recorded as research information.

4.4 A list of service providers and their contact numbers is available along with this information sheet, if you wish to keep a copy.

5. Questions or concerns

If you have any concerns about this participant information sheet, please contact me in the first instance, or you can contact Bharti/Rumi/Binita/Sangita. They can also escalate your concerns to my supervisors at the university if you wish, or to their respective institutional mentors. If you are still dissatisfied, they can further contact the University's Acting Data Protection Officer or the Chair of the Economics, Law, Management, Politics and Sociology Ethics Committee. **You also have a right to complain to the** Information Commissioner's Office if you suspect that your data has been mishandled by the university, and once again, you can route your questions, concerns and complaints through Bharti/Rumi/Binita/Sangita.

Appendix 3

Interview topic guide (translated from Hindi to English)

Part 1: First, we will talk a little about health and illness

1. Can you tell me about a time you were unwell in the last 1-2 years?
2. What happened?
3. What did you do to get better?/How did you manage the condition?
4. How is your health, usually?
5. What kind of health facilities are available in this area, public, private or otherwise?
6. Do these facilities have special services for women and girls?
7. Do you access these facilities, or some other facilities?
8. How has your experience at these facilities been?
9. Has there ever been a time when you wanted to visit a health facility but could not? 9a. *If not:* Why do you think that was?
10. Have you met the local ASHA worker here? 10a. *If yes:* What kind of facilities or information have you accessed through her?
11. You told me about different types of health facilities in the area. What are the kind of outstanding health needs you may have (*kami*) despite these facilities?
12. What kind of support do you get at home for your health/health needs?

Part 2: Let's talk about home and household now

Like you said, when you were unwell, you went to the health centre/went elsewhere/your family took care of you/you did not tell anyone (based on what the participant said in Part 1)...

1. Who made the decision to go to the health centre? *Subsequently amended to:* When you were unwell/in pain/pregnant, whom did you first speak to?
2. Who all were involved in your care/the decisions around your care?
3. What are the considerations that went into the decision to access or not access a particular facility?
4. How did you feel about accessing this facility/about this decision?
5. Were there other factors or persons outside of the household who were involved in the decision/in your care?
6. What kind of role does the community play in your care? (example: you know sometimes there are norms around childbearing and contraception, or alternatively resources at the community level)

7. Are your husband and you from the same community? (if the subject of the marital relationship and/or caste has not come up in the opening questions about health or decision-making)
8. How did you get married? (if is has not come up)

Part 3: To further understand the dynamics of the marital household, we will talk about the marital relationship and its influences on women's reproductive health.

1. How do you make decisions about your reproductive health? (about any aspect: contraception, antenatal care…)
2. Do you talk to your husband or someone else?
3. On what basis do you make these decisions?
4. What if there is a difference of opinion between your husband and you on a matter related to your reproductive health? What happens?
5. Do other household members get involved in the reproductive health decisions your husband and you make? If so, how?
6. How does their involvement influence your health?
7. Can you tell me about a time when you may have made a reproductive-health related decision? (whether about institutional care or otherwise)
8. Was there a time when you had to make a decision but you didn't want to? Can you tell me about such an experience?

Is there anything else you want to talk about in relation to these things, on record or otherwise?

Before we close, can I please cross-check a few things:

- What is your age?
- What is your husband's age?
- How long have you been married?
- Do you have children? If so, how many?
- Have you been living in your marital household (with in-laws) after marriage?
- Who all live in your marital household?
- Where is your birth home/how far from your marital home?

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