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Married Young Women's Sexual and Reproductive Health in Low-Income Communities in Mumbai, India

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Almost 50% of Indian women marry below the legal age of 18. This dissertation, using feminist and critical medical anthropological theories and a mixed methods approach, explores how young women in two low-income communities in Mumbai, India enact agency in their transition from their natal to marital families and the impact of agency on their sexual and reproductive health (SRH). This research employed qualitative (document analysis, key informant and in-depth interviewing and participant observation) and quantitative (survey instrument and biomarkers) methods to understand factors contributing to the timing of marriage and how these factors impact post-marital outcomes.

Globalization has created changes for women through new opportunities for education, work, and decision-making. However, these dynamics have created uncertainty for some men who feel left out of the economic and social advances of a globalized India. One result is the perception in low-income communities that gender-based violence is increasing. In response to this situation, early marriage, particularly in more patriarchal families, is seen as ensuring the safety and marriageability of women.

A key finding of this research is the impact of women's natal family experiences on marital dynamics and SRH. Many women grow up in more gender equitable families where girls are provided equal resources as their brothers and take advantage of opportunities to exercise agency. These young women often delay marriage and marry into families with similar gender equitable norms. Other young women grow up in families with patriarchal norms that they either reproduce through adolescent marriage into similarly patriarchal families or attempt to resist. Women with higher pre-marital agency who come from more gender equitable families tend to have more positive marital experiences and SRH. Women who come from more patriarchal families and either reproduce patriarchal norms or attempt to resist such norms in a non-supportive environment have poorer marital experiences and SRH.

These results indicate that theoretical frameworks focused on individual female agency within the marital context may be insufficient to account for women's ways of coping or the development of interventions. Rather, structural, community, and family level factors converge to contribute to women's pre-marital experiences that can impact post-marital experiences.

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Married Young Women's Sexual and Reproductive Health in Low-Income Communities in Mumbai, India

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Chapter 1: Introduction

There are nearly 600 million adolescent girls in low- and middle-income countries (UNFPA 2012), where marriage soon after menarche is common and young wives can face problems including limited education, social isolation, coercive sex, maternal morbidity and mortality, and increased STI/HIV risk (see Haberland, et al. 2003 for a review). Consistent with this pattern, almost 50% of women in India, mostly low-income, marry below the legal age of 18 (IIPS NFHS, 2008). This dissertation, using feminist, life course and critical medical anthropological theories and a mixed methods approach, explores the ways young women in low-income communities in Mumbai India, enact agency (defined here as a young woman's ability to make decisions regarding her behavior, either through subverting community norms or embracing them; see Abu-Lughod 1990; 1993; Kabeer 1999) in their transition from their natal to husband's family and the impact of their agency on their sexual and reproductive health (SRH).

The dissertation consists of seven chapters. This first chapter reviews the literature concerning globalization and sexual and reproductive health with a focus on South Asia, and concludes with a discussion of the theoretical frameworks employed in this study. The second chapter describes the methodological approaches and data analysis strategies employed in this study. The third chapter describes the structural context at the national, city, and community levels and defines culturally-specific concepts and terms that play a role in the lives of girls and young women. The fourth chapter provides an ethnographic description of young women's varied trajectories as they move from their natal families to the marital transition to their marital families and become wives, daughters-in-law, and mothers. The fifth chapter presents univariate, bivariate and multivariate analyses that test the hypotheses that emerge from the theoretical perspective and from the qualitative data. The sixth chapter discusses the qualitative and quantitative results in relation to the initial theoretical framework and draws conclusions regarding the study. The seventh chapter describes data dissemination conducted in and around the study area and the feedback received from stakeholders and people from the study communities concerning the validity of the results and its potential as a basis for interventions.

Background

There are approximately 1.5 billion people between the ages of 10-24 in the world, and 86% live in low- and middle-income countries. Of these youth living in low- and middle-income countries, 70% live in Asia (National Research Council 2005). Young people are growing up in a world with extensive social, cultural, and economic changes driven by globalization (Crane, et al. 2002; Dolby and Rizvi 2008; Drotner and Livingstone 2008; Eitzen and Zinn 2006). While globalization has created new opportunities for many young adults, researchers contend that globalization is also increasing gender and wealth inequities for a new generation (Gupta 2004; National Research Council 2005). Challenges facing young people range from education to employment to health; sexual and reproductive health (SRH) has been noted as a particular area for concern and action (Bearinger, et al. 2007; Blum and Nelson-Mmari 2004; Glasier, et al. 2006). Adolescent girls in low- and middle-income countries are at particular risk of SRH problems in both pre-marital and marital relationships. While globalization is providing new opportunities and reducing some SRH problems, it is also creating new challenges.

Definitions and Models of Globalization

Globalization is broadly defined as "a process whereby goods, information, people, money, communication, and fashion (and other forms of culture) move across national boundaries" (Eitzen and Zinn 2006). While these processes have always existed, historical events, neoliberal economic policies, and technological advances in the 20th century have accelerated and enabled corporations to enter previously unexploited countries and markets, expand manufacturing, and enable greater international communication. These activities propel both international and internal migration, and urbanization, and increase the impact of global organizations and institutions (Eitzen and Zinn 2006; Birn, et al. 2009).

There are several models that describe the globalization process. Traditionally, globalization has been viewed as a form of neo- or cultural imperialism in which Western countries export their culture to non-Western countries, resulting in uncritical adoption of Western culture and homogenization of these non-Western cultures (Crane 2002). More recently, globalization is recognized as a more dynamic process in which aspects of culture move in multiple directions, and individuals at the local level have a variety of

responses (Crane 2002; Ghosh 2011; Kjeldgaard and Askegaard 2006). In a similar process known as "glocalization", global structures or genres, such as soap operas or musical forms, are adapted for local audiences to convey local messages and values (Crane 2002; Wilk 1995).

While nearly everyone participates in processes of globalization and glocalization, young women are seen as instrumental in these processes. Young women are viewed as both contributing to change and the spread of ideas and culture, but they are also viewed as consumers of global culture and commodities (Kjeldgaard and Askegaard 2006; Lukose 2008:136-137). As a result, young women are simultaneously shaping and being shaped by globalization.

Globalization in South Asia

In South Asia, globalization is manifested through changes in education, employment, and access to technology and material goods. Researchers have traditionally viewed SRH in South Asia in a negative light, focusing on the pro-natalist cultural orientation (Stephenson 2006), the taboos on discussing sexuality (Abraham 2001) and the emphasis on family honor through virginity that limits acquisition of knowledge of sexuality and reproduction for many girls and young women (Jejeebhoy 1998). For most South Asian cultures, the literature emphasizes the limited training on sexuality and reproduction for girls (Abraham 2001; Ali, et al. 2006; Bhan, et al. 2004; Hamid, et al. 2010; Hennink, et al. 2005; Jejeebhoy 1998; Joshi 2010; McManus and Dhar 2008; Nastasi, et al. 1998; Santhya and Jejeebhoy 2003; Shaikh and Rahim 2006; Rashid 2000; Uddin and Choudhury 2008), and limited access to SRH services (Agampodi, et al. 2008; Joshi, et al. 2006; Mishra and Mukhopadhyay 2012; Rashid 2007). Recently more attention has been paid to the elements of globalization from the point of view of media and technology, formal education, employment, marriage, and SRH.

The role of media and technology

In terms of media, television in India was restricted to the single national broadcasting company "Doordarshan" from the 1950's to the 1980's, and few households had access to personal televisions (Kumar 2010). In the early 1990's new commercial satellite channels became available and personal televisions became more accessible. Television is now widely accessible to adolescents (Nayar and Bhide

2008; Verma and Larson 2002) at nearly any income levels, and young women are increasingly exposed to images of "modern" women, from both Western media and Bollywood films (Ghosh 2011; Mishra 2011). While Bollywood has long been popular, young women now have increasing opportunities to fulfill desires to emulate these images with "skinny jeans" and cosmetics through a growing consumer culture and the spread of malls throughout urban and suburban areas (Ghosh 2011; Mankekar 2004); even as they are restricted by conservative family rules and norms of appropriate behavior (Chakraborty 2010; Jackson, et al. 2007; Lukose 2005; Mishra 2011). Young women are increasingly exposed to soap operas, television shows, and state messages that encourage gender equity, reduced family size, and utilization of health care (Brown 1991; Kumar 2010; Mankekar 2004).

Stephenson and Tsui (2003) find that women in communities in Northern India with access to media publicizing women's health facilities, use these facilities more frequently. Mankekar (2004) finds that Indian-produced television shows increasingly examine issues of sexuality, providing women with more information and ways to discuss these topics. Similarly, a study of young women in colleges in Madhya Pradesh found that almost 50% received their information on contraceptives and the "ideal" family size from television (Nema and Sharma 2009). The positive effects of media on contraceptive knowledge and self-reported use have also been documented among women with little or no education (McNay, et al. 2003). There is some evidence that media in India has had an impact on reducing fertility. Although there are examples of the media's positive impact, Brown (1991) has suggested that "pro-social" soap operas will have limited impacts on changing gender norms, if the gender relationships portrayed do not resonate with viewers.

In general, the relationship between media exposure and sexual behaviors is complicated and not well understood (Bleakley, et al. 2008; Escobar-Chaves, et al. 2005). Chakraborty (2010) finds that while Muslim girls in urban *bustees* (slums) in Kolkata are hesitant to discuss sex and romance in classroom settings, they freely use Bollywood movies as a reference point for their own romantic fantasies. They also discuss romantic relationships in terms of the couples they see in Bollywood films, and develop vague expectations for how sexual relations occur based on these films. A study by Santhya, et al. (2011)

found that young women who viewed television and films "frequently" were more likely to engage in pre-marital sex. In addition, pornographic, or "blue" films are becoming more common on satellite TV and DVDs, even in rural areas of India, and are associated with pre-marital sex for young men, although there is a lack of research on the impact for young women (Jejeebhoy 2006). Young women in Bangladesh with greater access to television and radio have increased knowledge of STIs/HIV (Uddin and Choudhury 2008; Khan 2002).

New technologies, most importantly the cell phone and more recently the computer, are also having an important impact on young women. Chakraborty (2012) found that young women in bustees in Kolkata who had attended computer courses were using their new computer skills to develop online relationships with young men. Chakraborty finds that these young women use the internet both for "chatting" with new (mostly male) friends, and for mate-seeking. Young women find that meeting young men online is less risky than meeting them in person, although, some young women follow-up online exchanges with meetings or dates.

Although computer use is not widespread, particularly in low-income settings, over 9% of the Indian population uses a cell phone at least once a week, and these numbers are expected to grow (Nayar and Bhide 2008). Cell phone use in India is notable in that researchers have found that cell phone sharing is more prevalent, and occurs more for social than for economic reasons (Steenson and Donner 2009). Cell phone sharing within families or married couples maintains gender relations, but cell phone sharing among youth (friends, siblings) enables the growth and maintenance of broader social networks (Steenson and Donner 2009; Tenhunan 2008), and access to new sources of information. Cell phones also enable young women to communicate and have both platonic and romantic relationships with young men, outside of parental control (Steenson and Donner 2009). Cell phones are also changing the way in which marriages are arranged. Traditionally, men have been most involved in arranging marriages for their children, but cell phones allow more women to become involved as they communicate with members of their social networks to find additional options (Tenhunan 2008). There is also evidence that cell phones allow newly married young women to remain in closer contact with their natal families and their

premarital social networks. These electronic networks, in turn, allow young women to receive support during the frequently difficult transition to their husband's family (Tenhunan 2008). Only a few years ago, young women abused in their husband's urban home had few options for contacting their frequently rural natal families living at a distance; however now young women can alert their families to problems and receive assistance (Tenhunan 2008). By creating these new opportunities, cell phones are credited with empowering young people in India (D'Souza 2010).

While it appears that cell phones are creating increased opportunities for young adults to meet and share information, there is little research available on the explicit impact of cell phones on sexual or reproductive behaviors for young women in India, beyond the use of mobiles in female sex work, both to contact clients and in research with sex workers (Bradley, et al. 2012; Buzdugan, et al. 2009). For young women in the general population, there has only been anecdotal discussion of the use of cell phones by young women in schools in Delhi to access pornography and information regarding sex (McManus and Dhar 2008). Research on cell phone use in India has not caught up with this growing phenomena.

In Nepal, film and cable television have also been implicated in encouraging a growing "dating" culture among both urban and rural young women (Regmi, et al. 2011). Young women interviewed in a study by Regmi, et al. (2011) reported that they sought advice on relationships, kissing, and sexual health from films and the internet. Many young women had negative perceptions of premarital sex. However, some young women felt that in certain instances, such as with a long-term partner in anticipation of marriage, they could have sex without physical or social repercussions. The young women interviewed for this study also cited an increasing desire for boyfriends who could provide material goods and pay for dates at restaurants and the movies. Mathur, et al. (2001) also found a small number of young Nepalese women in both urban and rural areas who were engaging in pre-marital sexual relationships to obtain access to material resources. This desire for relationships with both romantic and financial benefits is consistent with a study by Puri and Busza (2004) that finds more young women working in factories in Kathmandu engaging in pre-marital sex. A recent review (Upreti, et al. 2009) of articles examining young adults' SRH knowledge and behaviors finds that, while young adults in Nepal have high general

knowledge of STIs/HIV, they continue to practice unsafe sexual behaviors. The authors find that young adults living in urban areas, and with greater access to media have higher levels of knowledge than young adults in rural areas. Globalization through the media in Nepal is increasing knowledge, but at the same time is also increasing risky and transactional sexual relationships among young women.

Although SRH knowledge for young women in Pakistan is lower than that of other South Asian countries, young women still receive some information on menstruation, contraceptives, romance, and kissing from television and movies (Hennink, et al. 2005; Shaikh and Rahim 2006; Hamid, et al. 2010). While the literature from Pakistan remains limited, it appears that globalization is acting more slowly on gender norms and roles in Pakistan than in other South Asian countries.

Female Education and Employment

Employment opportunities for women are credited as potentially one of the greatest catalysts of change throughout South Asia, as they are having impacts on education, gender equity, age at marriage and fertility. The growing technology industries in India increasingly require secondary education and fluency in English (Luke, et al. 2004; Nayar and Bhide 2008). Globalization is thus spurring a need for continued education, and privileging those capable of attending English medium schools (National Research Council 2005; Nayar and Bhide 2008). In India, data suggest that young women are attending secondary and post-secondary schools at an increasing rate and that the gender gap in education is closing. The growing consumer and "mall culture" is also creating new job opportunities for low-income women through employment in beauty salons and call centers (Ghosh 2011). Labor opportunities are a factor in women delaying marriage and childbearing to participate in either additional education or employment (Jensen 2012). However, many of the new job opportunities are exploitative. The growth of export-oriented manufacturing provides many low-income young women with jobs, but these jobs tend to be informally performed in the home (such as stitching and piecework), or in Export Processing Zones (EPZs) where they are unstable, pay less than minimum wage, and are not subject to basic regulation and protections (Ghosh 2002).

Education is cited as a major factor in both the increasing age at marriage and reduced family size (Bhadra 2000). Young women with higher levels of education who have been employed are less likely to exhibit strong son preference (Pande and Astone 2007). In spite of these gains, it is important to note the ways in which globalization hinders progress in young women's SRH and gender equity. While consumerism is creating new employment opportunities, it is also seen as a factor in increasing son preference and gender inequity as the financial burden of increasing dowries for female children becomes larger to keep pace with increasingly expensive consumption patterns (Basu 1999; Diamond-Smith, et al. 2008). The gender gap in education and vocational training for low-income young women contributes to the difficulty for young women to find employment (IIPS 2010; Mensch, et al. 2004). Vocational training for women has sometimes focused on traditional sources of income such as sewing rather than computers, and have not always encouraged young women to seek employment for cash income outside the household (Mensch, et al. 2004).

A study of marital violence in Bangalore found that young women who had ever been employed or received vocational training were more likely to have been physically abused by their spouse, challenging assumptions about the relationship between improving empowerment and gender equity (Rocca, et al. 2009). Young women in the work force continue to face discrimination from employers and earn less than their male counterparts (Kingdon and Unni 2001; Menon and Rodgers 2009). As a result, young women must continue to negotiate gender inequity and traditional norms to have any chance of receiving some of the potential economic benefits of globalization in the realm of employment and education.

Bangladesh illustrates a relevant example for women and employment. Globalization has generated new employment opportunities and problems for young women, particularly those young women in the ready-made garment industry. Young women are both stigmatized for working in these factories, and exploited by employers who require that they work long hours for low wages (Barkat and Majid 2003). While the garment industry is problematic in many respects (Islam, et al. 2010; Schensul, et al. 1994), it has also been credited with encouraging parents to provide further educational opportunities for their daughters (Amin, et al. 1998; Khosla 2009). The financial benefits of educating young women for future

work opportunities is beginning to outweigh the cultural imperative of early marriage and childbearing for lower-income individuals in Bangladesh (Schuler, et al. 2006). Non-governmental organizations (NGOs) have implemented a number of programs to provide school fees and stipends for young women in school (Mahmud and Amin 2006; Shafiq 2009). The longer young women attend school, the less likely they are to marry young (Field and Ambrus 2008).

Both negative and positive aspects of female employment have been examined in Bangladesh. It has been suggested that young women in Bangladesh who are employed are more likely to have pre-marital sex, due to the fact that they have greater mobility in the urban environments where they are employed (Rob and Mutahara 2001). There have been some indications that increased education for better employment opportunities, and employment in the garment industry enables young women to delay childbearing within marriage (Amin, et al. 1998; Schuler, et al. 2006). However, many low-income young women are required to leave their work and prove fertility early in their marriages (Rashid 2006). Young women who are able to continue to work after marriage, have been found to be at lower risk for sexual violence from their husbands than young women who are not financially contributing to their families (Hadi 2000). The reasons for this differential risk for sexual violence are unclear, but could be due to reduced poverty-related stress or a reassessment of the marital relationship as women gain greater control over finances (Hadi 2000).

In Sri Lanka, as in Bangladesh, much of the research on the impacts of globalization have focused on low-income young women's increasing participation in the workforce, particularly in "free trade zones (FTZs)" established in cities. Young women who work in these FTZs are usually unmarried, from rural areas, from poor families, raising money for dowry and stigmatized as loose women by those outside the FTZs (Hewamanne 2008; Hewamanne 2006; Shaw 2007). In spite of the challenges and stigma, Hewamanne (2008) finds that these young women are able to access and engage in a consumer culture, enjoy greater freedoms, and participate in a variety of social activities. Young women who participate in factory work feel that it both enables them to care for their families and provides greater independence, both while employed and after returning to their families (Attanapola 2004). Attanapola (2004) partially

attributes improving gender norms and concepts of gender equity to the work available to low-income young women in the FTZ. Attanapola (2008) also attributes work opportunities to increasing the average age of marriage, however other researchers (Malhotra and Tsui 1996) state that later marriage has always been favored in Sri Lanka.

There are greater sexual and reproductive risks for young women in the FTZ (Hettiaarachchy and Schensul 2001). A number of factors contribute to poor SRH for workers in the FTZ. When young women initially begin working in the FTZ, they generally have little SRH knowledge (Hettiaarachchy and Schensul 2001). In addition, young women routinely acquire boyfriends upon their arrival in the FTZ, and after being promised a long-term relationship and marriage, engage in pre-marital sex with their partners. Young women frequently become pregnant, and face limited options as they may lose both their employment and their relationships (Hettiaarachchy and Schensul 2001). Some young women obtain abortions, which may or may not occur in a facility with a physician or health professional. For young women who do not abort their pregnancies, they often try to avoid stigma and do not obtain pre-natal care. Many young women are unaware of maternal and child health (MCH) services and/or are unable to access them. In addition, the public MCH service is unable to handle all of the cases in the FTZ (Hettiaarachchy and Schensul 2001). Thus, young women in FTZs have many opportunities, but are also at high risk for SRH problems.

For young women in Sri Lanka not engaged in work in the FTZ, the impacts of globalization on their SRH is harder to discern. Fernando et al. (2009) find that a small proportion of young women in school are also engaging in pre-marital sex, and that young women from higher-income families were more likely to engage in pre-marital sex. The authors found relatively high knowledge regarding sex and reproduction among the students studied, and that cell phones were playing an increasing role in exposure to sex, as many students store sexually explicit materials on their cell phones (Fernando, et al. 2009). Several researchers have noted the need for greater access to SRH information and services for young adults in Sri Lanka (Fernando, et al. 2009; Nastasi, et al. 1998).

In Nepal, there continues to be an education gap between young men and women that impacts young women's knowledge of and access to reproductive health care. Furuta and Salway (2006) find that reduced education is related to fewer employment opportunities for women and a decreased status within their households. Child labor has been cited as one impediment to education for young women. Chakrabarty and Grote (2009) suggest that NGOs in Nepal working with carpet weavers to reduce child labor have made some progress in the promotion of greater educational attainment. Attempts have also been made at increased enforcement of labor laws, however, Baker and Hinton (2001) found that this enforcement only has an impact if there are educational and health facilities available for children and young women to attend while their parents work in factories that traditionally employed children. Some researchers also suggest that increased access to media and improved education and employment opportunities for young women in Nepal is contributing to a gradual increase in the age at marriage (Ghimire, et al. 2006; Yabiku 2004; Yabiku 2005). A more recent article from Bajracharya and Amin (2012) shows that a young woman's family's financial situation remains the most reliable indicator of early marriage and early employment. They also state that young women raised in impoverished households are still most likely to have fewer years of schooling. Thus, access to media and employment may only be impacting the age at marriage for middle- and upper-income young women (Bajracharya and Amin 2012).

Urbanization

Globalization is closely linked to changing economic policies and urbanization. Urbanization made particular strides in India in the post-WWII period, as manufacturing jobs in cities increased and economic advancement in rural areas became more limited (Pacione 2006; Srinavasan 2013; Swerts, et al. 2014). In the late 1908's and early 1990's India attempted to further integrate into the global economy through neoliberal economic reforms that relaxed government control to open markets to foreign investors, promote greater business competition and technological investments (Joseph 2007; Srinavasan 2013). These economic changes contributed to an increase in India's GDP (Srinavasan 2013). The neoliberal economic policies also contributed to a decline in the number of manufacturing jobs, which

reduced jobs for men, but increased employment opportunities for women (Nijman 2015). This decline in jobs for men led to a brief decline in urbanization in the 1980's, but urbanization has been increasing again since 2001 (Deshingkar 2006; Nijman 2015).

Urbanization has had a number of impacts on young women's SRH and marriage patterns. Overall, urbanization appears to loosen some cultural norms and practices. The importance of caste, both in daily life, as well as in arranged marriages appears to diminish in urban, low-income settings (Ali 2002; Demerath, et al. 2006; Saavala 2001). Also, given the space constraints in urban, low-income communities kinship relationships and living arrangements are changing, as the number of nuclear families increases, and extended families decreases (Gupta 2005; Luke, et al. 2004; Niranjan, et al. 2005; Singh, et al. manuscript in preparation). It also appears that some of the negative gender norms restricting women's activities and mobility may be abandoned in the urban environment (Garg 2001). With these loosening restrictions, and access to the technologies described above, unarranged, or "love", marriages are becoming increasingly common and more acceptable (Donner 2002; Ghosh 2011; Jauregui and McGuinness 2010).

There are some indications that young women have greater access to SRH information in the urban environment (IIPS 2010), but Abraham (2001) finds that women from low-income backgrounds are still subject to patriarchal and traditional norms that limit their information in the urban environment, relative to their male peers. There is also some evidence to suggest that young adults have increased opportunities to engage in pre-marital romantic and sexual relationships in the urban environment, in spite of space constraints (Chakraborty 2010). However, other evidence supports the view that urban areas actually afford fewer opportunities than rural areas for sexual relations (Alexander, et al. 2006; IIPS 2008). In terms of reproduction, urban areas afford greater access to contraceptives, although there continues to be low uptake of temporary contraceptives by women in low-income urban communities (Hazarika 2005). In addition, it has been suggested that greater accessibility to reproductive technologies, combined with increased space and economic constraints in the urban environment is perpetuating self-selective abortion and son preference (Khanna 1997; Khanna, et al. 2009).

Globalization, urbanization, education and employment is vastly altering the lives of some young women in South Asia and India, while leaving others out of these transformational developments. Increased desire for consumer goods and increasing financial pressures are leading many young women, with family support, to seek employment both before and after marriage. The value of education for young women is also increasingly recognized. The confluence of these two trends is resulting in later marriage and childbearing for many young women in South Asia. Delayed marriage and childbearing is also resulting in a shift from patriarchal, traditional women's roles to more gender equitable norms.

However, globalization is differentially impacting young women. Globalization also reinforces some negative gender biases and creates new risks for some young women, as they increasingly engage in pre-marital sexual relationships with little sexual and reproductive knowledge, and little support for single parenthood or access to maternal and child health care. The work that is available for low-income young women, while providing some financial benefits, also leaves them vulnerable to many health and social risks. In addition, there has been some suggestion that sexual violence may actually increase as women take on new roles and gain new earning power. It appears that, thus far, HIV/AIDS has had limited impact on young women not engaged in sex work in South Asia, however, there is also a need for improved sexual health services for young adults (Nair and Russell 2012).

This section has highlighted a variety of both positive and negative impacts, including on sexual and reproductive health, that globalization is having on young women and sexual and reproductive health in South Asia. Globalization is providing young women with positive benefits including new job opportunities, which may slowly be changing the traditional perception of daughters as an economic burden; allowing some young women to delay marriage and be more prepared for sex and reproduction after marriage; and providing young women with new sources of information and expanded social networks. At the same time, globalization may mean exploitation in low skilled jobs; perpetuation of gender inequity through disparities in pay and work conditions; and, greater sexual risk as women move more freely among men experiencing not experiencing globalization benefits. There are a few examples of glocalization as Indian national and regional culture molds globalization to achieve cultural fit, but the

forces of globalization are largely dominated by western nations and their corporate sectors. Western hegemony is particularly enacted through dominance of Western media and product development.

Theoretical Frameworks

This project presents three theoretical challenges. While there have been many studies that have described a stage in young women's lives, fewer studies examine young women's trajectories in a longitudinal, retrospective approach that considers both their natal family and the early years of marriage, (Schuler and Rotach 2010; Agrawal, et al. 2013; Lamb 2001). This study seeks to take a retrospective, longitudinal view by focusing on young married women aged 15 to 25 who can recount their natal family experiences as well as describing their marital life. To meet this challenge this study utilizes the life course approach (Bosch 2005; Bosch, et al. 2008; Clausen 1991; LeVine 2011; Shanahan 2000; Wiesner 1997; Willekens 1999; Worthman 2011) to understand key factors in a young woman's development that contribute to her sexual and reproductive health outcomes.

The second challenge is the need to view women's trajectories in the context of global, national and local structural changes that have been detailed in this chapter as they impact young women. To meet this challenge, this study uses a multi-level perspective that draws from critical medical anthropology and Scheper-Hughes and Lock's (1987) conceptualization of the "three bodies:" body politic, social body, and individual body.

The third challenge requires understanding young women's adaptations and sexual and reproductive health from a gendered perspective that considers women's practices of agency within a given cultural context. It is also important to understand how changing gender relations and power dynamics are impacting sexual and reproductive health outcomes. The lens and interpretations in this gendered perspective are best achieved through feminist anthropological theories (Abu-Lughod 1990; Ahearn 2001; Frank 2006; Ortner 2001; Walter 1995).

In this section, the theoretical frameworks that form the basis for the study's integrated theoretical model are briefly described. These theories include the life course and adolescent development approach, Bourdieu's (1977) theories of structure and practice that subsequently informed feminist theories of

agency (Abu-Lughod 1990; Ahearn 2001; Frank 2006; Ortner 2001; Walter 1995), and critical medical anthropology (CMA; Baer, et al. 2003; Scheper-Hughes and Lock 1987; Singer 1990; Singer 1989).

Life course approach

The life course approach (Bosch 2005; Bosch, et al. 2008; Clausen 1991; LeVine 2011; Shanahan 2000; Wiesner 1997; Willekens 1999; Worthman 2011) provides a framework that explores how precursors such as community and social norms, socialization, educational opportunities, familial and peer relationships, and mental and physical health impact young adults' trajectories and outcomes. Shanahan (2000) and Clausen (1991) provide a general understanding of the life course approach for adolescents that anthropologists have built upon. Clausen (1991) states that an individual's life course is the culmination of their physical and mental constitution, the sociocultural environment they have been raised and socialized in, and obstacles and opportunities encountered over the course of development. Clausen views adolescence as a crucial period in the life course, as it is where rational choices and agency begin to develop that can have great potential to impact the individual in adulthood. Those youth who are capable of planning and making socially appropriate choices will have higher levels of competence and more successfully develop into adults. Shanahan (2000) builds on Clausen by agreeing that adolescence is marked by the development of agency, but Shanahan states that the pathways and measures of reaching adulthood are drastically changing with the amount of time that youth take to reach adulthood now being extended. This longer maturation period has led psychologists to theorize a new developmental time period for 18-25 year olds in the life course known as "emerging adulthood" (Arnett 2000; Arnett 2007). Emerging adulthood occurs as more youth reach an age of semi-independence from parents and caretakers, but do not take on adult roles of marriage or parenting and instead pursue further educational and/or employment opportunities. While some evidence of this period has been found in non-Western countries (Facio and Micocci 2003; Nelson, et al. 2004; Seiter and Nelson 2011) and will be shown to be applicable to some young women in this study, this theory was developed primarily to explain trajectories in Western, industrialized countries (Arnett 2000; Arnett 2007).

The discussions of the life course framework by anthropologists LeVine (2011) and Worthman (2011) encourages researchers to explore cultural models of transitions to adulthood that youth begin learning from an early age and the ways in which young adults re-interpret these cultural models. They also find that the transition to adulthood is culturally constructed and sets forth a path to become an adult and obtain a "good life," but that through periods of social change these cultural models must necessarily undergo changes as different options are available to different generations and subgroups (LeVine 2011; Worthman 2011). Thus, the anthropological view focuses more on social and structural factors than an individual's competence and opportunities. While LeVine and Worthman draw on psychological anthropology, Wiesner (1997) takes an ecological approach to development and emphasizes that children grow and develop within particular ecological and cultural niches that produce "culturally organized, everyday routines of life in communities". Children learn in these routines and are socialized into different norms, competencies, and differing levels of independence. Wiesner (1997) views ethnographic fieldwork as well suited to understanding the particular ecological and cultural conditions that shape an individual's development, and the ramifications of these conditions on development. He suggests that any ethnographic work on development and the life course should pay particular attention to the cultural models held by parents, teachers, and other key individuals in a young person's life, the behaviors and beliefs of the young people themselves, and structural factors that shape norms and rules.

Critical medical anthropology (CMA)

CMA draws on conceptions of power and structure to explain phenomena of health and illness (Singer 1995; Scheper-Hughes and Lock 1987; Baer, et al. 2013; Singer 1989). CMA is rooted in the understanding that the global capitalist system creates power dynamics that structure and reproduce inequalities within and across societies in terms of health, illness/disease, and treatment (Baer, et al. 2003; Singer 1989). With this power dynamic as the context, CMA then seeks to understand how the structures that replicate inequality impact health at multiple levels: state and international policies and governing bodies, medical systems, interactions between health practitioners and patient, communities, and the individual's beliefs, experiences, and psychobiological system (Baer, et al. 2003; Singer 1989). CMA also

encourages collaboration with individuals impacted by inequity and seeks to find solutions to correct inequities (Singer 1995).

Within CMA, there are a number of perspectives that combine critical approaches with other traditional approaches in anthropology such as the biocultural and the ecological (Leatherman and Goodman 2011; Baer 1996; Baer and Singer 2009), and the interpretive (Scheper-Hughes and Lock 1987).

The approach put forth by Scheper-Hughes and Lock (1987), which they label the "Three Bodies" also seeks a multi-level approach, albeit one less tied to biological and ecological factors. In their discussion of the three bodies, Scheper-Hughes and Lock attempt to complicate traditional dualisms of ethnomedical studies and present a new model for understanding the functions and positions of the body. The first of the three bodies is the individual body, which consists of the individual's experiences and conceptualization of his or her body, which can be consistent with the feminist concept of agency. The social body consists of the ways in which the body is socially and culturally constructed consistent with the context within which life course trajectories play out. The body politic refers to the control of bodies by political, economic, and other structural forces (Scheper-Hughes and Lock 1987).

In this research I am expanding Scheper-Hughes and Lock's conceptualization to include the "biological body", or the bio-environmental component of how structural and cultural factors impact the individual's health. The critical biocultural approach seeks to understand how social and political processes interact with power inequities to impact human health at the biological level (Leatherman and Goodman 2011). The critical biocultural approach has led to the generation of new theories such as syndemics (Singer 2009; Singer, et al. 2006) and the related ecosyndemics (Singer 2010). Rather than simply viewing health problems as related to natural occurrences within an environment, the critical biocultural approach examines how social and structural forces reshape environments and thereby differentially impact sub-populations (Leatherman and Goodman 2011; Baer 1996). The syndemic and ecosyndemic approaches build on this critical biocultural approach to present an understanding how the global economic system creates social and environmental conditions conducive to the emergence, spread,

and adverse interactions between diseases and health conditions (Singer 2009; Singer 2010). The individual components of CMA, as well as the overarching framework, provides a direction for medical anthropology research that is both attentive to the power relations involved in illness, but also active in attempting to find correctives.

Feminist Theory

A key contribution of feminist theory to anthropology in general and this study specifically is the concept of "agency" that has been particularly applied to women. Agency encourages the researcher to not just see individuals as passive products of structural and cultural factors, but active participants in practices and decisions that affect their lives (Bourdieu, 1977; Abu-Lughod 1990; Ahearn 2001; Frank 2006; Ortner 2001; Walter 1995). Feminist anthropologists have built on these concepts to develop an understanding of the ways in which women enact agency (Orter 1989). Agency has been defined in multiple ways, however it is commonly conceptualized as the ability to act on one's goals and interests within a particular cultural context (Ahearn 2001; Kabeer 1999). Given that male domination has generally been viewed as universal (Rosaldo 2006), this view of agency generally entailed women's active resistance of dominant structures of power, by making choices traditionally restricted to them, or choosing to act in ways outside the normal range of possibilities dictated by gender norms (Ahearn 2001; Kabeer 1999; Mahoney and Yngvesson 1992). This notion of agency also implies a desire to change the dynamics of power relationships (Mahoney and Yngvesson 1992).

However, as other feminist anthropologists have noted, women enact agency through a number of routes, dependent upon the particular cultural and historical context (Rosaldo 2006; Frank 2006; Ahearn 2001; Walter 1995; Ortner 2001; Abu-Lughod 1990). Scholars have argued the definition of agency as active resistance does not adequately address variation between women's actions in different cultures; for example, for some Muslim women (Abu-Lughod 1990; Mahmood 2005) and women in South and East Asian contexts (Hilsdon 2007; Ram 1993), women enact agency not through active resistance to structures, but through their ability to make choices that enable them to achieve culturally proscribed gender normative standards. When women achieve these standards, they often use them to their benefit in

their dealings with men, as in the example Abu-Lughod gives of Bedouin women who strive to maintain their segregation from men, so that they may have greater freedoms than they would if there was no gender segregation (Abu-Lughod 1990:40). Thus, women can enact agency through resistance to structures or by maintaining the structure and using it to their benefit.

For Bourdieu, the most important aspect for social scientists is not universal or generalizable characteristics, but the particulars of what people actually do. People's actions are what Bourdieu refers to as "practice". Bourdieu believes that structure, or the elements that organize a society's power relationships, influences practice. Structure also produces individuals' dispositions and ways of being in the world, which Bourdieu labels "habitus". These behaviors and habitus, in turn, maintain and reproduce the structures that support a society. There is a reciprocal relationship between structure and practice, in which each reinforces and reproduces the other. Usually, individuals are able to gain agency and subvert the structure only during periods where the societal structures are being challenged, such as during periods of upheaval or rapid social change.

An integrated theoretical framework

The body politic provides a perpective on how structural forces, such as globalization, urbanization, Indian politics, and current and anticipated legislation (Sagade 2005; Van Willigen and Channa 1991) are shaping power dynamics and inter-personal relationships (Scheper-Hughes and Lock 1987; Singer 1990), women's educational attainment, orientation to modernity, employment, and SRH (Alexander, et al. 2006; Bhadra 2000; Chakraborty 2012; Ghosh 2011; IIPS 2008; Jensen 2012; Luke, et al. 2004; Pande and Astone 2007). Reproductive regulation is also a part of the body politic (Ginsburg and Rapp 1991; Rapp 2011; 2001) since it reflects the power dynamics within society. In particular, India has a history of population control efforts targeted at impoverished women, and increasing use of biomedical technologies in pregnancy and childbirth (Connelly 2008; Murthy, et al. 2002; Patel 2007; Srinivasan 1995; Unnithan-Kumar 2010; Van Hollen 1998; Van Hollen 2003).

The social body includes the "scripts" (Desai and Adrist 2010; Gagnon and Simon 1987) that govern religious, community, peer, and familial expectations for how a young woman makes the

transition from menarche to marriage to motherhood. Rituals and expectations for young women in these key transitions are largely concerned with protecting the young woman's family and community from the perceived pollution represented by the changes in a young woman's body (Abraham 2000; Bennet 1983; Jeffery and Jeffery 1997). Within each of these transitions, social and community networks play a major role in shaping expectations and behaviors (Chakraborty 2010; Kumar and Srivastava 2011; Mishra, et al. 2012; Netting 2010; Sivaram, et al. 2005; Still 2011). The social body also involves the ways young women conceptualize their sexual and reproductive health practices with respect to social norms (Kostick, et al. 2010; Nichter 1981; Unnithan-Kumar 2010; Unnithan-Kumar 1999).

The individual body in this project consists of young women's experiences within their natal families and communities that lead them to develop their agency, as well as their experiences in marriage that further shape their agency in the early years of marriage. Agency is defined as a young woman's ability to make decisions regarding her behavior, either through subverting community norms or embracing them (Abu-Lughod 1990; 1993; Kabeer 1999). Some young women make their own decisions regarding their education or employment opportunities and take a more active role in the arrangement of marriage (Fuller and Narasimhan 2008; Ghosh 2011; Jensen 2012; Netting 2010). Once married, many young women negotiate contraception, enjoy sex, and have husbands and in-laws sensitive to their needs, and mobility and independence (Allendorf 2012; Barua, et al. 2004; Bojko, et al. 2010; Char, et al. 2010). Researchers are also increasingly challenging the stereotype that women in Northern India and Muslim women are more subject to patriarchal norms than women in South India and Hindu women (Jeffery and Jeffery 2002; Jejeebhoy and Sathar 2001; Phillips 2005). Considering this variation, Abu-Lughod (1993) will be used as a model in this study to explore young women's variable agency through the transitions of menarche, marriage, and motherhood.

Given that male domination has been viewed as universal (Rosaldo 2006), the standard view of agency consists of women's active resistance against the dominant structures of power, by choosing to act outside the range of gender normative behaviors (Kabeer 1999; Mahoney and Yngvesson 1992). Feminist anthropologists have also noted that women enact agency through alternative routes (Ahearn 2001; Frank

2006; Ortner 2001; Rosaldo 2006; Walter 1995). For example, some Muslim women (Abu-Lughod 1993; Abu-Lughod 1990; Mahmood 2005) and women in South and East Asian contexts (Hilsdon 2007; Ram 1993), enact agency, not through active resistance to structures, but through their ability to make choices enabling them to achieve proscribed gender norms, also referred to as the "patriarchal bargain" (Kandiyoti 1988). When women achieve these standards, they may use them to their benefit in their dealings with men (Abu-Lughod 1990:40). Feminist anthropologists have built on Bourdieu's theories of practice (1977), to understand the ways women enact agency (Ortner 1989).

This project also expands upon Scheper-Hughes and Lock's "three bodies" to include a fourth body—the biological body. The biological body in this study draws on the critical biocultural and CMA literature (Baer 1996; Baer and Singer 2009; Leatherman and Goodman 2011; Singer 2009; Singer, et al. 2006) to consider the ways in which structural inequities "get under the skin" to differentially impact young women's health outcomes. Specifically, the "biological body" will be used to interpret how contextual factors contribute to young women's health outcomes as measured through the biomarker and self-reported health data.

The integration of these theories requires an examination of life course trajectories in the context of the power differentials imposed by the global, national cultural and community contexts in which young women differentially gain agency as they transition from their natal to marital families. See Figure 1 for a diagram representing the integrated framework.

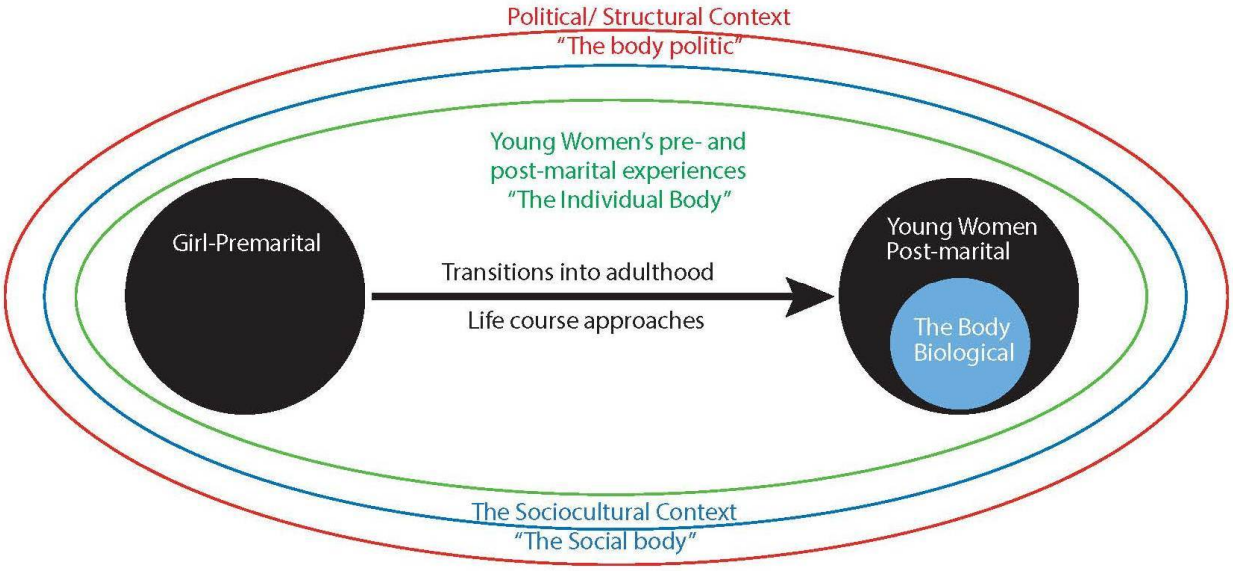

Figure 1: Integrated theoretical framework.

Specific aims

The specific aims of this project are to:

1. Describe young women's natal family dynamics and pre-marital social and community networks and the impact of these on their agency before marriage

2. Examine how young women's natal family experiences and agency impacts on their transition to and relationships with their husbands and husbands' families.

3. Identify the ways in which young women's agency (derived in part from her transitions and social and community networks), and sociocultural, and biological factors impacts their sexual and reproductive health.

Chapter 2: Methodology

This project employs multi-level, mixed methods to capture information on individual, social and structural factors, mirroring the theoretically derived research hypotheses. This project also utilizes a sequential explanatory research design (Creswell 2003; Ivankova, et al. 2006). In this design, qualitative methods are used for identification and discovery and to enhance the validity of quantitative instruments. The second, quantitative stage is used to test hypotheses concerning the predictive values of the independent variables for young women's SRH. In the third phase, specific results from the quantitative survey are investigated qualitatively to explain statistical relationships through women's and key informants' narratives.

Multivariate Hypotheses and Definitions of Measures:

Based on preliminary research in the study area as well as the literature, several key domains have been identified as potential factors contributing to young women's trajectories and their sexual and reproductive health. The key domains are natal family gender equity, agency, social networks, and marital relationships. The hypotheses below describe potential relationships and trends between the key domains.

1. Young women raised in gender inequitable families and who conform to patriarchal norms will have smaller pre- and post-marital social and community networks, less agency in the pre-marital period, more agency in the marital relationship, improved relationships with husband and husband's family, and intermediate SRH outcomes. By conforming, these young women will have less knowledge of reproduction and sexuality, but be better able to negotiate these issues and have more positive relationships with their husbands and in-laws by enacting the appropriate roles of wife and daughter-in-law.

2. Young women who resist the patriarchal norms of their natal family will have larger pre-marital social and community networks, more agency in the pre-marital period, less agency in the marital relationship, poorer relationships with their husband and husbands' families, smaller post-marital social and community networks, and poorer SRH. Consistent with research conducted in South Asia, those young

women who take on alternative roles within a non-supportive familial or community context will have poorer SRH (Kapadia-Kundu, et al. 2007; Krishnan, et al. 2010; Rocca, et al. 2009).

3. Young women from natal families with more gender equitable norms will have larger pre- and post-marital social and community networks, more agency both before and during marriage, improved relationships with husband and his family, and improved SRH outcomes. This hypothesis is based on the literature that suggests women with greater empowerment and support within natal and marital families have improved SRH outcomes (Schuler, et al. 2006; Hadi 2000; Jensen 2012; others).

The Sample

For all qualitative and quantitative data gathering, the focal sample was married women between the ages of 15-25. The selection of this age range and marital status allowed for the exploration of the transition from natal to husband's family by women who have experienced each of the stages of menarche, marriage, and pregnancy.

In terms of the general sampling criteria for young women, preliminary data revealed that the age group 15-25 would be most appropriate for the aims of the project. The parameters of the sampling frames for both interviews and the survey were age at marriage and religion. Attempts were made to include equal numbers of young women married below the age of 18 and at or over the age of 18. The importance of religion, particularly differences between Hindu and Muslim families and young women, have been noted by many researchers in India. Thus, religion was the second sampling criterion. For the survey, attempts were also made to obtain equal numbers of participants from different sub-areas of the study area.

Girls married under the age of eighteen, and to a lesser extent, individuals living in urban "slum communities" and newly married women constitute something of a "hidden and hard-to-reach population" necessitating non-random sampling strategies (Singer 2012; Magnani, et al. 2005; Muhib, et al. 2001; Cohen and Arieli 2011; Watters and Biernacki 1989). Prior information on age and gender and composition of household level data was not available. Many families rent their homes, and some sub-

areas of the study area contain illegal homes and buildings that may not be part of more formal surveys of the study area.

In addition, eighteen is the legal age of marriage for women in India. Although the law is often disregarded and not always enforced, underage marriage has become stigmatized throughout India. When asked their age at marriage, many women will not admit to being married earlier, out of fear for being reported to the authorities and facing legal consequences.

In addition, newly married women, particularly from low-income communities are often a very mobile population. Within the first few years of marriage, women may move back and forth between their natal families and their husband's family for several different reasons. Traditionally, women return to their natal family for support during their first pregnancy and delivery. Women may also be sent back to their natal families as a form of punishment for not meeting the expectations of their husband or in-laws. The financial condition of the husband and his family may also necessitate that the woman move from one household to another. If the husband is not earning well, he may move elsewhere, either taking his wife with him or allowing her to stay with her family. The mobility of newly married women means that, a household may have an eligible woman living there one week, who is gone the next week. A chain-referral or respondent driven sampling approach (Singer 2012; Magnani, et al. 2005; Johnston and Sabin 2010; Goel, et al. 2010) would not be appropriate for this population, given that many newly married women are restricted from speaking to individuals outside their household and as a result, newly married women tend to have very small social networks.

Due to the challenges associated with obtaining equivalent numbers of women married as adolescents versus women married as adults, multiple approaches were used to obtain the sample. First, different sub-areas within the two communities were chosen. Sub-areas were chosen based on relative socioeconomic status (i.e., equal numbers of more impoverished and less stable areas and less impoverished and more stable areas). Within sub-areas, community health volunteers (CHVs) NGO workers, and community mobilizers were enlisted to discuss the study on their door-to-door rounds, and refer interested and eligible participants. Such partnerships with community "gatekeepers" and

community-based organizations are a common method of recruitment in low-income settings as well as with hidden populations (Benoit, et al. 2005; Rashid 2007; Rashid 2011). Women who participated in the study would often tell neighbors, female relatives, or friends about the study and refer them to us as well. In this way, samples for both the qualitative and quantitative portions of the study were obtained.

Data Collection

The fieldwork for this project was carried out over three separate periods and informed by fieldwork in the study communities conducted for my master's degree in 2011. The first period was from May 2012 to August 2012 and focused on collecting the majority of the Stage 1 qualitative data. The second period was from January 2014 to September 2014. During these eight months, additional qualitative data and survey and biomarker data were collected. In January 2015 a return trip was made to Mumbai for dissemination and member checking focus group discussions.

Qualitative Data Gathering

Key Informant Interviews

Key informant interviews (N=6) were conducted with teachers, social workers, and NGO staff working in the study area in 2012. Additional key informant interviews (N=19) were conducted in 2014 with healthcare providers, community health volunteers (CHVs), NGO staff, a *Mahila Mandal* Federation worker, and mothers of young women in the study area. These interviews focused on understanding the social and cultural context of young women in the study area, and factors such as education, social norms, timing of marriage, and health and social problems faced by young women. Informal discussions with researchers working in the study area at the International Center for Research on Women and the Population Council also contributed information on the structure of the study area and key sociocultural factors pertaining to young women. All key informant interviews were conducted in their places of work or the urban health center.

Content analysis of media reports and national policies

A content analysis of policies and programmatic documents pertaining to underage marriage at the national level, women's empowerment, gender equity, violence, maternal mortality and morbidity

and, young women's health and nutrition, as well as news stories from national and international media sources was conducted. These analyses provided an understanding of national and structural factors impacting young women.

In-depth interviews

Interviews were also conducted with married young women between the ages of 15 to 25 (N=68). These interviews took four different formats. The first set of interviews consisted of unstructured prompts that attempted to identify important events and experiences in the lives of young married women. The next set of interviews were mini-life history interviews that built on the unstructured interviews by asking young women to describe their experiences at different key events or time points, such as the young woman's experiences leaving school, starting work outside the home, getting married, pregnancy and childbearing. These "mini" life history interviews were not full life histories, but rather focused on learning the circumstances surrounding key transition points in a woman's life. The third set of interviews were semi-structured and utilized an interview guide to ensure that all participants were asked about the same topics and questions (Schensul and LeCompte 2012; Bernard 2006). The semi-structured interviews focused on more specific questions regarding the dynamics of the young woman's natal family, mobility and social networks pre- and post-marriage, her marital relationship and her sexual and reproductive history. All of these interviews were conducted in 2012. In 2014, the fourth set of interviews was conducted. These interviews were also semi-structured, but focused primarily on young women's sexual and reproductive health, including questions on first night experiences, contraceptive use and fertility preferences, sexual behaviors engaged in, sexual and physical violence, ability to refuse sex and feelings regarding the sexual relationship. All interviews with young women were conducted in the study area in private homes, NGO offices, and the urban health center.

Quantitative Data Collection and Measures

Survey

After the collection of qualitative data, a survey instrument was constructed and administered to a sample of 150 young married women between the ages of 15-25 years old. The survey included

previously validated instruments from the RISHTA projects as well as items based on information from the in-depth interviews (see below for definitions of measures). The survey also contained a section on social networks, in which young women are asked to name 40 people whom they know, and collected basic demographic information on these alters, including relationship to the young woman (ego), gender, approximate age, where they live (inside or outside the community), their role and/or job in the community, and the types of information shared with these individuals. Survey and biomarker data collection were conducted in empty rooms in private homes and in a community NGO.

Definitions and operational measures

Validated scales from previous and current projects conducted in the study communities (Schensul et al., 2009), my preliminary work in the study communities and the results of the qualitative data gathering were used to operationalize the following constructs:

Natal family gender equity norms and behaviors

This scale assesses the extent to which girls are treated differently from male siblings and relatives or are provided with fewer resources because of their gender. Behaviors and norms included are reasons for leaving school, health problems and healthcare, and the rules, restrictions and responsibilities disproportionally imposed on children and young adults. This scale has 31 items and a Cronbach's alpha of .773.

Pre-marital Agency

This domain, using a scale adapted from Kostick, et al. (2010) and derived from the study communities, measures a girl's ability to make decisions regarding participation in cultural and religious programs, extracurricular activities, making purchases, media consumption, ability to speak with and socialize with non-family members, employment and/or continued education, marriage, and mobility (Kabeer 1999; Ram 1993), in the natal family. This scale has 16 items and a Cronbach's alpha of .730.

Pre-marital community and social network

This domain includes the individuals with whom the girl interacts and shares information prior to marriage. It is measured through a series of questions formatted for egocentric network interviews

(Wasserman and Faust 1994). The variable consisted of the size of the social network in terms of number of alters (individuals with whom the young woman interacts).

Marital communication and support

This variable includes ease of marital communication on different topics such as household matters and feelings, and the extent to which the woman's husband help with different household chores and work (cleaning, cooking, childcare, taking family members to the doctor). This scale has 16 items and a Cronbach's alpha of .805.

Marital Gender Equity Beliefs, Norms and Behaviors

This variable includes questions about gender equity beliefs and norms from a scale developed by the RISHTA study (Schensul et. al, under review), as well as questions about a woman's ability to make decisions regarding working outside the home, mobility, purchasing power, and how many children. This scale has 38 items and a Cronbach's alpha of .841.

Post-marital social & community network

This variable, measured the same way as the pre-marital social network, includes individuals with whom the woman interacts and shares information after marriage. The variable consisted of the size of the social network in terms of number of alters.

Marital Verbal Abuse

This variable included items regarding whether the woman's husband is suspicious or jealous of the woman interacting with other men, tries to restrict the woman from communicating with family or friends, yells at the woman, is overly critical of the woman, or insults and humiliates the woman. This scale has 13 items and a Cronbach's alpha of .834.

Marital Physical Abuse

This variable included items regarding whether and how often the woman's husband slaps, hits, punches, kicks, or beats the woman. This scale has 5 items and a Cronbach's alpha of .904.

Physical Health Problems Post-Marriage

This variable includes physical health problems such as irregular menses, vaginal discharge, headaches, loss of appetite, swelling of glands in the groin, infertility, lethargy, tuberculosis, anemia, malaria, and others. This scale has 29 items and a Cronbach's alpha of .798.

Reproductive Health

This variable includes reproductive events such as age at first pregnancy, numbers of pregnancies, miscarriages, stillbirths, abortions, C-sections, number of antenatal visits attended, physical health problems, biomarkers of body composition (Rockett, et al. 2004; Bosch 2005) and anemia (Ransom and Elder 2003). This scale has 29 items and a Cronbach's alpha of .832.

Sexual Health

This variable includes indicators provided by authors cited in the introduction, and operationalized into scales by Mehrotra et al. (2014). Variables in these scales include: STI/HIV knowledge, contraceptive use and ability to negotiate contraceptive use, ability to negotiate or refuse sexual, sexual pleasure, sexual problems and risk, and forced or coercive sex. This scale contains 32 items and a Cronbach's alpha of .803.

Biomarkers

As a component of the measurement of sexual and reproductive health, biomarkers were also collected during survey administration. The height and weight of each young woman was measured to calculate her body mass index (BMI). As has been noted by Rush, et al. (2009), BMI is not always an accurate indicator of malnutrition as it does not take into consideration cross-cultural differences. However, BMI is useful for understanding intra-community variation and malnutrition when examined as weight-for-age within the same ethnic, cultural, and gender groups (Cole, et al. 2007; Gallagher, et al. 1995; Duncan, et al. 2009). In this way, BMI serves as an internally derived scale, in which we can examine the relative range of values within the group, and triangulate with the other types of data collected. Height was also converted into a z-score and evaluated based on the World Health Organization's height for age standards (WHO 2007) to determine whether the young woman shows signs of stunted growth or short stature. Stunting indicates malnutrition during childhood and increases the

likelihood of delivery by cesarean section (Sheiner, et al. 2005). Short maternal stature or a stunted adolescent mother also increases the risk of stillbirth, fetal growth restriction/low birth weight at term, likelihood of being small-for-gestational age (Black, et al. 2013; Watson-Jones, et al. 2007), and has been linked to obstetric and gynecological complications such as perineal lacerations, need for complex episiotomies, and obstetric fistula (Ehrenberg, et al. 2003; Zheng and Anderson 2009).

To measure anemia, a Hemocue was used to estimate hemoglobin concentration in capillary blood (Bentley and Griffiths, 2003). The Hemocue is a small (weighs less than a pound), handheld device that runs on battery power. It only measures hemoglobin concentration and not any other indicators. Blood from a finger prick was collected in a microcuvette containing the necessary reagents, which was then inserted into the Hemocue to measure hemoglobin concentration after correcting for turbidity (Hemocue 2011). Within a few seconds, the Hemocue provides a digital reading of the hemoglobin concentration in the sample. The Hemocue has been proven accurate in field settings, and validated for use in India (Bentley and Griffiths, 2003; Sari, et al. 2001; Kapoor 2002).

Power calculations for survey sample

The survey sample consisted of 150 respondents; sufficient subjects to achieve standard power and significant levels. Given that (1) a standard Type I error of a = .05, (2) a 2-tailed test of all hypotheses, (3) a standard Type II error of b = .20 (power = [1- b] = .80), and (4) a medium effect size of interest, r =.30, then according to Cohen (1988), a sample size of n= 84 is sufficient to test the correlation of any pair of variables. Given the complexity of powering a path analysis, there is the need for approximately another df = 20 for the path analysis, resulting in a need for n = 104, handled by the proposed n = 150.

Data Analysis

This study collects qualitative and quantitative biological and social data, which enables triangulation of results, as different types of data are used to confirm and/or complement each other (Voils, et. al 2008; McNabb 1990). It is important to note, that while different types of data will be collected, they will be integrated using a common conceptual model (LeCompte and Schensul 2012).

Each data set will be analyzed separately and compared to identify convergence and discrepancies. Discrepancies will be resolved through further analysis and modification of the conceptual model.

Qualitative Data Analysis

All interviews were audio recorded, translated and transcribed in English. Codes and transcribed text were entered into Atlas.ti, (V6.2) a computer-based text-search program (Muhr, 2010). The key to effective qualitative data analysis is the coding system. Codes were developed in this research utilizing a tree diagram method in which factors were embedded in domains, allowing analysis to occur at the domain and the factor level (Schensul 1993). The coding scheme was deductively developed based on the domains in the research model and modified by the content of the key informant and in-depth interviews. Coding was conducted in multiple iterations to enable the emergence of novel themes. All text were coded and reviewed for patterns related to consistency, variation, and exemplary cases. Atlas.ti allows multiple codes to be searched at the same time, allowing for qualitative "testing" of hypotheses. In addition to generating important results that can only be gained qualitatively, the textual data is crucial to the formulation of the survey instruments (Nastasi & Schensul, 2005; Schensul, 1993).

Quantitative Data Analysis

Quantitative data was entered into SPSS 19.0 (2010). Descriptive statistics were obtained for continuous and categorical variables. Univariate and multivariate data analyses were conducted to describe the sample. To develop scales, factor analysis was used and variables meeting the appropriate cut-off were included. To calculate the scale, the means were taken of all the items to be included. Cronbach's alpha was calculated to assess the reliability of the scale. For scales that were previously developed in the RISHTA project, Cronbach's alpha was assessed to ensure that the scales remained valid for use in this population. Normality of the scales was checked and established. As needed, variables were recoded such all variables were at the same level of measurement and that positive outcomes received higher values and negative outcomes received lower values. Scales were all approximately normal, and did not require further normalization.

Data from the egocentric interview portion of the survey was entered into SPSS. The proportion of alters based on gender, kin/non-kin, and position in the community was calculated and entered into the dataset containing the other survey answers to enable further statistical analysis and explore relationships between social networks and other domains.

Bivariate correlations, and univariate and multivariate regressions were also conducted. Correlations using Pearson's r and t-tests were conducted to explore basic relationships and differences between groups. Simple univariate regressions were conducted with continuous variables. Multiple linear regressions were also conducted with continuous variables. For the multiple regressions, correlations between predictors were conducted, and multicollinearity statistics were examined to ensure that variables were not too closely correlated (which would impact amount of variation explained by a given predictor). The predictors for the multiple regression models were entered into blocks using the "enter" method in SPSS. Entering variables in this step-wise fashion enables the reader to see both the individual impact of a variable as well as the amount of additional variance explained by adding an additional predictor and the significance of adding an additional predictor. Entering variables into blocks also allows the researcher to control for different variables in the model, as well as to limit the impact of variables within a model that may be inter-correlated.

Ethical considerations in this research

This research was approved by the University of Connecticut Institutional Review Board (IRB; IRB protocol H13-138). Written informed consent was obtained from all participants. For illiterate participants, the consent form was read to them and they provided a signature or marking indicating their comprehension and consent to participate. Consent, interviews and surveys were conducted in the language that the participant felt most comfortable with which was Hindi, Marathi, or English.

To ensure confidentiality, all interviews, surveys and focus group discussions were conducted in private rooms. The only individuals present for interview, surveys, or focus group discussions were the participant, the researcher, the research assistant, and occasionally the participant's baby. Participants' names and addresses were not collected in fieldnotes or audio recordings. Instead, participants were

assigned an alphanumeric code. Consent forms, which were the only way to link a participant to the project, were kept in a locked cabinet at the Tata Institute for Social Sciences while in India and then transferred to the student researcher's locked office at the University of Connecticut.

Participants who described experiencing psychological trauma or domestic abuse were informed of NGOs who provide counselling and resources in the community and offered referrals if they wished. Participants who described health problems or who were anemic were provided information and informed of services provided at the Urban Health Center or local NGOs who provide care at little to no cost and offered referrals if they wished.

Chapter 3: National and Community Contexts

This chapter presents the multi-level structural and cultural context consistent with the theoretical framework utilized for this study. The chapter begins at the national level and discusses the extent to which national level policies, strategies, and programs are reaching the local communities and addressing key issues that include underage marriage, violence against women and girls, and health care for young women. It then moves on to the dynamics and changing context of the city of Mumbai, a description of the study communities and the salient cultural concepts and norms necessary to understand the local context within which girls and women adapt. The information for this chapter is drawn from review and analysis of policy, programmatic documents, and media stories, the literature, previous research conducted in the study area by the RISHTA project, discussions with key informants, and participant observation.

National Perspectives

The national women's movement has played a key role in addressing inequities and advocating for rights although many of the laws and policies enacted have been less than effective in implementation. The movement to expand women's rights began before Independence with the founding of the Indian National Congress in 1885 with increased emphasis on overall social reform (Basu 1995). This early movement was primarily led by men, and Indian women had little voice in this early social reform movement. Researchers have also noted that the earliest iteration of the women's movement was primarily concerned with Hindu women (Krishnaraj 2012; Mazumdar 1994). In the early part of the 20th century, primarily well-educated, upper-caste and class women, began participating in the larger movement towards Indian independence, and after Independence, the Congress party-led government attempted to fulfill some of the promises it had made to ensure equity. These promises were reflected in the Indian Constitution, which guaranteed women the rights to marriage and remarriage, to inheritance, and prohibitions on dowry. However, limited implementation of these rights as well as the fact that the declarations of rights did little to address social inequities (Subramaniam 2004), meant that gender equity continued to lag behind in many parts of India.

The economic crises in the 1960's contributed to increased women's activism in the 1970's (Sen 2004). The international community, specifically the UN's declaration in 1975 of a subsequent "International Women's Decade", is also attributed with spurring the women's movement in India (Agnihotri and Mazumdar 1995; Desai 1985). Drawing on the increased interest and activism as well as increased resources for women, in the 1980's women's centers were established that provided legal assistance and healthcare to women. These women's centers, in turn, contributed to the development of NGOs. NGOs in India deal with a wide variety of issues including access to land and resources, environmental degradation, health, violence, alcoholism and substance use, and other. NGOs also represent an opportunity for grassroots movements, drawing marginalized women into being more involved in the national Indian women's movement. However, echoing the early days of the women's movement, many NGOs are run by upper and upper-middle class women to serve women from low-income communities.

The modern iteration of the women's movement in India presents a contradiction. Upper and upper-middle class women with education and mobility continue to play a strong role in the national movement and in the support of more localized NGOs. These women have entered the work force and project an image suggesting that gender equity has greatly increased at the national level. At the same time, these movements have had little impact in the rural and urban communities where women lack opportunities for collective action and continue to be oppressed by patriarchal norms (Basu 1995).

NGOs have worked to provide education, services, and advocacy for women in marginalized communities. There are several ways in which education, services, and advocacy is provided. NGOs have tried to form women's groups (*Mahila Mandals*) in which women can collectively work on issues, however, participation in the Mahila Mandals as well as the overall impact of Mahila Mandals, continues to be quite limited in many urban and rural-poor communities. Some NGOs also work to help women set up self-help credit groups (*bachat guts*) to assist in the building of women's economic capacity and empowerment. Many NGOs also provide mobile health services in communities, with special focus on providing services to women. However, in communities where NGOs have attempted to foster activism to

further women's rights, these NGOs and their programs have met with many challenges. First, is skepticism on the part of women and men in the communities in which the NGOs work. It is very difficult to encourage women to participate in empowerment-building activities when there is no support from family or community for these activities. Second, poverty and limited education prevent many women from having the time or resources to participate in the women's movement. There also continues to be a disconnect between the women leading NGOs and the larger women's movement and the women this activism is meant to help. Due to these barriers, there continues to be limited input from the grassroots level and the women's movement in India continues to make slow progress in helping the most marginalized women.

Education

Researchers have noted that although India has had a commitment to universal education since Independence, the country has long lagged behind the rest of Asia in terms of literacy and education (Bhatty 2014; Grewal and Singh 2011; Tilak 1996; Weiner 1996). India's educational policies and programs have relatively recently undergone a great deal of change. The evolution of educational policies and programs have perhaps had the most impact on female literacy, as women have traditionally had more limited opportunities for education compared to men (Dommaraju 2009; Grewal and Singh 2011; Patkar 1995). The increase in female literacy has, in turn had an impact on social development within India (Dommaraju 2009; Dreze and Murthi 2001; Raj, et al. 2014).

The Constitution of India explicitly states that all Indian citizens have the right to a primary education, and declared that the state would provide free and compulsory education for children until age fourteen; however, implementation of universal education is weak (Bhatty 2014; Tilak 1996; Weiner 1996). In spite of renewed national commitments for free and compulsory education in national policies issues in 1968 and 1986, many Indian states did not have legislation supporting universal education (Bhatty 2014; Tilak 1996; Weiner 1996). Further, the meaning of "free" education varied from one part of India to another, but most often, families were responsible for paying for books, uniforms, supplies, teacher salaries, and transportation to and from school (Bhattacharya 2012; Tilak 1996). In addition, the

primary barriers to education, namely economic status and gender inequity (necessitating that girls not attend school or drop-out of school early) were not addressed by national or state policies and programs (Bhatty 2014; Patkar 1995; Tilak 1996; Weiner 1996).

In 2010, the "Right of Children to Free and Compulsory Education (RTE) Act" came into effect in India. This act explicitly states that, "no child, other than a child who has been admitted by his or her parents to a school which is not supported by the appropriate Government, shall be liable to pay any kind of fee or charges or expenses which may prevent him or her from pursuing and completing elementary education" (Government of India Ministry of Human Resource Development website 2015). In addition to clarifying what "free education" meant, the RTE act sets standards for education infrastructure, teacher training and deployment and student/teacher ratios. The RTE act also details the specific duties of the national, state, and local governments in ensuring education is completely free.

Although the RTE act has not been in effect for very long, researchers have pointed out its problems. Dubey (2010) notes that the act fails to make a concrete commitment of funding, preventing it from being fully implemented, and will further perpetuate inequities in the quality of education received by children from impoverished families. In addition, Dubey (2010) points out that the act does little to expand availability of secondary education. Others have raised similar concerns, noting that, although the goals of the act are admirable, it is unlikely that all stipulations in the act will be carried out without greater investment by national and state governments (Cheruvalath 2014; Kaushal 2012).

Early or "Child" Marriage

In India, underage marriage is referred to as "child" marriage. This terminology is due to legal precedents setting the age of consent in India as eighteen years old, with anyone under the age of eighteen referred to as a "child" in laws and policies (Sagade 2005). Other international organizations refer to early marriage as "forced" or "early" (Sagade 2005). International bodies, such as those under the United Nations (UN) do not explicitly prohibit early marriage, but do discourage marriage of minors through the promotion of children's and women's rights (Gaffney-Rhys 2011; Svanemyr, et al. 2012). India has ratified all of the UN's resolutions and conventions on the rights of women and children (Gupta 2012). In

India, child marriage has been illegal since the Child Marriage Restraint Act (CMRA) of 1929, which originally set the minimum age of marriage as fourteen for young women and eighteen for young men but was later amended to raise the minimum ages for women and men to eighteen and twenty-one respectively in 1978 (Ghosh 2011; Pande 2013; Sagade 2005: xxiv). Researchers have noted that, although the CMRA was originally progressive for its time, it has not been enforced very effectively (Gaffney-Rhys 2011; Ghosh 2011; Gupta, et al. 2008; Sagade 2005; Pande 2013).

In 2006, the CMRA was replaced with the Prohibition of Child Marriage Act, which put in place heavier penalties for anyone who performs or otherwise enables a child marriage (Ghosh 2011; Gupta 2012; Gupta, et al. 2008; Nanda, et al. 2012). The Prohibition of Child Marriage Act also enables a young woman who was married as a child to have her marriage declared "void" and receive maintenance payments and housing from her husband's family until she remarries (Ghosh 2011; Nanda, et al. 2012). However, researchers have noted that this new act also contains flaws and has not been effectively enforced (Ghosh 2011; Nanda, et al. 2012; Gupta 2012; Gupta, et al. 2008).

One reason that both the CMRA and the Prohibition of Child Marriage Act have been unsuccessful has been insufficient political will to ensure full implementation of the laws at the ground level (Economic and Political Weekly 2013; Gupta 2012; Nanda, et al. 2012). Political leaders are loath to develop local policies that would counter local cultural norms for arranged marriages. Poor national registration systems for both births and marriages have also created difficulties in enforcing the laws, as many families may not have official documentation of their child's age. In addition, many marriages continue to be unregistered, preventing authorities from possibly preventing or reporting child marriages (Gaffney-Rhys 2011; Ghosh 2011; Nanda, et al. 2012; Sagade 2005). A major failing researchers cite for the CMRA were punishments that were not particularly harsh (Sagade 2005), which some advocates feel has been improved in the new Prohibition of Child Marriage Act (Ghosh 2011; Nanda, et al. 2012). An additional problem with enforcement of the new law is that it requires the young woman and/or her family to report the marriage to the authorities for persecution or nullification to occur. Given the unlikelihood of a young woman or her family reporting a crime in which they were complicit, researchers

have pointed out that the new Prohibition of Child Marriage Act will fail to reduce child marriage without major social, cultural, economic, and political changes (Nanda, et al. 2012).

The gaps and loopholes that existed in the CMRA (Sagade 2005) have not been fully remedied in the Prohibition of Child Marriage Act (Ghosh 2011; Gupta 2012; Gupta, et al. 2008). Malhotra, et al. (2011) note that, although India has had laws against child marriage since before Independence, programs (both non-governmental and governmental) to reduce child marriage have really only been in existence since the 1990's in response to the International Conference on Population and Development in 1994 and have had only localized success to date.

Violence against girls and women

Much of the literature on violence against women in India focused on domestic violence within the marital dyad or violence from in-laws directed towards daughters-in-law (Jain, et al. 2004; Raj, et al. 2012; Visaria 2008; Yee 2013; many others). However, since the sexual assault of a young woman in Delhi in December 2012 made national and international headlines, the focus has shifted to now include harassment and violence against women and girls outside the domestic sphere. The 2012 Delhi rape provoked many changes in law, policies, and programs throughout India as well as a great deal of discussion about the safety of women and girls in India (Phillips, et al. 2015).

Observations, key informant interviews and the literature all indicate that women and girls in India experience a great deal of routine harassment outside the home, the most common of which is known as "eve-teasing" (Das, et al. 2012; Gilbertson 2014; Leach and Sitaram 2007; Nahar, et al. 2013; Rogers 2008; UN Women and ICRW 2012). Eve-teasing refers to a constellation of behaviors boys and men direct towards girls and women in public spaces as they walk down the street, walk through parks or markets, use public transportation, or other public spaces. These behaviors include yelling rude or explicit things, making explicit gestures, propositioning women or girls, and touching or groping women or girls in public spaces. Young women who are at particular risk for eve-teasing tend to be those with greater mobility, and eve-teasing has been noted to a particular problem for young women attending school (Gilbertson 2014; Leach and Sitaram 2007; Nahar, et al. 2013; Rogers 2008; UN Women and ICRW

2012). Although young women feel a great deal of concern over eve-teasing, they rarely report it to parents, community members, or authorities. Young women often feel that eve-teasing is such a minor and common offense, that it is not worth complaining about. Eve-teasing, like other forms of harassment and violence against women is highly stigmatizing toward the victim who is concerned that she is responsible (by attitude, mobility, and/or dress) for having provoked such attention. As a result, young women fear reporting their experiences to family or authorities. Victim-blaming by family members and/or authorities is a common concern and young women are afraid that reporting an incident will only cause harm to their or their family's reputation (UN Women and ICRW 2012).

There have been a wide variety of responses to the perceived increase in assaults, both nationally and at the local level. Policy and judiciary changes to allow for legal prosecution of assault were made in 2009 and 2013. In 2009, the High Court in Delhi set out the first national guidelines for collection of sexual assault forensic evidence and care for victims of sexual assault (Jain 2013). In 2013, the law was amended such that violence against women, including sexual assault and harassment was more clearly defined, penalties for different forms of violence clarified and increased, and a system of "fast track" courts set up to handle assault cases (Government of India 2013). However, researchers, lawyers, activists and the Indian media have noted several problems with these efforts, including inadequate implementation and the fact that the Indian High Court has declared that marital rape is still not considered a prosecutable offense (Himabindu, et al. 2014; Jain 2013; Khan and Barnagarwala 2014; Mandal 2014; Sequeira 2013; Yee 2013).

Researchers, activists and the media have also noted that the focus on violence and rape against women has produced a "push-back" from men, including conservative male politicians and religious leaders. Several politicians have publicly engaged in victim-blaming (Mishra 2014) or stated that the best way to prevent rape is for women to not stay out late at night, dress more modestly, and not have cell phones before marriage (Singh 2013; The Times of India 2008). Lodhia (2014) has documented how male backlash against anti-violence advocacy is contributing to a growing number of "men's rights" groups in India. Lodhia finds that these men's rights groups feel that women are misusing legislation to "break-up"

families, and that the best solution is to support a return to more traditional, patriarchal values. Others have noted how young men and boys who feel left out of some of the advances women are making are using eve-teasing as a means to regain power over girls and women (Nahar, et al. 2013; Rogers 2008). By eve-teasing girls and women and creating unsafe spaces, young men are able to exert hegemony over female mobility and reaffirm their own hyper-masculinity.

Healthcare for adolescents and young adults

Globally, the public health agenda has focused on infectious disease and maternal, neonatal and child health (MNCH). The Millennium Development Goals stress infectious disease control and MNCH outcomes, leading most low and middle income countries to prioritize programs targeted to these issues over adolescent's or women's gynecological health needs (Chandra-Mouli, et al. 2013; Gopalan and Durairaj 2012; Bingham, et al. 2003; Knaul, et al. 2012; Paolisso and Leslie 1994). Due to this focus, fewer resources have been directed towards the overall health of pre-marital adolescents and women. India has generally been reflective of these global trends, with limited attention and resources provided for dedicated adolescent's and women's services within public clinics and hospitals (Jejeebhoy, et al. 2014; Gopalan and Duriraj 2012; Nair and Russell 2012; Sanneving, et al. 2013; Bhatia, et al. 1997; Dabash, et al. 2005). However, more recently efforts have been made at the national level to create and provide access to services tailored to the specific needs of adolescents and young adults.

In 2006, the Government of India issued the Adolescent Reproductive and Sexual Health Strategy as a component of the Reproductive and Child Health Phase II Programme (Government of India 2006). The strategy outlined ways in which adolescent-friendly services for married and unmarried women and men could be integrated into the existing public health infrastructure. However, researchers have noted that this strategy was not implemented in most parts of India, resulting in limited availability of services and limited knowledge of services and utilization by adolescents (Jejeebhoy, et al. 2014; Nair and Russell 2012; Santhya, et al. 2014). Researchers have noted that the 2006 strategy failed to incorporate mental health services and sufficient SRH education and counselling (Jejeebhoy, et al. 2014; Nair and Russell 2012; Santhya, et al. 2014).

In recognition of the limitations of the 2006 strategy, the Indian government launched the *Rashtriya Kishor Swasthya Karyakram* (RKSK) framework for adolescent and young adult healthcare services (Santhya, et al. 2014; Jejeebhoy, et al. 2014; Government of India 2013). RKSK lays out concrete services to be provided at each level of the public healthcare system, to be delivered by healthcare providers and staff after receiving training on adolescent healthcare. RKSK is designed to address some of the gaps identified in the previous national strategy through incorporation of mental health services and health education. Researchers at the Population Council carried out an early evaluation of the implementation of RKSK from the perspective of providers (Jejeebhoy, et al 2014) and from the perspective of adolescents and young adults (Santhya, et al. 2014). Jejeebhoy, et al. (2014) find that although some providers received sensitization training on appropriate, non-judgmental ways to educate and communicate with adolescents, this training was limited and was not always put into practice by providers. In addition, providers continued to primarily focus on married and pregnant adolescents, rather than unmarried female adolescent girls or boys. Providers also identified problems with utilization of the services, including lack of knowledge that the services exist, limited mobility of adolescents and young adults, and the reluctance of adolescents to access the services. Adolescents who accessed the services reported mixed experiences, especially with respect to availability of privacy, adequacy of information provided, and providers' attitudes (Santhya, et al. 2014).

In spite of the many policies, programs and movements towards increased gender equity and development of needed services, implementation at the local level has been a major impediment to impact. This lack of implementation has had the most negative effect on low-income girls and women in rural and urban slum communities who continue to be missed by these national changes. As a result, many of the policies and programs described in this section have not yet had substantive, long-term impacts on the well-being of impoverished women.

National policy for low-income, "slum" communities

Urban poor communities, or "slums" have been defined by numerous organizations including the United Nations in a variety of ways. For the purposes of national surveys and the census, the Indian

government's Office of the Registrar (as stated in Gupta, et al. 2009:10) uses the following criteria to define a slum:

1. All specified areas in a town or city notified as "slum" by state by State/Local Government and UT [Union Territory] Administration under any Act including a "Slum Act,"
2. All areas recognized as "slum" by State/Local Government and UT Administration, Housing and Slum Boards, which may not have been formally notified as slum under any act, and
3. A compact area of at least 300 population or about 60-70 households of poorly built congested tenements, in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities.

South Asia is home to some of the largest slums in the world (Mahmud 2010; Rao 2006). The discussion of slums in India has examined the development of slums, both in terms of physical infrastructure and urban planning (Abbott 2002; Baviskar 2003; Bjorkman 2014; Ooi and Phua 2007; Patel, et al. 2014; Pucher, et al. 2005) as well as the ways in which neoliberal policies, urbanization and globalization have contributed to the need for slum communities (Deshingkar 2006; Mahmud 2010; Nijman 2015; Rao 2006). Most of the slums in India are the result of pre-existing housing shortages and rural to urban migration to take advantage of manufacturing and service sector jobs brought about through increasing industrialization and neoliberal economic policies (Baviskar 2003; Nijman 2008; Rao 2006). The literature on slums has also been concerned with how slums become legal or illegal and the implications of legality for residents to access services or mobilize resources (Baviskar 2003; Kumar 2008; Mahmud 2010; Nakamura 2014; O'Hare, et al. 1998).

The impact of slum housing and conditions on human health has also been a major topic in the literature and in the media. Most urban slum communities in India are located in areas of cities where the land is degraded or undesirable, such as near dumping grounds, industrial zones producing waste, or on swampy or marshy land. These less desirable parts of cities often lack or have extremely limited water and sanitation infrastructure. Housing in these settings is often overcrowded and poorly constructed with

found and hazardous materials. The environmental, housing, and infrastructure inadequacies combine to create settings ripe for the development and spread of infectious diseases (Riley, et al. 2007).

To understand health outcomes of those living in cities, and particularly in urban slums, a review of health and living conditions in eight Indian cities, using National Family Health Survey data, was undertaken by Gupta, et al. (2009). They found that vaccination coverage and antenatal care coverage was much lower for individuals living in slums compared to individuals living in non-slum areas of the cities. They also found that malnutrition and anemia were much higher for men, women, and children living in slums. Hazarika (2009) found that antenatal care was lower for women living in low-income communities. Hazarika (2009) also determined that unmet need and overall reproductive healthcare access was much lower in low-income communities in India. Kar, et al. (2001) in a study of immunization coverage in low-income communities in Delhi found that coverage was sub-optimal largely due to poor outreach and awareness of where services could be obtained. Overall, researchers have found that the primary barrier to obtaining healthcare in low-income communities in India is the lack of accessible and affordable healthcare (Agarwal and Taneja 2005; Gupta, et al. 2009; Hazarika 2009; Khan, et al. 2012). To attempt to address inequities in urban healthcare, a National Urban Health Mission (NUHM) was introduced in India's Eleventh Five Year Plan in 2008 (Gupta, et al. 2009). The NUHM was supposed to focus exclusively on low-income communities and other urban marginalized populations and expand existing health infrastructure and services. Implementation and rollout of the NUHM has so far been limited.

Mumbai

Mumbai (known as Bombay until 1995) is located on the Western Indian coast, in the state of Maharashtra. As of the 2011 census, the city of Mumbai (excluding Navi Mumbai, Thane, Vasai-Virar, Bhiwandi, and Panvel) has an estimated total population of 18,414,288 people, making it the largest city in India (Government of India 2011), and the fifth largest city in the world (United Nations 2014). Mumbai's reputation as a cosmopolitan city with a multicultural population dates back to the period when the British East India Company began developing trade activities based in the chain of islands that makes

up the city (Pacione 2005). Mumbai has undergone many changes, as it moved from a major center for the textile industry to the financial and commercial capital of India (Pacione 2005).

Mumbai has had space and housing problems since the colonial period, and these housing problems have only intensified over time, resulting in over half of Mumbai's population residing in a low-income community/slum (Nijman 2008; Schensul, et al. 2009). Much of Mumbai's slum population is due to a few factors. One factor is the displacement of people from land belonging to shuttered textile mills or land being developed for commercial purposes. Another factor is that migrants from across India continue to migrate to Mumbai to join family members already in Mumbai and to find work opportunities (Mahmud 2010; O'Hare, et al. 1998; Teltumbde 2013). The combination of limited space and poor urban planning has resulted in numerous infrastructural problems throughout the city of Mumbai that have been documented by a number of researchers (Bjorkman 2014; Mahmud 2010; Nijman 2015; Pacione 2006).

Mumbai has had the reputation for being a "safe" city (as opposed to Delhi, which is considered unsafe for women) where women and girls could walk freely even in the late hours of the night. Anecdotal accounts of harassment and the national discourse on violence against women and rape has also brought about new responses at the city level in Mumbai despite its reputation. On International Women's Day 2014, the Mumbai Office of the Commissioner of Police held an event to roll-out new initiatives to make Mumbai safer for women, and to describe initiatives already in place. These new programs and initiatives included: sensitization training for all Mumbai police; a designated 24-hour helpline that women can call and seek assistance from a police officer; a service where women can text the license plate number of the vehicle they are in to a Mumbai police server that will record the vehicle number; a designated desk in all police stations staffed by women for women to report incidents and receive support; a larger police presence at select train stations as well as a separate line for women, children, and the elderly to have priority access to registered taxis and rickshaws; and a handbook (which at the time was only published in English and Marathi) containing information on types of violence, how to file a complaint at a police station, what to expect after filing a complaint, the process for a medical examination in cases of sexual assault, and the process for court trials. These initiatives are in addition to

the Special Cells for Women and Children (units within police stations with social workers who can address the needs of women and children who have been abused or assaulted) that are already in existence (Dave 2013).

During the course of the field research for this study, the special helpline for women was much publicized and perceived by key informants to be a positive initiative. The other initiatives were seen by key informants as incompletely implemented. There did not appear to be any additional police presence at any of the major train stations in Mumbai (including a train station where a young woman had been abducted and raped earlier in the year), nor was a separate transportation line for women apparent. Not all police stations (including those in the study area) had designated desks staffed by women, and observations of a police station that did have a special women's desk revealed that few people coming to the police station knew of the desk or felt comfortable speaking to the young women staffing it. Further, the desk was staffed by student volunteers, and when the volunteers were unavailable, the desk was not staffed. It also did not appear that the handbook on women's safety had been circulated to community organizations or women in communities. Given that the handbook was only available in English and Marathi, the handbook may not have been helpful for communities not originally from Mumbai. A Mahila Mandal representative said that there was still the need to educate women on types of violence and the options for handling violence, and that this information was not readily available for women in low-income communities.

The study area

The study area consists of two adjacent communities in the northeastern portion of Mumbai. The area was originally settled in the late 1960's and early 1970's by individuals displaced from the southern part of the city. One of the communities (community A) borders a large dumping ground, where trash from different parts of Mumbai is deposited. Near the dumping ground is a large bus depot. Community A is further subdivided into approximately seventeen sub-areas. Each sub-area varies in terms of housing type, services available from the Mumbai Municipal Corporation, and socioeconomic status. Much of Community A consists of *pucca* (planned, durable materials, and stable) or *semi-pucca* (a combination of

durable and found materials) housing that is made either entirely or in part with poured concrete construction and have a water tap and a common building for toilets. The more established areas of Community A receive water and electricity from the city of Mumbai, and have toilets that are either maintained by the city or private collectives. Sub-areas closer to the dumping ground and newer, less legally recognized areas have more *katccha* (literally "trash" or "debris") houses constructed from found materials of plastic sheets or tarps, tin and burlap with roofs made of asbestos or tin sheets. Water and electricity in these less established sub-areas is much more sporadic and may be illegally obtained. Community A is predominantly (80%) Muslim (Schensul, et al. 2009). There are roads in this community, but they range from being paved and maintained to not being paved and nearly impassable during the monsoon season.

Community B is located near an Eastern railway station and bordered by a creek on the north side. Community B consists of approximately fifteen sub-areas, and is generally perceived to be more economically depressed than Community A. Two sub-areas have tenement apartment buildings that, although they are *pucca*, are generally over-crowded, poorly lit and ventilated, and poorly maintained. These apartments are part of larger efforts to "rehabilitate" slums occurring in other parts of Mumbai. The rest of Community B consists primarily of *semi-pucca* and *katccha* housing constructed from similar materials as the homes in Community A. As with Community A, some services such as water and toilets in some of the more established sub-areas are provided by the municipal corporation, whereas other sub-areas do not have access to these services. Community B is predominantly Hindu and Buddhist, although there is a growing Muslim presence in this community. The roads in this community also vary in paving and quality.

While the stereotypical image is that slum communities consist of a rural migrant population, for the most part, the residents of the study communities are long-term migrants with a mean time in Mumbai of 15 years (Schensul, et al. 2009). The combined population of the study area is approximately 700,000 (Schensul, et al. 2009). The overall religious distribution of the study area is 54% Muslim, 43% Hindu, and 3% Buddhist and Christian. Residents from the study area are primarily from Bihar, Uttar Pradesh,

rural Maharashtra, Karnataka, and Tamil Nadu. The average household income in the area is 4500 INR per month (approximately $75 USD per month). The study area contains small-scale factories (*zari* industry) that assemble piece goods into garments, bags, shoes, toys and packaging. There are also scrap, steel polishing, and construction companies in the study area. Many men in the study area also work as truck, taxi, or auto-rickshaw (three-wheeled taxis) drivers. Rag-picking, or collecting scraps for re-sale from the dumping ground is also a common occupation, particularly for women in the study area.

In terms of the household level and household composition, most households are nuclear (47%), followed by joint/extended households (37.1%), and households consisting of men only (15.8%). The average size of a home in the study area is one room, and the average number of people per household is 6.4, although there is some evidence to suggest that average family size is decreasing concurrent with a decrease in fertility required by the limitations of space and income. Most households have electricity on a regular or semi-regular basis, with electricity either coming directly into the home, or households sharing electricity run from a main line and splitting the bill.

Water and sanitation have long been a problem in the study area (Bjorkman 2014; Schensul, et al. 2009; Singh, et al. in preparation). Key informants feel that water and sanitation has somewhat improved over time, but that more needs to be done. The municipal corporation provides public wells and taps in some areas, but water is only available from these sources at certain times of day. In addition, many of the municipal wells and taps either do not work at all or have insufficient water pressure due to placement of illegal taps. For those who do not have access to taps or wells, they are required to purchase water from tanker trucks. Obtaining enough water for daily needs occupies a great deal of time for both women and children in the study area, as all the vessels in the home must be ready as soon as it is the "*pani* timing" (time to get water), all the vessels must be filled, returned to the family's home, and then covered with cloths. Women often have to schedule their days around when water is available for them.

Toilets are also a consistent problem; an average facility consists of 20 toilets (10 for females and 10 for males) and must serve 1,000 residents. Toilets constructed by the municipal corporation are irregularly cleaned and maintained. Other toilets are privately owned and require payment to be used but

are cleaner and more regularly maintained. Overall, residents feel that the cleanliness of the toilets available is quite poor, and many, primarily children and men, choose to defecate in open areas or drainage ditches to avoid the available facilities.

The toilets present additional challenges for women and girls. Toilets are frequently a site for eve-teasing and harassment from men hanging out near the toilets. In some sub-areas girls and women cannot go to the toilets unaccompanied. Previous research in the study area has also found that the toilets present problems for sexual relations, as women fear that going to the toilet at certain times of night will constitute an announcement to the rest of the community that she has had sex.

Education

Education in the study area has improved over time, but continues to be inadequate for the needs of the study area. There are a few public and private schools in the study area, but none of them provide secondary level education. The schools in the study area have mixed reputations. Some feel that the public schools actually provide good education, despite being crowded and having limited facilities. The private schools receive less positive reviews in terms of the quality of the education provided, and are more expensive. The limited facilities (especially toilets) and lack of security at public schools make some families hesitant to send their children and particularly girls to the public schools. Students seeking secondary education are required to attend school outside of the study area, creating challenges for those children (particularly girls) who have limited mobility and/or come from families with limited resources to pay for transportation. In addition, gateway exams are required to attend many secondary schools and colleges. These exams typically necessitate outside tutoring, which is an additional expense that is out of reach for many families in the study area. Due to the limited capacity of schools in the study area, the majority of children (both female and male) drop out of school by the seventh standard (approximately age 13).

Healthcare

Healthcare takes a variety of forms in the study area. Government healthcare is provided through an urban health center (UHC) and three health posts distributed in different parts of the study area. The

Department of Preventive and Social Medicine of a teaching hospital/medical college runs the UHC. The UHC is a one story building located on a major thoroughfare in Community A. The UHC has a variety of outpatient departments (OPDs) such as: general male and female health, pediatric growth and development, antenatal care, immunizations, geriatrics, and sexual health (primarily STI/HIV testing and counselling). The UHC also contains a small laboratory and pharmacy. The UHC is staffed by physicians, public health post-graduates, and medical interns from the preventive medicine department of the tertiary hospital. On an average day 150 to 200 patients will be seen at the UHC. The UHC also has a community development officer who coordinates some social services and organizes occupational classes for young women that take place in the UHC. Although adolescents attend the UHC for acute problems, there is no designated adolescent OPD at the UHC. The lack of a designated adolescent OPD at the UHC indicates that implementation of the new adolescent health guidelines has not yet occurred in the study area.

The health posts are small satellite clinics that provide immunizations, basic infant and child growth monitoring, Direct Observable Treatment Service (DOTS) for TB, antimalarial medication, birth control pills and condoms, antenatal vitamins and care for pregnant women, and referrals to other services as needed. The health posts are staffed by one government physician, one to two nurses, and community health volunteers (CHVs). CHVs work out of the health posts and also make door-to-door rounds in set sub-areas to provide education and distribute many of the services available at the health post.

The private health care sector in the study area is quite large and includes allopathic (approximately 10% of the private sector) and non-allopathic providers. The non-allopathic providers practice Indian systems of medicine including *Ayurveda*, *Unani*, and homeopathy (Schensul, et al. 2006). Although private providers cost more than care in the public sector, private providers are often preferred by many in the study area because patients feel more comfortable and respected by the private non-allopathic providers. However, these non-allopathic providers also do not provide much in the way of adolescent-friendly services.

Cultural Concepts

Over the past decade, the University of Connecticut, Center for International Community Health Studies, under the leadership of Dr. Stephen Schensul and in collaboration with a number of Indian colleagues and institutions have been conducting projects in the study area as part of the program "Research and Intervention in Sexual Health: Theory to Action" (RISHTA, or "relationship" in Hindi and Urdu). RISHTA has conducted projects focused on married men and women and the marital dyad in relation to the prevention of HIV/STIs. These projects have also contributed understanding of some culturally salient concepts that are important for understanding the results in subsequent chapters.

One significant concept that has arisen over the course of the research in the study area, and been documented by researchers working in other parts of India is *safed pani* (vaginal discharge). *Safed pani* is a common complaint for many women in the study area as well as in South Asia (Bang and Bang 1994; Nichter 1981; Kostick, et al. 2010; Patel, et al. 2008; Rashid 2007). *Safed pani* is also a common reason why women access non-MNCH healthcare. The National AIDS Control Organization (NACO) in India classified *safed pani* as pathological and an STI symptom to be treated with antibiotics. However, research has shown that *safed pani* is a non-specific symptom that is rarely pathological. Rather, it is an "idiom of distress" or somatization of a woman's negative life situation (such as domestic violence, economic instability, food insecurity, marital problems, sexual violence) (Nichter 1981; Kostick, et al. 2010).

Another significant concept in the study area is that of *tenshun*. *Tenshun* comes from the English work "tension" and refers to generalized stress, anxiety, and depression (Chatterjee, et al. 2008; Karasz, et al. 2012; Maitra, et al. in press). *Tenshun* is a more socially acceptable way for people in the study area to express their psychological stress and concerns. Women in the study area have a great deal of *tenshun* concerning a variety of issues in their lives. Women often feel that *tenshun* is both a source as well as a result of physical health problems, such as *safed pani*. Both sources and results of *tenshun* are woven through most women's narratives.

This chapter has introduced national/policy, city, and community contexts in which young women are growing up and confronting issues of marriage, violence, and health. The difficulties in

translating national policies down to the level of urban slum communities is also introduced in this chapter, and will be discussed further in the next chapters. This chapter also provided definitions for culturally salient terms and concepts. The background provided in this chapter is built upon in the next two chapters where young women's stories of transition are told and key hypotheses are tested.

Chapter 4: Transitions from Natal Family to Marriage to Motherhood

This chapter is organized into three primary sections. In the first section, young women's diverse experiences in their natal families are discussed, focusing especially on their daily lives and transitions into adolescence. The second section describes the transition young women make into adulthood that is signaled by preparation for entering the marital process including the family's search for a husband, expectations for marriage, and how young women experience this transition. The third section describes what life is like for these young women after marriage as they adjust to their new roles of daughter-in-law, wife, sexual partner, and mother. In each of the sections, the key quantitative variables drawn from the ethnographic data are identified and defined and will be the basis for analysis in the following chapter.

The data for this chapter were drawn from both the qualitative interviews and observations as well as the quantitative survey data. Key informant interviews were conducted with individuals working and/or living in the study area (see methods chapter for further details). The in-depth interviews and the survey sample consist of young married women between the ages of 15-25 who were asked to recall their pre-marital experiences growing up in their natal household, their transition to their marital family, and their lives after marriage. The qualitative and quantitative data provide a picture that belies stereotypes of the lives of girls and women in slum communities and financially marginal households in Mumbai by emphasizing the diversity of young women's experiences. Demographic characteristics in the chapter are from the survey since the age, ethno-religious membership and areas where data collection occurred are the same for both the survey and the in-depth interviews.

Ethno-religious Characteristics of the sample

The mean age of the young women who took the survey was 21.68. In this study, 53% of the participants are Muslim, 29% are Hindu and 18% are Buddhist. Although much is often made of religious differences in India, I found that the girls in this study did not present many differences along religious lines. There are a number of reasons for similarities among the different religious groups. Many Buddhists in the study area come from families who were part of the wave of low-caste Hindus who converted to Buddhism under the encouragement of Dr. B.R. Ambedkar in the late 1950's and early

1960's (Gokhale 1999; Verma 2010). As a result, many Buddhists continue to participate in Hindu cultural practices and holidays.

Due to the use of the temple and the priests for marriage, *poojas* (prayers) and special events such as moving to a new residence and the emphasis on home alters, Hindu temple participation is irregular. Muslim men are frequent participants in Friday prayers (*jumma namaz*) at the mosque and in addition may participate in home and work observance of multiple daily prayers. An increasing number of women are wearing the burqa and head scarfs indicating ascription to more religious orthodoxy. However, Muslim women in the study communities are not allowed to attend the mosque and as a result focus their daily prayers at home. There are female religious practitioners in the study area, known as *alimas*, who occasionally hold meetings that discuss religious issues for women outside the mosque, but attendance, especially by younger women, is limited.

There is a convergence in the celebration of Muslim, Hindu and Christian ritual days that are national and state holidays, such as *Ganpati*, *Krishna Janmashtami, Holi,* Christmas, and others. This convergence means that individuals from various religions celebrate religious and secular holidays together.

The primary differences are between Muslims and Hindus/Buddhists. Many Muslim women, both in the study areas as well as in this study wear some combination of *burquas*, *hijab,* and *niqab*. Hindu and Buddhist women do not wear these coverings, although more conservative Hindu women and girls are required to cover their heads with their *dupattas* (long scarves matching their outfits) when they leave their homes. Another key difference between Muslims and Hindus/Buddhists is that many Muslims, both within the study area as well as in other communities practice cross-cousin marriage, in which the preferred marriage partner is the father's sister's child or the mother's brother's child. The close residential and cultural proximity has contributed to many similarities among religious groups.

Life in the Natal Family

For the general community, 66% of the parental generation were migrants from rural areas in the northern and southern states. The young women in this sample are representative of the next generation in

which 64% of the sample were born in Mumbai. For the 36% not born in Mumbai, their places of origin were in rural areas or smaller towns of Maharashtra, Uttar Pradesh, and Bihar, although, there is a small subset of young women from large urban areas such as Pune or Bangalore. The majority of young women not from Mumbai moved to the study area either at marriage or after marriage when their husband became more economically stable in Mumbai. A small number (approximately 5-10%) of women immigrated to Mumbai as children with their parents.

Natal family composition and dynamics

The family and household structure are changing in India, particularly in urban areas. The constraints of space, the mobility of families, the search for economic stability, costs of raising children, and the reduction in fertility is contributing to a reduction in joint and extended families and an increase in nuclear families (Singh, et al. manuscript in preparation; Gupta 2005; Luke, et al. 2004; Niranjan, et al. 2005). In the study area, the great majority of girls (83%) grow up in nuclear families with both parents. If one parent was absent from the family, it was more often the father—3% grew up without a mother present in their natal family and 17% who grew up without their father in their natal family. The three instances in which a girl's mother was absent were because the mother had died of illness or in an accident when the girl was young. There was one woman who said that her mother left her family when she was very young and did not know why. The fathers who were widowers all remarried and the women stated that they had few problems with their stepmothers. As one woman said, "My stepmother treated me the same as her own daughter." The main reason for a father's absence was typically death due to illness or an accident, although a few women stated that their father's alcohol use or general unreliability rendered him absent from their families.

The absence of a father was a very de-stabilizing force for girls in the study area. Fathers are the primary breadwinners of the household and are generally the family member tasked with arranging marriages for children in the family. The loss or absence of a father places a heavy burden on the rest of the family.

Widowhood is a very difficult status for women in India. Widows are traditionally required to wear white and withdraw from society, as they are viewed as "bad luck". As a result, most widows in India have traditionally been unable to remarry. The rules regarding widowhood have loosened more recently, and widows are no longer as isolated or as socially ostracized, but it is still uncommon for a widow to re-marry (Lamb 2000; Mohindra, et al. 2012; Kadoya and Yin 2015; Chen 2008; Agrawal and Keshri 2014). Once a woman loses her husband, she is reliant on her natal family and/or herself, as her husband's family is less likely to continue the residential or support relationships of their son's widow or his children. One woman explained how her life changed after her father's death, "After my father died, my mother started working, sweeping out the office buildings. She brought us up by herself. Life was very hard and sad in my natal family."

Young women who grew up without one or more parents were more likely to live with extended family members such as aunts, uncles, and/or grandparents. One woman described how her father's alcoholism led her parents to stay separate intermittently, but that her grandmother would provide food and money for her and her siblings when needed. Another woman moved in with her uncle's family when both her parents died in an accident.

The siblings of the survey respondents ranged in total number from zero to twelve, with a mean of 3.7 siblings. Most young women had at least one brother and male siblings ranged from 0 to 7 (mean 1.8) and the number of female siblings also ranged from 0 to 7 (mean 1.9). The majority of young women in this study were the eldest in their families (35%), however there were many young women who were the second (25%) or third-born (22%) or who were the youngest. When young women lived with extended family members, they most often lived with their grandmothers (76% of joint families), followed by uncles (60%), cousins (56%), aunts (52%), and grandfathers (32%).

Most women describe their natal families as loving and caring, with young women feeling closer to some family members than others. Women who were the youngest in their families felt close to all their family members, because the youngest is often "given everything" and less is expected of her. Unless a girl's father drank, was abusive, or absent, most young women had positive relationships with

their fathers, but did not describe being particularly close to them in terms of sharing personal information or asking them for advice. However, there were three women who described their fathers as more sympathetic and a confidante. There were three girls with abusive fathers who they feared and avoided communicating with them. Generally girls felt slightly closer and more comfortable discussing problems with their mothers. However, most women said that they could not really discuss their friends or neighborhood gossip with their mothers. Girls also felt shy about asking their mothers about topics like menarche, marriage, sex or reproduction. Some girls did not feel comfortable discussing anything with their mothers, because they felt that their mothers were too strict and uncaring. One woman said, "My father is very good, but my mother gets annoyed. Sometimes, if we didn't do enough work in the house, my mother would get annoyed…and scold us… and then my father would tell my mother, 'Why do you get annoyed? You shouldn't scold them.' So, my father scolds my mother when she scolds us."

Girls described having a positive relationship with sisters and/or aunts closer to them in age, even if their aunts did not live in the household. Sisters and aunts were the adults that girls could go to with community or school problems. Sisters and aunts were also the most likely to provide girls with information on menses, marriage and sex. One woman described her relationship with her aunt,

> I was very close to my *mosi* [aunt], because she loved me the most…I would talk to her about my tensions. Because, my father would drink, and he would hit my mother, and then he would take all the money from the house, and I didn't like this. So, I wanted to tell someone about this, and I thought my *mosi* was the right person to be open to. (19 year old Buddhist woman, 7th standard education, married at age 18)

Girls do not feel as close to their brothers or uncles. Although most girls state that they get along well with their brothers, they did not share much personal information or rely on brothers as trusted confidants. There were a few girls for whom this was not the case, and they would discuss everything openly, including boyfriends, with their brothers. For another subset of girls, brothers were a source of tension, particularly when they were not behaving in accordance with parental rules and expectations or when girls felt that their family treated sons better than daughters. For approximately 10% of young women, brothers, uncles, and in a couple of instances grandfathers, served a more regulatory function by restricting her mobility, who she can talk to, dictating whether she can attend school and when she gets

married. Brothers and uncles more commonly take on this role in families where the girl's father is absent or unreliable, although there were a small number of girls who had restrictive male relatives even in the presence of their father. Some girls accepted the control of their male relatives; however several girls described a strong dislike for these relatives and relief when they were no longer under their control. Girls typically feel a lot of affection and support from their grandmothers, but are least likely to confide in them or ask advice from them. For girls in more unstable natal families, grandmothers provided a great deal of emotional and financial support. Women rarely had anything to say about other family members, such as cousins or in-laws from married siblings. Overall, parents and female family members were described as the most important familial relationships for girls.

Economics of the natal family

Although the term "slum" conjures images of severe poverty and deprivation, there is much economic diversity in the study area and in the economic conditions women describe in their natal families. While women had little idea of natal household income, issues of finances were discussed in all of the interviews. Financial conditions often had ramifications for a girl's educational opportunities, how she was treated relative to her male siblings and family members, and the timing of her marriage.

Many girls (52%) described feeling a great deal of anxiety over their natal family's financial condition, and 18% of the girls experienced some level of food insecurity in their natal families. Girls who experienced food insecurity described going to bed hungry and observing their parents going without food as well. A few of these girls also felt that, during periods of food insecurity their younger and/or male siblings would get a greater share of the limited resources. Girls growing up in families with more financial problems also described how they limited any requests to their parents, or described feeling guilty whenever they asked their parents for money for school or personal needs.

In families with more economic problems, the father either did not work or was underemployed in such jobs as daily wage work, auto-rickshaw and local driver, zari work, rag picking, selling fruit, and working on a farm or in a factory. In these families it was more common for mothers to work as maids, rag pickers, fruit and vegetable sellers, or zari workers. In these lower income families, it was also more

common for girls and their siblings to work, typically in similar income-producing work as their parents. In the sample, 39% of the young women worked before marriage.

Some girls felt that their siblings, particularly male siblings, did not do enough to improve the family's financial condition, increasing the burden on themselves to find work that would help support the family. Typical income-producing work for these girls were as zari/tikli workers, maids, factory workers, farm laborers, or daily wage work such as fetching water. One woman described the impact of her family's financial problems:

> My father died, so my mummy was the only one to look after us…so I thought I should stop going to school, so I could go to work with my mummy and help her. My mummy didn't want me to leave school, she wanted me to study at least until the 10th standard. She told me I work hard for you to pay the school fees and for everything, so you shouldn't have to leave school. She cried a lot… But, my mummy got my two sisters married, first one and then 6 months later, the other one. So, my mummy had a lot of loans, and I asked her how I should keep studying when you have all the loans? You will have to sit on the road trying to pay back all these loans and keep me studying. So, I took the decision to leave school and go to work as a maid to help my mummy. (23 year old Hindu woman, 9th standard education, married at age 17)

Other girls (approximately 15-20%) grow up in more comfortable families with fewer financial constraints. Girls from more comfortable families have fond memories of being well cared for in their natal families. Fathers in these families tend to have more lucrative work such as running small factories, working for the Mumbai municipal corporation, owning a successful farm, or doing skilled craft work such as carpentry or painting. Mothers in these families tend not to work, or work in positions requiring more education such as for NGOs, as a nurse, or as a teacher. In families with more resources, girls and their siblings are not required to work prior to adulthood. If children from more well-to-do families do work before adulthood, they tend to work in more skilled positions, such as teaching, doing data entry or secretarial work, working as a sales girl/boy in a shop in a mall, or working for large cell phone or technology companies. As one woman from a more affluent family stated, "In my natal family, I could have anything I asked for. My parents had no problems providing me with anything I asked." Girls from families with more financial resources did not describe concerns about asking their parents for personal

pocket money or money for school-related needs. Other women described themselves as being "middle-class" where money was not necessarily a problem.

For a subset of families that had fewer financial resources parents might privilege sons over daughters, believing that sons will ultimately do more to improve the family's financial condition. During interviews, women also stated that when families have limited economic resources and less gender equitable beliefs, sons are allowed to stay in school longer. Girls also felt that their brothers were more likely to attend private English-medium schools, whereas daughters attend public Hindi or Marathi medium schools or madrasa schools. During in-depth interviews, women described how their brothers were rarely held accountable for their whereabouts or actions, whereas girls in their families were all required to provide their parents with full reports when they returned home of how they spent the day. One girl described the different expectations of young men and women wanting to work:

> Girls aren't treated equally…If a boy wants to go for a job, he can go freely with no questions asked. If a girl wants to go for a job, she has many questions and rules about when she can go and work and who she will meet and when she will come home.

Young women described how, when resources were limited in their families, their brothers were often provided with more due to the perception that the boys in the family are more likely to lift the family out of poverty. Traditionally, boys are the ones to care for parents in their old age, because girls would move to their husband's family and care for his parents.

Gender norms in the natal family

Key informants stated that, historically, most families in the study area adhered to patriarchal norms in which young women did not receive the same care and attention as their brothers and were prevented from accessing educational and social opportunities. However, key informants also stated that gender norms and the position of women in the community have undergone some changes. One of the biggest changes cited by key informants is that many parents now feel that daughters are just as valuable as sons and should be cared for and educated accordingly. As one NGO worker stated,

> It used to be that parents thought their sons would look after them the best and daughters would leave them. Parents didn't educate their daughters because they would say, why water someone

> else's garden? But now, parents see that sons are not always so helpful and will go stay separate with his wife. Now, parents feel that daughters will look after them better, so they are educating them more.

Some young women explained that their families felt very strongly about treating all the children in the family equally. Equal treatment in these families meant that young women could pursue educational and/or employment opportunities to the same extent as their brothers. In addition, families with more gender equitable norms tend to treat their daughters and sons the same way in terms of household responsibilities, rules and mobility, healthcare, and food distribution. This equal treatment means that girls in more gender equitable families were typically allowed to move more freely in the community, were allowed to have friends and create and maintain a larger social network through participation in activities and cell phone use. In the survey sample, 41% of the girls had access to a cell phone before marriage and used the cell phone to talk to non-family members on a regular basis. As one woman explained, "I could go wherever I wanted to. My parents trusted me, so they didn't give me any rules." These girls were also more likely to be allowed to participate in extracurricular and job-training activities such as NGO programs, dance classes, tuitions (private tutoring), tailoring classes, beauty parlor and mehndi classes, and computer classes. Girls most frequently participated in sewing/tailoring classes (41%), mehndi classes (26%), youth mandals/clubs (11%), beauty parlor/beautician classes (11%), tuitions (tutoring) (10%), NGO programs (9%), religious groups (6%), computer classes (5%), informal cultural groups, such as dance classes (3%), and political parties (1%).

Gender equitable norms and behaviors were more common among families with more resources, as there was less need to make decisions about how to divide resources among family members. However, some girls with more gender equitable parents who had less resources, nonetheless described how their parents' lack of education made them prioritize their daughter's education and preparation for life beyond her natal family. Young women from such families stated that their parents wanted to make sure their daughters could "stand on their own feet" after leaving their natal family. It is also important to note that there was a small subset of young women who grew up in families with positive gender norms,

but due to parental concerns about anti-social elements in the communities, they had more educational opportunities but more limited mobility and smaller social networks. These young women were treated equally to their brothers, but their parents' concerns over violence in the community meant that none of the children in the family could do much socializing outside the family.

There were also many girls growing up in families with less equitable gender norms and practices. These families tended to provide their sons with more opportunities and resources and expect less from them in terms of rules and housework. Girls in these family settings often had very restricted mobility and were generally not allowed to attend school for very long or participate in extracurricular activities. As a result, they tended to have much smaller or non-existent social networks, largely due to restrictions on speaking to people outside their family. Their social networks consisted of family members, like siblings or aunts. One woman described the rules she had to follow in her natal family thus, "In my family, if you want to talk to people, you can only talk to girls. If you want to go somewhere, you can only go with your parents and no one else...I had a few friends, but I couldn't talk to them."

More patriarchal families had fears about dangers or negative elements in the community. Parents' primary concern was that their daughters might be raped, which would affect both the marriageability of the girl as well as the *izzat* (honor) of the family. Parents were also concerned about gossip that might be created by an unchaperoned girl moving freely in the community. Even if a girl did not have a boyfriend or engage in a pre-marital relationship, community gossip suggesting otherwise could be enough to damage her reputation and marriageability.

Eve-teasing and violence was a concern for many young women; 16% of the young women in the survey experienced eve-teasing. The most common sites of eve-teasing were locations within their communities such as the road near the bus depot, markets near their home, and public toilets. In addition, 27% of the young women stated that eve-teasing was a major source of tension before marriage. The fears of girls and their families about the community and public spaces in Mumbai were amplified by community perceptions of increasing violence as well as media reports of violence and TV news and

serials portraying violence against women as a common occurrence. As a result, some families greatly restricted their daughters' mobility and social activities.

Another perspective expressed by key informants and women was the fear that parents had about the ways in which the community is changing and becoming populated with more rebellious girls who might lead their own daughters astray. Women stated that their parents restricted their interactions with other girls out of fear that their daughters might learn bad habits or become more rebellious. One woman explained, "There are different types of girls. You can't say who is acting one way or the other. My parents didn't want me to join them and do anything wrong, so they restricted me in going with my friends or anywhere."

There were also some girls who grew up in families with gender inequitable beliefs, but they sought their own opportunities and social networks without their parent's knowledge or support. Although the families had more patriarchal beliefs, the parents might be absent from home more often due to work or other reasons, and therefore might not be able to exercise as much control over their daughters. In these instances, girls sought out larger social networks through the activities that they were allowed to participate in such as school or occupational classes. They also tried to pursue as many educational and/or extra-curricular and work opportunities for as long as they could. By rebelling against parental rules regarding mobility, socializing, and school or work, these girls embraced media images of what it means to be a "modern woman" in terms of having boyfriends, "hanging out" with friends, working outside the home, and wearing more Western attire.

Media consumption was also an important aspect of socialization that many girls discussed and shared with their friends. Although only 3% of the young women in the study had access to the internet before marriage, 52% had access to a cell phone, and 82% had access to television and/or films. Girls were also typically making their own decisions as to what types of media they consumed, with 60% stating that they were the ones who decided which TV shows and films they would watch. TV serials were mentioned by almost every woman who had access to a television before marriage. Women described how they would watch TV serials with their friends and later discuss what had happened in

each show. The most common serials women mentioned were *Crime Patrol* (presents dramatized accounts of crimes that have occurred in India), *Pavitra Rishta* (focused on a couple and their families in Mumbai), and *Yeh Rishta Kya Kehlata Hai* (about the lives of a couple who had an arranged marriage and their extended family members).

Crime Patrol was a particularly influential serial for both girls and their families. Girls enjoyed it because as one woman stated, "you get a lot of information from that serial. You get a lot of information about how to not trust strangers, don't talk to unknown people, all these things I learned from that. That's why I like that one the best." Women stated that when their parents saw *Crime Patrol* it made them more concerned about the possibility for rape and violence in their communities. Many of the other serials girls watched deal with dynamics between husbands, wives, and in-laws. Women described how they enjoyed watching these shows and discussing the proper behavior for a wife and daughter-in-law with their friends. Women said they talked with their friends about whether or not the character's behavior was appropriate and how they might act in a similar situation.

In general, women reported little violence in their natal families, although violence may be underreported due to the stigma attached to discussing domestic and child abuse and the high threshold for physical violence. A few women described instances in which their father would beat their mother, usually due to the father's alcohol use. Many women described being slapped by their parents for "back answering" or other types of disobedience, however women did not feel that being slapped was a form of violence. A few women stated that their uncle or brother had hit them for speaking to people outside the household or not wearing a head covering, but these instances were uncommon. Women's reports of more extreme instances of violence, such as beatings, were also rare. More extreme violence in the natal family was nearly always associated with a girl engaging in a relationship with a boy before marriage and/or being the subject of community gossip.

Education

Schooling played a major role in the life trajectories of girls. Departure from school often signaled a key point for girls when they began working for income or their families initiate the process of

arranging a marriage. The mean educational level of the women in this sample is 6.4 years. Girls experienced a great deal of *tenshun* regarding the ability to continue their education or not (42%). In both the qualitative and the quantitative samples, there was a subset of girls who either attended very little school or did not attend school at all leaving them illiterate (17%). A small subset of girls studied up to the 10th standard (12%), and an even smaller number of girls studied past the 10th and continued studying after marriage (7%). The majority (73%) of girls in both the qualitative and quantitative samples left school early in adolescence, typically in the 6th to 8th standard at 12 to 14 years of age.

The most common (29%) reason for leaving school early was the family's limited financial resources. Even though public education is supposed to be free for all Indian children ages 6-14, there are typically hidden costs associated with education such as uniforms, books, supplies, and transportation. In addition, free education beyond 7th or 8th standard was not available in all communities.

Financial problems are compounded by problems within the family, such as an absent or ill parent (7%) or multiple siblings. When there are multiple siblings, particularly multiple brother, girls might be encouraged to cut their education short so that they could work outside the home (11%), help with household work (27%), take care of younger siblings and give their siblings the opportunity to receive some education. The relationship between number of siblings and education is supported by a negative correlation between number of siblings and age at leaving school, indicating that as the number of siblings a girl has increases, the younger she is when she leaves school ($r= -.206$, $p<.05$). One girl explained,

> …after the 7th [standard], you have to go to some other school, and pay money. My father was not well, and it was not possible for my parents to pay. That doesn't mean that I didn't tell my parents that I wanted to study. I told them I wanted to stay and study. But, my mother told me, 'See, we have problems in the family, and how can we allow you to study?' (19 year old Muslim woman from Mumbai married at the age of 17)

Some of the girls (18%) described feeling uninterested in school due to being distracted or having difficulty with schoolwork, upset at being older than their classmates due to lapses in their education caused by illness, immigration to Mumbai or familial problems. One girl explained that she left school, because she was in the 8th standard but could not read. When these girls became disinterested in school

and chose to stop their education, they frequently did so with little protest from their families. One girl described her rationale for leaving school, "My parents got me admitted to school when I was 7 or 8 years old. But, I felt bad, because I was so much bigger than the other children in the class. So, I didn't want to study, and I just didn't go to school."

Concerns about the possibility for eve-teasing or violence was another major reason why young girls' parents or other family members removed girls from school (14%). Parents were very concerned about their daughters traveling to school, both due to the possibility of violence or eve-teasing that may occur while traveling, as well as the possibility for community gossip about a mobile girl that might damage of the *izzat* (honor) of the girl or her family. Both girls who were raised in Mumbai as well as girls raised in more rural areas cited dangers in the community as a rationale for leaving school. Only a few of the girls who cited violence or dangers in the community as a reason for leaving school actually experienced eve-teasing, yet the possibility for violence, was a powerful deterrent of traveling for education. As one girl explained, "My mother and father were staying in the village, and there was no one to accompany me to school, so I had to leave school."

There are a small number of young women who did not attend school or left school early due to their family's gender norms regarding women's education. Some families (5%) felt that young women should have their mobility restricted, particularly after menarche, as "girls who go out of the house will get spoiled", menarche was viewed by some families as the point at which a girl becomes an adult. There was also a small subset of families (11%) who felt that young women should not have more education than their husbands and should leave school upon marriage. There was another very small subset of families (less than 1%) in which male relatives felt that girls should simply not be allowed to receive any formal education.

Health problems before marriage

Women described having a number of health problems before marriage. Most of the health problems that young women reported prior to marriage were associated with menstrual cycles or the onset of menarche, including backaches (46%), headaches (64%), cramps (61%), loss of appetite (41%),

irregular cycles (30%), excessive bleeding (38%), and fatigue (28%). Some girls also have non-specific vaginal complaints such as white discharge (25%) and vaginal itching (15%). Girls also experienced more serious illnesses and health problems before marriage including anemia (21%), malaria (19%), tuberculosis (5%), and typhoid (2%). Despite these health problems, young women had limited access to healthcare or treatment to address these problems. Other than malaria, TB and tuberculosis, young women did not often receive treatment or healthcare for most of their health complaints. Both key informants and women themselves stated that unmarried girls in the community, especially if they were not in school, rarely received healthcare after the age of five unless they had a serious illness.

Menarche

Unlike many cultures where girls are given information about menses before menarche, women in this study reported that there was little preparation for menarche. Girls were given strict instructions as to how they should behave, but were not given any information or warning before menarche. Some schools provided information on menarche in health classes in the 8th, 9th, or 10th standards, but most young women were surprised and upset by menarche as described below.

Menarche has traditionally had great cultural significance across India, both as it signals a girl's entry into adulthood as well as the onset of specific menstrual-related rules and practices that a woman must follow. Historically, when a girl reached menarche, she was viewed as eligible for marriage. At this point, it becomes important for both the girl and her family that she, "not be spoilt" and that the woman and her family's *izzat*, or honor, be maintained. If a girl's reputation becomes damaged, then this also damages her chances for marriage, her sisters' chances for marriage, and the reputation of the whole family. Menarche has traditionally been a key transition point as the girl's family members attempt to protect the young girl's *izzat* by limiting her mobility, withdrawing her from school, forbidding her from speaking with people (particularly men or boys) outside the family, and requiring that the girl not leave the house without wearing an appropriate covering (such as a *burqa*, *dupatta* over her hair, and/or *hijab* and *niqab*). In addition to the new daily rules and restrictions, girls have also traditionally been required to observe additional rules during their menses. As a menstruating woman is seen as unclean, these

additional rules are intended to prevent a menstruating woman from polluting the home. More specifically, a menstruating woman is not supposed to cook, touch cooking or water vessels, touch religious items (such as statues of gods/goddesses or the Quran), and must sit physically separated from the rest of the family for the duration of her menstrual cycle.

The ways in which young women experience menarche and their menstrual cycles are undergoing many changes. The changing nature and variation in menstrual practices are reflected in the experiences of the young women in the study. The average age of menarche for the young women in this study was 13.3 years old (range: 10-18 years old), and all of the women in the study had reached menarche at the time of the interviews and surveys. The majority of the women in the interviews (90%) stated that they didn't know anything about menses, and there were numerous stories of young women feeling scared and confused when they started menstruating. As one girl described, "I didn't know anything. I had gone to the bathroom, and I was passing urine. And, all of a sudden there was blood. I was worried, I was like, what is this? I started screaming for my mummy. And, then my mummy came and asked me why I was screaming, and I pointed at the blood, and said see what has happened." Girls typically told their mothers, aunts, or sisters when they started menses and asked them for information and advice. The information that young women receive from these sources was typically vague; young women are told that they will have their menstrual cycle every month, they should use pads or cloths, and young women are told whether or not they will have new rules and restrictions. Several young women said that all their mothers told them about menses was that it meant, "now you are all grown up." The rest of the young women had heard about menses from teachers at their schools, typically in the 9th or 10th standard. These young women felt more prepared and they described less traumatic first experiences with menses: "I knew about it, because the school gave us information about it…The first time, I was in the village...I came home and told my mother about it. She arranged some cloths for me, and gave them to me."

Seventy-three percent of the girls in the sample had new rules and practices upon menarche. The most common rule (72%) was that girls were not allowed to touch religious items during their menstrual cycle. This was not a particularly onerous restriction for young women. As one Hindu woman explained,

"I did everything, all the work, I just didn't touch the gods and goddesses." The next most common (26%) rule was that after menarche young women had to wear a *burqa* or *dupatta* over their hair whenever they left the home. Girls did not have much to say about the requirement that they wear these coverings. Another change many girls (22%) experienced was having their mobility restricted. Several girls found that, after menarche, they were not able to spend free time "roaming around" with their friends but instead had to spend more time in the home. A smaller group of girls were told by their mothers and female relatives that when they were menstruating, they would have to "sit separately" from everyone else in the household (13%), and that they would not be allowed to cook or wash cooking vessels (14%). The reason for these practices was rarely made explicit to girls, but they felt that they were isolated to prevent them from dirtying things in the home. There was also some variation in the menstrual practices and restrictions followed, as some girls were required to sit separately, but allowed to cook, and other girls were not required to sit separately and were not allowed to cook. Some girls stated that their mothers needed them to help with household work and could not afford for them to practice traditional menstrual isolation. As one woman explained her menstrual regulations:

> I was not supposed to go near the Quran. I also couldn't go near the foodstuffs, because my mother told me that if I did, they would spoil. There are some other holy books that I wasn't allowed to touch. I wasn't allowed to touch the pickle container, because my mother told me that if I touched it, it would spoil. She said, if you want any food, just tell someone, and they will get it for you… One of my uncles was a baba [religious practitioner], and they don't want anything from women who are menstruating. So, what my mother would do is, she used to say, 'I won't let anyone know that you have prepared this.' And, then, she would have me still prepare food. My mom used to say, 'Every month, you'll be menstruating, and every month, it will be a problem for getting the work done.' So, she just wouldn't tell anyone that I was still cooking, and nothing bad ever happened.

Additional regulations that young women described included more household responsibilities (9%), not being allowed to speak to anyone outside the family (7%), and very infrequently, being withdrawn from school (2%). Female family members told young women that these restrictions were necessary because the girl was now "grown up", and could not risk speaking to boys or being seen unchaperoned outside the home. Although most girls were not required to follow all menstrual traditions and restrictions, strong

correlations between all the restrictions indicate that if a girl practices one restriction, she is more likely to also practice others.

Some women also described special ceremonies or *poojas* (prayers) that were done for their first menstrual cycle. In these ceremonies, *kumkum* (ceremonial powder typically made of turmeric) was applied to their foreheads, flowers might be put in their hair, prayers would be said, and mothers would tell girls this would happen to them every month. For other girls, menarche and subsequent menstrual cycles were marked by being given and eating special foods, such as dried fruits and nuts. These ceremonies, special foods and the requirement that girls not do household work during menses were explained to girls as a way for them to have rest and be relaxed and pampered during menses.

However, women often described feeling "*gande"* (dirty), comfortable, and embarrassed by the practices they were expected to follow. As one woman said:

> I wasn't allowed to cook when I was menstruating. When I couldn't do the cooking, my mother would do it. For 5 or 6 days, when I had my menses, I had to sit aside from everyone.
>
> [How did you feel?] I used to feel unrest. It was very embarrassing for me. I had my brother there and I had my father there. I used to wonder why this would happen to me every month, and it would make me feel so embarrassed…I never felt good about everything I had to do when I had my menses. My family used to serve me food and everything during my menses, and I didn't like that. But, what can I do? Those are the rules, and you have to follow them. There is nothing else to do.

These feelings of embarrassment and uncleanliness also impacted women's dietary habits during menses. Approximately 10% of the women stated that during menses they ate significantly less, because they felt that their hands were too unclean to touch food. Some women felt that using cloths (instead of pads) made them feel even dirtier, as described by this woman: "In the beginning, I used cloth, and recently, in the last 2 or 3 months, I started using pads. When I used the cloth, I used to feel all wet, and I would feel dirty about it, so I wouldn't want to eat…now I eat when I menstruate. Now, I use pads, and I feel drier and not so dirty." Other young women stated that they felt dirty and experienced loss of appetite regardless of whether they used pads or cloths.

For the remaining 27% of the young women, there were no new rules or traditions associated with menarche that they had to practice. Researchers have noted that as women move to urban areas and

increase their participation in the workforce, families cease requiring women to sit separately or not cook during menses. Young women did not know why their parents did not place any restrictions on them, they just simply stated that they did not have any additional rules after menarche, nor did they have to practice any of the traditional exclusions during menses. One woman said, "In Mumbai, people don't have any rules for menstrual cycles, but in the village they do."

Girls suffered from a number of menstrual-related health problems, such as abdominal cramps, headaches, and backaches. Several young women stated in interviews that their mothers would not allow them to take medication or obtain healthcare for menstrual-related problems. Young women explained that their mothers believed that treatment for menstrual-related problems leads to dependency on medications and/or worse problems during future menstrual cycles. As one woman stated, "…my mother wouldn't let me take any medicines for it [menstrual cramps]. She said that if you take medicines the first time, you will get in the habit and take medicines every month."

Menarche, is traditionally seen as the point at which families and communities believe that girls have become mature. Although some girls and their families wait years after menarche to arrange a daughter's marriage, menarche is the point at which girls start looking ahead to lives beyond their natal family.

Key Variables from the Natal Family

In the natal family, the three key variables that emerge are natal family economic status, natal family gender equity behaviors, and natal family agency. The economic status of the natal family uses food security and women's tensions over family finances as proxies for the natal family's economic status. Natal family gender equity is defined as behaviors the girl experienced in her natal family in which her male family members were favored over the girl. Gender equitable behaviors included allowing the girl to attend school as long as male relatives, providing the girl with the same nutrition and healthcare as male relatives, and giving the girl the same rules and responsibilities as her male relatives. Natal family agency is a measure of the girl's agency that she develops before marriage. Agency is defined as free mobility to different locations within the neighborhood; ability to be involved in decisions regarding her

life such as schooling, timing of marriage, working for income, media consumption; ability to choose how to spend money; and ability to talk to non-family members. These variables will be discussed further in the next chapter.

The Transition

The process of getting married marks a major transition for young women, as she goes from the recognition that the process of entering into marriage is starting, with steps that include negotiations with a prospective husband and his family, determining the dowry, to the preparations for the wedding, to the wedding ceremony and "first night", to the early months of adjustment to the new family. Each of these steps is highly variable, depending on the type of marriage as well as the individual characteristics of the girl and her family. Studies conducted in two prior community surveys (2002 and 2006) found that 90% of marriages were arranged (Bojko et al., 2010). In this study, 66% of the women had arranged marriages and 34% had love marriages, which may indicate a shifting trend. The age at marriage for the women in this study ranged from 12 years old to 24 years old.

The first part of the marriage process was the family's readiness to have their daughter become married. For some girls, their recognition came with the beginning of menarche: "…when I first got my menstrual cycle, I thought, now my parents will be getting me married." Other girls were informed by their parents that when the girl reached a certain age, finished or was withdrawn from school, her marriage would be arranged. For other girls, the realization that they were getting married is very sudden, and only occurs when a girl hears her parents discussing arrangements for her marriage, as happened to this girl: "In our religion, they don't ask us if we want to get married. My mother and father were talking about my marriage, and so that's how I knew about it."

Boyfriends and other interactions with boys

Boyfriends have traditionally been forbidden for girls in India. In fact, there are no words for "boyfriend" or "girlfriend" in Hindi, and people use the English words when discussing these relationships. However, as noted by both young women and key informants, having a boyfriend or girlfriend is becoming increasingly common among youth in India and in the study area. Almost 40% of

the girls in the study had boyfriends and/or had friends with boyfriends, and interactions with young men as potential romantic partners was another key part of their transition out of their natal families. These pre-marital relationships were largely non-physical. Young women described going to restaurants or the malls with their boyfriends, but rarely admitted to any physical intimacy. Girls with boyfriends had varying expectations for these relationships. Most girls had hopes that they would get married, but due to the boyfriends moving away, becoming involved with other young women, or having their marriage arranged, these relationships did not last. For most of the girls, marriages subsequent to having a boyfriend that were arranged by their parents did not pose a problem. One woman explained her relationship with her boyfriend:

> I had a boyfriend, and the boy used to stay right by my house. He was a worker in a small factory. But, when he was not well, there was no one to look after him here, so he went back to his village. While he was back at his village, his parents got him married. He didn't tell me or call me. I didn't try to call him either. My husband knows about this affair…My husband used to stay near to where I lived too. We played together, we went to school together, and we left school together. He has loved me since we were small. When the other boy went to his village, my husband said, "If he is gone, then I will marry you." …my husband and his relatives had gone to my parents and told them that, "We want to get him married to her." And, my parents were fine with it, and we got married. My husband was very happy when they decided to get me married to him. But, I wasn't happy…I was very sad. I would remember the other guy who I loved, and that's why I wasn't happy. But, now I am happy with my husband. (22 year old Muslim woman, 5th standard education, married at age 20)

Other girls did not have boyfriends, but heard a lot about boyfriends from their friends. Girls would offer their friends relationship advice such as good times to go meet their boyfriends without their parents finding out. Some girls also acted as messengers, relaying verbal messages or letters back and forth between the couple. One girl even helped her friend write "love letters" to her friend's boyfriend. Although girls enjoyed gossiping about their friends' relationships and offering advice, they were happy not to have the hassles associated with a boyfriend. One woman explained:

> My friends used to go out with their boyfriends from 2-4 in the afternoon, because that's the tuition time. They would bunk [skip] their tuitions, and go with their boyfriends. I would suggest to my friends that, if you want to go out somewhere, why don't you go out in the evenings? You should bunk your tuitions, and go out in the evenings. In the morning, from 7:00 to 12:30 you have school, and then after that, people go for different types of classes, like Arabic classes, and so you don't have any time. The tuition time is the best time to meet. They didn't always listen to me, but that's what I would suggest.

> Interviewer: When you had so many friends with boyfriends, did you ever think that you should have a boyfriend also?
>
> Participant: No, I didn't think of it, because the boys ditch a lot. When I was in the 5th [standard], one of my friends had a boyfriend who was working in a hotel, and he ditched her. They never get married, so it isn't any use falling in love with them, so I never felt like I should have a boyfriend. (15 year old Muslim girl, 9th standard education, married as soon as she turned 15)

Feelings about the transition

As girls began to realize that they were moving towards marriage, they had a variety of different emotions, ranging from excitement to sadness and anxiety. For girls who were confined to their homes, marriage represented an opportunity to get out of the house and escape the boredom of daily chores. As one woman explained:

> My uncle told my mother that there is a boy, and if she wanted to see that boy, then she could. My mother told me about this. My mother didn't want me to get married so soon, but I decided that I wanted to get married, because what will I do sitting at home? I decided that it would be better if I got married. (18 year old woman, 8th standard education, married at age 17)

Some women described feelings of sadness when they found out they would be getting married soon and leaving their natal families. Many women said that they started crying when their parents told them they were beginning the process to get them married. The realization that a girl is ready to be married is also very emotional for parents, as one woman described:

> My father isn't well, so my parents had to think about how long they would keep me without getting married. So, they decided that it would be good if I got married. I was not happy with this. I had not seen my husband, and I was crying a lot. I told them that I didn't want to get married so early. But, then, my father started crying, and I decided that I should get married. (19 year old Muslim woman, 7th standard education, married at age 17)

Arranging the marriage

With an arranged marriage, it was very common for girls to feel anxiety over the selection process. Thirty percent of the survey sample stated that details related to the arrangement of their marriage were a source of *tenshun* for them. The women described feeling concerned over a variety of factors that included: the expense associated with a wedding, the dowry, and the type of man and the man's family.

The dowry was a primary concern for young women and their families, as a woman who brings an inadequate dowry can be at higher risk for harassment from her in-laws. Although dowry has been illegal since the early 1960's, anti-dowry laws have done little to stop the practice and there is evidence to suggest that dowry has actually become more widespread (see Van Willigen and Channa 1991; Srinivasan and Bedi 2007; Srinivasan and Lee 2004; Kodoth 2008; Dalmia and Lawrence 2005; Caplan 1984; Lindenbaum 1981). For the young women in this study, dowry was provided in 55% of the arranged marriages (dowry is not given in love marriages). Dowry almost always included household goods such as furniture, linens, pots and pans, and dishes. In some rare instances, the husband's family might also expect a larger item, such as a refrigerator or washing machine. Dowry also typically included some cash and/or gold, which ranged from 25,000 INR (approximately $416 USD) in cash and 5 grams of gold to 75,000 INR ($1,250 USD) and 15 grams of gold. While some girls worked before marriage and tried to save money for these expenses, other girls were unable to work or had to put their savings towards other household expenses or other siblings' marriages. As one woman stated, "My sister and I were so close in age and married so soon that my parents had a lot of *tenshun [tension]* providing everything necessary for both of us."

For families (both Hindus and Muslims) with limited economic resources, it was often desirable for a girl to marry "within the relations", particularly a father's sister's son, a more distant cousin, or an uncle as family members were more likely to waive the dowry or request a smaller dowry. Marrying a cousin has the added benefit of knowing more about the type of family you will marry into and feeling more comfortable with this family. As a result, marriages within the relations can be planned more quickly and with less expense as the families are already familiar with each other.

Families often tried to find a "suitable boy" from a similar background and native state, so that their daughter's adjustment to the natal family would be less difficult. Mothers even focused on making sure that their daughters learned to cook the types of food that in-laws may request. Families also made enquiries in the community or the native place (village of origin) to learn more about the reputation of the young man and his family. For many families, it was also important that the husband be several years

older than the woman (the average age difference between husband and wife is 5.6 years). Education levels of the prospective couple have also traditionally been an important consideration. Several key informants and women described expectations that a woman should not be more educated than her husband. Many young women also stated that they had wanted a husband with either the same amount of education or more education than them. However, in the study sample, 29% of the women had more education than their husbands and 17% had the same educational attainment as their husbands. The mean difference in educational attainment between husbands and wives was only 1 grade.

Many women were also concerned about the physical appearance and personality of their prospective husband, as they rarely had the opportunity to evaluate the prospective husband's personality or appearance for themselves. Often, the young man's family (usually mother, father and sisters) came to meet the girl and had her serve them tea and/or food she has prepared to evaluate her as a potential daughter-in-law. These meetings could include the prospective husband, but not always. Only 29% of the young women with arranged marriages met their husband before the wedding ceremony, and families would only occasionally provide photographs of the young man before the wedding. Even if girls had the opportunity to see their future husband before the ceremony, they rarely had a chance to speak with him during these meetings. Engagements tended to be short, with most lasting less than six months. As a result, there was also little time for the couple to get to know each other while engaged. One woman described her pre-marital meeting: "We saw each other, and then a week later, we were married. We didn't see each other in person, but he saw my photo, and I saw his photo. His mother and sisters came to see me, and they liked me, and said that I was fine for their son, and in a week's time, we were married." Although some women stated that they were satisfied marrying whomever their parents or families chose, most women with arranged marriages felt some anxiety that their criteria and expectations for a husband were not always perfectly aligned with their parents' criteria and expectations.

Love-cum-arranged marriages and love marriages

Couples who dated before marriage often had a love marriage. Love marriages come with unique preparations and anxieties. Most couples had to date in secret and then eloped. Girls were often

introduced to their boyfriends by friends or met the boy in their neighborhood. Spending time with a boyfriend was very difficult, as girls were constantly worried about being caught by their parents or neighbors. Girls and their boyfriends would frequently have to find places outside the community to spend time together. Girls often enlisted help from their female friends to provide an alibi or act as a chaperone, so that the girl was not spending time alone with a boy. One woman met her boyfriend through a friend who was in her tailoring class. The girl and her friend would meet their boyfriends before or after tailoring class, and the two girls provided excuses for each other's parents.

The potential for a love marriage is anxiety producing for both a girl and her family. Anxieties are primarily due to the fact that most couples who have a love marriage are boyfriend and girlfriend before marriage, a relationship that is rarely sanctioned by family or community members. Girls and their boyfriends ran the risk of alienating their families and losing the support of their families. As most newly married couples rely heavily on their families for financial and emotional support, the potential for estrangement is problematic for the couple, and especially difficult for the girl. If the girl is disowned by her parents, and her marital relationship becomes strained, the girl cannot return to her natal family for support. Love marriages also have negative ramifications for the girl's family. Families worry that if one daughter has a love marriage, then the whole family's reputation will be damaged, making it more difficult for other daughters or female relatives to get married.

One form of marriage that alleviated some of the potential tension for couples dating before marriage was the "love-cum-arranged" marriage. In this type of marriage, the young woman and man each spoke to their families and told their families about their relationship. The two families then tried to "arrange" a marriage to minimize community gossip and avoid damage to either family's honor. One woman explained that her and her husband told their parents that they were dating, and asked their parents to arrange a marriage. The parents did so, and the couple continued to have positive relationships with their families after the marriage.

Other couples felt unable to tell their families about their relationship, and decided that an elopement was necessary. Some elopements were unplanned, with the couple staying out too late one

night and deciding that an elopement was necessary to prevent further damage to a woman's honor. Other elopements were more carefully planned with the help of the couple's friends. If the woman's family found out that she is going to elope, they usually sent a male relative to try to bring her home. Otherwise, the newly married couple (particularly the woman) generally returned home to upset and panicked family members. Here is one woman's account of her love marriage and elopement:

> R: When my mother found out about my boyfriend, she was very annoyed. She used to say bad things about him…and then I was beaten by my mother…He [the boyfriend] was in the village for a year or a year and a half. My brother and mother started looking for a husband for me, but they didn't know that I was engaged with this other fellow, and that I wanted to marry him. My brother didn't get me married to any of the boys, because none of them had their own room in Mumbai. As soon as my husband came back to Mumbai, we ran away and got married.
>
> I: What did your family say? How did they come to find out about it?
>
> R: One of my friends also had a boyfriend who she was engaged with, so all four of us ran away, and got married. The same day, my mother and brother found out about it. They were searching for me all day, and my husband's friend called him, and asked him where he was, and my husband told him, that we were in Pune, and had gotten married…My in-laws were ready to accept me. The problem was only with my family. A few days after we got married, we came back to Mumbai, and directly, I went to my in-law house. My mother and auntie came and met us. When my mother arrived, she started yelling at me, and [verbally] abusing me, and saying that it was not good that I had run away and got married. But, my mother told me, you can come along home, and I will get you married to this particular boy again. That same night, my mother took me home, and then 18 days later, my mother got us married in front of lots of people. That made it a more legal process. (24 year old Hindu woman, 7th standard education, married at age 21)

The wedding ceremony

The type of wedding ceremony was highly variable and largely dependent on the type of marriage and economic resources available. Love marriages, due to their unsanctioned nature, tend to have very small, non-religious ceremonies. A love marriage ceremony often consists solely of a courthouse ceremony, although as described above, some families may have an additional religious ceremony afterwards to preserve family appearances. One woman described her marriage in the following way: "Because my parents wouldn't support the marriage, we just went to the courts, filled out some papers, and had it done."

Arranged marriages are often more elaborate, and depending on the financial status of the bride's family may entail multi-day festivities, with multiple outfits for the bride and groom, musicians,

fireworks, food for hundreds of guests, taking place in a rented hall or lawn. For families with fewer resources, wedding ceremonies are simpler, single-day events. Families also occasionally combined weddings to try to reduce costs. Some young women who married as adolescents did so, in part, because their wedding could be combined with the wedding of an older sibling or cousin. Specific details of the structure of the wedding ceremonies also vary based on religion and family's native place (i.e., a Hindu wedding ceremony for a couple from Karnataka will be slightly different than a Hindu wedding ceremony for a couple from Maharashtra). Most wedding ceremonies were documented by both video and pictures. Several women also described feeling exhausted and somewhat sad by the end of the ceremony as they anticipated leaving their natal family.

The first night

The "first night" is when a woman and her husband consummate their marriage. Due to lack of knowledge and experience, first nights have traditionally been very traumatic experiences for young women (Khan, et al. 2005; Bloom, et al. 2000; Maitra and Schensul 2002). There was only one woman in this study who admitted to having sex before marriage. Thus, for nearly all the women in this study, this night is the first time they ever engaged in sexual intercourse. Nearly all women described having some pain and discomfort on their first night, but otherwise, there was great variability in young women's first night stories. Not all couples have sex the first night they are married. Some couples waited to consummate the marriage until later, ranging from a few days after marriage to several months. A few women stated that their weddings lasted until late in the evening, and when they and their husbands arrived home, they just fell asleep. A few couples were married far away from their homes and had to stay in crowded rooms immediately after marriage, so space constraints delayed the first night. There were also a few women who married very young, and they either stayed with their natal families or slept with female relatives until they were deemed mature enough to sleep with their husbands.

There is also variability in women's knowledge and expectations for what will happen on the first night. Some women were told about the first night by aunts, sisters or friends. However, this information varied from very vague to more specific. One woman stated that her aunt told her just before her wedding

that, “If your husband wants to do anything, don’t ignore him, don’t say no. Just say yes to whatever he wants.” Some women heard from friends that they would have to sleep in the same bed with their husband and hug and kiss him, but nothing else. Other women received more specific information from sisters who were already married, friends with books about sex, or from health classes in school. However, women did not always understand the information they received or felt too embarrassed to discuss their questions about sex with friends or teachers. One woman explained, “It is a custom for someone older to tell you what happens after marriage, so my older sister told me about what happens on the first night. But, when she told me all this, I felt very shy and didn’t understand it all.”

With varying expectations and fears of what they would be expected to do, some women resisted sleeping with their husband on the first night. Husbands and in-laws had a variety of responses to this resistance. Some husbands talked to their wives about why sex is important and made their wives feel more relaxed. However, as one woman stated, this did not always work:

> The first day, we got married, and then we both came up here to our room. I was sitting here alone, and then my husband came. As soon as I saw him, I was frightened. I got up from the bed, and sat in the corner. But, he was so caring. He told me, “You have nothing to cry about. Every girl has to get married, and she has to go to someone’s house. So, don’t worry, don’t take any tenshun. I am here for you.”
>
> Interviewer: Did this make you feel better?
>
> Participant: No, I still didn’t have any faith in him. [Laughs] (21 year old Muslim woman, illiterate, married at age 20)

Other women tried to appeal to their mother-in-law or sister-in-law to avoid sleeping with their husband. This typically did not work, as in-laws told the woman that this was simply another part of marriage to which she must adjust. Some women yelled and tried to hit their husbands to keep them away, as described here:

> For 15 days, I didn’t allow him to touch me. I used to hit him when he would try to come near me. I didn’t know about this, so whenever, he would try to come close, I would hit him!
>
> Interviewer: What did your husband do? Did he hit you in return?

> Participant: No. He told me about everything very nicely and politely. He said, "Each girl and each woman has to go through this. " When he told me about everything so nicely, then I slept with him. (19 year old Buddhist woman, illiterate, married at age 16)

Although some husbands were understanding of their new wife's fears, other husbands were not. Many husbands also knew little about sex and had few sexual experiences before marriage. Previous work in the study area found that many men were told by their friends that if a wife resisted sex on the first night, she should be forced and will later appreciate her husband for forcing her (Schensul, et al. 2004). There were several women in this study who said that when they refused to have sex with their husbands on the first night, their husband simply forced them to have sex.

For women unprepared for the first night, they described crying and feeling embarrassed, and they often did not get much sympathy from others, as this woman found:

> My first night, it was so painful, and I cried so much. My husband told his mother about it and he was supportive and offered to take me to a lady doctor for the pain. But, my mother-in-law accused me of having sex before I got married and said that all my crying was just an act and I was just showing off. (25 year old Muslim woman, 7th standard education, married at age 17)

Women with particularly severe pain during and after sex stated that they wanted to go to a doctor but also felt too embarrassed to ask their husband to take them.

Despite many negative first night stories, a number of women described very positive first night experiences. Those women with more positive experiences typically knew their husband before marriage and/or knew more about sex and therefore felt more comfortable and less scared and confused. Women also described how their husbands took time to talk to them on the first night, rather than just trying to get the woman to have sex with him immediately. These elements can be seen in this woman's first night story:

> The first night when we came together, my husband told me that his family is good, and I would have no problems, and I would lead a very good life with them. I was happy with what he said, and I felt relaxed, because there was someone there to care for me, and who could understand me. I didn't have any problems the first time we had sex. (17 year old Muslim woman, 5th standard education, married at age 16)

These first night experiences as well as the experiences women had in the first couple months of marriage often set the tone for women's marital and sexual relationships.

Life in the Marital Family

Demographic characteristics of the marital family

After marriage, it is traditional for women to move in with their husband and in-laws and live in a joint family. However, due to space constraints in the urban environment and the fact that many young men move to Mumbai and leave most of their family members in their natal place, more couples are creating their own nuclear households (Singh, et al. manuscript in preparation; Gupta 2005; Luke, et al. 2004; Niranjan, et al. 2005). Some couples only resided with the husband's family in the early months or years of the marriage, and then moved to a separate household due to either space constraints or disagreements among family members. In general, couples with arranged marriages tended to move into a joint family at least in the initial months or years of marriage, whereas couples with love marriages tended to form their own households.

In the survey sample, 53% of women live in a joint or extended family and 47% live in a nuclear household. Family sizes range from two (just the husband and wife) to 13 people. For those living in a joint family, the most common types of family members are mother-in-law (45%), husband's siblings (39%), father-in-law (33%), and husband's siblings' spouses (15%). There were five women who lived with their natal family after marriage. For three of these women, this unusual living situation was a result of their husbands working outside India. For the other two women, they were having difficulties with their in-laws, and so their husbands and natal families agreed to live together. The size of the family and the composition of the family in terms of presence or absence of in-laws plays an important role in the development of communication within the marital relationship. For couples residing in nuclear families, the proximity of in-laws (within the same community versus outside of Mumbai) can also impact the marital relationship.

The economic situation of the marital family can be understood both in terms of the house size, household possessions, and husband's income (in-laws' incomes were not collected in the survey). Most houses are one room (mean home size= 1.4 rooms), although house sizes range from one to six rooms. Most households have a gas or kerosene stove (96%), at least one shared mobile phone (89%), and a

television (74%). Less common household items, indicating households with more income, include a wife's personal cell phone (49%), refrigerator (35%), washing machine (17%), and computer (6%). Using food insecurity as an additional proxy of economic status of the marital family, 13% of the women reported having ever gone to sleep hungry due to lack of food in the household, and 40% of these women had gone to sleep hungry in the last month. Even for women who did not perceive that their marital families experienced regular food insecurity, there were a significant number (30%) of women who would eat less at meals because there was not enough food.

The mean age of women's husbands was 27.24, and the mean education level of husbands was 7.4 years. Over half of women's husbands are born in Mumbai (65%), and the most common native states are: Maharashtra, Uttar Pradesh, and Bihar. The mean length of time husbands have lived in the study area is 17.29 years. The mean husband's monthly income is 8616 INR ($143.60 USD; standard deviation of 6141.62 INR)[1]. Most men (46%) work as salaried employees for private companies in shops or factories, as daily wage workers (24%), or as drivers (14%). These jobs rarely require men to be away from home (87%), although a small subset of men have jobs that require them to be away from home on a regular basis (13%). Fewer women work after marriage (23%). The most common jobs for women who work after marriage (23% of the survey sample) are sewing/tailoring (34%), zari/tikli work (20%), and domestic service (17%). The average income for these women is 2884 INR ($48.06 USD) per month.

Adjusting to the marital family

Women describe a range of emotions about making the transition from their natal families to the marital household. Other than receiving training on household chores and cooking, women state that they receive very little preparation for the roles and responsibilities of marriage. The lack of preparation for marriage means that the transition to the marital family is highly dependent on whether she is in a nuclear or joint family, and if she is in a joint family, then the degree of understanding and acceptance of the relationship of the in-laws to the junior wife. For women marrying into a relative's household or marrying

[1] Note that there were a few husbands working outside India, in the Middle East or South Africa, where salaries are much higher.

into a family with whom they are familiar, the transition tends to be a little easier. Women with more positive transitions described how their husband and in-laws were patient and understanding of mistakes made with housework or cooking. These women were given a chance to acclimate to household work before being given full responsibilities, as described by this woman:

> I didn't have to do any work when I got there. My mother-in-law did everything...But, after a year, year and a half, I realized what marriage is. I have to look after the family and the household work and everything. So, now I do more work. (18 year old Muslim woman, 3rd standard education, married at age 15)

Women with positive relationships with their in-laws also felt that their in-laws treated them like another daughter, rather than a junior or subservient member of the family.

The transition for women also tends to be easier when they either do not live with in-laws or the extended family household is smaller. A small subset of women who married particularly early (age 15 or younger) were allowed to continue living at least part-time with their natal family for six months to a year after the marriage, and were also given fewer responsibilities due to being considered "too young". For these few younger brides, this also made the transition slightly easier. One woman described her transition to her husband's family:

> [My in-laws were] too good, because I knew them from before… I am free to talk to anyone. My husband has no problem at all, my mother-in-law has no problem at all. I am free to take my own decisions… With my husband and my in-laws, I can communicate very freely. I have no burdens, no tensions at all. It is very easy to live with them. (19 year old Muslim woman, 10th standard education, married at age 18)

Women with relatively smooth transitions typically continue to have close relationships with their natal family, and return home to their natal families for vacations or their first pregnancy/childbirth as is customary. Overall, women who more easily make the transition to their marital families feel that little changes in their relationship with their natal families.

Other women have great anxiety about what their lives will be like after marriage, and have a very difficult time adjusting to their new family. One woman described her feelings upon marriage:

> …after a few days, it was hard. I wasn't used to wearing sarees, because here, I would always wear dresses or kurtas. But, my mother-in-law wanted me to wear sarees, because in the village, they don't allow married girls to wear dresses. Because, they want you to cover your head. It was very difficult for me to all of a sudden wear sarees. And, then there was always something

> between me and my mother-in-law…like we were never comfortable with each other… (18 year old Buddhist woman, 8th standard education, married at age 17)

The transition to the marital family can be complicated by several factors. The most common challenge is a mother-in-law and/or sister-in-law who is overly demanding, verbally or physically abusive, and treats the new daughter-in-law as a servant.

Many women often describe feeling uncomfortable in their in-laws' home, as they are uncertain of how to talk, dress, or perform the tasks required of them. As one woman described:

> …they used to torture me, like they would say, I am not able to wash the utensils properly, I am not able to wash clothes properly, I am not able to do this properly, I am not able to do that properly. Whenever I used to do any work, they didn't appreciate me.

This uncertainty of how to behave and perform the role of a proper wife and daughter-in-law is intensified for women who move from Mumbai to the village or vice versa after marriage. The new environment creates additional challenges for the bride as she may have to learn new ways of cooking and cleaning or may have to dress differently than she is used to (wearing sarees instead of kurtas or keeping her face covered). For women moving from Mumbai to a more rural area, in-laws express concerns that the woman will be "too fashionable", and will have expectations for a life that is not possible in rural areas. One woman described the many problems she had adjusting to her in-laws:

> It's so different. They even use different words for different things. It makes it very difficult, and I get so angry at my parents. I was born and brought up in Mumbai, so how could they marry me to a guy who stays in the village?...[In Mumbai] I cook on a gas stove. There, I have to cook over an open fire. They use cow dung to clean surfaces. That is very difficult. Here, you wash utensils with soap and water. There, you have to wash utensils with burned cow dung [charcoal]…In the beginning, it was very difficult for me, because it was all so new. I had trouble cooking on an open fire. So, everything I cooked would burn…My sister-in-law, who is 14, used to explain to me how I should cook. My sister-in-law helped me, and now I can do it…I have mostly adjusted. But, the happiness that you get from your parents, you don't get that from your in-laws. There are so many restrictions in my in-laws house. I can't raise my voice, or say anything because I have to think about what will happen if I raise my voice. In my parent's home, I didn't have to think. I could raise my voice. Because, sometimes, you don't feel like working or doing something…you can tell your mother, I don't want to do something. But there [in-laws house], you have to think ten times. That life is not as good... (19 year old Muslim woman, 7th standard education, married for only a few months at the age of 19)

Women struggling to fit into their new homes may initially be distraught, crying and refusing to do housework or other chores. These women may also refuse to sleep with their husbands after the "first

night". When a woman fails to adjust and refuses to act in accordance with her husband's or in-laws' expectations, then the woman's family will be called and her family will be scolded for raising a disobedient and unprepared daughter. As a woman explained, "If you do anything wrong, if you don't wake up early enough to do the work, then your mother-in-law will call your mother in the village and tell everyone how lazy you are." After receiving such complaints, some natal families will come to visit their daughter in her new home to comfort her and convince her of the necessity of adapting to her new family. Natal family members may also try to speak with the woman's in-laws about being less abusive or demanding. In extreme cases of abuse, the woman may even return home with her natal family for a brief period of time (a few weeks to a month).

Other natal families provide much less support to the woman, and simply tell her she must find a way to adjust. As one woman stated, "When I came here, I felt lonely, and I started crying. My mother-in-law called my mother, and told her, your daughter is only crying and crying. My mother told me, no, child. This is your family, and these are the people that you will have to stay with."

Even if women make the adjustment to their new homes fairly easily, one aspect that remains problematic is whether or not they are allowed to speak to or socialize with anyone outside the household. This is a problem for women in joint as well as in nuclear families. Many women stated that their husbands or in-laws told them that they were not allowed to speak to anyone outside the household. The commonly cited reason for this was, "women [or neighbors] around here will give you wrong messages, and then that creates a problem in your family. So, it's better not to talk to anybody, so that nobody can spread rumors about me, or my family, and then the family won't be disturbed." Husbands and in-laws are very concerned about what others might say about the family, and how women might use this information. Although some women did not mind being restricted, others said this restriction made it harder for them to build a post-marital social network and feel comfortable in their new environment. Many other women did not have this restriction and were free to speak to whomever they wanted. The average size of women's marital social networks (average number of alters= 1.69) is essentially the same as their pre-marital social networks (average number of alters = 1.83), but the ranges of the size of marital

social networks (0 to 3 alters) is drastically smaller than the ranges of the size of pre-marital social networks (0 to 9 alters). The great majority of women (83%) did not express a desire to have more friends.

Tensions and communication in the marital family

As women settled into their new families, some of their initial anxieties fade, but women report additional tensions about other aspects of their married life. Emotional health was an area where there was some discrepancy between qualitative and quantitative data. In the interviews, the primary tensions women expressed were related to fertility, family's finances, communication with their husband and in-laws, husband's alcohol use, and the sexual relationship. In the surveys, the most common tensions are shown in Table 1, but are much more related to concerns over their children, the community, household finances, and relationships with husband and in-laws.

Women feel a great deal of concern about obtaining enough money from their husbands to run the household. These economic tensions often create communication problems between wife and husband as well as between a wife and her in-laws. If in-laws feel that their son is not supporting them well enough, then they will often blame his new wife. One woman described how financial problems led to disagreements within her joint family:

> Whatever my husband earns, when he gets his salary, he gives his salary in his mother's hands. She purchases everything that is needed for the household, all the food and such things. Half here and half there. Sometimes, it happens that it isn't sufficient, and so she comes to ask for more. Sometimes, I doubt whether, when I am not at home, if my mother-in-law comes and takes things from here… Now, this time, last time, it happened that they had not purchased…all the foodstuffs that are needed for the house, so my husband said, give me the money back, and I will purchase everything. My mother-in-law got so annoyed and said for so many years, you haven't asked for the money back, have you listened to your wife? Did your wife tell you anything, and that's the reason why you're asking me for this money back? For the past two months, I am looking after the house. I am looking after my husband, my father-in-law and myself, and I am not giving any of the foodstuffs to my sister-in-law. Because, she earns a lot, but my husband doesn't earn enough. (18 year old Hindu woman, 5th standard education, married at age 17)

Table 1: Sources of Tension for Women after Marriage

Source of tension	Frequency
Children's future (education, etc.)	72%
Daughter's future (arrangement of marriage, safety, etc.)	69%
Unhealthy environment in community	59%

Household finances	57%
Anti-social elements in the community (eve-teasing, violence, etc.)	39%
Water problem	35%
Relationships with in-laws	34%
Obtaining and preparing enough food for your family	26%
Abuse from husband	23%
Husband's alcohol use	21%
Relationship to natal family	15%
Communication with husband	12%
Sexual relationship	11%
Husband's extra-marital sex	10%
Pressure to have a son	5%
Reputation in the neighborhood	3%
Pressure to have more children	3%

Women also feel tension over communicating with their husbands. For women living only with their husbands, the concern over communication is lessened, but not completely gone. Women try to discuss their concerns with their husbands, as well as their husband's daily experiences but when their husbands work long hours, perceive it unnecessary or a waste of time to talk to their wives about anything beyond the household, this communication can be difficult. Less than half (48%) of the women stated that they regularly shared their feelings with their husbands, and 43% percent felt that their husbands regularly shared their feelings with them.

Many women felt that their husbands did not support them in household work. Over half of husbands were described as never being involved in most household chores (cleaning, paying bills, purchasing food, cooking). The only tasks husbands were frequently involved in were taking care of children (63%) and taking family members to the doctor (78%).

Some women were also discouraged by the fact that their husbands would not support their aspirations for work outside the home. One woman stated that her husband would not let her work because, "he said I already have trouble getting all the household work done, so how can I possibly take a job outside the home?" This woman felt frustrated that she could not use her college degree for anything other than housework.

Traditionally, women were not allowed to talk directly to their husband in front of their in-laws, further complicating communication in joint families. In large joint families, it is even more difficult for a woman and her husband to have many opportunities to communicate openly, especially if the woman has been taught that she should not necessarily expect to communicate openly with her husband or in-laws. In these situations, the mother-in-law may encourage her son to abuse his wife. As one woman explained:

> If your husband is not at home and the mother-in-law and daughter-in-law have a quarrel and the mother-in-law tells the son about it when he gets home, if the son doesn't abuse the daughter-in-law [for quarreling]…the mother-in-law won't be happy. The mother-in-law is only happy if her son abuses his wife. (22 year old Hindu woman, age at marriage and education not collected in the focus group discussion)

When a woman's husband has an alcohol problem, communication is even more diminished, and women have even more tension, regardless of whether the couple lives in a nuclear family or a joint family. Several women described feeling like they could not say anything to their husband when he was drinking for fear it would lead to a verbal altercation or physical violence. A husband's alcohol problem also typically puts more economic pressure on the family. Women with husbands who drank a lot stated that it was harder to ask their husbands for money. Husbands who drink also tended to isolate women from their natal families, creating additional tension for the woman. One woman explained the difficulties she had with her husband's drinking:

> My mother-in-law always asks her sons for money and food, but they didn't want to provide her with money all of the time…so there are always a lot of fights, and my husband drinks a lot because he has so many tensions…My husband used to hit me when he would drink. He used to hit me all the time, until my third delivery… (24 year old Buddhist woman, 6th standard education, married at age 16)

Some women who had love marriages also found that they were not able to communicate as easily with their husbands after marriage as they had before. Couples who have a love marriage are more likely to live separately from either side of the family. While living separately can be very helpful for some couples, this residential pattern also means that the couple does not have a source of support, whether emotional or financial. A few women stated that their husbands seemed changed after marriage and that they had difficulty coping with the stresses of living in their own household. As one woman said:

> Before we got married, he used to give me his salary and I was free to shop. Now, I have to ask him to get me things, but I can't demand things. If I try to ask for something, he won't provide it. He says that he knows what I need…He won't take me out much anymore. And, before marriage, I could talk to my college friends, but now my husband won't let me…He drinks a lot and suspects me of having something outside [an extra-marital affair], and when he comes home drunk, he hits me. (24 year old Buddhist woman, 12th standard education, married at age 20)

Communication with in-laws is also a major source of concern for women. Many women fear speaking to their in-laws because it may be viewed as disrespectful. Women describe how they often have to tolerate a great deal of grumbling and verbal abuse from their in-laws, particularly their mother-in-law and sister-in-law. However, many women stated that the longer they had to live with their in-laws, the less they quietly tolerated their in-laws' comments. Some women felt that their in-laws would never fully accept them into the family, no matter how long they lived together, which led to feelings of frustration for many. As one woman declared, "Even if you try to treat your in-laws like your family, they will never treat you that way!" Other women stated that they simply had to follow their in-laws rules and strive to be perfect at all times: "In your marital family, you have to act perfectly. If you put too much salt in the food, you will get in trouble. If you do anything wrong, cook wrong, you will get in trouble". Women living in nuclear families typically had far fewer problems with their in-laws.

Although many women described strained relationships with their husband and in-laws, there were also a substantial number of women with very positive marital relationships. Women who defined their relationship with their husband as "good" described their husbands as "open" and "supportive". Husbands who were capable of providing for their wives, and who could anticipate financial needs were also described favorably by their wives. Women also stated that they felt lucky when their husband did not have any bad habits like alcohol. Within these more positive marital relationships, women felt that they and their husbands had similar expectations for married life and that these expectations were being met. One woman described why she and her husband got along so well:

> He is very open, and doesn't restrict me from talking to anyone. But, he does say that I should make good friends and meet good people. He tell me that if I need anything, I can ask him, and if he doesn't give it to me, then I should tell him. He just wants me to behave in a respectful manner. Whatever I say, he listens to me, but I also have to listen to what he says. It's a good relationship. (19 year old Muslim woman, 7th standard education, married at age 19)

Many women have positive relationships with their in-laws. "Good" in-laws are often defined by women as in-laws with whom they can feel relaxed and who treat them like their own daughters. Women with better relationships with their in-laws look to them for support for a variety of things, including household work, raising children, and their relationship with their husbands. As they are often close in age, several women stated that their sisters-in-law (co-sisters) acted as their primary confidantes. Women also appreciate the help with household chores that sisters-in-law can provide, making it easier for women to work outside the home. One woman described her relationship with her sister-in-law thus:

> I am very close to my sister-in-law. She tells me about her husband, and I talk about my husband. We share our experiences with each other. She tells me about my husband and how he was before marriage. He used to have long hair, and he would roam around. But, now after marriage, he has become a good person. She also tell me about her husband, and how he used to fight with her, and how he was before marriage. Because my sister-in-law tells me these things, I don't feel like I'm such a new person to her. I feel like we have known each other for a long time. (20 year old Muslim woman, 10th standard education, married at age 18)

Several women also described positive relationships with their mother-in-law and father-in-law. When mothers-in-law and fathers-in-law treated women well, they often became another important person with whom to confide. Women who felt they could trust their mother-in-law would also ask them for medical advice and advice on childrearing. One woman had this to say of her marital family: "With my husband and my in-laws, I can communicate very freely. I have no burdens, no tensions at all. It is very easy to live with them." For a few women struggling to cope with their husband's alcohol use, their mothers-in-law were a source of a support and acted as a mediator. One woman's mother-in-law provided her with money for her children and support to obtain contraceptives.

Women have varying degrees of contact with their natal family after marriage. Some women remain in regular contact with their natal families, and see family members on a regular basis. These women feel that their relationship with their natal family members has not changed after marriage. However, many other families expect that when their daughters get married, they will see very little of them, as is traditional. These natal families expect their daughters to adapt to their new family and behave properly, but the family does not necessarily cut off all contact with their daughters. Women may not be allowed to return to their natal families very often, but they are almost always allowed to return home for

much of their first pregnancy and delivery. More recently, increased access to cell phones and relatively inexpensive prices for calls have promoted greater communication with more distant natal families, as documented in the study area, as well as by other researchers (Tenhunan 2008; Handapangoda and Kumara 2013). However, many women do not necessarily expect that their families will provide support or assistance with an abusive husband or in-law.

Husbands and in-laws rarely have contact with a woman's natal family, unless there is some problem that necessitates contact. Just as some husbands and in-laws attempted to restrict women's communication with others in the community, several husbands and in-laws restrict women's communication with their natal family members. One woman described how her mother-in-law punished her for visiting her aunt: "My mother-in-law wouldn't take me to the hospital because she was mad at me for going to my auntie's place. My auntie stays nearby, and my mother-in-law has told me many times not to go there."

Decision-making in the marital family

A woman's decision-making abilities in her marital family is another important component of her marital and in-law relationships. Decision-making ability is largely related to the type of household structure. If a woman lives in a nuclear family, she is more likely to make household and personal decisions regarding the purchase of major household goods ($R=.622$, $p<.001$), whether she can work outside the home ($R=.420$, $p<.001$), whether she can seek treatment for a health problem ($R=.225$, $p<.01$), and decide how many children to have ($R=.248$, $p<.005$). Women in nuclear families described the confidence they had in making some of these decisions: "…I can take my own decisions, and my husband is fine…If I want to go out somewhere, I don't have to ask. I can take my own decision, and I can go. I have no restrictions at all. I can go anytime, and come back anytime." However, it is not always the case that a woman living in a joint family cannot make any of her own decisions. Several women stated that if they wanted to buy something small for themselves, such as an article of clothing, or decide what would be cooked for dinner, they could make these decisions.

Overall, women in joint families are less able to take their own decisions, as they are viewed as too young and too junior within the household to make decisions that could impact their in-laws. As one woman in a focus group discussion stated, "No girl is allowed to take her own decisions in her marital family. Your mother-in-law and husband and maybe father-in-law will take all the decisions, so the new wife can't." However, there were several women who felt relieved not to have the responsibility of making household decisions. These women were happy to allow their mother-in-law and husband to make decisions about household purchases and even when the woman should become pregnant and how many children she should have. As one woman stated, "I have my mother-in-law to take decisions, so it's not my headache to make any decisions."

Violence in the marital family

Women have very different experiences with violence and abuse in their marital families. The most common forms of abuse from both husbands and in-laws are verbal and emotional. Husbands often expressed emotional abuse by yelling at his wife (38%), criticizing (29.3%) or nagging (20.7%), insulting and humiliating his wife in front of others (27.3%), becoming jealous and angry if his wife speaks to other men (35.3%), restricting his wife's interactions with her female friends (20.7%) or natal family members (18%), threatening to harm someone close to his wife (16.7%), not trusting his wife with any money (16%), or accusing his wife of being unfaithful.

Accusing a woman of being unfaithful is a relatively common tactic that husbands use to prevent their wives from refusing sex. Much of this verbal abuse arises from fights triggered by the problems with communication. If a husband comes home and feels that his wife has not done enough around the house or his mother complains about his wife he may start arguing with her which can escalate into insults, accusations, and restrictions.

Verbal abuse is also quite common from in-laws, and women reported that their in-laws would often insult and humiliate them (17%) and threaten to have the woman's husband divorce her (14%). Much of this verbal abuse stems from fights in which in-laws think that the woman is not meeting their standards for being a good daughter-in-law. Another form of abuse specific to in-laws that can be verbal

as well as physical is harassment related to insufficient dowry (reported by 15%). Several women described being harassed by their in-laws, because their parents had not provided enough dowry or had not paid a sufficient amount for the wedding. One woman stated that her mother-in-law offered to loan her parents money for some of the wedding expenses and gifts, but that this loan led to subsequent harassment:

> So, my mother-in-law paid 15,000, and it's been two and a half years, and now she wants to be paid back with interest. In the beginning she said that she would not take interest, but now, she says that she wants interest. And, so she abuses me, and says bad things about me. So, I got 5,000 from my own mother. But, then when I brought this money to my mother-in-law, she wouldn't take it. She said, give it to your father-in-law. I went to my father-in-law, and he said don't give it to me, give it to your mother-in-law. My mother-in-law told me to give it to my husband. But, I told her, I didn't get this money to give to my husband, I got it from my mother to give to you. My mother-in-law thought that I took this 5,000 from my husband, and that's why she wanted me to give it back to him. But, I'm still having a lot of problems with my mother-in-law. She refused to take the money, and just kept abusing me. She finally took the money, but she keeps abusing me for no reason. She'll be on the phone, and she'll be talking about me and the money. She was also saying bad things about my mother and my brother. It made me feel uneasy. (22 year old Buddhist woman, 10th standard education, married at age 19)

Women also experience physical violence from their husbands and in-laws, although this is less common. The most common forms of physical violence that women experience from their husbands is slapping (36%), getting kicked, dragged or beaten (17%), arm-twisting or hair pulling (17%), pushing or shaking (15%), punching (12%), or forced sex (11%). Women described that much of this violence was in the context of their husband's alcohol use and/or refusal of sex. Occasionally fights about other household matters would become physically violent, but this was less common. Physical violence from in-laws was much less frequent, with slapping reported as the most common (9%) form of violence young women experienced from in-laws. Slapping generally came from mothers-in-law or sisters-in-law. Male in-laws were less likely to abuse women in general, and if they become angry with the woman, they were more likely to verbally abuse her. There was only one woman who reported being hit by her male in-laws.

Physical health

Women also described health problems that they had experienced since marriage. In the interviews, the primary health complaints women had were related to vaginal discharge, general body aches and pains, irregular menses, and anemia. Women stated that although they may start treatment for

some of these problems, they usually discontinued treatment due to lack of time and/or mobility to obtain healthcare, expense associated with treatment, or feeling that the treatment was unnecessary and/or not working. In the survey, the most common health problems were backaches (70%), headaches (67%), pain in body (60%), giddiness/dizziness (58%), body weakness (49%), and loss of appetite (44%) (see Table 3 for other high frequency health problems and treatment rates).

Table 2: Percentages of health problems and treatment taken for health problems (N=150)

Health Problem	Percentage with problem in past 3 months	Percentage taking treatment for problem
Backache	70%	47%
Headache	67%	55%
Pain in body	60%	43%
Giddiness/Dizziness	58%	41%
Body weakness	49%	14%
Loss of appetite	44%	29%
Sleeplessness	43%	15%
Pain/cramps during menses	41%	23%
Fatigue	41%	10%
Lethargy	39%	9%
Pain in lower abdomen	38%	24%
Anemia	30%	19%
Increased frequency of micturition	30%	6%
Excessive vaginal bleeding	26%	12%
White discharge	25%	12%
Burning urination	24%	15%
Irregular menses	24%	16%
Constipation	22%	11%
Palpitations	22%	12%
Chest pain	22%	13%
Obstructed urine flow	13%	7%
Pain while urinating	11%	7%
Swelling of glands in the groin	10%	7%
Malaria	6%	6%

In terms of objective measures of health status, 86% of the sample was anemic according to the hemoglobin values obtained with the Hemocue. High rates of anemia could be due to a number of factors. Although, most women (95%) in the study eat a non-vegetarian diet at least sometimes, financial constraints and food insecurity may limit many women's protein intake. Limited protein intake is also

supported by preliminary stable isotope analysis of hair samples from women in the study area. Another reason for high levels of anemia is blood loss due to menstrual cycles or pregnancy. Malaria could be another reason for anemia, with 6.4% of the sample stating that they have had malaria since they have been married. From the BMI data (which is not available for participants who were pregnant), we found that 23% were underweight, 64% were normal weight, and 14% were overweight. We also observed that many (46%) of the women in the study are stunted/short stature, indicating early childhood malnutrition.

Key variables from the marital family

The key variables to be examined in the marital context in the next chapter are marital communication and support, marital gender equity beliefs and behaviors, verbal abuse, and physical abuse. Marital communication and support is defined in terms of a woman's ability to discuss different topics and feelings with her husband, and whether or not the husband helps his wife with different household matters. Marital gender equity beliefs and behaviors are defined using a gender equity norms scale and agency items developed in a previous project (Schensul, et al. in review) as well as a woman's ability to make decisions within the marital context. Verbal and physical abuse are defined in terms of presence or absence of different physical or emotional acts harming the woman.

Reproductive health

A woman's reproductive health is another important component of a woman's life after marriage. Once a woman gets married, both family and community members begin anticipating when a woman will achieve the next milestone, that of motherhood. Given the significance of children in terms of timing of first birth and subsequent births, gender of the children, and number of children, reproduction and childrearing can be a positive or a contentious issue for women and their families.

Women describe varying levels of control over their fertility in terms of the timing of both the first pregnancy as well as subsequent pregnancies. The average amount of time between marriage and the first pregnancy is 10.8 months with a range of -1 year to 4 years (note that one woman became pregnant before marriage), indicating that most women in the sample become pregnant within the first year of marriage. Some women stated that they and their husband felt that they should wait at least a year or two

before having the first child, and so they used contraceptives to delay the first pregnancy. There were also some women who wanted to delay their first pregnancy, but due to lack of knowledge of contraceptives, were unable. As one woman explained:

> When I took the pregnancy test, I saw that there were 2 lines, which meant that I was pregnant. So, I told my husband first. He was happy, because he wanted a baby. I was in tenshun, though. I wanted to wait for 2 or 3 years before having a child. But, after having sex only once or twice, after that I started vomiting. I couldn't do anything for it. I didn't want to get the child aborted, because this is what God gives, and you have to accept whatever he gives you. But, now I'm fine with it...When I found out that I was pregnant, I told my mom, and I told her that it was too early. My mom said that there is nothing that we can do. God has given you this, and you have to accept it. I am worried about how I will manage everything. After giving birth, I will have to look after the child and everything else, and I don't think that I'm capable of this. But, my in-laws and family are happy. (19 year old Muslim woman, 7th standard education, married at age 19)

There was another subset of couples who wanted to delay the first pregnancy and wanted to obtain contraceptives to do so, but due to family pressure were unable to access contraceptives. One woman with a husband who was travelling back and forth to Saudi Arabia encountered this problem:

> I know that to keep distance between children, you can use condoms. My husband told me about them, and he uses them sometimes. I didn't know about them until he told me about them. When we got married, we didn't want to have a child too soon. So, we used to use condoms. We thought we should wait to have a child until he [her husband] made one more trip to Saudi. But, my in-laws wanted me to conceive a baby, because they said that if he goes, it will be difficult for you to pass your time. But, if you have a child, you will be engaged in that. So, we stopped using condoms, and had a child. (20 year old Muslim woman, 10th standard education, married at age 18)

A small subset of women explicitly timed their first pregnancy to alleviate tensions in the household, because when a woman becomes pregnant, her status typically increases (Davis, et al. 2014).

Women who delay their first pregnancy, regardless of the reason, face considerable criticism from both in-laws and community members. There were some women who did not become pregnant soon after marriage, but it was due more to their husband travelling for work rather than a deliberate choice to delay pregnancy. These women described feeling frustrated by family and community speculation as to why they were not pregnant within a few months after marriage:

> I didn't want the child early, but how can you expect a girl to get pregnant within one week of marriage, especially when my husband was not staying with me? He was working in Pune, and I am staying here. But, my neighbors and family members were saying all kinds of rubbish things, like I am taking contraceptives, and that's why I am not conceiving a child. So, when my husband

> came here [permanently], I got pregnant. (22 year old Muslim woman, 5th standard education, married at age 20)

There was a subset of women who stated that they did not want to have a child too early in their marriage, because they wanted to get to know their husband and settle into their new life. These women felt having a child too early in the marriage would greatly inhibit their mobility and freedom and they were supported in this view by their husband and in-laws. However, there were some women who were ridiculed by family and community members for waiting to wait.

Perhaps the harshest consequences were reserved for women with fertility problems. The incidence of fertility problems in this sample was low (2%), but for the few women who experienced infertility, the consequences frequently entailed physical and emotional abuse from husbands, in-laws, and neighbors. Women who struggled with infertility were told by husbands and in-laws that they could be divorced and sent home to their natal families. Women were also beaten. One woman described the violence she had to endure as a result of her fertility problems:

> My husband has started hitting me, because I haven't conceived a child. He doesn't want me to sit next to him, and he hits me… He is beating me up many times, because I am not conceiving a child. I haven't told anyone else about it. Why tell? Both the husband and wife should solve their own problems. So, I try to solve the problem by keeping quiet and not fighting. I just cry and keep quiet. (18 year old Hindu woman, 5th standard education, married at age 17)

When women become pregnant, they are typically treated very well by their husbands and in-laws. Many women were given dispensation from some or all of their household chores, as their husbands or in-laws would take on additional responsibilities so that the woman can rest. For most women, being pregnant is also an opportunity for them to return to their natal families to give birth with their natal family's support. These trips to their natal families create problems linking pregnant women with antenatal care (ANC) and ensuring that pregnant women obtain the recommended four or more ANC visits. However, most women describe receiving good healthcare during their pregnancies. This is supported by ANC usage, which is generally high at 64% of the sample having attended the recommended four or more ANC visits prior to delivery. However, a subset of young women experienced complications resulting in bed rest, C-sections, and in some cases miscarriages and stillbirths.

When women gave birth, they were typically treated well, especially if it is a male child, by both their natal families and in-laws. Although most women state neither they nor their husbands care about the gender of their children, there were some women who described feeling a great deal of tension over not producing a male child in the first pregnancy or the right ratio of sons and daughters. One woman said that both her husband and mother-in-law treated her poorly after she delivered a second daughter, and that her husband refused to interact with his two daughters until his wife delivered a son.

The desired size and composition of the family also varies greatly for the women in this study. Many of the women in the study stated that they and their husbands only wanted two or three children because, "Nowadays who expects more than 2 or 3 children? Because, you have to look after them, you have to educate them, you have to give them everything that they need. Nowadays, it's not possible to look after so many children." There were also many couples where one or both of the spouses did not want to put a limit of the number of children, because they felt that the number of children should "be up to God". In-laws would also provide couples with their opinions on the ideal number of children to have, and this ideal tended to be higher than that of the couple. While some couples felt comfortable ignoring their family members' opinions on family size and composition, there were many couples where this was not the case. One woman stated how her mother-in-law's preferences impacted her ability to undergo sterilization:

> Both my husband and I only want 2 children. But, my mother-in-law says that I should deliver one female child. My mother-in-law says that, nowadays, sons don't look after their parents, so you should have one daughter, at least, to look after you. I wanted to get sterilized after my second child, and my husband was ready to give his signature for it, but my mother-in-law didn't want that. (24 year old Hindu woman, 7th standard education, married at age 21)

Given the generally low rates of contraceptive usage that have previous been recorded for the study area combined with the fact that many of the women in the study are relatively recently married and have not completed their families, contraceptive usage in this sample is predictably low. Of the survey sample, 39% had ever used a form of contraception and 33% of the survey sample is currently using a form of contraception. The most common forms of reversible contraception is female sterilization (11%), nirodh (condom; 9%), copper-t (5%), and birth control pills (5%). Many of the medically terminated

pregnancies (MTPs) that women had were also used as a form of contraceptive. Many young women underwent MTPs when they became pregnant too soon after another pregnancy or had exceeded their ideal family size but did not have access to other forms of contraceptive. Here again, most survey participants stated that the decision to use contraceptives was made either solely by the woman (19%) or jointly by the woman and her husband (64%), but contraceptive usage is impacted by many other factors as illustrated above.

Despite the young age of the sample, 11% have been sterilized. The rate of sterilization for women in this sample is similar to previous data collected in the community, where 12% of women in the community have undergone sterilization. The average age at sterilization for the women in this sample is 21.7 years old. Previous work in the study area on female sterilization also found that sterilization before the age of 30 was common (Brault, et al. under revision). Reasons for undergoing sterilization are very similar for women in this study and women in the previous study.

Sexual health

The wife-husband sexual relationship is a key area where women have variable ability to communicate with their husband, make decisions and control their bodies. Women's different first night experiences may set the tone for the sexual relationship throughout the marriage, although there was a small subset of women who had unpleasant first night stories, but later enjoyed having sex. Many women feel that sex is simply a necessary part of any marriage, another duty that they have to fulfill like housework. Most (74%) young women state that they can refuse sex at least sometimes, but many women stated in interviews that they cannot refuse sex very often, or at all: ""…I don't think I could refuse [sex]…You can't go in front of your husband. You can't go against what he wants, so there is no question of refusing." Many women described having sex when they did not feel like it, but rather out of duty. There were several common reasons for not refusing sex: concerns that refusal will result in violence or forceful/coercive sex, refusal of sex too often will result in the husband seeking another sexual partner and/or the husband suspecting the wife of having an extra-marital affair. As one woman explained,

> After marriage…when I would refuse sex, he would beat me up, and he would question me if I don't want to have sex with him, is there someone else who I want to have sex with or who I have been with? Whenever I refuse sex, he beats me up. For the first 2 or 3 months, when I would refuse sex, he would question me, do you have sex with someone else? I told him, how can you ask me this? And, then I went off to sleep. So, he started kicking me. Now also, he does the same thing when I refuse. He says, fine, if you won't touch me, then you are no one to me, I won't talk to you, I won't try to touch you, I won't take any tiffin prepared by you. (18 year old Hindu woman, 5th standard education, married at age 17)

However, there was also a subset of women who stated that they felt comfortable refusing sex with their husband whenever they did not want sex, and their husbands had not abused them. Women who feel comfortable refusing sex more often tend to be in couples with more open communication and discussion of their problems ($r = .170$, $p < .05$). As one woman stated, ""…if I refuse sex, it's not a problem for me. He tries to understand my problems, and why I'm saying no."

Although nearly three-quarters of women felt that they could refuse sex, it is less common that women feel that they can initiate sex (35%). Many women feel that initiating sex is the husband's role: "I feel shy [about initiating sex]. Always, he is the one who initiates." Several women stated that they were worried that if they initiated sex, then their husband might think they had pre-marital or extramarital sex. However, there was a small subset of women who felt comfortable initiating sex: "My husband and I have a very happy relationship. Sometimes I initiate sex, and sometimes he does. He's fine if I try to initiate."

There is also a variety in the types of sexual behaviors women and their husbands engage in. For nearly all participants, sex is defined as vaginal intercourse. However, the extent to which couples engage in other behaviors varies. Due to space and privacy concerns, sex does not always entail removing clothes (51% reported removing clothes last time had sex). Space and privacy also limit the amount of time a couple has to engage in sex, which also limits the types of behaviors in which the couple can engage. One woman explained that her and her husband had to schedule their sex around when his grandmother was in the house:

> When we first moved to his mother's house, we had our own room and privacy. Now, we have to share a room with my husband's grandmother. Before, when we had privacy, we could enjoy sex. Now, it is not so good, because his grandmother is there. We have to wait for her to leave, and sometimes we have time for sex, but sometimes she comes back home early which makes it hard. (20 year old Buddhist woman, 12th standard education, married at age 19)

Some women who find sex unpleasant do not like it when their husbands touch or kiss them. Several women expressed the opinion that "sex is only to conceive a child," and they do not want it to last any longer than necessary. One woman stated, "I only refuse sex when my husband takes a long time doing all these things like touching my breast and kissing. When he takes a long time, I refuse, because that is too dirty." In general oral and anal sex are very rare and activities women feel forced to do. However, there is a subset of women who prefer sex when there is more foreplay. Several women stated that they enjoyed sex more when there was more privacy and they could remove their clothes and engage in more activities, such as kissing and caressing, with their husband and as a result feel more "wet" when penetration occurs.

A common reason that women do not enjoy sexual activities is because of different sexual health problems. Although, most women describe pain and other sexual problems on the first night, a subset of women continues to have these problems throughout their marriage. The most common problems with sex that women report is a general lack of interest in any sexual activities (59%) and loss of sexual desire (25%), illustrated by this woman: "I always feel like having sex is doing something wrong, so I am never interested." Other less commonly occurring problems include continued pain or discomfort during sexual activity (15%), taking a long time to become aroused (14%), swelling of glands in the groin (10%), lack of lubrication (8%), ulcers in and around vagina (8%), and lack of water/toilet facilities (8%). Women with these problems try to refuse sex, and often their husbands are understanding. However, women said that if their husbands think that they are using these excuses too often, then their husband may force them for sex, perpetuating many of these problems.

Twenty percent of women in the survey believed that their husband had pre-marital sex, but only 4% believe that they have had extra-marital sex. There was only one woman in the study who reported being HIV positive, and none described being treated for any STIs. Only 5% of women feel that they are at risk for contracting an STI, and similarly, 5% believe that their husbands are at risk of contracting an STI. Those women who are concerned about the possibility of contracting an STI are largely the same women who feel that their husbands are having extra-marital sex.

This chapter has described the variety of ways in which women develop into adolescents and adults in the study area. By taking a longitudinal perspective, we are able to understand young women's experiences as they transition into adulthood, as well as challenges that young women encounter through these transitions. Several key aspects of women's lives discussed in this chapter have been formalized into variables. I explained these variables above, and the next chapter will test hypotheses regarding relationships among the variables that produce women's marital, sexual and reproductive outcomes.

Chapter 5: Bivariate and Multivariate Relationships among Key Variables to Understand Sexual and Reproductive Health Outcomes

Introduction

In the context of ethnographic research, there is a long and significant history of employing mixed methods, such that qualitative data is used to explore the range of possibilities and experiences of a group and quantitative methods are employed to test variation or relationships that emerge from the qualitative data (see Schensul and Schensul 2012; Pelto 2015; Bernard 2011). The previous chapter explored the range of variation in women's experiences as they move from childhood to adolescence to marriage to motherhood. The descriptive ethnography generated key quantitative variables reflecting aspects of women's lives that can be used to test to test the hypotheses outlined in the Methodology chapter that are associated with sexual and reproductive health outcomes.

The sequence of hypotheses to be examined starts with the natal family environment as measured by economic status and gender equity as well as the agency the girl develops in her natal family that impacts the timing of marriage. After marriage, hypotheses explore the marital context in terms of communication and support, gender equity beliefs, and abuse both in the relationships between marital variables as well as the impact of the natal family variables on the marital variables. The final section of this chapter examines the hypotheses that relate natal and marital family variables to reproductive and sexual health.

Natal Family Dynamics

There are two primary factors that affect the life course of girls: the degree of gender equity norms and behaviors in their natal family and their relative level of agency within the natal family context. See Figure 2 for relationships among natal family variables.

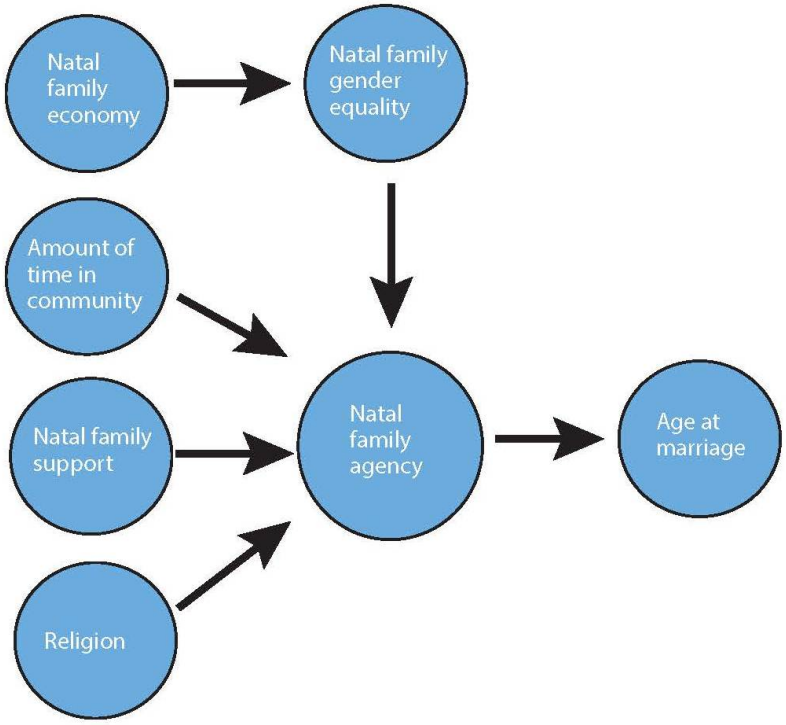

Figure 2: Key relationships among natal family variables.

Variables associated with natal family gender equity

In the previous chapter, many young women describe how their family's financial problems created an environment in which parents had to make choices about how to distribute limited attention and resources among their children, and that sons were often favored in such environments. In Table 1, the relationship between natal family economic status and gender equity is examined.

Table 1: Regression analysis of the association between natal family economic scale and natal family gender equity (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.476	.092	16.038	<.001
Natal Family Economics Scale	.131	.051	2.586	.011

R	R Square	Std. Error of Estimate
.208	.043	.186

The results indicate that the natal family's economic status is significantly associated with gender equitable behaviors in the natal family (Table 1), meaning that as economic status increases, so do gender equitable behaviors.

Concerns about neighborhood gossip, eve-teasing, and dangers in the community were also examined as a factor in natal family gender equity (Table 2).

Table 2: Regression analysis of the association between natal family gender equity and frequency of eve-teasing (dependent variable) before marriage.

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	2.112	.303	6.966	<.001
Natal Family Gender Equity	.417	.176	2.369	.019

R	R Square	Std. Error of Estimate
.191	.037	.407

Natal family gender equity is significantly associated with the frequency of eve-teasing a girl experiences before marriage meaning that girls who experience less "eve-teasing" grow up in more gender equitable families. Girls growing up in less gender equitable families described how their parents had more fears about the community and their daughter's safety in the community. More patriarchal families are also more concerned about the potential impact of community gossip on the family's *izzat*, and eve-teasing is one dimension of the perceived dangers of the community. One key informant explained how parental fears about the community perpetuates gender inequitable norms like early marriage: "Insecurity is a big problem in the community. Parents fear for their daughter's safety, and think it's better to get her married early before something bad can happen to her."

Factors associated with natal family agency

A girl's agency in her natal family is influenced by a number of factors. Table 3 examines several variables that were hypothesized to be associated with girl's agency including religion, length of time in the study community, and feelings of support from their natal family (Table 3).

Table 3: Regression analysis of religion, length of time in the community, and natal family as source of support, as associated with natal family agency (dependent variable).

Model	Variables	Unstandardized coefficients		t	Sig.
		B	Std. Error		
1	Constant	1.272	.056	22.749	<.001
	Religion	.128	.035	3.695	<.001
2	Constant	1.058	.057	21.372	<.001
	Religion	.118	.034	3.423	.001
	Length of time spent in study area	.006	.002	2.922	.004
3	Constant	1.058	.082	12.904	<.001
	Religion	.118	.033	3.545	.001
	Length of time spent in study area	.006	.002	3.150	.002
	Considers natal family as source of support	.064	.023	2.728	.007

Model	R	R Square	Std. Error of Estimate	Change Statistics				
				R-square Change	F change	Df1	Df2	Sig. F change
1	.291	.084	.145	.212	13.654	1	148	<.001
2	.367	.135	.144	.207	8.535	1	147	.004
3	.420	.177	.143	.202	7.444	1	146	.007

The regression in Table 3 shows that girls who have lived in the study area longer are more likely to have higher levels of pre-marital agency than girls who have spent less time in the study area. Girls who feel that their natal family is more supportive and helpful to the girl will also be more likely to have higher levels of pre-marital agency than girls who feel that their family members are less supportive. Muslim girls are more likely to have had higher levels of pre-marital agency than Hindu or Buddhist girls. As one woman (Muslim, married at age 19) stated, "I was very mobile here. If I wanted to go somewhere, my father was very supportive. I could go anywhere, I could talk to anybody."

The relationship of natal family agency and social network is examined in Table 4.

Table 4: Regression analysis of natal family agency as associated with pre-marital social network size (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	.590	.528	1.117	<.001
Natal Family Agency	.847	.355	2.383	.018

R	R Square	Std. Error of Estimate
.192	.037	.957

The association in Table 4 means that that as natal family agency increases, so does the size of a girl's social network in terms of the number of alters (friends and family members who the young woman talks to and socializes with). Qualitatively, young women who described taking more decisions for themselves also described having large groups of friends who they would share information and concerns with. The converse of the relationship between agency and social network size is those young women who have extremely limited decision-making abilities and have very few friends or people they can talk with outside their home. As one young woman explained,

> In the neighborhood, I didn't have any friends, because my family didn't allow me to go out of the house. The place I grew up, there were no girls. There were mostly men staying there, so that's why my brothers didn't want me to go out of the house and talk to them… I couldn't go out with any friends. (20 year old Muslim woman, married at age 19, 8th standard education)

Table 5 shows that agency is also associated with a girl's educational attainment.

Table 5: Regression analysis of natal family agency as associated with educational attainment (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	2.320	1.997	1.162	.247
Natal Family Agency	2.733	1.345	2.032	.044
R	R square	Std. Error of Estimate		
.165	.027	3.623		

The association in Table 5 means that higher levels of natal family agency are associated with more years spent in school. One of the biggest decisions women described making for themselves was whether or not to continue with their education. Many young women described how they were instrumental in deciding to continue with their education, and that they had decided to continue with their education, because they felt it important that they have the education necessary to support themselves.

The relationship between natal family gender equity and agency

Table 7 examines the hypothesis that natal family gender equity and natal family agency would be positively associated with each other.

Table 7: Regression analysis of natal family gender equity as associated with natal family agency (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.1793	.163	11.024	<.001
Natal Family Gender Equity	-.190	.094	-2.008	.046
R	R-square	Std. Error of Estimate		
.163	.027	.218		

However, a regression analysis with natal family gender equity as associated with natal family agency reveals that there is an inverse relationship between the two variables (Table 7). The inverse relationship between natal family gender equity and agency can be observed with a subset of young women who are discordant with their natal family's gender norms. There are some young women who grow up in families with less gender equitable norms and behaviors, but due to less parental control and more exposure to Indian and Western media, have higher levels of agency. With higher levels of agency and exposure to media, come aspirations to become more "modern" women with education, employment, cell phones, Western fashion, and even boyfriends and love marriages. Whether through education or employment, girls from gender inequitable families but with high agency attempt to delay marriage as long as possible and run the risk of alienating their natal families or becoming the subject of neighborhood gossip. One girl who exemplifies this low natal family gender equity, high agency trend described how she attempted to delay marriage in favor of continuing her education, but was forced to leave school due to community gossip and her family's desire to protect the honor of the girl and her family:

> I had to get married because my relatives made me…A boy loved me, but it was one-sided. I didn't love him... The boy told everyone that he was in love with me. He spread this rumor to everybody. And my relatives blamed me for this. My family beat me. And, then, somebody came, and I had to marry him…They wouldn't let me go to school anymore. I wanted to stay in school, but because of all this, I was not allowed to. I was not even allowed out of the house. So, they found a boy, and I had to marry him…it makes me sad. I wanted to study. I didn't want to get married! ...That boy who caused all this, he gets to continue to study, but I had to suffer. I didn't want to get married until I was 25 or 30. When I see people who are my age and they are working on their advanced degree, it makes me sad (22 year old Buddhist woman, married at age 19, completed 10th standard).

Transitions into marriage

In Table 6, the association between age at marriage and agency is examined.

Table 6: Regression analysis of natal family agency as associated with age at marriage (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	13.188	1.043	12.649	<.001
Natal Family Agency	3.177	.702	4.525	<.001
R	R Square	Std. Error of Estimate		
.349	.122	1.892		

Age at marriage is associated with a girl's agency, such that as agency increases so does the girl's age at marriage (Table 6). The positive relationship between agency and age at marriage indicates that young women with more agency are more likely to opt for a later marriage. One young woman typical of this trend who delayed marriage to continue her education explained,

> In the village, people complain about girls who get educated, and they spread rumors about girls who go to college. I was given a choice of who I married, but most girls don't get that. In this family [indicating husband's family] and my family, the environment is good. They totally supported my studies. (20 year old Hindu woman, is currently studying to complete her B.A., married for six months)

The converse of the relationship above is those young women with less agency who marry earlier, as adolescents. A typical experience of the timing of marriage for girls with less agency was:

> My parents didn't ask me if I wanted to get married when they started arranging it. Whatever my parents want, I have to be satisfied with. When they decided to get me married to this fellow, it was fine. My father doesn't keep well…If something happens, then who will be there to get me married? So, it's better that, before he's dead, my mom wanted to get me married. There are 10 people in my natal family… How long should I wait to get married? I am getting older, and my age will increase, and then it will be a problem for me to get married. (17 year old Muslim woman, 5th standard education, married at age 16)

Associations with marital family dynamics

The key variables that describe marital relationships are age at marriage, marital communication and support, a woman's gender equity beliefs and norms, physical abuse, and verbal abuse.

Marital communication and support

Marital communication and support are positively predicted by age at marriage (Table 8).

Table 8: Regression analysis of age at marriage as a predictor of marital communication and support (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.381	.257	5.367	<.001
Age at Marriage	.031	.014	2.163	.032

R	R Square	Std. Error of Estimate
.175	.031	.352

Table 8 shows that the older a young woman is when she gets married, the better her communication will be with her husband and the more support she will receive from her husband. Both women as well as key informants noted that women who delayed marriage typically were able to better communicate with their husband and in-laws. Key informants attributed the improved communication to the fact that women who delayed marriage were "more mentally mature" and felt more comfortable in their new role of wife.

Marital communication and support are also associated with a woman's gender equity beliefs and the difference in education between the woman and her husband (Table 9).

Table 9: Regression analysis of the difference in education levels between wife and husband and gender equity beliefs as predictors of marital communication and support.

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.484	.236	6.276	<.001
Education difference between Husband and Wife	-.013	.006	-2.066	.041
Martial GES	.325	.164	1.985	.049

R	R Square	Std. Error of Estimate
.246	.060	.347

Gender equity beliefs are associated with marital communication and support, meaning that the more gender equitable beliefs and norms that a woman holds, the better her communication will be with her husband and the more support in household work she will receive from her husband. The relationship between wife/husband educational differential and marital communication and support is significant, such that the women with more similar or equal levels of education will have higher levels of communication and support with their husbands and young women who have less education than their husbands, express gender inequitable beliefs will have poor communication or support from their husbands. On being asked

whether her husband ever helped with household work, one young woman (who did not attend school at all and married at age 18) laughed and said, "…How will he help me? Is it his duty? It is only the woman who should do the work, so this won't happen."

Marital gender equity attitudes and behaviors

A woman's gender equity attitudes and beliefs in the context of marriage are examined in relationship to age at marriage in Table 10.

Table 10: Regression analysis of age at marriage as a predictor of marital gender equity beliefs (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.173	.127	9.234	.000
Age at Marriage	.014	.007	2.021	.045

R	R Square	Std. Error of Estimate
.164	.027	.174

The results in the table above show that young women who marry later will have more equitable gender norms and behaviors after marriage. Qualitatively, the young women who chose to delay marriage tended to espouse more gender equitable norms, because they had chosen to delay marriage to pursue educational or employment opportunities.

It was hypothesized that there would be a relationship between natal family gender equity, natal family agency and marital gender equity beliefs. However, there is not a statistically significant relationship between marital gender equity beliefs and natal family gender equity (p=.731). The relationship between natal family agency and marital gender equity reveals a trend (p= .097) between natal family agency and marital gender equity. These weak relationships could be explained with qualitative data. There was a small group of young women who, while they may have had agency and been raised in a gender equitable environment, were not able to continue to espouse gender equitable beliefs in their marital family, due to the presence of their more traditional in-laws.

The association between marital gender equity beliefs and norms and marital communication and support is examined in Table 13.

Table 13: Regression analysis of marital communication and support as a predictor of marital gender equity beliefs and norms.

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.254	.078	16.023	<.001
Marital Communication and Support	.090	.040	2.251	.026

R	R Square	Std. Error of Estimate
.182	.033	.173

The relationship shown in Table 13 means that women who are able to effectively communicate with their husbands and feel supported by their husbands are more likely to also express gender equitable norms and beliefs. One woman described her relationship with her husband in these terms: "My husband is a good man [said in English]…He wants me to get my college degree, so I am taking correspondence classes…My husband says I am free to do a job, to wear whatever clothes I want…He is very supportive."

Verbal and Physical abuse

Many women experience verbal and physical abuse from their husbands, and abuse interacts with many pre-marital and marital variables to contribute to women's outcomes. The relationships between natal family gender equity, age at marriage, and marital communication and support is shown in Table 14.

Table 13: Regression analysis of natal family gender equity, age at marriage, and marital communication and support as associated with marital physical abuse (dependent variable).

Model	Variables	Unstandardized coefficients		t	Sig.
		B	Std. Error		
1	Constant	1.994	.323	6.177	<.001
	Natal family gender equity	.447	.188	2.382	<.05
2	Constant	.527	.467	1.129	.261
	Natal family gender equity	.566	.180	3.141	<.005
	Age at marriage	.071	.017	4.164	<.001
3	Constant	.177	.477	.370	.721
	Natal family gender equity	.571	.177	3.229	<.005
	Age at marriage	.063	.017	3.733	<.001
	Marital communication and support	.248	.094	2.626	<.05

Model	R	R Square	Std. Error of Estimate	Change Statistics				
				R-square Change	F change	Df1	Df2	Sig. F change

1	.192	.037	.434	.037	5.673	1	148	<.05
2	.372	.139	.412	.102	17.335	1	147	<.001
3	.421	.177	.404	.039	6.893	1	146	<.05

The relationships in Table 14 show that women who grow up in more gender equitable natal families, marry later, and have improved marital communication and support, experience less physical violence from their husbands. Natal family agency was not a significant predictor of physical abuse.

Table 15 examines the relationships between natal family gender equity, age at marriage, and marital communication and support.

Table 14: Regression analysis of natal family gender equity, age at marriage, and marital communication and support associated with marital verbal abuse (dependent variable).

Model	Variables	Unstandardized coefficients		t	Sig.
		B	Std. Error		
1	Constant	1.179	.199	6.177	<.001
	Natal family gender equity	.330	.116	2.382	<.05
2	Constant	.602	.298	1.129	.261
	Natal family gender equity	.377	.115	3.141	<.005
	Age at marriage	.028	.011	4.164	<.001
3	Constant	.177	.299	.370	.721
	Natal family gender equity	.571	.111	3.229	<.005
	Age at marriage	.063	.011	3.733	<.001
	Marital communication and support	.248	.059	2.626	<.05

Model	R	R Square	Std. Error of Estimate	Change Statistics				
				R-square Change	F change	Df1	Df2	Sig. F change
1	.228	.052	.267	.052	8.128	1	148	<.01
2	.305	.093	.262	.041	6.592	1	147	<.05
3	.400	.160	.253	.067	11.713	1	146	<.005

Table 15 shows that women who come from more gender equitable natal families, marry later, and have better marital communication and support also experience less verbal abuse. Natal family agency was also not a significant predictor of marital verbal abuse. In the interviews, women offered many illustrations of the ways in which poor spousal communication contributed to both verbal and physical abuse. As one woman explained, “If he doesn’t get things for me when I ask him. If he doesn’t give me money for something, then I will argue with him. Sometimes, when he gets angry with me, he beats me.”

The relationship between marital gender equity beliefs and norms and verbal abuse is examined in Table 16. This relationship is examined separately from the analysis in Table 16 due to collinearity between marital gender equity beliefs and marital communication and support.

Table 16: Regression analysis of marital gender equity beliefs and norms as associated with verbal abuse (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.364	.182	7.500	<.001
Marital GES	.266	.126	2.102	.037

R	R Square	Std. Error of Estimate
.170	.029	.271

Marital gender beliefs and norms are associated with verbal abuse, meaning that women with equitable gender norms and beliefs after marriage are less likely to experience verbal abuse (Table 16).

There is no statistically significant relationship between marital gender beliefs and physical abuse (p= .322). The non-statistically significant relationship could be due to the fact that physical abuse was generally less prevalent than verbal abuse in this sample. There is some evidence from studies previously conducted in the study area that many women, particularly those with less equitable gender norms do not necessarily perceive actions like slapping to be physical violence or women may perceive an action like slapping to be justified (Maitra and Schensul 2002).

Marital communication and support and marital gender equity beliefs are statistically significantly associated with each other, as well as a woman's risk of verbal or physical abuse from her husband. As shown in this section, the context of the marital family in terms of the marital relationship and women's gender beliefs and roles are also impacted by pre-marital factors, including the woman's age at marriage and the gender norms and behaviors of her natal family. In the next section, the focus shifts to examining women's health outcomes.

Marital Health Problems

Women's health problems were discussed in more broad, descriptive terms in the previous chapter, but there are also several key relationships between pre-marital and marital variables and

women's health problems. Table 17 examines the relationship between natal family factors and marital health problems.

Table 17: Regression analysis of natal family economic status and natal family gender equity associated with marital health problems (dependent variable).

Model	Variables	Unstandardized coefficients		T	Sig.
		B	Std. Error		
1	Constant	1.458	.096	15.137	<.001
	Natal Family Economics	.143	.053	2.693	.008
2	Constant	.582	.132	4.417	<.001
	Natal family economics	.065	.045	1.451	.149
	Natal family gender equity	.594	.071	8.351	<.001

Model	R	R Square	Std. Error of Estimate	Change Statistics				
				R-square Change	F change	Df1	Df2	Sig. F change
1	.216	.047	.195	.047	7.251	1	148	.008
2	.595	.353	.161	.307	69.741	1	147	.000

Marital health problems are predicted by natal family gender inequity and natal family economic status (Table 17). The relationships in Table 17 suggest that equitable treatment and food security from an early age contribute to fewer health problems later in a woman's life.

Tables 18 and 19 examine the relationships between marital verbal abuse and physical abuse with health problems.

Table 18: Regression analysis of the association between marital verbal abuse and marital health problems (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.428	.103	13.928	<.001
Marital verbal abuse	.164	.058	2.823	.005

R	R Square	Std. Error of Estimate
.226	.051	.194

Table 19: Regression analysis of the association between marital physical abuse and marital health problems (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.397	.100	13.951	<.001

Marital physical abuse	.115	.036	3.208	.002

R	R Square	Std. Error of Estimate
.255	.065	.193

As shown above, marital verbal abuse (Table 18) and marital physical abuse (Table 19) are associated with marital health problems. The relationship in Table 18 suggests that as marital verbal abuse increases, marital physical health will be poorer. The relationship in Table 19 suggests that as marital physical abuse increases, marital physical health will also be poorer. The analyses in Tables 17-19 support the relationship between positive natal family factors, positive marital relationship factors, and women's health outcomes.

Reproductive and Sexual Health Outcomes

Both the pre-marital context in terms of a girl's agency and treatment by her family, as well as the marital context in terms of relationships, abuse, and gender beliefs contribute to a woman's reproductive and sexual health outcomes in marriage.

Reproductive Health

Table 20 examines the relationship between natal family gender equity and reproductive health outcomes in a multiple regression model.

Table 20: Regression analysis of natal family gender equity, natal family agency, and marital verbal abuse as associated with reproductive health (dependent variable).

Model	Variables	Unstandardized coefficients		T	Sig.
		B	Std. Error		
1	Constant	.790	.108	7.290	<.001
	Natal Family Gender Equity	.523	.063	8.317	<.001
2	Constant	.611	.145	4.214	<.001
	Natal Family Gender Equity	.542	.063	8.570	.000
	Natal Family Agency	.100	.054	1.833	.069
3	Constant	.524	.150	3.499	<.001
	Natal Family Gender Equity	.511	.065	7.921	<.001
	Natal Family Agency	.089	.054	1.657	.100
	Marital Verbal Abuse	.089	.044	2.018	.045

Model	R	R Square	Std. Error of Estimate	Change Statistics				
				R-square	F change	Df1	Df2	Sig. F

				Change				change
1	.564	.319	.145	.319	69.180	1	148	<.001
2	.578	.334	.144	.015	3.359	1	147	.069
3	.593	.352	.143	.018	4.074	1	146	.045

In a hierarchal multiple regression model, natal family gender equity plays a very important role in predicting a woman's reproductive health outcomes (Table 20). Natal family agency is not quite a statistically significant predictor of reproductive health, but this could be due to inter-correlation between natal family agency and gender equity. The near significance of natal family agency as a predictor of reproductive health indicates a trend of natal family agency being a positive predictor of reproductive health. Marital verbal abuse, when added to the regression model is also significantly associated with of reproductive health. The regression model in Table 20 indicates that women who grew up in more gender equitable families, with more agency, and who experience less verbal abuse from their husband, have more positive reproductive health outcomes. Some of these positive reproductive health outcomes include delayed childbirth, fewer overall births, fewer miscarriages, and fewer abortions. See Figure 3 for key variables predicting reproductive health.

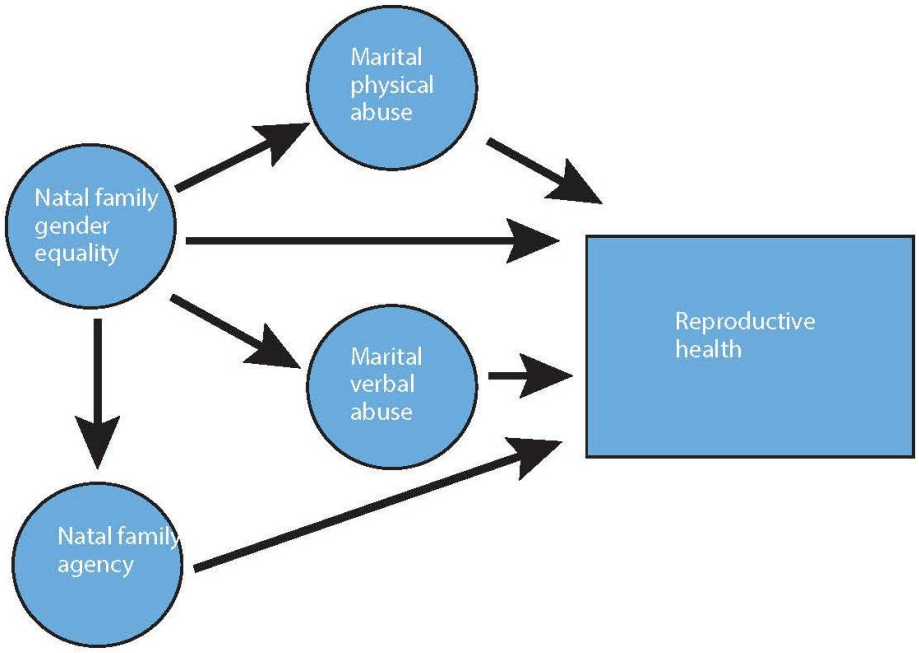

Figure 3: Key variables related to reproductive health.

Table 21 examines the relationship between natal family agency and the woman's current hemoglobin (as measured with the Hemocue).

Table 21: Regression analysis of association between natal family agency and hemoglobin values (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	6.659	1.287	5.174	<.001
Marital physical abuse	2.062	.867	2.377	.019

R	R Square	Std. Error of Estimate
.194	.038	2.317

Natal family agency is positively correlated with current hemoglobin, which is a component of reproductive health (Table 21). The positive correlation between agency and hemoglobin indicates that although agency may not have a direct impact on reproductive health outcomes, agency does impact components of reproductive health. One young woman described her reproductive decision-making, providing an example of some of the trends contributing to improved reproductive health:

> In the beginning, we [her and her husband] decided that we shouldn't have any children for at least 2 to 3 years. Because, if I conceive a child right away, it will be a problem for me to look after myself, my baby, the house, and my studies. So, I didn't want to have a child right away. Then, for 5 or 6 months, I thought about it and I took some pills in the beginning, so I wouldn't conceive a child. (twenty year old Hindu woman, married at age nineteen, currently in college)

The regression model in Table 20 also indicates that women who grew up in less gender equitable families, had less agency, and who experienced more verbal abuse from their husband have poorer reproductive health outcomes. Women who grew up in gender inequitable families are more likely to have experienced food insecurity before marriage, contributing to poor nutrition and high rates of stunting. Young women with less natal family agency are also more likely to have married earlier, which may explain poorer reproductive health outcomes such as more pregnancies with less birth spacing, more miscarriages, and more abortions.

Table 21 shows a comparison of reproductive histories between women married under age eighteen and women married over age eighteen. Only categories where there are statistically significant differences or trends pointing to differences are shown.

Table 25: Comparison of reproductive health indicators between young women married under 18 and young women married over 18.

	Early Marriage	Delayed Marriage	P-value
Mean age at 1st pregnancy	16.5 years	20.4 years	<.01
3 or more pregnancies	16.6%	2.1%	<.01
Stunting of the woman	55.17%	40.22%	.074

Table 21 shows a trend of adolescent mothers being in poorer nutritional health as indicated by the percentage of adolescent mothers who exhibit stunting or short stature. Table 21 also provides evidence that adolescent mothers are more likely to have multiple pregnancies, possibly contributing to other poor outcomes. Although not statistically significant, adolescent mothers also have higher rates of having had one or more miscarriages (16%) compared to women who delay marriage (9%), and a higher rates of having had one or more abortions (15% of adolescent mothers versus 11% of older mothers). One young woman who illustrates the factors contributing to poor reproductive health described her challenges as follows:

> …Since I have gotten married and come here, my menses are irregular. Sometimes, I don't get my menses for a month or two months. So, for two months, I didn't get my menses, and everyone in the family thought I was pregnant. I didn't go to the hospital or get any kind of check-up, but my mother-in-law thought I was pregnant. They all went to the village, and I was alone here with my husband. We had to fetch water, and we went there with big, big pots. I carried a heavy pot of water on my waist, and while I was doing this, I started to have very severe abdominal pain and bleeding. So, I think I had a miscarriage, but I'm not quite sure if I was pregnant or not…My mother-in-law and father-in-law have told me that if I don't conceive another child by the month of December, we will ask our son to take a divorce, and we'll get him married to another person. (19 year-old Buddhist woman, married at age 16, illiterate)

Physical abuse is also often associated with poorer reproductive health outcomes, but due to collinearity, physical abuse could not be examined in the model in Table 21. A separate model was used to examine the relationship between physical abuse and reproductive health (Table 22).

Table 22: Regression analysis of natal family gender equity and marital physical abuse as associated with reproductive health (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	.678	.120	5.642	.000
Natal Family Gender Equity	.498	.063	7.856	.000

Marital Physical Abuse		.056	.027	2.050	.042
R	R Square	Std. Error of Estimate			
.581	.337	.144			

The regression model above shows that reproductive health is associated with marital physical abuse (Table 22). This association indicates that women who experience less physical abuse also have better reproductive health outcomes.

Sexual Health

This section examines the associations between pre-marital factors, marital factors, and sexual health outcomes. Table 23 looks specifically at natal family agency, pre-marital social network, marital communication and support, marital gender equity norms and behaviors, and marital physical abuse.

Table 23: Regression analysis of pre-marital (model 1) and post-marital (model 2) variables associated with sexual health (dependent variable).

Model	Variables	Unstandardized coefficients		T	Sig.
		B	Std. Error		
1	Constant	1.327	.088	15.047	<.001
	Natal Family Agency	.128	.060	2.117	.036
	Pre-marital social network	.030	.014	2.167	.032
2	Constant	.428	.119	3.604	.000
	Natal Family Agency	.051	.049	1.048	.296
	Pre-marital social network	.025	.011	2.265	.025
	Marital Communication and Support	.069	.030	2.275	.024
	Marital Gender equity beliefs	.410	.061	6.714	.000
	Marital Physical Abuse	.109	.025	4.430	.000

Model	R	R Square	Std. Error of Estimate	Change Statistics				
				R-square Change	F change	Df1	Df2	Sig. F change
1	.268	.072	.159	.072	5.681	2	147	.004
2	.652	.425	.127	.353	29.450	3	144	.000

In the first step of the regression model shown in Table 27, natal family agency and pre-marital social networks positively predict sexual health such that as natal family agency and size of pre-marital social network increase, so do positive sexual health outcomes. In the second step of the model, marital communication and support, marital gender equity beliefs, and marital physical abuse are added and

positively predict sexual health outcomes. See Figure 4 for the key variables associated with sexual health.

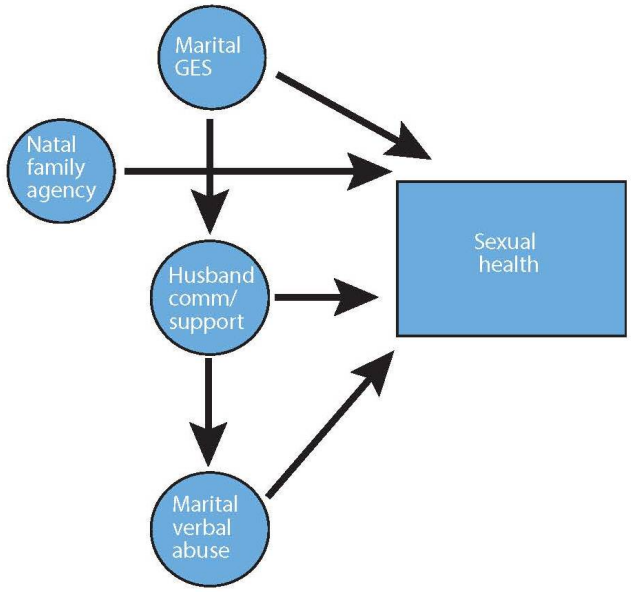

Figure 4: Key variables associated with sexual health.

Table 24 examines the association between marital verbal abuse and sexual health separately from the model above. This is, again, due to the fact that verbal abuse and physical abuse are too intercorrelated to be in the same model.

Table 24: Regression analysis of marital verbal abuse as associated with sexual health (dependent variable).

	Unstandardized coefficients		T	Sig.
	B	Std. Error		
Constant	1.130	.079	14.301	<.001
Marital Verbal Abuse	.251	.045	5.610	<.001

R	R Square	Std. Error of Estimate
.419	.175	.149

Table 24 indicates that less marital verbal abuse is associated with improved sexual health.

The regression analyses presented in Tables 23 and 24 indicate two different ways in which the natal and marital family contexts impact sexual health. Women who had more agency before marriage and larger social networks have more information regarding sex, and are less surprised and scared on their

first nights which contributes to more positive sexual initiation. As one woman stated, "Some girls are just more sexy…they know more about sex, so they can enjoy it more." As predicted by the regression models, women who are able to communicate more effectively with their husbands, have more gender equitable beliefs, and experience little or no physical abuse are also more likely to have positive sexual experiences.

Conversely, there are women who enter marriage with limited agency and knowledge of sex, contributing to unpleasant first night experiences. These unpleasant first night experiences, combined with poor marital communication and support as well as abuse from their husbands contribute to poor sexual relationships for many women. One woman described her early difficulties with sex:

> For a month after the wedding, I wouldn't let my husband sleep with me…My husband was annoyed. So, he packed up all of my things, and told me I should go back to my mother's home. Then, I explained to him, I don't know anything about sex, I don't know what it is all about. He asked me, how do not have any knowledge? Don't you watch movies? I said, I only watch Hindi movies and they don't show all about sex. He showed me a blue film, but that was too much. I was afraid, and I thought, is this what sex is like? Is this what he expects me to do? Blue films don't show normal sex. So, I was still not ready for it. So, he told me to go back to my mother's house, and said he wanted a divorce. And, my in-laws were angry and asked me, if you are so afraid of sex, why did you get married? …After a month, we slept together, and it was very painful for me and there was a lot of bleeding, and I didn't know why. After it was over, I ran to my mother-in-law, and she said that all this happens. My husband knew this, and he should have told me that this happens…I went to the doctor, and the doctor gave me some medication and the doctor told me not to have sex with my husband for at least 8 days. My husband didn't listen to this, and it was very painful. (22 year old Buddhist woman)

Summary of associations

This chapter has traced the ways in which pre-marital and post-marital variables are associated with each other. The natal family economic situation impacts the gender norms of the natal family. Natal family agency is associated with both contextual factors such as religion and amount of time spent in the study area as well as aspects of a girl's life beyond her family such as social networks and education. This section also examines associations between marital variables as well as the ways in which pre-marital characteristics can impact post-marital outcomes such as marital communication and support and abuse as well as physical, reproductive, and sexual health.

Chapter 6: Dissemination and Recommendations

This chapter presents the third stage of the research, focused on intervention and the need to understand what efforts have been made to meet the needs of girls and young women as reflected to date in the literature, that the development of effective interventions must be based on accurate ethnographic work, as well as participation by the study population in recommending interventions (Schensul 1985). This chapter reviews the literature for effective intervention for young women and girls and with this perspective sought feedback on the veracity of the results, and recommendations for intervention programs. The key to these steps was effective dissemination that could generate feedback with key stakeholders and the study population. The dissemination had three objectives: first and most importantly to deliver back to the study communities and key informants the results of research for which they played a key facilitating role (CBPR; Israel et al., 1998). Second, to try to assess the degree to which these results can contribute to social change, in keeping with the Transformative Anthropology approach (Schensul et al., 2015). Third, to validate the results by eliciting the perspectives of study community residents and key informants, described as "member-checking" (Miles and Huberman 1994; Lincoln and Guba 1985; Creswell and Miller 2000).

Learning from other programs

There have been a number of programs implemented both in India as well as other low and middle-income countries to address some of the antecedents and consequences of child marriage, and adolescent healthcare needs. In this section, these programs are discussed, and in combination with the results presented in the previous chapters, are used to help inform the recommendations at the end this chapter.

Programs to prevent child marriage

There have been three primary reviews of programs to reduce child marriage, and all three examined programs that have been implemented both in India as well as other countries around the world

(Jain and Kurz 2007; Lee-Rife, et al. 2012; Malhotra, et al. 2011). The reviews included the content of the programs, whether or not the programs were evaluated, the rigor with which the programs were evaluated, and the outcomes and limitations of the different types of programs (Jain and Kurz 2007; Lee-Rife, et al. 2012; Malhotra, et al. 2011).

The primary approaches and foci in the different programs and initiatives are: empowerment of girls through information, life-skill building, and social networks; education and mobilization of parents and community members; enhancing the accessibility and quality of education for girls; providing economic support and/or incentives to girls and/or their families; and fostering an enabling legal and policy framework (Jain and Kurz 2007; Lee-Rife, et al. 2012; Malhotra, et al. 2011). Most programs examined in all three studies used more than one approach. Programs seeking to empower girls attempt to do so through providing occupational and life skills training, information on health and social issues in a safe space where girls can meet other girls and build social networks. Programs working with parents and community members try to provide information and use role models to change gender norms and beliefs of the community and key decision-makers. Programs focusing on education attempt to provide resources for school preparation and enrollment (or re-enrollment in the case of girls who have had to drop out), as well as scholarships and monetary support for school supplies and uniforms. In the fourth approach, programs have provided cash or non-cash financial incentives to families or girls who remain unmarried to a certain age and/or provide microfinance and training to support income generation of girls. This financial incentive approach attempts to address some of the economic reasons families marry girls early, which is to offset the financial burden of daughters. The fifth approach focuses on legal and policy reform, advocating for the development, implementation, and enforcement of policies and initiatives supportive of girls and women. One separate report describes programs that have been conducted only in India (Gupta, et al. 2008), and another report describes financial incentive schemes that have been attempted in India (Sekher 2010). All the approaches described above have been used either separately or in combination in India.

The relatively short length of time initiatives and programs have been in existence is cited by researchers as a limitation to understanding which programs have been most effective (Gupta, et al. 2008; Jain and Kurz 2007; Lee-Rife, et al. 2012; Malhotra, et al. 2011). Researchers also state that many of the programs have not been evaluated in a scientifically rigorous manner further complicating understanding of what has been successful and what has not. However, based on the available evaluation data, researchers have been able to identify some programs and factors that have had positive impacts in India. Lee-Rife, et al. (2012) found that programs attempting to empower young women through provision of life-skill development, occupational training, health education and services, and included a community norms changing component were most successful in India. Lee-Rife, et al. (2012) termed these programs "horizontal" due to their multi-pronged approach. Jain and Kurz (2007), Malhotra, et al. (2011), and Gupta, et al. (2008) find results consistent with Lee-Rife, et al.

Gupta, et al. (2008) note that cash transfer schemes that provide families cash incentives for meeting certain milestones for their daughters, including waiting until their daughter is over 18 to get married have not fully taken effect, as the first cohorts of girls have not turned eighteen yet and the schemes have not been fully evaluated. Gupta, et al. (2008) do find that preliminary data shows that the cash incentives have had some implementation issues as not all families are aware of the program and states have not always supported the programs with adequate administrative resources. Sekher's (2010) review examines fifteen different cash incentive programs in India, and found similar problems across programs. In addition to the problems identified by Gupta, et al. (2008), Sekher also found that families had difficulties meeting the documentation requirements for each milestone and opening bank accounts to receive the incentives, and thus had difficulty obtaining incentives. Further evaluation of the impact of these cash transfer schemes on the age at marriage is ongoing as the first cohorts of girls enrolled are turning eighteen.

The researchers reviewing the programs around the world, as well as in India, note that there is a need for more programs that focus on married adolescents and not only unmarried girls and adolescents. Researchers also state that more programs need to focus on keeping young women in school, and making

it easier for young women (both married and unmarried) to re-enroll in school. Programs focused solely on the policy framework were less effective regardless of the country context. In addition, researchers point out that child marriage is impacted by multiple factors at a variety of levels and requires a multi-pronged, long-term approach, which may be difficult to fund and sustain (Gupta, et al. 2008; Jain and Kurz 2007; Lee-Rife, et al. 2012; Malhotra, et al. 2011).

Programs for adolescent health

In response to the issues with the 2006 adolescent health strategy, an adolescent healthcare and counseling clinic was developed, implemented and evaluated in a district in Kerala, India (Nair, et al. 2012). The clinics and strategies for outreach were developed in consultation with stakeholders including adolescents, young adults, teachers, parents, healthcare providers, and government officials. The clinics were able to offer comprehensive mental health counseling as well as adolescent SRH services to married and unmarried women and men.

The authors of the study report a positive response to the clinic, from both parents and adolescents. The authors also stated that, in the event that a trained mental health provider was not available, the training that the healthcare providers received for working with adolescents was sufficient to provide a first point of contact such that the adolescents in need of more in-depth mental health counseling could be referred. Nair, et al. (2012) feel that the model they introduced in Kerala could be replicated elsewhere, although they do not discuss sustainability of the clinics after the study ended.

Dissemination

A growing body of literature suggests that dissemination to a variety of groups outside academia is crucial to both creating change and also providing groups outside traditional research circles with a voice and opportunity to provide feedback to the researcher (Chen, et al. 2010; Kerner and Hall 2009; Kerner, et al. 2005; Wandersman, et al. 2008; Davis, et al. unpublished; LeCompte and Schensul 2015; AAA code of ethics 2012). However, dissemination of results to stakeholders, particularly to community members continues to be relatively rare, especially in anthropology. In health-related disciplines where dissemination is somewhat more common, there is debate over what is the most effective model for

dissemination (Chen, et al. 2010; Kerner, et al. 2005; Rabin, et al. 2010). Here, one approach to dissemination of preliminary results to a variety of audiences is described.

Methodology and Structure of Dissemination

I returned to Mumbai in January 2015 for dissemination and member-checking focus groups (Miles and Huberman 1994; Lincoln and Guba 1985; Creswell and Miller 2000). Three member-checking focus groups were conducted with married young women between the ages of 15-25. Although focus groups are often used for in the early stages of research for discovery, we found that focus groups were useful here by allowing participants to respond to more specific questions generated from data collection in the study area (Bernard 2006; Hautzinger 2012; Schensul and LeCompte 2012). There were between nine to twelve participants at each focus group. At the focus groups general trends and findings from the qualitative and quantitative data were presented and young women were asked to discuss the relevance of the findings to their own experiences. The focus group discussions were conducted in empty private homes and an NGO office in the study area.

Dissemination meetings and presentations were conducted at three NGO offices (approximately 10 to 20 participants at each meeting) and the urban health center in the study area (approximately 40 participants). All of the NGO offices were located in different areas within the study area. The audiences (primarily female) at the meetings at the NGO offices included: community residents, NGO field staff, and NGO coordinators/leadership. The audience at the urban health center was more evenly split between male and female and included: community health volunteers, physicians, and medical interns. Preliminary results were also presented to a methods class at the International Institute of Population Sciences in Mumbai, and to faculty and students at a smaller meeting at the Tata Institute of Social Sciences, also in Mumbai also in Mumbai. At the dissemination meetings, the methods and key trends and results of the study were presented via PowerPoint slides in formats tailored to the different audiences. Trends associated with gender equity, agency, timing of marriage, marital outcomes, abuse, and sexual and reproductive health were discussed. Audience members were encouraged to discuss whether they agreed

or disagreed with the findings, whether they could provide their own examples, and what they felt needed to be explored more in either this study or in future studies.

Resident Feedback

Changes in women's roles

For those who participated in the dissemination there was a recognition that the status of women in the study area has greatly improved, especially over the past two decades. NGO workers noted that, in particular, there is a much greater desire on the part of parents to make sure their daughters receive an education, both to improve her marriageability (parents of eligible sons increasingly recognize the advantages of two income families) and her earning potential. One NGO worker stated,

> In some parts of the community, girls have become very educated. Parents want their daughters to be educated because if a boy and his family comes to see your daughter, they will want to know your daughter's [educational] qualifications. Also, parents now realize that educated girls can earn more.

Young women pointed out, however, that there continues to be gender disparities in how much parents are willing to invest in their daughter's education. These young women also pointed out that, even if parents feel that their daughters should be educated, financial difficulties will create obstacles to a young woman's education, including favoring sons when resources are limited.

Many participants in the dissemination (both young women and individuals working in the study area) noted that with increasing education, there was also increasing acceptance for young women and girls to work outside the home. Participants described how historically, a woman working outside the home would be criticized and gossiped about (and so would her family members), but with the rise of more employment options for women (such as in malls, office buildings, or small factories), it was no longer as unusual for a woman to work outside the home. One Hindu woman (24 years old) explained in a focus group:

> Earlier, if girls went to work, then people would judge the family. Now, it's different, and they feel that it's good for girls to stand on their own feet and be more independent. It used to be that girls couldn't go out [to work] at all, but now you see them out a little more.

Participants in the dissemination feel that gender inequity within families has been greatly reduced through changing social norms. Greater awareness of the negative impacts of early marriage have contributed to a slow increase in the average age at marriage. One young women in a focus group explained that her mother had been married at the age of fifteen, but her parents had waited to get her married until she turned eighteen. However, gender inequitable norms persist in many sectors of the study area. NGO workers and researchers attribute persistent gender inequity to conditions within families, and state that young women and men, particularly those who are not in school, do not have many positive role models growing up. Rather, many adolescents reproduce the gender inequitable behaviors and norms that they witness as children. Young women in the focus groups agreed and stated that there are parts of the study area where beliefs about women continue to be "backward."

Participants in the dissemination also noted that the changes that have occurred in the study area have been slow and extremely uneven. Transportation to and from the study area and connectivity of the study area with the rest of Mumbai has improved. However, NGO workers commented that some places in the study area remain relatively isolated and underserved, creating pockets of young women who are at particularly high risk for early marriage and poor health outcomes. Some parts of the study area lack regular access to services such as water and electricity making it difficult for families to meet even the most basic needs of their children. NGO workers identified these areas as having young women who are the most isolated and difficult to engage in programs. In the better off sub-sections of the study area, young women are attending school and college and using new technologies such as cell phones and computers. Young women from these areas are more easily able to access existing programs for youth. Due to these disparities, dissemination participants felt that it was important not to overstate the impact that a "globalized India" is having on this corner of Mumbai.

Safety in the study area

A primary topic of discussion by all participants in the dissemination was safety in the study area. There was one section of the study area (predominantly Hindu area closest to the train station and services) where safety was viewed as less of a concern. However, all other areas were described as being

increasingly dangerous for girls and women. Increasing fear of violence was cited by nearly all groups as a primary factor perpetuating underage marriage in the study area. The general sense is that most parents have heard of the negative physical and social consequences as well as the potential legal ramifications of early marriage. However, parents perceive that the likelihood of physical or sexual assault endangering their daughters and rendering them unmarriageable is much greater than any negative consequence of early marriage. As a result, parents are continuing to seek early marriage. NGO workers described trying to talk parents into postponing marriages, but that these attempts were usually unsuccessful, particularly due to the overwhelming fear of negative elements in the community.

Once girls are married, the understanding is that they will be safe (restricted in her movements) and protected by their husbands and in-laws. However, young women in the focus groups stated that their concerns over safety in the study area did not end with marriage. Young women felt that gossip, eve-teasing, and assault were just as likely after marriage as before. One woman in a focus group narrated the following experience,

> …I was walking in the market with my husband three days ago. A fellow came up to me and touched me inappropriately. My husband tried to run after the fellow, but I told him not to bother. So, these things happen everywhere in the community whether you are married or not and whether you are accompanied by someone or not… in every lane these things happen. (25 year-old Muslim woman)

The concerns over violence are further compounded by an overwhelming sense among community members that law enforcement officers will either not respond to complaints or will blame the woman/family making the complaint. NGOs in the area have recently started trying to facilitate interactions between police and the community with respect to sexual violence.

Reasons for the increase in violence and perceptions of violence were also discussed in the dissemination. Young women in the focus groups were not sure why the area had become less safe. They did state that there were more boys "roaming around" who were not taking care of their families as they should have been and were engaged in *faltoo* (nonsense activities). Young women also noted that there were more reports of violence and sexual assault and that they heard more about rapes of girls and women

than in previous times. The sources of information on increased violence came from discussion within the community, as well as print and visual media.

Participants in the dissemination presentations had a broader range of theories as to why violence was an increasing concern. Some respondents felt that parents were not communicating enough with their children, especially with their sons. Many respondents feel that sons have been pampered to the extent where parents do not discipline them or encourage them to work or stay in school. Other respondents stated that it was simply more difficult for boys and young men to find work, resulting in boredom on the part of the young men. Participants described that there appeared to be more young men with nothing to do but hang around and "roam" creating opportunities for eve-teasing and harassing young women. In one dissemination meeting, community members and NGO workers also described how men were not adapting to the new roles of women very well, which could also be contributing to some resentment between the genders. The audience members in this dissemination noted that men had never really been expected to adjust their ways of thinking about women, or accommodate wives who wanted to work outside the home. Overall, participants also felt that reports of rapes and other forms of violence were a means of keeping women "in their place." Participants had mixed opinions as to whether or not the study area has actually become less safe or is just perceived that way due to increased reporting and media.

The Marital Relationship and Sexual and Reproductive Health Outcomes

In terms of the marital relationship, participants agreed with the trends identified in the research, including the greater difficulties that married adolescents have communicating with their in-laws and husbands. Respondents in the dissemination meeting felt that there was a need for more open communication between young women and their husbands, which does not always happen when the bride is an adolescent. Women in the focus groups noted that married adolescents also have greater difficulty asking for support from their natal family. These new brides fear the potential damage to their natal family's reputation if the bride is sent home to her natal family.

Participants in both the focus groups as well as the dissemination meetings strongly felt that the greatest barriers to positive sexual and reproductive health for young women are early marriage and lack

of information before marriage. Participants in the dissemination pointed out that adolescent girls are not physically or emotionally mature enough for the sexual relationship or childbearing. This lack of maturity is further complicated by the lack of knowledge that many young men and women have about sex and reproduction before marriage. Participants in the dissemination meetings said that women and men needed to be better prepared for sex and reproduction and ways to communicate about these aspects of marriage. Most of the women in the focus group discussions stated that they wished they had known more about sex before marriage. Women in the focus groups also felt that those young women who are better educated and know more about sex before marriage have more positive sexual relationships with their husband, because they know what to expect and are better able to contribute to creating a more equitable sexual relationship. Women in the focus groups requested that there be more information on sex, reproduction, and contraceptives to both young men and women in the study area.

Recommendations for positive change

Participants in the dissemination highlighted several deficits in services and programs in the study area. First, participants stated that there is a need for more interventions at the family and community levels. From the perspective of participants, family level interventions should work on facilitating communication between parents and children. Community level interventions need to focus on promoting gender equity and creating safer spaces for women and girls. Participants also felt that there was a need for more programs and services targeted to adolescents, both girls and boys. Specifically, they felt that there is a need for more health education classes, more life skills courses, more support to continue education (even after marriage), and more health services. Participants also noted that previous efforts for adolescents had been too transient to effect change, consisting of one day events, or programs linked to grants that disappeared when then the grant ended. Rather, participants stated that future programs need to be more sustainable.

Recommendations

The recommendations made during the dissemination as well as the programs described above indicate that addressing the impacts of early marriage on sexual and reproductive health requires multi-

sectoral approaches that can be sustained. Based on the results of this study, feedback from the dissemination, and the research from previous program and interventions, the following recommendations are made:

1. Provide adolescent-friendly training to the healthcare providers and CHVs working in the study area.
2. Develop an adolescent OPD in the UHC in keeping with the new adolescent healthcare policy, RKSK. As stated in the RKSK documents, healthcare, health education, and counseling should be provided to both married and unmarried adolescents in a sensitive and confidential manner.
3. There continues to be a need for more sustained health and gender equity education for young women and men in the study area. Therefore, we suggest expanding occupational and life skills courses for both young men and young women in the study area. Health and gender equity information could be easily incorporated into these classes.
4. Drawing from couples' interventions, address the antipathy between the genders.
5. There is also a desire on the part of many married women who either did not attend school or dropped out of school early to gain additional education, particularly once their own children are in school. Providing some adult learning opportunities in the study area would be another way for young women to gain new skills.
6. CHVs and NGOs need to make more efforts to reach out to those girls who are not in school and who have the most restricted mobility, as well as the parents of these girls. Girls who are not in school and have restricted mobility are at higher risk for early marriage and problems resulting from early marriage.
7. There is also a need for more counseling interventions involving the whole family to facilitate communication between parents and children.
8. There is a need for sexual and reproductive information for men.

9. Community level interventions need to bring together multiple sectors from schools, healthcare, law enforcement, religious institutions, NGOs, and families to address concerns over safety in the study area and ways to create a more supportive environment for women and girls in a way that does not further antagonize and alienate men and boys.

This study and the recommendations from the dissemination suggest a need for new approaches and interventions to support young women in the study area. One particularly high risk group of young women that was identified are young women who are not in school. One possible intervention could be situated in occupational classes. Existing occupational classes could be expanded to include a life-skills component promoting equitable gender norms and providing health information. Similar classes could also be developed for young men in the study area. As noted in the study, young women also need a supportive family and community context for individual-level interventions to be effective. One way to address the family and community levels would be to have meetings for parents jointly organized by the religious sector, NGOs, and law enforcement. At these meetings, parents could raise questions and concerns regarding their adolescent children and receive support from other parents as well as key mobilizers and leaders from the study area. Finally, to address some of the lapses in healthcare, a dedicated adolescent outpatient department should be established at the Urban Health Center in line with the new RKSK guidelines. To address communication concerns, family counseling sessions could be also be offered at the adolescent clinics in the UHC. These interventions draw on existing resources and attempt to address concerns raised in both the literature as well as in the study area.

Chapter 7: Discussion and Conclusions

This chapter integrates the qualitative, quantitative and dissemination results examined through the lens of the theoretical frameworks that guided the conceptualization of the research. Through an integrated framework using the life course approach, feminist theories of agency, and critical medical anthropology, young women's transitions are explored at the structural, cultural, and individual levels.

Orientations to Globalization and Gender Equity: Three Sub-groups of Young Women

Three sub-groups of young women have been identified. Each of these sub-groups represents girls growing up in families with different orientations towards gender equity and globalization, which are reflected in the socialization and agency of the young women. These pre-marital factors impact the timing of marriage for young women and as we saw in the qualitative and quantitative results, women's post-marital sexual and reproductive health outcomes.

Sub-group 1: Girls with high levels of agency growing up in globalized families

Young women in the first sub-group typically come from families with more resources that allow the family to provide girls with the same opportunities as their male siblings, including higher education in more expensive schools, fewer household responsibilities and rules, and improved access to food and healthcare. These families also have more gender equitable cultural models and have been able to take greater advantage of some of the positive impacts of globalization, such as employment in more stable sectors and more education and work opportunities for women. As a result, girls in this sub-group are encouraged to make more decisions for themselves in terms of pursuing an education and working before

marriage, and have more mobility allowing them to participate in activities both inside and outside the study area. Girls in this sub-group are able to develop more agency and have larger social networks.

In spite of community fears and less equitable gender norms that persist in many parts of the study area, girls in these families are taking advantage of the changes occurring in the more globalized India outside the community to use agency to resist patriarchal practices. This is in keeping with feminist anthropologists who have built on Bourdieu's (1977) theories of practice and agency to understand the ways in which women may enact agency in new ways during periods of social change. From a structural perspective, these young women are also experiencing the benefits of international and national discourses on the rights of girls and women, which are providing a more supportive social environment for these girls and women to gain more agency.

With higher levels of agency and a more supportive family context, girls in this sub-group are able to delay marriage until they are ready. Girls in this sub-group are also given more of a voice in the arrangement of their marriages and tend to marry into families with similar norms and expectations as their natal family. The similarities in expectations and environments between the natal and marital families mean that women in this sub-group have easier transitions. Women also have better relationships with their in-laws, and their in-laws and husbands are more flexible about allowing the young woman to continue her education or work outside the home. This more equitable and supportive environment enables young women in this sub-group to perpetuate gender equitable norms learned in their natal families, and to have better communication and receive more support from their husbands.

The ease in the transition from the natal family into marriage further emphasizes how the cultural models held by key adults in a young woman's life can impact positively on her sexual and reproductive outcomes. Women in this sub-group also have the most positive sexual and reproductive health outcomes. These women experience less abuse from their husbands, which contributes to more positive reproductive health outcomes. Women in this sub-group describe having more knowledge of different types of contraceptives that they have received from programs in school or from community NGOs. These young women are also comfortable discussing family planning and spacing with their husbands. Due to delayed

marriage, these young women also delay childbearing and thus have fewer overall births in addition to fewer miscarriages and abortions. Women in the first sub-group also qualitatively experience less food insecurity and have better nutrition, which may explain their lower rates of anemia. Higher hemoglobin and less anemia may also, in turn, be contributing to some of the improved reproductive outcomes observed for these young women. Women in this sub-group tend to conceive their first child soon after marriage, likely because they have delayed marriage and are more ready for the first child soon after marriage. With respect to reproduction, these women are able to take advantage of national policies and programs that have promoted greater education, a career orientation and smaller family norms.

Women in this sub-group tend to have more positive sexual experiences starting from the "first night." For women with more education, sex is less of a surprise, as they report having received some information in school and from NGO programs. These women also draw on the knowledge of their social networks and hear about sex through friends, neighbors, and older female relatives. Several women also said that on the first night, their husbands waited until they were ready and talked to them about having sex. While some women in this sub-group describe some physical discomfort the first time they have sex, they have less traumatic first night experiences. Women in this sub-group feel more comfortable communicating with their husbands about the sexual relationship. The high levels of natal family agency and gender equity that characterizes this first sub-group give women more confidence in negotiating the sexual relationship and support the belief that it is acceptable for women to enjoy intercourse and that intercourse is not only meant for male enjoyment.

Viewed through the lens of critical medical anthropology, this group's positive reproductive and sexual health outcomes can first be attributed to the fact that these women come from families and marry into families with fewer economic problems allowing them the hope of moving into India's rapidly growing middle class. The women in this sub-group have the economic advantage to alter patriarchal power dynamics within their marital relationships. Such relationships are dysfunctional in the new India, since they undermine the economic mandate and aspirations to move up in class. Second, policies and programs promoting the rights of women and girls, as well as reproductive rights have been internalized

by the women, their families, and their social networks, enabling them to gain an education, delay marriage, make their own reproductive decisions, and have improved health outcomes.

Sub-group 2: Girls reproducing patriarchal norms in more patriarchal families

The second sub-group consists of girls and women who have lower agency, and tend to reproduce patriarchal norms. The cultural model held by natal families in this sub-group is gender inequitable, limiting girl's opportunities in favor of male siblings who are more valued. Familial economic instability is more common for girls in this sub-group, further limiting girls' opportunities for education. In addition, young women in this sub-group described fears that their families had about dangers or negative elements in the community that represented a threat to young women's *izzat*. As a result, young women in this sub-group are extremely limited in where they can go and with whom they can speak. These restrictions result in very small or nonexistent social networks for the girls in this sub-group and reinforce patriarchal norms allowing decisions to be made by parents or other family members. These girls have extremely limited pre-marital agency, increased fears about the community and little agency to determine key decisions such as continuing education, determining which potential suitor to marry, or the age at marriage. As a result, most girls in this sub-group get married below the legal age with men who they know as cross-cousins or men they may meet only on the wedding day. This young age at marriage is seen by natal families in this subgroup as a means of ensuring daughters are restricted in movement and interaction so that they are safe in a perceived dangerous community as well as safely transferring the responsibilities for protection to the husband and his family before an untoward event would diminish the girl's marriageability.

Women in the second sub-group who grow up in gender inequitable families and have less agency replicate the normative experience of being a young, junior wife to be dominated by her mother-in-law, her husband and older sisters-in-law. Due to the younger age of marriage for these women, their transition to marital life is often more abrupt and difficult. These women find themselves in marital and family relationships that reproduce the patriarchal cultural model of their natal family, explaining their lower scores on the marital gender equity beliefs and norms scale. These women also have poorer

communication and receive less help and support from their husbands. Women in this sub-group expect that their marital relationship is not equal. Even though young women may feel overwhelmed by the household work required of them, they feel that taking care of everything in the house is their duty. It is also more common for younger brides to live in a joint family and have a more over-bearing mother-in-law. The more family members there are, the more difficult it can be for young women and their husbands to communicate openly. In joint families, sisters-in-law and mothers-in-law make communication even more difficult by criticizing a young woman to her husband and blaming a husband when his wife is not acting appropriately. Early marriage is also predictive of increased physical and verbal abuse for young women in this second sub-group.

Women in the second sub-group have varying degrees of contact with their natal family after marriage. The natal families for women in this group expect their daughters to adapt to their new family and behave properly, and do not allow their daughters to return home too often. While women may not be allowed to return to their natal families very often, many follow the cultural norm of returning home for much of their first pregnancy and delivery. However, the women in this sub-group will not necessarily expect that their families will provide support or assistance with a difficult husband or in-law.

For women in this sub-group, natal family gender inequity and increased marital abuse contribute to poor reproductive health outcomes. They have limited to no knowledge of contraceptives and often state that they never discussed the timing of pregnancies with their husbands and believe that their husbands and/or God should dictate family size. In-laws and husbands for young women in this sub-group also monitor women's reproductive choices more carefully and make more of the decisions as to when a young woman should have another child or whether the young woman should undergo sterilization. Some women stated that their in-laws would monitor their menstrual cycles to make sure that they were not artificially delaying the first pregnancy. As these young women marry earlier and have lower rates of contraceptive use for birth spacing, they tend to have more pregnancies, more miscarriages, more abortions and more unwanted children. Women in this sub-group are more likely to have experienced food insecurity, both before and after marriage, contributing to poorer nutrition. Poor

nutrition and multiple births contribute to the higher rates of anemia for this sub-group. These young women also have a higher rate of delivery by C-section, perhaps as a result of nutritional deficits and short stature/stunting or their young age and physical immaturity.

One positive reproductive trend for women in this sub-group is that they tend to delay the birth of the first child longer than young women who marry later. This delay may be due to the fact that by marrying early and fulfilling traditional gender norms, there is less concern by husband and in-laws that the woman will not continue to fulfill her duties by bearing children. In addition, young women living in joint families who conceive early in the marriage may be rewarded for being a "good" daughter-in-law by receiving more care and dispensation from household work during pregnancy. In this way, women in the second sub-group enact agency through what some researchers have called the "patriarchal bargain" (Kandiyoti 1988). By performing expected gender roles of early marriage and obedience to their husband and in-laws, these women are able to exert some agency over the timing of their first pregnancy. This manner of exerting agency (as opposed to active resistance) has been noted as more common in South Asian and Middle Eastern culture (Abu-Lughod 1993; Abu-Lughod 1990; Mahmood 2005; Hilsdon 2007; Ram 1993).

With respect to sexual health, women in the second sub-group have little knowledge of sex, which contributes to generally negative "first night" experiences. While some young women report that their husbands are understanding of their anxiety and reluctance, other young women state that their husbands are annoyed, treat them roughly, and force sex. The fear, physical discomfort, and belief that they should simply submit to their husband's sexual needs on the first night tends to set the tone for sexual relations for the rest of the marriage. Women in the second sub-group resign themselves to the idea that sex is simply another duty they must fulfill to conceive children and be a good wife. These young women frequently have little interest in sex, but must submit to the demands of their husbands and rarely initiate sex. These women experience more violence and forced sex, and voice the opinion that they cannot and should not refuse sex too often.

Women in the second sub-group experience more structural inequities, as they often come from impoverished families who have been left out of the economic advances being made in India. Persistent poverty, gender inequity, and increased dangers (both real and perceived) in the community prevent girls and their families from benefitting from national and international discourses of human rights suggesting that girls should delay marriage, sex and childbearing. International and national human rights policies and programs do not address the underlying social and economic inequities perpetuating early marriage. They have little opportunity or understanding of how to negotiate their sexual relationships or reproductive choices. Rashid (2011) in her work on early marriage and sexual and reproductive health in Dhaka slums finds that, in spite of national policies promoting delayed marriage and improved sexual and reproductive health services, the realities of life in a low-income urban community preclude many women from taking advantage of these policies or programs. Government family planning policies and programs have put a great deal of emphasis on sterilization, and do not attempt to provide many contraceptive options beyond sterilization to low-income women. Further, given that women in this sub-group have little knowledge of contraceptives and higher fertility than their more educated counterparts, women in this sub-group often see sterilization as their only option for preventing further conceptions.

Sub-group 3: Discordant girls resisting familial norms

The qualitative data and a small minority of survey respondents indicated a third major sub-group. The primary characteristic of this third group is discordance with the norms and aspirations of their natal family and/or their husband's family. Often, these women grow up in families with less gender equitable norms and behaviors, however, there were a few cases in which women grew up in families where they were treated very equitably and felt well supported by their natal family. These women have a great deal of agency and generally aspire to more globalized norms. Due to less parental oversight (often because both parents are working or one parent does not live with the family), these girls have larger pre-marital social networks. Whether through continued education or employment, these women attempt to delay marriage for as long as possible and are also the most likely to have a love or "love-cum-arranged" marriage. By pushing the boundaries, these women often run the risk of alienating their natal families or

becoming the subject of neighborhood gossip. These girls reject the cultural models provided by their natal family and instead seek out role models presented by the media or their friends. This third sub-group takes advantage of changing norms and opportunities presented by globalization to enact agency through active resistance of their natal family's norms (Kabeer 1999; Mahoney and Yngvesson 1992).

These women may not accept the norms of their patriarchal families, but some may also react against the desires of their more equitable families to adhere to more traditional norms. Some of the women who received support from their families to continue their educations, but opted to leave school or not attend college in favor of a love marriage without their family's approval. The negative relationship in the regression analysis between gender equity and natal family agency can also be accounted for women who are treated equitably, yet choose to act outside their parents' wishes. One woman in the survey sample described how her family had always supported her, had paid for her to attend an English medium school, and encouraged her to attend college. However, when she had a love marriage and left school before completing her degree, her family rarely contacted her and provided little support when she later had difficulties with her in-laws.

Women in the third sub-group tend to have the greatest difficulties after marriage. Given that most of the women in this sub-group have love marriages and/or alienate their natal families, they rarely can rely on their natal families for support. These women have more agency and believe they should be treated as equals with men, but they often lack the means to exercise this agency in the marital context. They have difficulties with their in-laws because the women have aspirations for education or employment that their in-laws do not support. These women are also more likely to clash with their new in-laws understanding of how a "good" daughter-in-law should behave. As a result, they also suffer more from having their mobility curtailed as they are used to having larger social networks and more mobility. One woman was not allowed to leave the house without her husband or mother-in-law, nor was she allowed to continue work or education. The woman stated that she loved her husband and was happy with how he treated her, but was frustrated by the restrictions placed on her by her in-laws and her husband's inability to advocate for her. Problems with in-laws for this third sub-group are often exacerbated by lack

of dowry, and several women in this sub-group described being harassed by in-laws due to nonexistent (in the case of love marriages) or inadequate dowry.

For some women, these problems with their husbands result from their greater agency resulting in poor marital communication and husbands' fears that their wives may have an extra-marital affair. Even though most of the women in the third sub-group had love marriages and felt that they were marrying men who were supportive of their aspirations, several young women in this sub-group felt that their husbands maintained a strong sense of patriarchy and became more restrictive after marriage.

Women in the third sub-group often find that their husbands have bad habits such as alcohol use or interest in other women. These problems also occasionally occur for women in the other sub-groups, but were most apparent and most often described by women in this sub-group. These women also report more verbal and physical abuse than the young women in either of the other two sub-groups. Due to lack of support from other family members, these young women are in a particularly precarious position. Some NGO workers believe that these couples are more likely to divorce, although there were no women in either the qualitative or the quantitative sample who had gotten divorced. In this study, there were two instances of young women who found their relationships with their husbands to be untenable, and these young women took their children and returned to live with their natal families for several months.

The quantitative data indicates that women in the second sub-group have the poorest marital outcomes in terms of verbal and physical abuse, and marital communication and support. However, the qualitative data indicates that the third sub-group struggles even more with these areas due to discordance with their in-laws, lack of support from family members, and suspicion and poor communication with spouses. Although women with less agency have poorer outcomes, they appear to be able to better adapt to marital and familial expectations due to their low expectations and more patriarchal beliefs than women in the third sub-group who have high expectations that are not realized. By attempting to enact agency as a form of resistance in a non-supportive environment, women in the third sub-group have fewer options and resources than women in the second sub-group, as would be predicted by feminist anthropologists' understandings of agency in South Asian and Middle Eastern contexts.

Women in the third sub-group tend to be in the most precarious position in terms of sexual and reproductive health outcomes. In terms of family planning and reproduction, women in the third sub-group tend to know more about contraceptives because they have heard about them in school programs, from friends, or through the media. These women also have greater desire to use contraceptives both to delay their first pregnancy as well as for birth spacing and preventing unwanted pregnancies. However, they are frequently prevented from using contraceptives by husbands and/or in-laws who have less knowledge of contraceptives and believe that women should not have the ability to make their own fertility decisions. There is a lot of pressure on women in the third sub-group to prove their fertility and therefore prove that, in spite of having a love marriage, they are capable of being a good daughter-in-law and wife. Due to reproductive pressure, young women in this sub-group tend to have more unwanted pregnancies and abortions. In addition, women in this sub-group tend to have more difficulties obtaining healthcare for sexual and reproductive health issues, because they often lack familial support to obtain such healthcare.

Women in the third sub-group also have very mixed sexual health outcomes. Most women in this group tend to have incomplete knowledge of sex. They may have heard some of their friends discuss sex or they may have heard a little about menstruation or sex in school, but their understanding of the details is not as complete as women in the first sub-group. Thus, women in this sub-group have mixed first night experiences. For some, the first night is as traumatic as it is for women in the second sub-group, but for other women the first night is a more pleasant experience. Some women in this sub-group describe engaging in and enjoying a variety of sexual behaviors, however several women also state that their husbands expect them to engage in sexual behaviors (such as anal or oral sex) with which they are uncomfortable. Women in the third sub-group, particularly the ones with love marriages, also face a lot of suspicion from their husbands whenever they refuse sex. Their husbands accuse them of having other partners or missing boyfriends they might have had before marriage. In the India urban context, love marriages are not a guarantee of gender equity and better husband/wife communication.

Women in this sub-group have embrace globalized norms in which women delay marriage and make their own decisions. However, these women do so in a non-supportive cultural context, in which a love marriage often means forfeiting natal family support, and continued patrilocal living arrangements that result in her not being able to make her own decisions after marriage. Women in this sub-group attempt to use contraceptives and exercise control over their reproductive health, but with incomplete knowledge and support, this becomes difficult. Women in this group may also have more interest and ability to negotiate the sexual relationship but are limited by the patriarchal attitudes of their husbands.

Although India has policies and programs promoting women's agency and expanding sexual and reproductive health availability, these are unevenly implemented in the study area. This uneven implementation means that even if women attempt to enact agency as policies and programs encourage, without a supportive familial and cultural context, these women will have sexual and reproductive health outcomes very similar to those women in the second sub-group. In addition, due to these women's resistance against their husbands and in-laws, they will also experience increased abuse in addition to poor health outcomes.

It is important to note that these sub-groups are not seen as being internally homogenous, completely separated or fixed. There is a great deal of variation within sub-groups. Young women in these groups are not static or rigid, as the social context and young women's lives continue to change both as a result of societal changes and special experiences in their lives (e.g. becoming a more senior woman, getting sterilized and becoming free from the burdens of additional children (Brault et. al. in press), participating in an NGO and becoming a leader in advocacy efforts). However, these sub-groups have heuristic and practical applications, reaffirming the need to question stereotypes of the homogeneity of slum-dwelling women and to recognize important variations and needs.

The contributions of and to anthropological theory

Globalization has been described as the process in which western countries impose a capitalistic economy, subjugating low and middle income countries into economic handmaidens for western economies while at the same time creating economic opportunities that provide individuals and families

access to modernity and freedom from a rigid and inequitable normative cultural system. Globalization is crucial to this study as a perspective on the multiple forces that act on national economic systems, social norms, the political, legislative and judicial process, media and technology. It also illustrates in dramatic fashion, the inherent inequities in national systems that result in differential impact of globalization, illustrated in the women in this study. This research has shown that to receive any of the benefits of globalization, some degree of economic stability is needed; that is that families need the resources to "buy into globalization" in an effort to move into the middle class. In other words, families need the financial resources to provide daughters with more education and mobility, which in turn, enables families and young women to enact more gender equitable norms. When families fail to have that stability and are denied access to potential upward mobility, this study has shown that they are left with the alternative of replicating conservative cultural norms that result in a retreat from globalization.

The "three bodies" approach (Scheper-Hughes and Lock 1987) helps us see how individual, socio-cultural, and structural/political dynamics impact young women's sexual and reproductive health. The body politic and critical medical anthropology allow assessment of the dominant paradigm in India that calls for a consumer society concomitant with the growth of the middle class. Feminist theory encourages exploration of the ways in which the national and international emphasis on the rights of girls and women translates down to the differential impacts on agency in low income and slum communities.

The policies and programs that emerge from globalization as it is manifested in India have thus far failed to address underlying economic and gender inequities. As a result, there is less opportunity for women with limited economic stability to benefit from rights-based policies and new economic opportunities (Rashid 2011). It is not possible to respond positively to a "stay in school" message generated by an NGO if one's family lacks the money to pay for the associated costs or if a daughter's labor is needed to support the family economically. It is not pragmatic to delay a daughter's marriage in a setting where she is at risk for loss of *izzat* and therefore reduced chances of later marriageability. It also becomes difficult for these women to make health and reproductive choices when these choices depend on information and access to contraceptives that are limited by poor implementation of programs to

provide healthcare and health education resulting in multiple births, abortions, and sterilization. The body politic also illustrates that reproductive choices and options reflect the power and economic dynamics within India as the poor continue to have differential access (Rapp 2011; 2001; Ginsburg and Rapp 1991; Van Hollen 1998; Connelly 2008; Srinivasan 1995; Murthy, et al. 2002; Unnithan-Kumar 2010; Patel 2007; Van Hollen 2003). Globalization, through its emphasis on market economics and individual achievement, combined with inequitable resource distribution is replicating the capitalistic process where the "rich get richer" while the poor must cope with growing inequality.

At the level of the social body, cultural norms have long dictated how girls make the transition into marriage and adulthood—girls would receive preparation in becoming an obedient and competent wife in their natal family, the family would protect the girl's *izzat*, and arrange an appropriate marriage for their daughter. To ensure this trajectory, young women left school early and were restricted to limited social networks. After marriage, daughters would move to husband's families and leave natal families behind to take on prescribed responsibilities, and obediently perform the tasks required by husbands and in-laws. Cultural norms also dictated the "script" for the marital sexual relationship (Gagnon and Simon 1987; Desai and Adrist 2010) in which naïve girls would have a traumatic sexual debut on the "first night", the sexual relationship would be unenjoyable and primarily for purposes of conceiving children (especially sons), and women could meet their own sexual and reproductive expectations by not refusing sex and providing a sufficient number of male children.

As exhibited by the young women in subgroup 1 in this study, these sociocultural norms are changing. The push towards a more highly educated workforce that includes women means that these girls have the potential to stay longer in school and/or receive vocational training. More of these young women are also pursuing work opportunities outside the home before marriage. As a result, these young women are developing larger social networks and obtaining more information about sex and reproduction and are also increasingly delaying marriage. For these young women who have an arranged marriage and come from families where their educational aspirations have been supported, their families are seeking husbands from similarly-minded families. Due to the higher levels of education, larger social networks,

and more support, these young women continue to pursue their educational or employment aspirations after marriage. These women are also changing the traditional sexual script, as they have more information and know more of what to expect on the first and subsequent nights. They perceive sex as something that can be both consensual and enjoyable.

The individual body points to a set of young women from patriarchal and low-income families who seek to enter the global domain but have limited resources to "buy" their entry. In spite of their limited resources, these young women enact agency to resist the patriarchal norms of their natal family. These acts of resistance allow these young women to develop large social networks, pursue some of their educational and/or employment goals, have love marriages, and impetus to attempt to negotiate marital and sexual relationships. However, there are limits to these women's abilities to exercise their agency, particularly if their husband and/or in-laws have different notions of the extent to which a woman should be allowed to make her own decisions. In such restrictive settings, women attempting to practice agency face an uphill battle, with negative ramifications for their sexual and reproductive health outcomes. Although they may have larger social networks before marriage, by having a love marriage, they lose access to some of the support of family and community networks after marriage. These young women do not have as supportive a social context; they are caught between conservative social norms and the promises of gender equity offered by globalization. For these young women, the agency and access they seek is undermined by their deviation from traditional norms and their economic and social inability to access globalized resources.

The individual body is the place where women's different experiences and different practices of agency play an important role in their transitions to adulthood and health outcomes. Girls growing up with more resources and gender equitable norms have more opportunities to exercise agency in making decisions about education, employment and the timing of marriage. Women carry these experiences and practices into their marriage, enabling them to better negotiate the marital and sexual relationship. Girls growing up with fewer resources and who experience more restrictions have very limited opportunities to exercise agency both before and after marriage. These women perpetuate more patriarchal practices.

However, through perpetuating more patriarchal norms and performing the role of a "good" daughter and wife, these young women receive small benefits in terms of being able to continue receiving some limited support from their natal families after marriage and being able to delay their first pregnancy.

At the level of the "biological body", we can see how economic inequities and patriarchal norms contribute to biological processes to impact health outcomes. Economic instability in the natal family contributes to food insecurity and stunting/short stature of young women, which in turn, impacts her reproductive outcomes. In addition, natal family economics, natal family gender norms, and agency also impact women's post-marital health outcomes, including anemia, such that those women growing up in economically stable families with positive gender norms and high levels of agency have fewer health problems, including lower rates of anemia. These trends indicate that economic inequities and social norms can be manifested in an individual's biology and can play an interactive role in the adaptations of young women.

In this study, the life course approach created the opportunity to assess the impact of natal family dynamics and agency on the marital relationship and sexual and reproductive health. A key finding from both the qualitative and quantitative data was the impact of natal family gender equity and the agency that a young woman develops has on her marital relationships and sexual and reproductive health outcomes. In keeping with the life course approach, each of the sub-groups above represents a different cultural model held by the young woman's natal family and how these cultural models impact a young woman's agency and her socialization. These different levels of agency, in turn, impact different key events in a young woman's trajectory (such as leaving school, working, marriage, and motherhood). Whereas most researchers have looked at sexual and reproductive health outcomes as they are constituted in the marital relationship, the key contribution of the life course approach in this study is that the dynamics of the natal family significantly contribute to the adaptations and outcomes of women within marriage.

This chapter has viewed the experiences of young women through the lens of critical medical anthropological, feminist, and developmental theories to understand the differential sexual and reproductive outcomes of young women in a low-income area in Mumbai, India. This discussion

highlights that the impacts of globalization and changing Indian culture on young women's transitions cannot be understood through a single perspective. Rather, it is necessary to understand structural power dynamics, sociocultural contexts, and varied individual experiences, agency, and health from a longitudinal perspective. Although young women are experiencing new opportunities in a new national and cultural context oriented to promoting women's rights, these opportunities are unequally distributed, and young women caught between the new and the old are at particular risk. This study points to the need that the varied impact of globalization requires diverse and multilevel interventions to address the sexual and reproductive needs of young women in the study communities.

Conclusions

India is undergoing a period of rapid economic and social change, especially with respect to roles and norms for women. These changes are impacting young women and men as they make their transitions into adulthood. Using a mixed methods approach, the lives of young women have been examined in two low-income "slum" communities. This research has emphasized the ways in which young women's pre and post-marital experiences impacts on their physical, reproductive, and sexual health. At the same time, the emphasis on policies and programs that are directed toward women's development in India are being unevenly implemented, particularly for marginalized communities. As a result families with greater financial resources are able to use those resources to secure improved education, employment, and marriages for their daughters while those families with fewer resources are unable to obtain the same opportunities. While those families with greater resources move more easily into the globalization process, families with less resources to react to globalization and westernization more negatively and adhere to a more traditional adaptation involving patriarchal norms and a more restrictive role for girls and young women. The challenge for the future is to find ways in which girls and young women in families with limited economic resources can take advantage of the positive aspects of globalization. In particular, those young women caught between conflicting familial and societal expectations will need special attention to ease their transitions into adulthood.

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Appendix 1: Codes for qualitative analysis in Atlas.ti

See methods for definitions of key domains and measures.

Community Changes

Education

Globalization

Health_Other

Husband Communication and Support

Marital Agency

Marital Family Dynamics

Marital Family Gender Norms

Marital Family Relationships

Marriage Preparations and Arrangement

Menarche

Natal Family Agency

Natal Family Dynamics

Natal Family Economic Status

Natal Family Gender Norms

Reproductive Health

Sexual Health

Violence

Appendix 2: Survey Instrument

Married Young Women's Survey Instrument

Section:1 Demographic Factors

No.	Questions and filters	Coding categories		Skip to
1.1	What is your current age?	(In completed years)	_____	
1.2	What is the highest class/standard you have completed? ("0" for no school)	No. of classes	_____	
1.3	What is your religion?	Hindu Muslim Buddhist Christian	1 2 3 4	
1.4	Were you born in Mumbai?	Yes No	1 2	→ **1.6**
1.5	If no, at what age did you move to Mumbai?	(Age in Years)	_____	
1.6	What is your Native State?	WRITE IN	_____	
1.7	How long have you lived in this community?	Years/Months	_____/_____	
1.8	Age at Marriage	(In completed years)	_____	

Section 2: Natal Family Dynamics

No.	Questions and Filters	Coding Categories		
2.1	How old were you when you left school? (Enter N/A if did not attend school)	Age in years	_____	
2.	Why did you leave school? (If didn't attend school, ask this question to determine why they weren't allowed to attend school) 1=Yes 2=No	2. 2 Needed for household work	1 2	
		2.3 Needed for work outside home	1 2	
		2.4 Limited mobility	1 2	
		2. 5 Onset of menarche	1 2	
		2.6 Marriage	1 2	
		2.7 Family finances	1 2	
		2.8 Uninterested in school	1 2	
		2.9 Dangers in community	1 2	

		2.10 Failed your courses	1 2	
		2.11 Other _____	1 2	
2.	Who did you live with in your natal family? 1= Yes 2= No	2. 12 Mother	1 2	
		2.13 Father	1 2	
		2.14 Aunts	1 2	
		2.15 Uncles	1 2	
		2.16 Brothers	1 2	
		2.17 Sisters	1 2	
		2.18 Cousins	1 2	
		2.19 Grandmother	1 2	
		2.20 Grandfather	1 2	
2.21	How many female siblings did you have?	Number	_____	
2.22	How many male siblings did you have?	Number	_____	
2.23	What position were you in your family? (Enter 1 for eldest, 2 for 2nd, etc.)	Number	_____	
2.24	Were you treated differently from your female siblings in any of the following? 1= Yes, 2=No (If no sisters, write N/A here and move to the next question)	2. 24a More responsibilities	1 2	
		2.24b Allowed to attend school for less time	1 2	
		2. 24c Given less to eat	1 2	
		2.24d More rules and restrictions	1 2	
		2.24e Less mobility	1 2	
2.25	Were you treated differently from your male siblings in any of the following? 1= Yes, 2=No (If no brothers, write N/A here and move to the next question)	2.25a More responsibilities	1 2	
		2.25b Allowed to attend school for less time	1 2	
		2.25c Given less to eat	1 2	
		2.25d More rules and restrictions	1 2	
		2.25e Less mobility	1 2	
2.26	Before marriage, how often did you experience eve-teasing?	Often Sometimes Never	1 2 3	
2.27	Where did you experience eve-teasing?	Write-in	_____	
2.28	Did your father ever do any of the following (Write N/A if father did not live with family)	2.28a	Slap you?	1 2

	(1-No, 2-Yes)			
		2.28b	Twist your arm or pull your hair?	1 2
		2.28c	Push you, shake you, or throw something at you?	1 2
		2.28d	Punch you with their fists or with something that could hurt you?	1 2
		2.28e	Kick you, drag you or beat you up?	1 2
2.29	Did your mother ever do any of the following?	2.29a	Slap you?	1 2
		2.29b	Twist your arm or pull your hair?	1 2
		2.29c	Push you, shake you, or throw something at you?	1 2
		2.29d	Punch you with their fists or with something that could hurt you?	1 2
		2.29e	Kick you, drag you or beat you up?	1 2

Section 3: Food & Nutrition in the Natal Family (Before Marriage)

3.1	In your natal family, did you <u>ever</u> go to sleep at night hungry because there was not enough food?	Yes No	1 2	
3.2	In your natal family, did anyone else <u>ever</u> go to sleep at night because there wasn't enough food?	Yes No	1 2	
3.3	In your natal family did you <u>ever</u> go without eating the whole day because there was not enough food?	Yes No	1 2	

3.4	In your natal family did anyone else ever go without eating the whole day because there was not enough food?	Yes No	1 2	
3.5	Did you eat a vegetarian or non-vegetarian diet?	Veg Non-Veg	1 2	
3.6	If you eat a non-vegetarian diet, how often do you have fish/seafood?	Often Sometimes Never	1 2 3	
3.7	If you ate a vegetarian diet, how often did you have milk or curd/dahi?	Often Sometimes Never	1 2 3	
3.8	If you ate a non-vegetarian diet, how often do you have eggs?	Often Sometimes Never	1 2 3	
3.9	How did this amount of protein (eggs/milk/meat) compare to your father?	More than Same as Less than	1 2 3	
3.10	How did this amount of protein (eggs/milk/meat) compare to your mother?	More than Same as Less than	1 2 3	
3.11	How did this amount of protein (eggs/milk/meat) compare to your male siblings?	More than Same as Less than	1 2 3	
3.12	How did this amount of protein (eggs/milk/meat) compare to your female siblings?	More than Same as Less than	1 2 3	

Section 4: Onset of Menarche

4.1	At what age did you have your first menses?	Age in years	_____	
4.21	Did your parents give you new rules?	yes no	1 2	If no, skip to section 5

4.22	What new rules did you have? 1= yes, 2=no	4.22a Less Mobility	1 2	
		4.22b More responsibilities	1 2	
		4.22c Not allowed to speak to men/boys	1 2	
		4.22d Not allowed to attend school	1 2	
		4.22e Not allowed to speak to anyone outside family	1 2	
		4.22f Had to sit separate during menses	1 2	
		4.22g Not allowed to cook during menses	1 2	
		4.22h Not allowed to touch religious items (statues of gods/goddesses, Quran, etc.)	1 2	
		4.22i Required to wear a burqua/dupatta when outside	1 2	

Section:5 Natal Family Social Support and Social Networks (from SUBI)

		Not at all	To some extent	Very much
5.1	**Did you consider the other members of your natal family a source of help to you in finding solutions to most of the problems you had?**	1	2	3
5.2	Did you think that most of the members of your family felt closely attached to one another?	1	2	3
5.3	Did you think that you would be looked after well by other members of your family in case you were seriously ill?	1	2	3
5.4	Did you feel your relatives would help you out if you were in need?	1	2	3
5.5	Did you feel your friends would help you out if you were in need?	1	2	3
5.6	Did you sometimes worry about the relationship you and your family had?	1	2	3
5.7	Did you wish to have more friends than you actually have?	1	2	3
5.8	Did you sometimes feel that you lack a real close friend?	1	2	3
5.9	Did you sometimes worry that you did not have close personal	1	2	3

	relationships with other people?			

Section 6: Work in the natal family

	Questions and filters			
6.1	Did you work for cash (money) before marriage?	Yes No	1 2	**If no, skip to section 7.**
6.2	If yes, did you work in or outside the home?	Home-based worker Outside home Both	1 2 3	
6.3	What was the nature of your work? Write here the respondent's actual work) _____	Govt.job Private job Domestic servant Small or Petty Business Zari/Tikli industry worker Sewing/tailoring Teacher Daily wage Rag picker Other,Specify_____	1 2 3 4 5 6 7 8 9 10	
6.4	How much did you earn in a month (in Rs.)	Rupees	_____	

Section:7 Natal Family Agency SCALE

No.	**Questions and filters**	**Coding categories**		**Skip to**
7.1	Who in your family decided when it was time for you to get married?	Self Jointly with parents Parents Other family members	1 2 3 4	
7.2	Who in your family decided it was time for you to leave school (if respondent did not attend school, ask who decided that she could not attend school)?	Self Jointly with parents Parents Other family members	1 2 3 4	
7.3	If you wanted to buy yourself a small item of jewelry, such as a bangle/ would you feel free to do it without consulting your family?	Yes No	1 2	
7.4	If you worked in your natal family: Did you put aside money to spend as you wish?	Yes No	1 2	

7.5	Did you have access to a cell phone in your natal family (either own cell phone or shared with a family member)?	Yes No	1 2	If no, skip to 7.7
7.6	How often did you talk to a non-family member on the cell phone?	Often Sometimes Never	1 2 3	
7.7	Did you have access to the internet?	Yes No	1 2	
7.8	Did you watch tv/movies in your natal family?	Yes No	1 2	
7.9	Who decided what you watched?	Self Parents Jointly with Parents Other Family Members	1 2 3 4	
Did you have to ask a family member for permission to go to:				
7.10	The local market?	Yes No	1 2	
7.11	The local health center?	Yes No	1 2	
7.12	A place outside Shivajinagar (e.g. Sion Hospital)?	Yes No	1 2	
7.13	A community center, park, or plaza?	Yes No	1 2	
7.14	The home of relatives or friends in the community?	Yes No	1 2	
7.15	An event in the community (wedding, NGO or school programme, etc.)?	Yes No	1 2	
7.16	An event outside the community (wedding, NGO or school programme)?	Yes No	1 2	

Section:8 *TENSHUN in the Natal Family*

To what extent did concerns about the following cause you *tenshun* when you were in your natal family?		**Rating:** 1 = To a great extent 2 = To some extent 3 = Not at all
8.1	Family's financial situation	1 2 3
8.2	Pressure to get married	1 2 3
8.3	Details related to arrangement of marriage	1 2 3
8.4	Schoolwork or anything related to school	1 2 3
8.5	Continuing your education	1 2 3
8.6	Relationship with your parents	1 2 3
8.7	Relationship with your friends	1 2 3
8.8	Your reputation among neighbors (e.g. neighborhood gossip)	1 2 3
8.9	Household work/responsibilities	1 2 3
8.10	Eve-teasing in the community	1 2 3
8.11	Any other tensions? (write in)	_____ _____

Section 9 Natal Family Health Problems

Problems	**Had the problem in your natal family** **1= Yes 2= No**	**Treatment taken for this problem** **1=Yes 2=No**
Backache	9.1 1 2	9.2 1 2
Headache	9.3 1 2	9.4 1 2
Giddiness (Dizziness)	9.5 1 2	9.6 1 2
Pain in body	9.7 1 2	9.8 1 2
Loss of appetite	9.9 1 2	9.10 1 2
Chest pain	9.11 1 2	9.12 1 2

Palpitations	9.13 1 2	9.14 1 2
Pain in lower abdomen	9.15 1 2	9.16 1 2
Irregular menses	9.17 1 2	9.18 1 2
Pain or cramps during menses	9.19 1 2	9.20 1 2
Excessive bleeding from vagina	9.21 1 2	9.22 1 2
White discharge from vagina	9.23 1 2	9.24 1 2
Itching in and around vagina	9.25 1 2	9.26 1 2
Swelling in ankles	9.27 1 2	9.28 1 2
Body weakness	9.29 1 2	9.30 1 2
Sleeplessness	9.31 1 2	9.32 1 2
Fatigue	9.33 1 2	9.34 1 2
The lethargy	9.35 1 2	9.36 1 2
Constipation	9.37 1 2	9.38 1 2
Malaria	9.39 1 2	9.40 1 2
Tuberculosis	9.41 1 2	9.42 1 2
Diabetes	9.43 1 2	9.44 1 2
Anemia	9.45 1 2	9.46 1 2
Other Health Problems (write-in)	_____ _____	1 2 1 2

Section 10 Organization participation (Social and Political) in your natal family

No.	Question and filters	Coding categories		
10…	When you were in your natal family, did you participate in any of the following:	10.1	Youth mandals	1 2
		10.2	Sewing/Tailoring class	1 2
		10.3	Mehndi class	1 2
		10.4	Beauty parlor class	1 2
		10.5	Computer class	1 2
		10.6	NGOs/CBOs	1 2
		10.7	programmes	1 2
		10.8	Tuitions	1 2
		10.9	Informal cultural groups	1 2
		10.10	Religious groups	1 2
			Political parties	

Section 11 Pre-Marital Social Networks

Question and filters		Residence 1=in community 2=out of community	Relation-ship 1=family 2= friend/non-relative	Discuss family	Discuss HH issues	Discuss SRH	Discuss other topics
Before you were married, who were the people you talked to about anything (school, friends, movies/tv, family relationships, health, problems, etc.)? **Provide their initials, gender and approximate age.** Probe for people who might have been in the same groups woman said she participated in above.	1_____	1 2	1 2	1 2	1 2	1 2	- _____
	2_____	1 2	1 2	1 2	1 2	1 2	_____
	3_____	1 2	1 2	1 2	1 2	1 2	_____
	4_____	1 2	1 2	1 2	1 2	1 2	_____
	5_____	1 2	1 2	1 2	1 2	1 2	_____
	6_____	1 2	1 2	1 2	1 2	1 2	_____
	7_____	1 2	1 2	1 2	1 2	1 2	_____
	8_____	1 2	1 2	1 2	1 2	1 2	_____
	9_____	1 2	1 2	1 2	1 2	1 2	_____
	10_____	1 2	1 2	1 2	1 2	1 2	_____
	11_____	1 2	1 2	1 2	1 2	1 2	_____
	12_____	1 2	1 2	1 2	1 2	1 2	_____
	13_____	1 2	1 2	1 2	1 2	1 2	_____
	14_____	1 2	1 2	1 2	1 2	1 2	_____
	15_____	1 2	1 2	1 2	1 2	1 2	_____

Now, we will discuss your married life with your husband and his family.

Section: 12 <u>Husband</u>

No.	Questions and filters	Coding categories		Skip to
12.1	What is your Husband's age	In completed years	_____	

12.2	What is the highest grade he has completed? ("0" for no school)	No. of classes		
12.3	What is your husbands' Native State?	WRITE IN	_____	
12.4	Was he born in Mumbai?	Yes No	1 2	→12.6
12.5	If no, at what age did he move to Mumbai	Age in Years	_____	
12.6	How long he has been staying in this community?	In Years	_____	
12.7	What was your husbands' age at the time of marriage?	In completed years	_____	
12.8	What is your husband's religion?	Hindu Muslim Buddhist Christian	1 2 3 4	

No.	**Question and filters**	**Coding categories**	
12.9	Nature of your husband's work? (Write here the respondent's actual work) 12.9.1 _____	Not Working	00
		Daily Wage worker	01
		HMV driver	02
		LMV driver	03
		Business	04
		Petty trader	05
		Hawker	06
		Casual worker	07
		Construction worker	08
		Contractor	09
		Industrial worker	10
		Salaried Private	11
		Salaried Government	12
		OtherSpecify_____	13

12.10	How much does he earn in a month (in Rs.)? [if give daily wage, then confirm with her the # days he works per month and calculate Monthly] If husband doesn't work, then provide household income.	Rupees	_____
12.11	Whether your husband stays away from home overnight for work purposes?	More than once per week Once per week Once per month Rarely Never	4 3 2 1 0

Section:13 Household

No.	Questions and filters	Coding categories			Skip to
13.1	How many rooms are there in your household? (Including kitchen)		No. of Rooms	_____	
No.	**Questions and filters**	**Coding categories**			**Skip to**
13.2	Number of people in your current residence?			_____	
13..	Types of people in household: 1=Yes 2=No	13.3	Mother-in-law	1 2	
		13.4	Father-in-law	1 2	
		13.5	Husband's Siblings	1 2	
		13.6	Husband's sibling's spouses	1 2	
		13.7	Husband's sibling's children	1 2	
		13.8	Own children	1 2	
		13.9	Natal family	1 2	
13..	What household items do you have at home?	13.10	Refrigerator	1 2	
		13.11	Gas/kerosene stove	1 2	

	1=Yes 2=No	13.12	Washing machine	1 2	
		13.13	Motorcycle/ scooter	1 2	
		13.14	Bicycle	1 2	
		13.15	Shared mobile phone	1 2	
		13.16	Personal mobile phone (owned by woman)	1 2	
		13.17	Computer	1 2	
		13.18	Television	1 2	

Section:14 **WOMEN'S CURRENT LIFESTYLE**

No.	Questions and filters	Coding categories		Skip to
14.1	Do you work for cash (money)?	Yes	1	
		No	2	→ **14.6**
14.2	If yes, do you work in or outside the home?	Home-based worker	1	
		Outside home	2	
		Both	3	
14.3	What is the nature of your work? Write here the respondent's actual work) _____	Govt.job	1	
		Private job	2	
		Domestic servant	3	
		Small or Petty Business	4	
		Zari/Tikli industry worker	5	
		Sewing/tailoring	6	
		Teacher	7	
		Daily wage	8	
		Rag picker	9	
		Other,Specify_____ ___	10	
14.4	How much do you earn in a month (in Rs.)	Rupees	_____	

14.5	Who decides how to spend your earnings?	Self Jointly with Husband Husband Other Family members	1 2 3 4	

Financial Power

14.6	Do you have a bank account?	Yes No	1 2	

Section 15 Food & Nutrition in the Marital Family (after marriage)

15.1	In your marital family did you <u>ever</u> go to sleep at night hungry because there was not enough food?	Yes No	1 2	
15.2	In your marital family, did you <u>ever</u> go without eating the whole day because there was not enough food?	Yes No	1 2	
15.3	In last one month, did you go to sleep at night hungry because there was not enough food?	Yes No	1 2	
15.3a	If yes, how many times did this happen in the last one month?	Number	———	
15.4	In the last one month, did you go without eating the whole day because there was not enough food?	Yes No	1 2	
15.4a	If yes, how many times did this happen in the last one month?	Number	———	
15.5	Do you eat a vegetarian or non-vegetarian diet?	Veg Non-Veg	1 2	
15.6	If you eat a non-vegetarian diet, how often do you have fish/seafood?	Often Sometimes Never	1 2 3	
15.7	If you eat a non-vegetarian diet, how often do you have eggs?	Often Sometimes Never	1 2 3	

15.8	If you eat a vegetarian diet, how often do you have milk or curd/dahi?	Often Sometimes Never	1 2 3	
15.9	How did this amount of protein (milk/egges/meat) compare to your husband?	More than Same as Less than	1 2 3	
15.10	How did this amount of protein (milk/eggs/meat) compare to your father-in-law?	More than Same as Less than	1 2 3	
15.11	How did this amount of protein (eggs/milk/meat) compare to your mother-in-law?	More than Same as Less than	1 2 3	
15.12	When do you usually take your meals?	Before other family members Same time as other family member After other family members	1 2 3	
15.13	If you take your meals after everyone else, do you eat less, because there is not enough food?	Yes No	1 2	

Section 16 Organization participation (Social and Political) in your marital family

No.	Question and filters	Coding categories			
15…	Since you have been married, have you participated in any of the following:	16.1	Mahila mandals	1	2
		16.2	Bachat Gut	1	2
		16.3	Chitfund/B.C.	1	2
		16.4	Credit cooperative society	1	2
		16.5	NGOs/CBOs	1	2
		16.6	Political party	1	2
		16.7	Informal cultural groups	1	
		16.8	Religious groups	2	
				1	2

Section 17 Post-Marital Social Networks

Question and filters		Residence 1=in community 2=out of community	Relation-ship 1=family 2= friend/non-relative	Discuss family	Discuss HH issues	Discuss SRH	Discuss other topics
After you were married, who were the people you talked to about anything (community, friends, movies/tv, family relationships, health, problems, etc.)? **Provide their initials, gender (M/F) and approximate age.** Probe for people who might have been in the same groups woman said she participated in above.	1_____	1 2	1 2	1 2	1 2	1 2	-_____
	2_____	1 2	1 2	1 2	1 2	1 2	_____
	3_____	1 2	1 2	1 2	1 2	1 2	_____
	4_____	1 2	1 2	1 2	1 2	1 2	_____
	5_____	1 2	1 2	1 2	1 2	1 2	_____
	6_____	1 2	1 2	1 2	1 2	1 2	_____
	7_____	1 2	1 2	1 2	1 2	1 2	_____
	8_____	1 2	1 2	1 2	1 2	1 2	_____
	9_____	1 2	1 2	1 2	1 2	1 2	_____
	10_____	1 2	1 2	1 2	1 2	1 2	_____
	11_____	1 2	1 2	1 2	1 2	1 2	_____
	12_____	1 2	1 2	1 2	1 2	1 2	_____
	13_____	1 2	1 2	1 2	1 2	1 2	_____
	14_____	1 2	1 2	1 2	1 2	1 2	_____
	15_____	1 2	1 2	1 2	1 2	1 2	_____

Section: 18 INFORMATION ON Marriage

18.1	Was your marriage?	Love Arranged	1 2	If love, skip to section 19

18.2	If arranged did you meet your husband prior to the ceremony?	Yes No	1 2	
18.3	Did you agree to the marriage?	Yes No No voice	1 2 3	
18.4	Was dowry given?	Yes No	1 2	

Section:19 Husband Help and Support

No.	Questions and filters		Coding categories		
19…	In the last three months, has your husband been involved in… 1= R: Regularly 2= S: Sometimes 3= N: Never	19.1	Cooking	1 2 3	
		19.2	Fetching water from common tap	1 2 3	
		19.3	Washing clothes	1 2 3	
		19.4	Washing utensils	1 2 3	
		19.5	Home cleaning	1 2 3	
		19.6	Taking family members to the doctor	1 2 3	
		19.7	Purchasing vegetables and groceries	1 2 3	
		19.8	Payment of electricity bill	1 2 3	
		19.9	Going to ration shop	1 2 3	
		19.10	Taking care of children	1 2 3	
19.11	Do you listen to your husband's suggestions in family matters/HH work?		Always Sometimes Never	1 2 3	
19.12	Does your husband listen to your suggestions in family matters/HH work?		Always Sometimes Never	1 2 3	
19.13	Do you talk to your husband about your problems?		Always Sometimes Never	1 2 3	

19.14	Does your husband talk with you about his problems?	Always Sometimes Never	1 2 3
19.15	Do you discuss about sex freely with your husband?	Always Sometimes Never	1 2 3
19.16	Does he discuss sex freely with you?	Always Sometimes Never	1 2 3
19.17	Do you share your feelings with your husband?	Always Sometimes Never	1 2 3
19.18	Does your husband share his feelings with you?	Always Sometimes Never	1 2 3

Section:20 Marital Social Support and Social Networks (from SUBI)

		Not at all	To some extent	Very much
20.1	**Do you consider the other members of your household a source of help to you in finding solutions to most of the problems you have?**	1	2	3
20.2	Do you think that most of the members of your household feel closely attached to one another?	1	2	3

20.3	Do you think that you would be looked after well by other members of your household in case you were seriously ill?	1	2	3
20.4	Do you feel your friends/relatives would help you out if you were in need?	1	2	3
20.5	Do you sometimes worry about the relationship you and your husband have?	1	2	3
20.6	Would you wish to have more friends than you actually have?	1	2	3
20.7	Do you sometimes feel that you lack a real close friend?	1	2	3
20.8	Do you sometimes worry that you do not have close personal relationships with other people?	1	2	3

Section:21 Marital Agency SCALE

No.	Questions and filters	Coding categories	
21.1	Please tell me who in your family decides the following: whether to purchase major goods for the household, such as a TV/refrigerator	Self Jointly with Husband Husband Other Family members Jointly with All Family Members	1 2 3 4 5
21.2	Please tell me who in your family decides the following: whether you can work outside the home?	Self Jointly with Husband Husband Other family members Jointly with All Family Members	1 2 3 4 5
21.3	Please tell me who in your family decides the following: whether you can seek treatment for a health problem?	Self Jointly with Husband Husband Other family members Jointly with All Family Members	1 2 3 4 5

21.4	Please tell me who in your family decides the following: how many children to have?	Self	1
		Jointly with Husband	2
		Husband	3
		Other family members	4
		Jointly with All Family Members	5
21.5	If you wanted to buy a dress/sari for yourself, would you feel free to do it without consulting your husband (or a senior member of your family)?	Yes	1
		No	2
21.6	If you wanted to buy a small item of jewelry, such as a bangle, for yourself would you feel free to do it without consulting your husband (or a senior member of your family)?	Yes	1
		No	2
21.7	Does your husband give you his salary?	On regular basis	1
		Only when asked	2
		Does not give at all	3
21.8	Do you put aside money to spend as you wish?	Yes	1
		No	2
21.9	The local market?	Yes	1
		No	2
21.10	The local health center for your own health problems?	Yes	1
		No	2
21.11	The local health center for your children's health problems?	Yes	1
		No	2
21.12	A place outside Shivajinagar/Mankhurd (e.g. Sion Hospital)?	Yes	1
		No	2
21.13	A community center, park, or plaza in the community?	Yes	1
		No	2
21.14	The home of relatives or friends in the community your natal place?	Yes	1
		No	2

Section 22: Women's Marital Health Problems

Problems	Had the problem in the last three months 1= Yes 2= No	Treatment taken for this problem in the last three months 1=Yes 2=No
Backache	22. 1 1 2	22. 2 1 2
Headache	22.3 1 2	22.4 1 2
Giddiness (Dizziness)	22.5 1 2	22.6 1 2
Pain in body	22.7 1 2	22.8 1 2
Loss of appetite	22.9 1 2	22.10 1 2
Chest pain	22.11 1 2	22.12 1 2
Palpitations	22.13 1 2	22.14 1 2
Pain in lower abdomen	22.15 1 2	22.16 1 2
Swelling of glands in the groin	22.17 1 2	22.18 1 2
Irregular menses	22.19 1 2	22.20 1 2
Pain or cramps during menses	22.21 1 2	22.22 1 2
Excessive bleeding from vagina	22.23 1 2	22.24 1 2
Infertility	22.25 1 2	22.26 1 2
Obstructed urine flow	22.27 1 2	22.28 1 2
Pain while urinating	22.29 1 2	22.30 1 2
Burning urination	22.31 1 2	22.32 1 2
White discharge from vagina	22.33 1 2	22.34 1 2
Ulcers in and around vagina	22.35 1 2	22.36 1 2
Itching in and around vagina	22.37 1 2	22.38 1 2
Swelling in ankles	22.39 1 2	22.40 1 2
Pain during intercourse	22.41 1 2	22.42 1 2
Sexual dissatisfaction	22.43 1 2	22.44 1 2
Loss of sexual desire	22.45 1 2	22.46 1 2
Body weakness	22.47 1 2	22.48 1 2

Sleeplessness	22.49 1 2	22.50 1 2
Increased frequency of micturation	22.51 1 2	22.52 1 2
Fatigue	22.53 1 2	22.54 1 2
The lethargy	22.55 1 2	22.56 1 2
Constipation	22.57 1 2	22.58 1 2
Malaria	22.59 1 2	22.60 1 2
Tuberculosis	22.61 1 2	22.62 1 2
Diabetes	22.63 1 2	22.64 1 2
Anemia	22.65 1 2	22.66 1 2
Other Health Problems (write-in)	22.67_____ 22.69_____	22.68 1 2 22.70 1 2

Section:23 *TENSHUN in the Marital Family*

To what extent did <u>concerns about the following</u> cause you *tenshun* when you were in your natal family?		**<u>Rating</u>:** 1 = To a great extent 2 = To some extent 3 = Not at all
23.1	Household finances	1 2 3
23.2	Relationship with in-laws (expectations, conflict, etc.)	1 2 3
23.3	Your children (education, health, future, etc.)	1 2 3
23.4	Pressure to have a baby boy	1 2 3
23.5	Your daughter (behavior, future marriage, etc.)	1 2 3
23.6	Abuse/harassment from your husband (violence, suspicion, arguing, etc.)	1 2 3
23.7	Husband's alcohol use	1 2 3
23.8	Communication with your husband	1 2 3
23.9	Sexual Relationship with your husband	1 2 3
23.10	Pressure from husband or family to have children/more chidren	1 2 3
23.11	Your reputation among neighbors (e.g. neighborhood gossip)	1 2 3
23.12	Obtaining/preparing enough food for your family / self	1 2 3
23.13	Relationship to natal family	1 2 3

23.14	Water Problem	1 2 3
23.15	Unhealthy environment (bad smell, garbage, fly etc.)	1 2 3
23.16	Husband's extramarital sex	1 2 3
23.17	Anti-social elements in community (boys/men tease girls/women; harassment to move out or pay rent or electricity illegally; theft)	1 2 3
23.18	Any other tensions? (write-in)	_____ _____

Section:24 MARITAL RELATIONSHIP

No.	Questions and filters	Coding categories	
24.1	How would you describe your marital relationship?	Very Happy	1
		Somewhat happy	2
		Neither happy nor unhappy	3
		Somewhat unhappy	4
		Very unhappy	5

When your husband gets angry does he:

No.	Questions and filters	Coding categories	
24.2	Insult and humiliate you?	Always	1
		Sometimes	2
		Never	3
24.3	Yell at you	Always	1
		Sometimes	2
		Never	3
24.4	Does he criticize you?	Always	1
		Sometimes	2
		Never	3
24.5	Does he nag you?	Always	1
		Sometimes	2

		Never	3
24.6	Are you able to disagree with each other without becoming angry?	Always Sometimes Never	1 2 3

Section 25: MARITAL VIOLENCE from Husband and In-laws

No.	Questions and filters		Coding categories	
25…	First, I am going to ask you about some situations which happen to some women. Please tell me if these apply to your relationship with your husband. 1=Yes 2=No	25.1	He is jealous or angry if you talk to other men.	1 2
		25.2	He frequently accuses you of being unfaithful.	1 2
		25.3	He does not permit you to meet your female friends.	1 2
		25.4	He tries to limit your contact with your natal family.	1 2
		25.5	He insists on knowing where you are at all times.	1 2
		25.6	He (does/did) not trust you with any money.	1 2
		25.7	He says or does something to humiliate you in front of others	1 2
		25.8	He threatens to hurt or harm you or someone close to you	1 2
25….	Did your husband ever do any of the following How often did this happen in the past 12 months (1 –often, 2 – Sometimes 3-Never)	25.9	Slap you?	1 2 3
		25.10	Twist your arm or pull your hair?	1 2 3
		25.11	Push you, shake you, or throw something at you?	1 2 3
		25.12	Punch you with his fist or with something that could hurt you?	1 2 3
		25.13	Kick you, drag you or beat you up?	1 2 3
		25.14	Physically force you to have sexual intercourse with him even when you did not want to do	1 2 3
		25.15	Force you to perform any sexual acts you did not want to?	1 2 3

25…	Did any of your in-laws ever do any of the following: How often did this happen in	25.16	Slap you?	1 2 3
		26.17	Twist your arm or pull your hair?	1 2 3
		25.18	Push you, shake you, or throw	1 2 3

	the past 12 months? (1—Often, 2—Sometimes, 3—Never) If doesn't have any in-laws, write N/A and move to next section.		something at you?	
		25.19	Punch you with his fist or with something that could hurt you?	1 2 3
		25.20	Kick you, drag you or beat you up?	1 2 3
		25.21	Insult and humiliate you?	1 2 3
		25.22	Threaten to have your husband divorce you?	1 2 3
		25.23	Harass you due to insufficient dowry?	1 2 3

Section: 26 Alcohol and Tobacco Use (Husband)

	Question and filters		**Coding categories**		**Skip to**
26.1	Does your husband currently eat tobacco or smoke cigarettes (tobacco paan or Mishri or Mawa)?		Yes No	1 2	
26.2	Does your husband drink alcohol?		Yes No	1 2	 →next section
26.3	During the past 30 days, how many days did he drink?		Number of days (Code 0 for never)	 _____ _	
26.4	How many times in the past 30 days, did he come home heavily drunk?		Number of days (Code 0 for never)	 _____ _	
26.5	During the past 12 months, did your husband's expenditures alcohol leave the family with inadequate money for household maintenance (i.e. food, educational fees, clothing)?		Many times Sometimes Rarely Never	1 2 3 4	
26….	During the past 12 months, did your husband's alcohol use lead him to be abusive toward you?	26.6 26.7 26.8 26.9	Emotional abuse Physical abuse Sexual abuse Verbal abuse	1 2 1 2 1 2 1 2	

Section 27: Women's tobacco use (If no tobacco use, move to next section):

Please tell me whether you currently use any of the following products, and how often you use them.

	Mishri	Paan with tobacco	Gutkha	Chewed tobacco packet	Chewed tobacco loose
27… How many days in last 7 days have you used this product**?** Actual number of days----------	27. 1	27.2	27.3	27.4	27.5
27... On an average day when you use it how many times did you use it? (Exact Number)	27.6	27.7	27.8	27.9	27.10

Section 28 SEXUAL HEALTH					
Birth Control and Reproductive Decision-making Reproductive History					
28.1	**Total number of pregnancies**		Number	_____	If 0, 28.13
28.2	Number of live births		Number	_____	
28.3	Number of living children		Number	_____	
28.4	Number of stillbirths		Number	_____	
28.5	Number of unintended / unwanted pregnancies		Number	_____	
28.6	Number of MTPs/Induced Abortion		Number	_____	
28.7	Number of spontaneous abortions		Number	_____	
28.8	Number of children who died within the first year		Number	_____	
28.9	Number of C-sections		Number	_____	
28.10	Number of children who died after the first year		Number	_____	
28.11	**Your age at first pregnancy**		Number	_____	
28.12	**Number of pre-natal/antenatal visits before 1st pregnancy**		Number	_____	
Birth Control Methods					
28.13	**Have you ever**	Yes	1	If no, skip 28.17	

	used any kind of contraceptive method to delay or stop pregnancy?	No	2→		**Section 29: Marriage and marital sex**
28.14	**Are you currently using any contraception (including female sterilization)?**	Yes No	1 2→	If no, skip to 28.17	
28.15	**What is the type of current method?**	Oral Pills Copper-T/IUD Nirodh/Condom Safe period Withdrawal Male Sterilization Female Sterilization	1 2 3 4 5 6 7		
28.16	**If sterilized, at what age you were sterilized?**	(age in completed years)	_____		
28.17	**Who decides whether or not you and your husband use contraception?**	Myself Husband Both Others specify_____	1 2 3 4		

29.	On the first night of marriage, did your husband… 1= Yes 2= No	29.1 29.2 29.3 29.4 29.5 29.6	Make you feel comfortable Wait till you were mentally prepared Explained what would happen Initiated sex Wait till you initiated sex Force you for sex	1 2 1 2 1 2 1 2 1 2 1 2	

29.7	Was the experience	Positive Somewhat positive Not positive at all	1 2 3	

Questions and filters	**Coding categories**	
29. 8 How many times did you have penetrative sexual intercourse with your husband in the last one month?	(No. of times)	|___|___| **If not 00**
29.9 How often do you initiate sex with your husband?	Always Sometimes Never	1 2 3
29.10 Can you refuse if your husband demands sex and you don't want it?	Always Sometimes Never	1 2 3
29.. When you and your husband have sex, have you done any of the following: 1=yes, 2=no	29.11 Stroking hair	1 2
	29.12 Keeping leg on body	1 2
	29.13 Husband keeping leg on body	1 2
	29.14 Husband lying on wife	1 2
	29.15 Kissing lips	1 2
	29. 16 Tickling	1 2
	29.17 Caressed body parts	1 2
	29.18 Kissing body	1 2
	29.19 Husband caressing breast	1 2
	29.20 Kissing with tongue	1 2
	29.21 Husband kissing breast	1 2

	29.22 Touching genitals with hands	1 2
	29.23 Saw husband's genitals	1 2
	29.24 Removed clothes fully	1 2
	29.25 Penis in vagina	1 2
	29.26 Masturbated husband	1 2
	29.27 Get masturbated by husband	1 2
	29.28 Oral sex with husband	1 2
	29.29 Receiving oral sex from husband	1 2

Section: Sexual Symptom Questions

Have you ever experienced:	Yes, I do, currently	Yes, I have, in the past	No, never
29.30 A lack of interest in sexual activity	1	2	3
29.31 A lack of lubrication	1	2	3
29.32 Taking a long time to get aroused	1	2	3
29.33 Pain or discomfort during sexual activity	1	2	3
29.34 Difficulty achieving orgasm	1	2	3
29.35 Lack of privacy for sexual activity	1	2	3
29.36 Ever refused sex because of lack of water/toilet facilities	1	2	3

Section 30: <u>Sexually Transmitted Disease Knowledge Scale</u> **Answer: Correct ( ) Incorrect ( )**	**Correct (1)**	**Incorrect (2)**	**Don't know (3)**
30.1 Only bad people get sexually transmitted diseases.	1	2	3
30.2 If anybody has signs of a sexually transmitted disease he/she should get an antibiotic from the chemist	1	2	3
30.3 Having a sexually transmitted disease increases the chances of getting AIDS.	1	2	3
30.4 Condoms cannot protect against a sexually transmitted disease.	1	2	3
30.5 When persons have an STD, They should use a condom while having sex.	1	2	3
30.6 I can tell by appearance if someone has a sexually transmitted disease.	1	2	3
30.7 A person can get a sexually transmitted disease from an unclean public toilet.	1	2	3
30.8 If a person takes an antibiotic before having sex it cannot prevent a sexually transmitted disease.	1	2	3
30.9 HIV can be spread by using someone else's personal belongings, like a comb or a hairbrush.	1	2	3
30.10 A person can get HIV from casual contact (such as shaking hands, coughing, using the same toilet seat) with people who have the disease.	1	2	3
30.11 HIV can be spread through hugging.	1	2	3
30.12 HIV can be spread from a female to her unborn child during pregnancy.	1	2	3

Section 31: Husband's EMS/Sexual History

31.1	To your knowledge, has your husband had pre-marital sex with a woman?	Yes No Don't know	1 2 3
31.2	Had extra-marital sex with a woman?	Yes No Don't know	1 2 3
31.3	Had sex with sex workers?	Yes No Don't know	1 2 3
32.4	Is he currently involved in sex with other women?	Yes No Don't know	1 2 3

Section 32: Perceived Sexual Risk

32.1 How possible is it that you might get a sexually transmitted disease.	High	1
	Low	2
	No risk	3
	Don't know	4
32.2 How possible is it that your husband might get a sexually transmitted disease.	High	1
	Low	2
	No risk	3
	Don't know	4

Sr. No.	**Norms**	**(1)** Strongly agree	**(2)** Agree	**(3)** Disagree	**(4)** Strongly disagree
33.1	A wife should eat after her husband and children have had their food.	1	2	3	4
33.2	A woman should always be ready whenever husband wants to have sex.	1	2	3	4
33.3	A woman should obtain permission for treatment from the husband for any kind of health problems.	1	2	3	4
33.4	A wife should manage the household with whatever money the husband gives.	1	2	3	4
33.5	A woman is responsible for her poor health.	1	2	3	4
33.6	A man should have control over his wife.	1	2	3	4
33.7	A woman should work only with other women outside of the house.	1	2	3	4
33.8	If wife disobey husband she should be sent to her maternal home (as punishment).	1	2	3	4
33.9	A woman can beat/hit her husband whenever her husband beats her.	1	2	3	4
33.10	Only man is responsible for household finance.	1	2	3	4
33.11	Woman can get spoiled if she goes out of her home	1	2	3	4
33.12	A wife should take permission from the husband when she goes any where out of house.	1	2	3	4
33.13	A wife should think about her husband and children's health before her.	1	2	3	4
33.14	Women's engage in sex only for men's satisfaction.	1	2	3	4
33.15	Status of women is lower than man.	1	2	3	4
33.16	If a husband is angry he can yell at his wife.	1	2	3	4
33.17	A wife should always criticize husband's bad behavior.	1	2	3	4
33.18	A woman should talk about her health	1	2	3	4

	problems only with other women.				
33.19	Woman should always cover their head/wear burkha/dupatta before stepping out of the house.	1	2	3	4
33.20	A husband should only talk about household work and childcare issues with the wife.	1	2	3	4
33.21	If a husband beats his wife, she should not share it with anyone.	1	2	3	4
33.22	Only the wife is responsible for all house hold work.	1	2	3	4
33.23	A man can spend any amount of time with his friends, as he wishes.	1	2	3	4
33.24	A woman should finish all the household work before taking rest.	1	2	3	4
33.25	Husband is a woman's pride	1	2	3	4
33.26	woman is responsible for reputation, honor, respect of the family.	1	2	3	4
33.27	A woman can participate in community activity as per her wish.	1	2	3	4
33.28	A woman can talk to men other than her husband	1	2	3	4
33.29	A wife can be beaten up if she does not listen to (obey) her husband.	1	2	3	4

No.	Questions	Coding categories	
35.1	Height	Write-In cm	_____
35.2	Weight (Note: do not collect if pregnant) If pregnant, write N/A	Write-In kg.	_____
35.3	Body fat (Note: do not collect if pregnant) If pregnant, write N/A	Write-In	_____
35.4	Hb value from hemocue		_____
35.5	Hair collected?		1 Yes 2 No
35.6	Verbal Permission to Collect Hair from Husband?		1 Yes 2 No (declined) 3 No (Husband is outside of Mumbai)

DHANYAWAD (Thank you)

Appendix 3: List of items from scales

Natal Family Econ/Food Security Status scale (5 items; alpha .845)

- Young woman ever went to sleep hungry in natal family
- Anyone ever go to sleep hungry in natal family
- Young woman ever went without eating for a whole day in natal family
- Anyone ever went without eating for a whole day in natal family
- Natal Family Financial Tenhun

Gender Inequity scale items (31 items in all; alpha .773):

- Physical health
- Left or quit school: needed HH work
- Left or quit school: needed for work outside home
- Left or quit school: limited mobility
- Left or quit school: marriage
- Left or quit school: family finances
- Left or quit school: dangers in community
- Treated diff from male sibs: more responsibilities
- Treated diff from male sibs: allowed to attend school for less time
- Treated diff from male sibs: more rules and restrictions

Natal family agency scale items (16 items in all; alpha .730)

- Had to ask permission to go to local market
- Had to ask permission to go to local health center
- Had to ask permission to go to place outside of SN/Mankhurd
- Had to ask permission to go to community center, park or plaza
- Had to ask permission to go to home of relatives/friends in community
- Had to ask permission to go to event inside the community
- Had to ask permission to go to event outside the community
- Participation Mehndi class
- Participation Sewing class
- Who decided when you left school
- Who decided what tv/movies you watched
- Who decided when you got married
- Talking to non-family members on the phone
- Working for cash before marriage
- Could purchase small items if wanted
- Could put aside money if wanted

Post-marital Agency (9 items; alpha .714)

- Had to ask permission to go to local market
- Had to ask permission to go to local health center for own health problems
- Had to ask permission to go to local health center for children's health problems
- Had to ask permission to go to place outside of SN/Mankhurd
- Had to ask permission to go to community center, park or plaza
- Had to ask permission to go to natal place
- Who decides whether to buy large household items
- Who decides how many children to have
- Who decides if you can work outside home

Possible combined agency scale (22 items; alpha=.709)

- Please tell me who in your family decides whether to purchase major goods
- Please tell me who decides how many children to have
- If wanted to buy dress/sari for self would have to ask husband

- If wanted to buy small item of jewelry like bangle would have to ask husband
- Marital mobility questions
- Does husband give salary
- Marital do you put aside money
- Who decided when it was time to get married
- Who decided when you should leave school
- Natal family if wanted to buy small jewelry could without asking permission
- Natal family mobility questions

Sexual Health Scale Based on Mehrotra, et al 2014 paper (with very minor adjustments, 32 items; alpha=.803)

- Problems with sexual dissatisfaction
- Problems with loss of sexual desire
- All STI/HIV Knowledge Questions Recoded
- Husband forces sexual intercourse
- Husband forces you to perform sexual acts you don't want to
- Wife discusses sex with husband
- Husband discusses sex with wife
- The sexual relationship is a source of tenshun
- Husband's EMS is a source of tenshun
- Currently using contraception (including sterilization)
- Can initiate sex with husband
- Can refuse sex
- Ever experience lack of lubrication
- Ever experience taking a long time to get aroused
- Ever experience pain or discomfort during sex
- Ever experience difficulty achieving orgasm
- Ever experience lack of privacy
- Possibility of getting STD/HIV—self
- Possibility of getting STD/HIV—husband
- GES item, Husband should be ready whenever husband wants sex
- GES item, Women engage in sex only for men's satisfaction

Sexual and Reproductive Health Scale (same as above, with added items below; reliability of .769)

- Total number of pregnancies
- Number of C-sections
- Hb value
- BMI
- Number of ANC visits

Revised Gender Equity/Marital Agency combined construct (38 items; alpha .857)

- All GES scale questions
- Dichotomized who decides whether to buy large goods
- Dichotomized who decides if you can work outside home

- Have to ask permission to go to market
- Have to ask permission to go to hlth center for own problems
- Have to ask permission to go to hlth center for child's health problems
- Have to ask permission to go to place outside community
- Have to ask permission to go to place in community
- Have to ask permission to go to home of friends or relatives
- Corrected dichotomized who decides how many children to have

Reproductive health scale separated from sexual health (29 items; alpha .832)

- Dichotomized total number of pregnancies
- Dichotomized total number of miscarriages
- Dichotomized total number of C-sections
- Dichotomized age at first pregnancy
- Dichotomized number of MTPs/abortions
- Dichotomized Hb value
- Dichotomized BMI
- Health problem backache
- Health problems headache
- Health problem pain in body
- Health problem loss of appetite
- Health problem chest pain
- Health problem palpitations
- Health problem pain in lower abdomen
- Health problem swelling of glands in the groin
- Health problem irregular menses
- Health problems pain or cramps during menses
- Health problems excessive bleeding from vagina
- Health problems pain while urinating
- Health problems burning urination
- Health problems white discharge
- Health problems itching in and around vagina
- Health problems swelling in ankles
- Health problems body weakness
- Health problems sleeplessness
- Health problems increased frequency of micturation
- Health problems fatigue
- Health problems lethargy
- Health problems constipation

Marital Verbal Abuse (13 items; alpha= .834)

- Husband gets jealous or angry if talk to men
- Husband accuses you of being unfaithful
- Husband doesn't permit to meet female friends
- Husband tries to limit your contact with natal family

- Husband insists on knowing where you are at all times
- Husband does not trust you with any money
- Husband does or says something to humiliate you in front of others
- Husband threatens to hurt or harm you or someone close to you
- Husband insults and humiliates
- Husband yells at you
- Husband criticizes you
- Husband nags you
- Able to disagree without becoming angry

Marital Physical Abuse (5 items; alpha= .904)

- How often husband slaps you
- How often husband twists your arm or pulls your hair
- How often husband pushes, shakes, or throws things at you
- How often husband punches you with fist or something that could hurt you
- How often husband kicks you, drags you, beats you up

Marital GES & Agency (38 items; alpha= .841)

- All Marital GES questions
- All mobility questions
- Purchasing power
- Who decides whether can work outside the home
- Who decides how many children to have

Marital Health Problems (29 items; alpha= .798)

- All physical health problems except for sexual problems or low frequency health problems

Marital Communication and Husband Help Scale, not dichotomized (16 items, alpha .805)

- Husband has helped with household chores (all items)
- Do you listen to husband's suggestions in family matters/HH work
- Does your husband listen to your suggestions in family matters/HH work
- Do you talk to your husband about your problems
- Does your husband talk to you about your problems
- Do you share your feelings with your husband
- Does your husband share your feelings with you